

**SGI** Sustainable  
Governance  
Indicators

# 2014 Health Report

Health Policy



## Indicator

## Health Policy

## Question

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

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

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

## Switzerland

## Score 9

Health care in Switzerland is said to be qualitatively excellent. A policy making health insurance mandatory ensures that the total population is covered, but care is expensive. Cost efficiency is a potential problem, in particular with regard to the organization of hospitals. Life expectancy is very high, life expectancy at birth is 80.3 years for males and 84.7 years for females. As of 2011, a 65-year-old male could expect to live for another 19 years on average, while a woman of the same age could look forward to another 22 years. This is about two years more than in Germany. Obviously, the health care system is important in this respect but is not the only explanatory variable; differences may also be due to the country's socioeconomic resources, natural environment, or other variables.

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

Health care insurance is provided by a large number of competing mutual funds (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.

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

## Australia

### Score 8

The Australian health care system is a complex mix of public sector and private-sector health care provision and funding. Correspondingly, its performance on quality, inclusiveness and cost efficiency varies across the board. 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% private health insurance subsidy. Medicare is the most important pillar in delivering affordable health care to the entire population, but it has design features that decrease efficiency and do not promote equity of access. For example, the level of the subsidy is generally not contingent on the price charged by the doctor. The PBS is perhaps the most successful pillar of health care policy in Australia, granting the Australian community access to medications at a low unit cost.

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

Regarding inclusiveness, significant inequality persists in access to some medical services, such as non-emergency surgery and dental care. Indigenous health outcomes are particularly poor. In 2012, the federal government announced a dental scheme aimed at addressing inequity in access to dental care. Commencing in 2014, the scheme will deliver subsidized dental care for most children and low-income adults. Lack of access to non-emergency surgery reflects, to a significant extent, the funding constraints of the states and territories, which are responsible for funding

public hospitals. This was a significant motivation behind the 2011 National Health Reform Agreement, which was signed by all members of the Council of Australian Governments (the forum for cooperative action by the Commonwealth, state and territory governments) except Western Australia. The agreement sets out structural reforms to the health system, and seeks to provide for more sustainable funding arrangements for Australia's health system. Key features of the agreement include additional federal funding for hospitals from 2014 – 2015 to 2019 –2020 and for non-emergency surgery from 2009 – 2010 to 2015 – 2016; establishment of an Independent Hospital Pricing Authority to set a national efficient price for hospital services and a National Health Performance Authority to monitor and report on hospital performance; and the establishment of “Medicare Locals” nationally to coordinate and integrate primary care.

Finally, concerning cost-effectiveness, the health care system is a complex mixture of public and private funding and provision which is rife with inefficiency and wrong incentives. Total health care expenditure is relatively low, but as is the case in most developed countries, the government faces significant challenges due to rising costs from an aging population and development of new diagnostic tools and treatments. Indeed, rising costs underpinned the 2011 National Health Reform Agreement, which seeks to both increase funds available to the hospital system and improve the effectiveness with which hospital resources are deployed.

Citation:

National Health Reform Agreement 2011: <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/health%20Reform%20Agreement.pdf>  
[http://www.yourhealth.gov.au/internet/nhra-agreement/\\$File/National%20Health%20Reform%20Agreement.pdf](http://www.yourhealth.gov.au/internet/nhra-agreement/$File/National%20Health%20Reform%20Agreement.pdf)

## Austria

### Score 8

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

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

A second complexity in the system is produced by the division of responsibilities between the federal and state governments. Public health care insurance is based on federal laws, but the hospitals are funded by the

states. This state-level responsibility affects both publicly owned and privately owned hospitals.

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

The development of the health care environment in Austria has echoed overall EU trends. Life expectancy is rising, with the effect that some costs, especially those linked to elderly care, are also going up.

## Belgium

### Score 8

In Belgium, public hospitals own and maintain good equipment and university hospitals offer advanced treatments, given the institution's participation in medical research. Yet Belgium puts too little emphasis on prevention, and spends more than similar countries on (subsidized) drugs, which may pose problems in the long-run sustainability of the healthcare system.

The country's health care system covers a wide swath of the population. Access to health services is inexpensive, and most of the population is covered by public health insurance. Extensions to public insurance are also inexpensive, and can be obtained through the mutualités/mutualiteiten, or through an individual's employer in some larger firms and administrations. But in this regard as well, sustainability may be at stake in the longer term. The problem is that costs have been contained by cutting wages and hospital costs in ways that do not seem viable for the future, even more so with an aging population. Inclusiveness may be threatened in the medium-term.

## Canada

### Score 8

The overall quality of the Canadian health system is very good, as evidenced by the high level of life expectancy. Long waiting times for certain procedures, largely confined to those that are non-life threatening, are however a major complaint of the public. A recent report from the Health Council of Canada (2013) found only limited progress in reducing these wait times. The inclusiveness of the Canadian health system is impressive, with high-quality health care freely provided for virtually the entire population. Lack of income is not a barrier to treatment. As there is no private health-care system, the rich do not receive superior health care to the poor. One effect of the equity in access to health care services is the small gap in

perceived health between the top and bottom income quintiles. One access issue is presented by the exclusion from Medicare coverage of dental care, vision care and drugs prescribed for use outside of hospitals, resulting in unequal access across income groups to these types of health-care services.

