SOCIAL PROTECTION COMMITTEE ANNUAL REPORT 2018

REVIEW OF THE SOCIAL PROTECTION PERFORMANCE MONITOR AND DEVELOPMENTS IN SOCIAL PROTECTION POLICIES

Annex 3. JAF Health Country Analyses

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This annex contains extracts from the JAF Health country analyses and presents the main conclusions of the analyses, from a social protection perspective.

DATA FROM THE JOINT ASSESSMENT FRAMEWORK (JAF)

JAF Health currently includes 93 indicators agreed with Member States divided into six dimensions: 1) Outcome; 2) Access; 3) Quality; 4) non-healthcare determinants; 5) Resources; 6) Socio-economic.

JAF Health follows the foundations and structure of JAF, which was jointly adopted by the Employment Committee and the Social Protection Committee in 2010. JAF is an analytical tool based on a set of commonly agreed indicators showing good and bad performance towards the main Europe 2020 targets. This tool was developed to provide a transparent and understandable framework for tracking progress and monitoring the Employment Guidelines under Europe 2020. In the JAF methodology the values of each indicator are standardised, in order to put different indicators on the same scale. It was agreed to use the EU average as the mean. The standardised score is calculated as follows:

Standardised score indicator x =

*[(value of indicator x – EU average of x)/standard deviation across EU MS of x] * 10*

JAF includes both levels and 3-year changes (where available) for each indicator. Standardised scores for changes are calculated as follows:

Standardised 3-year change score indicator x =

*[(3-year change value of indicator x – 3-year change of EU average of x)/standard deviation of 3-year changes across EU MS of x] * 10*

Standardised scores for changes should be interpreted as relative changes with respect to the EU average[1].

The ISG agreed to be consistent with the EPM and SPPM methodology for the assessment of the results and for the identification of challenges and good outcomes. Consistently this note defines standardised scores:

a. between -7 and +7 as around the EU average (0);

[1] There may be cases in which a 3-year positive change in absolute values corresponds to a relative negative change of the standardised score.

b. from -7 to -13 or from +7 to +13 as **better (+) / worse (-) than the EU average** (depending on the polarity of the indicator);

c. smaller than -13 or bigger than +13 as **considerably better (++) / worse (--) than the EU average** (depending on the polarity of the indicator);

3-year changes are to be considered up to the latest available year. The reading of 3-year changes as around the EU average, better/worse or considerably better/worse follows is based on the same thresholds as for levels (see point a), b), c) above).

In the charts, the colours are assigned as follows:

- red if the standardised value is considerably worse than the EU average;
- orange if the standardised value is worse than the EU average;
- white if the standardised value is around the EU average;
- yellow if the standardised value is better than the EU average;
- green if the standardised value is considerably better than the EU average;

AUSTRIA

With health spending above the EU average (and projected to rise) and a relatively high number of physicians, most health outcomes in Austria are around the EU average, while healthy life years at birth are worse than average. Indicators on quality are generally good, with the exception of in-hospital mortality following AMI. In the context of a fragmented statutory health insurance system, administrative expenditure is above the EU average. Austria's complex health system has been reformed to improve governance. It provides quasi-universal coverage and unmet need for medical care is better than the EU average, although some people may remain uninsured (unemployed without entitlement to social benefits and irregular migrants). Lifestyle among young, in particular smoking and drinking, and obesity are an issue in Austria, while several measures have been taken to generally address public health challenges.

Resources, Coverage and Organisation of the Health System

Health spending in Austria is above average

In 2015, Austria spent more on health than the EU average both in per capita terms (3,765 pps) and when measured as a share of GDP (10.3%). Health spending is expected to rise further due to a number of factors, including population ageing, technological progress and rising incomes: between 2013 and 2060 public spending on health as a share of GDP is projected to increase by 1.3 percentage points, which is around the EU average (0.9 percentage points). Long-term care spending according to the System of health Accounts - SHA accounted for 1.5% of GDP in 2015, which is around the EU average. While this share had been stagnating in Austria it increased in most other EU countries. Spending on administration (3.8% of current health spending) and rehabilitation (6.5%) are above the EU average. Otherwise, the spending structure does not differ notably from other EU countries.

