



# Health Report

Health Policy

## Sustainable Governance Indicators 2018

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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.

### Canada

Score 8

Like educational policy, health care is primarily the responsibility of the individual provinces. Canadians are generally in good health, as evidenced by the high and rising level of life expectancy.

The most glaring problem with the Canadian system is timely access to care. The number of practicing doctors and hospital beds per 1,000 inhabitants is well below the OECD average, as is the number of MRI and CT units per million (OECD, *Health at a Glance 2015*). In a recent study by the Commonwealth Fund surveying 11 high-income countries, Canada ranked last for providing timely access to care. Canadians regularly experience long waiting times for medical care, including access to family doctors, specialists and emergency services. The Canadian Institute for Health Information reported in 2017 that over the last several years waiting times for elective or less urgent procedures have increased, despite efforts to reduce the waiting times. However, for more urgent procedures there has been an increase in the number of patients receiving care within the medically acceptable benchmark, albeit with considerable variation across the provinces.

Inefficiencies in the system have led to patients traveling abroad to receive medical treatment and increased demand for domestic for-profit clinics, which endangers Canada's otherwise impressive record of equity in health care. A recent report by the Fraser Institute estimated that over 63,000 Canadians received non-emergency medical treatment outside Canada in 2016. Lack of income, on the other hand, is not a barrier to treatment, with high-quality care freely provided for virtually the entire population. One effect of equity in access to health care services is the small gap in perceived health between the top and bottom income quintiles. However, since dental care, eye care and drugs prescribed for use outside of hospitals are excluded

from general coverage, not all income groups have equal access to these types of health care services – low-income Canadians are far more likely to decline prescriptions or skip dental visits.

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.

Overall, Canada’s health care system outperforms the United States but trails behind that of comparable European countries (e.g., Germany, the United Kingdom and the Netherlands). The Commonwealth Fund report ranked Canada third to last overall on a comparative score card of 11 health care systems.

Citation:

Canadian Institute for Health Information (2017), Wait Times for Priority Procedures in Canada, 2017, posted at [https://www.cihi.ca/sites/default/files/document/wait-times-report-2017\\_en.pdf](https://www.cihi.ca/sites/default/files/document/wait-times-report-2017_en.pdf)

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Organization of Economic Development. “Health at a Glance 2015,” OECD Indicators, retrieved from [http://dx.doi.org/10.1787/health\\_glance-2015-en](http://dx.doi.org/10.1787/health_glance-2015-en)

“Leaving Canada for Medical Care, 2017,” Fraser Research Bulletin, Fraser Institute, June 2017.

## Denmark

### Score 8

The main principles of health care in Denmark are as follows: universal health care for all citizens, regardless of economic circumstance; 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 health care spending in Denmark is high, the OECD considers its performance “subpar.” In 2016, health spending in Denmark was 10.4% of GDP (11th highest among OECD countries), of which 8.7% is public (fifth highest among OECD countries). There has been an upward trend in health care expenditures, mainly driven by a policy shift from a top-down system to a more demand-driven system. This shift has been motivated by a concern about long waiting lists; to address this, the government has moved to offer a “time guarantee,” where patients in the public health care system can turn to a private provider if a public hospital can’t meet a specified wait time limit for treatment.

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. This governance structure is creating problems, with regions having difficulties in meeting the objectives formulated for the health care system.

Life expectancy in Denmark in 2016 was 80.8 years, slightly above the OECD average, but below the level in comparable countries. Life expectancy is on an 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.

Recently, there has been much public debate about the quality of Danish hospitals. Increasing medicine prices are putting pressure on the financing of health care. The government's program puts emphasis on a right to swift diagnosis and treatment as well as special efforts targeted at elderly medical patients. Since Denmark lags behind neighboring countries when it comes to cancer treatment, the government plans a new cancer strategy.

The current government is optimistic about the health care sector, claiming that one extra doctor and one extra nurse per day have been employed since the beginning of the decade, and that waiting times have been halved.

Citation:

OECD, Health at a glance 2017," (accessed 7 December 2017).

Prime Minister Lars Løkke Rasmussen's Opening Address on 3 October 2017," [http://www.stm.dk/\\_p\\_14597.html](http://www.stm.dk/_p_14597.html) (accessed 21 October 2017).

## Estonia

Score 8

In terms of health care quality, Estonia serves as a valuable example for how to achieve sound outcomes with scarce resources. Regular public opinion surveys commissioned by the National Health Insurance Fund reveal that most respondents are satisfied with the quality of health services (68%). Satisfaction with access is significantly lower (38%) and has been slowly but steadily declining since 2012.

Estonia has a social-insurance-based health system that includes some non-Bismarckian features such as general practitioners (GP). The insurance principle makes access to health service dependent on insurance status rather than universal. Working-age people who are not employed or in education are not covered by the national health insurance. As a result, about 7% of the total population does not have free access to health care and a further 7% have gaps in coverage because of non-regular work contracts. Supplementary private health insurance (medigaps) has been added to the government agenda, with debates expected to start in 2018.

Long waiting times to see specialists or receive inpatient care are another major problem resulting primarily from structural factors such as budgetary limits and a bias toward acute/hospital care. The ageing of medical personnel and the shortage of nurses also pose challenges. However, the most significant social problem is inequality across income groups in terms of unmet health needs and self-perceived health status. Here, Estonia ranks at the very bottom among OECD countries.

Citation:

[http://www1.haigekassa.ee/sites/default/files/uuringud\\_aruanded/kuvandiuring/arstiabi\\_uuringu\\_aruanne\\_2016\\_kantar\\_emor.pdf](http://www1.haigekassa.ee/sites/default/files/uuringud_aruanded/kuvandiuring/arstiabi_uuringu_aruanne_2016_kantar_emor.pdf) [in Estonian]

## Germany

### Score 8

The German health care system is of high quality, inclusive and provides health care for almost all citizens. Most employees are insured in public health insurance systems, while civil servants, the self-employed, high earners and some other groups are privately insured. It is, however, challenged by increasing costs. Recently, the system's short-term financial stability is better than expected due to buoyant contributions resulting from the employment boom. However, long-term financial stability is challenged by the aging population and increasing costs within the health care system. Health care spending in Germany as a proportion of GDP is the third highest in the world and higher than the OECD average (11.3% of GDP compared to 9% of GDP for OECD average).

In its coalition agreement, the grand coalition negotiated a variety of reform measures for the 2013 to 2017 term to increase the quality of health care, redefine some financial details, and reorganize the registration of physicians in private practice and the distribution of hospitals. However, the government only introduced minor changes. One is the so-called law of strengthening self-administration in health care (“Selbstverwaltungsstärkungsgesetz”). With this law, the Federal Ministry of Health aims to strengthen its influence over the National Association of Statutory Health Insurance Physicians, which had been engaged in criminal financial activities. The German parliament passed the law on 27 January 2017. However, lobby groups were successful in reducing government control vis-à-vis doctors' associations and other interest groups.

Other important policies included a reduction in the contribution rate from 15.5% to 14.6% of gross wages and the confirmation of a fixed contribution rate for employers of 7.3%. Employee contributions are 7.3% of gross wages, equal to employers' contributions. The additional contribution from employees, which was previously a lump-sum contribution, is now calculated as a percentage of their assessable income and varies between insurance companies (the average premium is now 1.1%), reintroducing an element of competition. In addition, the federal subsidy for the national health care fund was raised by €0.5 billion to an overall total of €14.5 billion.

In 2015, the contribution rate for long-term care insurance increased by 0.3 percentage points and by a further of 0.2 percentage points in 2017. Thus, an additional €5 billion will be available for improvements in long-term care. A part of the additional revenue feeds a precautionary fund intended to stabilize future contribution rates. In addition, families that wish to provide care at home are given greater support. Two additional important policies were the Hospital Structures Act

and an act to strengthen long-term care (“Pflegestärkungsgesetze II und III”). The aim of the Hospital Structures Act, effective from January 2016, is to improve the quality of hospital care and increase the financing available to hospitals. In long-term care, a new system of assessing the needs was introduced. The new system no longer calculates the time needed for nursing care but assesses the degree of self-reliance restrictions. It takes into account all kinds of self-reliance restrictions: disabilities both in physical and mental health, and in cognition. The hitherto three care levels (Pflegestufen) are replaced by five new care degrees (Pflegegrade). The government also introduced the E-Health Act, which includes the introduction of an electronic health card to improve internet-based communication in the health care system.

