



# Health Report

Health Policy

## Sustainable Governance Indicators 2020

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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, healthcare 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. In 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 healthcare. 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 healthcare 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 healthcare services – low-income Canadians are far more likely to decline prescriptions or skip dental visits. In the 2019 election campaign, Trudeau pledged to implement a national pharmacare program, although the administration has not made clear how it would fund such a program.

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

Overall, Canada's healthcare 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 healthcare systems.

Citation:

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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 healthcare, regardless of economic circumstance. Services are offered "free of charge" and elected regional councils have governed the sector since 2007. Because financing through taxes depends on the state budget, regional authorities depend on annual budget negotiations with the Ministry of Finance.

Although healthcare spending in Denmark is high, the OECD considers its performance "subpar." In 2018, health spending in Denmark was 10.5% of GDP (11th highest among OECD countries), of which 8.8% is publicly funded (fifth highest among OECD countries). There has been an upward trend in healthcare 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.

Life expectancy in Denmark in 2018 was 81 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 hospital services. Increasing medicine prices are putting pressure on the financing of healthcare. A recent priority has been cancer treatment, an area in which Denmark has been lagging behind equivalent countries.

The establishment of large centralized (rather than regionally administered) hospitals has been contested and various problems in relation to, for example, electronic patient records remain unresolved. There has been debate around the idea of bringing some basic healthcare activities closer to the population via local healthcare centers. The role of the regions has also been debated and it was proposed that responsibility for healthcare should be transferred from the regions to the central state. However, this proposal does not have the support of the new government.

The new Social Democrat government has increased funding for the regional healthcare sector in order to employ more doctors, nurses and other healthcare personnel. The aim is to increase the number of nurses by 1,000 by 2021. In an agreement with the Danish regions and municipalities, the government has agreed to train 100 extra doctors in general medicine to increase public access to general physicians.

Citation:

OECD, Health at a glance 2019,” (accessed 30 november 2019).

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## Estonia

### Score 8

Estonia has a social insurance-based healthcare system, which includes some non-Bismarckian features such as general practitioners. The insurance principle makes access to healthcare services dependent on labor market status. Working-age people who are not in employment or education are not covered by the national health insurance. On average, 6% of the population are not guaranteed free access to healthcare due unemployment or irregular work contracts; the problem is worse among men, ethnic minorities and young people aged 26 – 30. The minister of social affairs started a discussion on universal healthcare in 2018, although the new government – which has been in office since spring 2019 – has not made any progress on the issue.

Another issue is decreasing public satisfaction with access to healthcare services in general and to specialist care in particular. Moreover, unmet healthcare needs differ across population groups, with low-income groups, the elderly and rural residents particularly disadvantaged. In 2017, 12.7% of Estonians reported having unmet healthcare needs due to cost, distance to travel or waiting times, which was the highest proportions in the European Union (HIT 2018). To tackle the problem of high out-of-pocket costs, compensation for prescription costs has been increased for people suffering from chronic illnesses. However, regional inequalities have increased, because austerity measures have centralized specialist care in larger hospitals.

In contrast to coverage and access issues, the quality of healthcare in Estonia is good, despite a level of expenditure well below the OECD average.

Citation:

Health Systems in Transition (2018). Estonia Health System Review [https://www.sm.ee/sites/default/files/content-editors/Tervishoid/hit\\_-\\_estonia\\_-\\_web\\_version\\_01.06.2018.pdf](https://www.sm.ee/sites/default/files/content-editors/Tervishoid/hit_-_estonia_-_web_version_01.06.2018.pdf) (Accessed 13.10.2019)

## Germany

Score 8

The German healthcare system is inclusive and of high quality, and provides healthcare for almost all citizens. Most people in regular employment are insured through the public health insurance systems, whereas civil servants, self-employed people, people with high incomes and some other groups tend to be privately insured. However, the system faces challenges in the form of increasing costs. Recently, the system's short-term financial stability has been better than expected due to buoyant contributions resulting from the employment boom. However, long-term financial stability will be challenged by the aging population and increasing costs within the healthcare system. Healthcare spending as a proportion of GDP in Germany is among the three highest such levels in the OECD world, and is considerably higher than the OECD average (11.2% of GDP compared to an OECD average of 8.8%). In per capita terms, health spending in Germany is nearly \$6,000 per year. This is the fourth-highest position and is again significantly higher than the OECD average of about \$4,000 (OECD 2019).

In its coalition agreement, the grand coalition negotiated a variety of reform measures to increase the quality of healthcare, redefine some financial details, reorganize the registration of physicians in private practice, and adjust the distribution of practicing doctors and hospitals. All measures have been formulated rather vaguely and no important details have yet been determined. But a minimum range of medical-service opening hours for outpatient care of 25 hours per week was adopted, and the ministry will promote the introduction of electronic patient records in the medical practices and the health insurance institutions.

Contribution rates have been largely stable over recent years, consisting of a general rate of 14.6% of gross wages plus an insurer-specific contribution rate that averaged

0.9% in 2019. The insurer-specific contribution, previously paid solely by the employee, is now shared equally between employer and employee, like the general rate. The resulting average combined contribution rate is 15.5% which has to be paid on income up to (an annually increasing upper) ceiling. Effectively, this formula implies that absolute contribution levels will grow dynamically in pace with the overall increase in wage levels. The federal subsidy for the national health fund was raised in 2017 by €0.5 billion to a total of €4.5 billion and was kept constant in 2019.

On 10 October 2018, the cabinet decided to increase the contribution rate for long-term care insurance by 0.5 percentage points. As of 1 January 2019, it was 3.05%, with single contributors required to pay a rate of 3.30%. Thus, a total of more than €5 billion will additionally be available for improvements in long-term care. A part of the additional revenue will be placed in a precautionary fund intended to stabilize future contribution rates. In addition, families that wish to provide care at home will be given greater support.

Finally, the coalition agreement has sought to increase the number of medical student places, and to improve the training given to midwives by making this a graduate-level profession.

While the government has been ambitious in fostering a high-quality health system, it has not acted sufficiently to limit spending pressure. In particular, it has been hesitant to open the system to more competition (e.g., with respect to pharmacies).

Citation:

OECD 2019:

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

Statistisches Bundesamt 2019: <https://de.statista.com/statistik/daten/studie/244326/umfrage/zuschuss-des-bundes-zum-gesundheitsfonds/>

[http://www.sozialpolitik-aktuell.de/tl\\_files/sozialpolitik-aktuell/\\_Politikfelder/Finanzierung/Datensammlung/PDF-Dateien/tabII6.pdf](http://www.sozialpolitik-aktuell.de/tl_files/sozialpolitik-aktuell/_Politikfelder/Finanzierung/Datensammlung/PDF-Dateien/tabII6.pdf)

## Israel

### Score 8

Under the 1994 National Insurance Act, all citizens in Israel are entitled to medical attention through a health maintenance organization. This is a universal and egalitarian law, allowing for broad access to subsidized primary care, medical specialists and medicines. A 2012 OECD survey identified the Israeli healthcare system as one of the best in the developed world, ranking fifth with a score of 8.5 out of 10. In 2019, Israel ranked 10 out of 56 countries in the Bloomberg Health-Efficiency Index.

