



Health Report

Health Policy

Sustainable Governance Indicators 2017

Indicator

Health Policy

Question

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

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

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

Canada

Score 8

Like educational policy, health care is primarily the responsibility of the individual provinces. Canadians are generally in good health, as evidenced by the high and rising level of life expectancy. The 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 2015).

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 report from the Health Council of Canada (2013) found only limited progress in reducing these wait times. In 2015, patients could expect to wait 9.8 weeks for medically necessary treatment after seeing a specialist – almost three weeks longer than the time physicians consider to be clinically “reasonable” (7.1 weeks).

Inefficiencies in the system have led to patients travelling abroad to receive medical treatment and increased demand for domestic for-profit clinics, which endangers Canada’s otherwise impressive record of equity in health care. A recent report by the Fraser Institute estimated that over 45,000 Canadians received non-emergency medical treatment outside Canada in 2015. Lack of income, on the other hand, is not a barrier to treatment, with high-quality care freely provided for virtually the entire population. One effect of equity in access to health care services is the small gap in perceived health between the top and bottom income quintiles. 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 ranks poorly on some safe-care measures according to a 2014 report by the U.S.-based Commonwealth Fund comparing health care systems internationally.

The cost efficiency of the Canadian health system is not impressive. Canada's health spending as a share of GDP, while well below that of the United States, is above that of many European countries.

Overall, Canada 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/rpt_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 2015", OECD Indicators, retrieved from http://dx.doi.org/10.1787/health_glance-2015-en

"Leaving Canada for Medical Care, 2016", *Fraser Research Bulletin*, Fraser Institute, October 2016.

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 2014, health spending in Denmark was 10.6% of GDP (8th highest among OECD countries), of which 8.9 % is public (4th highest among OECD countries). 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)

OECD Health Statistics, http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT

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.

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 some 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 18 larger governmental entities from 2019 on. These services are presently managed by more than 150 municipal-level authorities; thus, the reform is expected to yield substantial public savings. At the same time, a planned reform envisions allowing greater freedom in choosing between public and private health care providers, though this reform's implementation is subject to considerable political conflict and debate.

Citation:

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

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

Germany

Score 8

The German healthcare system is of high quality, inclusive and provides healthcare 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. Healthcare 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 2016).

In its coalition agreement, the current grand coalition negotiated a variety of reform measures to increase the quality of healthcare, redefine some financial details, and reorganize the registration of physicians in private practice and the distribution of hospitals. However, the government only introduced minor changes. The most important change is the so-called law of strengthening self-administration in healthcare (“Selbstverwaltungsstärkungsgesetz”), which tries to enhance ministerial influence over the self-governing bodies. With this law, the Federal Ministry of Health aims to strengthen its influence over the National Association of Statutory Health Insurance Physicians, which had been engaged in criminal financial activities. The law is still pending in the legislature. Other 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% of gross wages 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.

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 € 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 healthcare system.

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

Citation:

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

https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/Gesetze_und_Verordnungen/GuV/S/SVSG_Kabinett.pdf

<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. In 2016, Israel's health system remained successful thanks to good health outcomes and a strong primary healthcare system. Nonetheless, there are specific challenges, such as a high percentage of private spending for health, overcrowded hospitals and nursing shortage, that require improvement.

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 widespread healthcare coverage, inequalities in health outcomes and access to health services have persisted. 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. 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.

Recently, the minister of health stated that he highly recommends increasing the "health tax" by 0.6%, reform "elderly nursing" services, reduce waiting periods and improve the overall quality healthcare provision by increasing the number of medical staff in hospitals.

Citation:

Linder-Gantz, R., "Litzman: The mental health reform will go ahead without delay", *TheMarker*, 8.6.2015 (Hebrew): <http://www.themarker.com/news/health/1.2655273>

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

Linder-Gantz, R. "It is time to increase the health tax", *TheMarker*, 21.8.2016, <http://www.themarker.com/news/health/1.3045231>

Guter, Aviv, "Litzman: Netanyahu has Promised me that the Elderly Nursing Reform will Pass" *Calcalist*, 14.9.2016, <http://www.calcalist.co.il/local/articles/0,7340,L-3697946,00.html>

Swirsky, S., E. Konor-Atias and R. Zelinger, "Social status report 2015", December 2015. (Hebrew) <http://adva.org/wp-content/uploads/2016/01/social-2015-1.pdf>

OECD Health Policy Overview. Health Policy in Israel. March 2016,
<https://www.oecd.org/health/health-systems/Health-Policy-in-Israel-March-2016.pdf>

Luxembourg

Score 8

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

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

However, at a cost of \$5,160 per person per year, Luxembourg's health care system is the 7th most expensive system within the OECD group. The high cost of the health care system is due to high wages, a high ratio of technical medical equipment to residents and low out-of-pocket costs for patients. Furthermore, authorities have repeatedly tried to limit the range of medical treatments offered by general hospitals in favor of providing treatment through specialized health care centers.