While the government has been ambitious in fostering a high-quality health system, it is not sufficiently limiting spending pressure. In particular, it has been hesitant to open the system to more competition (e.g., with respect to pharmacies). When the European Court of Justice ruled against fixed prices for prescription drugs, the minister of health was quick to announce a ban on mail-order pharmaceuticals.

Citation:

<http://stats.oecd.org/Index.aspx?DataSetCode=SHA>

[https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3\\_Downloads/Gesetze\\_und\\_Verordnungen/GuV/S/SVSG\\_Kabinett.pdf](https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/Gesetze_und_Verordnungen/GuV/S/SVSG_Kabinett.pdf).

<http://www.bmg.bund.de/en/health>

## Israel

### Score 8

Under the 1994 National Insurance Act, all citizens in Israel are entitled to medical attention through a health maintenance organization (HMO). This is a universal and egalitarian law, allowing for broad access to subsidized primary care, medical specialists and medicines. A 2012 OECD survey identified Israeli health care system as one of the best in the developed world, ranking fifth with a score of 8.5 out of 10. In 2016, Israel’s health system was still perceived as being strong and successful thanks to good health outcomes and a strong primary health care system.

According to the most recent research published, life expectancy in Israel is relatively high, ranking sixth among the OECD countries. Nonetheless, there are specific areas of the health care system that need further improvement, as revealed by the high percentage of private spending for health, continued overcrowding in hospitals and the shortage of nurses. The OECD has acknowledged the Israeli system’s efficiency, as expressed in part through a unique auditing and regulatory system for HMOs that involves constructive criticism and guidance as opposed to monetary inducements. However, the OECD has also criticized 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 overworked personnel.

Health professionals have publicly stated that the OECD survey was premature, as a deterioration in services produced by recent policy reforms has simply not yet become evident. Despite broad health coverage, inequalities in health outcomes and access to health services have persisted. Low-income families still have poor access to dental care and nursing services. Non-Jewish Israelis from poor socioeconomic groups, as well as those living in the north and south periphery regions, experience worse health and have high health-risk factors.

Privatization pressures are increasing within the Israeli health system. An increase in the use of supplemental and private medical-insurance and health care plans is resulting in reduced equality within the system.

According to a 2017 Taub Center study, health care spending as a share of GDP has remained fairly stable over the past two decades, at about 7% of GDP compared to an average of 10% in other OECD countries. However, the share of public funding in the total national expenditure on health has declined, from about 70% to 61% (compared to about 77% share of public finding among the OECD countries). Consequently, private expenditure on health care has increased as a share of total household expenditure, from 4.5% in 2000 to 5.7% in 2015.

The quality of health services and facilities varies by geographical location, with periphery facilities often struggling to attract skilled personnel. Nevertheless, the Israeli system is fairly equitable in international comparison.

Citation:

OECD, "Health Policy in Israel," OECD Health Policy Overview, April 2016, <https://www.oecd.org/israel/Health-Policy-in-Israel-April-2016.pdf>

Swirsky, S., E. Konor-Atias, "Social status report 2016," January 2017. (Hebrew)  
<http://adva.org/wp-content/uploads/2017/03/SocialReport2016.pdf>

Chernichovsky, Dov, "Current Developments in the Health care System," Policy Research, 21.12.2017,  
<http://taubcenter.org.il/current-developments-in-the-health-care-system/>

## Luxembourg

Score 8

Luxembourg's well equipped hospitals offer a wide range of services, including high-tech and expensive treatments. Waiting lists are rare, except for some services that are in high demand (e.g., MRI scans). Nevertheless, Luxembourg also has the highest share of patient transfers to other countries for treatment within the EU. Due to the country's small size and the absence of a university hospital, it is not possible to provide all medical treatments. Necessary medical transfers to neighboring countries have the beneficial side effect of being more cost-effective for the state health insurance program, as those services are in general less expensive abroad.

Drawbacks of Luxembourg's system include the 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 only responsible for a certain number of patients, which prevents any sort of group or collective treatment options. Therefore, some hospitals have re-organized to keep doctors' offices in-house without changing their status as independent physicians.

However, at a cost of \$7,463 per person per year, Luxembourg's health care system is (after the United States and Switzerland) the third most expensive system within the OECD. The high cost of the health care system is due to high wages, a high ratio of medical equipment to residents, a low generic substitution rate and, after Germany, the second highest government and compulsory insurance schemes with low out-of-pocket pharmaceutical expenditure for patients (2015: 13%).

Nevertheless, between 2006 and 2016, the increase in life expectancy in Luxembourg (1 year) and Sweden (0.6 year) were the lowest in the EU. Possible reasons might be the large foreign population (47%), the continued environmental impact of the former heavy metal industry and the high consumption of alcohol.

Furthermore, authorities have repeatedly tried to limit the range of medical treatments offered by general hospitals in favor of providing treatment through specialized health care centers. In addition, the government announced the establishment of a medical school (*Medicinae Bacculaureus*) in 2020 to combat the lack of doctors in Luxembourg.

Citation:

Eurostat regional yearbook 2016. Eurostat, 2016. [www.ec.europa.eu/eurostat/documents/3217494/7604195/KS-HA-16-001-EN-N.pdf/76c007e9-6c1d-435a-97f8-e5ea700aa149](http://www.ec.europa.eu/eurostat/documents/3217494/7604195/KS-HA-16-001-EN-N.pdf/76c007e9-6c1d-435a-97f8-e5ea700aa149). Accessed 21 Feb. 2017.

Health at a Glance 2017: OECD Indicators. OECD, 2017. [dx.doi.org/10.1787/health\\_glance-2017-en](https://dx.doi.org/10.1787/health_glance-2017-en). Accessed 21 Dec. 2017.

Mémorial A n° 60 de 2008. Le gouvernement du Grand-Duché de Luxembourg, 2008. [legilux.public.lu/eli/etat/leg/memorial/2008/60#page=2](http://legilux.public.lu/eli/etat/leg/memorial/2008/60#page=2). Accessed 21 Feb. 2017.

Rapport Social National 2016. Gouvernement du Grand-Duché de Luxembourg, 2017. [www.gouvernement.lu/6913487/rapport-social-national-2016-rsn](http://www.gouvernement.lu/6913487/rapport-social-national-2016-rsn). Accessed 4 Dec. 2017.

## New Zealand

### Score 8

Since 2009, health reforms have encompassed the consolidation of regional hospitals and primary-care organizations, increased use of benchmarking and further decentralization. Although there is both public and private provision of health care, access to the public hospital system is freely available to all residents. Health care is not only generally of a high quality, it is also cost effective and relatively efficiently managed. However, concerns about rising costs and a lack of productivity gains led to the appointment of a ministerial review group and a national health board in 2009, tasked with improving coordination between the government ministry and district

health boards, and providing advice on the allocation of budgets. The OECD points out that the biggest projected long-term public spending pressure is in health care, which is expected to jump from 6.2% of GDP in 2015 to 9.7% of GDP in 2060, owing to both aging demographics and the expected increase in expensive new treatments. The gap in health status between Maori and non-Maori has been reduced, particularly regarding smoking-related illnesses and obesity. 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 OECD reports.

Citation:

OECD Health Statistics 2015: How Does Health Spending in New Zealand Compare (Paris: OECD 2015).

OECD Health Statistics 2016 (<http://www.oecd.org/els/health-systems/health-data.htm>) (accessed 19 September, 2016).

OECD Economic Survey of New Zealand 2017. (<http://www.oecd.org/newzealand/economic-survey-new-zealand.htm>) (accessed 24 September 2017).

Collins, Simon, 2016. Maori men suffering in disability statistics. New Zealand Herald. 27 June 2016 ([http://www.nzherald.co.nz/maori/news/article.cfm?c\\_id=252&objectid=11663847](http://www.nzherald.co.nz/maori/news/article.cfm?c_id=252&objectid=11663847)).

