Health Report

Health Policy

Sustainable Governance Indicators 2022

SGI Sustainable Governance Indicators

BertelsmannStiftung

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

As has been witnessed globally, health policy in Canada has also been very heavily impacted by the pandemic. While healthcare, like educational policy, is primarily the responsibility of the individual provinces, all levels of government have been focused in their efforts, and expenditures, on dealing with the health crisis. Initially health policy pivoted to focus on procurement of personal protective equipment and, while Canada was slow in acquiring vaccines, by December 2020, Canada had begun to complete major acquisitions with provinces and territories delivering doses into arms.

In Canada, vaccine takeup has generally proven strong, with concerted education campaigns and regular briefings by respective medical health officers, often on a daily basis. Mask mandates and capacity limits both for outdoor and indoor activities have been recurring features across the country as COVID-19 waves have peaked and waned, with provincial and territorial jurisdictions establishing their own protocols. The federal government has also locked down borders during the pandemic and has followed with mask mandates for federally-regulated activities, including travel. As a result, vaccine takeup has been quite strong; as of 28 December 2021, 77.38 persons were fully vaccinated per 100 population.

Despite progress on the vaccine front, the impacts on the healthcare system have been marked. Even before the pandemic the most glaring problem with the Canadian system was timely access to care. In a 2017 study by the Commonwealth Fund, Canada ranked last for providing timely access to care out of 11 high-income countries. As hospitals and healthcare units pivoted to deal with COVID-19, redirecting resources to emergency and intensive care, these wait times and access issues became even more acute. The Canadian Institute for Health Information

reported that almost 560,000 fewer surgeries were performed between March 2020 to June 2021, in comparison with 2019. The Canadian Medical Association has championed the need for change, highlighting the immense challenges with which the Canadian healthcare system is "struggling" and calling for an infusion of CAD 1.3 billion in funding on the part of the federal government.

The pandemic also revealed extremely inadequate measures being taken in long-term care homes; in the first wave of the pandemic, 80% of fatalities were in long-term care facilities (OECD 2021). Seniors groups have called for more stringent regulations regarding long-term care but this issue continues to be one of tension between the federal government and the provinces.

With respect to access, income is not a barrier to treatment, with care freely provided for almost the entire population. 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. In the 2019 election campaign, Trudeau pledged to implement a national pharmacare program, although the administration has not made it clear how it would fund such a program.

A 2021 Commonwealth Fund study found that Canada's healthcare system outperforms the United States but trails behind that of comparable countries (e.g., Norway, the Netherlands, Australia). The Commonwealth Fund report ranked Canada second to last overall on a comparative score card of 11 healthcare systems.

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Denmark

Score 8

All Danish citizens are entitled to healthcare, regardless of economic circumstance. Services are offered free of charge, and elected regional councils have governed the sector since 2007. Though there is a formal health tax, the government determines this as part of its overall tax policy, and the regions must follow a budget that is determined in annual budget negotiations with the Ministry of Finance.

In 2019, life expectancy in Denmark was at 81 years, which is slightly above the OECD average, but below that of comparable countries. The life expectancy of women is somewhat higher than that of men. 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, and there has been a growing focus on the issue of inequality in longevity.

Recently, there has been much public debate about the quality of hospital services. Increasing prices for medicine are putting pressure on efforts to finance healthcare. Cancer treatment has become a priority, as it is an area in which Denmark lags behind similar 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. The debate continues concerning bringing some basic healthcare activities closer to the population via local healthcare centers, and the government has taken steps in this direction.

The pandemic has severely affected the healthcare sector, and there is a large backlog of patients waiting for treatment. The country faces challenges related to staffing shortages, the need to reduce accumulated overtime hours, and pay issues for nurses in particular. Nurses in the country rejected a decision resulting from collective bargaining in 2020 that led to the government intervening in order to bring an end to the conflict. A so-called wage structure committee has been appointed to analyze pay structures within the public health sector.

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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 already in 2018, although government cabinets have not made any progress on the issue.

Instead of the major reform, some smaller measures have been implemented in order to improve the system's inclusiveness and quality. Uninsured people are included in

screening programs of major oncological diseases (2021), e-consultations of special care doctors have been launched (2020) and a nationwide e-booking system has been opened (2019). The latter two measures were especially important to address large regional inequalities in access to high-quality hospital care.

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

Germany

Score 8

The German healthcare system is of high quality, inclusive and provides healthcare for nearly all citizens. Most employees are insured by the public health insurance system, whereas civil servants, self-employed persons, high-income individuals and some other groups are privately insured. The system is, however, increasingly challenged by rising costs. Prior to the COVID-19 pandemic, the system's financial stability was stable due to buoyant contributions resulting from the employment boom. However, aging demographics and increasing healthcare costs are placing growing pressures on the system, which guarantees equal access to all necessary medical services that are of a high standard.

As has been the case for any other country, the COVID-19 pandemic has put the system under severe stress. However, Germany's health system proved better prepared for such a catastrophic event than many other countries because it features a high number of intensive care beds, regular hospital beds, doctors and nurses relative to the population (Rüb et al., 2021). Shortages occurred but the health sector basically remained functional even in the context of a severe pandemic environment and, unlike in several other countries, COVID-19 patients received professional treatment at the state of the medical knowledge through all phases of the pandemic during the reporting period. The coordination of scarce resources such as intensive care beds across states was successful in reducing scarcity in regional infection hotspots. All this has contributed to an effective protection of lives: Hardly any other comparable country in Europe has been able to protect the lives and health of its population as successfully as Germany during the pandemic, measured in terms of coronavirus-related deaths relative to the population (Heinemann, 2021). At the same time, the pandemic has confirmed some well-known weaknesses, among them the lagging state of the German health system in terms of digitalization and the increasing shortage of highly qualified caregivers. The outgoing government has addressed some of these issues, but it remains to be seen how successful these reforms turn out to be.

The pandemic has further increased the health system's cost pressure, a problem for which the new government has so far no convincing answer. The coalition agreement features vague statements regarding a "rules-based dynamization of the federal grant

to the statutory health insurance" (Koalitionsvertrag, 2021, p. 87) but the agreement is silent on new financing sources or measures to limit increases in spending. In particular, the new government appears as hesitant as its predecessor to open the system to more competition (e.g., with respect to pharmacies).

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Israel

Score 8

Generally, the healthcare system in Israel is characterized by a publicly funded universal provision of services. At the same time, there remain significant gaps in between the quality of health services in the center and the periphery, and household out-of-pocket healthcare spending is relatively high due to partial privatization.

All residents in the country are eligible for medical insurance, which covers primary and secondary care, hospital services, and highly subsidized medications and medical technologies. A further layer of medical insurance is available for additional payments to one of the four non-commercial HMOS (health management organizations) that provide medical services in Israel.

The Israeli healthcare system's ability to cope, adapt and respond to COVID-19 and any other big-scale pandemic came under scrutiny during the initial COVID-19 outbreak. According to the State Comptroller (2020), Israel lacked a proper supply of medicines, vaccines and hospitalization solutions (e.g., hospital beds, vacancy in emergency rooms and ventilators), and stated that Israel was not prepared to handle large-scale outbreaks.

The State Comptroller also mentioned that the Ministry of Health (MOH) lacked an efficient system to monitor and track the spread of the coronavirus, and faced issues with the documentation of the epidemiological examinations (State Comptroller 2020; Druckman 2020). To fill this void, the Israeli military became highly involved in managing and executing policies, such as tracking the spread of the virus, throughout the crisis (Zeitun 2020).

To meet the growing need for facilities to treat COVID-19 patients, most hospitals opened designated coronavirus wards that take care of critically ill patients. Other designated facilities included so-called COVID-19 hotels, which were used to accommodate people in isolation and were overseen by the Israeli military (Clalit 2020). The government also formed a specialized unit dedicated to protecting elderly citizens in nursing homes (Ministry of Health 2020).

During the outbreak, Israel decided that all medical services related to COVID-19 would be provided free to illegal foreigners, despite most not having medical insurance. Other services such as housing, and places for isolation and treatment were offered by various local authorities to low-income migrants.

In terms of medical staff, in April 2020, the MOH called for an increase in the number of doctors in hospitals that handle COVID-19 patients by roughly 300. By August 2020, only 156 out of these 300 positions had been filled (Knesset 2020). The government allocated about ILS 14.5 billion (approximately 3% of the yearly budget) to handling the health-related costs of the pandemic, including the costs of additional ventilators and protective gear for the medical staff, and the procurement of medicine and ambulatory services.

Although the government allocated funds to combat the spread of the disease, a gap persists in investment in health services between the different regions of the country. This influences the medical treatment given to infected patients. On some occasions, patients were transferred from hospitals in the periphery to hospitals in the center of the country due to the inability of peripheral hospitals to appropriately treat patients with COVID-19 (Ron 2020).

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Luxembourg

Score 8

Luxembourg has one of the best healthcare systems in Europe, based on a high standard of state-funded medical coverage. While 99% of the population is covered by the state healthcare system, about 75% have some extra form of private health insurance. Healthcare is administered by the Ministry of Health, which is responsible for policy, regulation and overseeing services. The majority of funding comes from the health insurance contribution to the National Health Fund. This payment is carried out via Luxembourg's Social Security System, which represents 84% of total public healthcare expenditure. The compulsory insurance scheme covers 80% to 90% of overall healthcare costs. Residents have to pay between 10% and 20% of a general service's costs, up to 20% of prescription costs (60% for non-essential medication), and around €22 a night for hospital stays. The country is one of the lowest healthcare spenders in the EU (just 6.2% of GDP per year), but has one of the highest per capita expenditures (over €5,500 per person per year). After the United States and Switzerland, Luxembourg has the third-most-expensive healthcare services within the OECD, due to high wages, a high ratio of medical equipment to residents, and a low generic substitution rate.

The Grand Duchy's health system has considerable material resources for a country its size. In 2020, the Hospital Federation (FHL) – which includes four hospital centers, six specialized hospital establishments (heart surgery, radiotherapy, neuropsychiatry, post-oncology, geriatrics and functional reeducation), an institution for end-of-life care, and a diagnostics center – had 2,657 beds, an operating budget of €1,182.9 million, and a workforce of approximately 17,595 people, of which 70% are cross-border workers. In 2021, approximately 209,014 workers crossed the Luxembourg border on a daily basis (+2.7% compared with 2020). The coronavirus pandemic showed that the country's medical and hospital sectors are entirely dependent on this cross-border workforce. When France decided on 13 March 2020 to close its border with Luxembourg, the Grand Duchy faced the real risk of "a collapse of the health system."

