



Health Report

Health Policy

Sustainable Governance Indicators 2016

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 policymaking 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 81 years for males and 85 years for females. As of 2014, 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. These subsidies vary by canton, and policy change is frequent. For example, the canton of Bern has reduced subsidies in recent years. In general, 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. In 2014, the people decided in a popular vote to retain present system.

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

Australia

Score 8

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

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

Regarding inclusiveness, significant inequality persists in access to some medical services, such as non-emergency surgery and dental care. Indigenous health outcomes are particularly poor. In 2012, the federal government announced a dental scheme aimed at addressing inequity in access to dental care. Launched on 1 January 2014, the scheme provides up to AUD 1,000 per two-year period for basic dental services for children of low and middle income families. The scheme also increased funding available to the states and territories for dental services for low-income adults. Lack of access to non-emergency surgery reflects, to a significant extent, the funding constraints of the states and territories, which are responsible for funding public hospitals. This was a significant motivation behind the 2011 National Health Reform Agreement, which sought to provide for more sustainable funding arrangements for Australia's health system. Key features of the agreement include additional federal funding for hospitals from 2014 – 2015 to 2019 –2020 and for

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

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

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

Canada

Score 8

Like educational policy, health care is primarily the responsibility of the individual provinces. Canadians are generally in good health, as evidenced by the high level of life expectancy. The quality of the Canadian health system is good but continues to trail behind that of comparable European countries. The number of practicing doctors and hospital beds per 1,000 inhabitants is well below the OECD average, as is the number of MRI and CT units per million (OECD, *Health at a Glance* 2013).

The most glaring problem with the Canadian system is timely access to care. Canadians regularly experience long waiting times for certain procedures (largely confined to those that are not life threatening). A recent report from the Health Council of Canada (2013) found only limited progress in reducing these wait times.

Inefficiencies in the system have led to increased demand for for-profit clinics, which endangers Canada’s otherwise impressive record of equity in health care. Currently, with high-quality care freely provided for virtually the entire population, lack of income is still not a barrier to treatment. One effect of equity in access to health care services is the small gap in perceived health between the top and bottom income quintiles. One additional access issue is presented by the exclusion from

Medicare coverage of dental care, vision care and drugs prescribed for use outside of hospitals, resulting in unequal access across income groups to these types of health-care services.

Quality of care is also of some concern. Canada has relatively high rates of infant mortality, and according to a 2014 report by the U.S. based Commonwealth Fund that compared health care systems internationally, ranks poorly on some safe-care measures.

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

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

Citation:

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

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

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

Organization of Economic Development. "Health at a Glance 2013", OECD Indicators, retrieved from <http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf>

Czech Republic

Score 8

The Czech health care system, based on universal compulsory insurance, ensures a wide range of choice for both providers and consumers of health care, and provides a level of service which is high by international standards. Public health insurance in the Czech Republic is provided through seven health insurance companies, the largest being the General Health Insurance Company (Všeobecná zdravotní pojišťovna). In line with its campaign promises, the Sobotka government abolished the charges introduced in 2012 for outpatient services and for prescriptions at the pharmacy. In contrast, the regulatory fee for medical emergencies has remained in force. In 2015, a discussion on obligatory vaccinations against infectious diseases emerged. As it stands, children can only attend a nursery or preschool if they have

received the required regular vaccinations, have evidence of immunity against a particular disease or evidence that they cannot be vaccinated due to a permanent contraindication (a prohibition against vaccination for health reasons). Opponents of mandatory vaccinations have called for changing the law on public health protection, arguing that only parents have the right to decide whether or not to vaccinate a child. This proposal did not find a majority in the Chamber of Deputies.

Denmark

Score 8

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

Although Denmark spends a lot on health care, the OECD considers its performance “subpar.” In 2013, health spending in Denmark was 10.4% of GDP, well above the OECD average of 8.9%. There has been a trend of increasing health expenditures, mainly driven by a policy shift from a top-down system to a more demand-driven system. This shift has been motivated by a concern about long waiting lists; to address this, the government has moved to offer a “time guarantee,” where patients in the public health care system can turn to a private provider if a public hospital can’t meet a specified wait time limit for treatment.

The 2007 structural reform shifted the responsibility for hospitals and health care from the old counties to the new regions. Health care is financed by a specific tax, however, which is part of the overall tax rate and over which regions have no control. This governance structure is creating problems, with regions finding that they have an insufficient degree of freedom to meet the objectives formulated for the health system.

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

Recently, there has been much public debate about the quality of Danish hospitals. Increasing medicine prices are putting pressure on the financing of health care. The new government’s September 2015 budget proposal includes an extra DKK 2.4 billion for the health sector. The government’s program puts emphasis on a right to swift diagnosis and treatment as well as special efforts targeted at elderly medical patients. Since Denmark lags behind neighboring countries when it comes to cancer treatment, the government plans a new cancer strategy.

Citation:

OECD, Health at a glance 2015," (accessed 17 December 2015).

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

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

Estonia

Score 8

In terms of health care quality, Estonia can serve as a good example for how to achieve positive health outcomes with scarce resources. Public opinion surveys, regularly requested by the National Health Insurance Fund reveal that a majority of the population is well satisfied with the quality of and access to health services (70% and 41% respectively). However, compared to previous years, the primary indicators of satisfaction have declined by 3% to 5%.

Estonia has a social-insurance-based health system that includes some non-Bismarckian features such as general practitioners (GP). The insurance principle leads to a situation where access to health service is not universal, but depends on insurance status. Members of the working-age population not employed or in school are not covered by the national health insurance program. As a result, about 5% of the total population does not have free access to health care.

Long waiting times to see specialists or receive inpatient care are another major problem resulting primarily from structural factors such as budgetary limits and a bias toward acute/hospital care. The aging of the country's medical personnel and a shortage of nurses also pose challenges. However, the most significant social problem with the Estonian health care system is inequality across income groups, especially in terms of self-perceived health status. Here, Estonia is at the absolute bottom among OECD countries. This problem has not been given almost no policy or political attention.

Citation:

World Bank (2005).The State of Health Care Integration in Estonia. Summary Report. https://www.haigekassa.ee/sites/default/files/Maailmapanga-uuring/veeb_eng_summary_report_hk_2015_mai.pdf (accessed 30.10.2015)

Finland

Score 8

Health policies in Finland have over time led to improvements in public health such as a decrease in infant-mortality rates and the development of an effective health-insurance system. Finnish residents have access to extensive health services despite comparatively low per capita health costs. Yet criticisms are common regarding life expectancy, perceived health levels, the aging population and an inadequate provision of local health care resources. Finland's old-age dependency ratio is increasing substantially, although not as dramatically as in other EU countries. Many

clinics formerly run by municipal authorities have been privatized, which has led to increasingly attractive employment conditions for physicians.