Government outlays and social health insurance spending are around the EU average

In Austria, the proportion of compulsory insurance funding (44.8% of current health expenditure in 2015) and the proportion of government outlays (30.8%) are around the EU average. The remaining spending stems from households' out-of-pocket payments (17.9%) and voluntary schemes (6.5%), both similar to the EU average.

Quasi-universal coverage is provided by a social health insurance system which contributes, along with national and regional authorities to financing service delivery

A statutory social health insurance system provides universal coverage with services being delivered by a mix of public and private providers. The social health insurance system directly pays, among other, for pharmaceuticals and ambulatory care, and pools funds with the federal and regional governments to finance hospital care.

The Austrian health system provides universal coverage and a comprehensive benefit package

Austria provides coverage for 99.9% of its population, mainly through 18 social health insurance funds. There is no competition between funds and affiliation is automatically determined by place of occupation. Entitlement is based on compulsory insurance contributions which are shared between employees and employers. Dependents are covered free of charge and for people without automatic coverage there is a possibility to obtain coverage with an SHI fund on a voluntary basis (e.g. people in "mini-jobs" whose income does not exceed a certain threshold). Those remaining uninsured include the unemployed without entitlement to social benefits and irregular migrants[2]. All funds cover broadly the same benefits although some differences exist. The benefit package is broad and covers most common medical care needs.

Most co-payments are for consultations with doctors that have no contract with SHI

Regulations on cost-sharing and exemptions vary between insurance funds, although some legal standard are set. For the majority of the population, co-payments apply to a number of services in particular hospital care, as well as pharmaceuticals and medical goods. Physicians who are not under contract with the SHI system can set their fees but patients who consult them are only reimbursed 80% of the negotiated tariff which applies to contracted physicians.

Exemptions from co-payments exist, in particular for prescription fees. Population groups exempted include patients with infectious diseases, asylum seekers, beneficiaries of certain social benefits and people with income below a certain threshold. Exemption from prescription fees also gives automatic exemptions from a range of other co-payments. In addition, prescription fees are capped for all insured individuals at 2% of their annual net income.

The health system is fragmented, with responsibilities shared between federal and regional governments and self-governing bodies

[2] The third sector, e.g. some charities, may offer access to hospitals or doctors, nurses and other care-takers (including interpreters) for these uninsured persons.

Governance of the Austrian health system is shared between the federal and the regional level (Länder) and many responsibilities have been delegated to self-governing bodies (social insurance and other providers, e.g. Austrian chamber of physicians). The federal government is responsible for regulating social insurance and most areas of health care provision – except hospital care, where the basics are defined at the federal level but the Länder are responsible for the specifics of legislation and implementation. The 18 social health insurance funds collectively negotiate with regional medical chambers and other health professions regarding health care provision in the areas of ambulatory and rehabilitative care as well as pharmaceuticals.

Service delivery is predominantly private for ambulatory care and public for hospital care

Primary care is mainly provided by self-employed GPs working in solo practices. Patients can freely choose their GP, even among those that are not contracted by the SHI (in which case they may face significant co-payments). Contracted GPs receive a mix of capitation and fee-for-service; non-contracted GPs bill patients on a fee-for-service base. There is no gate-keeping in place and patients can in general contact specialists without referral. Since 2005, "Regional Health Funds" have been established in each region as a purchasing agents for hospital care. They pool resources from federal authorities, Länder and social insurance funds and pay for inpatient care provided by public and non-profit hospitals on the basis of Diagnosis Related Groups (DRGs).

Austria has a relatively high number of physicians

In 2015, there were 510 practicing physicians per 100,000 population in Austria, considerably above the EU average. Yet, as a quota on first-year students was introduced in 2006, Austria has witnessed a substantial decline in medical graduates in recent years. The number of nurses stood at 822 per 100,000 population, which is around the EU average.