New Zealand Health Research Strategy 2017-2027. Ministry of Health. (<http://www.health.govt.nz/publication/new-zealand-health-research-strategy-2017-2027>) (accessed 24 September 2017)

## South Korea

### Score 8

South Korea's health care system is characterized by universal coverage and one of the highest life expectancies in the world, all while having one of the OECD's lowest levels of overall health expenditure. President Moon has announced a new "Mooncare" health care plan, and the government will provide KRW 30.6 trillion (.8 billion) over the next five years to cover all medical treatments. In the future, medical insurance will cover all forms of treatment, excluding plastic surgery and cosmetic procedures. Additionally, new measures that can act as safety nets for families facing astronomical health care costs have been announced. The government's intention is to create a medical safety net that leaves no patient untreated in times of emergency. The Moon administration has thus proposed expanding the state insurance policy to include not only the four major diseases – cancer, cardiac disorders, cerebrovascular diseases and rare incurable illnesses – but all other major diseases, including Alzheimer's disease. Under the newly proposed health care policy, patients in the lower 50% of the income bracket would be able to receive medical coverage costing up to KRW 20 million.

Citation:

OECD, OECD Health Policy Overview: Health Policy in Korea. April 2016. <https://www.oecd.org/korea/Health-Policy-in-Korea-April-2016.pdf>

Korea.net. President announces new 'Mooncare' health care plan. Aug 11, 2017. <http://www.korea.net/NewsFocus/policies/view?articleId=148430>

## Switzerland

### Score 8

Health care in Switzerland is said to be qualitatively excellent. According to the OECD, its health system is among the best in the OECD. Mandatory health insurance ensures that the total population is covered. However, care is expensive. Health insurance premiums (at constant prices) have nearly doubled over the past twenty years. 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 81 years for males and 85 years for females. As of 2015, 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 more than one additional year compared to Germany and Austria, the same as in Italy and one year less than in France. 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. These subsidies vary by canton, and policy change is frequent. For example, the canton of Bern reduced subsidies in recent years. More recently, however, a popular vote forced the cantonal administration to reestablish the former system of subsidies. In general, health care reforms have not been particularly successful in terms of improving efficiency or controlling the structural rise in health expenditures. In 2016, health expenditure was equal to 12% of GDP, compared to 17% in the United States, 11% in Germany and France, and 9% in Italy.

Health care insurance is provided by a large number of competing mutual funds (non-profit 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. Currently, a number of attempts to curb the large increase in health expenditures are meeting stiff resistance from vested interests, such as doctors, hospitals or health-insurance funds.

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. There remains, however, some concern about the centralization of medical services and sufficiency of medical coverage in marginal regions.

## Australia

### Score 7

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, several 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 2014, the federal government launched a dental scheme aimed at addressing inequity in access to dental care, but the current coalition government has wound back the scheme. 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 2015 to 2020 and for non-emergency surgery from 2010 to 2016, and the establishment of an Independent Hospital Pricing Authority to set a national efficient price for hospital services and a National Health Performance Authority to review hospital performance. However, in its first budget in 2014, the Abbott government reduced hospital funding and implemented a freeze on the indexation of subsidies for out-of-hospital medical services until 2018. However, this freeze was partially removed by the Turnbull government as of July 2017.

Finally, concerning cost-effectiveness, the health care system is rife with inefficiencies and perverse 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.

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 7

The Austrian health care system is based on several pillars. Public health insurance covers most 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 respects – 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 ongoing conflict between the policy intentions of the federal government and state governments about the responsibility for health care provision is a permanent topic of Austrian politics and draws attention to the demographic changes' impact on the health care system.

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.

The political conflict rooted in the deconcentration of the system could become more significant. Regional and local interests are not always satisfied with the policies of the federal government, while the federal structure of Austria's political system makes it necessary to find a broad consensus. Some observers argue that there are too many veto players in the Austrian health care system. This may become even

more significant as some state governments are controlled by parties that oppose the new federal coalition government.

Citation:  
Report of the Austrian Audit Court dating 12-2015:  
<http://www.rechnungshof.gv.at/berichte/ansicht/detail/medizinische-fakultaet-linz-planung.html>

## Belgium

### Score 7

In Belgium, public (or publicly funded) 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 to be a benchmark of efficiency with regard to affordable access to health care.

A problem is that costs have been contained by reducing wages and hospital costs in ways that do not seem viable in the long run, particularly given the 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. As a result, inclusiveness is under threat in the medium term and already a challenge in some rural areas.

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

Recently, entire areas of state competences regarding health care have been devolved to the regions (Wallonia, Flanders and Brussels) with the aim of increasing local accountability. However, this risks a loss of coordination and increased costs (e.g., excess spending on medical equipment) in a country where regions are so small that patients may easily move between regions, and the resulting competition may lead to excess spending. There is also a risk of losing management competence, as the pool of ministers and experts is considerably 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 (especially in the 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. These standards have remained stable in recent years.

In the domain of the more complex systems of secondary and tertiary health care, a more problematic situation is evident regarding the public health care system. 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) vary widely.

A survey released in May 2017 by Centro de Estudios Públicos (CEP), one of Chile's most important polling agencies, showed that 45% of the respondents cited health care as their second highest concern (after criminality, 51%, and followed by education, 38%).

Citation:

Healthcare as one of the chief concerns:

[http://www.latinnews.com/component/k2/item/70237.html?period=2016&archive=26&Itemid=6&cat\\_id=804376:chile-seeking-to-address-the-chief-public-concern&Itemid=6](http://www.latinnews.com/component/k2/item/70237.html?period=2016&archive=26&Itemid=6&cat_id=804376:chile-seeking-to-address-the-chief-public-concern&Itemid=6)

[https://www.cepchile.cl/cep/site/artic/20170831/asocfile/20170831165004/encuestacep\\_jul\\_ago2017.pdf](https://www.cepchile.cl/cep/site/artic/20170831/asocfile/20170831165004/encuestacep_jul_ago2017.pdf)

## Czech Republic

### Score 7

The Czech Republic spends slightly less on health care than the more advanced European countries. Relative to GDP, health care spending has fallen in recent years. The 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. Life expectancy slightly increased in the review period. Public health insurance in the Czech Republic is provided through seven health insurance companies, the largest being the General Health Insurance Company (Všeobecná zdravotní pojišťovna). Indicators of inpatient and outpatient care utilization point to unnecessary consumption of goods and services, and inefficiencies persist in the allocation of resources in the hospital sector. The Sobotka government has done little to address these issues. As for health care policy, the government's focus rested on the abolition of unpopular health care

fees introduced in 2008 under the center-right government of Mirek Topolánek, a campaign promise that was implemented early in the term. In December 2016, parliament adopted a law limiting smoking in restaurants, pubs, bars and other facilities, putting an end to the Czech Republic's status as one of the last havens for tobacco smokers in Europe.

## Finland

### Score 7

Health policies in Finland have over time led to palpable improvements in public health such as a decrease in infant-mortality rates and the development of an effective health-insurance system. Furthermore, Finnish residents have access to extensive health services despite comparatively low per capita health costs. Yet criticisms are common regarding life expectancy, perceived health levels, the aging population and an inadequate provision of local health care resources. Also, Finland's old-age dependency ratio is increasing substantially, although not as dramatically as in some other EU countries, and many clinics formerly run by municipal authorities have been privatized. Government planning documents outline preventive measures. For example, the 2015 Public Health Program describes a broad framework to promote health across various sectors of the government and public administration. Similarly, the Socially Sustainable Finland 2020 strategy sets out the current aims of Finland's social and health policy. In November 2015, the government agreed on a major social and health care reform (SOTE) that will move responsibilities for social welfare and health care services from municipalities to 18 larger governmental entities (counties) beginning in 2020. Also, a planned reform envisions greater freedom for clients in choosing between public and private health care providers; at the time of writing, however, the implementation of this reform remains the subject of considerable political conflict and debate. After concerns by the Constitutional Law Committee in June 2017, the government will now issue a new proposal on the SOTE reform in early 2018.

#### 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;

<http://alueuudistus.fi/en/social-welfare-and-health-care-reform>.

## 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 also offers services for illegal immigrants and foreigners.

The problem is cost efficiency and the containment of deficits, which have been constant in recent years. Savings have improved recently, but the high level of medication consumption still needs to be tackled with more decisive measures. The lack of doctors in rural areas and in some poor neighborhoods is a growing issue. The unsatisfactory distribution of doctors among regions and medical disciplines would be unbearable without the high contribution of practitioners from foreign countries (Africa, Middle East, Romania). New policies are expected in order to remedy first the deficits and second the “medical desertification.” More generous reimbursements of expenses for glasses and dental care (a traditionally weak point of the system) have been promised by Macron and the new government.