Government planning documents outline preventive measures. For example, the 2015 Public Health Program is a central document that describes a broad framework to promote health across various sectors of the government and public administration. Similarly, the Socially Sustainable Finland 2020 strategy sets out the current aims of Finland's social and health policy. In November 2015, the government agreed on a major social and health care reform (SOTE) that will move responsibilities for social welfare and health care services from municipalities to 15 larger governmental entities. These services had up to now been managed by more than 150 municipal-level authorities; thus, the reform is expected to yield substantial public savings.

Citation:

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

Germany

Score 8

The German health care system is of high quality, inclusive and provides health care for almost all citizens. It is, however, challenged by increasing costs. Recently, the system's short-term financial stability was better than expected due to buoyant contributions resulting from the employment boom. However, long-term financial stability is challenged by the aging population. Health care spending as a proportion of GDP in Germany is higher (11.0% of GDP compared to 8.9% of GDP for OECD average) and increasing faster since 2010 than the OECD average (OECD, 2015). In its coalition agreement, the current grand coalition negotiated a variety of reform measures to increase the quality of health care, redefine some financial details, and reorganize the registration of physicians in private practices and the distribution of hospitals. The government is in the process of realizing many of these reforms. However, the government's health care reform agenda fails to address the high levels of health care expenditure.

The most important policies were the reduction of the contribution rate from 15.5% to 14.6% of gross wages and the confirmation of a fixed contribution rate for employers of 7.3%. Employee contributions are 7.3% and again equal employers' contributions. The additional contribution from employees, which was previously a lump-sum contribution, is now calculated as a percentage of their assessable income and can vary between insurance companies, reintroducing an element of competition. The strong growth in health care spending has forced the majority of insurance companies to increase contributions for 2016, despite the employment boom. This indicates that high levels of health care expenditure are a severe problem.

In 2015, the contribution rate for long-term care insurance increased by 0.3 percentage points. It will increase by a further 0.2 percentage points in 2017. Thus, a total of €5 billion will additionally be available for improvements in long-term care. A part of the additional revenue will feed a precautionary fund intended to stabilize future contribution rates. In addition, families that wish to provide care at home are given greater support. Two additional important policies were the Hospital Structures Act and an act to strengthen care provision in the statutory health insurance system. The aim of the Hospital Structures Act, effective from January 2016, is to improve the quality of hospital care and increase the financing available to hospitals. The care provision act guarantees a high level of access to medical care for patients in the future. These two acts will be key to increasing the quality of the German health care system.

Citation:

OECD (2015): OECD Gesundheitsstatistiken 2015, Ländernotiz: Wie hoch sind die Gesundheitsausgaben in Deutschland? 7. Juli 2015.

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

Israel

Score 8

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

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

Despite wide health coverage, low-income families still have poor access to dental care and nursing. Israeli health services also experience privatization pressures. An increase in supplemental and private medical-insurance and health care plans has resulted in reduced equality within the system. This process has been aggravated by a contraction in public funding: In terms of ensuring access to health care and when adjusting for population age, Israel ranks 16th out of 24 OECD countries surveyed.

Furthermore, the quality of health services and facilities varies based on geographic location, with periphery facilities often struggling to attract skilled personnel. Still, the Israeli system is fairly equitable in international comparison.

In 2013, the then minister of health chaired a special committee to strengthen the public health system, addressing core issues such as public and private health care services, private insurance regulation, the dual role of the ministry as regulator and service provider, and medical tourism in hospitals. However, the implementation of its recommendations was halted by the 2015 elections, which resulted in a new coalition. The current minister has chosen to advance reforms in mental health, technology and dental services, aiming to reduce waiting periods and improve accessibility for medical services.

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http://taubcenter.org.il/wp-content/files_mf/educationpolicybrieftaubcenter2015hebrew.pdf (Hebrew).

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

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Ministry of Health, "The insured population," Israeli Ministry of Health, 30.1.2012, (Hebrew).

Luxembourg

Score 8

Luxembourg's well-equipped hospitals offer a wide range of services, including high-end, expensive treatments, and waiting lists are rare, except for some services that are highly demanded. Luxembourg also has the highest share of patient transfers to other countries for treatment within the European Union. Due to the country's small size and the absence of a university hospital, it is not possible to provide every medical specialization. Necessary medical transfers to neighboring countries have the side effect of being beneficial for the finances of the state health-insurance program, as those services are in general less expensive abroad.

Drawbacks to the Luxembourg system include the aforementioned lack of a

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

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

However, Luxembourg's health care system is also considered one of the most expensive within the OECD countries, ranked fourth after Switzerland, Norway and the United States. The reasons for this include the country's high wages, the high ratio of technical medical equipment to residents and the low out-of-pocket costs for patients. Furthermore, authorities for years have tried to limit general provisions offered by all hospitals, instead offering incentives to limit treatment in specialized centers, for example. Another indicator is average treatment duration. At 7.35 days in 2013, Luxembourg has the highest average length of hospital stay in the European Union.

The introduction of the psychotherapists' law will improve the provision of health care, but also implies additional charges. While necessary health care reforms have been initiated, most of the details are still far from being implemented. Due to the favorable labor market and sustainable economic growth, the country's health-insurance funds recorded a net profit of 18% in 2015. Despite these factors, the new government is expected to swiftly implement a comprehensive reform of the health-insurance system (for example, introducing digital patient files, a primary-doctor principle and a performance-oriented fee-per-case system) with the aim of improving long-term budgetary sustainability within the health care and statutory nursing care systems.

Citation:

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

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

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

<http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do>

New Zealand

Score 8 Although there is both public and private provision of health care, access to the public hospital system is freely available to all New Zealand residents. Health care is not only generally of a high quality, it is also cost effective and relatively efficiently managed. At the same time, the sector faces growing expectations and rising cost pressures, partly as a result of an aging population, but also as a result of gradual increases in the numbers of immigrants. Gains have been made in terms of reducing the health status gap between Maori and non-Maori. Gaps in life expectancy have been reduced but more remains to be done, including changes in behavior and lifestyle. Concerns about health disparities have been an ongoing concern, as noted by 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, which are tasked with improving coordination between the ministry and district health boards and providing advice 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.

