

SGI Sustainable Governance
Indicators 2009

Social Affairs

Health care report



Indicator **Health care policy**

Question **How effective and efficient are health care policies?**

30 OECD 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 = Most people receive high-quality, cost-efficient health care.*
- 8-6 = Most people receive high-quality, but inefficient health care.*
- 5-3 = Most people receive poor-quality, inefficient health care.*
- 2-1 = Health services are of poor quality, underfinanced, overloaded, unreliable, and inefficient.*

Austria

value 9 In Austria, almost the entire population enjoys access to basic medical treatment, and 98 percent of the population is covered by the statutory health insurance. At the same time, however, rising costs have underlined that structural reforms are needed in order to maintain the country's high level of health care. Structural reforms have come about in a number of areas. First, there has been a resulting trend of obtaining an additional private insurance policy, which provides its holders with access to a broader spectrum of health-care services. Second, with health care being administered primarily at the state level, a 2005 reform aimed to reduce structural redundancy. In addition, a newly created Federal Health Agency issues guidelines for health-care planning, which are then implemented by "State Health Platforms." Since 2006, the aim of integrated planning has also been furthered by a "Structural Plan for Health Care." Lastly, planning is underway for a Federal Institute for Quality in the Health Care System, which will monitor standards of structural, process and outcome quality.

Belgium

value 9 Since 1980, Belgium's health system has been organized at both the federal and regional levels. The federal government is responsible for mandatory health insurance, hospital financing and pharmaceutical registration. Regions are responsible for health provisions, child and maternity health services and hospital investments.

High-quality health care is available for a large portion of the population. The number of physicians and therapists per capita is high, and hospitals and therapeutic units are distributed adequately. Life expectancy is high at 80 years, while infant mortality is low.

The health system is financed mainly through taxes and social security contributions. It is based on the principles of equal access and freedom of choice. Patients pay a fixed share of the cost of ambulatory care; they pay a fixed amount for hospital treatment, while health insurance covers the difference. Patients and consumers are relatively satisfied with the system, although the rising cost of health care provisions is one cause for complaint. Health services on offer have been made more consistent, and the management of the overall system, especially that of hospitals, has become more professional as hospitals have merged into consortia and networks. This consolidation has allowed for economies of scale in the provision of medical services by reducing the number of extremely expensive pieces of equipment such as PET scanners, as one example, without a decrease in service quality. Despite these positive developments, the system still shows room for improvements in efficiency.

Annotation:

European Observatory on Health Care Systems, “Health Care Systems in Transition: Belgium,” <http://www.euro.who.int/document/e71203.pdf> (accessed February 18, 2008).

Denmark

value 9

The main principles of health care in Denmark are: guaranteed health care services for all, regardless of economic circumstances; free health care; and governance of the sector, and especially hospitals, by elected regional bodies. Whereas these regional bodies were once the county councils, they have been the regional councils since the 2007 administrative reform. However, since health care financing is provided by the state via taxes, the regional authorities must negotiate their budgets annually with the Ministry of Finance. In 2005, total health care spending in Denmark was 9.1 percent of GDP, which is slightly above the OECD average. In that same year, 84.1 percent of health spending was funded by public sources, which is well above the OECD average. Moreover, life expectancy in Denmark that year was 77.9 years, which is slightly lower than the OECD average. Comparatively speaking, Denmark spends a lot on treatment but very little on prevention, such as school programs for health and dental education. There are, however, regular campaigns against smoking and alcohol abuse as well as others promoting healthy eating and exercise habits. The most significant problem in the health care sector has been long waiting lists, which are primarily a direct consequence of tight budget steering and the expansion of medical possibilities. The demand for medical services has also been constantly expanding, especially as more and more treatments become possible. Thus, when demand exceeds the budget, waiting lists result. For example, the waiting list for 23 types of cancer treatment in July 2002 varied between 2 and 4 weeks. By April 2007, however, the waiting lists for the same treatments had increased to between 2.4 and

5.6 weeks. This problem has also persisted even though it has received much political attention.

Annotation: OECD, “OECD Health Data 2007. How Does Denmark Compare,” <http://www.oecd.org/dataoecd/46/32/38979778.pdf> (accessed June 15, 2007).