Citation:

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

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Rapport Social National 2015. Le gouvernement du Grand-Duché de Luxembourg, 2015. www.mfi.public.lu/publications/Solidarite/RSN-2015.pdf. Accessed 21 Feb. 2017.

New Zealand

Score 8

Since 2009, health reforms have encompassed the consolidation of regional hospitals and primary-care organizations, increased use of benchmarking and further decentralization. Although there is both public and private provision of health care, access to the public hospital system is freely available to all residents. Health care is

not only generally of a high quality, it is also cost effective and relatively efficiently managed. However, concerns about rising costs and a lack of productivity gains led to the appointment of a ministerial review group and a national health board in 2009, tasked with improving coordination between the government ministry and district health boards, and providing advice on the allocation of budgets. The gap in health status between Maori and non-Maori has been reduced, particularly regarding smoking-related illnesses and obesity. Gaps in life expectancy have been reduced but more remains to be done, including changes in behavior and lifestyle. Concerns about health disparities have been an ongoing concern, as noted by OECD reports.

Citation:

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

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

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

New Zealand Health Strategy update. 28 June, 2016 <http://www.health.govt.nz/about-ministry/what-we-do/new-zealand-health-strategy-update> (accessed 19 September, 2016).

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 has increased significantly since 2000, but total expenditure on health care still totaled just 6.9% of GDP in 2015, below the OECD average of 8.9%. 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/societataglance-asiapacificedition2011.htm>

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OECD, Health at a Glance 2015, <http://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm>

Switzerland

Score 8

Health care in Switzerland is said to be qualitatively excellent. According to the OECD, its health system is among the best in the OECD. Mandatory health insurance ensures that the total population is covered. However, care is expensive.

Health insurance premiums (at constant prices) have nearly doubled over the past twenty years. Cost efficiency is a potential problem, in particular with regard to the organization of hospitals. Life expectancy is very high, life expectancy at birth is 81 years for males and 85 years for females. As of 2015, a 65-year-old male could expect to live for another 19 years on average, while a woman of the same age could look forward to another 22 years. This is 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 reduced subsidies in recent years. More recently, however, a popular vote forced the cantonal administration to reestablish the former system of subsidies. In general, health care reforms have not been particularly successful in terms of improving efficiency or controlling the structural rise in health expenditures.

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

Australia

Score 7

The Australian health care system is a complex mix of public-sector and private-sector health care provision and funding. Correspondingly, its performance on quality, inclusiveness and cost efficiency is variable across the components of the system. The federal government directly funds health care through three schemes: Medicare, which subsidizes services provided by doctors; the Pharmaceutical Benefits Scheme (PBS), which subsidizes prescription medications; and a means-tested

private health insurance subsidy. Medicare is the most important pillar in delivering affordable health care to the entire population, but it has design features that decrease efficiency and do not promote equity of access. For example, the level of the subsidy is generally not contingent on the price charged by the doctor. The PBS is perhaps the most successful pillar of health care policy in Australia, granting the Australian community access to medications at a low unit cost.

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

Regarding inclusiveness, significant inequality persists in access to some medical services, such as non-emergency surgery and dental care. Indigenous health outcomes are particularly poor. In 2014, the federal government launched a dental scheme aimed at addressing inequity in access to dental care, but the current coalition government has wound back the scheme. Lack of access to non-emergency surgery reflects, to a significant extent, the funding constraints of the states and territories, which are responsible for funding public hospitals. This was a significant motivation behind the 2011 National Health Reform Agreement, which sought to provide for more sustainable funding arrangements for Australia's health system. Key features of the agreement include additional federal funding for hospitals from 2015 to 2020 and for non-emergency surgery from 2010 to 2016, and the establishment of an Independent Hospital Pricing Authority to set a national efficient price for hospital services and a National Health Performance Authority to review hospital performance. However, in its first budget in 2014, the Abbott government reduced hospital funding and implemented a freeze on the indexation of subsidies for out-of-hospital medical services until 2018. This freeze has since been extended by the Turnbull government to 2020 and is likely to result in increased costs for patients.

Finally, concerning cost-effectiveness, the health care system is rife with inefficiencies and perverse incentives. Total health care expenditure is relatively low, but as is the case in most developed countries, the government faces significant challenges due to rising costs from an aging population and development of new diagnostic tools and treatments.

Citation:

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

Austria

Score 7

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

The public insurance system differs in some 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 ongoing conflict between the policy intentions of the federal government and state governments about the responsibility for health care provision is a permanent topic of Austrian politics and draws attention to the demographic changes' impact on the health care system.

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

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

The 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.gov.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. As a result, inclusiveness is under threat in the medium term and already a challenge in some rural areas.

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 (especially in the waiting times for non-emergency services). A significant reform has been implemented gradually since 2003, expanding the range of guaranteed coverage and entailing a corresponding extension of government subsidies to low- and middle-income population groups. In contrast to other policies,

this reform has been pursued in a very consistent and solid way, although some failures can be detected regarding the budget provided for public health and administrative processes. Above all, primary health care within the public system has shown great advances in coverage and in quality. These standards have remained stable in recent years.