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 northern and south, experience worse health and have high health-risk factors. In fact, the quality of healthcare services and facilities varies significantly by location. Facilities in peripheral regions often struggle to attract skilled personnel, as exemplified by the looming closure of the emergency rooms in Kiryat Shmona. In peripheral regions, there are about 20% fewer beds per capita and 40% fewer surgery rooms per capita.

Comparing healthcare in Israel's peripheral regions with central parts of the country, the number of hospitals and medical staff per resident is low, medical staff on average are less skilled, waiting times for specialist care are longer, and medical facilities are poorly equipped. In addition, life expectancy in peripheral regions is 81, while in central regions it is 84. The difference between the number of doctors per person is also notable, with 2.3 doctors per 1,000 civilians in Israel's northern and southern regions compared to 5.1 in Tel Aviv. This image was echoed by the 2018 State Comptroller's report. According to the report, Israel lacks a long-term plan for addressing the shortage of hospital beds and medical staff, and a plan for a new hospital in southern Israel. However, the Israeli system is fairly equitable by international comparison, performing well across various health indices, such as life expectancy.

Citation:

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## Luxembourg

Score 8

Over the last year, it has become increasingly apparent that Luxembourg's highly praised healthcare system has shortcomings. The population is growing quickly, and the health system is not keeping pace. Although there is still no shortage of doctors and nurses in the capital and the Diekirch area, except at the emergency room at

night and on weekends, there is a lack of trained medical staff in other parts of the country. Furthermore, the Luxembourg healthcare system remains too dependent on professionals from abroad.

The country's policymakers are attempting to ensure that more nurses and doctors are trained, but these efforts have thus far been insufficient.

Due to the country's small size and the absence of a university hospital, it is not possible to provide all medical treatments domestically. 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.

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

Citation:

Etat des lieux des professions médicales et des professions de santé au Luxembourg, Rapport final et Recommandations, Version 2019-10-01.

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## New Zealand

### Score 8

New Zealand's public healthcare policies achieve high-quality and inclusive healthcare 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 healthcare, 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 public healthcare system is already showing signs of being overburdened. Reports of chronically understaffed hospitals abound, large numbers of specialist referrals are declined because of a lack of resources and waiting lists for surgical procedures have become a serious issue. Mainly due to lengthy waiting lists in the state healthcare system, a large number of New Zealanders (around 1.37 million) now have private "queue jumping" health insurance. In recent years, however, premiums have increased continuously, thereby fueling income-related inequality in healthcare.

During the 2017 election campaign, the three parties that now represent the government announced plans to improve primary care. In particular, Labour



committed to increasing the intake to 300 general practitioner 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 an NZD 1.52 billion increase in health spending for the 2018–2019 year (the 2017 National Party government had increased funding by NZD 825 million). The majority of the new funding is for capital investments in building and restoring hospital buildings (NZD 750 million) and boosting the support fund for District Health Boards in deficit (extra NZD 100 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. In the 2019 "well-being" budget, mental health received the biggest funding and investment boost on record. Of a total of NZD 1.9 billion, half a billion is earmarked for the "missing middle," that is, the mild-to-moderate anxiety and depressive disorders that do not require hospitalization.

A particular challenge is the persistent gap in health status between Māori and non-Māori parts of the population. For one, Māori life expectancy is lower than that for non-Māori, according to 2013 Ministry of Health figures. Life expectancy at birth was 73.0 years for Māori males and 77.1 years for Māori females; it was 80.3 years for non-Māori males and 83.9 years for non-Māori females. In addition, the 2017–2021 Ministry of Health and Addiction Workforce Action Plan finds that, while Māori make up approximately 16% of New Zealand's population, they account for 26% of all mental health service users.

#### Citation:

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## South Korea

### Score 8

South Korea's healthcare 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" healthcare 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. In July 2019, a revised law came into effect that requires foreign nationals without employer-provided health insurance to enroll in the country’s National Health Service. According to the Health Ministry, this new law will give foreign residents the same medical benefits and services as Koreans. One major problem in the Korean healthcare system is the comparatively low number of doctors and nurses per capita. Mental health care remains underdeveloped in Korea, a problem reflected in the OECD’s second-highest suicide rate.

Citation:

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

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## Spain

Score 8

The Spanish national healthcare system is a highly decentralized one. This is because executive competences are transferred to the 17 autonomous communities, with the national level responsible for certain strategic areas as well as for the overall coordination and the national monitoring of regional performance. The healthcare system largely achieves the criteria of quality, inclusiveness and cost efficiency. According to the 2019 edition of the Bloomberg Healthiest Country Index, which examined 169 economies, Spain is the healthiest country in the world, while its healthcare system ranks third in terms of efficiency. OECD data also shows that Spain has the second-highest life expectancy after Japan, with Spain predicted to rank first by 2040. Spaniards’ self-perceptions of their health status and their national healthcare system reflect a degree of satisfaction that is quite high in cross-OECD comparison.

However, rates of mental illness, diabetes and drug consumption are higher than the European averages. Population aging and the subsequent increase in the incidence of chronic diseases present significant challenges to the system’s sustainability over the medium and long term. Moreover, the number of practicing doctors and nurses, and available hospital beds per 1,000 residents is relatively low while other deficiencies relate to waiting lists, patient rights and sickness prevention. There is interregional inequality too.

Nevertheless, access to a core set of high-quality healthcare services is today guaranteed through a public insurance system that covers 99% of the population. In 2019, the Ministry of Health, Consumer Affairs and Social Welfare launched a number of initiatives. These initiatives included the withdrawal from market of thousands of homeopathic products, as well as the drafting of legislation to regulate

euthanasia and incorporate a “right to die” in public healthcare for patients that have “a serious and incurable” or “incapacitating” disease that causes “unbearable suffering.”

Citation:

Enrique Bernal-Delgado (2018), Spain – Health system review – [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/378620/hit-spain-eng.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0008/378620/hit-spain-eng.pdf?ua=1)

Bloomberg (2019), Healthiest Country Index

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

## Switzerland

### Score 8

Healthcare in Switzerland is said to be excellent in terms. 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 82 years for males and 85 years for females (2018). As of 2018, 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 healthcare 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, healthcare reforms have not been particularly successful in terms of improving efficiency or controlling the structural rise in health expenditures. In 2018, health expenditure was equal to 12% of GDP, compared to 17% in the United States and 11% in France and Germany.

Healthcare 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 healthcare 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.