Iceland

value 9

Health care policies provide high-quality, state-of-the-art health care for all Icelandic citizens, in an increasingly efficient manner. Nevertheless, the distribution of responsibilities between the public sector, which owns and operates all hospitals, and the private sector, which in recent years has increasingly offered various medical services at private clinics, remains skewed in the favor of the public sector. University Hospital, the largest hospital in Iceland, remains in difficult financial straits, as the government has proven unwilling to provide more public funds or to permit the hospital to raise revenue on its own by means such as levying patient service fees. The shortage of staff, especially among nurses, can be a threat to patient safety due to work pressure and long hours. More broadly, the system faces long wait lists for many operations and services such as retirement homes, as well as other problems. The government and opposition alike have shown themselves unwilling to allow market forces a bigger role in the provision of health care, a dilemma that also affects universities and the education sector.

Luxembourg

value 9

The public health system offers general coverage, generous reimbursement of health costs and freedom of choice. The fact that private health insurance plans play only a marginal role indicates that the universal social security coverage is quite satisfactory. Luxembourg’s medical infrastructure is well developed, and in some fields there is even overcapacity. However, the system is very cost intensive, and government attempts to reduce inefficiencies in the hospital infrastructure have not yielded the expected benefits. Although Luxembourg can currently bear these expenses, the government must act to keep this issue under control, or risk the future financial sustainability of the system.

Sweden

value 9

Swedish health care is of good quality and basically free for all the country’s inhabitants. Although the health care system is primarily public, a large number of private providers have emerged during the 2000s, and this is viewed as an expanding

sector.

There are a number of inefficiencies in the social insurance system funding health care. According to a special commission of inquiry, since the early 1990s, the proportion of the population between 20 and 64 living on some kind of social insurance has grown from around 15 percent to around 20 percent. Moreover, the proportion of this same age group living on sickness insurance has grown from 2.5 percent in 1997 to almost 4 percent today, and the proportion that has gone into early retirement has grown from around 6 percent in the early 1990s to 9 percent today. The issue of how these burdens on the social insurance system will be handled was one of the most important political issues during the period under observation and continues to be so. The main problem facing the health care system today is meeting increasing demand. A very large number of people are forced to wait for what are frequently months rather than weeks before undergoing necessary surgical procedures, tests or other treatments. Last year, Sweden's parliament passed a law (also referred to as "a health care guarantee") stating that all patients are entitled to treatment no more than three months after their initial contact with a doctor. Moreover, if the county in which the patient lives cannot meet this deadline, the patient will be advised to go to another county with a shorter waiting period. While this new policy appears to have improved the problem to some degree, the fact is that access remains a significant problem in Sweden's health care system. All dental care in Sweden is subsidized, and it is free for those younger than 19. Nevertheless, the fact that the pricing of dental care was deregulated in 1999 has been criticized for allegedly turning dental health into a class issue and making dental care unaffordable to the less well-off. Before the 2006 election, the Social Democratic government made an election pledge to reform the dental care system, but it was not re-elected. On the other hand, the center-right government currently in power has publically acknowledged the need for dental care reform. Some type of reform is expected next year, and it will reportedly include some type of protection against high costs for patients between the ages of 20 and 64.

Switzerland

value 9

The Swiss health system provides excellent health care to almost the entire population, thanks to the country's mandatory health insurance plan. However, the system is very expensive, due both to a high quality of service and a lack of efficiency. The organization of hospitals and the general lack of competition within the health system are also contributing factors. Health insurance in Switzerland is based on a very liberal model – when assessing contributions, neither income nor the number of family members are considered. However, children are afforded a reduced rate of contribution. The liberal model has been weakened in recent years, with low-income individuals and their families receiving some benefits.

Australia

value 8

The Australian health care system is based on a unique mix of private and public insurance and care institutions, providers of services, and a range of funding and regulatory mechanisms. The division of responsibilities between the Commonwealth and the states is a further complicating factor. Correspondingly, its performance on quality, inclusiveness and cost-efficiency measures varies. 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 30 percent subsidy for private health insurance. Medicare is the most important pillar in delivering affordable health care to the entire population, but its features decrease efficiency of the system and do not promote equity of access. The PBS is perhaps the most successful pillar, providing widespread access to medications at a low unit cost by utilizing the government's position as a monopoly buyer to ensure the lowest possible price. The quality of medical care in Australia is generally high, but a number of hospital treatments are difficult to access for persons without private insurance. Indeed, waiting periods for non-emergency operations in public hospitals can last many years. Public funding of dental care is also very limited and privately provided dental procedures can be prohibitively expensive for low-income persons. Nevertheless, despite its limitations, the system delivers generally high overall standards of care, in spite of the difficulties of distance, conflict between the state and Commonwealth governments over funding and management, and the entrenched problems of indigenous health. Attempts to introduce market-oriented reforms and to reduce government subsidization of the system have largely been resisted.