Policy Developments

Austria's complex health system has been reformed to improve governance

A 2013 health reform sought to improve coordination and cooperation between stakeholders in a fragmented health system. The reform put in place a target-based governance system through a contractual agreement between the federal government, regional governments and social insurance funds. For each of three key areas – structure of provision, processes of care, and focus on outcomes – the contract sets out strategic goals and defines operative targets, together with measures for achieving them. At the same time, institutional capacity for governance was raised by establishing a federal and nine regional commissions, which are the main bodies responsible for implementing the target-based governance system. The 2017 health reform extended this new form of governance at least until to 2021.

Strengthening primary care has been a major aim of recent and current reforms

Primary care is one of the priorities of the 2017 health reform measures. The reform aims to enhance primary care capacity through the establishment of new multi-disciplinary primary care units. The reform envisages the creation of at least 75 primary care units by 2021 and EUR 200 million were earmarked for this purpose. The multi-disciplinary units should comprise at least a core team of GPs and qualified nurses but can also include paediatricians and other health and social professionals such as physiotherapists or social workers. The reform further aims to increase access to primary care by ensuring longer opening hours, particularly during evenings and weekends, in an attempt to reduce contacts with hospital outpatient departments.

Several measures aim to address public health challenges

In addition to a number of initiatives to curb tobacco consumption and better protect non-smokers, Austria published its first Addiction Prevention Strategy – covering illegal and legal drugs– in 2016, providing the basis for the direction of addiction policy in the coming years. Austria also developed a National Action Plan on Nutrition, first adopted in 2011 and updated in 2012 and 2013, which aims to reduce over-, under- and malnutrition and to reverse the trend of rising overweight and obesity rates by 2020. The Action Plan establishes targets as well as strategies and documents ongoing and planned measures of Austrian nutritional policy. This was complemented in 2013 by the National Action Plan on Physical Activity, which sets targets for specific population groups and gives recommendations on possible measures to increase physical activity.

JAF Health Results

Health outcomes in Austria are around the EU average, with the exception of healthy life years at birth

Healthy life years show negative developments in the last three years, especially for women at birth the trend was considerably worse than the EU average. In 2015, the level of healthy life years at birth (57.9 for men and 58.1 for women) is worse than the EU average. Although life expectancy at 65 is around the EU average, it shows no improvements over the last three years. These variables are identified as health challenges.

Access - The data on access dimension are generally better than the EU average

The available indicators do not show any challenge in the access domain. In 2016, unmet need for medical is better than the EU average.

Quality - The indicators on quality dimension are generally good, with the exception of in-hospital mortality following AMI

Although the indicator of in-hospital mortality following AMI is improving considerably more than the EU average in the last three years, it is still worse than the EU average. Breast cancer screening among women aged 50-69 is around EU average in 2014, but it shows a considerably negative development between 2008 and 2014. These variables are identified as health challenges. On the other hand, the vaccination coverage rates of children for DTP (98%) is identified as a good health outcomes, as it shows a considerable positive development in the past three years. Screening for cervical and colorectal cancer (both for women and men) are considerably better than the EU average in 2014.

Non-health determinants - Lifestyle among young, in particular smoking and drinking, and obesity are an issue

Data on lifestyle domain in 2008 for Austria is only available for smoking and obesity rate.

In 2014, smoking rate among women is considerably worse than the EU average, although among men is around the EU average, these two indicators are improving less compared to the EU average change between 2008 and 2014. Similarly, obesity among men is around the EU average, but also shows less improvement compared to the EU average change. These variables are identified as health challenges.

Risky single occasional drinking among young is worse than the EU average. On the other hand, physical activity is considerably better than the EU average among adults, while for young is only better than the EU average. Inequality in alcohol use and fruit consumption between educational groups is limited and better than the EU average.