Citation:

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## Australia

### Score 7

There have been no notable developments in healthcare policy under the Morrison government. The Australian healthcare system is a complex mix of public and private sector healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare system is rife with inefficiencies and perverse incentives. Total healthcare 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:  
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## Austria

### Score 7

The Austrian healthcare 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 healthcare 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 healthcare 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 healthcare provision is a permanent topic of Austrian politics and draws attention to the demographic changes' impact on the healthcare system.

The complex structure of the Austrian healthcare 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 healthcare costs.

The development of the healthcare 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 healthcare 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 healthcare system.

One change that the ÖVP-FPÖ government had started to affect could be reversed by the next government, which will likely form at the beginning in 2020. The ÖVP-FPÖ government had reduced the influence of organized labor on the public insurance system. The next coalition (which will probably comprise the ÖVP plus a new partner) may reverse the change to the balance between federal, provincial and municipal interests – and especially the recent change to the balance between organized business and organized labor.

A major issue in the political debate on healthcare has been the shortage of physicians in some (non-urban) regions. The next government will be forced to incentivize physicians to work in rural areas.

## 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 healthcare is quite affordable, thanks to generous subsidies. Belgium fares quite well in terms of the efficiency of its healthcare system. It ranks close to Sweden, which is often considered to be a benchmark of efficiency with regard to affordable access to healthcare.

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 healthcare system.

Recently, entire areas of state competences regarding healthcare 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>

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## Chile

### Score 7

For more than three decades, Chile has maintained a dual health system, with one pillar represented by private insurance and private healthcare services chosen by self-financing participants (typically upper-middle-income and high-income groups), and another pillar of public, highly subsidized insurance and public healthcare services for participants who pay only part of their health costs. This dual system provides broad coverage to most of the population, but with large differences in the quality of healthcare provision (especially in the waiting times for non-emergency services). Significant reforms have 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, these reforms have 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 healthcare 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 healthcare, a more problematic situation is evident regarding the public healthcare system. These levels show funding gaps and an insufficiency of well-trained professionals. There is still a huge gender gap with regard to healthcare contribution rates, since maternity costs are borne only by women. For these reasons, the quality and efficiency of public healthcare provision (government clinics and hospitals) vary widely.

A survey released in May 2019 by Centro de Estudios Públicos (CEP), one of Chile's most important polling agencies, showed that 34% of the respondents cited healthcare as their third-highest concern (after crime: 51%, and pensions: 46%).

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](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)

[https://www.cepchile.cl/cep/site/docs/20190612/20190612104953/encuestacep\\_mayo2019.pdf](https://www.cepchile.cl/cep/site/docs/20190612/20190612104953/encuestacep_mayo2019.pdf)

## Czechia

Score 7

The healthcare system, based on universal compulsory insurance, ensures a wide range of choice for both providers and consumers of healthcare 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. Czechia has long shown very low neonatal mortality rates. Czech healthcare has been financed primarily through a public health-insurance system. Public sources account for about 85% of healthcare financing in Czechia. The aging of the Czech population will have a significant impact on the growth of healthcare and social care costs in the coming years, placing the current financing system under strain. In 2018, only minor healthcare policy changes were made. The year 2019 brought more significant changes, with the amendment of the Health Insurance Act. This entailed the biggest changes in 20 years in the system of reimbursement for the use of medical devices, to the benefit of patients. Spending on preventive health programs has increased, and health-insurance funds' coverage of dental care and home-based palliative care has improved.

## 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 healthcare resources. Also, Finland's old-age dependency ratio is increasing substantially, although not as dramatically as



in some other EU member states. 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. The Sipilä government initiated a major social and healthcare reform (SOTE) that would have shifted responsibility for social welfare and healthcare services from the municipalities to 18 larger governmental entities (counties). In addition, the planned reform envisioned giving patients greater freedom in choosing between public and private healthcare providers. However, as Sipilä failed to secure a majority in parliament for the healthcare reform, his government resigned in March 2019. Its successor, the Rinne government, signaled that would implement the reform, but this remained a subject of debate at the time of writing.

Citation:

"Government Resolution on the Health 2015 Public Health Programme." Helsinki: Publications of the Ministry of Social Affairs and Health, 2001;

Juha Teperi et al., "The Finnish Health Care System," Sitra Reports 82, 2009;

"Socially Sustainable Finland 2020. Strategy for Social and Health Policy," Ministry of Social Affairs and Health, 2014;

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

## 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 healthcare, one of the highest ratios in Europe. The health system includes all residents, and also offers services for illegal immigrants and foreigners (to the point that some asylum-seekers from countries such as Georgia have come primarily with the aim of receiving free medical care).

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 and implemented in 2018. An ambitious plan to reform the healthcare 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 healthcare 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. The social security budget, which was originally forecast to reach a positive balance in 2019 for the first time since 2012, will in fact be in deficit at least through 2023 as a consequence of the measures implemented in the wake of the Yellow Vest protests.

## Italy

### Score 7

Italy's national health system provides universal comprehensive coverage for the entire population. The healthcare system is primarily funded by central government, though healthcare 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 healthcare 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 healthcare. However, due to differences in local infrastructures, cultural factors, and the political and managerial proficiency of local administrations, the quality of public healthcare varies significantly 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 healthcare 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. The existing system of national quality standards (correlated with resources), which is meant to be implemented across regions, has not yet produced the desired effect of reducing the quality divide between the North and South.

Preventive healthcare 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 healthcare user.

To contain further increases in healthcare costs, payments to access tests, treatments and drugs exist. Although these payments are tied to income levels, they nevertheless discourage a significant number of the poorest residents from accessing necessary healthcare services. Similarly, additional medical services are only partially covered by the public healthcare system, while only basic dental healthcare is covered. The first Conte government did not focus strongly on reducing cross-regional differences in healthcare quality.

Citation:

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<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 healthcare system. Life expectancies are among the top three in the world for women (87 years at birth) and for men (81 years). In the Bloomberg Healthiest Country Index, Japan was ranked at fourth place in 2019. 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 healthcare system, in combination with traditionally healthy eating and behavioral habits, delivers good quality.

Challenges for the healthcare system include the needs to contain costs, enhance quality and address imbalances. The national health insurance program continues to show a structural deficit despite additional fiscal support provided in a 2018 reform package.

Although spending levels are relatively low by international standards, Japan's population has reasonably good healthcare access due to the comprehensive National Healthcare Insurance program. A 2019 OECD review on public health in Japan reaches a positive verdict on Japan's primary strategy, Health Japan 21, but points to further room for improved focus and coordination.

