



Health Report

Health Policy

Sustainable Governance Indicators 2019

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Indicator

Health Policy

Question

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

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

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

Canada

Score 8

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

The most glaring problem with the Canadian system is timely access to care. The number of practicing doctors and hospital beds per 1,000 inhabitants is well below the OECD average, as is the number of MRI and CT units per million. A 2017 study by the Commonwealth Fund, Canada ranked last for providing timely access to care out of 11 high-income countries. Canadians regularly experience long waiting times for medical care, including access to family doctors, specialists and emergency services. In its latest report on the health of Canada's seniors, the fund documents that Canada was below the international average, with only about 40% of seniors able to get a same- or next-day appointment with their regular physician, and performed worst for waiting times for specialists, with almost 30% of seniors having to wait two months or longer for a specialist appointment.

The Canadian Institute for Health Information reported in 2017 that over the last several years waiting times for elective or less urgent procedures have increased, despite efforts to reduce them. However, for more urgent procedures there has been an increase in the number of patients receiving care within the medically acceptable benchmark, albeit with considerable variation across the provinces.

Income is not a barrier to treatment, with high-quality care freely provided for almost the entire population. However, inefficiencies in the system have led to patients traveling abroad to receive medical treatment and increased demand for domestic for-profit clinics, which endangers Canada's otherwise impressive record of equity in health care. A recent report by the Fraser Institute estimated that over 63,000

Canadians received non-emergency medical treatment outside Canada in 2016. One effect of equity in access to health care services is the small gap in perceived health between the top and bottom income quintiles. However, since dental care, eye care and drugs prescribed for use outside of hospitals are excluded from general coverage, not all income groups have equal access to these types of health care services – low-income Canadians are far more likely to decline prescriptions or skip dental visits.

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

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

Citation:

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

Commonwealth Fund (2017), *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, posted at <http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/>

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"Leaving Canada for Medical Care, 2017," *Fraser Research Bulletin*, Fraser Institute, June 2017.

Denmark

Score 8

There is a universal entitlement for all citizens to health care, regardless of economic circumstance. Services are offered "free of charge" and elected regional councils govern the sector. Because financing through taxes depends on the state budget, regional authorities depend on annual budget negotiations with the Ministry of Finance.

Although health care spending in Denmark is high, the OECD considers its performance "subpar." In 2016, health spending in Denmark was 10.4% of GDP (11th highest among OECD countries), of which 8.7% is public (fifth highest among OECD countries). There has been an upward trend in health care expenditures, mainly driven by a policy shift from a top-down system to a more demand-driven system. This shift has been motivated by a concern about long waiting lists. Patients now have a "time guarantee," making it possible to opt for a private provider if a public hospital can't meet a specified wait time limit for treatment.

The 2007 structural reform shifted the responsibility for hospitals and health care from the old counties to the new regions. Health care is financed by a specific tax, however, which is part of the overall tax rate and over which regions have no control. This governance structure is creating problems, with regions having difficulties in meeting the objectives formulated for the health care system.

Life expectancy in Denmark in 2016 was 80.8 years, slightly above the OECD average, but below the level in comparable countries. Life expectancy is on an upward trend. There has been a marked decline in smoking in Denmark in recent years, but obesity rates have increased. The social gradient in health remains strong.

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

The current government is optimistic about the health care sector, claiming that one extra doctor and one extra nurse per day have been employed since the beginning of the decade, and that waiting times have been halved. Nevertheless, the government has proposed a new health care policy reform, which aims to improve coordination between the systems, as the prime minister explained in his opening speech to the parliament on 2 October 2018. The government has proposed creating 21 new health care communities around some existing hospitals, covering four to five municipalities, although further details are not yet available. A further reform could lead to the abolishment of the regions, which are headed by elected politicians. While abolishing the regions is supported by the Danish Peoples' Party and has some support in the three-party government, the opposition, including the Social Democrats, see the regions as an integral part of Danish democracy.

While improving cancer treatment was seen as a priority area in recent years, the government is now (October 2018) promising DKK 2.1 billion over the next four years for psychiatry.

Citation:

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

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

The prime minister's speech at the opening of the Danish Parliament - Folketinget (2 October 2018), http://stm.dk/_p_14747.html (accessed 7 November 2018).

Estonia

Score 8

The quality of health care in Estonia is good despite a level of expenditure well below the OECD average. Surveys commissioned by the National Health Insurance Fund reveal that the public is satisfied with the quality of health services (68%). Satisfaction with access is significantly lower (38%) and has been slowly but steadily declining since 2012. The main reason for dissatisfaction are the long waiting times to see specialists or receive inpatient care, which are primarily due to budgetary limits and a bias toward acute/hospital care.

Estonia has a social-insurance-based health system that includes some non-Bismarckian features such as general practitioners (GP). The insurance principle makes access to health service dependent on labor market status. Working-age people who are not employed or in education are not covered by the national health insurance. As a result, 6% of the total population are not guaranteed permanent free access to health care due to a lack of employment or irregular work contracts. The minister of social affairs recently started a discussion on universal health care, but Estonia's political parties are sharply divided over the issue.

Income-related health inequalities, as evidenced by unmet health needs and self-perceived health status, remain the most significant problem for health policy. Here, Estonia ranks at the very bottom among OECD countries. To tackle the problem of unmet health needs, which result from high out-of-pocket health care costs, the prescription compensation has been increased for people suffering from chronic illnesses. This measure could have a substantial effect on health equality, since expenditure on medications form the largest share (41%) of out-of-pocket payments.

Citation:

Evaluation of health and health care 2016. / In Estonian/ https://www.sm.ee/sites/default/files/content-editors/Ministeerium_kontaktid/Uuringu_ja_analuusid/Tervisevaldkond/arstiabi_uuringu_aruanne_2016_kantar_emor.pdf (accessed 16.12.2018)

Germany

Score 8

The German health care system is of high quality, inclusive and provides health care for almost all citizens. Most employees are insured in the public health insurance systems, whereas civil servants, self-employed persons, persons with high income and some other groups are privately insured. The system is, however, challenged by increasing costs. Recently, the system's short-term financial stability is better than expected due to buoyant contributions resulting from the employment boom. However, long-term financial stability will be challenged by an aging population. Health care spending as a proportion of GDP in Germany is the fifth highest in the OECD and considerably higher than the OECD average (close to 10% of GDP compared to an OECD average of 6% of GDP). In per capita terms, health care spending in Germany is far above the OECD average.

In its coalition agreement, the grand coalition negotiated a variety of reform measures to increase the quality of health care, redefine some financial details, and reorganize the registration of physicians in private practice, and the distribution of practicing doctors and hospitals. The financing side, in contrast, has received little attention recently. The only substantial change has been the decision that the insurance company-specific additional contribution rate will be financed equally by both employers and employees from January 2019. This additional contribution is the only significant competitive element in the otherwise fully harmonized statutory insurance market. It comes on top of the general contribution rate of 14.6% that has always been shared equally between both sides. Recently, strong employment rates and incomes has allowed most insurance companies to reduce their additional contribution rates. Moreover, the federal subsidy for the national health fund was raised in 2017 by €0.5 billion to a total of €14.5 billion, which was kept constant in 2018.

In October 2018, the cabinet decided to increase the contribution rate for long-term care insurance by 0.5 percentage points. As a result, an additional €5 billion will be available for improvements in long-term care. A proportion 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 will be given greater support.

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.