In the domain of the more complex systems of secondary and tertiary health care, a more problematic situation is evident. 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.

A survey released in August 2016 by Centro de Estudios Públicos (CEP), a Chilean polling agency, showed that 30% of the respondents cited health care as their third highest concern (after criminality, 44%, and economic development, 32%).

Citation:

Healthcare as one of the chief concerns:
http://www.latinnews.com/component/k2/item/70237.html?period=2016&archive=26&Itemid=6&cat_id=804376:chile-seeking-to-address-the-chief-public-concern&Itemid=6

Czech Republic

Score 7

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). At the beginning of its term, the Sobotka government abolished the health care fees that were introduced in 2008 under the center-right government of Mirek Topolánek, so that user fees are limited to fees for emergency medical services and dental services.

Indicators of inpatient and outpatient care utilization point to unnecessary consumption of goods and services, and inefficiencies in the allocation of resources in the hospital sector. According to the European Commission's 2015 Ageing Report, health care expenditure is projected to increase from 5.7% of GDP in 2013 to 6.7% in 2060. While these problems have been known for some time, they have not been addressed yet. In 2016, the debate on the pros and cons of mandatory vaccination has continued.

France

Score 7

France has a high-quality health system, which is generous and largely inclusive. Since its inception, it has remained a public system based on a compulsory, uniform insurance for all French citizens, with employers' and employees' contributions

calculated according to wage levels. Together with widespread complementary insurances, they cover most individual costs. About 10% of GDP is spent on health care, one of the highest ratios in Europe. The health system includes all residents, and also offers services for illegal immigrants and foreigners.

The problem is cost efficiency and the containment of deficits, which have been constant in recent years. 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). However, the deficit will decrease below €10 billion, which is an important success after so many years of increasing deficits. 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 still needs to be tackled with more decisive measures. The lack of doctors in rural areas and in some poor neighborhood is a growing issue. The unsatisfactory distribution of doctors among regions and medical disciplines would be unbearable without the high contribution of practitioners from foreign countries (Africa, Middle East, Romania).

Italy

Score 7

Italy's national health system provides universal comprehensive coverage for the entire population. The health care system is primarily funded by central government, though health care services and spending are administered by regional authorities. On average, the services provided achieve medium to high standards of quality. A 2000 WHO report ranked the Italian health care system second in the world and a recent Bloomberg analysis also ranked the Italian system among the most efficient in the world. However, due to significant differences in local infrastructures, cultural factors, and the political and managerial proficiency of local administrations, the quality of public health care varies across regions. In spite of similar levels of per capita expenditure, services are generally better in northern and central Italy than in southern Italy. In some areas of the south, corruption, clientelism and administrative inefficiency have driven up health care costs. In these regions, lower quality levels and typically longer waiting lists mean that wealthier individuals will often turn to private-sector medical care. Regional disparities also lead to a significant amount of health tourism heading north. Early moves in the direction of fiscal federalism are now stimulating efforts to change this situation through the introduction of a system of national quality standards (correlated with resources), which should be implemented across regions.

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

To contain further increases in health care costs, payments to access tests, treatments and drugs exist. Even if these payments are inversely linked to income, they nevertheless discourage 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 only basic dental health care is covered.

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.who.int/whr/2000/en/>

<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 (2.0 deaths per 1,000 live births). A prevailing shortage of doctors represents one serious remaining bottleneck. The number of doctors per capita is some 40% lower than in Germany or France. However, judging on the basis of fundamental indicators, Japan's health care system, in combination with traditionally healthy eating and behavioral habits, delivers good quality.

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 open questions remain. In early 2016, a medical council approved cost-saving and efficiency-enhancing revisions to the fees that hospitals and pharmacies can charge. It is still unclear whether and how to set limits on covering the extremely expensive new drugs in the public healthcare system.

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. In the 2016 White Paper of the Ministry of Health, Labor and Welfare, the so-called double care problem is singled out for future action, as many middle-aged households care for both their children and the older generation.

Citation:

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

Tomoko Otake, How Japan is tweaking the cost of health care, The Japan Times, 17 February 2016, <http://www.japantimes.co.jp/news/2016/02/17/national/social-issues/japan-tweaking-cost-health-care/>

Lithuania

Score 7

In Lithuania, some health outcomes are among the poorest in the European Union. For example, the mortality rate of 20 to 64 year olds is the highest in the European Union. Lithuania has one of the highest alcohol consumption rates in the world. In 2015, consumption of absolute alcohol equaled 14 liters per person aged 15 and over. According to the 2010 Eurobarometer report, only 40% of Lithuanians assessed the overall quality of the country's health care as good in 2009, compared to an EU-27 average of 70%. The Lithuanian health care system received the seventh-lowest rating in the European Union, with 58% of respondents saying that the overall quality of health care was fairly or very bad.