## Italy

### Score 7

Italy’s national health system provides universal comprehensive coverage for the entire population. The health care system is primarily funded by central government, though health care services and spending are administered by regional authorities. On average, the services provided achieve medium to high standards of quality. A 2000 WHO report ranked the Italian health care system second in the world and a recent Bloomberg analysis also ranked the Italian system among the most efficient in the world. A 2017 study published by Lancet rated the Italian system among the best in terms of access to and quality of health care. However, due to significant differences in local infrastructures, cultural factors, and the political and managerial proficiency of local administrations, the quality of public health care varies across regions. 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.

To contain further increases in health care costs, payments to access tests, treatments and drugs exist. Even if these payments are inversely linked to income, they

nevertheless discourage a growing number of the poorest from accessing necessary health care services. Similarly, additional medical services are only partially covered by the public health care system, while only basic dental health care is covered.

Citation:

<http://www.who.int/whr/2000/en/>

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

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30818-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30818-8/fulltext)

## Japan

Score 7

Japan has a universal health care system. Life expectancies are currently the second-highest in the world – 80 years for men and 87 for women (at birth). Infant-mortality rates are among the world’s lowest (2.0 deaths per 1,000 live births). 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.

Challenges for the health care system include the needs to contain costs, enhance quality and address imbalances. Some limited progress with respect to cost containment has been made in recent years.

Although spending levels are relatively low in international comparison, Japan’s population has reasonably good health care access due to the comprehensive National Health Care Insurance program. The 2016 revision of the Act Securing Hometown Medical and Long-Term Care facilitates the integrated delivery of medical and long-term care services for the elderly.

Citation:

Kyodo News, Burden of “double care” of young and old grows in Japan: survey, 4 October 2016, <http://kyodonews.net/news/2016/10/04/82421>

Suzuki, Itoko: Japan’s Health Care Support for Elderly Revisited, PA Times, American Society for Public Administration, 31 January 2017, <http://patimes.org/japans-health-care-support-elderly-revisited/>

## Lithuania

Score 7

In Lithuania, some health outcomes are among the poorest in the European Union. For example, the mortality rate of 20 to 64 year olds is the highest in the European Union. Lithuania has one of the highest alcohol consumption rates in the world. In 2015, consumption of absolute alcohol equaled 14 liters per person aged 15 and over. 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.

The Lithuanian health care system includes public-sector institutions financed primarily by the National Health Insurance Fund, and private sector providers financed the National Health Insurance Fund and out-of-pocket patient costs. Lithuania spent less than 5% of its GDP on health care in 2012. Though government health care expenditure in the same year was above the EU average of 15%. Between 2008 and 2013, GDP growth exceeded growth in public health care expenditure. In 2016, the National Health Insurance Fund amounted to €1.5 billion and exceeded 6% of GDP. Spending on preventive-care and other related health care 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 care expenditure) is quite high.

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 access to health care for vulnerable groups. New prevention-focused programs were introduced by the National Health Insurance Fund. Furthermore, the scope of the new State Public Health Promotion Fund under the Ministry of Health was recently expanded to support additional public health interventions.

Seeking to improve service quality and cost efficiency, the 2008 to 2012 government sought to optimize the network of personal health care organizations. The overall number of health care organizations was consequently reduced from 81 to 62 by the end of 2012. The 2012 to 2016 government by contrast placed more emphasis on the accessibility of health care services, the role of public health care organizations in providing these services, and the issue of public health in overall health care policy. At the end of 2015, the government approved a plan to consolidate health care providers. However, this has not brought any significant change. The Skvernelis government's focus shifted to reducing the availability of alcohol and tightening regulations in the field of pharmaceuticals, making the minister of health care the least popular minister in the government by late 2017.

There is a need to make the existing health care system more efficient by shifting resources from costly inpatient treatments to primary care, outpatient treatment and nursing care. The performance of the health care system could be improved by strengthening outpatient care, disease prevention, the affordability of health care and promoting healthier life style choices. In 2017, the parliament increased excise duties on alcohol and passed amendments to the Alcohol Control Law, which will raise the legal age for alcohol consumption from 18 to 20, restrict hours of alcohol sales and ban alcohol advertising. These legal provisions will come into force between 2018 and 2020. Some additional alcohol-control measures (including a requirement to

transport and store alcoholic beverages in non-transparent packaging, and introduce special alcohol consumption zones during public events) were rejected during the parliamentary decision-making process.

Citation:

The 2010 Eurobarometer report is available at [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_327\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf)  
COMMISSION STAFF WORKING DOCUMENT, country report Lithuania 2017: <https://ec.europa.eu/info/sites/info/files/2017-european-semester-country-report-lithuania-en.pdf>  
Murauskienė L, Janonienė 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](http://www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf).

## Malta

### Score 7

Malta provides quality health care to all citizens, with extensive inpatient and outpatient hospital services offered for free. This is reinforced by agreements with the United Kingdom and Italy to service patients in need of special treatments unavailable locally. The Euro Health Consumer Index 2016 found, however, that despite Malta's decent access to health care, performance lagged when it comes to treatment results and that there are gaps in the public subsidy system. In 2017, measures were put in place to expand current subsidies. The government now supports oncology patients, providing otherwise expensive treatments for free.

Vulnerable groups are entitled to state support for a list of prescription medications and all citizens are entitled to free medicine for specified chronic diseases (e.g., high blood pressure and diabetes). Malta has one of the lowest percentages in the EU of self-reported unmet need for medical care at 0.8% of the total population. Much has been done to reduce patient waiting times and dependence on private hospital care. The most recent NAO report stated that there was a 22% decrease in patient waiting time for elective operations. Notwithstanding, the average patient waits eight months for their first outpatient appointment, double that of the United Kingdom. However, between 20% and 50% of these first appointments could have been treated by regional units, indicating that primary care is not acting as an effective gatekeeper to secondary care. The report also indicates that the main hospital had improved outpatient services. The government has addressed the general hospital's limited bed capacity by building new wards and devising plans to add new buildings to the existing infrastructure. It also opened a new oncology hospital on the same site. A new outpatient block should be completed by 2020. Joint projects with the private sector to upgrade Karen Grech Hospital, Saint Luke's Hospital and the Gozo General Hospital in 2018 have stalled; the public has called for a reassessment of the project, which is now being scrutinized by parliament. There have been repeated demands for reform of the mental health sector and for a new mental health hospital. Meanwhile, it was recently announced that Malta will be one of the first countries to meet its Hepatitis C elimination target and a campaign for the legalization of medical cannabis is ongoing.

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% of hospital beds publicly owned and managed, with only a small number of private hospitals. Malta has fewer hospital beds per 100,000 inhabitants than its European counterparts, but also shorter hospital stays than the EU average. Health care as a percentage of GDP has increased from 8.1% in 2003 to 9.8% in 2014 (the 2014 EU average was 10%). Health-related expenditure amounted to more than €407 million between January and September 2017. The European Commission has expressed concerns about Malta's ability to meet growing long-term care demands.

Citation:

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 A Healthy Weight for Life: A National Strategy for Malta 2012-2020  
 Commission Staff Working Document - Country Report Malta 2016 SWD (2016) 86 final p.20  
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 TVM 27/01/2015 Government to announce development of new buildings at Mater Dei  
 Malta Independent 20/09/2015 Sir Anthony Mamo oncology center officially inaugurated  
 Budget Speech 2018 (English) p.80-81  
 Times of Malta 01/11/2017 Malta will be one of first countries to eliminate Hepatitis C  
 The Malta Independent 14/10/2017 Cannabis should be made available for those over 21; ReLeaf launches pro-legalization manifesto  
 Health care Delivery in Malta 2012 p. 13  
 A National Health Systems Strategy for Malta 2014-2020 p.22  
 Commission Staff Working Document - Country Report Malta 2017 SWD (2017) 83 final p.16  
 National Statistics Office (NSO) News Release 174/2017  
 Malta Independent 29/09/2016 Maltese people aged 80 have life expectancy of more than 9 years - Eurostat  
 National Audit Office Performance Audit: Outpatient Waiting at Mater Dei Hospital 2017  
 Doctors may strike over hospital deal Times of Malta 28/01/18

## Norway

Score 7

Norway has an extensive health care system, providing high-quality services to its resident community for free. All residents have 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 is the case 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 the government financing 84% of health care spending.