Citation:

OECD 2018:

<http://www.oecd.org/health/health-systems/Health-Spending-Latest-Trends-Brief.pdf>

Statistisches Bundesamt 2018: <https://de.statista.com/statistik/daten/studie/244326/umfrage/zuschuss-des-bundes-zum-gesundheitsfonds/>

Israel

Score 8

Under the 1994 National Insurance Act, all citizens in Israel are entitled to medical attention through a health maintenance organization (HMO). This is a universal and egalitarian law, allowing for broad access to subsidized primary care, medical specialists and medicines. A 2012 OECD survey identified Israeli health care system as one of the best in the developed world, ranking fifth with a score of 8.5 out of 10. In 2018, Israel scored 6 out of 56 countries in the Bloomberg Health-Efficiency Index. Despite the general positive foundations of Israel's health care, local experts warn that the continual erosion of the health care budget and personnel have put the system in a dire state, and that without an increase of about 2% of GDP (about ILS 26 billion) the public health system will not be able to sustain its current load.

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

According to a 2018 Taub Center study, health care spending as a share of GDP has remained fairly stable over the past two decades, at about 7% of GDP compared to an average of 10% in other OECD countries. However, the share of public funding in the total national expenditure on health has declined, from about 70% to 61% (compared to about 77% share of public funding among the OECD countries). Consequently, private expenditure on health care has increased as a share of total household expenditure, from 4.5% in 2000 to 5.7% in 2015.

The quality of health services and facilities varies by geographical location, with periphery facilities often struggling to attract skilled personnel, and the looming closure of peripheral emergency rooms in Kiryat Shmona. In Israel's peripheral regions, there are about 20% less beds per capita and 40% less surgery rooms per capita. Nevertheless, the Israeli system is fairly equitable in international comparison.

Citation:

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

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

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

Lee J Miller and Wei Lu, "These Are the Economies With the Most (and Least) Efficient Health Care," Bloomberg website, 19.09.2018:
<https://www.bloomberg.com/news/articles/2018-09-19/u-s-near-bottom-of-health-index-hong-kong-and-singapore-at-top>

Luxembourg

Score 8

Luxembourg's well equipped hospitals offer a wide range of services, including high-tech and expensive treatments. Waiting lists are rare, except for some services that are in high demand (e.g., MRI scans). Nevertheless, Luxembourg also has the highest share of patient transfers to other countries for treatment within the 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 beneficial side effect of being more cost-effective for the state health insurance program, as those services are in general less expensive abroad.

Drawbacks of Luxembourg's system include the lack of a university hospital and the individual nature of doctor's contracts and treatment responsibilities. Most resident general practitioners and medical specialists sign contracts with individual hospitals and are only responsible for a certain number of patients, which prevents any sort of group or collective treatment options. Therefore, some hospitals have re-organized to keep doctors' offices in-house without changing their status as independent physicians.

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

Citation:

OECD Health Statistics 2018. <http://www.oecd.org/els/health-systems/health-data.htm>. Accessed 23 Oct. 2018.

Health at a Glance 2017: OECD Indicators. OECD, 2017. [dx.doi.org/10.1787/health_glance-2017-en](https://doi.org/10.1787/health_glance-2017-en). Accessed 23 Oct. 2018.

New Zealand

Score 8

New Zealand's public health care policies achieve high-quality and inclusive health care for most citizens but, similar to other OECD countries, cost efficiency and long-term public spending pressures remain an issue. The OECD points out that the largest projected long-term public spending pressure is health care, which is expected to jump from 6.2% of GDP in 2015 to 9.7% of GDP by 2060, owing to both aging demographics and the expected increase in expensive new treatments. The gap in health status between Māori and non-Māori is still substantial. Much has to do with differences in behavior and lifestyle, particularly regarding smoking-related illnesses and obesity. During the 2017 election campaign, the three parties that now represent the government announced plans to improve primary care. In particular, Labour committed to increase the intake to 300 GP training places per year and to initiate a review of primary care funding. In May 2018, the new government announced a review of the health and disability system with a report due to be published in 2020. Health was the main winner in the government's first, cautious budget, goals for which included a NZD1.52 billion increase in health spending for the 2018-19 year (the 2017 National government had increased funding by NZD825 million). The majority of the new funding is for capital investments in building and restoring hospital buildings (NZD750 million) and boosting the support fund for District Health Boards in deficit (extra NZD100 million). Other measures included extending coverage of free doctors' visits and prescriptions to children up to the age of 13 years (resulting in free visits to an estimated 56,000 extra children), and extending access to low-cost doctors' visits for those low-income New Zealanders holding Community Services Cards.

Citation:

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

Ministry of Health. 2018. Life expectancy. 2 August 2018. <https://www.health.govt.nz/our-work/populations/māori-health/tatau-kahukura-māori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/life-expectancy>

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South Korea

Score 8

South Korea’s health care system is characterized by universal coverage and one of the highest life expectancies in the world, all while having one of the OECD’s lowest levels of overall health expenditure. President Moon has announced a new “Mooncare” health care plan, and the government will provide KRW 30.6 trillion (.8 billion) over the next five years to cover all medical treatments. In the future, medical insurance will cover all forms of treatment, excluding plastic surgery and cosmetic procedures. The Moon administration has thus proposed expanding the state insurance policy to include not only the four major diseases – cancer, cardiac disorders, cerebrovascular diseases and rare incurable illnesses – but all other major diseases, including Alzheimer’s disease. Co-payment levels remain high in Korea, but under the newly proposed health care policy, patients in the lower 50% of the income bracket would be able to receive medical treatment costing up to KRW 20 million. Additionally, new measures intended to act as safety nets for families facing astronomical health care costs have been announced. The government’s intention is to create a medical safety net that leaves no patient untreated in times of emergency. Mental health issues are not currently well addressed in Korea, a problem reflected by the large numbers of suicides; indeed, the country’s suicide rate is the second-highest in the OECD. One major problem in the Korean health care system is the comparatively low number of doctors and nurses per patient, particularly in some surgery departments.

Citation:

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

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

Ebesutani, Chad. 2018. “Korea’s struggles with mental health insurance coverage: lessons learned from the US”. The Korea Times, March 26. Retrieved September 20, 2018 (https://www.koreatimes.co.kr/www/nation/2018/05/119_245967.html)

Spain

Score 8

The national health care system is highly decentralized, relatively well-thought out, and largely achieves the criteria of quality, inclusiveness and cost efficiency. According to two recent Bloomberg health-related indexes, which examine 169 economies, Spain is now the healthiest country in the world (it placed sixth in the

previous edition, published in 2017), while its health system ranks third in terms of efficiency. OECD data also show that Spain has the second-highest life expectancy, after Japan (and is forecast to become first by 2040). Spaniards' self-perceptions of their health status and their national health care system reflect a degree of satisfaction that is quite high in cross-OECD comparison. However, rates of mental illnesses, diabetes and drug consumption are higher than the European averages.

Access to a core set of high-quality health services is guaranteed through a public insurance system that covers 99% of the population. However, the number of practicing doctors, nurses and hospital beds per 1,000 residents is relatively low. The most recent reports also emphasize deficiencies related to waiting lists, patient rights and sickness prevention. There is interregional inequality too. The system's sustainability is at risk over the medium and long term, as a consequence of the aging population and the subsequent increase in the incidence of chronic diseases. During 2018, the austerity-era legislation that had excluded undocumented migrants from health coverage was reversed, and the new government invited regional health authorities and civil society representatives to participate an open debate on reform of the system, with the aim of reestablishing universal coverage.