Figure 1 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 2 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

BELGIUM

Although health expenditure is relatively high, the old age dependency ratio is growing less rapidly than in other EU countries and projected future growth in health expenditure is limited. The shortage of doctors is being addressed. The Belgian health system is strongly based on social insurance and achieves good overall performance though inequalities exist in access. Some inequalities can also be observed in certain health outcomes and risk factors. The system of insurance institutions is undergoing an evolution towards "health funds". Federal and federated entities play different but complementary roles, while the geographical distribution of medical care is perceived as a growing concern. The above EU average suicide rate (although on a declining path) and alcohol use (especially among young) are identified as health challenges.

Resources, Coverage and Organisation of the Health System

Health spending in Belgium is relatively high but projected future growth is limited

Belgium spends a relatively high proportion of its GDP on health (10.5% in 2015), above the EU average of 9.9% and rising somewhat faster. If measured on a per capita basis, health spending in Belgium is also above the EU average (3,546 pps). Health spending is expected to continue to increase due to a number of factors, including population ageing, technological progress and rising incomes. However, between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.1 percentage points[3], which is the smallest projected increase in the EU. Belgium reports spending 2.6% of GDP on long-term care[4]. This share is considerably above the EU average[5], although for Belgium the reporting of this expenditure is of broad nature, including the social component of long-term expenditure, which may not be (yet) fully reported by other Member States.

In terms of structure, Belgium has considerably higher spending on rehabilitative care (7%) than the EU average. In 2015, the share of spending dedicated to long-term care (health) (24%) was also considerably above the average figures reported in the EU and had been increasing faster over the three preceding years. The shares of health spending that go to prevention and administration are around the ones seen in most other EU countries. However, while the proportion of health spending dedicated to prevention had increased in recent years, the share of spending on administration has decreased.

The financing structure is characterised by the prominent role of social insurance

The share of health expenditure financed from compulsory contributory insurance schemes in Belgium is 59.2% in 2015 compared to an average of 43.4% across EU countries (in 2014), with the remaining part of public spending financed by government schemes (18.3%).

Belgium has near universal coverage in a social insurance-based health system

The Belgian health system is based on the principle of compulsory insurance and achieves nearly universal coverage of the population (99%). People have access to a very broad publicly-financed benefit package with cost-sharing for most services.

Scope of services covered is wide with few exemptions

For medical services, the detailed fee schedule for health services providers also defines the public benefit basket. This means that services not included in the fee schedule are not reimbursed by the compulsory health insurance. This refers to, for example, acupuncture and homeopathy but voluntary complementary insurance may reimburse part of these costs. Other goods and services, such as plastic surgery, orthodontics and spectacles are only covered under certain conditions by the compulsory health insurance.

Cost sharing applies to the most health services but levels of user charge vary

Cost-sharing applies to most health care goods and services in the public benefit basket. For outpatient care, patients pay in principle the full fee at the point of service before claiming reimbursement from their sickness fund. However, inpatient care and medicines dispensed in pharmacies are paid for by compulsory health insurance and patients only have to pay user charges. This third-party payer system is gradually enlarged further to improve access to ambulatory care, notably for vulnerable persons (chronic conditions, beneficiaries of preferential reimbursement[6], palliative

[3] For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

[4] The reporting of data on long-term care may still differ in the level of precision with which the system of health accounts 2011 (SHA 2011) has been implemented in EU countries.

[5] This assessment is based on to the methodology applied to this analysis agreed in the Indicators' Subgroup of the Social Protection Committee, as explained in the foreword.

[6] Beneficiaries of preferential reimbursement are: beneficiaries of social assistance allowances (resource guarantee), beneficiaries of allowances for handicapped persons, handicapped children or children disabled for at least 66%, orphans and non accompanied underaged foreign persons, low income households, (including low income

home care,..). The level of co-payment varies between the different goods and services. Some people (see footnote), mostly low-income or suffering from chronic conditions benefit from a preferential reimbursement status (lower co-payments). Above an annual limit varying with the income, co-payments are also reimbursed to the patients (the so called 'maximum bill') . These measures to improve financial protection and increase access were strengthened and simplified in 2015.