Although the entire population has access to high-quality health care services, the efficiency of this system is questionable. A major structural health care reform introduced in 2002 transferred ownership of all public hospitals from individual counties to the central state. This shift involved the creation of new and larger health care regions that were tasked with managing the delivery of services delivery, but without ownership. The reform objective was to institute a stricter budget discipline

by streamlining health care services and promoting regional coordination. In recent years, new reforms have been introduced, closing down or integrating several smaller hospitals with larger hospitals, and encouraging more cost-effective treatment and equitable access to expertise. However, this reform has met with some local protest, as citizens prefer not to have to travel too far to a hospital

## Spain

### Score 7

The Spanish national health care system is highly decentralized, relatively well-thought out, and largely achieves the criteria of quality, inclusiveness, and cost efficiency. According to a Bloomberg Index, Spain is the sixth healthiest country in the world (and OECD data show it has the second-highest life expectancy, after Japan). 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. 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. Access to a core set of high-quality health services is guaranteed through a public insurance system that covers 99% of the population. However, the number of practicing doctors, nurses and hospital beds per 1,000 residents is relatively low. The general quality of this system has deteriorated in recent years due to austerity measures (although health care spending still accounts for approximately 9% of GDP, close to the OECD average). The most recent reports emphasize deficiencies related to waiting lists, patient rights and sickness prevention. There is also interregional inequality. The system has recently become more cost efficient, particularly with regard to pharmaceutical spending. However, the system's sustainability is at risk over the medium and long term, as a consequence of the aging population (one out of five Spaniards will be older than 65 by 2025) and the subsequent increase in the incidence of chronic diseases.

#### Citation:

OECD, State of Health in the EU: "Spain Country Health Profile 2017" <http://www.oecd-ilibrary.org/docserver/download/8117631e.pdf?expires=1511483073&id=id&accname=guest&checksum=E06FBC18C2F0B44B2F9042D89C87C48C>  
 Bloomberg 2017 Healthiest Country Index  
<https://www.bloomberg.com/news/articles/2017-03-20/italy-s-struggling-economy-has-world-s-healthiest-people>  
 Bloomberg 2017 Health-Care Efficiency Index  
<https://knoema.es/opambfb/health-care-efficiency-around-the-world>

## 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 challenge, as pointed out in previous assessments, 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 2015 suggest that more than 700,000 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, or that patients are offered a brief consultation with a medical doctor, which means that the 90-day rule on service delivery is met.
- 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>).

Dickinson, H. and J. Pierre (2016), "Between substance and governance: Healthcare governance and the limits to reform," *Journal of Health Organization and Management* 30:1-9.

## Turkey

### Score 7

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. In particular, the maternal mortality rate fell from 28.5 deaths per 100,000 live births in 2005 to 16 deaths a decade later. There has also been a sharp decline in infant mortality from 20.3 deaths per 1,000 live births in 2005 to 11 in 2016. As a result, Turkey has met its Millennium Development Goal target on both counts.

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.

By 2014, Turkey had achieved near-universal health-insurance coverage, increasing financial security and improving equity in access to health care nationwide. 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.

The key challenge in health care is to keep costs under control as demand for health care increases, the population ages and new technologies are introduced. Total health expenditure as a share of GDP has been increasing steadily since 2003, reaching 5.4% in 2015. In 2015, 78% of this spending was funded by public sources, as compared to a 62% public share in 2000.

#### Citation:

Ministry of Health (2016) 'Sağlık İstatistikleri Yıllığı 2015,' Ankara

World Health Organization (2017) 'Turkey: WHO Statistical Profile', Geneva.

## Cyprus

### Score 6

Cyprus has a potential for high-quality health care services offered by both the main public sector, and 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 been reversed due to 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. This

is witnessed by a low infant-mortality rate (6.9 per 1,000 in 2015) and a high life expectancy at birth (79.8 for men and 83.5 for women in 2015). Preventive medicine is specifically promoted, with Cyprus ranking high worldwide with respect to expenditure in this area.

Reforms on public health care access since 2013 are leading to the exclusion of groups based on criteria such as levels of income or property ownership. These exclusions encompass 20% – 25% of the population. Most serious is the requirement to complete three years of contributions before benefiting from the system. The system features unequal distribution of services and inequities in access to care. The private sector is unregulated in respect to prices, capacity and quality of care; coverage is inadequate and ineffective (EU report 2016).

Cyprus has failed to meet its MoU obligations for establishing a national health care system (NHS) and offering full services by 2016. In 2017, a law for an NHS was voted on and approved. In addition, the government promoted the privatization of hospitals.

Citation:

1. Joint report on health care services - Cyprus, EU 2016, [http://ec.europa.eu/economy\\_finance/publications/eip/pdf/ip037bycountry/joint-report\\_cy\\_en.pdf](http://ec.europa.eu/economy_finance/publications/eip/pdf/ip037bycountry/joint-report_cy_en.pdf)

2. Free health care milestone... Cyprus Mail, 19 June 2017 <http://cyprus-mail.com/2017/06/19/free-healthcare-milestone-means-hurdles-remain>

## Iceland

Score 6

On average, the health care system in Iceland is efficient and of a high quality. Iceland has one of the highest average life expectancy rates in the world. However, there is considerable variation across regions. For example, health care services in Reykjavík and its surroundings as well as the northern city of Akureyri are much better than in more peripheral areas where patients have to travel long distances to access specialized services. After the 2008 economic collapse, substantial cutbacks for a number of regional hospitals were introduced, closed departments, and centralized specialized care facilities. In addition, smaller regional hospitals and health care centers have serious problems in recruiting doctors.

The University Hospital in Reykjavík (Landsspítalinn Háskólasjúkrahús), by far the largest hospital in Iceland, has for several years been in a difficult financial situation. The 2013-2016 government did not provide adequate additional public funds nor did it allow the hospital to independently raise funds through, for example, patient service fees. The resulting shortage of nursing and other medical staff increased the work pressures on existing staff, including their hours of work. One of the issues in the 2013 election campaign was the question of how to finance a redevelopment of the University Hospital in Reykjavík and the health care system in general. In the 2016 election campaign, this question appeared to be the most important issue for

both political parties and voters. This has already led to a modest increase in public health care expenditure.

Opinions remain sharply divided among political parties as to whether partial privatization of hospital services would be desirable.

Life expectancy in 2016 was 82 years, the 13th highest in the world, up from 73 years in 1960 when life expectancy in Iceland was second only to that of Norway (World Bank, 2016).

Citation:

<https://www.stjornarradid.is/media/fjarmalaraduneyti-media/media/frettatengt2016/Fjarlagafrumvarp2017.pdf>

World Bank (2016), World Development Indicators, <http://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN>.

## Netherlands

### Score 6

The Netherlands' hybrid health care system continues to be subject to controversy and declining consumer trust. The system, in which a few big health insurance companies have been tasked with cost containment on behalf of patients (and the state), is turning into a bureaucratic quagmire. Psychotherapists, family doctors and other health care workers have rebelled against overwhelming bureaucratic regulation that cuts into time available for primary tasks. With individual obligatory co-payment levels raised to €375 (including for the chronically ill), patients are demanding more transparency in hospital bills; these are currently based on average costs per treatment, thereby cross-subsidizing costlier treatments through the overpricing of standard treatments. The rate of defaults on health care premiums to insurance companies and bills to hospitals and doctors is increasing rapidly. All this means that the system's cost efficiency is coming under serious policy and political scrutiny.

In terms of cost efficiency, according to the new System of Health Accounts, the Dutch spend 15.4% of GDP on health care, or €5,535 per capita. The WHO's Europe Health Report 2015 still shows the Netherlands as the continent's highest spender on health care, spending 12.4% of GDP on health care. This is largely due to the relative amount spent on long-term care – hence the major concern among policymakers. On the plus side, care costs in 2012 rose by 3.7% – a lower rate of increase than during the previous decade, but higher than in the 2010 to 2011 period. Moreover, the number of people employed in health care was lower than in previous years. Labor productivity in health care rose by 0.6% on an annual basis, with the gains coming almost entirely in hospital care. Profits for general practitioners, dentists and medical specialists in the private sector increased much more than general non-health business profits. A proportion of health care costs are simply transferred to individual patients by increasing obligatory co-payment health insurance clauses. A means of improving patients' cost awareness is through increased transparency within health care institutions (e.g., rankings with mortality and success rates for certain treatments per hospital).