Citation:

OECD(2018), Spain Country Profile, <http://www.oecd-ilibrary.org/docserver/download/8117631e.pdf?expires=1511483073&id=id&accname=guest&checksum=E06FBC18C2F0B44B2F9042D89C87C48C>

Bloomberg (2017), Healthiest Country Index

<https://www.bloomberg.com/news/articles/2017-03-20/italy-s-struggling-economy-has-world-s-healthiest-people>

<https://www.bloomberg.com/news/articles/2019-02-24/spain-tops-italy-as-world-s-healthiest-nation-while-u-s-slips>

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 (2017). As of 2017, a 65-year-old male could expect to live for another 20 years on average, while a woman of the same age could look forward to another 23 years. 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. In general, health care reforms have not been particularly successful in terms of improving efficiency or controlling the structural rise in health expenditures. In 2017, health expenditure was equal to 12% of GDP, compared to 17% in the United States, 12% in France and 11% in Sweden.

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, voters decided in a popular vote to retain the present system. Currently, a number of attempts to curb the large increase in health expenditures are meeting stiff resistance from vested interests, such as doctors, hospitals or health-insurance funds.

Even given these problems, the quality and inclusiveness of Swiss health care has shown itself to be outstanding, and there is no reason to expect any major change in this respect in the coming years. There remains, however, some concern about the centralization of medical services and sufficiency of medical coverage in marginal regions.

Australia

Score 7

The Australian health care system is a complex mix of public 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 fail to 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 people 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 those on low incomes 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 withdrawn support for 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 more sustainable funding arrangements for Australia's health system. Key features of the agreement included: additional federal funding for hospitals from 2015 to 2020 and for non-emergency surgery from 2010 to 2016; 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 was partially removed by the Turnbull government in July 2017.

Finally, concerning cost-effectiveness, the health care system is rife with inefficiencies and perverse incentives. Total health care expenditure is relatively low, but as is the case in most developed countries, the government faces significant challenges due to rising costs from an aging population and development of new diagnostic tools and treatments. The government's Productivity Commission made a number of recommendations to improve cost-effectiveness, including eliminating low-value health interventions, adopting the principle of patient-centered care, and making better use of health system data.

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)

Productivity Commission five-year productivity review: <https://www.pc.gov.au/inquiries/completed/productivity-review/report>

Sunil K. Dixit; Murali Samasivan: A review of the Australian health care system: A policy perspective, Sage Med, April 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5900819/>

Austria

Score 7

The Austrian health care system is based on several pillars. Public health insurance covers most persons living legally in Austria, while a competitive private health-insurance industry offers additional benefits. However, major inequalities in health

care have arisen, particularly between those able to afford additional private insurance and those who cannot.

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

A second complexity in the system is produced by the division of responsibilities between the federal and state governments. Public health care insurance is based on federal laws, but the hospitals are funded by the states. This state-level responsibility affects both publicly owned and privately owned hospitals. The ongoing conflict between the policy intentions of the federal government and state governments about the responsibility for health care provision is a permanent topic of Austrian politics and draws attention to the demographic changes' impact on the health care system.

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

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

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

The new government has started to restructure the institutions of public health care. The government is centralizing the diverse institutions which – enjoying a high degree of autonomy – have defined the Austrian health care system for decades. In the immediate future, the government will be forced to confront the shortage of physicians, which is already affecting services in some parts of the country.

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

Belgium

Score 7

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

A problem is that costs have been contained by reducing wages and hospital costs in ways that do not seem viable in the long run, particularly given the aging population. Too few graduate doctors are allowed to practice, and the short supply of doctors is increasingly translating into abusive and underpaid or unpaid working hours (totaling 70-100 hours per week) for young graduates.

Such bottlenecks may compel an increasing number to leave the public system and the constraints imposed by state subsidies, and move to fully private practices. As a result, inclusiveness is under threat in the medium term and already a challenge in some rural areas.

Another issue is that Belgium does not emphasize prevention sufficiently, and spends more than similar countries on subsidized drugs. This has generated a structural increase in health policy costs and hampers lasting 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.

Citation:

<https://plus.lesoir.be/187789/article/2018-11-02/apres-une-garde-de-24h-je-me-sens-juste-abimee-lenfer-des-assistants-en-medecine>

Chile

Score 7

For more than three decades, Chile has maintained a dual health system, with one pillar represented by private insurance and private health care services chosen by self-financing participants (typically upper middle-income and high-income groups),

and another pillar of public, highly subsidized insurance and public health care services for participants who pay only part of their health costs. This system provides broad coverage to most of the population, but with large differences in the quality of health care provision (especially in the waiting times for non-emergency services). A significant reform has been implemented gradually since 2003, expanding the range of guaranteed coverage and entailing a corresponding extension of government subsidies to low- and middle-income population groups. In contrast to other policies, this reform has been pursued in a very consistent and solid way, although some failures can be detected regarding the budget provided for public health and administrative processes. Above all, primary health care within the public system has shown great advances in coverage and in quality. These standards have remained stable in recent years.

In the domain of the more complex systems of secondary and tertiary health care, a more problematic situation is evident regarding the public health care system. These levels show funding gaps and an insufficiency of well-trained professionals. There is still a huge gender gap with regard to health care contribution rates, since maternity costs are borne only by women. For these reasons, the quality and efficiency of public health care provision (government clinics and hospitals) vary widely.

A survey released in November 2017 by Centro de Estudios Públicos (CEP), one of Chile's most important polling agencies, showed that 36% of the respondents cited health care as their third highest concern (after crime, 47%, and pensions, 38%).

Citation:

Healthcare as one of the chief concerns:

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

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Czechia

Score 7

Czechia spends slightly less on health care than the more advanced European countries. Relative to GDP, public health care spending has fallen in recent years, down from 7.1% in 2013 to 6.2% in 2016, the last year for which full data are available. The health care system, based on universal compulsory insurance, ensures a wide range of choice for both providers and consumers of health care and provides a level of service which is high by international standards. Life expectancy slightly increased in the review period; however, there are regional differences. Public health insurance in Czechia is provided through seven health insurance companies, the largest being the General Health Insurance Company (Všeobecná zdravotní pojišťovna). Indicators of inpatient and outpatient care utilization point to unnecessary consumption of goods and services, and inefficiencies persist in the allocation of resources in the hospital sector.

In 2018, there have been only minor changes in health care. The spending on preventive health programs has increased, the coverage of dental care and home-based palliative care by health insurance funds improved. These improvements have in part been financed by a rise in the health care contributions for state-insured persons (children, pensioners, unemployed or mothers on maternity leave).

Finland

Score 7

Health policies in Finland have over time led to palpable improvements in public health such as a decrease in infant-mortality rates and the development of an effective health-insurance system. Furthermore, Finnish residents have access to extensive health services despite comparatively low per capita health costs. Yet criticisms are common regarding life expectancy, perceived health levels, the aging population and an inadequate provision of local health care resources. Also, Finland's old-age dependency ratio is increasing substantially, although not as dramatically as in some other EU member states, and many clinics formerly run by municipal authorities have been privatized. Government planning documents outline preventive measures. For example, the 2015 Public Health Program describes a broad framework to promote health across various sectors of the government and public administration. Similarly, the Socially Sustainable Finland 2020 strategy sets out the current aims of Finland's social and health policy. In November 2015, the government agreed on a major social and health care reform (SOTE) that will move responsibilities for social welfare and health care services from municipalities to 18 larger governmental entities (counties) beginning in 2020. Also, a planned reform envisions greater freedom for clients in choosing between public and private health care providers; at the time of writing, however, the implementation of this reform remains the subject of considerable political conflict and debate. After concerns by the Constitutional Law Committee in June 2018, the SOTE reform is expected to come into force in early 2021.