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

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. New prevention-focused programs were recently introduced by the National Health Insurance Fund.

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 2012 to 2016 government by contrast placed 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. At the end of 2015, the government approved a plan to consolidate health care providers. However, this has not brought any significant change.

There is a need to make the existing health care system more efficient by shifting resources from costly inpatient treatments to primary care, outpatient treatment and nursing care. The performance of the health care system could be improved by strengthening outpatient care, disease prevention and health promotion. Though the

2012 to 2016 government has proposed a new inter-institutional plan to reduce alcohol consumption, parliament is yet to pass any legislation. Health care reform is likely to be a key policy priority of the senior coalition partner, the Lithuanian Farmers and Greens Union, as the party's manifesto included proposals to improve health care outcomes, such as prioritizing preventive care, and restricting the availability of alcohol and tobacco products.

Citation:

The 2010 Eurobarometer report is available at http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf
COMMISSION STAFF WORKING DOCUMENT, country report Lithuania 2016:
http://ec.europa.eu/europe2020/pdf/csr2016/cr2016_lithuania_en.pdf
Murauskienė L, Janonienė R, Veniute M, van Ginneken E, Karanikolos M. Lithuania: health system review. *Health Systems in Transition*, 2013; 15(2): 1–150. http://www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf.

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 and Italy to service patients in need of special treatment not available locally. A 2015 survey conducted by the independent research center Numbeo stated that Malta had the second-best health care in Europe. The Euro Health Consumer Index 2015 claimed, however, that Malta had decent access to health care, but its performance lagged when it comes to treatment results, emergency cardiac care flagged in particular. This is coupled with the fact that only a third of Maltese citizens had a proportionate body weight in 2016 even though a healthy weight strategy has been in place since 2012.

Vulnerable groups are entitled to state support for a list of prescription medicines, and all citizens are entitled to free medicine in relation to specified chronic diseases (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 treatment costs can be thousands of euros. Much has been done to reduce patient waiting times and dependence on private hospital care. The government has addressed the general hospital's limited bed capacity by building new wards and devising plans to add new buildings to the existing infrastructure. It also opened a new Oncology Hospital on the same site. The new general hospital opened in 2008 with fewer beds than the previous hospital. Joint projects with the private sector should result in the upgrading of Karen Grech Hospital, St Luke's Hospital and the Gozo General Hospital in 2018. The government contracts signed with Vitals Global Healthcare are presently being scrutinized by Parliament. A recently launched patients' rights charter by the government, which includes the right to access one's medical files should improve access to medical care. However the charter remains non-binding. Additionally the Ombudsman has pointed out that the partial privatization of three state hospitals would impair patients' rights by precluding complaints to his office.

The private sector accounts for approximately two-thirds of the workload in primary health care; however, health care delivery in Malta is dominated by the public sector, with 96% of hospital beds publicly owned and managed, with only a small number of private hospitals. Malta has fewer hospital beds per 100,000 inhabitants than its European counterparts, but also shorter hospital stays than the EU average. In 2013, Malta's public health care expenditure amounted to 5.7% of GDP, which is lower than the EU average of 6.9% of GDP. Nonetheless, this expenditure is expected to increase to 7.8% of GDP in 2060 on par with the EU average, particularly since Malta has one of the highest life expectancy rates in the EU. In the 2017 budget, funding for health care increased including funding for a new in-vitro fertilization program.

Citation:

Times of Malta 05/09/2012 Three health agreements signed with Italy
 Malta Today 25/01/2015 Malta's health care ranked second best in Europe
 Euro Health Consumer Index 2015 p. 13
 Times of Malta 09/10/2016 70 per cent of Maltese are too fat for their own good
 A Healthy Weight for Life: A National Strategy for Malta 2012-2020
 Commission Staff Working Document - Country Report Malta 2016 SWD (2016) 86 final p.20
 Times of Malta 18/10/2015 Two new wards to open
 TVM 27/01/2015 Government to announce development of new buildings at Mater Dei
 Malta Independent 20/09/2015 Sir Anthony Mamo oncology center officially inaugurated
 Healthcare Delivery in Malta 2012 p. 13
 A National Health Systems Strategy for Malta 2014-2020 p.22
 Malta Independent 29/09/2016 Maltese people aged 80 have life expectancy of more than 9 years - Eurostat
 Malta Today 25/11/16 Parliament's health committee to examine hospital contracts
 Independent 21/11/16 Health minister Chris Fearnle launches patients charter
 Times of Malta 03/12/16 Parsing the patients charter

Norway

Score 7

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

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

by streamlining health care services and promoting regional coordination. However, reorganization has been slow and costly and – even after 15 years and counting – is nowhere near complete. Vast amounts of resources are being consumed by red tape and 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 Bloomberg Index, Spain is the sixth healthiest country in the world (and OECD data show it has the second-highest life expectancy, after Japan). Low mortality rates from all causes of death (including heart diseases, cancer, transport accidents or infant mortality) demonstrate the effectiveness of the policy. However, rates of mental illnesses, diabetes and drug consumption are higher than the European averages.