In consequence, the government launched the national consultation on health ("Gesondheetsdësch") in order to develop a strategy addressing the current gaps. Based around the University of Luxembourg, a new system of training for healthcare professionals is to be launched in 2023, offering various levels of qualification (new bachelor-level programs for general and specialized nursing, for midwives, and for technical medical assistants in radiology). The Lycée Technique pour Professions de la Santé (a technical secondary school specializing in health professions) also remains an important player in the field. The reorganization of higher education in the area of health professions will be evaluated in 2028.

The health technology ecosystem is also being reformed, with a focus on diagnostics, digital health, health data analysis and portable medical devices. Its management is

conducted by the Luxembourg HealthTech Cluster (HTC), which by 2019 included around 136 specialist public and companies, with 1,600 professionals and a value added of €180 million (0.35% of GDP). The 2021-2025 investment program is focused on the "Südspidol" (total budget of €542 million, 80% funded by the government), which will bring together the hospitals of Esch-sur-Alzette, Dudelange and Niederkorn. The new consortium, which will diminish the operating costs of the three existing hospitals by 15%, will meet the growing healthcare needs of the Greater Region.

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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 public healthcare system is already showing signs of being overburdened. Reports of chronically understaffed hospitals abound, large numbers of specialist referrals are declined due to 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 1.4 million) now have private "queue jumping" health insurance. In recent years, however, premiums for such products have increased continuously, thereby fueling income-related inequality in healthcare (Jones and Akoorie 2018)

Despite problems of under-resourcing (there are only around 150 ICU beds and just over 500 ventilators across the whole country), lockdowns and other policy interventions prevented the public healthcare system from being overwhelmed during the COVID-19 pandemic. The health system also played an important role in successfully delivering the COVID-19 testing and vaccination programs.

The Labour government (2017-) has identified public health as a policy priority. In the 2019 "well-being" budget, mental health received the biggest funding and investment boost on record. Of a total of $1.9 billion, half a billion dollars were funneled toward the "missing middle" – that is, the mild-to-moderate anxiety and depressive disorders that do not require hospitalization (McCullough 2019). The 2020 budget gave districh health boards (DHBs) an extra $3.92 billion over four years and a one-off $282.5 million to catch up on elective surgery after the COVID-19 disruption (RNZ 2020). In April 2021, the government announced that it would embark on a major shake-up of the health system, abolishing all DHBs and replacing them with a central agency and a Māori Health Authority alongside it. The 2021 budget allocated $486 million for these reforms, and health boards are set to receive $2.7 billion over the coming four years to manage cost and population pressures (Manch 2021).

A particular policy 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 (Walters 2018). Moreover, Māori and Pasifika have been at higher risk of catching COVID-19; as of late 2021, most current cases and hospitalizations were among Māori and Pacific New Zealanders, despite the fact those groups make up less than 30% of the total population (McClure 2021).

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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. The World Health Organization (WHO) rated Korea’s universal healthcare (UHC) coverage at 85.7 (i.e., 85.7% of the population has basic coverage) in 2017, higher than the OECD average of 80. Korea’s healthcare system performed well on the stress test provided by COVID-19. As of January 2021, Korea had the second-lowest number of COVID-19 cases (per 100,000 people) in the OECD. Indeed, Korea has been internationally lauded for its rapid and effective pandemic containment, in particular its testing, contact-tracing and quarantine procedures.

Yet while some laud Korea for achieving this with relatively low public health expenditure (5% of GDP in 2019 compared to the OECD average of 6.6%), Korea’s low public spending is augmented by high levels of private spending. Levels of out-of-pocket spending by Korean households are among the highest in the OECD. In 2019, the WHO reported that 22% of the households spend around 10% of their total consumption on health; and 4% of households spend 25% of total consumption on health. These figures are significantly (3-4 times) higher than the OECD average – which indicates that many more households in Korea are at risk of catastrophic (unaffordable, poverty-inducing) health spending.

Since the launch of the more generous “Mooncare” healthcare plan in 2017, the government share of total healthcare expenditure has increased from 59% in 2016 to 62% in 2020. Moreover, private, out-of-pocket outlays declined from 33% of total health spending in 2016 to 29% in 2020. Mooncare’s ongoing expansion of healthcare to cover all medical treatments rather than just four major diseases (cancer, cardiac disorders, cerebrovascular diseases and rare incurable illnesses) – is

likely to reduce the incidence of catastrophic healthcare spending by Korean households.

Mooncare has come at a cost. The National Assembly Budget Office projects that government healthcare insurance expenditures will more than double between 2020 and 2030. The financial balance of the health insurance system, which recorded a surplus for seven straight years through 2017, went into deficit in 2018 (when Mooncare was introduced).

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Spain

Score 8

In 2018, the Bloomberg Healthiest Country Index ranked Spain as the healthiest country in the world. However, the country's aging population and the accompanying increase in the incidence of chronic diseases poses a risk to the system's sustainability. Funding cuts to the healthcare sector following the 2008 financial crisis have led to increasing variability in the quality of healthcare services across autonomous communities, which are responsible for the delivery of healthcare services. Numerous experts and practitioners have for some time been denouncing the cuts inflicted on the system, and the consequent lack of human and material resources. The system is designed in a relatively efficient way to offer primary care. However, COVID-19 has revealed weaknesses in the healthcare system, both in terms of public health policy and patient care. Health workers organized strikes in 2020 and 2021 to protest dangerous working conditions during the COVID-19 pandemic, as well as problems with pay and staffing linked to budget cuts in previous years. At the beginning of the pandemic, due to a combination of party politics, territorial cleavages and long-standing institutional deficits, such as poor

coordination among governments and an unclear division of competences, decisions were made relatively late and slowly. Moreover, the lack of capacity (data collection, material, testing and analysis) conditioned Spain's public health responses. Nevertheless, coordination improved over time, and representatives of the health authorities began meeting frequently to exchange information and reach agreements, such as on common standards for PCR tests, the closure of bars, restricting smoking in public spaces, and the implementation of measures for residences for the elderly.
During the first six months of 2021, Spain's COVID-19 vaccination campaign progressed very well. In December 2021, more than 80% of the Spanish population was already immunized, and fears of the omicron variant had triggered new rounds of vaccination.

There are still important differences between autonomous communities regarding spending. There is a group of autonomous communities with an expenditure of around €1,300 per inhabitant (Andalusia, Madrid, Catalonia, La Rioja, Murcia and Valencia) and a group of autonomous communities where expenditure per capita is around €1,900 (Basque Country, Navarre and Asturias). These differences are due to geographic and sociodemographic situations, but also have an impact on healthcare provision.
In 2018, Spain adopted a national law that significantly expanded healthcare access to all residents, including undocumented migrants. However, limited geographic access to primary care in rural areas is a major challenge. Numerous experts and practitioners (e.g., the Spanish Society for Public Health and Health Administration) have for some time been denouncing the cuts inflicted on the system, and the consequent decline in healthcare equity. The Spanish government has recognized this situation, and has initiated several reforms to improve healthcare provision, but the results will not be visible until 2022.

The coalition government program (adopted in January 2020) included the goal of increasing spending on the national health service to 7% of GDP by 2023. The spending increase includes €1 billion for acquiring COVID-19 vaccines, and €1.09 billion for modernizing and updating primary care. Spending will also increase for the National Health System Quality Plan.

The RRP includes a set of measures to strengthen and expand the capacities of the National Health System. According to the plan, and as a lesson from the crisis, the National Ministry of Health will improve its constitutionally determined coordination function and seek to ensure national standards in healthcare delivery. Moreover, the coordination and multilevel governance in the management of the National Health System will be improved. In this regard, the government proposed the creation of National Public Health Center to help improve system governance and to foster cooperation mechanisms between the healthcare and public health services of the autonomous communities. Within this context in December 2021, the government approved the National Mental Health Strategy for 2022 – 2026, together with the regional governments.

Citation:
Erkoreka, Mikel; Grau Creus, Mireia; Kölling, Mario (2021) Decentralisation and COVID-19: the Spanish territorial system under pressure, en Nico Steytler (ed.) Comparative Federalism and COVID-19: Combatting the Pandemic, Routledge.

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Switzerland

Score 8

Healthcare in Switzerland is said to be qualitatively excellent. According to the OECD, its healthcare system is among the best in the OECD, but also one of the most expensive (OECD 2022). 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 20 years. Cost efficiency is a major problem, in particular with regard to the organization of hospitals and the price of pharmaceuticals.

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 2019, health expenditure was equal to 11% of GDP, compared to 17% in the United States and 13% in Germany (OECD 2022). In 2018, the healthcare system was financed by the public sector (29%), by health insurance, which is organized as private mutual funds (37%), by other (private) health insurance (9%) and by patient self-payments (26%) (BfS 2020b). These self-payments are very high by international comparison. According to a 2011 OECD report, “Switzerland has among the highest percentage of out-of-pocket costs as a share of health expenditure in the OECD” (OECD 2011: 35). Drawing on several studies, the federal government reported that the proportion of people who forego medical services for cost reasons is in the range of 10-20% of the population. According to a report by the OBSAN, the proportion of the population that has given up going to the doctor because of cost-related reasons rose sharply between 2010 and 2016, and is most marked in the 18 to 45 age group, with an increase of around 15% (Merçay 2016). The proportion of those who would forego necessary services is in the lower single-digit percentage range, although it is very difficult to define “necessary treatments” (Bundesrat 2017: 22-26).

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.

The pandemic revealed some existing tensions regarding the issue of hospital care and in particular the shortage of medical staff working in hospitals, which led to the overloading of staff or delays to non-urgent procedures and interventions. In this context, voters accepted an initiative that modified the constitution in 2021. The initiative states, "The Confederation and the cantons recognize and promote care as an important part of healthcare and ensure that sufficient, high-quality care is available to all. They shall ensure that a sufficient number of qualified nurses are available to meet the increasing demand and that the persons working in nursing are trained and qualified in accordance with their training and skills are deployed in accordance with their training and skills."

Another aspect of the Swiss healthcare system is the decentralization of health policy, which is basically a cantonal responsibility. By implication, Switzerland has 26 different healthcare systems, which are only marginally coordinated. This could be an asset, if all of these healthcare administrations react appropriately, swiftly and professionally to challenges such as the recent pandemic, which showed regional variation in depth and development. However, it could also be a major vulnerability, if some of these healthcare administrations fail to cope with the challenges due to political reasons or due to reasons of quality of administration.

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. The system produced excellent outcomes during the pandemic. There remains, however, some concern about the centralization of medical services and sufficiency of medical coverage in marginal regions.