In terms of quality and inclusiveness, the system remains satisfactory. However, Dutch care does not achieve the highest scores in any of the easily measured health indicators. Average life expectancy (79.1 years for males, 82.8 for women) and health-status self-evaluations have remained constant. Patient satisfaction is high (averaging between 7.7 and 7.9 on a 10-point scale), especially among elderly and lower-educated patients. Patient safety in hospitals, however, is a rising concern both for the general public and for the Health Inspectorate. Since 2013, waiting lists for specialist care have been a growing concern. In 2017, the problem worsened, particularly for age-related conditions, and drastically for some regions in the country with aging and decreasing populations. A combination of factors – insufficient specialists, inadequate regional distribution, lack of coordination between health care providers and insurers, and poorly managed waiting lists – requires a concerted effort by all parties.

The level of inclusiveness is very high for the elderly in long-term health care. However, there is a glaring inequality that the health care system cannot repair. The number of drug prescriptions issued is much lower for high-income groups than for low-income groups. In terms of healthy life years, the difference between people with high and low-income levels is 18 years. Recent research has also revealed considerable regional differences with regard to rates of chronic illnesses and high-burden diseases; differences in age composition and education only partially explain these differences.

Citation:

Maarse, H., Jeurissen, P. and D. Ruwaard, 2016. Results of the market-oriented reform in the Netherlands: a review. *Health Economics, Policy and Law*, 11,2:161-178

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

Barometer Nederlandse Gezondheidszorg 2016: Transitie zorgsector zet druk op financiële performance., EY 2016  
Gezond verstand, publieke kennisorganisaties in de gezondheidszorg, Rathenau Instituut, 6 september 2017

<https://www.nza.nl/publicaties/nieuws/Plan-van-aanpak-tegen-te-lange-wachttijden-ziekenhuis/>

“We vertrouwen de dokter blind en de zorg voor geen meter. Hoe komt dat?,” in *De Correspondent*, 10 August 2015

“Terug aan tafel, samen de klacht oplossen: Onderzoek naar klachtbehandeling in het sociaal domein na de decentralisaties,” *Nationale Ombudsman*, 2017/035

“Toezicht op de zorg is een flipperkast,” in *NRC-Handelsblad*, 24 September 2015

“Waarom zijn tarieven van ziekenhuizen nog geheim?,” *NRC-Handelsblad*, 27 August 2016

## Portugal

### Score 6

Portugal’s population shows comparatively good levels of overall health. However, as in other areas of public policies, the country’s National Health System (NHS) came under financial pressure in the previous review period because of the pressure on Portugal to curb public expenditure.

In May 2015, the OECD published a near-200-page book evaluating Portugal's health care, called "OECD Reviews of Health Care Quality – Portugal: Raising Standards." The findings, as stated in the book's executive summary, are relatively positive. They call attention to the following points:

- An impressive array of quality-monitoring and improvement initiatives;
- A primary-care system that performs well, with rates of avoidable hospitalization, which is among the best in the OECD for asthma and chronic obstructive pulmonary disease (COPD);
- Significant efforts being made to reorganize the country's hospital sector; and
- Sustained progress in containing spending, while maintaining efforts to improve care quality.

A recent OECD report on the issue of health care in Portugal documented overall improvement in this area.

At the same time, the period revealed some gaps in the health care system, notably in terms of providing adequate safety measures. In October 2017, at the close of the review period, there was an outbreak of Legionnaires' disease at one of Lisbon's public hospitals, killing at least two people and infecting a further 30 hospital patients. It appears that the bacteria came from the hospital's water supply.

Citation:

<https://data.oecd.org/portugal.htm#profile-health>

Reuters (2017), "Legionnaires' disease in Lisbon hospital kills two, 32 infected," 7/11/2017, available online at: <https://www.reuters.com/article/us-portugal-health-legionnaires/legionnaires-disease-in-lisbon-hospital-kills-two-32-infected-idUSKBN1D7235>

Marlene Carriço (2017), "Sobe para 19 número de casos de Legionella com ligação ao Hospital S. Francisco Xavier em Lisboa," Observador – 4/11/2017, available online at: <http://observador.pt/2017/11/04/8-casos-de-legionella-diagnosticados-no-hospital-s-francisco-xavier/>

## United Kingdom

### Score 6

The National Health Service (NHS) remains a cornerstone of the United Kingdom's universal welfare state and is widely regarded as a core public institution. However, the decentralization of clinical commission groups, which has affected all 8,000 general practices in England, has been controversial. Most health care provided by the NHS is free at the point of delivery. However, there are charges for prescriptions and dental treatment, though specific demographic groups (e.g., pensioners) are exempt from these charges. 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 health care 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 Human Development Index (HDI) health index is very high (0.909). The financial position of many hospital trusts is rather precarious and has been the subject of growing concern over the last year, with more hospitals struggling to maintain standards.

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. Quality is generally high. However, input and outcome indicators of health care, such as how quickly cancer patients are seen by specialists or the incidence of "bed-blocking" (i.e., where complementary social care is difficult to arrange and so patients are kept in hospital), vary considerably across localities. A report by the Commission on the Future of Health and Social Care in England recommended that health and social care services should be much more closely integrated, but there has, to date, been little improvement. Winter health care "crises" have become the norm as hospitals struggle to cope with emergency admissions and have to cancel routine operations to free bed-space. This is partly because of the aging of the population, but also highlights inadequacies in funding and in organization of care services for the elderly. Social care is funded by local authorities and has been financially squeezed, resulting in more costly hospital care having to be used.

The NHS is invariably at the center of heated public debates. Lately, the debate has been sparked by the changes in the 2016/17 tariff, which regulates public funding for patient treatment and staff salaries. The tariff changes have shifted and reduced the public payment to clinics and acute trusts – private hospital operating companies commissioned by the Department of Health. These changes contradicted many existing business models and aggravated the funding crises of several major acute trusts. There has also been a long-running dispute over the pay and working conditions of junior doctors, which has led to strikes. The protracted dispute between the government and junior doctors' concerns government attempts to achieve full 7/24 operation in response to concerns that treatment at weekend was of lower standard, but the government's plans have still not come to fruition. Nevertheless, UK health care remains way above average on an international scale.

The unclear future status of EU working migrants has many health experts worried, since the UK health service relies on the recruitment of staff at all levels from other EU member states and third countries.

Citation:

[http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Commission%20Final%20%20interactive.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf)

## Ireland

Score 5

Quality:

The public perception of the Irish public-health system remains very negative due to the publicity received by numerous cases of negligence, incompetence and lack of

access. However, objective indicators of health outcomes are relatively good in Ireland and continue to improve. This despite the increased level of obesity, problems with excessive alcohol consumption, continuing fairly high levels of smoking and the pressure on health budgets.

The length of waiting lists for many hospital procedures and the number of hospital patients who have to be accommodated on “trolleys” (or gurneys) continue to be serious problems and attract vociferous negative publicity. Monthly data are now published on these waiting lists by the Health Services Executive; their reduction has been (repeatedly) declared a government priority.

#### Inclusiveness:

The Irish health care system is two-tier, 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. However, the rising cost of private health insurance is leading to a steady increase in the number of people relying on the public system.

The introduction of universal health insurance had been declared a government priority, but in October 2014 the newly appointed minister for health expressed his opinion that this target was “too ambitious” to be achieved over the coming five years. During 2015, however, general practitioner care was made available free of charge to those in the population under 6 and over 70, regardless of income. In the 2016 budget this was extended to all children under the age of 12. This budget also significantly increased the funds available to the public-health system, although cost overruns and financial strains will undoubtedly continue to plague the system.

#### Cost efficiency:

The Irish health system is costly despite the favorable (that is, relatively young) age structure of the population. When spending is standardized for the population’s age structure, Ireland emerges as having the third-highest level of health expenditure relative to GDP within the OECD. In several reviews of its “bailout” 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

Overall, public spending on health care is comparatively high but the quality of health care varies widely across Mexico, with different regions showing broad variation 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 largely limited to middle-class and upper-

class Mexicans, who encompass roughly 15% of the total population, but receive about one-third of all hospital beds. 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 states. In 2016, a National Agreement Toward Health Service Universalization was signed, which aims to ensure portability across providers.