Canada

value 8

Canadians consider the universal character of the public health system to be an important element in societal integration and one that fosters Canadian distinctiveness vis-à-vis the United States. Health policy is a shared jurisdiction in Canada. The Canada Health Act sets out the primary framework for health policy and stipulates five criteria (public administration, comprehensiveness, universality, portability and accessibility). In order to be eligible for federal transfers, provincial health insurance schemes must comply with these five criteria. Insured health services are medically necessary hospital, physician and surgical-dental services. Health care provision in Canada is unique in that it does not generally allow for the private provision of health care services in hospitals and clinics. Canada has universal coverage for essential health services, and there is generally a high level of public satisfaction among users of the system as well as excellent health outcomes. Canada is first among OECD countries in terms of the percentage of its health care expenditures spent on preventive health care programs. Canada's single-payer

system also allows it to have lower levels of spending on health care relative to the depth of the coverage it provides. Coverage for dental care and pharmaceuticals, however, is not as comprehensive, and in most provinces these services are privately funded and provided. Of the three criteria – quality, inclusiveness (equity in access) and cost efficiency – the Canadian health system suffers most obviously in terms of quality. The Health Accord of September 2004, which was signed between the federal government and the provinces, aimed to restore long-term health funding and to address several major problems related to the quality of health services, most notably the reduction of long waiting times. The federal government committed itself to spend CAD 41 billion within the next 10 years in order to enlarge its financial contribution to provincial health schemes on a stable and predictable basis, to address the waiting-time problem by establishing a Patient Waiting Time Guarantee, and to improve preventive health care spending and early diagnosis measures. In the budgets of 2006 and 2007, the Conservative successor government under Prime Minister Stephen Harper did not alter this new commitment of the federal government in health policy.

Finland

value 8

Citizens have a choice between a low-cost basic health care plan covering all medical dimensions and provided by communal health care agencies, or paying more and taking advantage of additional private health care services. Health policies have successfully promoted some aspects of public health, with examples including the very low level of infant mortality and an efficient health insurance system. However, other aspects remain more neglected. In particular, the aging of the population and insufficient local government resources for health care create and aggravate problems.

These issues have been foreseen, and preventive measures outlined in planning documents such as the Health 2015 Public Health Program, which identifies targets for Finland's national health policy. The main focus of the strategy is health promotion rather than developing the health care system further. This "Health in All Policies" program is a cooperative venture, providing a broad framework for health promotion across different sectors of the administration. However, it acknowledges that public health is largely determined by factors outside the control of the health care system, such as lifestyles, living environment and the quality of products. Another national objective is to secure better access to information for patients, by means of the digitalization of patient data and development of the national health care infrastructure and information network.

Annotation: Finland Ministry of Social Affairs and Health, "Government Resolution on the Health 2015 Public Health Program." (Helsinki: Publications of the Ministry of Social Affairs and Health, 2001) Ministry of Social Affairs and Health, "EHealth Roadmap – Finland," Report 2007:15 (Helsinki: Ministry of Social Affairs and Health, 2007).

France

value 8

The health system in France is available to all societal groups and is valued highly internationally. It is also very expensive: a whopping 10 percent of country's GDP is spent on the health service sector. Measures introduced in recent years to reduce costs, rationalize and increase the efficiency of the French health system have only been partly successful. The increasing expenditure and deficit (a predicted €12 billion in 2007) is seen as a high priority for reform by the current government at the time of writing, and is needed to maintain the high standard of care provided by the current health system.