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

Citation:

Health Council of Canada (2013) "Progress Report 2013: Health care renewal in Canada," May. [http://www.healthcouncilcanada.ca/r\\_pt\\_det.php?id=481](http://www.healthcouncilcanada.ca/r_pt_det.php?id=481)

## Czech Republic

### Score 8

The Czech health care system, based on universal compulsory insurance, ensures a wide range of choice for both providers and consumers of health care, and provides a level of service which is high by international standards. In 2011, a new health reform was adopted, which entered into force in 2012. Given the growing costs of current public health care and the aim of cutting public spending, the primary objective of the reform is to ensure financial sustainability and effectiveness both by cutting costs where possible and by increasing payments from the public. One controversial issue was the impact on access for lower income groups. The aim was to increase charges on basic treatments (with exclusions for the lowest income groups), to increase charges on hospital stays and to allow for extra payment to receive "above-standard" treatment – all while maintaining free provision of the more expensive treatments. This was gradually defined as meaning greater comfort without any difference in medical effectiveness. Details remained unclarified in 2013, but the reform included protections for patients' rights if service was unsatisfactory, a right to choose the medical provider and a level of charges that was not high by international standards.

## Denmark

### Score 8

The main principles of health care in Denmark are as follows: universal health care for all citizens, regardless of economic circumstances; services are offered "free of charge"; and elected regional councils govern the sector.



Because financing through taxes depends on the state budget, regional authorities depend on annual budget negotiations with the Ministry of Finance.

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

While health expenditures for a number of years did not grow more than GDP, there has been an upward trend during the period of 2000 – 2007. In 2010, health spending amounted to 11.1% of GDP, which is higher than the OECD average of 9.5%. That puts Denmark in 7th place among OECD countries when it comes to spending. This increase is mainly driven by a change in policy from a top-down system to a more demand-driven system. The latter has been motivated by a concern about long waiting lists and the move to offer a “time guarantee” where patients under the public system can turn to a private provider if the public health care system can’t meet the time limit for treatment in a public hospital. In addition, the government has aimed to bring more private providers into the sector. This is also reflected in the tax deductibility of employer-provided, private health insurance (abolished by the new government as of 2012).

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

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

Life expectancy in Denmark is now 79.3 years, half a year less than the OECD average. There has been a marked decline in smoking in Denmark in recent years, but obesity rates have increased. The social gradient in health remains strong.

Citation:

OECD, “OECD Health Data 2012: How Does Denmark Compare,” (accessed 19 April 2013).  
OECD Economic Surveys - Denmark, Overview, January 2012. <http://www.oecd.org/economy/49447668.pdf> (accessed 19 April 2013)

## Estonia

### Score 8

In terms of health care quality, Estonia can serve as a good example for how to achieve positive health outcomes with scarce resources. The high quality of medical services can be attributed to two main factors: policy learning that has come from having a long-standing universal health system with total population coverage, and to the high quality of in-service training in medical schools and in at the University of Tartu. Other supporting factors include a policy focus on disease prevention and exercise (especially for children and youth), and increasing public awareness about healthy lifestyles. However, concerning the latter, there are sharp disparities across income levels and socioeconomic status.

In the 1990s, Estonia created a social insurance based health system, which included some non-Bismarckian features such as general practitioners. Yet, the principle behind the system affects access to health services. Members of the working-age population who are not employed or in school are not covered with health insurance. As a result, quite a large share of the population lacks access to the free health care (according to various estimates about 10%). And when unemployment increased as a result of the 2008 global economic crisis, the number of uninsured people jumped as well.

Strict insurance and cost efficiency principles have brought not only positive outcomes, but also some negative social effects. One of the major problems has been long wait times to see specialists and receive in-patient care. Emigration of personnel due to low wages has further burdened the system. A second major problem is stark inequality across income groups, especially in terms of self-perceived health status.

## Finland

### Score 8

Health policies in Finland have supported important aspects of public health, such as a low infant mortality and an efficient health insurance system. Finnish residents have access to extensive health services, and yet total per capita health costs remain comparatively low. Still, the system runs into criticisms regarding life expectancy and perceived health levels, and specific problems, such as an aging population and a lack of health care resources at the local level, add to the difficulties. It is estimated that the old age dependency ratio in Finland will be the highest of all EU countries as of 2025. Many formerly municipal clinics are now run by private companies, which also provide physicians with more attractive employment conditions. Government planning documents outline preventive measures; the 2015 Public Health Program is the central document, describing a broad



framework to promote health across different sectors of government and public administration. A major structural reform plan (SOTE) seeks to move responsibilities for social welfare and health care services from municipalities to larger governmental entities.

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.

## Germany

### Score 8

The German health care system is characterized by very high medical standards and a high degree of medical innovation, the products of which are quickly made available to patients. Thus, financing issues rather than quality challenges top the health-policy agenda. However, after a decade of rapid policy change, reform zeal has come nearly to a standstill. The so-called health fund became effective in January 2009, but was recently reformed under the Christian Democrat-Free Democratic Party coalition. Contributions to the health fund have been fixed, which essentially means that future increases in health expenditure will have to be paid for by the insured via extra lump-sum charges. For the time being, however, the system is stronger than expected from a financial perspective. According to the Federal Health Ministry, the public health care insurers made a surplus of €5 billion in 2012, and no extra charges are currently being levied. The surplus even led to the abolishment of the €10 consultation fee in 2013.

High-income earners are allowed to opt out of the compulsory health care insurance program after one year of exceeding the state system's income threshold (instead of the previous three years previously), switching instead to a private insurance company. Under a previous legislative oversight, private insurers were unable to cancel contracts with insured persons who were not able or willing to pay their premiums. However, in 2009, health insurance coverage whether in the private or state sector became compulsory. Thus, Germany's population today has nearly universal insurance coverage.

The government has additionally sought to contain pharmaceutical costs. In 2011, the parliament passed a law reorganizing the pharmaceutical market (Arzneimittelmarkt-Neuordnungsgesetz, AMNOG). Under the provisions of this measure, pharmaceutical companies are required to provide a dossier on the expected additional benefits of new drugs in comparison to older products. Based on this dossier, a federal joint committee consisting of insurers, doctors and hospitals decides what value a new pharmaceutical actually has. The evaluation in turn forms the basis for price negotiations

between health insurers and manufacturers. However, the German health care system remains in dire need of further cost controls. In 2011, the cost of treatment, rehabilitation and care in Germany rose to more than €287 billion, 11.3% of GDP, or €3,590 per capita. This was a new all-time high.