Public health issues are aggravated by the lack of access to quality health services. Though most Mexicans are affiliated with the different sources of health care providers, including public and private, there are still issues of quality that negatively affect public health. For example, with some 13 million Mexicans suffering from diabetes, the country has one of the highest rates of diabetes among all OECD countries. The lack of sufficient health care and infrastructure means that diabetes patients suffer from several complications.

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. With a disproportionately young population, Mexico currently has a demographic advantage. As a result, health care spending accounts for a relatively small share of GDP. However, large-scale migration is placing increasing pressure on public services.

Citation:

<http://www.oecd.org/mexico/Health-Policy-in-Mexico-February-2016.pdf>

<http://www.who.int/bulletin/volumes/95/6/17-020617/en/>

## Poland

Score 5

Public health insurance covers some 98% of Poland's citizens and legal residents and is financed through social-insurance contributions. 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. Moreover, the poor quality of some services falls far under citizens' expectations, and for some services, patients must wait for an unreasonable duration. Aggravated by the migration of many doctors to other EU countries, Poland has a low doctor-patient ratio, with only

2.3 doctors per 1,000 inhabitants. The PiS government has called for a comprehensive health care reform and for expanding health care spending. In 2017, it has proceeded with its plans to abolish the National Health Insurance Fund, NFZ, and return to the tax financed system that existed before 1999. However, health policy in the period under review has been dominated by strong conflicts between the medical staff and Minister of Health Konstantyn Radziwiłł over salaries and working conditions, which manifested in frequent strikes and demonstrations, including a hunger strike of several doctors from summer to October 2017. The creation of a new hospital network aimed at improving services for patients through better coordination of services, easier access to specialists and reduced waiting times for medical treatment has included the big public hospitals but has left other hospitals out.

## Slovenia

### Score 5

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, additional insurance offered by two other 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 well above the OECD average. However, both the compulsory public health insurance scheme and the supplementary health insurance funds have suffered from severe financial problems for some time, resulting in financial problems among the majority of health providers. Since 2015, several scandals about irregularities and corruption in procurement in hospitals have been reported.

Health care reform has featured prominently in the coalition agreement of the Cerar government, which promised to re-expand public scheme coverage and to delineate more clearly between standard and extra services. Despite many calls for reforms both inside and outside the governing coalition, however, the specification and implementation of the 2015 National Healthcare Plan has progressed slowly. At the beginning of 2017, Minister of Health Milojka Kolar Celarc eventually presented a reform proposal that called for the abolition of voluntary additional health insurance and the imposition of flat rate levies of between €20 and €75 per month. This proposal met strong criticism from various sides, including both social partners. Controversies with the trade unions were also prompted by an agreement between the government and the doctor's trade union in March 2017. After six months of tough negotiations and industrial action by doctors, most demands made by the doctors – relating to working standards and wages – were met. The agreement was criticized by other trade unions, including those representing nurses, for destabilizing the public sector's salary system. In July 2017, in an attempt to close an important gap in the Slovenian health care system, the government submitted to the public an

act on long-term care that outlines a system of standardized care assessments and a list of services for the frail to be rolled out as of 2020.

## United States

### Score 5

For many years, the U.S. health care system has provided the best care in the world, though highly inefficiently, to the majority of residents – those with health insurance coverage. The system has provided significantly inferior care to the large segment without coverage (especially people of relatively low income, ineligible under the means-tested Medicaid program). In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA, Obamacare). The main goals of the legislation were to lower costs in the health care sector and extend health care coverage to more people. The design of the ACA was essentially to fill gaps in the patchwork of financing arrangements that were embodied in the existing health care system.

Health care reform has been highly controversial and partisan, both before and after its enactment. Republicans consistently vowed to “repeal and replace” Obamacare from 2010 to 2016, while offering no specific plans for its replacement. Some state governments headed by Republican governors declined to provide the expanded Medicaid coverage to low-income families, even though the federal government would pay 90% of the cost. The Supreme Court narrowly upheld the ACA against two potentially catastrophic challenges. Despite early problems in implementation, the program was proving successful by 2016.

In 2017, the Trump administration and Republican majorities in the House and Senate tried to enact a repeal bill but could not achieve sufficient agreement within the party on a specific measure. The effort was hampered by the Republicans’ unwillingness to consult with Democrats, to hold open hearings on proposals, or to focus on solving the specific problems of the existing program. Although the ACA has gradually become quite popular, the potential for continuing efforts at repeal will hamper the stabilization of health care insurance markets. Trump’s tax reform will eliminate major tax subsidies in the health care system, especially for low-income people. This will result in a higher number of uninsured people.

Citation:

Kaiser Family Foundation, *The Affordable Care Act’s Little-noticed Success: Cutting the Uninsured Rate*, 2016, <http://kff.org/uninsured/perspective/the-affordable-care-acts-little-noticed-success-cutting-the-uninsured-rate/>

## 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. Due to robust economic growth and the decline in unemployment, the financial balance of the health care system has improved.

The quality of health care services is average to lower. While life expectancy has risen and infant mortality has dropped, overall mortality and morbidity have 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. The system also suffers from serious policy instability with frequent changes in the Ministry of Health. Over the last decade, ministers of health have served on average less than 11 months. In October 2017, the minister of health, Nikolay Petrov, was the first minister in the third Borissov government to resign following allegations about his involvement in a corruption scandal, while in his previous capacity as director of one of the largest hospitals in the country.

The practice of unregulated payments to doctors is widespread. Those who can afford to make unregulated payments, receive faster and better health care. This problem seems to be widely recognized, and during discussions on the 2018 budget all parliamentary parties expressed agreement that the system has too many leakages and needs a considerable overhaul. Reform proposals include demonopolization of health insurance at least to some extent and improvements in internal controls to stop embezzlement.

Citation:

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

## Croatia

Score 4

In Croatia, most health care services are provided by the government and are part of the country's social health insurance system. Employer and employee contributions, plus some funding from the public budget, account for 85% of all health care spending, leaving only 15% to market schemes and private spending. 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. There are 568 hospital beds per hundred thousand of the population (the EU average is 526 beds per hundred thousand), and around 300 practicing physicians per hundred thousand of the population, the same as in the EU. As a percentage of GDP, government spending on health care is close to the EU average, and there is little room for reducing expenditure. 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. Resources are not always used efficiently, and suppliers' interests often lead to the duplication of resources or syphoning of funds. The low employment rate and aging demographics have produced a persistent financial deficit within the system, which is covered by the central government's budget. Due to resource constraints, patients are expected to make co-payments for a growing range of services. Since EU accession, the number of physicians and other medical professionals leaving Croatia has reached alarming proportions.

Progress with health care reform under the Plenković government has been limited. The long-planned functional integration of hospitals was initiated in July 2017 as six pairs of hospitals signed their integration agreements. However, the passage of the announced National Plan for the Development of Hospitals 2017-2020 has been delayed, even though its predecessor had expired at the end of 2016.

## Greece

### Score 4

Owing to the prolonged economic crisis, there have been massive cuts in public and private health care spending. As OECD data shows, since 2009, per capita spending on public health care has been cut by nearly a third – more than €5 billion between 2009 and 2014. By 2014, public expenditure had fallen to 4.7% of GDP, from a pre-crisis high of 9.9%. This decline in health care spending has been larger for pharmaceuticals and smaller for hospitals. Though shortages of spare parts have meant that scanning machines and other sophisticated diagnostic equipment are increasingly faulty.

The first months of 2017 presented a number of positive developments: the government announced plans to appoint more than 8,000 doctors and nurses, discussions about new legislation on primary health care began, while health care statistics for 2015 indicated a recovery in expenditure. In 2017, the philanthropic Stavros Niarchos Foundation announced a \$238 million grant to enhance and upgrade Greece's public health sector.

Greece is one of the lowest spenders for the share of preventive health measures in total health care expenditure. At the same time, compared to other EU member states, Greece shows one of the largest shares of out-of-pocket household expenditure in total health care expenditure. This highlights three perennial problems affecting Greek health care policy: the lack of long-term planning and programming with regard to preventive health measures, the large volume of unrecorded and untaxed transactions between patients and doctors, and the differential in health care access based on the purchasing power of households.