Level of out-of-pocket payments is close to the EU average

In 2015, the share of out-of-pocket payments in total health spending stood at 18% in Belgium - around the EU average. Voluntary insurance in Belgium can cover the full or part of the user charges borne by patients after reimbursement by the compulsory insurance , including both co-payments (for reimbursable services) as non-reimbursable services.. As a share of total health spending, voluntary health insurance accounts for 5% in Belgium - a value around the EU average.

Different roles for federal and federated entities in Belgium with SHI having the main purchasing role

The Belgian health system is characterised by compulsory social health insurance and involvement by both federal and federated government entities. Compulsory health insurance is executed through six private, not-for-profit national associations of sickness funds and one public sickness fund, that fulfill the 'interface' role with the patient. Federal authorities are responsible for regulating and financing the compulsory health insurance and hospitals, setting minimum standards, legislating professional qualifications, and registering and controlling prices of pharmaceuticals. The federated entities (three regions and three communities) are responsible for health promotion and prevention, providing maternity and child health care, social services, community care, long-term care as well as coordination and collaboration in primary health care and palliative care, and financing hospital investment. The compulsory health insurance is managed by the National Institute for Health and Disability Insurance (NIHDI), which will transfer the necessary means to the sickness funds to reimburse the health care costs of their members.

Service delivery is mainly private in primary care with patient choice

The vast majority of GPs work as independent, self-employed health professionals while medical specialists can work in health institutions (mostly hospitals) and/or on an ambulatory basis in private practice. Patients can freely choose their doctor. As there is no systematic gatekeeping by GPs, people have free access to medical specialists and hospital care. Several features of the health care delivery system enhance the availability of services in Belgium. For example, home visits to patients by GPs are regular practice and, typically, there are no problems to get quick access to GPs, although waiting times for specialised services (e.g., mental health specialists) can exist. Nurses play a key role in providing services to people with chronic diseases or disability.

There are many different types of hospitals in Belgium, including general acute care hospitals (113), specialized hospitals (20), geriatric hospitals (8) and psychiatric hospitals (68). The majority of hospitals are private not-for-profit with the rest being publicly owned. Intermediary structures and services include day care in hospital and long-term care centres.

Growing concerns about shortages of doctors in Belgium.

In 2015, the ratio of practicing physicians per population was below the EU average (302 per 100,000 population)[7]. With 1102 per 100,000 population, the ratio of practicing nurses and midwives was around the EU average. However, the rate of increase was higher than on average across EU countries between 2011 and 2014, mainly due to a strong increase in the number of nurse graduates in Belgium. Hospital employment is around the EU average (1307 full-time equivalent jobs per 100,000 population).

Between 2004 and 2011 the numerus clausus (annual quota) of medical graduates that were allowed to train as GPs or specialists was set at a fairly low level raising questions whether the future supply of doctors would meet the demand. In response to these concerns, the federal government has steadily increased the numerus clausus since 2011 resulting in a capacity rise of over 60% between 2008-2011 and 2015-2018. In addition, several innovative measures have been taken to extend the roles for other health care professionals, such as nurses and pharmacists, to improve access to services for the population.

Policy developments

Recent reforms cover a wide range of issues, such as affordability

In addition to the initiatives aiming to improve access to affordable care for vulnerable groups and to increase health workforce capacities mentioned earlier, there are other initiatives covering different areas of the health system.

pensioners, lone parents, widow(er)s, invalid persons and long term ill.

[7] The ratio for Belgium includes only physicians above a legally defined minimum activity threshold for physicians. Other EU countries may not apply this threshold.

Lifestyle and health workforce

Recent health promotion campaigns, for which federated entities are responsible, have been designed to promote further reduction in tobacco smoking, healthy eating and increasing vaccination rates among target groups. To improve care coordination, new care models have been introduced in particular to address care needs of patients with diabetes and other chronic conditions.

In September 2016, the first pieces of a broader reform of the practice of health care professionals were presented. Some of the main objectives of this reform are a greater collaboration between health care professionals, a greater recognition of health care professionals on the basis of their acquired skills and continuing education, and improving the health literacy of the population while reaffirming the central role of the patient.