Netherlands

value 8

The Act on Quality of Health Institutions (“Kwaliteitswet zorginstellingen”) regulates the quality of health care provision. Although this act provides general quality guidelines, it leaves institutions much room for formulating how they will meet these standards. According to the Netherlands Health Care Inspectorate (IGZ), the country generally provides quality health care, although improvements could be made in terms of transparency and information in order to enable clients to make better medical decisions. In addition, it must be said that quality has recently decreased in some areas. For example, there are long waiting lists for certain types of surgery and an insufficient number of convalescent homes and youth-care facilities. The system of financing health care underwent a complete transformation in January 2006. The new system obliges everyone living in the Netherlands and paying income tax to pay into a common insurance system that entitles all individuals access to a standard package of insurance benefits. Individuals are free to choose their preferred insurer, and insurers are obliged to accept all applicants. As a result, insurers in this system compete to attract subscribers. Moreover, insurers act as powerful purchasing agents by choosing between various offers for care from hospitals and other providers. In doing so, they exert pressure on the providers to offer quality health care at the lowest possible cost. The government hopes that this highly regulated and supervised market-oriented system will be more consumer-friendly and, above all, improve the system's efficiency. However, the merging of many large organizations in the industry threatens to reduce the competition these changes were meant to encourage and thereby prevent the intended reductions in costs and improvements in quality. In addition, some fear that the substantial power of the big insurance companies – and their focus on cost reduction – will result in a decrease in quality care.

New Zealand

value 8

New Zealand's health care system has undergone several changes in the last decade. A "purchaser/provider" market-oriented model was introduced in 1993, although a more community-oriented model now prevails. A devolved system of regional health boards running a population-based health system was established in 2000. The 21 district health boards are guided by overarching government strategies and supported by the Ministry of Health, which provides national policy advice, regulation, funding, and monitoring. This means that eligible people receive free inpatient and outpatient public hospital services, subsidized prescription items and various disability support services. The eligibility for financial support has been widened in recent years, so that many people pay reduced charges. Public hospital admission is free to all New Zealand citizens and residents, though access is limited by waiting lists for some procedures. Private health insurance plans and private hospitals provide a means of "queue jumping."

The government drug-purchasing agency, Pharmac, has sought competition and greater choice in purchasing medicines. The subsidization of some expensive drugs and the use of preferred providers and generic substitution have been controversial issues. Unlike other countries such as Australia, New Zealand does not have an obligation to support research and development in the pharmaceutical industry, which means that Pharmac can focus exclusively on health outcomes. Nevertheless two problem areas remain. First, recent system changes have hampered efficiency, with key actors jostling for bureaucratic or market position. Second, health care provision for Maori needs to be improved. The gap between the life expectancies of Maori and non-Maori citizens has been increasing rather than decreasing in recent years.

Norway

value 8

Norway has an extensive health system, providing good services to its resident community. Anyone who is resident in Norway has a right to publicly provided economic assistance and other forms of community support during illness. Health care for mothers and children is especially good, as in other Scandinavian countries. Infant mortality is the sixth lowest in the world. Per capita health expenditures in Norway are more than 50 percent higher than the OECD average. The country's total health expenditures total about 12 percent of GDP, a third more than the OECD average.

The public share of this expenditure in Norway is also high, with 84 percent of health spending financed by the government. Health care costs accounts for a growing proportion of total public spending, with its share rising from below 16 percent in 1997 to slightly above 19 percent in 2006. Inpatient and day cases make up the largest single share of central government expenditure.

Yet although Norway offers high-quality health care services to the entire population, its efficiency is questionable. A recent study based on 47 Finnish and 51 Norwegian public hospitals found that the average level of cost efficiency was 17 percent to 25 percent lower in Norwegian than in Finnish hospitals. In a major health care reform in 2002, ownership of all public hospitals was transferred from the regions to the central state. Subsequently, new “health care regions” were established, larger than the previous ones. These were given management responsibility, without ownership. The intention was for these regions to streamline and coordinate health care services, and impose a stricter regime of budget discipline. However, reorganization has been slow, and remains ongoing. Vast amounts of resources are being consumed by procedural work and pervasive conflict, and the efficiency gains, if any, have yet to be identified. This reform has been uniquely unsuccessful by Norwegian standards. A previous reform, which came into effect in 2001, established a general-practice system for the first time, so that all persons and households would have a designated primary care doctor or practice. This was implemented with relative ease, and contributed to a notable improvement in access to quality primary health care.