Citation:
Bundesrat 2017: Kostenbeteiligung in der obligatorischen Krankenpflegeversicherung. Bericht des Bundesrats in Erfüllung des Postulats Schmid-Federer vom 22.03.2013 (13.3250 «Auswir-kung der Franchise auf die Inanspruchnahme von medizinischen Leistungen») 28.06.2017, Bern: Bundesrat.

https://stats.oecd.org/Index.aspx?DataSetCode=SHA

GDK 2016: Schweizerische Konferenz der Kantonalen Gesundheitsdirektorinnen und -direktoren und odasanté: Nationaler Versorgungsbericht für die Gesundheitsberufe 2016. Nachwuchsbedarf und Massnahmen zur Personalsicherung auf nationaler Ebene, Bern: GDK

MERCAY 2016: Expérience de la population âgée de 18 ans et plus avec le système de santé – Situation en Suisse et comparaison internationale: Analyse de l'International Health Policy Survey 2016 du Commonwealth Fund sur mandat de l'Office fédéral de la santé publique (OFSP) (Obsan Dossier No. 56) (p. 186). Neuchâtel: Observatoire suisse de la santé

SRF News: Pflege am Limit – Risikozone Spital: Pflegende schlagen Alarm.

https://www.srf.ch/news/abstimmungen-28-november-2021/pflege-initiative/pflege-am-limit-risikozone-spital-pflegende-schlagen-alarm

Australia

Score 7

As with most countries, the COVID-19 pandemic has created significant challenges for the healthcare sector. However, aside from the injection of funding into vaccine and treatment development and deployment, 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 subsidies 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. 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.

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

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

Austria

Score 7

The Austrian healthcare system is based on several pillars. Public health insurance covers the basic needs of most persons living legally in Austria, while a competitive private health-insurance industry offers additional benefits. Inequalities in healthcare have arisen, particularly between those able to afford additional private insurance and those who cannot. Still, inequalities between ordinary and private patients are much less pronounced than, for example, in Germany. In contrast to Germany, civil servants pay into the same public health insurance system as everyone else. One element of the government's tax reform passed in late 2021 included a reduction in health insurance contributions for lower income earners (worth about €300 per year).

On 1 January 2020, as a part of an ongoing healthcare reform, the Austrian Health Insurance Fund (Die Österreichische Gesundheitskasse, ÖGK) was created by merging the nine former regional health insurance funds. The ÖGK is based in Vienna. With a volume of benefits of almost €15.3 billion and about 20,000 contractual partners, the Austrian Health Insurance Fund covers the healthcare services of about 7.2 million people. A key motive for this reform was cost reduction (which was mainly achieved by cutting personnel) to be accompanied by making more resources available to patients. However, in early assessments of the ÖGK in 2021, it became clear that personnel costs had increased by more than 3%.

The development of the healthcare environment in Austria is largely in line with European trends. At the height of the coronavirus pandemic, the Austrian healthcare system was tested to its limits. A survey study found that public trust in the Austrian healthcare system decreased significantly over the first year of the pandemic (early 2020 through to early 2021), although less so than trust in the government. In the wake of the coronavirus pandemic, life expectancy for people living in Austria decreased slightly, but less dramatically than in several other countries.

Austria has remained a top scorer in terms of the number of physicians per 1,000 inhabitants. However, a recurrent issue in recent political debates on healthcare in Austria has been the shortage of physicians in some (non-urban) regions. More importantly, the share of physicians that were contracted partners of the public health insurance system (Kassenärzte) decreased (from 4,213 to 4,054) between 2010 and 2020. Meanwhile, the number of physicians servicing private patients (Wahlärzte) increased over the same period (from 2,119 to 2,653). As private patient physicians

in general are not available to people without private healthcare insurance, and given population aging and therefore increased demand on healthcare services, this development provides a clear picture as to the overall quality of services provided (exclusively) by the public healthcare system.

Citation:
https://viecer.univie.ac.at/corona-blog/corona-blog-beitraege/corona-dynamiken22/

https://orf.at/stories/3227790/

https://www.diepresse.com/5862134/mangel-an-kassenshyarzten-schieflage-verstarkt-sich

Belgium

Score 7

The Belgian healthcare system is very efficient in normal circumstances: public (or publicly funded) hospitals own and maintain excellent equipment, and university hospitals offer advanced treatments, given the institutions' participation in medical research. Coverage is broad and inclusive. Access to healthcare is also generally affordable and inclusive, with ample public intervention helping to cover costs of medication and treatment.

However, as emphasized in previous years, the system was not totally sustainable previously, and the COVID-19 crisis has pushed the system beyond its limits. Cost cuts have reduced the appeal of many medical professions, particularly for nurses, which has now created an increasingly critical skills shortage. A schizophrenic policy of "numerus clausus" restricts the number of young graduates allowed to practice medicine, despite the looming lack of doctors.

A second problem came to light during the COVID-19 crisis: the Belgian system does not engage sufficiently in prevention, and was ill-prepared for a public health or epidemiologic crisis. The country indeed has a robust supply of well-equipped hospitals (public, private and linked to the major universities). On paper, it also boasts a comparatively large medical workforce; according to data from Eurostat and the OECD, it has the OECD's second-highest number of general practitioners per capita (but official data also count retired doctors: for a small fee, doctors can maintain their prescription rights beyond retirement, and are then still counted as being active). The number of nurses per capita is also comparatively high, although recent news reports claim that the sector is hemorrhaging workers since the COVID-19 crisis.

The common point is that the objective of containing public deficits was partially reached by reducing wages and hospital costs (including a reduction in the total number of hospital beds) in ways that may not be entirely viable in the long run, particularly given the aging population. Too few doctors are allowed to graduate and practice, while the short supply of doctors in hospitals is increasingly translating into abusive and underpaid or even unpaid working hours (totaling 70-100 hours per week) for young graduates. While the number of doctors is high, this tendency to

limit the supply of doctors also has an impact on healthcare access, mainly for those who don't know how to navigate the medical sector.

Prevention is furthermore not Belgium's strong suit. While it boasts advanced warning systems for flu-like symptoms, it performs much less well on several cancer types. Expected "healthy life years at birth" is close to but below the EU average. Although Belgium was part of the WHO's influenza preparedness initiative, it did not invest in emergency drills, and did not have concrete plans ready for an epidemic of COVID-19 proportions. As a result, the 2019 Global Health Security Index for Belgium was very high overall, but the country scored a zero in the categories of "Emergency Preparedness and Response Planning" and "Risk Communication." This diagnostic proved painfully relevant during the crisis.

Citation:
Doctors and nurses per capita: https://ec.europa.eu/eurostat/statistics-explained/images/e/e3/Physicians%2C_by_speciality%2C_2018_Health20.png

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https://www.belgiqueenbonnesante.be/images/KCE/A6_Pract_nurse_FR.jpg
https://statbel.fgov.be/fr/themes/datalab/personnel-des-soins-de-sante
Hospital beds and equipment: https://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_resource_statistics_-_beds
https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_resource_statistics_-_technical_resources_and_medical_technology

Budget cuts: https://www.levif.be/actualite/belgique/qui-a-coupe-dans-mes-soins-de-sante-sophie-wilmes-a-t-elle-une-part-de-responsabilite/article-normal-1269381.html

Healthy life years: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthy_life_years_statistics
Preparedness:

https://www.euro.who.int/en/health-topics/communicable-diseases/influenza/pandemic-influenza/pandemic-preparedness

https://www.covid19healthsystem.org/countries/belgium/livinghit.aspx?Section=3.1%20Planning%20services&Type=Section

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https://www.revuepolitique.be/le-systeme-de-sante-au-prisme-du-virus/

Fallon, C., Thiry, A. & Brunet, S. (2020). Planification d'urgence et gestion de crise sanitaire. La Belgique face à la pandémie de Covid-19. Courrier hebdomadaire du CRISP, 2453-2454(8-9), 5-68. https://doi-org.ezproxy.ulb.ac.be/10.3917/cris.2453.0005

Very critical article on the Belgian response: https://www.revuepolitique.be/covid-19-agir-plutot-que-reagir/

Report to the parliament: https://www.rtbf.be/info/dossier/epidemie-de-coronavirus/detail_que-dit-le-rapport-d-yves-coppieters-pour-la-commission-speciale-sur-la-gestion-du-coronavirus?id=10574411

Chile

Score 7

For more than three decades, Chile has maintained a dual health system with one private and one public pillar. The private pillar includes private insurance and private healthcare services chosen by self-financing participants (typically upper-middle-income and high-income groups). The public pillar includes highly subsidized insurance and public healthcare services for participants, who pay only part of their health costs. Although this dual system provides broad coverage to most of the population, it also perpetuates a quality gap with regard to healthcare provision (especially in the waiting times for non-emergency services), with the participants in the public system being strongly disadvantaged. 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. For these reasons, the quality and efficiency of public healthcare provision (government clinics and hospitals) vary widely.

There is still a huge gender gap with regard to healthcare contribution rates, since maternity costs are borne only by women. A draft law which seeks to implement a Universal Health Plan for private health insurance (Instituciones de Salud Previsional – ISAPRES) in order to put an end to discrimination in access based on age, gender or preexisting conditions was still pending in parliament as of the time of writing.

Near the beginning of the COVID-19 pandemic, the government created a fund of about $306 million to support the health system (earmarked for additional supplies, health staff and increases in hospital capacities, among other purposes). Although there have been critical peaks, the health system as such has not collapsed. A mental-health support program tasked with providing guidance to people affected psychologically by the pandemic was put in place by the second half of 2020. Chile is characterized by a high coronavirus vaccination rate (86.58% of the population were fully vaccinated by the end of the period under review) compared both with other Latin American countries and other OECD member countries.

A survey released in August 2021 by Centro de Estudios Públicos (CEP), one of Chile’s most important polling agencies, showed that 38% of the respondents cited

healthcare as their third-highest concern (after crime: 42%, and pensions: 41%). This trend has remained stable in the recent past.

Citation:
Healthcare as one of the chief concerns:
Centro de Estudios Públicos (CEP), August 2021, https://www.cepchile.cl/encuestaCEP, last accessed: 13 January 2022.

Statistics and Research on Coronavirus (COVID-19) Vaccinations:
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Centro de Investigación Periodística (CIPER), "Estatus socioeconómico: un factor de riesgo para la actual pandemia de COVID-19", May 2021, https://www.ciperchile.cl/2021/05/05/estatus-socioeconomico-un-factor-de-riesgo-para-la-actual-pandemia-de-covid-19, last accessed: 13 January 2022.