Citation:

Japan's health insurance system remains deficit-ridden despite reforms, The Japan Times, 17 August 2018, <https://www.japantimes.co.jp/news/2018/08/17/national/japans-health-insurance-system-remains-deficit-ridden-despite-reforms/>

OECD, OECD Reviews of Public Health: Japan, Paris 2019

Japan No. 4 healthiest nation as Spain tops list, The Japan Times, 25 February 2019, <https://www.japantimes.co.jp/news/2019/02/25/world/science-health-world/japan-no-4-healthiest-nation-spain-tops-list/>

## 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 healthcare as good in 2009, compared to an EU-27 average of 70%. The

Lithuanian healthcare system received the seventh-lowest rating in the EU, with 58% of respondents saying that the overall quality of healthcare was fairly or very bad.

The Lithuanian healthcare 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. Government expenditure on healthcare was quite stable from 2012 to 2016, amounting to 5.8% of GDP in 2016. As a percentage of current healthcare expenditure, spending on preventive care and other related programs is quite low, while the share of spending on pharmaceuticals and other medical non-durables is quite high.

The provision of healthcare 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 healthcare services. Out-of-pocket payments remain high (in particular for pharmaceuticals), a fact that may reduce access to healthcare 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 expanded to support additional public health interventions.

The 2008 – 2012 government sought to improve service quality and cost efficiency by optimizing the network of personal healthcare organizations. The overall number of healthcare organizations was consequently reduced from 81 to 62 by the end of 2012. By contrast, the 2012 – 2016 and 2016 – 2020 governments placed more emphasis on the accessibility of healthcare services and the issue of public health. More specifically, the Skvernelis government reduced the availability of alcohol and tightened regulations on pharmaceuticals in the market. For instance, in 2017, the parliament increased excise duties on alcohol and passed amendments to the Alcohol Control Law (raising the legal age for alcohol consumption from 18 to 20), restricted the allowable hours of alcohol sales, and banned alcohol advertising. The National Health Insurance Fund has carried out an in-depth analysis of the hospital sector and developed a blueprint for consolidating the hospital network, the results of this work have not been published due to strong opposition to such reform in parliament. More recently, the Ministry of Healthcare has announced proposals for improving the provision of emergency services through collaborations between different service providers (involving local emergency services and large hospitals located in the major cities).

Despite this initiative, the potential for rationalizing the use of resources in the healthcare sector remains largely unfulfilled. There is a need to make the existing healthcare system more efficient by shifting resources from costly inpatient treatments to primary care, outpatient treatment and nursing care. According to the European Commission's 2019 report, the performance of the healthcare system could be improved by increasing the quality, affordability and efficiency of services, which would in turn improve health outcomes in the country.

## Citation:

The 2010 Eurobarometer report is available at [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_327\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf)  
COMMISSION STAFF WORKING DOCUMENT, country report Lithuania 2019: [https://ec.europa.eu/info/sites/info/files/file\\_import/2019-european-semester-country-report-lithuania\\_en.pdf](https://ec.europa.eu/info/sites/info/files/file_import/2019-european-semester-country-report-lithuania_en.pdf)  
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## Malta

### Score 7

Malta provides quality healthcare 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 that are unavailable locally. 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.

In 2018, the *Lancet* medical journal ranked Malta ninth in its annual health-related index. However, the Euro Health Index 2018 ranked the country at 27th place, finding that despite decent access to healthcare, performance lags when it comes to treatment results, and that there are notable gaps in the public subsidy system. Malta's mediocre ranking may also be due to poor scores for access to psychiatric care for children and suicide reduction, and a zero score for the country's nonexistent abortion rights. Accessibility of patient records was also flagged. With a childhood obesity rate of 5.5%, Maltese children are among Europe's most affected by severe childhood obesity.

Malta fares well in terms of self-reported unmet need for medical care, with just 0.2% of the total population reporting such a need, compared to the EU-28 average of 1.8%. 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 times for elective operations. Nonetheless, the average patient waits around 40 weeks for their first outpatient appointment.

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. Increased investments in regional centers that offer primary care were announced during the 2020 budget speech.

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. To this end, a Mental Health Strategy for the period 2020 – 2030 maps out the strategic direction required to effect the required changes in this area. Healthcare provisions also have to be updated to deal with a more diverse population. Meanwhile, medical cannabis was legalized in 2018.

The private sector accounts for approximately two-thirds of the workload in primary healthcare; however, healthcare 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. While the country's overall stock of doctors and nurses is close to the EU average, the number of specialists remains relatively low. Health-related expenditure is forecast to increase by 2.7 percentage points by 2070 compared to the EU average of 0.9 percentage points. Health system capacity is being stretched due to a combination of factors, including population expansion due to increased immigration, a buoyant tourism industry, demographic aging and altered risk-taking behaviors. The European Commission has indeed expressed concerns about Malta's ability to sustain growing long-term care demands, and has recommended that Malta take action to ensure the sector's sustainability. To this end, a new public-private partnership contract for three existing hospitals was agreed in 2015. However, aspects of the deal are now currently under investigation

Citation:

Times of Malta 05/09/2012 Three health agreements signed with Italy  
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 A Mental Health Strategy for Malta 2020-2030  
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## Norway

### Score 7

Norway has an extensive healthcare 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. Healthcare 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 healthcare 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 healthcare spending.

Although the entire population has access to high-quality healthcare services, the efficiency of this system is questionable. A major structural healthcare 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 healthcare regions that were tasked with managing the delivery of services, but without ownership. The reform objective was to institute a stricter budget discipline by streamlining healthcare services and promoting regional coordination. In recent years, new reforms have been introduced that have involved 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 resistance, as citizens balk at facing long travel distances to the next hospital. Like many other countries, Norway faces the challenge of meeting ever-higher expectations regarding treatment among a population with increasing living standards in a context of increasing health costs.

## Sweden

### Score 7

The healthcare 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 healthcare sector.

The general account of Swedish healthcare is that once you receive it, it is good. Funded primarily by the government, the Swedish healthcare system is decentralized with regional governments (landsting) allocating 90% of their budgets to healthcare services. Healthcare 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. Healthcare is driven by three contending sources: elected officials, the medical profession and the market. These three sources governing the healthcare 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 healthcare sector.

From the patient's perspective, a key problem is accessibility. This applies to accessing general practitioner, specialist or emergency services. Patients in need of care are required to make an appointment with a primary healthcare 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 a medical doctor in weeks or even months. An evaluation published in 2019 suggests that there has been some moderate improvement in terms of general practitioner waiting times.

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 healthcare.

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 healthcare 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 see a general practitioner 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 healthcare 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.

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## Turkey

### Score 7

Due to a series of substantial healthcare reforms implemented since 2003, Turkey had achieved near-universal health insurance coverage by 2014, improving equity in access to healthcare nationwide. The scope of the vaccination program has been broadened, the scope of newborn screening and support programs have been extended, community-based mental healthcare services have been created, and cancer screening centers offering free services have been established in many cities.

The key challenge in healthcare is to keep costs under control as demand for healthcare increases, the population ages and new technologies are introduced. Total healthcare expenditure as a share of GDP amounted to 4.5% during 2017. In 2017, public sources funded 78% of total healthcare spending, compared to 62% in 2000.