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

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

South Korea

Score 8 South Korea has a high-quality and inclusive medical system, and experienced the highest increase in life expectancy among OECD countries – an increase of 27 years, to 79.8 years – between 1960 and 2008. Preventive health checks have a high priority and are covered by insurance. Health spending per person increased significantly between 2000 and 2011, the highest growth rate among OECD countries. Yet total expenditure on health was only 7.4% of GDP in 2011, below the OECD average of 9.3%. The public sector provides slightly more than half of all health care funding. The universal health insurance system has relatively low premiums but high co-payments. South Koreans can freely choose doctors, including private practitioners, but coverage for medical procedures is less comprehensive 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. However, the Park government has gradually expanded the medical-insurance system to cover some rare diseases.

Citation:

OECD, Society at a Glance 2011, <http://www.oecd.org/korea/societat/aglance-asiapacificedition2011.htm>

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

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

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

United Kingdom

Score 8

The National Health Service (NHS) remains a cornerstone of the United Kingdom's universal welfare state and is widely regarded as a core public institution. However, the decentralization of clinical commission groups, which has affected all 8,000 general practices in England, has been controversial. Most health care provided by the NHS is free at the point of delivery. However, there are charges for prescriptions and dental treatment, though specific demographic groups (e.g. pensioners) are exempt from these charges. There is a limited private health care system.

While patient convenience may not be a central focus of NHS provision, attempts have been made to improve local health care by creating Health and Well-Being Boards to bring together representatives from all social services as well as elected representatives. The NHS's quality as measured by the Human Development Index (HDI) health index is very high (0.931). The financial position of many hospital trusts is rather precarious.

As a universal service, the NHS scores very highly in terms of inclusion. The Health and Social Act 2012 now also allows patients to choose a general practitioner without geographical restrictions. Quality is generally high. However, input and outcome indicators of health care, such as how quickly cancer patients are seen by specialists or the incidence of "bed-blocking" (i.e. where complementary social care is difficult to arrange and so patients are kept in hospital), vary considerably across localities. A report by the Commission on the Future of Health and Social Care in England recommended that health and social care services should be much more closely integrated.

The NHS is invariably at the center of heated public debates. Lately, the debate has been sparked by the changes in the 2016/17 tariff, which regulates public funding for patient treatment and staff salaries. The tariff changes have shifted and reduced the public payment to clinics and acute trusts – private hospital operating companies commissioned by the Department of Health. These changes contradicted many existing business models and aggravated the funding crises of several major acute trusts. There has also been a long-running dispute over the pay and working conditions of junior doctors, which has led to strikes. The dispute between the government and junior doctors concerns government attempts to achieve full 7/24 operation in response to concerns that treatment at weekend was of lower standard. Nevertheless, UK health care remains way above average on an international scale.

Citation:

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf

Austria

Score 7

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

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

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

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

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

The cap placed on the maximum number of working hours allowed for doctors in Austrian hospitals has exposed just how difficult conditions in Austrian hospitals can be. Many doctors are overworked and - in comparison to their counterparts in other EU countries - underpaid. Young doctors in particular are leaving the country for jobs in Germany, Switzerland or elsewhere. Other factors driving this brain drain include an excessive bureaucracy and weak practical training for young doctors in Austrian hospitals.

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

Belgium

Score 7

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

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

Another issue is that Belgium insufficiently emphasizes prevention, and spends more than similar countries on subsidized drugs, which generates a structural increase in health policy costs and hampers long-run sustainability within the health care system.

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

Chile

Score 7

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

failures can be detected regarding the budget provided for public health and administrative processes. Above all, primary health care within the public system has shown great advances in coverage and in quality. In the domain of the more complex systems of secondary and tertiary health care, a more problematic situation is evident. These levels show funding gaps and an insufficiency of well-trained professionals. There is still a huge gender gap with regard to health care contribution rates, since maternity costs are borne only by women. For these reasons, the quality and efficiency of public health care provision (government clinics and hospitals) varies widely.

France

Score 7

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

The problem is cost efficiency and the containment of deficits, which have been constant in recent years. Since 1996, parliament has voted on an annual expenditure target for the whole system but, in practice, this target has been regularly exceeded (facing a deficit of €13.2 billion in 2014 and €12.8 billion in 2015). The government foresees that this deficit will decrease below €10 billion in 2016, but this will largely depend on the anticipated creation of new jobs (60,000 in 2015 and, hopefully, 130,000 in 2016). The government has found it difficult to impose targets for the evolution of expenditures, pharmaceutical prices, medical treatment, physician remuneration and wages (for hospital employees). Savings have improved recently, but the high level of medication consumption is an issue still to be tackled with more decisive measures.

A new, and contested, health bill is currently under consideration in parliament. Its most disputed reform would remove the current patient co-pay; instead, exclusively the social security system would remunerate doctors. The medical profession argues that that this "socialization" of the system would spell the end of freely choosing one's doctor.

Italy

Score 7

Italy's national health system provides universal comprehensive coverage for the entire population. The health care system is funded primarily through the central government, but health care spending is administered by regional authorities. On

average, the services provided achieve medium to high standards of quality (a recent Bloomberg analysis ranked the Italian system among the most efficient in the world), but, due to significant differences in local infrastructures, cultural factors, and the political and managerial proficiency of local administrations, the quality of public health care is not nationally uniform. In spite of similar levels of per capita expenditure, services are generally better in northern and central Italy than in southern Italy. In some areas of the south, corruption, clientelism and administrative inefficiency have driven up health care costs. In these regions, lower quality levels and typically longer waiting lists mean that wealthier individuals will often turn to private-sector medical care. Regional disparities also lead to a significant amount of health tourism heading north. Early moves in the direction of fiscal federalism are now stimulating efforts to change this situation through the introduction of a system of national quality standards (correlated with resources), which should be implemented across regions.

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

To contain further increases in health care costs, payments to access tests, treatments and drugs exist. Even if these payments are inversely linked to income, they nevertheless discourage some of the poorest from accessing necessary health care services. Similarly, additional medical services are only partially covered by the public health care system, while dental health care is not covered at all.

Over the last few years, the number of people accessing health care services offered by NGOs formerly operating in developing countries has increased.

Citation:

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

Japan

Score 7

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

Nonetheless, the health care system faces a number of challenges. These include the needs to contain costs, enhance quality and address imbalances. Some progress with respect to cost containment has been made in recent years, but the LDP-led government seems to have been determined to postpone adjustments for electoral

reasons. The Ministry of Health, Labor and Welfare has dragged its feet on liberalizing the market, and a considerable number of regulations deemed excessive or unnecessary remain in place. More positively, the 2015 Health Policy White Paper, including its list of recommendations, was prepared in collaboration with American and European business organizations in Japan.