The system does contain certain inequalities in terms of access. While patients with private insurance coverage get fast access to all kinds of diagnostic tests and specialized doctors, patients with coverage from the statutory health insurance plans face somewhat longer waiting times and the potential for a rise in copayments. As a consequence, some observers have proposed creating a fully integrated insurance system (Albrecht et al. 2013).

## Israel

### Score 8

The Israeli Ministry of Health is in charge of health care policy, medical services and mental health services. Under the 1995 National Insurance Act, each citizen in Israel is entitled to medical attention through a health maintenance organization (HMO). This is a highly universal and egalitarian law, allowing for broad access to subsidized primary care, medical specialists and medicines. Although there are active efforts to expand the current basket of covered health services to include items such as nursing and dental care, budgetary considerations has prevented these additions. This means that low-income families have poor access to dental care.

As are other fields, Israeli health services are experiencing privatization pressure. There has been a rise in supplemental private medical-insurance and health care plans, which has reduced equity within the health care system overall. This process has been accompanied by a decrease in the amount of public financing provided. Furthermore, the quality of health services and facilities varies on the basis of geographical location, with periphery facilities often struggling to attract highly skilled personnel. However, in general, the Israeli system is fairly equitable in international comparison.

A 2012 OECD survey conducted in Israel identified it as one of the best health care systems in the developed world. The level of health care was ranked fifth in the survey group, with a score of 8.5 out of 10, exceeded only by Switzerland, New Zealand, Australia and Canada. Although the OECD noted Israel's low average level of public funding, nursing shortage and overcrowded hospitals, it cited decreasing mortality rates and high doctors/population ratios. Israeli public and political debate over this survey is more skeptical. Health professionals have publicly stated that the OECD survey was premature, as the deterioration in services has not yet become widely evident, but is starting to make a dent in the quality of public care.

The OECD also gave Israel high marks in terms of system efficiency. For example, it noted Israel's unique auditing and regulatory system for HMOs, which offers constructive criticism and guidance as opposed to monetary inducements. However, the report is more critical of a lack of communications between HMOs and hospitals. Similar criticisms have been made by NGOs, which note that recent privatization campaigns have led to a deterioration in efficiency, with Israeli facilities suffering from long waiting times and exhausted personnel.

Citation:

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

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

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

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

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

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

## Lithuania

### Score 8

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

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

Nevertheless, new prevention-focused programs were recently introduced by the National Health Insurance Fund. The provision of health care services varies to a certain extent among the Lithuanian counties; the inhabitants of a few comparatively poor counties characterized by lower life expectancies (e.g., Tauragė county) on average received fewer health care services. Seeking to improve the quality of services and their cost efficiency, Lithuanian policymakers are optimizing the network of personal health care organizations; the overall number of these bodies was reduced from 81 to 62 by the end of 2012.

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)  
 The 2007 Eurobarometer report is available at  
[http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_283\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf)

## Luxembourg

### Score 8

Luxembourg's well-equipped hospitals offer a wide range of services, including high-end, expensive treatments, and waiting lists are rare. Interestingly, Luxembourg also has the highest share of patient transfers to other countries for treatment within the European Union; the country has no university hospital and as provisions in general are less expensive abroad, such transfers are in essence a net positive for the state health insurance scheme.

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

Luxembourg's system of health insurance providers has been gradually unified; in January 2009, of the nine – typically corporatist – providers, six were merged into a single national health insurance (Caisse nationale de santé). The remaining three independent schemes are for civil servants, and while they operate independently, they offer the same coverage and tariffs for health care provisions. The overall objective is to end up with a universal system; the system up to now functions with equal contributions from employees and employers, plus an important contribution from the state. The same tariff structures exist for all doctors and patients (including for the three

independent insurance programs). Access to treatment under the Luxembourg health care system is limited to contributors (employees, employers and their co-insured family members) only. It excludes newcomers without a work contract or those who do not have another form of voluntary insurance coverage. Applicants for international protection are insured via the competent ministry. Furthermore, Luxembourg's national insurer offers generous reimbursements; out-of-pocket expenses for patients in Luxembourg are the lowest within the OECD.

However, Luxembourg's health care system is also considered one of the most expensive within the OECD countries, ranked fourth after Switzerland, Norway and the United States. The reasons for this include the country's high wages, the high ratio of technical medical equipment to residents and the low out-of-pocket costs for patients. Furthermore, authorities for years have tried to limit general provisions offered by all hospitals, instead offering incentives to limit treatment in specialized centers, for example.

Citation:

Act of 15 May 2008: Introduction d'un statute unique, Luxembourg: <http://www.legilux.public.lu/leg/a/archives/2008/0060/2008A0790A.html>

OECD (2008),

Lenz, M. J., Conen, D. (Décembre 2012), Plan hospitalier 2013; Vu de l'Étranger: Les Particularismes Luxembourgeois, in: InSight, SantéSécu:

[http://alk.lu/alklu\\_cms/sites/default/files/u5398/InSight\\_Sonderausg\\_2012\\_frz\\_final.pdf](http://alk.lu/alklu_cms/sites/default/files/u5398/InSight_Sonderausg_2012_frz_final.pdf), pp. 21-23

Hartmann-Hirsch, C. (2010), The State of the Luxembourg's Welfare State: the Effects of the Crisis on a Corporatist Model Shifting to a Universalistic Model, working paper no. 2010-44, CEPS/INSTEAD: <http://www.ceps.lu/pdf/3/art1601.pdf>

## New Zealand

### Score 8

Health care in New Zealand is generally of a high quality, is cost effective and relatively efficiently managed. At the same time, the sector faces growing expectations and rising cost pressures. Gains have been made in terms of reducing the health status gap between Maori and non-Maori. Gaps in life expectancy have been reduced but more remains to be done, including changes in behavior and lifestyle. Concerns about health disparities have been an ongoing concern, as noted by Organization for Economic Co-operation and Development (OECD) reports. Concerns about rising costs and a lack of productivity gains in the sector led to the establishment of a ministerial review group and a national health board in 2009, with the task of improving coordination between the ministry and district health boards and to advise on the allocation of budgets. Health reforms since 2009 have encompassed regional consolidation of hospitals and primary care organizations, increased use of benchmarking and greater decentralization.