Health insurance institutions are evolving towards "health funds"

The role of health insurance institutions is changing. In an agreement signed between the Belgian government and seven health insurance institutions in 2016, the latter committed to continue their evolution towards becoming “health funds” with the main goal of improving and retaining the health of their members. The agreement also contains reciprocal engagements concerning policy support, among others through the provision of data by the health insurance institutions. Another important element emphasises the good governance and sound financial management of these organisations.

JAF Health Results

Overall health outcomes

Health outcomes are around the EU average, with the exception of the suicide rate and inequality in self-perceived health. In 2014, the number of deaths due to self-harm / suicide is worse than the EU average, but shows some positive development. This variable is identified as a health challenge. In 2015, inequality in self-perceived health (as good/very good and bad/very bad) between income groups is worse than the EU average and it is identified as a health challenge.

Access: There are sign of warning about the social and geographical dimensions of access

In 2016, unmet need for medical care due to distance is around the EU average, but shows a considerable negative development. The gap in unmet need for medical care between the bottom and top income group is worse than the EU average. These issues are identified as health challenges.

Quality: Quality is around the EU average

In-hospital mortality following stroke was around the EU average in 2011 (9.3%), with an increase between 2008 and 2011 (latest year currently available in JAF) considerably larger than the average change across EU countries (where it often decreased). However, in 2014 it decreased to 8.4%. The vaccination coverage rate of children for DTP (99% in 2015) is identified as a good outcome as it is considerably above the 95% recommended threshold.

The other indicators of the JAF quality dimension are around the EU average and do not show particular trends.

Non-health determinants: Alcohol use, including among young and women, is a challenge

In 2014, alcohol use among young and fruit consumption among young are worse than the EU average. These variables are identified as health challenges. The obesity rate and vegetable consumption are considerably better or better than the EU average and they are identified as good health outcomes.

Inequality in some aspects of lifestyle is also an issue

The smoking rate is around the EU average, but the gap between income groups is considerably higher than the EU average. Similarly, the overall obesity rate is better than the EU average and has been in decline over the last years, but the gap between income groups is above the EU average. There are no data on physical activity for 2008 and 2014.