According to the European Commission (2018), Turkey has a good level of preparation in the area of public health. Though it still needs to increase institutional/administrative capacity, inter-sectoral cooperation, financial resources and appropriate diagnostic facilities to address public health issues at central and provincial level.

Citation:

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## Cyprus

### Score 6

The launch of a national health system (NHS, in Greek GESY) in June 2019 is expected to enable access to high-quality healthcare services. Healthcare in the public sector, in private clinics, and from individual doctors has until now been affected by deficiencies in the system and a lack of regulation. Along with the NHS various health-insurance schemes and private sector services will continue. Despite constraints and deficiencies in infrastructure and human resources, the quality of services offered by the public system is acknowledged by the World Health Organization to be high. 2017 data show a very low infant-mortality rate (1.3 per 1,000 births) and a high life expectancy at birth (80.0 for men and 84.1 for women). Preventive medicine is specifically promoted, with Cyprus ranking high worldwide with respect to expenditure in this area.

The NHS offers the opportunity for all contributors to benefit, putting an end to healthcare eligibility criteria introduced in 2013 that led to the exclusion of various groups. However, Cyprus should also address problems identified in a 2016 EU assessment, which noted that the private sector is unregulated with respect to prices, capacity and quality of care.

The major challenges ahead include securing adequate funding and the sustainability of a fully operational scheme, while also effectively addressing problems that emerged in the initial operation stages. There is also need for further actions, such as making hospitals and the whole system fully autonomous. Such a reform would constitute a proper response to criticism from private sector doctors, trade unions, employers associations and others, about the sustainability of the system and its potential exploitation by some doctors and patients.

Citation:

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## Iceland

Score 6

On average, the healthcare system in Iceland is efficient and of a high quality. However, there is considerable variation across regions. For example, healthcare 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, and various departments and centralized specialized care facilities were closed. In addition, smaller regional hospitals and healthcare 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 healthcare 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 healthcare expenditure. A considerable amount of money has also been granted to renovating old buildings 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.

Life expectancy in 2017 was 82 years, the 20th 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 about the same in 2017 as in 2011, a six-year stagnation that has never been recorded previously in Iceland. Twice before, a four-year stagnation had followed an economic shock: in 1967 – 1971, following the collapse of herring fishing; and, in 1984 – 1988, following a government clampdown on double-digit inflation with the restoration of positive real interest rates through the introduction of financial indexation.

Citation:

Government budget (Fjárlagafrumvarp), <https://www.stjornarradid.is/media/fjarmalaraduneyti-media/media/frettatengt2016/Fjarlagafumvarp2017.pdf>. Accessed 22 December 2018.

World Bank (2019), World Development Indicators, <http://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN>.

## Netherlands

### Score 6

The Netherlands' hybrid healthcare system continues to be subject to controversy and declining consumer/patient trust. The latest decline in trust has been fueled by the continuing trend of hospital bankruptcies. The system, in which the country's few large 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 healthcare workers have rebelled against overwhelming bureaucratic regulation that cuts into time available for primary tasks. With individual obligatory copayment levels raised to €375 (including for the chronically ill and individuals with low incomes), 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 healthcare 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 healthcare, or €5,535 per capita. According to the OECD Health at a Glance 2019 report, total expenditure is 9.9% of GDP. When both government spending and private spending are combined, the total costs of care show a steady increase since 2014, exceeding the rate of inflation. The steepest increase is in specialized medical care in hospitals, with long-term care showing some decrease. Moreover, the number of people employed in healthcare was lower than in previous years. Labor productivity in healthcare 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 healthcare costs are simply transferred to individual patients by increasing the obligatory copayment associated with health insurance. One means of improving patients' cost awareness is through increasing transparency within healthcare institutions (e.g., by providing mortality and success rates rankings for certain treatments per hospital). However, patients are not able to choose their treatment centers freely, but are forced to choose from institutions that contract directly with their insurance company.

In terms of quality and inclusiveness, the system remains satisfactory. Rates of private insurance coverage remain high, but with a slightly decreasing trend since 2007. Rates of dental coverage are quite low at 11%, resulting in considerable income-related differences in dental care. A total of 12.4 % of the population postpones or forgoes medical treatment due to limited availability, while just 5.8% forgoes medical treatment because of affordability concerns, the lowest such rate in the OECD, although with a significant gap between those with lower incomes (a 20% rate) and higher incomes.

However, Dutch medical care does not achieve the highest scores in any of the easily measured health indicators. Average life expectancy (80.2 years for males, 83.3 for women) and health-status self-evaluations have remained largely unchanged over recent years. Patient satisfaction is high (averaging between 7.7 and 7.9 on a 10-point scale), especially among elderly and lower-educated patients. However, patient safety in hospitals is a rising concern for both the general public and the Health Inspectorate. Since 2013, waiting lists for specialist care have been a growing concern. This trend continued through 2018, particularly for age-related conditions, and was particularly notable among some regions in the country with aging and decreasing populations. The situation in the psychiatric care sector are particularly troublesome. Recently, general practitioners have also expressed grave concerns about rising work pressures, staff shortages and time-consuming bureaucracy.

The level of inclusiveness is very high for the elderly in long-term healthcare, in spite of the fact that the sector is struggling with staff shortages, resulting in high employee turnover and absentee rates. However, there is a glaring inequality that the healthcare system cannot repair. The number of drug prescriptions issued is much lower for high-income groups than for low-income groups. People with high and low income levels show a difference of 18 years in terms of overall healthy life years. The difference in life expectancies between those with higher and lower levels of education is also growing, with this difference at five years for men and more than four for women. Recent research has also revealed considerable regional differences with regard to rates of chronic illnesses and high-burden diseases; differences in age composition and education only partially explain these differences.

In the area of disease prevention, a number of observers have deemed the national prevention agreement to be unsatisfactory, retaining too much influence by the tobacco, alcohol and food industries.

Citation:

Barometer Nederlandse Gezondheidszorg 2019: Rentement stijgt ten koste van personeel, EY 2019

Gezond verstand, publieke kennisorganisaties in de gezondheidszorg, Rathenau Instituut, 6 september 2017

Van verschil naar potentieel. Een realistisch perspectief op de sociaaleconomische gezondheidsverschillen. WRR Policy Brief 7, August 2018

Nederlandse Zorgautoriteit, NZa: uitgaven langdurige zorg groeien sneller dan verwacht, 13-06-2019, <https://www.nza.nl/actueel/nieuws/2019/06/13/nza-uitgaven-langdurige-zorg-groeien-sneller-dan-verwacht>

Nederlandse Zorgautoriteit, Stand van de zorg 2018, (<https://magazines.nza.nl/standvandezorg/2018/03/investeren-in-gezondheidswinst-voor-de-patient>, consulted 6 November 2018)

Huisartsen sturen Hartenkreet aan politiek, 28 oktober 2019, <https://www.nhg.org/actueel/nieuws/huisartsen-sturen-hartenkreet-aan-politiek>

<https://www.dutchnews.nl/news/2019/04/health-covenant-heavily-influenced-by-food-and-alcohol-industry-say-experts/>

CBS: verschil hoogopgeleide en laagopgeleide wordt groter, NRC Next, 16 August 2019

<https://www.nu.nl/economie/4368814/nza-weigerde-terecht-tarieven-per-zorgaanbieder-openbaar-maken.html> (november 2019)

Zorgen voor burgers: onderzoek naar knelpunten bij de toegang tot zorg, De Nationale Ombudsman, 14 mei, 2018

## 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. Most healthcare 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 healthcare system.