Citation:

OECD Economic Surveys: New Zealand (Paris: OECD 2011).

OECD Health Data 2012: How Does New Zealand Compare (Paris: OECD 2012).

## South Korea

### Score 8

There were no major changes in the health care system during the period under review. Korea has a high-quality and inclusive medical system, and has seen the OECD's highest increase in life expectancy – a rise of 27 years since 1960 to about 79.8 years in 2008. Health spending per person has grown significantly over the past decade, but stood at 7.2% of GDP in 2010, much lower than the OECD average of 9.5%. The public sector provides slightly more than half of all health care funding. The universal health insurance system has relatively low premiums but high co-payments. Koreans can freely choose doctors, including service at most privately owned clinics, but the scope of coverage of medical procedures is narrower than in most European countries. Out of pocket payments account for 32% of all health expenditure. High co-payments have the problematic effect that access to medical services depends on personal wealth.

Citation:

OECD, *Society at a Glance 2011*, <http://www.oecd.org/korea/societyataglance-asiapacifiedition2011.htm>

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

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

## Sweden

### Score 8

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 wait times in emergency wards 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 the administrative oversight of health care quality is weak.

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

The key problem, as pointed out in the 2011 report, is a governance problem. Health care is driven by three contending sources: elected officials, the medical profession and the market. These three sources governing the health care system send different signals, make different priorities, and



allocate resources differently. This bureaucratic split at the top has the effect of reducing quality, inclusiveness and cost efficiency.

Partly as a result of these problems, a rapidly increasing number of people in Sweden purchase private health insurance. Estimates suggest that about 500,000 Swedes, or about 5% of the population, have purchased a private health insurance policy.

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 national government has introduced a “care guarantee,” (“vårdgaranti”) which entitles a patient to treatment within 90 days after first seeing a general practitioner. Evaluations suggest that the guarantee has somewhat improved the situation but also that a large number of patients still have to wait beyond the stipulated 90 days for treatment.
- Properly assessing cost efficiency in the health care sector is extremely difficult. The medical profession advocates that evidence-based assessment of costs for treatment and medication are used to a greater extent than is presently the case, that is, costs should be related to expected patient utility.

Citation:

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

## United Kingdom

### Score 8

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

While patient convenience may not be a central focus of NHS provision, attempts have been made to improve local healthcare by creating Health and Well-Being Boards to bring together representatives from all social services

as well as elected representatives. The NHS' quality as measured by the HDI health index is very high (0.951).

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

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

## Chile

### Score 7

For more than three decades, Chile has maintained a dual health system, with one pillar represented by private insurance and private health care services chosen by self-financing participants (typically upper middle-income and high-income groups), and another pillar of public, highly subsidized insurance and public health care services for participants who pay only part of their health costs. This system provides broad coverage to most of the population, but with large differences in the quality of health care provision (including waiting times for non-emergency services). A significant reform has been implemented gradually since 2003, expanding the range of guaranteed coverage and entailing a corresponding extension of government subsidies to low- and middle-income population groups. In contrast to other policies, this reform has been pursued in a very consistent and solid way, although some failures can be detected regarding the budget provided for public health and administrative processes. Above all, primary health care within the public system has shown great advances in coverage and in quality. In the domain of the more complex systems of secondary and tertiary health care a more problematic situation can be observed. These levels show deficits in budget and in the number of well-trained professionals available. There is still a huge gender gap in the contribution rate, since maternity costs are borne only by women.

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

## Cyprus

### Score 7

High-quality medical services are provided by the public sector, which is the main system available, the private sector – clinics and individual doctors – as well as by several other programs typically reserved for professional groups. A shift toward private health care prior to 2011 has been reversed, as the number of those who can afford the cost is declining. Despite constraints and deficiencies in infrastructure and human resources (as shown in OECD statistics), which lead to long queues, waiting lists and delays, the quality of services offered by the public system is acknowledged by the WHO to be high. This is also testified by indicators for 2011, such as those for infant mortality (2.6 per 1,000 births) and life expectancy at birth (79 years for men, 82.9 for women). Preventive medicine is specifically promoted, with Cyprus ranking high with respect to expenditure in this area.

Although access to public health-care services is based on specific criteria, the system is quite inclusive, and health care is available both in hospitals in the main towns and in townships and rural centers. Emergency services are available for free to all. All employees of the public service are also eligible for free health care and medicinal products, irrespective of income. This creates an imbalance in access, given that public-sector salaries and benefits are already significantly higher than in the private sector.

The main problem is that Cyprus is the only EU member lacking a national health system, though a law on the issue was passed in 2001 and an organization for the system's creation has been formed. This limits inclusiveness, and helps maintain the high cost of private-sector medical services.

## France

### Score 7

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

The problem is cost efficiency and the containment of deficits, which have been frequent in recent years. Since 1996, parliament has voted on an annual expenditure target for the whole system but, in practice, this target

has been regularly exceeded. The government has found it difficult to impose targets for the evolution of expenditures, pharmaceutical prices, medical treatment and remuneration. Savings have improved recently but the high consumption of medicine is an issue still to be tackled with more decisive measures.