Czechia

Score 7

Healthcare in Czechia is based on universal compulsory insurance and largely financed from public sources. While healthcare spending has been relatively low from an international perspective, the healthcare system is rather inclusive, ensures a wide range of choice for both providers and consumers of healthcare, and provides a high level of service by international standards. Prior to the COVID-19 pandemic, Czechia had among the lowest levels of unmet needs for medical care due to financial reasons, distance or waiting times in the European Union (OECD/ European Observatory on Health Systems and Policies 2021: 15). However, life expectancy, although steadily increasing before the COVID-19 pandemic, has remained more than two years below the EU level, and there have been substantial differences in health outcomes between the capital region of Prague and the rest of the country. In structural terms, the Czech healthcare system has suffered from a strong reliance on hospitals and a shortage of nurses.

The Czech healthcare system largely withstood the first wave of the COVID-19 pandemic. Despite the massive additional public spending, however, some hospitals found themselves on the brink of being overwhelmed during the second wave of the pandemic, when the number of infections was rather high in Czechia. Life expectancy fell by about one percentage point in 2020, which is stronger than in most EU member states (OECD/ European Observatory on Health Systems and Policies 2021: 4). On the positive side, the COVID-19 pandemic has fostered the digitalization of the healthcare sector and has led to some improvements in administrative methods.

Citation:
OECD/European Observatory on Health Systems and Policies (2021): State of Health in the EU: Country Health Profile Czechia. Paris: OECD, Brussels: European Observatory on Health Systems and Policies (https://ec.europa.eu/health/system/files/2021-12/2021_chp_cs_english.pdf).

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. Finnish residents have access to extensive health services despite comparatively low per capita health costs. The Finnish healthcare system is based on public healthcare services to which everyone residing in the country is entitled. According to the constitution of Finland, the public authorities are to guarantee adequate social, health and medical services and health promotion to everyone. In other words, it is the constitutional duty of the public authorities to provide equal access to high-quality healthcare and disease protection (EU-Healthcare 2020).

In Finland, municipalities are responsible for organizing and financing healthcare, although this responsibility will be transferred to the regional level beginning in 2023. A municipality can organize services by providing them directly or in collaboration with other municipalities, or by purchasing services from private companies or non-profit organizations.

Healthcare services are divided into primary healthcare and specialized medical care. Primary healthcare services are provided at municipal healthcare centers. Specialized medical care is usually provided at hospitals. Municipalities form hospital districts that are responsible for providing specialized medical care in their area. In addition, joint municipal authorities belong to one of five catchment areas for highly specialized medical care.

The national hospital system delivers high-quality care for acute conditions, but there is a recognition that key challenges include improving primary care for the growing number of people with chronic conditions, and improving coordination between primary care and hospitals.

The Finnish healthcare system divides people into two main categories. Occupational primary healthcare is available for employed people. Those outside the labor force – such as the unemployed, temporary workers and self-employed people – rely on the public healthcare service, which has fewer resources and offers fewer services. As a result, socioeconomic inequalities in health outcomes persist.

Citation:
“Government Resolution on the Health 2015 Public Health Programme.” Helsinki: Publications of the Ministry of Social Affairs and Health, 2001;
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“Socially Sustainable Finland 2020. Strategy for Social and Health Policy,” Ministry of Social Affairs and Health, 2014;
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Tiirinki H, Tynkkynen LK, Sovala M, et al. 2020. COVID-19 pandemic in Finland – Preliminary analysis

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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 medicine 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 implemented by Macron in 2018. An ambitious plan to reform the healthcare system was announced in September 2018. 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 rerouting 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.

The pandemic has further aggravated the crisis at the country's public hospitals. At the beginning, some regions, particularly in the country's eastern territories, did not have enough beds equipped to handle the most severe COVID-19 symptoms. Support from neighboring countries (Germany, Switzerland) helped the system get over the peak of the crisis. On the whole, the public system has shown sufficient resilience, but at time of writing, is on the verge of implosion in spite of a massive injection of money. Not only there are not enough nurses, but many have resigned

either because salaries were insufficient, or because they had moved to bordering countries (Luxembourg, Switzerland). Others still had simply resigned due to exhaustion. In spite of an overall increase in salaries after years of freeze, the malaise within the medical professions is far from being addressed, as it results from complaints about management and organization, insufficient medical and non-medical staff, and difficult working conditions

Citation:
OECD: France: Country Health Profile 2021
https://read.oecd-ilibrary.org/social-issues-migration-health/france-country-health-profile-2021_7d668926-en#page3

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, which are highly autonomous with respect to designing their own organizational system. 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.

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.

Preventive healthcare programs are effective and well publicized in some regions (especially in Tuscany, Veneto and Emilia Romagna, and other northern and central regions), but are much weaker and less accessible to the average healthcare user in other regions (e.g., Calabria and Sicily).

During the COVID-19 pandemic, some weaknesses in the healthcare system emerged. It became clear that in some regions (especially in Lombardia, Piemonte and Friuli Venezia Giulia, and in most southern regions) the organizational delivery of healthcare was too heavily centered on large, high-quality hospitals, while proximity assistance delivered by family doctors and local hospitals was insufficient.

Citation:
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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). The Bloomberg Healthiest Country Index ranked Japan at fourth place in 2021. Infant-mortality rates are among the world's lowest (2 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 about 40% lower than that found 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.

Although Japan has fared comparatively better than other OECD countries in terms of COVID-19 cases and deaths, the pandemic has nevertheless strained its healthcare system. The political fallout of the pandemic has also been serious. The Abe administration was widely criticized for its poor handling of the COVID-19 outbreak in 2020, and in 2021, Prime Minister Suga was forced to resign only a year after assuming the position largely due to his administration's decision to hold the Tokyo Olympics and the slow response to the pandemic prior to the event. Japan was also slow to roll out vaccination, which did not begin until the summer of 2021. By the end of the year, though, over 70% of the population were reported to be fully vaccinated. Challenges for the healthcare system also include the need to contain costs, enhance quality and address imbalances. The national health insurance program continues to show a structural deficit despite additional fiscal support that was 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 room for improved focus and coordination.

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Lithuania

Score 7

In Lithuania, some health outcomes are among the poorest in the EU. Lithuania has among the bloc's lowest expected years of healthy life at birth, as well as one of the lowest life expectancies. The situation for males is particularly bad – the gender life expectancy gap in 2020 was the largest in the EU (at nearly 10 years).

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 7% of GDP in 2019, below the EU average of 9.9%. 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 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. Although the two liberal parties in the new coalition which came to power in 2020 have proposed relaxing alcohol consumption restrictions, the parliament and the government have refused to adopt the measures.

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. The current coalition government intends to reform healthcare networks to improve the sector's inclusiveness and cost efficiency, but it is unclear whether these plans can gain the necessary support in the parliament. The government's plan to use some of the Recovery and Resilience Fund money allocated by the EU to Lithuania for reforms in the healthcare sector may provide an additional incentive to pursue reforms and maintain continuity after the next parliamentary elections.

Another major problem is corruption in the healthcare sector. The sector continues to be plagued by a culture of informal payments and "special connections." Furthermore, a case of suicide by a medical practitioner in 2021 led to public discussions of rampant mobbing in the system.

The COVID-19 pandemic resulted in massive challenges to the healthcare system. To some extent, the inefficiency of Lithuania's healthcare system has turned out to be a slight advantage due to the overcapacity of hospital beds. According to The Economist, Lithuania experienced one of the world's highest excess death rates during the pandemic. As for vaccination, Lithuanians have been more reluctant than most Western Europeans, but the country actually has one of the highest rates in Central Eastern Europe.

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

Malta

Score 7

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 an extensive list of chronic diseases (e.g., high blood pressure and diabetes). Couples are entitled to IVF services, which had a success rate of 18.38% in 2020, 4.20 percentage points lower than in 2019. This is in part due to the lack of pre-implantation genetic testing. The government also supports oncology patients, providing otherwise expensive treatments for free.

Although Malta has experienced the largest real-terms growth rate in total health spending in the European Union over the last 10 years, its public funding healthcare share remains low at 63.5% when compared to the EU average of 79.7%. Health-

related public expenditure was increased by an additional €130 million during 2020 to cater for pandemic-related expenses. Despite the island's small size, Malta implemented a robust COVID-19 prevention and containment strategy. Ad hoc hospital facilities were set up, an efficient network of drive-thru testing facilities provided free access to swab tests from February 2020 onward and the country was declared the nation with the world's highest vaccination rate in 2021.

The crowd-sourced data platform Numbeo currently ranks the Maltese healthcare system 17th among 36 European countries. However, gaps in the system are still prevalent. The state-run mental health hospital is regarded as providing sub-par services, abortion remains a criminal offense and the country consistently holds one of the highest obesity rates in the European Union. The COVID-19 pandemic has highlighted structural weaknesses in the healthcare sector, including low hospital capacity and insufficient investment in prevention, which accounted for 1.3% of total healthcare spending in 2018, which is less than half the EU average of 2.9%. Strengthening health promotion and prevention, and filling gaps in the healthcare workforce are key priorities. Commitments to enhance the use of digital healthcare, ongoing reforms to primary care, and investment in physical infrastructure and the healthcare workforce will help to build a more resilient healthcare system. Ensuring access to innovative medicines is a major challenge in Malta and has been a policy priority.

Malta fares well in terms of self-reported unmet need for medical care due to financial reasons with just 6% of the total population reporting such a need, compared to the EU average of 13%. Much has been done to reduce patient waiting times and it was recently announced that surgery waiting lists have been halved. In addition, 89% of the Maltese population in the highest income quintile report being in good health, compared with 58% of those in the lowest. These income-based disparities were much larger in Malta than on average in the European Union.

Healthcare delivery in Malta is dominated by the public sector with only a small number of private hospitals. Malta 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. Private and public GPs act as partial gatekeepers to public outpatient hospital services. However, many people choose to seek outpatient care directly from private specialists without a referral, often to circumvent long waiting lists for certain specialists in the public sector, essentially creating a de facto two-tier healthcare system. Strengthening primary care and the provision of outpatient services has been high on the government reform agenda in recent years.

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, the National Audit Office has recently identified more than 60 contractual breaches and gross negligence.

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Times of Malta 02/01/2022 '60 Breaches'
EU Commission: State of the Health in the EU Malta 2021

Norway

Score 7

Norway has an extensive healthcare system that provides high-quality services to its resident community. All residents have a right to publicly provided services if needed. This applies both to treatment at hospitals organized as state enterprises, as well as long-term care services provided by local authorities. There is a patient copayment system involving a upper limit of NOK 2,921 per patient per year. Local care services also include copayments that are set at local levels. Within this system of universal health insurance there is an anomaly: Dental healthcare is a market system, in which the state pays for children and a few other groups only. Despite the role of copayments and market elements, the system as a whole provides high-quality services for the entire population. Social inequality persists with regard to health and longevity. However, these inequalities are better explained by lifestyles and occupational hazards than by unequal access to and quality of the health services provided.