Despite consistent real increases in public funding for healthcare by governments of all colors, provision has been unable to keep pace with rising demand. Winter healthcare "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. While patient convenience may not be a central focus of NHS provision, attempts have been made to improve local healthcare by creating Health and Well-Being Boards to bring together representatives from all social services as well as elected representatives. The quality of NHS services, monitored by an independent Care Quality Commission, is high, as reported by the Human Development Index (HDI) health indicator. 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 and missing targets for patient waiting times.

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 healthcare, such as how quickly cancer patients are seen by specialists or the incidence of “bed-blocking” (i.e., where complementary social care is difficult to arrange and so patients are kept in hospital), vary considerably across localities. A report by the Commission on the Future of Health and Social Care in England recommended that health and social care services should be much more closely integrated, but there has, to date, been little improvement.

The NHS is invariably at the center of heated public debates, with competing narratives again evident in the 2019 election campaign. 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. A new working contract for junior doctors including a pay rise, and friendlier rules for weekends and long shifts came into practice in 2019. Nevertheless, healthcare 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://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf)

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

<https://www.theguardian.com/society/2019/jun/26/junior-doctors-agree-to-82-pay-riseending-four-year-dispute>

## 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 HSE; their reduction has been (repeatedly) declared a government priority.

#### Inclusiveness:

The Irish healthcare 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 healthcare 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 healthcare over-runs. However, if there is a downturn in tax revenues and given the alarming healthcare 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 healthcare is comparatively high but the quality of healthcare 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 healthcare south of the border. Private, self-financed healthcare 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 healthcare 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 healthcare 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 healthcare and infrastructure means that diabetes patients suffer from several complications.

The government has been attempting to make healthcare 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.

In the first year of López Obrador's new presidency, healthcare sector representatives and workers repeatedly complained about the austerity measures imposed by the government. This led among other things to the resignation of the head of the IMSS. Even though the government responded by increasing the healthcare sector's budget, Health Minister Alcocer made it clear that the government would continue to fight against excessive prices and resource waste.



Although he received broad support for this, patient representatives advocated for maintaining the current system and improving the supply of medication. However, it does seem that López Obrador's austerity measures will hit the most vulnerable in society and people who live in remote areas the hardest.

In August 2019, President López Obrador announced a new program to improve the healthcare system. Furthermore, the Instituto de la Salud para el Bienestar was founded. This new institution is supposed to improve healthcare provision for citizens that are unable to access existing social security systems.

Citation:

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

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

[https://www.latinnews.com/component/k2/item/80361.html?archive=33&Itemid=6&cat\\_id=817617:mexico-rowing-back-on-healthcare-sector-austerity](https://www.latinnews.com/component/k2/item/80361.html?archive=33&Itemid=6&cat_id=817617:mexico-rowing-back-on-healthcare-sector-austerity)

<https://www.americasquarterly.org/content/amlos-false-sense-austerity>

## 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 healthcare 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 member states, Poland has a low doctor-patient ratio, with only 2.3 doctors per 1,000 inhabitants. Mortality indicators showed a visible increase in the number of deaths in 2017 and 2018, which was clearly related to the declining availability and quality of healthcare services, particularly in rural areas. The PiS government has not yet launched the comprehensive healthcare reform that it has promised several times. However, it has adopted a number of minor measures such as the creation of a new hospital network and pilot projects to test ways of improving the coordination of primary care. Health policy has been dominated by conflicts between medical staff and the government over salaries and working conditions, which resulted in frequent strikes and demonstrations. The government responded by promising salary increases for physicians and an increase in public healthcare spending from about 4.7% to 6% of GDP by 2024. This topic featured prominently in the 2019 election campaigns.

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>).

## Portugal

**Score 5** 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 healthcare system is largely reactive and concentrated on “big ticket” statistics (e.g., life expectancy and infant mortality). The healthcare system pays relatively little attention to women’s concerns during childbirth. Likewise, the number of healthy years a person can expect to live after 65 years of age is well below the EU average, particularly for women, even though average life expectancy exceeds the EU average. The most recent Eurostat data indicates that Portugal has the seventh lowest number of healthy years after 65 years old for women and 11th lowest for men in the European Union in 2017.

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 healthcare sector affected by de facto restrictions on expenditure.

These financial constraints have led to reductions in a number of services and even forced some hospitals to stop providing certain services. For instance, the Garcia da Orta hospital in Almada was forced to close the pediatrics emergency service, while the obstetrics emergency service in Beja was temporarily closed on five occasions due to a lack of doctors between the beginning of the review period and mid-June 2019. Overall, it appears that the cumulative effects of restrictions over the last several years is now negatively affecting the quality and inclusiveness of healthcare services. In addition, as the Public Health Service (SNS) is a disaster, a large number of doctors and nurses are leaving Portugal for other countries. A situation that will only get worse.

Healthcare professionals, including doctors, have held several strikes over disputes regarding pay and working conditions. As is the case with education, these strikes concern the amount of resources made available by the government for healthcare.

There are substantial political obstacles to achieving agreement on healthcare policy (and on how to fund it).