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;

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

France

Score 7

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

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

The problem is cost efficiency and the containment of deficits, which have been constant in recent years. Savings have improved recently, but the high level of medication consumption still needs to be tackled with more decisive measures. The lack of doctors in rural areas and in some poor neighborhoods is a growing issue. The unsatisfactory distribution of doctors among regions and medical disciplines would be unbearable without the high contribution of practitioners from foreign countries (Africa, Middle East, Romania). New policies are expected in order to remedy first the deficits and second the “medical desertification.” More generous reimbursements of expenses for glasses and dental care (a traditionally weak point of the system) were promised by Macron during the electoral campaign and implemented in 2018. An ambitious plan to reform the health care system was announced in September 2018, but has yet to be implemented. The plan proposes to develop an intermediary level between hospitals and individual doctors, which would involve establishing structures that enable the various medical professions to provide collective and improved services in particular in rural areas. The aim is to alleviate the excessive burden on hospitals by derouting the care for basic treatments toward these health care centers (Maisons de santé). The plan also proposes to recruit several thousand medical assistants (to deal with the bureaucratic component of the profession) and eliminate the *numerus clausus* for university admissions. Finally, the social security budget is foreseen positively balanced in 2019 for the first time since 2012.

Italy

Score 7

Italy’s national health system provides universal comprehensive coverage for the entire population. The health care system is primarily funded by central government, though health care services and spending are administered by regional authorities. On average, the services provided achieve medium to high standards of quality. A 2000 WHO report ranked the Italian health care system second in the world and a recent Bloomberg analysis also ranked the Italian system among the most efficient in the world. A 2017 study published by *Lancet* rated the Italian system among the best in terms of access to and quality of health care. However, due to significant differences in local infrastructures, cultural factors, and the political and managerial proficiency of local administrations, the quality of public health care varies across regions. In spite of similar levels of per capita expenditure, services are generally better in northern and central Italy than in southern Italy. In some areas of the south, corruption, clientelism and administrative inefficiency have driven up health care costs. In these regions, lower quality levels and typically longer waiting lists mean that wealthier individuals will often turn to private sector medical care. Regional disparities also lead to a significant amount of health tourism heading north. Early

moves in the direction of fiscal federalism are now stimulating efforts to change this situation through the introduction of a system of national quality standards (correlated with resources), which should be implemented across regions.

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

To contain further increases in health care costs, payments to access tests, treatments and drugs exist. Even if these payments are inversely linked to income, they nevertheless discourage a growing number of the poorest from accessing necessary health care services. Similarly, additional medical services are only partially covered by the public health care system, while only basic dental health care is covered.

Citation:

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

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

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

Japan

Score 7

Japan has a universal health care system. Life expectancies are currently the second-highest in the world for women (87 years at birth) and third-highest for men (81 years). Infant-mortality rates are among the world's lowest (2.0 deaths per 1,000 live births). A persistent shortage of doctors represents one serious remaining medical-system bottleneck. The number of doctors per capita is some 40% lower than in Germany or France. However, judging on the basis of fundamental indicators, Japan's health care system, in combination with traditionally healthy eating and behavioral habits, delivers good quality.

Challenges for the health care system include the needs to contain costs, enhance quality and address imbalances. The national health insurance program has a structural deficit, which remains despite additional fiscal support provided by the state in the 2018 reform package; this was in turn based on 2015 legislation, which also improved some management issues.

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

Citation:

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

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Lithuania

Score 7

In Lithuania, some health outcomes are among the poorest in the EU. For example, the mortality rate of 20 to 64 year olds is the highest in the EU. 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 EU, with 58% of respondents saying that the overall quality of health care was fairly or very bad.

The Lithuanian health care system includes public-sector institutions financed primarily by the National Health Insurance Fund, and private sector providers financed the National Health Insurance Fund and out-of-pocket patient costs. Between 2008 and 2013, GDP growth exceeded growth in public health care expenditure. In 2016, the National Health Insurance Fund amounted to €1.5 billion and exceeded 6% of GDP. Spending on preventive-care and other related health care programs as a percentage of current health care expenditure is quite low, while spending on pharmaceutical and other medical non-durables (as a percentage of current health care expenditure) is quite high.

The provision of health care services varies to a certain extent among the Lithuanian counties; the inhabitants of a few comparatively poor counties characterized by lower life expectancies (e.g., Tauragė county) on average received fewer health care services. Out-of-pocket payments remain high (in particular for pharmaceuticals), a fact that may reduce access to health care for vulnerable groups. New prevention-focused programs were introduced by the National Health Insurance Fund. Furthermore, the scope of the new State Public Health Promotion Fund under the Ministry of Health was recently expanded to support additional public health interventions.

Seeking to improve service quality and cost efficiency, the 2008 to 2012 government sought to optimize the network of personal health care organizations. The overall number of health care organizations was consequently reduced from 81 to 62 by the end of 2012. The 2012 to 2016 government by contrast placed more emphasis on the accessibility of health care services, the role of public health care organizations in providing these services, and the issue of public health in overall health care policy.

At the end of 2015, the government approved a plan to consolidate health care providers. However, this has not brought any significant changes. The Skvernelis government's focus shifted to reducing the availability of alcohol and tightening regulations on pharmaceuticals, acting on the assumption that the choices of patients must be more strictly regulated.

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. According to the European Commission's 2018 report, the performance of the health care system could be improved by strengthening outpatient care, disease prevention, the quality and affordability of health care, and promoting healthier life style choices. In 2017, the parliament increased excise duties on alcohol and passed amendments to the Alcohol Control Law, which will raise the legal age for alcohol consumption from 18 to 20, restrict hours of alcohol sales and ban alcohol advertising. These legal provisions will come into force between 2018 and 2020. Some additional alcohol-control measures (including a requirement to transport and store alcoholic beverages in non-transparent packaging, and introduce special alcohol consumption zones during public events) were rejected during the parliamentary decision-making process.

Citation:

The 2010 Eurobarometer report is available at http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf
COMMISSION STAFF WORKING DOCUMENT, country report Lithuania 2018: <https://ec.europa.eu/info/sites/info/files/2018-european-semester-country-report-lithuania-en.pdf>
Murauskiene L, Janoniene 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

in 2018, Malta was ranked at 9th place in the annual health-related index published in the medical journal *Lancet*. With regard to general performance, the country advanced five places relative to the previous year, and obtained full marks for 10 indicators. The Maltese population enjoys the highest healthy life expectancy in the EU, and access to services is generally good. Malta provides quality health care to all citizens, with extensive inpatient and outpatient hospital services offered for free. This is reinforced by agreements with the United Kingdom and Italy to service patients in need of special treatments unavailable locally. However, the Euro Health Consumer Index 2017 found that despite Malta's decent access to health care, performance lagged when it came to treatment results. Moreover, there were noticeable gaps in the public subsidy system and little data on drug usage. Vulnerable groups are entitled to state support for a list of prescription medications, and all citizens are entitled to free medicine for specified chronic diseases (e.g., high blood pressure and diabetes). Couples are entitled to IVF services, and the government also supports oncology patients, providing otherwise expensive treatments for free.

Malta fares well in terms of self-reported unmet need for medical care, with just 2.8% of the total population reporting such a need, compared to the EU-28 average of 4.5%. Much has been done to reduce patient waiting times and dependence on private hospital care. A 2017 National Audit Office (NAO) report stated that there had been a 22% decrease in patient waiting time for elective operations. Nonetheless, the average patient waits eight months for their first outpatient appointment, a time double that of the United Kingdom. However, between 20% and 50% of these first appointments could have been treated by regional units, indicating that primary care services is not serving as an effective gatekeeper for secondary care. The report also indicates that the main hospital had improved outpatient services.