## Iceland

### Score 7

Health care policies in Iceland have in modern times provided high-quality health care to all citizens, very efficiently. However, this has varied regionally. The capital area of Reykjavík and its surroundings, as well as the northern city of Akureyri, have had significant advantages compared with other more peripheral areas. This has meant that patients in more remote regions have had to travel sometimes fairly long distances to get specialized medical help. The economic crisis forced the government to undertake serious cutbacks in peripheral-region hospitals, closing departments and centralizing specialized care facilities. In addition, smaller regional hospitals and health care centers have had serious problems in recruiting doctors. The University Hospital in Reykjavik (LSH), by far the largest hospital in Iceland, has for some years been in difficult financial straits, as the government has been unable either to provide additional public funds or permit the hospital to raise revenue independently through means such as patient service fees. The resulting shortage of nursing and other medical staff has undermined patient safety due to heavy work pressures and long hours. Patients around the country sometime have to wait for months for appointments with specialized doctors.

## Italy

### Score 7

Italy's national health system provides universal comprehensive coverage for the entire population. Depending on income levels, limited contributions to the costs can be due. The health care system is funded predominantly by the national budget, but is administered by regional authorities. On average the services provided achieve medium to high standards of quality, but, due to significant differences in local infrastructures, cultural factors, and the political and managerial proficiency of local administrations, the quality of public health care is not nationally uniform. In spite of similar levels of per capita expenditure, services are generally better in northern and central Italy than in southern Italy. In some areas of the south, health care costs are also out of control because of corruption, clientelism and administrative inefficiency. 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 programs are effective and well publicized in some regions (for instance, in Tuscany and other regions of northern and central Italy) but are much weaker and less accessible to the average health care user in other regions like, for example, Sicily.

## Japan

### Score 7

Japan has a universal health care system. It also has one of the world's highest life expectancies – 79 years for men and almost 86 for women (at birth). Infant mortality rates are among the world's lowest (2.8 deaths per 1,000 live births). However, a prevailing shortage of doctors represents one serious remaining bottleneck. The number of doctors per capita is some 40% lower than in Germany or France. However, judging on the basis of fundamental indicators, Japan's health care system, in combination with traditionally healthy eating and behavioral habits, delivers good quality.

Nonetheless, the health care system faces a number of challenges, as pointed out by the OECD in 2009. These include the needs to implement cost containment, enhance quality and address imbalances. Some progress with respect to cost containment has been made in recent years, but the new LDP-led government seems determined to postpone adjustments for electoral reasons. For instance, senior citizens are supposed to pay 20% of hospital or clinic charges themselves according to law, but a temporary reduction of this share to 10%, introduced in 2008, is to be continued. In January 2013, the Supreme Court ruled against a ban on online sales of certain over-the-counter drugs, but the government has shown itself reluctant to change existing rules accordingly, despite Prime Minister Abe's stated intention of making health care deregulation a future area of strategic growth.

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

#### Citation:

Jones, R. S. and B. Yoo (2011), "Japan's New Growth Strategy to Create Demand and Jobs," OECD Economics Department Working Papers, No. 890, OECD Publishing. <http://dx.doi.org/10.1787/5kg58z5z007b-en> (accessed in June 2012)

## Malta

### Score 7

Malta provides quality health care to all its citizens, with quality inpatient and outpatient hospital services for free. This is reinforced by agreements with the United Kingdom and in 2012, with Italian hospitals to service patients in need of special treatment not available locally. In the last World Health Organization (WHO) world ranking of health systems, Malta placed fifth worldwide. A number of private hospitals also exist, but until recently there has been little or no cooperation between the state and private sectors.

Inclusiveness, however, can at times be more theoretical than real. All citizens are entitled to free hospital care and vulnerable groups are entitled to state support for a list of prescription medicines. All citizens are entitled to free medicines in relation to specified chronic diseases such as high blood pressure and diabetes. However, the support given to oncology patients is limited and such patients have to purchase expensive treatments, often running thousands of euros. Patients suffering from other conditions, although treated in state hospitals, are still required to provide medication themselves, as in the case of patients with certain kinds of eye conditions. Here too, costs can be exorbitant. Long waiting lists tend to push many patients to access health needs through private options, though in 2012 the government fostered cooperation with private hospitals to reduce waiting lists for certain in-demand procedures. The private sector accounts for approximately two-thirds of the workload in primary health care; however, health care delivery in Malta is dominated by the public sector, with 96% (1,748 beds) of hospital beds publicly owned and managed, while the remaining 85 are privately owned. Inadequate managerial capacity and political interference sometimes undermine equity in health delivery and the unacceptable waste of medical resources has recently been brought to light.

In 2010, Malta's total health care expenditure in relation to GDP was 8.6%. This compares well to the EU-27 average of 9%. It is estimated that in Malta, as much as 65% of total health care expenditure is financed by the government. Unfortunately, the lack of reliable data makes an evaluation of cost efficiency difficult to determine. The European Union has often stressed to Malta the need for reform, emphasizing that current health policies are no longer sustainable.

#### Citation:

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

The World Health Report 2000

Healthcare Delivery in Malta 2012 [www.pwc.com/en\\_MT/.../healthcare/.../healthcare\\_delivery\\_august\\_2012](http://www.pwc.com/en_MT/.../healthcare/.../healthcare_delivery_august_2012)



## Netherlands

### Score 7

The hybrid professional market system for health care provision is no longer contested. A recent report by the Social and Economic Council of the Netherlands intends to strengthen outcome steering against input and throughput steering. A considerable expenditure rise in long-term care is expected and is of great concern to policymakers, as is an anticipated deficit in human capital.