Citation:

Diário da Região Setubalense (2019), “Crise nas urgências deixa saúde da região em quarentena,” available online at: <https://www.diariodaregiao.pt/ultimas/2019/10/15/crise-nas-urgencias-deixa-saude-da-regiao-em-quarentena/>

Eurostat (2019), “Healthy life years and life expectancy at age 65 by sex,” available online at: [https://ec.europa.eu/eurostat/databrowser/view/tepsr\\_sp320/default/bar?lang=en](https://ec.europa.eu/eurostat/databrowser/view/tepsr_sp320/default/bar?lang=en)

Público (2019), “Médicos marcam dois dias de greve, em 2 e 3 de Julho,” available online at:

<https://www.publico.pt/2019/06/03/sociedade/noticia/medicos-marcam-marcam-greve-3-julho-1875204>

Observador (2019), “Urgência de Ginecologia/Obstetrícia de Beja fecha pela 5.<sup>a</sup> vez este ano por falta de médico,” available online at: <https://observador.pt/2019/06/14/urgencia-de-ginecologia-obstetricia-de-beja-fecha-pela-5-a-vez-este-ano-por-falta-de-medico/>

RTP (2019), “Administração do Hospital Garcia de Orta reuniu com chefes de equipas de urgências,” available online at: [https://www.rtp.pt/noticias/pais/administracao-do-hospital-garcia-de-orta-reuniu-com-chefes-de-equipas-de-urgencias\\_v1177659](https://www.rtp.pt/noticias/pais/administracao-do-hospital-garcia-de-orta-reuniu-com-chefes-de-equipas-de-urgencias_v1177659)

<https://observador.pt/.../medicos-e-enfermeiros-realizam-segundo-dia-de-paralisacoes/visao.sapo.pt/.../2019-01-23-O-que-esta-em-causa-na-nova-Lei-de-Bases-da-Saude-e...>

<https://observador.pt/.../ps-rompe-com-psd-na-negociacao-da-lei-de-bases-da-saude/>

## Slovenia

### Score 5

The Slovenian healthcare 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. While total health spending is well above the OECD average, both the compulsory public health insurance scheme and the supplementary health insurance funds have suffered from 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 surfaced. These scandals, combined with the growing lack of general practitioners in primary care, threaten to cripple the entire system.

Healthcare reform has been on the political agenda for some time and has featured prominently in the coalition agreement of the Šarec government. As under the previous government, however, progress has been slow. The governing parties have held different views on reforms, which have been difficult to reconcile. The outside coalition partner, The Left (Levice), for instance, has pressed hard to re-expand the public health insurance scheme to the detriment of the supplementary health insurance funds. Because of these internal conflicts, the Šarec government did not relaunch the preparation of a new draft healthcare and health insurance act already announced under its predecessor until fall 2019.

## United States

### Score 5

For many years, the U.S. healthcare system has provided the best care in the world, though highly inefficiently, to most of its residents, that is, those with health insurance coverage. It has provided significantly inferior care to the large numbers

without coverage, in particular, people with relatively low incomes or those who are 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 healthcare coverage to more people. The ACA was essentially designed to fill gaps in the existing healthcare system’s patchwork of financing arrangements.

In 2017, the Republican 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 (despite the prior Supreme Court ruling), and the Trump administration authorized “short-term” insurance plans that included sharply reduced coverage. The elimination of the individual mandate has increased the numbers of those not covered by health insurance and increased the cost of premiums for those who are covered. In 2018, the number of people in the United States without health insurance rose to 27.5 million, up from 25.6 million in 2017. In 2019, the Trump administration continued efforts to undermine the operation of the ACA on several fronts.

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 healthcare 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 healthcare 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 the robust economic growth and the decline in unemployment, the financial balance of the healthcare system has improved.

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

Health policy has suffered from a frequent turnover of ministers and their teams, along with a resulting policy instability. Kiril Ananiev, the minister of health in the

period under review, is a significant exception, having already served more than two years. Moreover, he has a background in finance rather than in medicine. However, he has done little to address the problems of the Bulgarian healthcare system.

Citation:

Atanasova, E., M. Pavlova, E. Moutafova, B. Rechel, W. Groot (2013): Out-of-pocket payments for healthcare 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 healthcare 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 healthcare 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 European Union. As a percentage of GDP, government spending on healthcare is well below the EU average (6.8% vs 9.8%). In terms of expenditure per capita, Croatia spends less than €1,300, with only Romania and Latvia lagging further behind. The structure of expenditure is unfavorable, and too much is spent compared to the EU average on drugs and medical equipment, which could be improved by scaling up purchases and increasing transparency, as well as by rationalizing the prescription of drugs and antibiotics. Prevention programs are seriously under-resourced. The low employment rate and aging demographics have produced a persistent financial deficit within the system. Since joining the European Union, the number of physicians and other medical professionals leaving Croatia has reached alarming proportions.

Access to care is adversely affected by regional variations in the range of care provided, the quality of services suffer from weak organization, a lack of digitalization and the inadequate monitoring of treatment outcomes. In addition, there are significant health inequalities between low- and high-income groups. Life expectancy in Croatia is 78.2 years, lower than the EU average of 81.0. Healthy life expectancy at the age of 65 is five years, one of the lowest in the European Union. Croatia has the eighth highest obesity rate in the EU-28 and also has one of the highest prevalence of daily smokers.

The Plenković government has so far done relatively little to address these problems. While the increase in the healthcare insurance contribution rate from 15% to 16.5% as of January 2019 has provided additional resources, the functioning of the healthcare system has been left largely untouched. The long-awaited adoption of the National Hospital Development Plan took until September 2018 and its implementation has been largely unsatisfactory. A recent series of scandals around

Minister of Health Milan Kujundžić has once more shown the pervasiveness of corruption in the healthcare system.

Citation:

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 healthcare spending. Since 2009, per capita spending on public healthcare has been cut by nearly a third. In 2019, Greece spent \$2,238 per capita on healthcare – more than one-third less than the OECD average. This amounted to 7.8% 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.

Private spending is fueled not only by the population's health status, but also by the supply of health practitioners and the availability of private diagnostic centers; in 2019, Greece had 6.1 practicing physicians per 1,000 people in the population, the highest such ratio in OECD. However, there were only 3.3 practicing nurses per 1,000 people – around 40% of the OECD average of 8.8. Moreover, Greece also had one of the EU-28's highest shares of MRI units and medical scanners per 1 million people.

Seeking to balance this oversupply of private medical services, the government implemented a system of local public healthcare units (TOMY) during the period under review. The new system should have offered a major improvement over the past, moving in the right direction by required that practicing doctors become family doctors (i.e., general practitioners responsible for a few thousand insured citizens each). Implementation of the new system faced challenges, as Greece currently 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, while there should be around 8,140 in order to meet the EU average. Specialized doctors (of whom Greece has an oversupply) had no incentive to provide primary healthcare under the newly established terms of the program, and were reluctant to enroll in a system that would tie them to predetermined levels of compensation. Meanwhile, patients continued to trust their own usual private-practice doctors, to whom they pay out-of-pocket fees. As a consequence, only several hundred doctors had agreed to work with the new system by mid-2019.

Greece also remained one of the lowest spenders on the share of preventive health measures in total healthcare 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. 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 healthcare remain intact, there is a lack of long-term planning and programming with regard to preventive healthcare measures. In addition, there is a high volume of unrecorded and untaxed transactions between patients and doctors as well as a differential in healthcare 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](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.

Data on the number of health practitioners, MRI units and scanners in Greece, in comparison to EU-28, is drawn on the European Commission's publication available at [https://ec.europa.eu/health/sites/health/files/state/docs/2018\\_healthatglance\\_rep\\_en.pdf](https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf)

OECD, Health at a Glance, 2019 (<https://www.oecd-ilibrary.org/docserver/4dd50c09-en.pdf?expires=1573899838&id=id&accname=guest&checksum=0AF638931BE42FB05F03185C22CE01DE>)

## Latvia

Score 4

In 2016, an OECD review stated that the healthcare 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 healthcare system in Latvia. However, waiting times remain long for key diagnostic and treatment services, and 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.