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

Lithuania

Score 7

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

Lithuania spent only about 7% of GDP on health care in 2010. This share increased during the 2007 – 2009 period, fell again in 2010 due to the economic crisis, with lower contributions by employees and their employers to the National Health Insurance Fund largely offset by budgetary transfers. Spending on preventive-care and other related health programs as a percentage of current health care expenditure is quite low, while spending on pharmaceutical and other medical non-durables (as a percentage of current health expenditure) is quite high.

Nevertheless, new prevention-focused programs were recently introduced by the National Health Insurance Fund. The provision of health care services varies to a certain extent among the Lithuanian counties; the inhabitants of a few comparatively poor counties characterized by lower life expectancies (e.g., Tauragė county) on average received fewer health care services. Out-of-pocket payments remain high (in particular for pharmaceuticals), a fact that may reduce health access for vulnerable groups. Seeking to improve service quality and cost efficiency, the previous government sought to optimize the network of personal health care organizations; the overall number of these bodies was consequently reduced from 81 to 62 by the end of 2012. The current government by contrast places more emphasis on the accessibility of health services, the role of public health care organizations in providing these services, and the issue of public health in overall health policy. There is a need to make the existing health care system more efficient, by shifting more resources from costly inpatient treatments to primary care, outpatient treatment and nursing care. A new plan to consolidate the network of health care providers

(especially hospitals) has been proposed by the Ministry of Health Care, but has met with strong opposition from the parliamentary health care committee and some interest groups.

Citation:

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

Malta

Score 7

Malta provides quality health care to all its citizens, with quality inpatient and outpatient hospital services offered for free. This is reinforced by agreements with the United Kingdom, as well as additional contracts struck in 2012 with Italian hospitals to service patients in need of special treatment not available locally. The World Health Organization (WHO) in its first World Health Report in 2000, ranked Malta's health care system among the top ten in the world. Meanwhile, a 2015 survey from Numbeo, an independent research center, stated that Malta had the second best health care in Europe. However, in December 2013 the Euro Health Consumer Index gave Malta low scores in terms of patient rights and information, waiting times, and lack of physical education. The government has launched a food and nutrition policy and action plan to tackle Malta's high incidence of obesity and undiagnosed diabetes.

A small number of private hospitals also exist.

While vulnerable groups are entitled to state support for a list of prescription medicines, all citizens are entitled to free medicines in relation to specified chronic diseases such as high blood pressure and diabetes. However, other more expensive treatments – for instance, those required by oncology patients or necessitated by certain eye conditions – are given only limited coverage, and such patients face treatment costs amounting to thousands of euros. Much has been done to reduce patient waiting times and dependence on private hospital care. The government has also addressed the general hospital's limited bed spaces by building new wards, which had opened in 2008 with fewer bed spaces than the previous hospital. The government has also opened a new Oncology Hospital on the same site.

The private sector accounts for approximately two-thirds of the workload in primary health care; however, health care delivery in Malta is dominated by the public sector, with 96% (1,748 beds) of hospital beds publicly owned and managed, and the remaining 85 are privately owned. Inadequate managerial capacity and political interference sometimes undermine equity in health delivery and the unacceptable waste of medical resources has recently been brought to light.

In 2010, Malta's total health care expenditure amounted to 8.6% of GDP, compared to an EU27 average of 9%. Public financing accounts for as much as 65% of total health care expenditure in Malta. Unfortunately, the lack of reliable data is an obstacle to the accurate evaluation of cost efficiency. A more recent EU-wide study indicated that Malta's health care expenditure amounted to 9.1% of GDP, compared to an EU28 average of 8.7%. The European Union has often stressed the need for reform to ensure sustainability. Indeed, a Health Care Reform process is currently being developed aims to achieve a sustainable level of expenditure, while also ensuring an adequate level of provision. A National Health Systems Strategy for 2014 to 2020 was published in 2014.

Citation:

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<http://www.timesofmalta.com/articles/view/20151018/local/two-new-wards-to-open.588577>
 Euro Health Consumer Index 2013
 Malta Today 25/1/2015 Malta's Healthcare Ranked second best in Europe

Norway

Score 7

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

Yet though Norway offers high-quality health care services to the entire population, the efficiency of this system is questionable. In a major structural health care reform in 2002, ownership of all public hospitals was transferred from counties to the central state. Subsequently, new health care regions were established, which were larger than the previous ones. These regions were given responsibility for managing service delivery, but without ownership. The intention was for these regions to streamline and coordinate health care services, thus imposing a stricter regime of budget discipline. However, reorganization has been slow and costly; the process

remains ongoing, and even after more than 10 years, is nowhere near complete. Vast amounts of resources are being consumed by procedural work and pervasive conflict, while efficiency gains, if they are to come, have yet to be identified. This reform has been uniquely unsuccessful by Norwegian standards. A previous reform, which came into effect in 2001, established a general-practitioner system for the first time, thus ensuring that all persons and households would have a designated primary-care doctor or practice. This was implemented with relative ease, and contributed to a notable improvement in access to high-quality primary health care.

Spain

Score 7

The Spanish national health care system is relatively well-thought out and it largely achieves the criteria of quality, inclusiveness and cost efficiency. According to a report published in 2015 by the OECD, the country's life expectancy is the second-highest in the OECD (after Japan). Low mortality rates from all causes of death (including heart diseases, cancer, transport accidents or infant mortality) demonstrate the effectiveness of the policy. However, rates of mental illnesses, diabetes and drug consumption are higher than the European averages. The same report recommended that Spain better address tobacco smoking, alcohol consumption and obesity among adults and children; avoid unnecessary hospital admissions by improving treatment for people living with one or more chronic diseases; and improve the quality of acute care for people admitted to hospital for heart attacks or strokes, thus increasing survival rates.

Spaniards' self-perceptions of their own health status and their opinions regarding the national health care system reflect a degree of satisfaction that is quite high in cross-OECD comparison. Access to a core set of high-quality health services is guaranteed through a public insurance system that covers 99% of the population. However, the number of practicing doctors, nurses and hospital beds per 1,000 residents is relatively low. Moreover, the general quality of this system has deteriorated in recent years due to austerity measures (although health care spending still accounts for approximately 9% of GDP, close to the OECD average). The most recent reports emphasize deficiencies related to waiting lists, patient rights and sickness prevention. There is also interregional inequality.