Figure 3 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

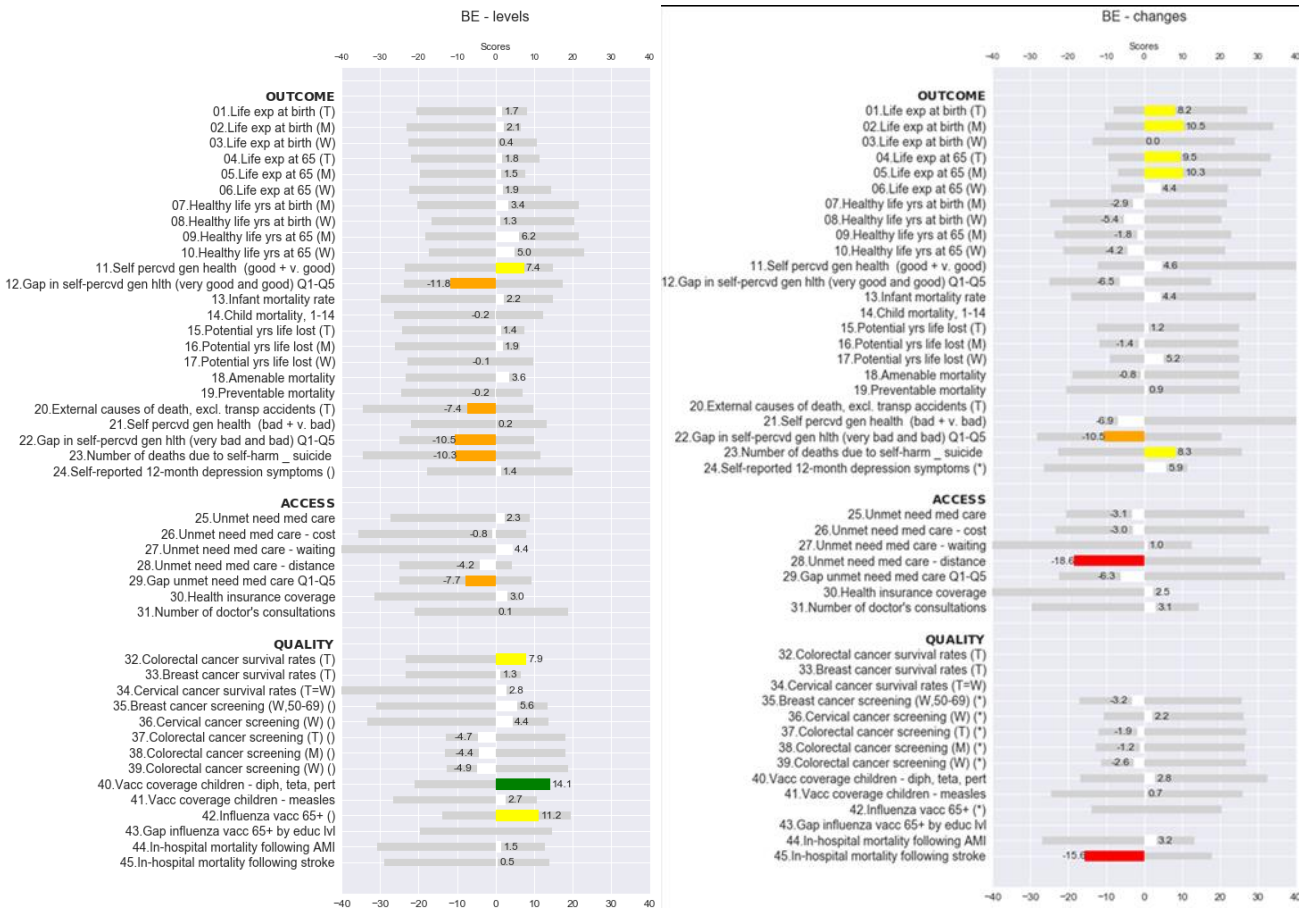

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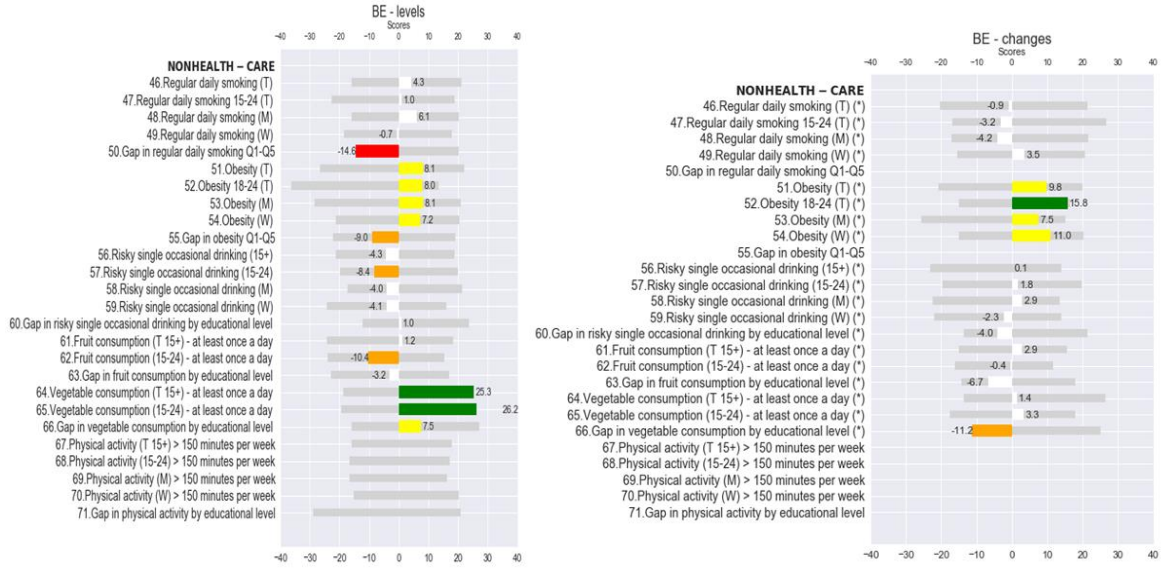
Figure 4 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