Spaniards' self-perceptions of their own health status and their opinions regarding the national health care system reflect a degree of satisfaction that is quite high in cross-OECD comparison. Access to a core set of high-quality health services is guaranteed through a public insurance system that covers 99% of the population. However, the number of practicing doctors, nurses and hospital beds per 1,000 residents is relatively low. 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. 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? www.oecd.org/spain/Health-at-a-Glance-2015-Key-Findings-SPAIN.pdf

February 2016, The Guardian: "Which country has the world's best healthcare system?"

<https://www.theguardian.com/society/2016/feb/09/which-country-has-worlds-best-healthcare-system-this-is-the-nhs>

Sweden

Score 7

The health care system continues to be a problem area for Sweden, as is the case for most European countries. The media regularly reports on excessive waiting times in

emergency rooms and scandals in long-term care, in which patients received sub-standard treatment. These weaknesses may be the consequence of far-reaching privatization measures during the most recent past. Another problem is that the administrative oversight of health care quality is weak.

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

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

Partly as a result of these problems, a rapidly increasing number of people in Sweden purchase private health insurance. Estimates in 2015 suggest that more than 700,000 Swedes, or about 15% of the working population, have a private health insurance policy, either purchased privately or provided by the employer. The rapidly increasing number of private health insurance policies clearly suggests a lack of faith in the expediency and quality of public health care.

Specific assessments:

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

Citation:

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

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

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

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.

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 (2016), 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 5.1% in 2013. In 2013, 78% of this spending was funded by public sources, as compared to a 62% public share in 2000. In Turkey hospitals play a dominant role accounting for 52% of all health spending, representing a rapid increase in hospital spending. In 2012 the Turkish Hospital Agency was established to run the hospitals.

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.

Citation:

Organization for Economic Co-operation and Development (2015) 'Country Note: How does Health Spending in Turkey Compare?', in OECD Health Statistics 2015, Paris: OECD

World Bank (2016) 'World Bank Group - Turkey Partnership: Country Program Snapshot', Washington D.C.

World Health Organization (2014) 'Country Cooperation Strategy at a Glance: Turkey', Geneva.

United Kingdom

Score 7

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 and has been the subject of growing concern over the last year, with more hospitals struggling to maintain standards

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

The NHS is invariably at the center of heated public debates. Lately, the debate has been sparked by the changes in the 2016/17 tariff, which regulates public funding for patient treatment and staff salaries. The tariff changes have shifted and reduced the public payment to clinics and acute trusts – private hospital operating companies commissioned by the Department of Health. These changes contradicted many existing business models and aggravated the funding crises of several major acute trusts. There has also been a long-running dispute over the pay and working conditions of junior doctors, which has led to strikes. The protracted dispute between

the government and junior doctors concerns government attempts to achieve full 7/24 operation in response to concerns that treatment at weekend was of lower standard, but the government's plans have still not come to fruition. Nevertheless, UK health care remains way above average on an international scale.

Citation:

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

Cyprus

Score 6

Cyprus has a potential for high-quality health care services offered by both the main public sector, and by private clinics and individual doctors. Various health-insurance schemes also cover professional groups. A shift toward private health care in the early 2000s has been reversed due to income decline. Despite constraints and deficiencies in infrastructure and human resources (see OECD statistics) that lead to long queues, waiting lists and delays, the quality of services offered by the public system is acknowledged by the World Health Organization (WHO) to be high. This is witnessed by a very low infant-mortality rate (1.4 per 1,000 in 2014) and a high life expectancy at birth (80.7 / 84.5 for men/women in 2014). Preventive medicine is specifically promoted, with Cyprus ranking high worldwide with respect to expenditure in this area.

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

The MoU obligations that Cyprus establishes a national health care system (NHS), offering initially basic services in 2015 and full services in 2016 have so far not been met. At present (2016) the privatization of hospitals is promoted as a first step to an NHS.

Citation:

1. Joint report on health care services - Cyprus, EU 2016, http://ec.europa.eu/economy_finance/publications/eaip/pdf/ip037bycountry/joint-report_cy_en.pdf

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. After the 2008 economic collapse, the left-wing cabinet 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 had (and still have) serious problems in recruiting doctors. Waiting times for appointments with specialized doctors can extend to several months.

The University Hospital in Reykjavik (Landsspítalinn Háskólasjúkrahús), by far the largest hospital in Iceland, has for several years been in a difficult financial situation. The 2013-2016 government has not provided adequate 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 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 while many others resigned. Some but not nearly all of those resignations were withdrawn following the decision to increase their wages considerably. Many of those who resigned are seeking employment in other Nordic countries. The situation calmed down a bit in 2016.