The government has initiated a number of infrastructure projects over the last few years. For example, the general hospital's limited bed capacity has been increased by building new wards and devising plans to add new buildings to the existing infrastructure, while a new oncology hospital has been added on the same site. An additional 300 beds are expected to be added over the next four years, along with a new outpatient block, an acute-care mental hospital and a new maternity ward. A long-term strategic health care plan for the period 2020 – 2030 is currently being drafted, while state-of-the-art robotic technology for surgical operations is expected to enter service in 2019. Patients will also started being treated remotely. There have been repeated calls for reform of the mental-health sector and for a new mental health hospital. A 2018 NAO audit described the country's mental-health hospital as underfunded, understaffed and lacking in adequate security. Meanwhile, medical cannabis was legalized in 2018. A WHO study determined that Malta has the second highest rate of obesity in Europe.

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 only a small number of private hospitals. Malta also has fewer hospital beds per 100,000 inhabitants than many of its European counterparts. Health-related expenditure is equivalent to 2.9% of GDP. The country's stock of doctors and nurses is close to the EU average. The European Commission has expressed concerns about Malta's ability to meet growing long-term care demands due to its aging population and has recommended that Malta take action to ensure the sector's sustainability.

Citation:

Times of Malta 05/09/2012 Three health agreements signed with Italy

<https://deputyprimeminister.gov.mt/en/cbhc/Pages/Entitlement/Reciprocal-Agreement-MaltaUK.aspx>

Euro Health Consumer Index 2017 p. 16

Times of Malta 06/0/2018 104 IVF births at Mater Dei in first two years

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[explained/index.php?title=File:Share_of_persons_aged_16_and_over_reporting_unmet_needs_for_medical_examination_or_treatment,_by_detailed_reason,_2016.png](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Share_of_persons_aged_16_and_over_reporting_unmet_needs_for_medical_examination_or_treatment,_by_detailed_reason,_2016.png)

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The Malta Independent 29/09/2018 PM Muscat meets Steward Healthcare top officials, visits hospital in Boston

Times of Malta 04/07/2018 Mt Carmel Hospital is under-funded, under staffed and lacking security, audit finds

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 State of health in the EU: Malta, country health profile 2017, OECD, European observatory on health systems and policies

Norway

Score 7

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

Although the entire population has access to high-quality health care services, the efficiency of this system is questionable. A major structural health care reform introduced in 2002 transferred ownership of all public hospitals from individual counties to the central state. This shift involved the creation of new and larger health care regions that were tasked with managing the delivery of services delivery, but without ownership. The reform objective was to institute a stricter budget discipline by streamlining health care services and promoting regional coordination. In recent years, new reforms have been introduced, closing down or integrating several smaller hospitals with larger hospitals, and encouraging more cost-effective treatment and equitable access to expertise. However, this reform has met with some local protest, as citizens prefer not to have to travel too far to a hospital

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 considerably. In particular, Turkey has achieved the largest gains in life expectancy since 1970 among the OECD countries. While life expectancy among males was 70.5 in 2002, it has increased to 75.3 in 2016. Similarly, while life expectancy among females was 74.7 in 2002, it has increased to 80.7 in 2016. The maternal mortality rate fell from 28.5 deaths per 100,000 live births in 2005 to 14.7 deaths in 2016. There has also

been a sharp decline in infant mortality from 20.3 deaths per 1,000 live births in 2005 to 9.7 in 2016. As a result, Turkey has met its Millennium Development Goal target on both counts.

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

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

The key challenge in health care is to keep costs under control as demand for health care increases, the population ages and new technologies are introduced. Total health expenditure as a share of GDP has amounted to 4.6% during 2016. In 2016, 78% of this spending was funded by public sources, as compared to a 62% public share in 2000.

Citation:

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World Health Organization (2018) 'Turkey: WHO Statistical Profile', Geneva.

Cyprus

Score 6

The potential for high-quality health care services in the public sector, in private clinics, and from individual doctors is being eroded by deficiencies in the system and a lack of regulation. The absence of a national health system has allowed various health-insurance schemes and private sector services to dominate. Constraints and deficiencies in infrastructure and human resources result in long queues, waiting lists, and delays. Notwithstanding, the quality of services offered by the public system is acknowledged by the World Health Organization to be high. Cyprus has a low infant-mortality rate (2.6 per 1,000 in 2016) and a high life expectancy at birth (80.3 for men and 84.7 for women in 2016). Preventive medicine is specifically promoted, with Cyprus ranking high worldwide with respect to expenditure in this area.

Reforms introduced in 2013 on criteria for accessing health care (e.g., level of income and property ownership) resulted in the exclusion of various groups. These

criteria and the requirement to complete three years of contributions before benefiting from the system resulted in the exclusion from care of 20% to 25% of the population. According to a 2016 EU assessment, the private sector is unregulated in respect to prices, capacity, and quality of care, while coverage remains inadequate and ineffective.

Actions toward establishing a national health system (NHS) missed the target of full services by 2016. The ongoing implementation of measures provided by a 2017 NHS law are expected to allow for the implementation of a functioning system in 2019. However, reactions by private sector doctors, aiming to promote their pay scale demands and other issues, may delay progress.

Citation:

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Iceland

Score 6

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

The University Hospital in Reykjavík (Landspítalinn Háskólasjúkrahús), by far the largest hospital in Iceland, has for several years been in a difficult financial situation. The 2013 – 2016 government did not provide adequate additional public funds nor did it allow the hospital to independently raise funds through, for example, patient service fees. The resulting shortage of nursing and other medical staff increased the work pressures on existing staff, including their hours of work. One of the issues in the 2013 election campaign was the question of how to finance a redevelopment of the University Hospital in Reykjavík and the health care system in general. In the 2016 election campaign, this question appeared to be the most important issue for both political parties and voters. This has already led to a modest increase in public health care expenditure. A considerable amount of money has also been granted to renovating old houses around Reykjavík University Hospital over the last decade.

Opinions remain sharply divided among political parties as to whether partial privatization of hospital services would be desirable. The current minister of health,

Svandís Svavarsdóttir (Left-Green Movement), took several significant steps from this toward partial privatization in 2018.

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). Even so, life expectancy was the same in 2012 and 2016, a four-year stagnation that has occurred only twice before in Iceland. On both occasions, the period of stagnation followed an economic shock: in 1967 – 1971 following the collapse of herring fishing; and in 1984 – 1988 following double-digit inflation, and the restoration of positive real interest rates and introduction of financial indexation.

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Netherlands

Score 6

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

In terms of cost efficiency, according to the new System of Health Accounts, the Dutch spend 15.4% of GDP on health care, or €5,535 per capita. The WHO's Europe Health Report 2015 still shows the Netherlands as the continent's highest spender on health care, spending 12.4% of GDP on health care. The costs of care, both government spending and private contributions, show a steady increase (which exceeds inflation) since 2014. The steepest increase is in specialized medical care in hospitals, with long term care showing some decrease. Moreover, the number of people employed in health care was lower than in previous years. Labor productivity in health care rose by 0.6% on an annual basis, with the gains coming almost entirely in hospital care. Profits for general practitioners, dentists and medical specialists in

the private sector increased much more than general non-health business profits. A proportion of health care costs are simply transferred to individual patients by increasing obligatory co-payment health insurance clauses. A means of improving patients' cost awareness is through increased transparency within health care institutions (e.g., rankings with mortality and success rates for certain treatments per hospital).