South Korea

value 8

The national health care system was launched in 1977, with medical insurance for employees and their dependents in companies having more than 500 employees. In 1989, the national health insurance system was extended to the whole nation. This is a mandatory social insurance system, funded through the contributions of the insured and government subsidies. The system is comprehensive but shallow, because it has many payment exclusions and high co-payments. General levels of health spending are among the lowest in the OECD, and are much lower than would be expected given the country’s level of development and level of health achieved. Despite the universal insurance system, many health expenses are still covered individually. Out-of-pocket payments are much higher than in other OECD countries, accounting for 44 percent of health spending, while public health insurance contributions amount to only 33 percent of all health expenditure. High co-payments might be efficient in the sense that they keep health costs low, but they also prevent access to health services for the poor even when they are insured. The Medical Aid Program, which supports low income patients, covers only 3.5 percent of the population. The provision of health services is mostly market based. Patients can freely choose their doctors and even choose between Western and traditional treatment. The downside is that doctors and hospitals have incentives to increase consumption by their patients, thus driving up health costs. For example, hospitals keep patients longer than necessary (the so-called hotel effect). Prevention and health promotion as a cost-effective means of health service is arguably the weakest point of the Korean health system. Preventive checkups are

often not covered by the health insurance. There are few public campaigns for healthy individual behavior such as smoking cessation.

Czech Republic

value 7

The health care system was developed in the early 1990s and modeled after examples from neighboring western European countries. All citizens are entitled to free treatment paid for through state and private insurance schemes. The Czech health care system ensures a wide scope of choice for both providers and consumers of health care and provides fairly good services. Nevertheless, the system does not prioritize prevention over treatment, and it also suffers from management problems and rising costs. While the center-left government refrained from initiating major reforms, the new center-right government has announced the introduction of charges regarding prescriptions and visits to physicians.

Germany

value 7

Health care in Germany is widely available, broadly inclusive, generally of high quality and quite expensive. The country's health policy has been subject to constant reform over many years. The principles underlying the system, that is to provide medically necessary care to all SHI insurees, together with growing demand, have seemingly pushed the country's system to its limits. Indeed, German health care is – in absolute terms – very expensive when compared to other developed nations' systems. Given that contributions to health insurance are borne by employees and employers, any future reforms which aim to limit health care costs should also help limit the country's non wage labor costs. In 2007, the grand coalition devised an extensive health care reform plan that aims to reduce costs by increasing competition between service providers, and contained provisions to bring 200,000 previously uninsured citizens into the medical system, introducing for the first time, universal health insurance, with an obligation to take out health insurance and – for insurers – to take on applicants. Today, public criticism is still leveled at what some see as a “two-class” system. However, the country's public health care system as a whole is still good in covering 90 percent of the population and providing patients with state of the art medical care. The financial basis is less solid, raising the question of whether quality can be sustained in the future.

Ireland

value 7

Health care in Ireland is typically delivered using a mix of private and public systems, and most of the health care infrastructure is in private hands. There

continues to be considerable disagreement about the appropriate amount that the public and private systems should each provide, about the equity of the “two-tier system,” and about why the public health system continues to fail to deliver high quality service despite the infusion of very large additional resources. From 1980 to 2005, the percentage of the population covered by supplementary private health insurance doubled from 25 percent to 50 percent. This figure is high by European standards and reflects the fact that, in Ireland, private insurance subscriptions are both relatively inexpensive and eligible for tax relief. Health services are free at the point of use for those with low incomes. Reforms have often proved difficult to implement in the Irish health service. Nevertheless, one should note some recent health-related improvements. Since 2000, the age-standardized death rate in Ireland for both men and women has fallen from about 20 percent above the EU-15 rate to slightly below this rate. The reasons behind this rapid improvement in health outcomes have yet to be researched, but they are likely to include some combination of increased prosperity, higher spending on health care, improved housing conditions and a reduction in air pollution.

Italy

value 7

Italy’s national health system is administered by 20 regional health authorities. The system is universal, comprehensive and funded through general local taxation. However, the quality of public health care is not always exemplary. Public services are inefficiently organized in some areas of the country, thus making overall care less effective.

There appears to be some difference in quality standards between the north and the south, which is also less wealthy, even though resources allocated by the central government to the regions are proportionally very similar. Lower efficiency and bribery are to blame for at least part of this gap in quality. In this context, wealthier people often prefer to subscribe to private health insurance or pay out-of-pocket so they can choose any doctor or specialist as well as avoid the long waiting lists common in the public system. An effort to improve efficiency nationwide was put in place a few years ago by introducing a private-sector managerial approach to the public health care system, and by making regional governors responsible for local deficits, forcing them to balance the health care budget through higher local taxes on households and corporations.

Overall, the health care system provides quality health care for a majority of the population at no or limited cost. Preventative health care in many sectors is still underdeveloped.