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 five healthcare regions that were tasked with managing the provision of services. The objective of

the reform was to institute a stricter budget discipline by streamlining healthcare services and promoting regional coordination. In recent years, a reform 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 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

Sweden offers universal healthcare regardless of employment status through a single-payer, tax-funded system. Healthcare is regulated and controlled at the national level, while the planning, financing and provision of healthcare services, including specialist and hospital care, is the responsibility of the 21 regions. Healthcare spending per capita was the fourth-highest in the EU in 2019, or third-highest if counted as a share of GDP. Even though the growth in public spending had not been modest in the years leading up to the pandemic, the government increased it substantially in 2020 and 2021 as part of the response to the COVID-19 crisis (OECD, 2021).

Primary healthcare is provided in local healthcare centers. There has been some degree of privatization when it comes to local healthcare centers, but hospitals are publicly owned (Blomqvist and Winblad 2014; Rönnestad and Oskarsson 2020; see also Sparf and Petridou 2021). The number of people with private health insurance has increased considerably in recent years, though it remains marginal (OEDC, 2021). Regardless, it presents a concern when it comes to equitable access to services.

The Swedish healthcare system is based on the premise that healthcare must be egalitarian, accessible, evidence-based, effective and based on people’s individual needs. Accessibility is one of the premises of good care quality according to the Health and Medical Services Act (Socialstyrelsen 2020). Despite this mission, there have been intractable problems with accessibility. The picture is nuanced, however. On the one hand, during the first 12 months of the pandemic, only one in six people reported any unmet needs with regard to medical care, which is lower than the EU average. The reason for this may be the step-up in teleconsultation (and digital tools had already been widely used) as a concerted effort to combat the consequences of the pandemic. On the other hand, excessive waiting times for specialist consultations and non-urgent surgeries have been a staple of the Swedish healthcare system (OECD, 2021).

The key challenge is a governance problem. Healthcare is driven by three contending sources: elected officials, the medical profession and the market. These three sources 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.

Responses to remedy the problems plaguing healthcare have spanned decades and include changes in legislation (including the waiting-time guarantee), continuous national assessments of waiting times, and contractual agreements between the government and the regions (Socialstyrelsen 2020). Pre-pandemic waiting time rules for care were as follows:

• An individual seeking primary healthcare shall be able to contact a primary healthcare provider on the same day.
• An individual seeking primary healthcare shall have a medical opinion by a doctor or other primary-care physician within three days.
• Those needing specialist healthcare shall not wait more than 90 days for a visit after a referral has been sent out.
• Those in need of an operation or other specialist treatment shall not wait for more than 90 days (Socialstyrelsen 2020). Faced with a longer waiting time, one has the right to seek care in a region other than the region in which one is registered. Waiting times are reported in a database and are made available to the public. In practice, this does not provide solutions, but it increases the transparency of the system. Indeed, one may travel to a different region to receive care, but that is hardly a realistic option for many patients. Furthermore, this does not always entail shorter wait times.

Compared internationally, people in Sweden wait longer for access to primary care. Moreover, they typically do not have a regular physician, though they have a regular local healthcare center. However, increasingly fewer people in Sweden feel that the physician they meet is aware of their medical history. Additionally, people with complex health problems report coordination failures that result in dissatisfaction with the healthcare they receive (Inspektionen för vård och omsorg 2020; Myndigheten för vård-och omsorgsanalys 2020).

The pandemic has exposed (and deepened) the existing lack of qualified personnel. There exist regional variations, but for example, 19 of 21 regions report that they lack nurses, while many regions also report a paucity of psychologists, dentists, delivery and X-ray nurses, and specialist doctors, with rural areas having greater shortages than big cities (Inspektionen för Vård och Omsorg, 2021). The findings of the Coronavirus Commission concur that the health system was able to respond effectively to the pandemic only by repurposing scarce personnel from other activities, and by delaying other healthcare services and procedures (Coronakommissionen, 2021).

The Swedish response to the pandemic garnered international (and some domestic) criticism (for a discussion, see Coronavirus Commission, 2021; Petridou, 2020; Zahariadis et al. 2021). The Coronavirus Commission (Coronakommissionen, 2021) generally posits that the response to the pandemic was slow, and it is true that

COVID-19 death rates in Sweden were higher than those in other Scandinavian countries, overwhelmingly within the elderly population (OECD, 2021; Petridou 2020). However, life expectancy is higher than in most other EU countries, even accounting for the spike in deaths in 2020, while gender and social inequalities are not as prominent as elsewhere when it comes to life expectancy. The Public Health Agency of Sweden expects that this picture will change somewhat since the excess mortality due to the pandemic was higher among lower income and immigrant populations (OECD, 2021; Folkhälsomyndigheten, 2021).

In summary, the healthcare system in Sweden is sound and provides good quality care to all citizens, but it is still characterized by labor shortages, and healthcare services suffered due to the pandemic.

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Turkey

Score 7

Thanks to a series of healthcare reforms implemented since 2003, Turkey had achieved near-universal health insurance coverage by 2014, improving equity in access to healthcare nationwide. The vaccination program has been broadened, the scope of newborn screening and support programs has 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 remains keeping costs under control as demand for healthcare increases, the population ages and new technologies are introduced. Total health expenditure rose to TRY 201 billion in 2019, with a 21.7% increase in comparison to 2018. The total health expenditure as a share of GDP increased from 4.7% in 2019 to 5.0% in 2020. The rate of public health expenditure to total health expenditure was 79.2% in 2020, while private-sector health spending consisted of 20.8% of all expenditure.

In 2020, a total of 1,534 hospitals actively served patients. From 2019 to 2020, the number of actively used hospital beds increased by 13,678, reaching 251,108. The number of adult intensive care beds rose from 25,364 to 32,663. For the same period, the total number of physicians increased from 160,810 to 171,259, while the number of healthcare personnel increased from 1,033,767 to 1,142,469. Adequate payment of medical staff, however, remains a pressing issue.

To tackle the pandemic, the Ministry of Health attempted to increase the quality of health facilities and protect public health in accordance with the EU directives on communicable diseases and WHO international health regulations. Since the outbreak of the pandemic, Turkey has usually had enough capacity with regard to protective materials, disinfectants, masks and ventilators.

By December 2021, more than 9 million people in the country had been infected with COVID-19, and nearly 79.000 people had lost their lives in connection with the disease. The country’s comprehensive vaccination program started in January 2021. As of 25 December 2021, more than 128 million doses of the vaccine, mainly of Chinese origin, had been administered. This means that 82.7% of citizens over 18 were fully vaccinated, yet were largely insufficiently protected against the virus and its variants. Turkey is executing seven vaccine development projects at the same time. The inactivated TURKOVAC vaccine, developed by the Health Institutes of Turkey and Erciyes University, was permitted for emergency use in December 2021.

Healthcare access is equitable. Turkey, in coordination with WHO/Europe, assists in providing healthcare services to refugees and migrants. The government has employed 4,000 Syrian health workers. More than 97 million polyclinic services were provided to Syrians, and the number of surgical operations reached 2.6 million.

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Cyprus

Score 6

The General Health System (GESY) started operation in June 2019 and, from June 2020, has gradually offered an increasingly full array of services. Healthcare entered a new era with services provided to all residents. This replaced the previous unregulated system, which suffered from the highest rates of out-of-the-pocket spending in Europe, long waiting times, and inequalities in access and inefficiency.

The system responded well to the challenges posed by the pandemic, with limited impact on health in general and a low number of deaths. Despite constraints and deficiencies affecting the quality of healthcare, the state of health in Cyprus is better than on average in the EU27. In 2019, the infant mortality rate was 2.6 per 1,000 live births, and life expectancy at birth was 80.1 years for men and 84.2 for women.

The major challenges facing the system include proving the system’s resilience in the face of the pandemic, securing adequate and sustainable funding, and becoming fully autonomous and self-sufficient within five years (i.e., by mid-2024). However, some critics have pointed to cases of abuses of the system, which increases spending beyond the amount budgeted. Both the IMF and the European Commission have expressed concerns and warn that increased spending presents, among other things, a risk to public finances.

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Iceland

Score 6

While the healthcare system in Iceland is efficient and of a high quality, 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. There is limited political support for easing the situation by allowing the hospital to independently raise funds through, for example, patient service fees similar to those charged by private clinics. The resulting shortage of nursing and other medical staff increased the work pressures on existing staff, including their hours of work. Despite these difficulties, 79% of Gallup respondents expressed trust in the healthcare system in early 2021, almost one year into the pandemic.

The healthcare system is a top priority for the general public. In 2016, a third of the electorate signed a record-breaking petition challenging the government to devote 11% of GDP to healthcare provision, up from 8% of GDP. The government responded by increasing public healthcare expenditure to 10% of GDP. A considerable amount of money has also been granted to renovating old buildings around Reykjavík University Hospital over the last decade, an ongoing project.

Opinions remain sharply divided among political parties as to whether partial privatization of hospital services would be desirable.

Life expectancy in 2019 was 83 years, the 18th highest in the world, up from 73 years in 1960 when life expectancy in Iceland was second only to that of Norway (World Bank, 2021). Even so, life expectancy in 2019 was about three to four months less than in 2012, a seven-year stagnation that has not been recorded previously in Iceland. Twice before, a four-year stagnation had followed an adverse 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.

As in education policy, equity issues concerning access to and provision of healthcare are mostly related to regional differences. Stiff political opposition to increased private enterprise in healthcare provision – opposition to the partial Americanization of Iceland’s essentially European model of healthcare – stems mostly from concerns about equal access. Even so, the share of private clinics in healthcare provision continues to rise.

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Netherlands

Score 6

In 2020, the Dutch hybrid healthcare system was subjected to the stress test of the COVID-19 pandemic. Both the vulnerabilities and the strengths became highly visible and gained importance. Never before has the healthcare system received so much attention and public scrutiny. Never before was the healthcare system the central driving force of all government policymaking for two years already. The healthcare system functioned in crisis mode, with priorities gradually shifting from homes for the elderly to the availability of intensive care beds, balancing COVID-19 treatment and general care. Mass vaccination was the key concern of 2021, with an extra mobilization for a booster campaign at the end of the year. Prevention tactics and long-term strategy for living with COVID-19 are yet to be developed.