In early 2016, Dr. Kári Stefánsson, director of Decode Genetics, started an online petition where people demanded that the government should increase health care spending to 11% of GNP. A new petition record of 85,000 people was set, a clear sign that Icelanders want to strengthen or rebuild the health care sector. Before the 2016 parliamentary election, every political party promised to give improved health care a high priority.

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

Citation:

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

Netherlands

Score 6

The Netherlands' hybrid health care system continues to be subject to controversy framed as a power conflict between insurers and providers. A decline in consumer trust in insurers threatens the legitimacy of the reform. 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 achieve 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 obligatory co-payment levels raised to €75 (including for the chronically ill), patients are demanding more transparency in hospital bills; these are currently based on average costs per treatment, thereby cross-subsidizing costlier treatments through the overpricing of standard treatments. The rate of defaults on health care premiums to insurance companies and bills to hospitals and doctors is increasing rapidly. All this means that the system's cost efficiency is coming under serious policy and political scrutiny. 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. In terms of healthy life years, the difference between people with high and low-income levels is 18 years. Recent research has also revealed considerable regional differences with regard to rates of chronic illnesses and high-burden diseases; differences in age composition and education only partially explain these differences.

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 by ever increasing obligatory co-payment clauses in health insurance. A 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.

Citation:

Maarse, H., Jeurissen, P. and D. Ruwaard, Results of the market-oriented reform in the Netherlands: a review. *Health Economics, Policy and Law* (http://journals.cambridge.org/abstract_S1744133115000353)

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

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

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

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

Portugal

Score 6

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

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

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

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

Unsurprisingly, health is a big issue in the Program do XXI Governo Constitucional. However, with the continuing economic challenges and the need to reduce public debt, there is limited scope for government action.

Citation:

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

United States

Score 6

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 has been highly controversial and partisan, both before and after its enactment. Republicans have consistently vowed to repeal and replace Obamacare, while offering no specific plans for the replacement. Some state governments headed by Republican governors have declined to provide the expanded Medicaid coverage to low-income families, even though the federal government would pay 90% of the cost. The Supreme Court narrowly upheld the ACA against two potentially catastrophic challenges.

As of 2016, 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% in 2016. 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. The departure of several insurance companies from ACA healthcare exchanges along with sharp increases in some premiums in 2016 indicated the need for restructuring and reform under the incoming administration.

Citation:

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

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. Public money accounts for 85% of all health care spending, leaving only 15% to market schemes and private spending. The system is broadly inclusive. Primary care is widely available while specialized care is provided in regional hospitals and national clinical centers which divide work on the basis of the complexity of procedures. There are 568 hospital beds per hundred thousand of the population (the EU average is 526 beds per hundred thousand), and around 300 practicing physicians per hundred thousand of the population, the same as in the EU. As a percentage of GDP, government spending on health care is close to the EU average, and there is little room for reducing expenditure. However, access to care is adversely affected by the regional variation in the range of care provided, and there is evidence of significant health inequalities between low and high-income groups. 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 aging population have produced a persistent financial deficit within the system, which is covered by the central government's budget. Due to resource constraints, patients are expected to make co-payments for an increasing range of services. The Milanović 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. Dario Nakić, minister of health in the Orešković government, also emphasized the need for reducing hospital losses through rationalization and improved cooperation among hospitals, but did not initiate major changes before he was replaced following the 2016 elections.

Citation:

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

Radin, D. (2013): The effect of EU Membership on the health care systems of member countries in Central and Eastern Europe, in: *Politička misao: Croatian Political Science Review* 50(5), 141-154.

Ireland

Score 5

Quality:

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

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

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

Inclusiveness:

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

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

Cost efficiency:

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

Citation:

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

Mexico

Score 5

Overall, public spending on health care is comparatively high but the quality of health care varies widely across Mexico, with different regions showing broad variation in the quality and variety of services available. Some U.S. citizens come to Mexico as health tourists, taking advantage of cheaper health care south of the border. Private, self-financed health care is largely limited to middle-class and upper-

class Mexicans, who encompass roughly 15% of the total population, but receive about one-third of all hospital beds. Around one-third of the population (most of whom work in the formal sector) can access health care through state-run occupational and contributory insurance schemes such as the Mexican Social Security Institute (Instituto Mexicano del Seguro Social, IMSS) and the State Employees' Social Security and Social Services Institute (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, ISSSTE). These are based on automatic contributions for workers in the formal sector and, in practice, work reasonably well, although with some variation across different parts of the country. The system has been decentralized to the states. In 2016, a National Agreement Towards Health Service Universalization was signed, which aims to ensure portability across providers. 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.

Poland

Score 5

Public health insurance covers some 98% of Poland's citizens and legal residents and is financed through social insurance contributions. However, access to health care is highly uneven, as public health insurance covers only a limited range of services, and out-of-pocket payments feature prominently in the system. Moreover, the poor quality of some services falls far under citizens' expectations, and for some services, patients must wait for an unreasonable duration. The PiS government has called for a comprehensive health care reform and for expanding health care spending. Plans presented in summer 2016 envisaged the abolition of the National Health Insurance Fund NFZ and the funding of health care by a special fund in the state budget financed by income tax revenues, i.e., a return to the system that existed in Poland before the major reform of 1999. One bill has been adopted granting people over 75 years of age free access to medication from 1 September 2016 onwards.