Japan

value 7

Introduced in 1961, Japan's system of universal health coverage provides acceptable health care for everyone, thanks to the nearly universal insurance scheme. For instance, annual health checks are provided free to just about everyone in Japan, including foreigners. Still, the system faces a number of problems. Costs have outpaced income from premiums for many years. Policymakers have attempted to fix this problem, and in 2002 expenses were for the first time less than the year before. However, cost containment is not very effective, and the goal of safeguarding quality has persistently clashed with cost reduction proposals. For instance, treatment of cancer, the largest cause of death in Japan, has frequently been found to be inadequate. Observers complain about falling standards of training and lower pay, limiting incentives for doctors. The conservative, top-down way of taking care of patients – frequently, they are not even informed about the seriousness of their possibly fatal disease – is also a persistent problem. Traditionally, Japanese policy has focused on curing rather than preventing health problems. As life and eating patterns change, critics have argued that health care policy should be more preventive. Companies are taking the lead in this regard, as policy has adjusted slowly. Nevertheless, the revised medical service system will require health insurance to cover regular checkups for people 40 years of age and above, beginning in 2008. The health care system's efficiency has also been questioned. Hospitals do not provide good information on service quality. Progress in this area is slow, although measures to improve governance have been proposed. In 2004, the government agency supervising health insurance was beset by scandals; as a partial result, a 2006 law will transform the agency into an association by late 2008.

Spain

value 7

Public health care policies provide high-quality health care that is free of charge for all citizens. Beneficiaries need only to be registered in a Spanish municipality to receive free care. However, the health care system's weaknesses stem from quality issues and accessibility; long waiting lists for treatment, for example, have caused growing dissatisfaction among patients. From a cost perspective, the medium and long-term sustainability of the health system is threatened. The Spanish public expenditure on health is comparatively low within the context of the European Union, which helps to explain the system's social polarization as approximately 30 percent of the wealthiest portions of the population subscribe to supplementary private healthcare. Insufficient attention in the health care budget is given to prevention and primary health care issues versus excessive spending on pharmaceuticals, hospitals and specialized medical attention. The process of health policy decentralization to Spain's regions has stimulated regional differences in the provision of services, partly damaging the territorial

equality of the system. National standards are either absent or not enforced. As a result, policies and quality vary greatly within the state among the autonomous communities. In order to deal with issues of coordination and to improve the quality and cohesion of the health care system, law 16/2003 was passed and a quality plan was adopted. Other important measures in 2006 were approved to guarantee the financial viability of the national health system and moderate its increased costs, such as the rational use of medicines and healthcare products act and the strategic pharmaceutical policy plan.

United Kingdom

value 7

As the cornerstone of the British welfare system, the National Health Service (NHS) survived even the Conservatives' emphasis on privatization in the 1980s and early 1990s. The system combines universal coverage – a great plus – with central management and control, and is considered to be inexpensive or underfunded in comparison with other countries, depending on the point of view. In the late 1990s, the Blair government set about to match European spending levels and service quality. A massive increase in NHS spending – by 48 percent in the five years up to 2004/05, followed by another 23 percent through 2007/08 – has yielded positive results, although there is some debate regarding the proportion thereof that has translated into cost inflation due to labor market constraints. Despite the improvements made to the system, the United Kingdom lags behind many European countries in terms of health provision in certain areas such as cancer treatment. Dental care is not covered by NHS and there is some concern about private vs. NHS patients' access to dentists. The Healthcare Commission, which provides an independent check on the quality of NHS services in England, reported in October 2006 that almost half of the hospital trusts providing acute care were rated only “fair” or “weak.” Primary-care trusts, which buy health care for patients living in their areas, were given even worse ratings, with two-thirds landing in the two lowest categories. The Commission also found that 37 percent of trusts had failed to manage their finances adequately for the year through March 31, 2006. The aforementioned spending increases have resulted in substantial increases to doctor and nurse salaries, and they have reduced waiting times for patients. Down from an average wait time of 9 months for inpatient care in 1988 to 3 months in 2004, the average wait time nonetheless remains long at 2.5 months. The changes made to the health system's incentive structure and improvements in patient choice have altered the system substantially, but expectations have changed just as quickly. Patient satisfaction has therefore not increased in line with spending, which is in part due to the system's laborious and centrally imposed bureaucracy. Furthermore, devolution has resulted in different health strategies being adopted in various parts of the United Kingdom.