On the positive side, the Netherlands performs well on key health indicators, such as life expectancy, self-reported health status and patient satisfaction. The system is generally inclusive: the number of citizens who forgo medical treatment due to affordability is the lowest in the OECD (5.8%). In addition, in spite of the many concerns in the sector, long-term elderly care is highly inclusive and affordable. The proportion of elderly people in long-term care centers is decreasing (115,000 people in 2019), however, due to the policy shift to extramural care, people in care today generally have relatively more serious health issues and needs. Since the increase of the copayment for nursing home care, many patients have delayed their admission to care homes. They rely longer on home care and as a result, the total cost of care has slightly decreased. The added burden of expenditure and efficiency issues, as well as the chronic shortage of staff, made elderly care homes a particularly vulnerable part of the healthcare system during the coronavirus pandemic. Many homes for the elderly were hit hard, with high numbers of deaths early in the pandemic. In addition, intramural care for the elderly relied heavily on volunteers and family members, and the burden of keeping basic operations going increased after the lockdown.

Prevention in the Netherlands is organized through general practitioners who act as gatekeepers to healthcare services. These GPs maintain a high level of trust among the Dutch population, which remained stable at around 95% during the pandemic. The general policy response to the system, however, effectively bypassed general practitioners, as the focus was on intensive-care units, hospital beds, ventilation devices and hospital staff. The shortage of general practitioners has become significant in some places, and structural solutions have not yet been found. Ongoing non-COVID-19-related care – which remained in the hands of general practitioners, but with limitations imposed by hospitals – has become problematic.

The focus on efficiency and cost containment in recent years has left the Netherlands with significant pressure on bed occupancy, a push to shorten the average hospital

stay and a need to plan routine procedures tightly, with little room for contingencies. The challenges presented by the COVID-19 pandemic – an increased number of long-term intensive care and hospital stays, varying and unpredictable care outcomes, and little control over the number of patients requiring hospitalization – exposed the vulnerability of the system. Furthermore, nursing and care staff are notoriously underpaid, overworked and in high demand, which proved to be an impediment to flexibility and the expansion of care during COVID-19 without jeopardizing other necessary care. The various professional organizations (e.g., for specialists, intensive-care physicians, general practitioners, nurses and care workers) all have different and sometimes contrary stakes, both financial and organizational. Hygiene, prevention, testing and vaccination tasks are in the hands of the municipal healthcare services, which adds another dimension to the complex task of coordination. Vaccination programs are voluntary, but the coverage rate is quite high in the Netherlands. In recent years, a decline in the vaccination rate of children has prompted debate about mandatory vaccinations as an access requirement for childcare. Nonetheless, the Netherlands vaccination campaign has been largely successful. Unvaccinated groups are most typically found within migrant enclaves, religious groups and a group that chooses not to trust the government.

Citation:
Kiezen voor Houdbare Zorg. Mensen, middelen en maatschappelijk draagvlak (rapport nr. 104, WRR, 2021)

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

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Portugal

Score 6

Portugal has an inclusive national health system that covers the entire population. Access to hospitals is mediated by relatively low fees, with exemptions for low-income households and other groups. There is some inequality in access to primary healthcare, with about 10% of the population not having a steady GP. However, while this creates an additional barrier to accessing primary healthcare, it does not exclude access altogether.

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. In the context of the pandemic, this has been reflected in the country's stellar performance in terms of vaccination, with the country registering the highest vaccination rates in the world in September 2021.

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 for 2019 indicates that Portugal has the sixth-lowest number of healthy years after 65 for women and the ninth-lowest for men in the European Union, both constituting a drop of one position in the ranking vis-à-vis 2017.

The period under review saw the confluence of two distinct issues: First was the pressure exerted by the pandemic on the national health system; and second was the continued financial pressure to curb public expenditure, with the healthcare sector affected by de facto restrictions on expenditure. The combination of these forces led to reductions in some services and to resignations by medical directors in protest. However, the situation appears to be more positive than in the previous report, as the government increased recruitment of doctors and nurses into the health system in 2020, with an increase of over 1,000 doctors (an increase of 6%) and of over 1,750 nurses (increase of 3.7%).

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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, and treasured, 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., prescriptions for pensioners and dental care for the poor) 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 occurred repeatedly as hospitals struggle to cope with emergency admissions and have to cancel routine operations to free bedspace. This is partly because of population aging, but it 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. Reports regularly refer to a service that, while offering excellent clinical care, often struggles to cope. The quality of NHS services, monitored by the independent Care Quality Commission, is high, as reported by the Human Development Index (HDI) health indicator. The financial position of a number of hospital trusts is rather precarious and has been the subject of concern in recent years, 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 allows patients to choose a general practitioner without geographic 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. However, there has, to date, been little improvement, although the government has now earmarked an increase in national insurance to pay for enhancements in social care once the pandemic-induced backlog in healthcare is dealt with.

The NHS is invariably at the center of heated public debates, with competing narratives again evident in the 2019 election campaign. The pandemic posed

substantial challenges to the NHS, although the NHS coped and its popularity was used to leverage the government's lockdown message ("stay home, protect the NHS, save lives"). In spite of sizable increases in funding, elective surgery had to be postponed for many conditions, and delays in referrals and diagnoses for other diseases risked poorer health outcomes. In the early stages of the pandemic, shortages of personal protective equipment, inadequate testing capacities, and limited "track and trace" capabilities added to the pressure on the service. But subsequently, the early rollout of vaccinations, a high vaccine take-up rate and rapid innovation in methods for treating COVID-19 patients enabled the NHS to avoid being overwhelmed. Nonetheless, the United Kingdom suffered a comparatively high rate of deaths of 2,574 per million inhabitants. This rate is a little lower than in Belgium or Italy, but around a quarter higher than that seen in countries such as Austria or France.

The end of "free movement" after leaving the European Union has negatively affected the retention and recruitment of healthcare workers from EU member states, which UK healthcare services at all levels relied on in the past. There is also a dependence on workers from elsewhere in the world. Although plans to boost the training of indigenous staff are being developed, it will be some time before they do much to reduce the dependence on foreign-trained staff.

Citation:
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United States

Score 6

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.

The COVID-19 pandemic stressed the massive inequalities at the center of the U.S. healthcare system. Immediately after become President, Biden signed many executive orders meant to reserve some of the Trump-era policies on healthcare meant to weaken the ACA. Signed in March 2021, the American Rescue Plan also featured temporary increases in premium tax credits and other measures that should improve access to healthcare coverage. The administration would like these policies, which are only in effect until the end of 2022, to become permanent, which would have a positive impact on healthcare provision in the United States.

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/

Ireland

Score 5

Quality:
While the public healthcare system is regarded as having weathered the storm brought about by the COVID-19 pandemic relatively well, the public perception of the Irish healthcare system remains very negative amid cases of negligence, incompetence and a lack of access, which are highlighted regularly in the media. However, objective indicators of health outcomes are relatively good in Ireland and continue to improve. This is despite the increased level of obesity, problems with excessive alcohol consumption, fairly high levels of smoking and the pressure on healthcare budgets. Indeed, Ireland now has the highest life expectancy of any EU member state. Those born in 2020 can expect to live to 82.6 years, compared to the EU average of 80.4 years (Moloney, 2022). This is consistent with the Irish ranking on the U.N. quality of life indices, where the country ranked second (after Norway) in 2020 (O' Leary, 2020)

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 cause serious problems and attract vociferous negative publicity. Monthly data on waiting lists are now published by the Health Service Executive (HSE) and a reduction in waiting times has been (repeatedly) declared a government priority.

Inclusiveness:
The Irish healthcare system is two-tiered, with slightly more than half the population relying exclusively on the public healthcare system and the rest paying for 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, access to primary (general practitioner) care was made available free of charge to people aged under six or over 70, regardless of income. In the 2016 budget, this was extended to all children under the age of 12 and successive governments have pledged to raise this threshold in the years ahead. This budget also significantly increased the funds available to the public healthcare system, although cost over-runs and financial strains will undoubtedly continue to plague the system. Government spending on healthcare reached the record level of €21 billion in 2022. Despite this, there remains a deep level of dissatisfaction with the public system, which is marked by very long waiting periods to see consultants, and regular waits of up to 24 hours for treatment in hospital accident and emergency units.

Cost efficiency:
The Irish healthcare system is costly, despite the relatively favorable (that is, relatively young) age structure of the population. Ireland emerges as having the sixth-highest level of healthcare expenditure relative to GDP within the European Union (OECD, 2021). In several reviews of its "bailout" agreement with Ireland between 2011–2013, the Troika expressed concern about continuing over-runs in healthcare spending, which 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 Claims Agency.

COVID-19 costs to the healthcare service were €640 million over budget in 2021, although this was offset by underspending on recruitment and missed targets to increase hospital and homecare capacity. At the time of writing, the HSE is understood to expect a total deficit of between €80 and €140 million for 2021, in the €21 billion health budget (Bray, 2022). 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 or further increases in inflation, given the alarming healthcare over-runs to date, there is the potential for a major fiscal crisis associated with this sector.

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

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 agreements of both the Šarec and Janša governments. For both governments, however, progress has been slow. Under the Šarec government, the coalition parties held different views on reforms, which were difficult to reconcile. The outside coalition partner, the Left (Levice), for instance, pressed hard to expand the public health insurance scheme to the detriment of the supplementary health insurance funds. When the coalition parties disagreed, the Left withheld its support for the government, which led to its demise. Under the Janša government, the Long-Term Care Act was finally adopted, after being prepared and discussed for almost two decades. However, the exact budget for long-term care has yet to be decided. In addition, the Janša government presented ambitious plans to tackle the issue of healthcare waiting times, but this has largely been postponed by the COVID-19 pandemic. The pandemic put the entire healthcare system under substantial distress, but – after expanding the capacity of ICUs – the system managed to cope with the surge in admissions during the first four waves of the pandemic. Though healthcare spending has increased steadily, reaching $2,283 PPP in 2019, it is still below the EU average.

Citation:
European Observatory on Health Systems and Policies 2021: Slovenia: health system review 2021. Health Systems in Transition, Vol. 23 No. 1https://eurohealthobservatory.who.int/publications/i/slovenia-health-system-review-2021

European Observatory on Health Systems and Policies 2021: Health systems review and policy brief on EU support tools launched in Slovenia. 19 October 2021 News release. https://eurohealthobservatory.who.int/news-room/news/item/19-10-2021-health-systems-review-and-policy-brief-on-eu-support-tools-launched-in-slovenia

Croatia

Score 4

Most healthcare services in Croatia are provided by the state 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 low employment rate and the country's demographic aging have together contributed to a persistent financial deficit within the system. On the upside, the system is broadly inclusive, but patients often found themselves on long waiting lists for treatments and check-ups even before the pandemic.