Relative satisfaction with the present health care system is based on the following evidence:

### Quality

Mortality from cardiovascular diseases has continued to decrease. While deaths from cancer were slightly up, preventive breast cancer screening for women is almost exhaustive. Average life expectancy is up; there are fewer heavy smokers and drinkers, and obesity seems to have stabilized. Patient satisfaction is high (between 7.7 and 7.9), especially among the elderly and lower-educated patients. Patient safety in hospitals, however, is a rising concern both for the general public and for the (underperforming) Health Inspectorate.

### Inclusiveness

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

### Cost Efficiency

In the new System of Health Accounts, the Dutch rank second only after the United States (11.9% and 17.4% of GDP for health care), followed closely by France and Germany. This is largely due to the relative amount spent on long-term care – hence the concern among policymakers. On the plus side, it should be mentioned that care costs in 2011 were at +3.2% – much lower than in the previous decade; the number of people employed in care was up +2.9%. Labor productivity in health care rose by +0.6% annually – almost all in hospital care and none in long-term care. Private business profits for general practitioners, dentists and medical specialists in particular increased much more than general business profits.

## Citation:

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

CBS (2012) Gezondheid en zorg in cijfers 2012, Den Haag

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

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

## Norway

### Score 7

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

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

## United States

### Score 7

In March 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA), thereby implementing major parts of Obama's reform proposal. The main goals of the legislation are to lower costs in the health care sector and extend health care coverage to more people. The design of the ACA is essentially to fill gaps in the patchwork of financing arrangements that are embodied in the existing health care system. Specifically, it provides a mandate for employers of a given size to provide coverage for employees; it requires individuals (not otherwise covered) to obtain coverage, providing subsidies for individuals who otherwise cannot afford coverage; it expands the state-administered Medicaid program for low-income citizens, raising the income ceiling for eligibility; it requires health insurers to extend coverage of an insured family's children to the age of 25; and it prohibits insurers from denying coverage on the basis of "pre-existing conditions." Although it will not achieve universal coverage, it is projected to increase coverage from 83% to 94% of the population. Many of those not covered will be healthy young people who could afford coverage but who choose to pay the penalty associated with the individual mandate rather than pay out of pocket for insurance. According to calculations by the Congressional Budget Office, the ACA will reduce the federal deficit by \$85 billion.

Health care reform was a highly controversial topic and still is a contested political issue. Republicans in the House voted 37 times to repeal "Obamacare." Public opinion has been fairly evenly divided on approval versus disapproval of the bill – although a large fraction of those who disapprove believe that the bill did not go far enough. As of 2013, the administration is in the throes of an extraordinarily difficult implementation process, with many provisions going into effect between 2014 and 2019. Some state governments, especially those headed by Republican governors, have so far declined to provide the expanded Medicaid coverage to low-income families, even though the federal government would pay 90% of the cost. Other states are also declining to set up state-level insurance cooperatives for individual purchases of insurance.

Meanwhile, the ACA has no major provisions that will help reduce health care costs. The health care system – accounting for about 17% of GDP in one of the world's wealthiest economies, and yet producing worse health and longevity results than many other countries experience – will continue to be highly wasteful.

## Portugal

### Score 6

Portugal's population shows comparatively good levels of overall health. Life expectancy has continued to grow, and in 2011 surpassed the EU average for the first time for males (77.6 years versus an 77.4 EU average), and for the first time since 2005 for females (84 years versus an 83.2 EU average). Infant mortality also diminished, and remains lower than that of Denmark, Germany, France or the Netherlands.

Portugal has a universal and general National Health Service (NHS), accessible to all residents. This has come under particular financial pressure as a result of the pressure on Portugal to curb public expenditure. Health expenditure has been considerably cut and the costs levied for using the NHS have increased – more than doubling in 2012. These higher costs – with an emergency room visit now costing €20 or almost 5% of the net monthly minimum wage – appears to have an adverse impact on inclusiveness, as they may price out some poorer users.

Overall, Portugal presents a cost efficient health system. It has successfully cut health expenditure further in the last two years, albeit at the cost of inclusiveness and, to a lesser extent, of quality.

Citation:

(1) Eurostat data -"Life expectancy at birth, by sex"

## Slovenia

### Score 6

The Slovenian health care system is dominated by a compulsory public insurance scheme. This scheme guarantees universal access to basic health services, but does not cover all costs and treatments. In order to close this gap, citizens can take up additional insurance by Vzajemna, a new mutual health insurance organization established in 1999 or, since 2006, by commercial insurance companies. The quality of services, which are partly delivered by private providers and are organized locally, is relatively good, and total health spending is slightly below the OECD average. However, both the compulsory public health insurance scheme and the supplementary health insurance providers have suffered from severe financial problems for some time. While the need for reforms has been broadly accepted, no major reforms have been adopted.

## Spain

### Score 6

The relatively well-considered (in terms of quality, inclusiveness and cost efficiency) Spanish public health care system has suffered remarkable budgetary cuts during the period 2011 – 2013. The most significant adjustment measure introduced was the Royal Decree Law of “Urgent Measures to Guarantee the Sustainability of the National Health System and Improve the Quality and Security of its Prestations” in April 2012. This new legislation meant: (1) refusal to give assistance to unregistered immigrants and (2) an increase of the percentage of medicines paid for by the users, including senior citizens (who have now to pay 10%) and general workers (40% to 60% depending on their incomes). Following this reform, the inclusiveness of the system has eroded while cost efficiency has improved, particularly regarding pharmaceuticals. However, health care spending still absorbs a large amount of public money, representing approximately 9.3% of GDP – near the OECD average.

Whereas the current economic crisis makes the situation very difficult in the short run, population aging trends (in 10 years time, one out of five Spaniards will be over 65 years old), chronic disease proliferation, new and highly expensive treatments, and a general abuse of free medical appointments put the sustainability of the system at high risk in the medium and long term. Quality has deteriorated in recent years. The most recent reports emphasize deficiencies in patient rights and sickness prevention. There is also significant interregional inequality. Waiting lists continue to grow, and the use of alternative private services has increased accordingly, thus further lowering inclusiveness.