Inclusiveness suffered at the beginning of the 2011 – 2015 legislative term as a consequence of the royal decree law dubbed “Urgent Measures to Guarantee the Sustainability of the National Health System and Improve the Quality and Security of its Services.” This legal reform, approved in 2012, involved two main measures. The first blocked the provision of assistance to unregistered immigrants (although primary healthcare for illegal immigrants was reinstated in 2015). The second measure consisted of an increase in the share of pharmaceutical costs paid for by patients, including senior citizens (who must now pay 10%) and general workers (who must cover 40% to 60% of medicine costs, depending on their incomes).

Conversely, the system has recently become more cost efficient, particularly with regard to pharmaceutical spending. However, the system's sustainability is at risk over the medium and long term, as a consequence of the aging population (one out of five Spaniards will be older than 65 by 2025) and the subsequent increase in the incidence of chronic diseases.

Citation:

OECD. 2015. Health at a Glance: How does Spain compare?

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Sweden

Score 7

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

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

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

Partly as a result of these problems, a rapidly increasing number of people in Sweden purchase private health insurance. Estimates in 2015 suggest that more than 600,000 Swedes, or about 15% of the working population, have a private health insurance policy, either purchased privately or provided by the employer. The rapidly increasing number of private health insurance policies clearly suggests a lack of faith in the expediency and quality of public health care.

Specific assessments:

- The quality of advanced medical care is generally quite good. The care provided by hospitals draws on close access to research centers and is of high standard.

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

Citation:

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Turkey

Score 7

The 2003 Health Transformation Program has produced significant improvements in Turkey’s health care system in terms of access, insurance coverage, and services. As a result, the health status of Turkey’s population has improved significantly. In particular, maternal mortality rate fell from 28.5 deaths per 100,000 live births in 2005 to 15.94 deaths in 2013. There has also been a sharp decline in infant mortality from 20.3 deaths per 1,000 live births in 2005 to 12 in 2012. As a result, Turkey has met its Millennium Development Goal target on both counts.

Recently, new legislation was introduced restructuring the Ministry of Health and its subordinate units, while enhancing its role in health-system policy development, planning, monitoring and evaluation. A new public health institution has been established to support the work of the Ministry of Health in the area of preventive health care services.

Turkey has increased access to and utilization of health services by expanding health-insurance coverage. The targeted Green Card Program for the poor and its integration into the social-security system has increased coverage considerably. The introduction of family-physician practices helped increase coverage further. The Family Medicine Program introduced in 2010 assigned each patient to a specific doctor. The program was established throughout the country. Currently, Community Health Centers provide free-of-charge logistical support to family physicians for priority services such as vaccination campaigns, maternal and child health and family planning services.

By 2014, Turkey had achieved near-universal health-insurance coverage, increasing financial security and improving equity in access to health care nationwide. The scope of the vaccination program has been broadened; the scope of newborn screening and support programs have been extended; community-based mental-health services have been created; and cancer screening centers offering free services have been established in many cities.

As emphasized by the World Bank (2015), the key challenge in health care is to keep costs under control as demand for health care increases, the population ages, and new technologies are introduced. Total health expenditure as a share of GDP has been increasing steadily since 2003, reaching 5.4% in 2012. In 2012, 77% of this spending was funded by public sources, as compared to a 62.9% public share in 2000. According to the OECD, the supply of health workers has increased considerably over the last decade. The number of doctors per capita has risen considerably since 2000, from 1.3 doctors per 1,000 people in 2000 to 1.7 in 2012; similarly, the number of nurses has increased from 1 nurse per 1,000 people in 2000 to 1.8 nurses in 2012. In 2000, there were two hospital beds per 1,000 people, a figure that had risen to 2.7 beds per 1,000 in 2012. As a result of these achievements, life expectancy at birth has increased from an average of 71.1 years in 2000 to 74.6 in 2012 (72 years for men, 77.2 years for women).

As access has widened, the government has focused attention on efficiency improvements and cost control, while maintaining high-quality services for the entire population. The authorities have launched an ambitious health public-private partnership program, aiming to leverage private funding and efficiencies in the management of integrated new hospital campuses, while redeveloping existing hospital buildings as part of ongoing urban renewal efforts.

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United States

Score 7

In March 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA). The main goals of the legislation were to lower costs in the health care sector and extend health care coverage to more people. The design of the ACA is essentially to fill gaps in the patchwork of financing arrangements that are embodied in the existing health care system. Specifically, it provides a mandate for employers of a given size to provide coverage for employees; it requires individuals not otherwise covered to obtain coverage, providing subsidies for individuals who otherwise could not afford coverage; it expands the state-administered Medicaid

program for low-income citizens, raising the income ceiling for eligibility; it requires health insurers to extend coverage of an insured family's children through the age of 25; and it prohibits insurers from denying coverage on the basis of pre-existing medical conditions.

Health care reform was a highly controversial topic before and during the policy's passage, and remains a contested political issue. Republicans in the House have voted well over 50 times to repeal "Obamacare." Public opinion has been fairly evenly divided on approval versus disapproval of the bill. Some state governments headed by Republican governors have so far declined to provide the expanded Medicaid coverage to low-income families, even though the federal government would pay 90% of the cost. The Supreme Court has upheld the ACA against two potentially catastrophic challenges, rendering in one case a 5-4 decision validating the law's individual mandate to obtain insurance.

As of 2015, the program's results continue to provoke controversy. An April 2015 Urban Institute analysis indicated that the share of adults aged 18 to 64 without health coverage declined from 18.1% in 2013 to 10.1% in 2015. The number of uninsured adults fell by 15 million between September 2013 and March 2015, a decline of 42.5%. At the same time, growth in health care spending fell from 9.9% in 2008 to 6.8% in 2015. However, the numbers enrolled through the ACA's federal and state marketplaces declined during 2015.

Cyprus

Score 6

High-quality medical services are provided by the public sector, which is the main system available, as well as by private clinics and individual doctors. Various health-insurance schemes also cover professional groups. A shift toward private health care in the early 2000s has been reversed due to income decline. Despite constraints and deficiencies in infrastructure and human resources (see OECD statistics) that lead to long queues, waiting lists and delays, the quality of services offered by the public system is acknowledged by the World Health Organization (WHO) to be high. A very low infant-mortality rate (1.6 per 1,000 in 2013) and a high life expectancy at birth (80 years for men, 84.8 for women in 2013) are indicative of this high quality. Preventive medicine is specifically promoted, with Cyprus ranking high worldwide with respect to expenditure in this area.