In this regard, Croatia's healthcare system represents one of the country's biggest ticking bombs with regard to long-term fiscal sustainability and social cohesion. As of this writing, the outstanding debt of the healthcare system (predominantly to wholesale pharmacies) amounted to HRK 4.5 billion, and had risen rapidly since the beginning of 2021 at a monthly pace of HRK 283 million. This has occurred despite the fact that the number of non-COVID-19 treatments has been significantly reduced. Many patients are complaining that their access to healthcare has deteriorated during the pandemic. Furthermore, since joining the European Union in 2013, the number of physicians and other medical professionals leaving Croatia has reached alarming proportions.

The dire state of the Croatian healthcare system has persisted in spite of repeated financial injections over the course of 2021, to the tune of HRK 4.1 billion, by the Ministry of Finance. Without any meaningful reform on both the expenditure and revenue sides of the budget, the system will periodically stray from one crisis into another, shifting steadily escalating fiscal costs to future taxpayers. Furthermore, there is a significant risk of future supplier boycotts, such as the one dating from April 2021, when wholesale pharmacies halted both medicinal products and drug deliveries to state hospitals as part of their bargaining strategy with the government. The vendors were seeking to collect outstanding dues and shorten the average maturity of debts from whopping 210 to 180 days.

The government will probably use its current strong foothold to press ahead and impose limited reforms in 2022. However, timid proposals by the minister of health dating from autumn 2021 included increasing out-of-pocket expenses for uninsured patients, introducing obligatory healthcare contributions for workers who are less than 30 years old, and attempting to push off a far higher share of sick leave and maternity benefits to employers. The proposals avoided any mention of cost optimization, which is the crux of the problem. In addition, in the 2012-2019 period, the current health expenditure per capita rose at a pace two times faster than the

average expenditure for all EU member states, albeit from a relatively low level. Ceteris paribus, the aforementioned reforms will almost certainly fall short of introducing the most needed reforms due to opposition from many vested interests such as hospitals, associations representing medical personnel, private suppliers of medical equipment, and so on. Party patronage can be often observed in the way hospitals' governing councils are formed, and in their influence on the appointment of hospital directors. Governing councils are disproportionately staffed by representatives of county and city governments. Politics often trumps competence and coherent planning.

The Croatian healthcare system faces serious challenges due to a lack of coordination between managers and physicians. The role of politics in appointing hospital directors is too discretionary, and directors often lack a clear mandate to steer their institutions. In addition, there is essentially no coherent set of criteria for evaluating their performance, and no plans to develop such criteria. As a result, management of the healthcare system is vulnerable to party patronage. Such practices tend to weaken inclusiveness and equitable access. Finally, the system is overly fragmented and does not reap economies of scale in public procurement.

Access to care is adversely affected by regional variations in the range of care provided, the quality of services suffers from weak organization, a lack of digitalization and the inadequate monitoring of treatment outcomes. Healthy life expectancy amounts to 68.6 years, one of the lowest such levels in the EU. Unfortunately, Croatia has one of the highest obesity rates, the highest level of alcohol consumption per capita and the highest share of smokers in the population.

All things considered, it is hardly surprising that in 2018 Croatia experienced 371 deaths per 100,000 inhabitants from treatable and preventable diseases, as well as from conditions that could have been avoided either through better healthcare and/or better public health interventions. This number ranks Croatia at 20th place in the EU. This number will be much grimmer when the figures for 2020 and 2021 arrive. Unfortunately, Croatia has done a poor job of vaccinating the population aged 60 or older against the coronavirus; at the end of 2021, more than 20% of this cohort remained unvaccinated. Overall, the vaccine rollout was slow during 2021. This conclusion is corroborated by the upsetting fact that at the beginning of 2022, Croatia had the tenth-highest figure globally in the number of coronavirus deaths per million inhabitants.

Greece

Score 4

Since the onset of the pandemic crisis in Greece, spending on public healthcare has increased. In 2019, Greece spent $2,238 per capita on healthcare – more than one-third less than the OECD average. Also in 2019, healthcare expenditure amounted to 7.8% of GDP (EU-27 average: 9.9%). Greece trailed behind other EU member states

on healthcare spending as a result of massive cuts during the economic crisis of 2010–2018. 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 average.

Public spending on healthcare is often above targeted expenditure because of mismanagement of the public procurement of medical equipment and supplies by public hospitals, and pressure exerted by pharmaceutical companies and private healthcare providers on healthcare practitioners and public hospitals. In order to counter this trend during the economic crisis, the government introduced a "claw back" requirement. The government collected from healthcare providers all funds spent over the legislated ceiling for public spending on pharmaceuticals and other healthcare services. This practice was continued in 2020–2021, despite arrears from previous years.

Private spending is fueled by the supply of healthcare practitioners and the availability of private diagnostic centers. In 2019, Greece had 6.1 practicing physicians per 1,000 people, 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. These outcomes result from the country's haphazard medical school system. 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 rural or remote areas, as most doctors prefer to work in the hospitals of the two largest cities, Athens and Thessaloniki. Moreover, Greece had one of the EU-27's highest shares of MRI units and medical scanners per one million people.

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.

Seeking to balance the oversupply of private medical services and the uneven structure of the public hospital system, in 2017, the government legislated a system of local public healthcare units (TOMY). The new system should have marked a major improvement over the past, moving in the right direction by requiring that practicing doctors become family doctors (i.e., general practitioners responsible for a few thousand insured citizens each). Implementation of the new system started slowly in 2018–2019, but was halted thereafter due to the change of government and the limited interest of doctors. 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. In 2020 and 2021, the government increased the primary healthcare workforce, but newly hired doctors and nurses were largely channeled toward public hospitals, which in the period under review faced the challenge of treating COVID-19 patients.

In order to meet the demands presented by the COVID-19 pandemic, Greece doubled its intensive care unit bed capacity and occupancy rates never exceeded full capacity.

In 2020, the government imposed two strict lockdowns to prevent the spread of COVID-19 through the population and started a nationwide program of vaccination. By the end of 2021, the proportion of fully vaccinated people reached a ceiling of 66% of the population, while only 35% had received a booster (third dose). A total of over 21,000 COVID-19-related deaths occurred in 2020–2021 – close to the EU average.

In general, the country performed relatively well during first waves of the COVID-19 pandemic in 2020, but underperformed in 2021. Meanwhile, while clientelistic structures in the provision of healthcare remained intact, there was 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:
Eurostat data on public healthcare spending for 2020 is available at https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics

European Commission / OECD, State of Health in the EU: Greece Country Health Profile 2021 available at https://www.oecd-ilibrary.org/social-issues-migration-health/greece-country-health-profile-2021_4ab8ea73-en

Data on out-of-pocket expenses on health and on the number of doctors is available on this SGI platform.

The law establishing the local healthcare units (known as TOMY, see Law 4486/2017) was passed in August 2017.

EU comparative data on Covid-19-related cases and deaths is available at https://qap.ecdc.europa.eu/public/extensions/COVID-19/COVID-19.html#global-overview-tab

Comparative data on vaccinations is available at https://ourworldindata.org/covid-vaccinations?country=GRC

Comparative OECD data: OECD, Health at a Glance: Europe 2020 available at https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2020_82129230-en

Latvia

Score 4

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. Life expectancy remains low in Latvia compared to other EU countries, mainly due to low public spending on health, issues with the accessibility of care and the high prevalence of behavioral risk factors.

The national health system (NHS) in Latvia is subject to strong government oversight and offers universal coverage of the population, a general tax-financed provision of healthcare, and a purchaser-provider split. However, only 61% of total healthcare expenditure came from public funding sources in 2019, which is a considerably lower proportion than the average for the EU (80%). The system as a whole remains underfunded.

In terms of access, 4.3% of the population reported having forgone medical care in 2019 due to costs, travel distances or waiting times. This is above the EU average of 1.7 %. 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 is twice the EU average.

Since 2018, medical staff salaries have increased, on average, between 10% to 20% annually. In 2019, the average monthly salary among doctors was €2,003, and the current government plan foresees further wage increases, reaching a target salary of €3,833 in 2027.

Even though health expenditure per capita has increased by 75% since 2010, the OECD has noted that this level remains the fourth-lowest in the EU, and only 61% of health expenditure is publicly funded, which makes the share of out-of-pocket spending the second-highest in the EU.

The Ministry of Health has put strategic emphasis on prevention and health promotion. The National Action Plan on the Consumption of Alcoholic Beverages and Limitation of Alcoholism 2020-2022 is an example of this. However, the overall lack of resources has limited the effectiveness of these efforts.

Citation:
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Mexico

Score 4

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. 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. The government has been attempting to make healthcare more affordable and extend it to more people outside the formal sector. In order to expand the insurance principle, in 2003 the government set up the so-called Popular Insurance (Seguro Popular) program, which was 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 were still substantial problems in terms of funding, and serious transparency deficiencies.

In August 2019, President López Obrador announced a new program to improve the healthcare system. The Instituto de la Salud para el Bienestar (INSABI) was founded, replacing the previous decentralized Popular Insurance program. This new institution is supposed to improve healthcare provision for citizens that are unable to access existing social security systems. However, some experts have been critical, noting that the centrally organized INSABI will lead to further centralization and greater control of resources by the government.

With the world's third-highest number of deaths during the coronavirus pandemic, Mexico's healthcare system was hit hard. During the fight against the spread of the coronavirus, there were serious accusations from the opposition that the government was contributing to unnecessary deaths through negligent behavior, as well as through the politicization of the coronavirus vaccination campaign.

Citation:
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Poland

Score 4

The Polish healthcare system is generally effective, but underfunded and sometimes inaccessible (OECD/European Observatory on Health Systems and Policies 2021). 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 (23% of health care spending while the EU average is 16%). 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. Poland's health problems based on air pollution, tobacco consumption and poor diet are therefore difficult to handle.

During the COVID-19 pandemic, the shortcomings of the Polish healthcare system became evident. Initially, the government reacted quickly and pumped €1.7 billion into the system, reorganized hospitals into special COVID-19 clinics, bought respirators, provided more intensive-care beds, developed telemedicine options and paid an additional salary to employees in the healthcare sector. The handling of the second pandemic wave in autumn 2020 was less successful. Scandals around the purchase of tests and respirators forced the health minister to step down in August 2020 (Wanat 2020), and excess mortality in 2020 and 2021 was among the highest in the European Union (Tilles 2022). As part of the "Polish Deal," the government has announced an increase public healthcare spending from the current 6.5% to 7% of GDP by 2027.