In terms of quality and inclusiveness, the system remains satisfactory. However, Dutch care does not achieve the highest scores in any of the easily measured health indicators. Average life expectancy (79.1 years for males, 82.8 for women) and health-status self-evaluations have remained constant. Patient satisfaction is high (averaging between 7.7 and 7.9 on a 10-point scale), especially among elderly and lower-educated patients. Patient safety in hospitals, however, is a rising concern both for the general public and for the Health Inspectorate. Since 2013, waiting lists for specialist care have been a growing concern. The trend has continued into 2018, particularly for age-related conditions, and drastically for some regions in the country with aging and decreasing populations. Particularly troublesome is the situation in psychiatric care.

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

Citation:

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Portugal

Score 6

Portugal performs comparatively well across a number of health policy indicators, including life expectancy and infant mortality, with results that significantly outperform the level of public expenditure.

At the same time, the focus of the health care system is largely reactive and focused on “big ticket” statistics (e.g., life expectancy and infant mortality). The health care system pays relatively little attention to the women’s concerns during childbirth. Likewise, the number of healthy years after 65 years of age is well below the EU average, even though the life expectancy exceeds that of Portugal’s EU counterparts.

As in other public policy areas, the country’s national health system came under financial pressure in the previous review period because of the pressure on Portugal to curb public expenditure. Likewise, while the Costa government seeks to end austerity, it also aims to sustain budgetary consolidation, with the health care sector affected by de facto restrictions on expenditure.

These financial constraints led a number of hospital boards and service directors to resign in 2018. Between March and September 2018, resignations – in protest to the lack of resources, equipment and conditions – affected four public hospitals. In addition, there were numerous strikes by nurses and medical technicians in protest to the lack of funding.

Citation:

Diário de Notícias (2018), “Vivemos mais anos do que a média da UE mas menos saudáveis,” available online at: <https://www.dn.pt/portugal/interior/vivemos-mais-anos-do-que-a-media-da-ue-mas-menos-saudaveis-9166882.html>

Público (2018), “Este ano mais hospitais já tiveram demissões em bloco,” available online at: <https://www.publico.pt/2018/09/05/sociedade/noticia/este-ano-mais-hospitais-ja-tiveram-demissoes-em-bloco-1843181>

Sweden

Score 6

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. The Health and Social Care Inspectorate was created in 2013 to address problems with administrative oversight of the health care sector.

The general account of Swedish health care is that once you receive it, it is good.

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. Governance problems are rarely solved by pouring more financial resources into the organization, which has thus far largely been the typical political response to problems in the health care sector.

From the patient’s perspective, a key problem is accessibility. Patients in need of care are to make an appointment with a primary health care provider, not with a hospital, but even primary care often struggles to meet the demand. Referrals to specialists may offer the patient an appointment with an medical doctor in weeks or even months. Partly as a result of these problems, a rapidly increasing number of people in Sweden purchase private health insurance. Estimates in 2018 suggest that more than 650,000 Swedes have a private health insurance policy, either purchased privately or, more common, provided by their 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, center-right government (2006 – 2014) 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 formally 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: Health care governance and the limits to reform," *Journal of Health Organization and Management* 30:1-9.

United Kingdom

Score 6

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

While patient convenience may not be a central focus of NHS provision, attempts have been made to improve local health care by creating Health and Well-Being Boards to bring together representatives from all social services as well as elected representatives. The NHS's quality as measured by the Human Development Index (HDI) health index is very high (0.922). The financial position of many hospital trusts is rather precarious and has been the subject of growing concern over the last year, with more hospitals struggling to maintain standards.

As a universal service, the NHS scores very highly in terms of inclusion. The Health and Social Act 2012 now also allows patients to choose a general practitioner without geographical restrictions. Quality is generally high. However, input and outcome indicators of health care, such as how quickly cancer patients are seen by specialists or the incidence of "bed-blocking" (i.e., where complementary social care is difficult to arrange and so patients are kept in hospital), vary considerably across localities. A report by the Commission on the Future of Health and Social Care in England recommended that health and social care services should be much more closely integrated, but there has, to date, been little improvement. Winter health care "crises" have become the norm as hospitals struggle to cope with emergency admissions and have to cancel routine operations to free bed-space. This is partly because of the aging of the population, but also highlights inadequacies in funding and in organization of care services for the elderly. Social care is funded by local authorities and has been financially squeezed, resulting in more costly hospital care having to be used. New reports regularly refer to a service which while offering excellent clinical care, often struggles to cope.

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 24/7 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, health care in the United Kingdom remains way above average on an international scale.

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

Citation:

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

<http://hdr.undp.org/en/countries/profiles/GBR>

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 six 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 over-runs 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 over-runs in health spending. These have continued since Ireland exited the bailout program. The Irish Fiscal Advisory Council in its November 2018 report highlighted the extent of cost over-runs in the health care service, stating that the HSE had exceeded its allocation by more than €2 billion over the previous four years. The report recognized that part of this over-run was due to high payments for medical cases settled by the State Claim Agency. The buoyancy of government tax revenues has enabled the government to absorb the health care over-runs. However, if there is a downturn in tax revenues and given the alarming health care over-runs to date, there is the potential for a major fiscal crisis.

Citation:

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

Mexico

Score 5

Overall, public spending on health care is comparatively high but the quality of health care varies widely across Mexico, with different regions showing broad variation in the quality and variety of services available. Some U.S. citizens come to Mexico as health tourists, taking advantage of cheaper health care south of the border. Private, self-financed health care is largely limited to middle-class and upper-class Mexicans, who encompass roughly 15% of the total population, but receive about one-third of all hospital beds. Around one-third of the population (most of whom work in the formal sector) can access health care through state-run occupational and contributory insurance schemes such as the Mexican Social Security Institute (Instituto Mexicano del Seguro Social, IMSS) and the State Employees' Social Security and Social Services Institute (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, ISSSTE). These are based on automatic contributions for workers in the formal sector and, in practice, work reasonably well, although with some variation across different parts of the country. The system has been decentralized to the states. In 2016, a National Agreement Toward Health Service Universalization was signed, which aims to ensure portability across providers.

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

The government has been attempting to make health care more affordable and extend it to more people outside the formal sector. In order to extend the insurance principle, in 2003 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. According to experts, the program was widely successful. By 2017, the percentage of uninsured people had decreased from 50% to 21.5%. However, there are still substantial problems in terms of funding and serious transparency deficiencies persist. During the presidential election campaign, reform of the health system was not a major issue. The newly elected president made rather vague suggestions, although his general position is to make the health system more inclusive.

Citation:

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

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

<http://blogs.lse.ac.uk/latamcaribbean/2018/07/19/big-promises-few-details-the-uncertain-future-of-mexican-healthcare-under-amlo/>

Poland

Score 5

Public health insurance covers some 98% of Poland's citizens and legal residents and is financed through social-insurance contributions. However, access to health care is highly uneven, as public health insurance covers only a limited range of services, and out-of-pocket payments feature prominently in the system. Moreover, the poor quality of some services falls far under citizens' expectations, and for some services, patients must wait for an unreasonable duration. Aggravated by the migration of many doctors to other EU countries, Poland has a low doctor-patient ratio, with only 2.3 doctors per 1,000 inhabitants. Mortality indicators show a visible increase in the number of deaths in 2017 and 2018 that is clearly related to the declining availability and quality of health care services, particularly in the countryside.