Portugal

value 6

The overall quality of health services in Portugal is relatively satisfactory, but its efficiency could be improved. The main problem in the public and political agenda concerns the extent to which the system's financial sustainability can be achieved while at the same time avoiding inequity in coverage and obtaining efficiency gains. Over the last two decades, public health spending in Portugal has risen very rapidly, and it is already above the OECD average as a percentage of GDP. Portugal has a National Health System (Serviço Nacional de Saúde, or SNS) that provides universal coverage and is primarily financed by taxes. Indicators for the population's health and health provision have seen massive improvements in the decades following the creation of the SNS, particularly as relates to infant mortality. In general, although it is not as good as it is in other EU countries, the health care enjoyed by the Portuguese population is relatively good. Health care delivery is based on both public and private providers. Approximately a quarter of the population enjoys private supplemental health insurance coverage through health subsystems and voluntary health insurance. Public provision concentrates on primary care and hospital care. Medications, diagnostic technologies and private practice by physicians constitute the bulk of private health care provision. Satisfaction rates with the SNS are rather high, despite recurrent complaints about the conditions of hospitals and health centers and delays in consultations and surgeries. Moreover, there is broad public and political consensus about preserving a SNS with universal coverage. Despite the steady growth of public health expenditures, the SNS has not undergone any major financing changes since the early 1990s. On the other hand, many measures have been adopted so as to improve its efficiency (e.g., public-private partnerships (PPPs) for new hospitals, a change in SNS hospital management, the use of generic pharmaceuticals, liberalizing prices, and reducing administrative prices for pharmaceutical products).

Annotation:

Barros, P. and Simões, J., "Portugal: Health System Review," in *Health Systems in Transition*. (European Observatory on Health Systems and Policies, 2007);1-140.

Slovakia

value 6

Slovakia moved from a Soviet-style national health system to a health insurance system in the 1990s. The latter has provided universal access to reasonably good health care, but has suffered from inefficiencies and rising costs. Upon coming to power in 2002, the Dzurinda government began reforming the health care system to increase the system's efficiency and to reduce costs. It aimed to introduce a two-tier system consisting of a mandatory health insurance scheme with competing insurance funds to finance a basic basket of services and voluntary health insurance schemes

covering additional services. Because of the partial privatization of health care, reforms were highly unpopular. Confronted with heavy political resistance, the Dzurinda government failed to complete the reforms before the 2006 elections. The government postponed the privatization of state-run hospitals and defining the universal level of health care services. For its part, the Fico government has partially undone some of its predecessor's reforms and has increased the state's role.

United States

value 6

In general, the U.S. health-care system provides very high-quality care to the large majority of the population that has health coverage under private insurance plans, Medicare (the federal health program for the aged) and Medicaid (the federally funded, state-administered health-care program for low-income individuals), although Medicaid care is sometimes lower in quality. Nevertheless, the system has two serious problems. First, about 47 million (out of 300 million) Americans do not have insurance coverage. The uninsured include many families that number among the “working poor,” that is, those whose employers do not provide health insurance and who cannot easily afford to purchase health insurance on the private market. The number of uninsured also includes many healthy, younger people who could afford insurance but choose not to spend the money to do so. When uninsured people find that they need medical care, they either pay for it out-of-pocket, obtain care for free (hospitals are required to provide charitable care to needy patients via emergency rooms) or forgo treatment. Uninsured patients often receive substandard care. There is also substantial underinsurance, particularly in terms of dental care. So far, Massachusetts is the only state in the United States that has introduced health-care coverage for all its citizens. If the Democrats win the presidency and maintain control of both houses of Congress in 2008, universal health care will be a high priority on the legislative agenda.

Annotation:

All data from Department of Health and Human Services, “Health, United States, 2006,” Washington, D.C., http://www.cdc.gov/nchs/data/health_us/2006.pdf#highlights. For a thorough overview of health-care policy issue, see: Victor R. Fuchs And Allan M. Garber, “Health and Medical Care,” in *Agenda for the Nation*, edited by Henry J. Aaron et al, (Washington D.C., Brookings), 145–182

Hungary

value 5

Hungary moved from a Soviet-style national health system to a health insurance system in the 1990s. The latter has suffered from inefficiencies, most notably in the hospital sector, and from rising costs. Fiscal restrictions and a strong reliance on

informal payments have limited actual access to health care and have undermined its universal character. The Gyurcsány government launched a large-scale health care reform in December 2006 that aimed at reducing inefficiencies and at improving access to health care by replacing informal payments with a system of official co-payments. The initiation and consolidation of reforms has been complicated by rifts within the governing coalition and fierce resistance by the medical profession and the population.