Access to public health care services was subject to reforms in 2013, leading to the exclusion of groups based on criteria such as high incomes or significant property holdings. These exclusions encompass 20% – 25% of the population. Most serious is the requirement to complete three years of contributions before benefiting from the system. A special income-based contribution has been imposed, and new minimum rates apply for services and medicines. For the first time, groups previously eligible for free health care, such as public servants, are required to pay contributions. Public

health care is available both in hospitals in the main towns and townships, and in rural medical centers.

The provisions of the MoU require that Cyprus establish a national health care system (NHS). However, plans that originally called for basic NHS services to commence in 2015 and be completed in 2016 have become stalled. New proposals seek to include the private sector and insurance companies in the system; however, this has drawn objections from certain parties and groups.

Citation:

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Iceland

Score 6

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

The University Hospital in Reykjavik, the largest hospital in Iceland, has for several years been in a difficult financial situation. The government has not provided additional public funds nor allowed the hospital to independently raise funds through, for example, patient service fees. The resulting shortage of nursing and other medical staff has increased the work pressures on existing staff, including their working hours. One of the issues in the 2013 election campaign was the question of how to finance a redevelopment of the University Hospital in Reykjavik. Many of the buildings are old and dilapidated, yet investment is also required to fund the purchase of new equipment. Discontent with this situation led to a strike by doctors in late 2014, which resulted in a considerable wage increase for doctors in January 2015 as well as a government commitment to build a new hospital. In spring 2015, nurses and radiologists went on strike with many resigning. This was only partly reversed following a decision to increase their wages considerably. Many of those who resigned are seeking employment in other Nordic countries. This situation will take many years to resolve.

Netherlands

Score 6

The Netherlands' hybrid health care system continues to be subject to controversy and contestation. Although the health care system's expenditure-growth rate fell to a 15-year low from 2012 to 2013, the WHO's Europe Health Report 2015 shows the Netherlands as the continent's highest spender on health care, expending 12.4% of GDP. However, Dutch care does not take the highest scores in any of the easily measured health indicators. The health care system, in which a few big health insurance companies have been tasked with cost containment on behalf of patients (and the state), is turning into a bureaucratic quagmire. Psychotherapists, family doctors and other health care workers have rebelled against overwhelming bureaucratic regulation that cuts into time available for primary tasks. Family doctors, paradoxically, were first sued by the Inspectorate for Financial Markets (AFM) because their collaborative, organized resistance against unreasonable tariff demands and administrative duties by the insurance companies was interpreted as illegal "cartelization"; however, they later won this legal fight. With individual co-payment levels raised to €375, patients are demanding more transparency in hospital bills; these are currently based on average costs per treatment, thereby cross-subsidizing costlier treatments through the overpricing of standard treatments. The rate of defaults on health care premiums to insurance companies and bills to hospitals and doctors is increasing rapidly. All this means that the system's cost efficiency is coming under serious policy and political scrutiny. Nevertheless, in terms of quality and inclusiveness, the system remains satisfactory.

Mortality as a result of cardiovascular diseases has increased slightly in recent years. While deaths from cancer have increased somewhat, preventive breast-cancer screening for women is nearly universal. Some 4% to 5% of the Dutch population suffers from diabetes. Average life expectancy (79.1 years for males, 82.8 for women) and health-status self-evaluations have remained constant; there are fewer heavy smokers and drinkers, and obesity seems to have stabilized. Patient satisfaction is high (averaging between 7.7 and 7.9 on a 10-point scale), especially among elderly and lower-educated patients. Patient safety in hospitals, however, is a rising concern both for the general public and for the Health Inspectorate. In 2014, the Borstlap Commission's report clearly revealed that the Health Inspectorate was not adequately performing its regulatory and oversight tasks. The Inspectorate's independence, information and personnel management has been undermined by scandals, and its organizational culture has proven resistant to criticism.

The level of inclusiveness is very high for the elderly in long-term health care, while the number of drug prescriptions issued is 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 much longer. In terms of healthy life years, the difference is actually 18 years. Recent research has also revealed

considerable regional differences with regard to rates of chronic illnesses and high-burden diseases; differences in age composition and education only partially explain these differences.

In terms of cost efficiency, according to the new System of Health Accounts, the Dutch spend 15.4% of GDP for health care, or €5,535 per capita. This is largely due to the relative amount spent on long-term care – hence the concern among policymakers. On the plus side, it should be mentioned that care costs in 2012 rose by 3.7% – a lower rate of increase than during the previous decade, but higher than in the 2010 – 2011 period. Moreover, the number of people employed in health care was lower than in previous years. Labor productivity in health care rose by 0.6% on an annual basis, with the gains coming virtually entirely in hospital care, with little in long-term care. Profits for general practitioners, dentists and medical specialists in the private sector increased much more than did general non-health business profits. Part of the costs for health are simply transferred to individual patients. Even with obligatory health insurance, co-payment requirements means that care and medicine costs up to €375 (€360 in 2012) are borne by the patients themselves. Another means of increasing patients' cost awareness is through increased transparency within health institutions (e.g., rankings with mortality and success rates for certain treatments per hospital). More patients are going to independent treatment centers (ZBC's) that have an increasing diversity of health care specialties. The struggle for cost efficiency has led to increasing centralization of power at the level of health institutions' managers and insurance companies, frequently at the expense of health professionals.

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"Toezicht op de zorg is een flipperkast", in NRC-Handelsblad, 24 September 2015

Portugal

Score 6

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

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

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

However, the report also calls attention to several challenges with regard to improving the quality of health care in Portugal.

Citation:

<http://www.oecd.org/health/health-systems/Review-of-Health-Care-Quality-Portugal-Executive-Summary.pdf>

Slovenia

Score 6

The Slovenian health-care system is dominated by a compulsory public-insurance scheme. This scheme guarantees universal access to basic health services, but does not cover all costs and treatments. In order to close this gap, citizens can take out additional insurance offered by Vzajemna, a mutual-health-insurance organization established in 1999, or, since 2006, by two additional commercial insurance companies. The quality of services, which are partly delivered by private providers and are organized locally, is relatively good, and total health spending is well above the OECD average. However, both the compulsory public health-insurance scheme and the supplementary health-insurance funds have suffered from severe financial problems for some time, resulting in financial problems among the majority of health providers. Health-care reform has featured prominently in the coalition agreement of the Cerar government, which promised to re-expand public scheme coverage and to delineate more clearly between standard and extra services. However, the adoption of a National Healthcare Resolution Plan has been postponed several times. During the period under review, there were two strikes organized by medical staff and doctors in April and May 2015 in which doctors demanded an average salary equal to three times the average Slovenian salary. In the biggest hospital in the country, Klinični center Ljubljana, an audit at the children's cardiac surgical ward revealed a number of irregularities and four deaths resulting from inadequate treatment in the program.