## Turkey

### Score 6

Health care has improved in terms of quality, inclusiveness and cost efficiency, and the sector has grown nearly fourfold over the last decade. From 2003 to 2011, the number of intensive-care beds increased to 20,977 from 2,214, and the number of full-time beds increased to 38,272 from 6,839. The government financed the construction of 544 hospitals and medical buildings and 1,467 first-step health facilities. Between May 2011 and May 2012, the percentage of the population covered by the social security system rose from 84% to 86%. The mandatory General Health Insurance System, in force as of January 2012, extends health coverage to the whole population, while contributions paid by the individual or by the state are based on a means test. In this context, the number of people who pay for medicine or health care themselves decreased to 11.1% (2011) from 32.1% (2003).

Health care overall has improved in coverage area and in quality. Health services are now free of charge; the scope of the vaccination program was broadened; the scope of newborn screening and support programs were extended; “community-based” mental health service was initiated; and cancer screening centers offering free services were established in many cities.

The Medium-Term Plan (2013 – 2015) designates health as a priority area for public expenditures. Total health expenditure as a share of GDP has been increasing steadily since 2003, reaching an estimated 6.5% in 2010. According to the World Health Organization (WHO), Turkey maintained 167 active physicians per 100,000 people in 2012. This is an increase compared to 143 physicians per 100,000 people in 2008, but is still considerably below the level of other OECD member countries. In this context, in February 2012 the government removed legal obstacles to hiring foreign doctors and nurses in private health institutions.

Citation:

Ministry of Development: Turkey's Sustainable Development Report: Claiming the Future, June 2012, Ankara.

Ministry for EU Affairs (2013)“2012 Progress Report prepared by Turkey”, Ankara.

World Bank (2013)“World Bank Group - Turkey Partnership: Country Program Snapshot”, Washington D.D.: The World Bank.

## Croatia

Score  
value\_6

In Croatia, health care services are mainly publicly provided on the basis of a system of social health insurance paid through employer and employee contributions. The system is broadly inclusive. Primary care is widely available while specialized care is provided in regional hospitals and national clinical centers which divide work on the basis of the complexity of procedures. However, access to care is adversely affected by the regional variation in the range of care provided, and there is some evidence of significant health inequalities between low and high income groups (Mastilica, 2012). Resources are not always used efficiently and suppliers' interests often lead to duplication of resources or syphoning of funds. Due to the low employment rate and the ageing population, the system runs at a constant deficit which is covered from the central government budget. Due to resource constraints, patients are expected to make co-payments for an increasing range of services. The Milanović government adopted a National Health Care Strategy 2012 – 2020 in September 2012, which apart from a detailed analysis of the current situation, provided a list of detailed proposals for gradual improvement of the health care system, while ruling out any radical reforms. By reducing the social insurance contribution to the Croatian Health Insurance Fund (Hrvatski zavod za zdravstveno osiguranje, HZZO) from 15% to 13%, it further limited the available resources.



Citation:

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

## Ireland

### Score 5

#### Quality:

During the period under review, the task of rationalizing and streamlining the delivery of public health services has continued in the face of opposition from those living in areas that are losing their small-scale hospitals and units in favor of a smaller number of more centralized "centers of excellence." The gradual improvement in the overall delivery of health care and outcomes has often received less than its deserved publicity. Measured in terms of outcomes (life expectancy, infant mortality rates, survival rates from major illnesses), the system compares reasonably well with those of other western European countries.

#### Inclusiveness:

The Irish health care system is a two-tier system, with slightly more than half the population relying exclusively on the public health system and the rest paying private insurance to obtain quicker access to hospital treatment. The rising cost of private health insurance is leading to a steady increase in the numbers relying entirely on the public health system. Problems with access to health care provoke more complaints and controversies than any other public service in Ireland. These center round waiting lists and overcrowding rather than the quality of the care. In many areas the quality of the medical care that is provided through the public health system compares favorably with that provided through the private system. In November 2012, the government published a new strategic plan called "Future Health." One of its core aims is to introduce universal health insurance.

#### Cost efficiency:

The Irish health system is costly relative to GDP despite the favorable (that is, relatively young) population age structure. When spending is standardized for the population age structure, Ireland emerges as having the third highest level of health expenditure relative to GDP among the OECD countries. In their most recent review of the agreement with Ireland, the Troika expressed concern about the continuing overruns in health spending and now intends to monitor this spending monthly.

Citation:

For a recent study of the cost efficiency of the Irish health system see:  
<http://www.publicpolicy.ie/wp-content/uploads/HealthSystemIreland.pdf>

## Mexico

### Score 5

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

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

## Poland

### Score 5

Public health insurance covers some 98% of Polish citizens and legal residents in Poland. However, access to health care is highly uneven, as public health insurance covers only a limited range of services and as out-of-pocket payments feature prominently in the system at large. Moreover, the poor quality of some services falls far under citizens' expectations, and for some services, patients must wait for an unreasonable duration. As a result, a 2012 survey found that only 11% of respondents had a positive opinion about the work of the country's National Health Insurance Fund (Narodowy Fundusz Zdrowia, NFZ). The reforms by the Tusk government have largely focused on the corporatization of hospitals. As this has not resulted in an improvement of working conditions or in an improved quality of health care,

the reforms have been widely criticized. In October 2012, the Health Minister Bartosz Arlukowicz announced a new round of reforms, with a focus on decentralizing decisions made by the NFZ.