Upon coming to office, the PiS government called for a comprehensive health care reform that included far-reaching changes such the abolition of the National Health Insurance Fund (NFZ) and a move to tax-financed health care. While many of these radical structural changes were quickly abandoned, the government adopted a number of measures such as the creation of a new hospital network and pilot projects

to test ways of improving the coordination of primary care. However, health policy has been dominated by strong conflicts between medical staff and the government over salaries and working conditions, which manifested in frequent strikes and demonstrations in the second half of 2017. The government responded by promising salary increases for physicians and an increase in public health care spending from about 4.7% to 6% of GDP by 2025. Following the cabinet reshuffle in January 2018, which led to the replacement of Minister of Health Konstantyn Radziwiłł with Łukasz Szumowski, the deadline for reaching the 6% goal has been brought forward to 2024.

Citation:

Sowada, C., A. Sagan, I. Kowalska-Bobko (2019): Poland: Health System Review 2019. Brussels: European Observatory on Health Systems and Policies/ WHO (<https://apps.who.int/iris/bitstream/handle/10665/325143/18176127-eng.pdf?sequence=7>).

Slovenia

Score 5

The Slovenian health care system is dominated by a compulsory public-insurance scheme. This scheme guarantees universal access to basic health services but does not cover all costs and treatments. In order to close this gap, citizens can take out additional insurance offered by Vzajemna, a mutual health insurance organization established in 1999, or, since 2006, additional insurance offered by two other commercial insurance companies. The quality of services, which are partly delivered by private providers and are organized locally, is relatively good and total health spending is well above the OECD average. However, both the compulsory public health insurance scheme and the supplementary health insurance funds have suffered from severe financial problems for some time, resulting in financial problems among the majority of health providers. Since 2015, several scandals about irregularities and corruption in procurement in hospitals have been reported.

Health care reform featured prominently in the coalition agreement of the Cerar government. Despite many calls for reforms both inside and outside the governing coalition, however, the specification and implementation of the 2015 National Healthcare Plan has progressed slowly. The government's agreement with the doctor's trade union on working standards and wages in March 2017 was criticized by other public sector unions, including those representing nurses and police, for destabilizing the public sector's salary system. The widespread dissatisfaction with the agreement fueled the public sector strikes in February 2018, which contributed significantly to the fall of the Cerar government. The continuation of health care reform was a top priority in the coalition agreement of the new Šarec government.

United States

Score 5

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

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

In 2017, the Trump administration and Republican majorities in the House and Senate tried to make good on their effort to overturn the ACA but could not achieve sufficient agreement within their own party to enact a replacement. However, their tax bill effectively abolished the individual mandate (a requirement for otherwise uncovered individuals to purchase health insurance), which is central to making the ACA financially viable. In addition, Republican officials in 19 states filed a lawsuit seeking to invalidate the ACA (notwithstanding the prior Supreme Court ruling), and the Trump administration authorized “short-term” insurance plans that included sharply reduced coverage.

Republican activity in this regard has destabilized health insurance markets and will slow the expansion of coverage under the ACA. Because Democrats succeeded in using the health care issue against the Republicans in the 2018 congressional election campaign and have gained majority control of the House of Representatives, Republican efforts to overturn the ACA may now subside.

Citation:

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

Bulgaria

Score 4

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

negotiate a national framework health contract with the fund. Public health care spending relative to GDP is similar to other countries in East-Central Europe. After increasing by about one percentage point over the last decade, it is projected to stay at the current level of 4.5% of GDP over the medium term. Due to robust economic growth and the decline in unemployment, the financial balance of the health care system has improved.

The performance of the health care system in Bulgaria has been mixed. The system is inclusive, providing at least some level of health care for all who need it. Important outcome indicators (e.g., life expectancy and infant mortality) have visibly improved in recent years. However, the practice of unregulated payments to doctors is widespread. Those who can afford to make unregulated payments, receive faster and better quality health care. The system also suffers from substantial financial leakages, with public funds appropriated and misused by private actors.

Health care policy has been characterized by serious policy instability. Over the last decade, ministers of health have served on average less than 11 months. As a result, few of the regularly announced reforms have actually been implemented.

Citation:

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

Croatia

Score 4

In Croatia, most health care services are provided by the government and are part of the country's social health insurance system. Employer and employee contributions, plus some funding from the public budget, account for 85% of all health care spending, leaving only 15% to market schemes and private spending. The system is broadly inclusive. Primary care is widely available while specialized care is provided in regional hospitals and national clinical centers which divide work on the basis of the complexity of procedures. There are 538 hospital beds per hundred thousand of the population (little more than the EU average) 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 well below the EU average. Access to care is adversely affected by the regional variation in the range of care provided, the quality of services suffers from weak organization, a lack of digitalization and an inadequate monitoring of treatment outcomes. In addition, there is evidence of significant health inequalities between low and high-income groups. The low employment rate and aging demographics have produced a persistent financial deficit within the system. In late 2017, the debt of the health care system reached more than HRK 8.2 billion – approx. 2.2% of GDP, prompting another emergency allocation from the national budget. Since EU accession, the number of physicians and other medical professionals leaving Croatia has reached alarming proportions.

The Plenković government has so far done relatively little to address these problems. While the increase in the health care insurance contribution rate from 15% to 16.5% as of January 2019 will provide additional resources, the functioning of the health care system has been left largely untouched. The long-awaited adoption of the National Hospital Development Plan took until September 2018. A new health care bill submitted in early summer 2018 triggered large protests of primary health care physicians, who took to the streets against the government renegeing on its earlier promise to allow all physicians to work as private practitioners rather than as employees in community health centers.

Citation:

European Commission (2019): Country report Croatia 2019 Including an In-Depth Review of the prevention and correction of macroeconomic imbalances. SWD(2019) 1010 final, Brussels, 28-29 (<https://ec.europa.eu/info/sites/info/files/2019-european-semester-country-report-croatia-en.pdf>).

Radin, D. (2018) Health Policy in Croatia: A Case of Free Falling, in: Z. Petak, K. Kotarski (eds.), Policy-Making at the European Periphery: The Case of Croatia. Cham: Palgrave Macmillan, 247-264.

Greece

Score 4

Since the onset of the economic crisis in Greece, there have been massive cuts in public and private health care spending. Since 2009, per capita spending on public health care has been cut by nearly a third. In 2015 (latest year for which OECD data are available), Greece spent €1,650 per capita on health care – over one-third less than the EU-28 average. This amounted to 8.4% of GDP (down from 9.9% in 2009, the last pre-crisis year). Moreover, only 59% of health spending was publicly funded. Private spending, meaning out-of-pocket expenses (which were rarely taxed), stood at 35% and was more than double the EU-28 average.

In 2017, the government announced plans to appoint family doctors in an effort to ease pressure on secondary health care. A new law provided for the establishment of local public health care units (TOMY). The new system should have offered a major improvement over the past. While in the right direction, the new system required that practicing doctors become family doctors (i.e., general practitioners responsible for a few thousand insured citizens each). Implementation of the new system confronted challenges as Greece lacks sufficient general practitioners. According to a study conducted by the Greek Health Ministry and World Health Organization, there are currently about 3,800 general practitioners in Greece when, according to the EU average, there should be around 8,140. In addition, specialized doctors (of whom Greece has an oversupply) had no incentive to provide primary health care under the newly established terms and were reluctant to enroll in a system which would tie them to predetermined levels of compensation. Meanwhile, patients continued to trust their own doctors, whom they pay out-of-pocket fees in their private practices. As a result, by the late autumn of 2018 only several hundred doctors had agreed to work with the new system.