Citation:

"Audit at children's cardiac surgical ward finds at least four child deaths as a result of medical errors", RTVSLO MMC, 21 August 2015, <http://www.rtvsllo.si/news-in-english/audit-at-children-s-cardiac-surgical-ward-finds-at-least-four-child-deaths-as-a-result-of-medical-errors/372276>.

Croatia

Score 5

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 contribution of public money in funding health care is approximately 85%, leaving only 15% to market and private consumption schemes. The system is broadly inclusive. Primary care is widely available while specialized care is provided in regional hospitals and national clinical centers which divide work on the basis of the complexity of procedures. There are 568 hospital beds per hundred thousand of the population (the EU average is 526 beds per hundred thousand), and around 300 practicing physicians per hundred thousand of the population, the same as in the EU. The government spent 6.8% of GDP on health care in 2013, which is slightly below the EU-27 average of 7.2%, and there is little room for reducing expenditure. However, access to care is adversely affected by the regional variation in the range of care provided, and there is evidence of significant health inequalities between low and high income groups. Self-reported health status is worse among low-income groups than in the EU as a whole. Resources are not always used efficiently, and suppliers' interests often lead to duplication of resources or syphoning of funds. The low employment rate and the aging population has produced a persistent financial deficit within the system, which is covered from the central government's budget. Due to resource constraints, patients are expected to make co-payments for an increasing range of services. The government adopted a National Health Care Strategy 2012 – 2020 in September 2012, which provided a list of detailed proposals for gradual improvement of the health care system, while ruling out any radical reforms. In the period under review, the focus rested on the separation of the Croatian Health Insurance Fund from the central-government budget and a reduction in the number of hospitals and hospital beds.

Citation:

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

M.Vehovec(2014) *O zdravstvu iz ekonomske perspektive (On Health from the Economic Perspective)*, Zagreb: Ekonomski institut.

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

Eurostat data on hospital beds

Eurostat data on practicing physicians [tps00044] on hospital beds [tps00046] and on health finance (gov_10a_exp)

Ireland

Score 5

Quality:

The public perception of the Irish public health system remains very negative due to the publicity received by numerous cases of negligence, incompetence and lack of access. However, objective indicators of health outcomes are relatively good in

Ireland and continue to improve. This despite the increased level of obesity, problems with excessive alcohol consumption, continuing fairly high levels of smoking and the pressure on health budgets.

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

Inclusiveness:

The Irish health care system is two-tier, with slightly more than half the population relying exclusively on the public health system and the rest paying private insurance to obtain quicker access to hospital treatment. However, the rising cost of private health insurance is leading to a steady increase in the number of people relying on the public system.

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

Cost efficiency:

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

Citation:

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

Mexico

Score 5

The quality of health care varies widely in Mexico, and different regions show broad differences in the quality and variety of services available. Some U.S. citizens come to Mexico as health tourists, taking advantage of cheaper health care south of the border. Private, self-financed health care is limited for the most part to middle-class and upper-class Mexicans. This group encompasses about 13% of the total

population, but receives about 33% of all hospital beds. A larger minority of around one-third of the population (most of whom work in the formal sector) can access health care through state-run occupational and contributory insurance schemes such as the Mexican Social Security Institute (Instituto Mexicano del Seguro Social, IMSS) and the State Employees' Social Security and Social Services Institute (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, ISSSTE). These are based on automatic contributions for workers in the formal sector and, in practice, work reasonably well, although with some variation across different parts of the country. The system has been decentralized to the state level.

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

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

Poland

Score 5

Public health insurance covers some 98% of Poland's citizens and legal residents. However, access to health care is highly uneven, as public health insurance covers only a limited range of services, and out-of-pocket payments feature prominently in the system at large. Moreover, the poor quality of some services falls far under citizens' expectations, and for some services, patients must wait for an unreasonable duration. In the period under review, implementation of two reform packages adopted in 2014, the "waiting lists" and "oncology" packages, were initiated. At the same time, the Kopacz government failed to pass more comprehensive reforms that had been announced.

Bulgaria

Score 4

The Bulgarian health care system is based on a regulated dual monopoly: on the one hand a state-owned and state-controlled health fund financed through obligatory contributions by all income earners, and on the other, a union of health providers that negotiate a national framework health contract with the fund. Public health care

spending relative to GDP is similar to other countries in East-Central Europe and increased by about one percentage point of national income in the last decade. The system is inclusive and provides at least some level of health care for all who need it.

Inclusiveness, however, is undermined significantly by the fairly widespread practice of unregulated payments to doctors. Those who can afford to make these payments, receive faster, better care. The quality of health care services is average to lower. While life expectancy has risen and infant mortality has dropped, overall mortality and morbidity have remained high. A major efficiency problem of the Bulgarian health system is the lack of incentives for preventive measures and for stimulating healthier lifestyles, given that prevention is by far the least costly way of improving the health situation. There have been some improvements in the organization of emergency care in 2015, and some steps have been announced at the political level toward the introduction of an electronic health card, but the major challenges remain.

Citation:

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

Hungary

Score 4

Since the 2014 elections, health care has become the most conflict-ridden policy field in Hungary. A continuing series of scandals in the field have made this a major Fidesz policy weakness subject to public protest. Health-care policymaking has suffered from the absence of a ministry tasked with addressing with health care issues and a limited health-care budget. While per capita health expenditure has risen since 2009, public spending for health is one of the lowest in OECD. No major organizational reforms have been adapted in the review period. The Orbán government has failed to tackle the widespread mismanagement and corruption in the health sector, the large debt burden held by hospitals, the discretionary refusal of services by medical staffers, and the increasing brain drain of doctors and nurses to other countries. In summer 2015, a series of scandals in the health sector surfaced, indicating that the worsening situation has become unacceptable for medical employees. By wearing black rather than the traditional white uniform, nurse Mária Sándor became an emblematic figure of mass protests. The Hungarian Chamber of Health Employees (Magyar Egészségügyi Szakdolgozói Kamara, HCHE) ordered an ethical investigation against her but dropped it after the mass protest wave. Eventually, the president of HCHE resigned. As a reaction to the miserable situation, State Secretary Gábor Zombor also resigned in August 2015. It took the government two months to appoint a new state secretary. Mária Sándor has recently formed a new interest organization, For the Hungarian Health Sector (a Magyar Egészségügyért).