Citation:
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Slovakia

Score 4

Slovakia has a mandatory health-insurance system that provides all residents with primary, secondary and tertiary care, pharmaceuticals and medical devices (OECD/ European Observatory on Health Systems and Policies 2021). 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. This comparatively low pre-pandemic density of doctors and nurses and workforce capacity constituted a major bottleneck in Slovakia's pandemic response.

During the 2016-2020 term, a planned healthcare reform failed. The then health minister Andrea Kalavská announced an additional €90 million investment in the healthcare sector and 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.

The new center-right government responded to the COVID-19 pandemic by trying to boost physical and human resources. Vaccination began at the end of 2020, but has progressed slowly. Building on the reform attempt in the previous term, the new center-right government also prepared a hospital reform, which was approved by parliament after much haggling in December 2021. This reform aims to ensure greater expertise and hospital specialization by redefining the roles and status of hospitals according to the care they provide to patients. Healthcare reform has featured prominently in the government's Recovery and Resilience Plan. Slovakia will receive €1.533 billion from the EU Recovery Fund to strengthen its healthcare system. These resources will be split into three parts: €1.163 billion for hospital, emergency and primary care (including optimization of the hospital network); €105 million for mental healthcare; and €265 million for long-term social and healthcare.

Citation:
OECD/European Observatory on Health Systems and Policies (2021): State of Health in the EU: Country Health Profile Slovakia. Paris: OECD, Brussels: European Observatory on Health Systems and Policies (https://eurohealthobservatory.who.int/docs/librariesprovider3/country-health-profiles/chp2021pdf/slovakia-countryhealthprofile2021.pdf?sfvrsn=f219e058_5&download=true).

Bulgaria

Score 3

Bulgaria is similar to other EU countries in terms of how its healthcare system is organized (i.e., it features private and public pillars) and financed (i.e., public spending on the system comprises 4.5% of GDP and private spending comprises 3.5% of GDP). Two features are somewhat specific for Bulgaria: financing is dominated by the National Health Fund (NHF, funded by taxes) and the system involves relatively high (46-47% over the last ten years) out-of-pocket payments (OPP) (NB: OPPs are common among most new EU member states, where the average rate is 25-30%).

As of December 2021, Bulgaria ranked second in the world with regard to COVID-19 deaths per one million population. The 148,000 COVID-related deaths registered in 2021 marks the country's second-highest number of deaths in one year on record since 1888; this was exceeded only by the 151,000 deaths resulting from war and influenza in 1918. The mortality rate in 2021 (22 deaths per 1,000) was the highest since 1919.

Before COVID-19, Bulgaria had one of the EU's highest numbers of hospital beds per 1,000 (616.8) and healthcare personnel numbers were also relatively high. However, medical staff in Bulgaria complained during the pandemic of being underpaid and underequipped. Private hospitals were excluded from the COVID-19 response system until February 2021. Throughout most of 2020, public testing and efforts to ensure sufficient supplies, equipment and medicine remained chaotic.

While the situation improved during the second half of 2020, the number of deaths in 2021 exposed several systemic weaknesses in the healthcare system. The overall management of the system, including analysis and healthcare finance statistics, remain poor. Bulgaria had one of the lowest vaccination rates in the EU. Over the last ten years, household spending (above contributions to NHF) on healthcare has grown by 39% – one-fourth of this in the period from 2020 to 2021. Out-of-pocket payments to public and private hospitals is high due in part to the limited accessibility of high quality and timely medical services. Lower income groups are practically excluded from having access to such services. According to estimates, about 20% of the population do not have health insurance and do not contribute to NHF. For some groups such as Roma, the percentage is about 55%. The reasons for this situation are not well studied, but this might be a side-effect of labor market regulations and other factors.

Citation:
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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. Life expectancy in Hungary is lower than in most of the country's EU neighbors, and disparities across gender and socioeconomic groups are substantial. Hungary has one of the highest avoidable death rates in the European Union. Healthcare has suffered 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 in search of better salaries. At the same time, the healthcare system remains excessively hospital-centric, and lacks a sufficient focus on primary care and prevention. Even very small hospitals are maintained, although they cannot operate efficiently – the fear of public protests

against the centralization of hospitals prevents necessary reform. Those who can afford it have sought treatment from the growing number of private healthcare institutions. Private medical institutions have been growing under the Orbán regime, as their high profitability has made them a good business opportunity for Fidesz oligarchs. This shift has also provided medical staff – both physicians and assistants – a major opportunity to earn extra income in addition to their poorly paid positions in state-run hospitals. But even for the less well-off, out-of-pocket payments have been high.

Despite a few announced reforms, healthcare was low on the priority list for the fourth Orbán government before the COVID-19 pandemic. Policymaking has suffered from the absence of a separate ministry tasked with addressing healthcare issues and the fact that the Hungarian Medical Chamber (Magyar Orvosi Kamara, MOK) has been loyal to the government rather than to the profession. When the COVID-19 pandemic hit, the government first reacted by introducing a number of emergency measures. It hectically sought to secure equipment and ended up buying too much equipment at overpriced rates. When the number of infections rose, the government sought to increase the number of available hospital beds and to boost capacities for care. In April 2020, Minister of Human Resources Miklós Kásler instructed hospitals to free up 60% of their beds (about 36,000 out of 60,000) for treating coronavirus patients almost overnight. Whereas in retrospect this measure appears vastly exaggerated, at the height of the first wave of the pandemic, this was obviously hard to know. However, the way the government carried out this policy tells a great deal about the nature of the Hungarian government and the state of the Hungarian healthcare system. The government simply ignored the opposition voiced by hospital directors and the patients who were sent home. In many cases, non-COVID-19 patients were discharged without adequate alternative care and others were required to share already-full rooms with other patients. The centralization, if not militarization of healthcare continued in the second half of 2020. The Medical Service Act, which entered into force on 18 November 2020, transformed the governance of healthcare (Albert 2021). The newly created National Hospital Chief Directorate (Országos Kórházi Főigazgatóság, Okfö) has become the ruling center of all medical institutions. Hospital directors have as a result lost their main decision-making powers, primarily on budgeting and employment matters. While public sector physicians have seen a strong increase in their wages, they have also been provided a new, almost military employment status. This allows Okfö and/or hospital directors to send them to work for other hospitals on short notice, and limits their opportunity to operate their own private practices and take a part-time job in the private healthcare sector. General practitioners, pediatricians and dentists working in primary care who are normally self-employed and not covered by the new law, as well as nurses, have called for pay increases similar to that of doctors in the public sector. The tremendous pressure of the COVID-19 pandemic on the weak and terribly underfinanced healthcare system has led to exhaustion among medical staff and has further accelerated the country’s brain-drain problem. From 2019 to 2020, the number of practicing doctors fell sharply from 41,282 to 37,188.

Since the end of 2020, the government's measures against the COVID-19 pandemic have largely focused on fostering vaccination. However, the government has lacked a clear vaccination strategy, and has not complemented vaccination efforts with mask obligations, social distancing and contact-tracing. As a result, infection and death numbers have been high, with the poorer strata having been hit most strongly.

Citation:
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Romania

Score 3

Romania is an upper-middle-income country with an ever-decreasing population, due to low fertility and high mortality, as well as high levels of migration. This has resulted in a relatively old demographic and an old-age dependency ratio – those over the age of 65 – of 27%. The life expectancy of Romanians (73 years) in 2021 remained below the EU average (81 years). Moreover, there is a gap in the quality of healthcare provision between urban versus rural areas. In rural areas, the mortality rate is 15.4 per 1,000 individuals, compared to 11.7 per 1,000 individuals in urban areas. For Romanian women, breast and cervical cancer cause the highest mortality rates for those aged between 15 and 49, with cervical cancer in Romania being at the highest rate in the region. Romanian public maternity wards have been accused of having a high degree of "obstetric violence, or the use of procedures that are not medically necessary (e.g., C-sections and episiotomies), and verbal and emotional abuse is prevalent. Furthermore, the rate of amenable mortality in Romania is the highest in the European Union for women and the third highest for men.

As a result of the Romanian government's handling of its healthcare woes, opportunities to improve health outcomes through the provision of essential services and public health interventions are pivotal for the improvement of the state healthcare system. Improvements in screening for cervical cancer (25%) can be made to catch up to the EU average (60%); measles vaccination rates (87%) trail the European Union's rate by 10 percentage points and the number of primary healthcare (PHC) contacts per person remains well below the EU average. More importantly, however, preventing flight in medical professionals to other EU member states remains a problem. There is an exodus of medical personnel, who head for employment elsewhere in the European Union, where they are offered better facilities and higher pay.

According to some doctors, almost 90% of the hospital budget is used to cover the salaries of the medical personnel, which increased in an effort to prevent brain drain. But this led to hospitals being unable to offer basic medication to patients, who need to cover it from their personal pocket. The funding allocation is not sustainable and did not result in the provision of cost-efficient healthcare.

As it pertains to coverage, the National Health Strategy 2014–2020 and the accompanying Action Plan 2014–2020 attempts to align Romania with the WHO's Regional Office for Europe and the European Commission to 1) improve public health and reduce the burden of non-communicable diseases; 2) ensure access to quality and cost-effective health services; and 3) cut the costs of healthcare systems, maintaining efficient ordinances. Under the present circumstances, however, the lack of furthering healthcare coverage has worsened the situation in Romania. Despite attempts by the government to improve the provision of public healthcare, most citizens avoid the program offered by the state, instead choosing to enroll in the private healthcare system. Despite more confidence in the private healthcare system, it also remains under fire for poor service provision, complex coverage plans and costly premiums. Consequently, Romania continues to struggle with high mortality rates in preventable or treatable diseases, such as diabetes, cardiovascular diseases, cancer, tuberculosis and hepatitis.

During the early months of the COVID-19 pandemic, the crisis completely congested the Romanian healthcare system. As a result, Romania activated a €400 million loan from the World Bank to help prevent and respond to the ramifications of the pandemic. Still, in late 2020, all 2,000 intensive care beds were occupied, and 50 critically ill patients had to be transferred to hospitals in Hungary and Poland. Much of the failure in curbing the rise in coronavirus cases is directly correlated to the low vaccination rate in Romania, standing at 30% – significantly lower than the EU average. Then Prime Minister Florin Citu's decision to relax restrictions was hugely popular in June, but this accentuated the stresses on the healthcare system, resulting in 15,000 daily cases in late 2021. Thus, the combination of a relaxed vaccination program and a laissez-faire approach to lockdowns by the government, worsened by the decision to sell "unwanted vaccines," has set Romania on a trajectory toward a healthcare crisis.

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