Greece also remained one of the lowest spenders on the share of preventive health measures in total health care expenditures. In addition, in the period under review as in the past, the distribution of the 131 public hospitals across Greece remained highly uneven, resulting from a patronage-based selection process that determines where hospitals should be built. Furthermore, there were eight state medical schools in the country, producing hundreds of doctors every year. Medical school graduates, being unable to find a job in the public health care system (owing to spending cuts) or to establish a personal clientele, often emigrated to northern European countries (Germany, the Scandinavian countries and the United Kingdom) to practice medicine. At the same time, Greece faced a chronic lack of nurses (a low-status, low-paid job) and a similar lack of medical personnel in the periphery of the country, as most doctors preferred to work in the hospitals of the two largest cities, Athens and Thessaloniki.

In summary, while clientelistic structures in the provision of health care remain intact, there is a lack of long-term planning and programming with regard to preventive health care measures. In addition, there is a high volume of unrecorded and untaxed transactions between patients and doctors as well as a differential in health care access based on the purchasing power of households.

Citation:

Data on per capita spending on health, general healthcare expenditure and public/private spending is available by OECD at https://ec.europa.eu/health/sites/health/files/state/docs/chp_gr_english.pdf

Data on expenditure on preventive medicine is available on this SGI platform.

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

Latvia

Score 4

In 2016, an OECD review stated that the health care system in Latvia broadly delivers effective and efficient care considering its severe underfunding and a higher level of demand compared to most OECD countries. Universal population coverage, highly qualified medical staff, the innovative use of physician's assistants have been noted as positive aspects of the current health care system in Latvia. 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 EU member states. Latvia also lags behind in the development of evidence-based reform proposals.

The economic crisis in 2008 resulted in a dramatic decrease in public funding for health care. The crisis gave impetus to structural reforms, which aimed to reduce costs, for example, by shifting from hospital to outpatient care. Furthermore, the

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

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

The main challenge for health care policies remains low public spending – around 10% of public spending is allocated to health care, compared to an average of about 15% in EU member states and OECD countries. This limits access to quality and timely care.

Until recently, Latvia had universal health care insurance and a single-payer system financed through general taxation. However, health care reforms were introduced in 2017 (with a planned transition period in 2018) to address the issues highlighted. This comprehensive health care reform aims to introduce a health care insurance component and to separate the provision of public health services into two “baskets,” specifically a full basket available to persons paying social security contributions or defined as vulnerable (e.g., children and pensioners) and a “minimum basket” that provides a reduced set of health care services to people who do not pay social security contributions. Although the health care reform can be seen as timely, it has stalled. Its success in improving the quality and availability of health care services will depend on how efficiently the resources are used.

Citation:

1. IMF (2018) Republic of Latvia: Selected Issues, Available at: <https://www.imf.org/en/Publications/CR/Issues/2018/09/05/Republic-of-Latvia-Selected-Issues-46207> , Last assessed: 29.12.2018.
2. OECD (2018), Spending on Health: Latest Trends, Available at: <http://www.oecd.org/health/health-systems/Health-Spending-Latest-Trends-Brief.pdf> , Last assessed: 29.12.2018
3. European Commission (2018) ESPN Flash report: Changing the funding of the Latvian compulsory healthcare system: for better or for worse?, Available at: ec.europa.eu/social/BlobServlet?docId=18722&langId=en; Last assessed: 29.12.2018
4. European Commission, State of Health in the EU: Latvia. Country Health profile 2017. Available at: https://read.oecd-ilibrary.org/social-issues-migration-health/latvia-country-health-profile-2017_9789264283466-en#page1 , Last assessed: 29.12.2018.
5. OECD (2016). OECD Reviews of Health Systems.Latvia 2016. OECD Publishing, Paris. Available at: <http://dx.doi.org/10.1787/9789264262782-en>, Last assessed: 29.12.2018.

Romania

Score 4

Romania has a public health insurance system. Despite its claim to universal coverage, however, only around 86% of the population are insured. Access to health care is further limited by a high salience of informal payments and a low density of doctors in rural areas. The problems are aggravated by relatively low public spending, large-scale emigration of medical staff and rampant corruption. The sorry state of the Romanian health care system is documented by the country's poor showing in the World Bank's 2018 Human Capital Index, where Romania lags behind all EU Member States and many other European countries including Ukraine, Albania, and Georgia. According to the HCI, Romanian children born in 2018 will be only 60% as productive as they could be with improved medical and educational support. Worse still is that Romania's score on the index has declined in the last six years and is likely to decline further still until structural and consistent reforms are undertaken.

Despite significant increases in health-sector wages, Romania struggles to attract, train and retain health professionals. While the government has improved the state of medical equipment provision, as is stipulated in the Romanian National Health Strategy, the country lacks the important structural conditions that would ensure the efficient use of this equipment over the long-term. Corruption in the health sector remains a critical obstacle to expanding access and improving coverage. Furthermore, the politicization of public spending, particularly through wage increases, continues to hamper long-term gains in achieving universal health care coverage.

Citation:

Farcasanu, D. (2018): ESPN Thematic Report on Inequalities in Access to Health Care: Romania. Brussels: EU.

World Bank, Human Capital Project (<https://www.worldbank.org/en/publication/human-capital>).

Slovakia

Score 4

Slovakia has a mandatory health-insurance system that provides all residents with primary, secondary and tertiary care, pharmaceuticals and medical devices. The state covers the health-insurance costs of children, students, pensioners, the (registered) unemployed and women on maternity leave. From a comparative perspective, the quality and efficiency of health care services are relatively low. A government spending review published in autumn 2016 showed that there is significant scope to increase the cost-effectiveness of various areas of health care. Bad working conditions in the Slovak health sector and mass migration of doctors and nurses to other EU countries have resulted in a shortage of staff. The Slovak Medical Chamber estimates that Slovakia has a shortfall of about 3,000 doctors. If those who have already reached retirement age but are still practicing are counted, then the deficit

reaches 5,000 doctors. The average age of medical doctors ranges between 55-57 years.

After the 2016 elections, the Fico government announced that it would replace the existing reform strategy for 2014 – 2020 with a new and updated strategy, but failed to do so. The implementation of the existing strategy has proceeded slowly and selectively. In 2017, the gradual introduction of DRGs in hospital financing started. After eight years of preparation, the new e-health system became operational in January 2018. By contrast, other initiatives such as the implementation of a new integrated care model have been stalled. Under the new prime minister, Peter Pellegrini, Minister of Health Tomáš Drucker became Minister of the Interior and was replaced by the former state secretary Andrea Kalavská. In July 2018, Pellegrini himself announced new plans for hospital reforms that focused on introducing a stronger differentiation between general hospitals and those with a specialized or highly specialized focus.

Citation:

European Commission (2019): Country Report Slovakia 2019. SWD(2019) 1024 final, Brussels, 20-22 (https://ec.europa.eu/info/sites/info/files/file_import/2019-european-semester-country-report-slovakia_en_0.pdf).

Hungary

Score 3

Health care has been one of 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 has suffered from the absence of a ministry tasked with addressing health care issues and from a limited health care budget, which is one of the lowest in the OECD with spending per capita at around 50% of the EU average. The Orbán governments have failed to tackle the widespread mismanagement and corruption in the health sector, the large debt burden held by hospitals, the discretionary refusal of services by medical staffers, and the increasing brain drain of doctors and nurses to other countries. Good quality services are available in the private sector, but only for a small share of society. Despite some reform announcements in the campaign to the 2018 elections, health care has remained a low priority issue for the new Orbán government. Anikó Nagy, the new State Secretary for Health resigned already in early October, after less than five months in office.

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