Spending on healthcare is low in Latvia compared to other OECD countries and less than 60% of healthcare costs are covered by publicly mandated schemes. Overall health expenditure amounts to less than 6% of GDP, compared to an average of 8.8% in the OECD. Similarly, public coverage for pharmaceutical costs is lower in Latvia (less than 40% of total pharmaceutical costs) than in other OECD countries (57%), which means almost two-thirds of pharmaceutical spending is covered by out-of-pocket payments. Because direct payments by households toward healthcare costs make over 40% in Latvia, people often either delay or do not access healthcare at all.

In 2018, the government increased spending on healthcare by 22%, financing it in part through a social contribution. It was planned that from 2019, micro-enterprise and self-employed workers, and recipients of a foreign pension would contribute via a levy equivalent to 5% of the minimum wage, otherwise individuals would have access to only basic healthcare services.

This plan is likely to lead to higher costs in the future, as people denied access – and consequently go without care for prolonged periods of time – may experience more serious and costly problems in the future. Furthermore, considerable administrative costs are likely to occur as well, as was illustrated by the delay in introducing the reform as doctors were unable to locate patients' insurance details using the current IT systems. The reform has been postponed until 2021 to address these and other shortcomings.

In addition, as far as the hospital system is concerned, much remains to be desired with regard to the quality and efficiency of the services. For example, Latvia's 30-day mortality rate after admission to hospital for a heart attack is the highest in the European Union and twice the EU average.

Future challenges will include stabilizing the system, addressing the discussed drawbacks and reducing shortages of skilled medical staff. In addition, increasing the low rate of pay for medical professionals remains a challenge, despite a Saeima decision in 2018 to raise remuneration by 20%. Finally, centralizing services and developing cooperation between hospitals, as well as reviewing performance, governance and accountability mechanisms in hospitals would further improve the healthcare system in Latvia.

Citation:

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2. OECD (2019) OECD Economic Surveys: Latvia, Available at: <https://www.oecd.org/economy/surveys/Latvia-2019-OECD-economic-survey-overview.pdf>, Last assessed: 30.10.2019
3. 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: 30.10.2019.
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## Romania

Score 4

Romania's healthcare system continues to suffer from low public spending, mass migration of medical staff, corruption and inefficiency. As a percentage of GDP, public healthcare spending is the lowest in the EU – at about half the EU average. In



those fields where there have been spending increases – for instance, in preventive care – the money has been poorly allocated. The Ministry of Health estimates that 43,000 doctors left the country in 2007-2017, with 10,000 leaving in 2017/18 alone; the effects of recent wage increases for doctors remain insignificant (150 Romanian doctors returned to the country, according to the Minister of Health). Wage increases have similarly proven largely ineffective in combating corruption within the sector, with bribery of medical staff a common occurrence. While the government has taken measures aiming to foster transparency, an assessment of these measures has yet to be released. Cost efficiency seems to remain extremely low. Access to care for vulnerable groups and those living in rural areas is also limited, while access to rehabilitative, palliative, and long-term care overall is poor. As a whole, the health of Romania's population remains below the EU average, with a life expectancy of 75.3 years at birth in 2016, compared to 81 years for the EU.

Budgetary constraints, a lack of political commitment, and limited administrative capacity within the Ministry of Health have further hampered planned reforms in 2019. Announced projects such as the construction of additional regional hospitals, the development of integrated community care centers, and measures to increase uptake of e-health solutions, including a shift to electronic health records, have been delayed. In April 2019, the government adopted an emergency degree that has obliged the national health insurance fund (CNAS) to cover part of the costs if the insured take up private medical services, prompting debate as to whether this might boost competition and improve services to patients or simply increase healthcare costs and disparities in access.

## 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 healthcare services are relatively low. A government spending review published in autumn 2016 showed that there is significant scope to increase the cost-effectiveness of various areas of healthcare. Bad working conditions in the Slovak health sector and mass migration of doctors and nurses to other EU member states 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 and 57 years.

The third Fico government announced in 2016 that it would replace the existing reform strategy with a new and updated strategy, but failed to do so. Even the implementation of the old strategy has proceeded slowly and selectively. In 2017, the

gradual introduction of DRGs in hospital financing started. In 2018, the government carried out the first step of a three-step debt settlement plan for hospitals, without tackling the root causes of the accumulation of hospital arrears. Reacting to the threat of looming strikes, Andrea Kalavská, the health minister since March 2018, announced an additional €90 million investment in the healthcare sector. She also prepared a comprehensive hospital reform, which was supported by many experts as well as by the parliamentary opposition. Approved by the cabinet after months of discussion at the end of September 2019, the reform was eventually withdrawn from the parliament's agenda because of opposition from Smer-SD, orchestrated by former prime minister Robert Fico.

Citation:

European Commission (2020): Country Report Slovakia 2020. SWD(2020) 524 final, Brussels, 25-26 ([https://ec.europa.eu/info/sites/info/files/file\\_import/2019-european-semester-country-report-slovakia\\_en\\_0.pdf](https://ec.europa.eu/info/sites/info/files/file_import/2019-european-semester-country-report-slovakia_en_0.pdf)).

## Hungary

### Score 3

Health outcomes in Hungary lag behind most other EU member states due to both the low performance of healthcare provision and unhealthy lifestyles. The number of avoidable deaths in Hungary is one of the highest in the European Union. Healthcare has been one of the most conflict-ridden policy fields in Hungary. A continuing series of scandals have made this issue a major Fidesz policy weakness and a subject of large-scale public protest. Healthcare has suffered from the absence of a ministry tasked with addressing healthcare issues and from a limited healthcare budget, which is one of the lowest in the OECD with spending per capita at around 50% of the EU average. A large number of medical doctors and nurses have emigrated to the West due to the very low salaries. Consequently, some sectors of hospitals have been closed because of the lack of doctors. At the same time, very small hospitals are maintained although they cannot be operated efficiently – the fear of public protests against a centralization of hospitals prevents necessary reform. 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 staffs, 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, healthcare has remained a low priority issue for the fourth Orbán government. In 2019, the responsibility for medical schools and the health research budget has been transferred from the Ministry of Human Resources (EMMI) to the Ministry of Innovation and Technology (ITM), so that institutional fragmentation has further increased.

Citation:

Kingsley, P., B. Novak (2019): In Hungary, Viktor Orbán Showers Money on Stadiums, Less So on Hospitals, in: New York Times, October 26 (<https://www.nytimes.com/2019/10/26/world/europe/viktor-orban-soccer-health-care.html>).

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