Latvia

Score 4

In 2011, Latvia adopted a new Public Health Strategy for the 2011 – 2017 period, placing a high policy priority on primary care, essential medicines, outpatient services, integrated emergency services and serving the poor via a new social safety net. The economic crisis resulted in a decrease in financial resources made available for health care and created new impetus for structural reforms aimed at reducing costs, for example, by shifting from hospital to outpatient care. Attempts to tie individual access to health services and income tax payments stalled at the political level. As of 2014, a “diagnosis-related group” system is being introduced to improve the financing of health care services.

Public expenditure on health care was equal to 3.7% of GDP in 2011. Latvia has one of the highest private, out-of-pocket health care expenditure rates among EU member states. Patients’ private expenditure on health care constituted 40% of total health care financing in 2011. Additional financial allocations to the health system in 2014 were aimed at reducing patients’ out-of-pocket expenses, reducing patient waiting times, and raising the salaries of the system’s lowest wage earners. Total expenditure on health care amounted to 6.6% of GDP in 2011, under the EU average for public health care expenditure.

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

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

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

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

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

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

Citation:

1. World Health Organization and European Observatory of Health Systems and Policies (2012), Latvia: Health System Review, Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/186072/e96822.pdf, Last assessed: 20.05.2013.
2. International Social Security Association (2010), ISSA Crisis Case Study: Latvia, p.1, Available at: www.issa.int/content/download/129030/2632870/file/2Latvia.pdf, Last assessed: 20.05.2013.
3. World Bank, Latvia - First Special Development Policy Loan: Safety Net and Social Sector Reform Program, Project Description, Available at: <http://www.worldbank.org/projects/P115732/latvia-first-special-dpl-safety-net-social-sector-reform-program?lang=en>, Last assessed: 20.05.2013.
4. Euro Health Consumer Index 2013, Available at: <http://www.healthpowerhouse.com/index.php?Itemid=55>

Romania

Score 4

Romania has a public health-insurance system. Despite its claim to universal coverage, only 86% of the population was insured in 2014. This coverage deficit has been highlighted by the deadly fire in Bucharest in October 2015, as it turned out that many victims were not insured. The quality and equity of Romania's public-health system has been undermined by inadequate funding: Romania has the lowest health-budget allocation of any EU member state. Moreover, after a gradual increase from 3.5% of GDP in 2002 to 4.8% in 2010, health-care spending declined again to 4.2% in 2014 and 4% in 2015 budget despite rising health-care demand. As the result of this underfunding and inefficient rules, the de facto availability of many medical services is severely limited, thereby leading to widespread bribe-giving by patients even for basic services as well as to significant inequities in medical-care access. Moreover, the low wages in the health sector have favored the out-migration of doctor and other medical staff. Health Minister Nicolae Banicioiu warned that

doctors' migration to other parts of Europe might leave Romania with a severe shortage within three years. In reaction, the Ponta government adopted a 25% increase to health system staff salaries beginning on 1 October 2015.

A major reform project in 2015 has been the introduction of health insurance cards in mid-2015. A new regulation states that only medical emergencies will be treated in the absence of a health card, otherwise patients unable to present proper identification will be required to pay out-of-pocket for the services they receive. The measure seeks to modernize the health-care system by synchronizing medical information among health-care providers. However, the distribution of the new cards suffered from problems, with thousands of Romanians queuing up at Health Insurance Houses to request cards they were supposed to have received by mail. Marginalized groups such as the Roma and newly arriving refugees are at risk if unable or unwilling to acquire the newly required documentation, and thus are left to pay out-of-pocket for essential medical services.

Slovakia

Score 4

Slovakia has a mandatory health-insurance system that provides all residents with primary, secondary and tertiary care, pharmaceuticals, and medical devices. The state covers the health-insurance costs of children, students, pensioners, the (registered) unemployed and women on maternity leave. From a comparative perspective, the quality and efficiency of health-care services are relatively low, and the high degree of politicization and frequent changes to health-care policy have served as further barriers to improvement. The Fico government's health policy has been erratic. A reform strategy developed for 2014-2020 has to date not been implemented. Although President Kiska massively criticized the state of Slovak health care, the government failed to address the widespread and widely perceived corruption in the system. The latter featured prominently in the period under review because of a number of spectacular corruption scandals which led to the resignation of Health Minister Zuzana Zvolenská in November 2014 and of Marcel Forai, the director of the public health-insurance scheme, in September 2015. In addition, there have been several corruption scandals involving several leading Smer-SD officials.

Citation:

-Terenzabi, Michaela, Kiska slams government for health care, in: Slovak Spectator, 19.3.2015; <http://spectator.sme.sk/c/20056612/kiska-slams-government-for-health-care.html>

-Health insurance system needs a cure, in: Slovak Spectator, 20.10.2015; <http://spectator.sme.sk/c/20062014/health-insurance-system-needs-a-cure.html>

Transparency International Slovakia, Monitoring Transparency in Health Care 2015; <http://www.transparency.sk/en/monitoring-transparentnosti-v-sektore-zdravotnictva/>

Greece

Score 3

After the crisis erupted, public spending on health care was subjected to cuts similar to those effected in other welfare policies. Moreover, the restructuring of Greek

public debt in February 2012 negatively affected the finances of health insurance funds, which held some of that debt. After 2010, the economic crisis became a severe crisis for health insurance funds. Moreover, as Eurostat data shows, in 2012 government expenditure on health care (excluding the expenditure of social security funds) was roughly equal to household out-of-pocket expenditure on health care. This speaks volumes to two perennial problems of Greek health care policy: first, the volume of transactions between patients and doctors which goes unrecorded and is not taxed; and second, the differential in health care access based on the purchasing power of households.

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

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

There is a very unequal distribution of 131 public hospitals across the territory of Greece, resulting from a patronage-ridden selection process where hospitals should be built. The number of doctors in the country is also quite high (in 2011 there were 4.4 doctors per 1,000 residents, in contrast to 3.8 for every 1,000 residents in Germany). However, there is a lack of nurses, while ministry-level mismanagement of health services combined with the reluctance of doctors to serve in hospitals located away from Greece’s largest cities have resulted in a highly uneven distribution of medical personnel. Moreover, major budget cutbacks for public hospitals have left some hospitals without enough medicines and medical supplies. In summary, the quality and inclusiveness of health care deteriorated over the last five years, but cost efficiency improved substantially.

Citation:

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

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

Data on health expenditure is taken from Eurostat and is available at http://ec.europa.eu/eurostat/statistics-explained/images/1/1c/Healthcare_expenditure_by_financing_agent%2C_2012_%28%25_of_current_health_expenditure%29_YB15.png

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