## Slovakia

### Score 5

Slovakia has a mandatory health insurance system that provides all residents with primary, secondary and tertiary care, pharmaceuticals and medical devices. The state covers health insurance for children, students, pensioners, (registered) unemployed and women on maternity leave. Since 2004, citizens can choose between a public and two private health insurance funds. From a comparative perspective, the quality and efficiency of health care services are relatively low, and the high politicization of and the frequent changes to health care policy have not helped to achieve improvements. While the Radičová government stressed market principles and individual responsibility, the Fico government has put more emphasis on equity issues and on improving the financial situation of the public health insurance fund. It has called for the return to a single public health insurance fund and the nationalization of the two private health insurance funds, threatening repeatedly that the government would be ready to use all legal means to reach this aim.

## Bulgaria

### Score 4

The Bulgarian healthcare system is based on a regulated dual monopoly: on the one hand a state-owned and controlled health fund financed through obligatory contributions by all income earners, and on the other, the union of health providers who 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. The quality of health care services is average to lower. While life expectancy has risen and infant mortality has dropped, overall mortality has remained high. A major efficiency problem of the Bulgarian health system is the lack of incentives for preventive measures and for stimulating healthier lifestyles, given that prevention is by far the least costly way of improving the health situation.

## Hungary

### Score 4

Health care has been one of the most conflicted policy fields in Hungary. Policy-making has suffered from the lack of a separate ministry dealing with health care concerns. The Orbán government's organizational reforms have been largely confined to the nationalization of hospitals, which were previously run by municipalities. This move has made it easier to reduce overcapacity and to reduce regional and local disparities, but has also raised the danger of over-centralization. The Orbán government has failed to tackle mismanagement and corruption in the health sector, the discretionary refusal of services and the increasing brain drain of doctors to other countries. The severe cuts in public spending on health care have further aggravated these problems.

## Latvia

### Score 4

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

Public spending on health in Latvia totaled 3.7% of GDP in 2011. Latvia has one of the EU's highest rates of private, out-of-pocket health care expenditure. Patients' private expenditure on health care constituted 40% of total health financing, bringing total spending to 6.6% of GDP. This remains under the EU average for public health care funding.

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

The Euro Health Consumer Index 2012 ranks Latvia near the bottom of the ranking index, at 31st place out of 34 countries. The country's health care system is based on a residence principle. Residents have free access to a family physician, who approves state-paid further treatment. This system results in long queues. Health care benefits are available at state- and

municipality-owned institutions, as well as private inpatient and outpatient facilities. The large copayment required for services presents barriers to lower-income groups. The implementation of the Social Safety Net Strategy 2009 – 2011 sought to address this by introducing a compensation mechanism for low-income groups. Needy and low-income households received full exemptions from copayments and pharmaceuticals charges in order to lower the burden of health costs; in total, 61,000 outpatient visits and 3,800 inpatient visits were covered for these patients under the program.

Financial constraints focus public monies on the provision of emergency care, while creating long waiting times for nonemergency care. Low-income households not qualifying for assistance face steep patient copayments and pharmaceutical charges, limiting access to care.

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

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

- the share of resources allocated to health care is inadequate
- the allocation of resources among different providers is improving – shifting from expensive hospital care to less costly ambulatory care, and putting a higher priority on primary care. Latvia succeeded in reducing inpatient care expenditures from 50% of the total in 2008 to below 35% in 2011
- the share of resources allocated to different types of services is not efficient, as evidenced by long waiting lists, a lack of attention to chronic conditions, and a lack of focus on preventable lifestyle diseases.

Citation:

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

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

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

## Romania

### Score 4

Romania has a public health insurance system with claim to universal coverage. However, the quality and equity of Romania's public health system has been undermined by inadequate funding: Romania has the lowest health budget allocation of all EU member states. Since 2002, the healthcare budget fluctuated around 3.5% to 4% of GDP, though this share has increased marginally to 4.2% in 2013. Due largely to this underfunding, the de facto availability of many medical services is severely limited, thereby leading to widespread bribe-giving by patients even for basic services. Moreover, for many specialized procedures patients have to resort to private providers, which offer higher quality services but are often quite expensive, thereby leading to significant inequities in medical care access. Cost efficiency is undermined by the failure of the National Health Insurance Agency (CNAS) and the local authorities to monitor the hospitals' performance and program investments in the sector. The complex and sometimes contradictory set of regulations concerning the relationship between the private and the public sector further aggravates this problem.

## Greece

### Score 3

Up until the onset of the crisis, Greece spent little on pharmaceuticals and, despite inefficiencies of resource management and an established corruption culture affecting access, it still performed comparatively well in terms of infant mortality and life expectancy. For instance, in the 2000s in Greece infant mortality decreased over time, according to OECD data.

After the crisis erupted, however, public spending on health care was subjected to cuts similar to those effected in other welfare policies. Social insurance funds delayed payments to pharmacies. The latter used to deliver medicines to insured patients over the counter and then obtain payment by submitting receipts to the patients' social insurance funds. However, these funds saw their finances deteriorate as they depended heavily on the state budget. Moreover, the restructuring of the Greek public debt in February 2012 affected negatively the finances of health insurance funds, which held parts of that debt. In 2011 – 2013 the economic crisis was transformed into a severe crisis for social insurance funds.

Similar trends occurred in the finances of public hospitals, which also depended on social insurance funds for health care costs incurred by insured patients. Payments to hospitals came in arrears, while the Ministry of Health's budget was itself subjected to cuts.



Eventually, at various time points in 2011 – 2013 suppliers of necessary goods and services to public hospitals delayed or completely refrained from making deliveries to such organizations. Additionally, the motivation of doctors serving in public hospitals suffered from wage cuts imposed across the public sector.

Event though public health care was in crisis, no patient was refused treatment in Greek hospitals, including non-citizens who had never paid any social insurance contributions, such as the migrants from South Asia and Sub-Saharan Africa. Yet the fact remains that health care policy only partly achieved the three criteria, namely quality, inclusiveness and cost efficiency.

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