Slovenia

Score 5

The Slovenian health care system is dominated by a compulsory public-insurance scheme. This scheme guarantees universal access to basic health services, but does not cover all costs and treatments. In order to close this gap, citizens can take out

additional insurance offered by Vzajemna, a mutual health insurance organization established in 1999, or, since 2006, 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. An internal study by the Ministry of Health at the end of 2015 revealed many irregularities and deficits in the biggest Slovenian hospital, Klinični Center Ljubljana.

Health care reform has featured prominently in the coalition agreement of the Cerar government, which promised to re-expand public scheme coverage and to delineate more clearly between standard and extra services. Despite many calls for reforms both inside and outside the governing coalition, however, the adoption of the announced National Healthcare Resolution Plan has been postponed several times. Doctors started striking in early November after failing to find common ground with the government on pay and workload standards in negotiations that lasted for almost a year.

Citation:

European Observatory on Health Systems and Policies (2016): Slovenia: Health System Review 2016. Brussels (www.euro.who.int/__data/assets/pdf_file/0018/312147/HiT-Slovenia_rev3.pdf?ua=1).

Slovenia Times (2016): Slovenian doctors on strike, activities to be stepped up. November 8, 2016 (<http://www.sloveniatimes.com/slovenian-doctors-on-strike-activities-to-be-stepped-up>).

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. Save for some improvements in the organization of emergency care, no substantial reforms were undertaken under the second Borissov government.

Because of the robust economic growth and the decline in unemployment, however, the financial balance of the health care system improved in 2015 and 2016.

Citation:

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

Hungary

Score 4

Health care has become the most conflict-ridden policy field in Hungary. A continuing series of scandals have made this issue a major Fidesz policy weakness and a subject of large-scale public protest. Health-care policymaking has suffered from the absence of a ministry tasked with addressing health care issues and from a limited health-care budget, one of the lowest in OECD. 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. This has not changed under the new State Secretary Zoltán Ónodi-Szűcs, who came to office in October 2015 after the “nurses in black” mass protests that summer. In the period under review, the main reform project has been a monstrous organizational reform in which those units of the National Health Insurance Fund (Országos Egészségbiztosítási Pénztár, OEP) dealing with cash benefits were merged with the Pension Insurance Fund (Országos Nyugdíjbiztosítási Főigazgatóság, ONYF), whereas the other units became the National Institute of Health Insurance Fund Management (Nemzeti Egészségbiztosítási Alapkezelő, NEAK).

Latvia

Score 4

In 2016, an OECD review stated that the health care system broadly delivers effective and efficient care considering its severe underfunding and a higher level of demand compared to most OECD countries. Latvia has universal health care insurance and a single payer system financed through general taxation. Universal population coverage, highly qualified medical staff, the innovative use of physician’s assistants are positive aspects of the system. However, substantial challenges remain, including disproportionately high out-of-pocket expenses (one in five people report foregoing health care due to cost), and long waiting times for key diagnostic and treatment services. Mortality rates for men, women and children are higher than in most other EU countries.

The economic crisis in 2008 resulted in a dramatic decrease in public funding for health care. The crisis gave impetus to structural reforms, which aimed to reduce costs, for example, by shifting from hospital to outpatient care. 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 has been introduced to improve the financing of health care services. Latvia is lagging in its ability to develop evidence-based reform proposals. Attempts to introduce e-health and IT solutions have been lagging.

Public expenditure on health care was equal to 3.7% of GDP in 2014. Latvia has one of the highest private, out-of-pocket health care expenditure rates within the European Union. Patients’ out-of-pocket health care expenses constituted 36.82% of total health care financing in 2014. Additional financial allocations to the health system in 2014 aimed to reduce patients’ out-of-pocket expenses and patient waiting times, and raise the salaries of the system’s lowest wage earners. Total expenditure on health care amounted to 5.88% of GDP in 2014, below the EU average for public health care expenditure.

Although Latvia ranks among the worst performing countries in the Euro Health Consumer Index, there have been substantial improvements in recent years. In 2015, Latvia ranked 29 out of 35 countries, compared to 32 in 2013 and 31 in 2012. The EHCI points to an improvement in infant mortality from 6.2 deaths per 1000 births (red score) in 2012 to 3.9 deaths per 1000 births (green score) in 2014.