In addition to these policy-related problems, public health care in Greece also suffers from two key structural problems. First, the long-term irrational distribution of resources, including funds, supplies and personnel, which is defined by a chronic

clientelistic logic, rather than rational, that permeates the Ministry of Health's relationships with regional and local state-run health care services. Second, the fragmented and sprawling character of hospital care. The distribution of the 131 public hospitals across Greece is highly uneven, resulting from a patronage-based selection process that determines where hospitals should be built. Further, there are eight state medical schools in the country, producing hundreds of doctors every year. Yet, at the same time, there is a lack of nurses. Moreover, there is a highly uneven distribution of medical personnel across hospitals, as doctors prefer to work in the hospitals of the two largest cities, Athens and Thessaloniki.

Pharmaceutical spending in Greece has been significantly affected by the crisis (though it had previously reached very high levels in per capita expenditure). The large reductions in drug spending have come as a result of a series of government measures aimed at reducing the price of pharmaceuticals. Some cost reductions have shifted to households, while major budget cuts for public hospitals have left some hospitals without enough medicines and medical supplies. However, pharmaceutical spending (at more than 25% of total health care spending remains among the highest in the OECD).

Nevertheless, there have been some positive government initiatives. The Ministry of Health has issued instructions to state hospitals to provide medicine, tests and treatment to uninsured patients without charge. Indeed, since June 2014, uninsured people have been covered for prescribed pharmaceuticals, emergency department services in public hospitals, as well as for non-emergency hospital care under certain conditions. Moreover, in the period under review, a new law established 75 local public health care units (TOMY). Although there have been many problems in recruiting medical personnel to the TOMY, their establishment was an improvement over the past. If implemented, the new policy measure will shift demand for medical care away from private doctors and public hospitals toward local, primary health structures.

Citation:

Data on per capita spending on health is taken for OECD and is available at <https://www.oecd.org/els/health-systems/Country-Note-GREECE-OECD-Health-Statistics-2015.pdf>

Data on the different types of health expenditure is taken from Eurostat and is available at [http://ec.europa.eu/eurostat/statistics-explained/images/1/1c/Healthcare\\_expenditure\\_by\\_financing\\_agent%2C\\_2012\\_%28%25\\_of\\_current\\_health\\_expenditure%29\\_YB15.png](http://ec.europa.eu/eurostat/statistics-explained/images/1/1c/Healthcare_expenditure_by_financing_agent%2C_2012_%28%25_of_current_health_expenditure%29_YB15.png)

The new law establishing the local health care units (TOMY, Law 4486/2017) around Greece was passed in August 2017.

## Latvia

Score 4

In 2016, an OECD review stated that the health care system broadly delivers effective and efficient care considering its severe underfunding and a higher level of demand compared to most OECD countries. Latvia has universal health care

insurance and a single payer system financed through general taxation. Universal population coverage, highly qualified medical staff, the innovative use of physician's assistants are positive aspects of the system. However, substantial challenges remain, including disproportionately high out-of-pocket expenses (one in five people report foregoing health care due to cost), and long waiting times for key diagnostic and treatment services. Mortality rates for men, women and children are higher than in most other EU countries. Latvia is lagging to develop evidence-based reform proposals.

The economic crisis in 2008 resulted in a dramatic decrease in public funding for health care. The crisis gave impetus to structural reforms, which aimed to reduce costs, for example, by shifting from hospital to outpatient care. As of 2014, a "diagnosis-related group" system has been introduced to improve the financing of health care services. In 2017, the Latvian parliament is considering a substantial reform to the system. According to the government's own estimates, the reform is projected to push 300,000 people out of health care coverage. The new system will tie health care coverage to tax payments and is being touted as a way to improve tax revenues. The new system increases allocations for public health spending, which are expected to be used to improve salary levels in the medical professions, to stave off personnel shortages.

The introduction of e-health and IT solutions began in 2017, after a considerable delay. The new system has come under heavy criticism and the requirement to use the system was one of the factors contributing to a family doctor strike in 2017.

Public expenditure on health care was equal to 3.2% of GDP in 2016. Latvia has the highest private, out-of-pocket health care expenditure rates in the EU. Patients' out-of-pocket health care expenses constituted 41.6% of total health care financing in 2015. Total expenditure on health care amounted to 5.7% of GDP in 2016, below the EU average for public health care expenditure.

Over the course of 2016 and 2017 there have been many personnel changes in the upper management levels of the health care system. High turnover in senior management positions within the ministry and health agencies raises concerns of consistency and institutional memory within the system.

Although Latvia ranks among the worst performing countries in the Euro Health Consumer Index, there have been substantial improvements in recent years. In 2016, Latvia ranked 29th out of 35 countries, compared to 32nd in 2013. The EHCI points to an improvement in infant mortality from 6.2 deaths per 1,000 births (red score) in 2012 to 3.9 deaths per 1,000 births (green score) in 2014, and 3.8 in 2016.

Citation:

1. OECD (2016) Health Spending Data. Available at: <https://data.oecd.org/healthres/health-spending.htm>, Last assessed 12.11.2017

2. Euro Health Consumer Index 2016, Available at: [https://www.healthpowerhouse.com/files/EHCI\\_2016/EHCI\\_2016\\_report.pdf](https://www.healthpowerhouse.com/files/EHCI_2016/EHCI_2016_report.pdf). Last assessed 12.11.2017

3. OECD (2016). OECD Reviews of Health Systems. Latvia 2016. OECD Publishing, Paris. Available at: <http://dx.doi.org/10.1787/9789264262782-en>

## Romania

### Score 4

Romania has a public health insurance system. Despite its claim to universal coverage, however, only around 86% of the population are insured. Access to health care is further limited by a high salience of informal payments and a low density of doctors in rural areas. The problems are aggravated by relatively low public spending, large-scale emigration of medical staff and rampant corruption. The ongoing implementation of the Romanian National Health Strategy 2014-2020 has been marred by shifting priorities and poor investment planning. Tensions between Prime Minister Tudose and Health Minister Florian Bodog increased after the prime minister had criticized Bodog's handling of a measles outbreak in September 2017 involving a shortage of vaccines that resulted in the death of 17 children. Training and retaining medical professionals has proven a significant challenge for Romania, to the extent that a new National Centre of Human Resources is being established to grant assistance to the Romanian doctors abroad who want to return.

## Slovakia

### Score 4

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. From a comparative perspective, the quality and efficiency of health care services are relatively low. A government spending review published in autumn 2016 showed that there is significant scope to increase the cost-effectiveness of various areas of health care. Population aging, bad working conditions in the Slovak health sector and mass migration of doctors and nurses to other EU countries have resulted in a shortage of staff. The Slovak Medical Chamber estimates that Slovakia has a shortfall of about 3,000 doctors. If those who have already reached retirement age but are still practicing are counted, then the deficit reaches 5,000 doctors.

The third Fico government initially announced that it would replace the existing reform strategy for 2014 – 2020 with a new and updated strategy, but failed to do so. The implementation of the existing strategy has proceeded slowly and selectively. In 2017, the gradual introduction of DRGs in hospital financing started. After eight years of preparation, the new e-health system is scheduled to become operational in January 2018. Little has been done to tackle the widespread corruption in the health care system. Some steps have been taken in the period under review (rationalization of hospital care) but other initiatives have stalled, such as the integrated care model.

Citation:

Ministry of Finance (2017): National Reform Programme of the Slovak Republic 2017. Bratislava, 44-47. (<https://ec.europa.eu/info/sites/info/files/2017-european-semester-national-reform-programme-slovakia-en.pdf>).

OECD (2017): Economic Survey Slovak Republic. Paris, Chap. 2.

## Hungary

### Score 3

Health care has become the most conflict-ridden policy field in Hungary. A continuing series of scandals have made this issue a major Fidesz policy weakness and a subject of large-scale public protest. Health care policymaking has suffered from the absence of a ministry tasked with addressing health care issues and from a limited health care budget, which is one of the lowest in the OECD. The Orbán governments have 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 and nurses to other countries. The main reform project of the third Orbán government has been a monstrous organizational reform in which those units of the National Health Insurance Fund (Országos Egészségbiztosítási Pénztár, OEP) dealing with cash benefits were merged with the Pension Insurance Fund (Országos Nyugdíjbiztosítási Főigazgatóság, ONYF), whereas the other units became the National Institute of Health Insurance Fund Management (Nemzeti Egészségbiztosítási Alapkezelő, NEAK). Inspired by the widespread feeling that health care is the worst public service in the country, the democratic opposition parties began the drafting of a common basic program for health care policy in mid-September 2017.

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