Mexico

value 5

Health care in Mexico is characterized by the fragmentation typical in the country's other policy areas. The more developed the region, the better its health services. A minority of the population has access to modern treatment and prevention, but the majority of Mexicans have inadequate care. On the positive side, indicators of life expectancy and infant mortality have improved significantly in Mexico over the last generation, although they are still low by OECD standards. The Mexican public health system provides services only to those workers who participate in the formal sectors of the economy. Moreover, these services' quality has substantially deteriorated, largely due to an irresponsible employee pension system that consumes large amounts of available resources. The health insurance system is inefficient, with its separation of the Mexican Institute of Social Security and the Popular Health Insurance program, and the OECD has recommended their unification into a single system. Thus, the overall health care system has not been able to provide high-quality health service for the majority of the population.

Greece

value 4

Pockets of good public health care exist in Greece, along with good medical schools and an overabundance of medical doctors. However, the public health system is ailing. Public health is organized on the basis of a National Health System, following the British NHS model. Since its inception in 1983, the system has been plagued by problems of inefficiency, uneven quality of care and acute regional disparities. Long waiting lists are common, inefficiency is rampant in public hospitals' procurement systems, and primary health care is not effectively organized. Patients are often tempted to hand out bribes to public hospital doctors and nurses in order to obtain good medical care. Greece's low per-capita health expenditures are part of the problem. Among old EU member states, per capita expenditures are lower only in Spain and Portugal. As a result, people have begun turning away from the public health system, and today private health spending is among the highest in the European Union. Future costs will be even higher, as the aging of the population and retiree health problems, along with the cost of drugs and medical tests, put more pressure on public health and

health insurance budgets. It will be necessary to upgrade the management of public hospitals, streamline the health sector's public procurements, and rationalize public hospital expenses. New incentives are necessary to increase the number of general practitioners (currently a rare category of medical doctor) and to address the health care needs of the population residing in small towns and rural areas, where vast geographical disparities in health care persist.

Poland

value 4

The health care system is characterized by the coexistence of a decrepit public system and an expanding, largely unregulated private system. Public spending on health care in Poland is among the lowest in the OECD. The poor compensation of nurses and doctors in the public sphere has led to a high number of vacancies and a strong reliance on informal payments. Access to high-quality health care thus strongly depends on a citizen's income and personal connections. Confronted with nurses' and doctors' strikes, the PiS government conceded in offering some modest increases in health care spending, but did not initiate more structural reforms as had been suggested by Zbigniew Religa, the much-respected health minister.

Turkey

value 4

In 2006, Turkey introduced a law that established universal health insurance, strengthened the institutional capacity of the social security system and established a better infrastructure for health and social security services. Health services are to be provided under a common standard, and the compulsory Universal Health Insurance system is to cover the whole population. According to the law, premiums are to be collected according to the individual's ability to pay, and health insurance premiums of those who cannot pay will be paid by the government. While the number of patients per doctor was 792 in 2000, this number fell to 715 in 2005. However, this figure is still far above the EU average of 288. Furthermore, there are imbalances in health care provisions and services at regional and urban-rural levels. Total health expenditures, which accounted for 6.6 percent of GDP in 2000, reached 7.6 percent in 2005. Insufficient infrastructure, unqualified personnel and overall poor quality at the primary level of health services and an inefficient referral system has caused patients to seek out secondary or tertiary level health services which come with higher service costs, which in turn overcrowds such services, decreasing the quality of services in hospitals overall. The government under Prime Minister Recep Tayyip Erdogan united the country's two hospital groups, the SSK (Social Insurances Agency) and state hospitals run by the Ministry of Health (SB), under public ownership. This step relieved the legacy pressure on the SSK and led to more balanced services for broader parts of the population. Additionally, the government removed policies that granted special

benefits to state officials. Those insured by public insurance now have direct access to the higher-quality health care of university hospitals. At the same time, the government eliminated waiting lines in front of public pharmacies. In tandem with all these actions was the establishment of a single Social Security Agency (SGK), which replaced the big three public social insurance agencies (Emekli Sandığı, SSK and Bag-Kur), Policy holders and services were integrated through the elimination of obvious differences in terms of services and contributions.

This report is part of the Sustainable Governance Indicators 2009 project, which assesses and compares the reform capacities of the OECD member states.

More on the SGI 2009 at www.sgi-network.org

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