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

Romania

Score 4

Romania has a public health insurance system. Despite its claim to universal coverage, however, many citizens are not insured, as highlighted by the deadly nightclub fire in Bucharest in October 2015. Access to health care is further limited by a high salience of informal payments and a low density of doctors in rural areas. The problems are aggravated by relatively low public spending, large-scale emigration of medical staff and rampant corruption. In 2016, an outbreak of a nosocomial infection at a Bucharest hospital, summer protests by doctors demanding better pay for over-time hours and the resignation of Health Minister Voiculescu helped to put health care reform on the agenda. However, overall changes remained

modest. While the medical staff benefited from the wage increases in the public sector and health care spending increased in the course of the amendments to the 2016 budget, relatively little was done to address other structural problems. A new law on community care setting up health centers and teams, adopted as part of the government's anti-poverty package in October 2016, might improve access to healthcare for vulnerable groups in rural areas. Compared to its predecessor, the new national anti-corruption strategy 2016-2020 from August 2016 put more emphasis on fighting corruption in the health sector.

Citation:

European Observatory on Health Systems and Policies (2016): Romania: Health System Review 2016. Brussels (http://www.euro.who.int/__data/assets/pdf_file/0017/317240/Hit-Romania.pdf?ua=1).

Slovakia

Score 4

Slovakia has a mandatory health-insurance system that provides all residents with primary, secondary and tertiary care, pharmaceuticals, and medical devices. The state covers the health-insurance costs of children, students, pensioners, the (registered) unemployed and women on maternity leave. From a comparative perspective, the quality and efficiency of health-care services are relatively low. A government spending review published in autumn 2016 showed that there is significant scope to increase the cost-effectiveness of various areas of healthcare and identified potential savings of up to €74 million in 2017. The health policy of the second and third Fico governments has been erratic. A reform strategy developed for 2014-2020 has been implemented only very slowly and selectively and will, according to announcements by the new coalition government, be replaced by a new strategy. Little has been done to tackle the widespread corruption in the health care system, an issue highlighted by President Kiska.

Citation:

European Commission (2017): Country Report Slovakia 2017. SWD(2017) 90 final/2, Brussels, 17-18 (https://ec.europa.eu/info/sites/info/files/2017-european-semester-country-repor-t-slovakia-en_0.pdf).

Greece

Score 3

The first issue usually noted about health care policy in Greece is the issue of cuts in health care spending because of the crisis. Indeed, as OECD data shows, between 2009 and 2013 per capita spending on health care in Greece contracted by a massive 25%. However, the percentage of GDP continues to be above the OECD average. Moreover, increasing health care spending would not by itself resolve policy-related and structural problems in health care provision in Greece.

Greece is one of the lowest spenders for the share of preventive health measures in total health care expenditure. At the same time, compared to other EU member

states, Greece shows one of the largest shares of out-of-pocket household expenditure in total health care expenditure. This speaks volumes to three perennial problems of Greek health care policy: first, the lack of long-term planning and programming with regard to preventive health measures; second, the volume of transactions between patients and doctors which goes unrecorded and is not taxed; and third, the differential in health care access based on the purchasing power of households.

In addition to these policy-related problems, public health care in Greece suffers also from structural problems. These problems are, first, the long-term irrational distribution of resources, including funds, supplies and personnel, which results from a chronic application of a clientelistic, rather than rational, logic permeating the relations between the Ministry of Health and regional and local state-run health services; and, second, the fragmented and sprawling character of hospital care. There is a very unequal distribution of the 131 public hospitals across the territory of Greece, resulting from a patronage-based selection process determining where hospitals should be built. Further on, there are eight state medical schools in the country, producing hundreds of doctors every year. At the same time, there is an obvious lack of nurses. Moreover, there is a highly uneven distribution of medical personnel in hospitals, as doctors prefer to work in the hospitals of the two largest cities, Athens and Thessaloniki. Moreover, major budget cutbacks for public hospitals have left some hospitals without enough medicines and medical supplies.

Pharmaceutical spending in Greece has been significantly affected by the crisis. The large reductions in drug spending have come as a result of a series of government measures aimed at reducing the price of pharmaceuticals. However, some cost reductions have shifted to households.

In summary, both the quality and inclusiveness of health care have deteriorated in the period under review, in continuation of negative trends of the previous years. However, there were some positive government initiatives. The Ministry of Health issued instructions to state hospitals to provide medicine, tests and treatment to uninsured patients without charge. Indeed, since June 2014, uninsured people were covered for prescribed pharmaceuticals, emergency department services in public hospitals, as well as for non-emergency hospital care under certain conditions. The Syriza-ANEL government made access easier.

Citation:

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

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

Address | Contact

Bertelsmann Stiftung
Carl-Bertelsmann-Straße 256
33311 Gütersloh
Germany
Phone +49 5241 81-0

Dr. Daniel Schraad-Tischler
Phone +49 5241 81-81240
daniel.schraad-tischler@bertelsmann-stiftung.de

Dr. Christian Kroll
Phone +49 5241 81-81471
christian.kroll@bertelsmann-stiftung.de

Dr. Christof Schiller
Phone +49 5241 81-81470
christof.schiller@bertelsmann-stiftung.de

Pia Paulini
Phone +49 5241 81-81468
pia.paulini@bertelsmann-stiftung.de

www.bertelsmann-stiftung.de
www.sgi-network.org