BULGARIA

With the lowest GDP per capita and the highest rate of poverty and social exclusion in the EU, as well as with health expenditure below the EU average, most health outcomes in Bulgaria are considerably worse than the EU average. Only infant mortality is considerably improving. Bulgaria records the lowest life expectancy of women in the EU. The quality of healthcare is worse or considerably worse than the EU average and there are also signs of a worsening of prevention, in particular due to the low vaccination coverage rates of children for DTP. Lifestyle is generally worse than the EU average, in particular for smoking, diet and physical activity and is some case it is worsening, while a few indicators are better (obesity among women and alcohol use among young). Bulgaria as recently scaled up health promotion and prevention with the National Prevention Programme (2014–20). In Bulgaria, healthcare is not universal and the contribution of out-of-pocket payments to health expenditure is the highest in the EU. Health insurance is estimated to cover 92-93% of the population. The insurance system puts vulnerable groups, such as the long-term unemployed and the poor at risk of being uncovered. Unmet need for medical care, especially due to costs, is considerably improving in relative terms. However, with the considerable regional variation in the density of GPs and in the number of enlisted patients per GP, the challenge of unmet need due to distance remains (although improving as well). Shortages in health workforce capacity, due the low numbers of graduates and to economic emigration, also remain a challenge of the Bulgarian healthcare system.

Resources, Coverage and Organisation of the Health System

Health spending per capita is below the EU average

Health spending per capita in Bulgaria, which stood at 1,224 pps in 2015, was well below the EU average. However, health spending measured as a share of GDP (8.2%) was similar to other EU countries. Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and a rise in incomes: between 2013 and 2060 the percentage of GDP spent on health is projected to increase by 0.4 percentage points in Bulgaria, which is below the EU average (0.9%) . In terms of structure, Bulgaria spends less on long-term care (0.01% of health expenditure) and administration (1.32%) than other EU countries. Spending on curative-rehabilitative care represents only 46% of health spending and a significant share of financial resources in Bulgaria are dedicated to medical goods (44%), in particular pharmaceuticals.

Government health expenditure in Bulgaria is below the EU average, while out-of-pocket payments are high

In Bulgaria, compulsory health insurance accounts for 41.9% of health expenditure, which is similar to the EU average. Government outlays, make up 9.2% of health spending, which is below the EU average. The remaining part consists mainly of households' out-of-pocket payments (47.7%), which are considerably above the EU average, and voluntary schemes (1.2%) which are of less importance in Bulgaria than in most other EU countries.

Partial coverage is provided by social health insurance (SHI) which contracts large numbers of providers

A single mandatory national health insurance fund (NHIF) provides a basic package of benefits to those insured and contracts public and private providers in a service delivery system which remains hospital-centric.

Population coverage is not universal in the Bulgarian health system

While SHI is compulsory, an estimated 7-8% of the population did not have SHI coverage in 2015. This can be partly explained by the fact that people who fail to pay three monthly contributions in the previous 36 months lose coverage. This especially puts vulnerable groups, such as the long-term unemployed and the poor, at risk. Furthermore, some people may not be aware of their eligibility to receive government subsidies to help cover SHI contributions. Lack of insurance is particularly prevalent among the Roma population, of which 35% have no health coverage.

Social insurance provides a basic package of benefits, but no long-term care

The SHI system guarantees access to a basic package of health services for the insured population. It covers primary and specialised outpatient medical and dental care; laboratory services; hospital diagnostics and treatment; and highly specialised medical activities. Emergency care, mental health care, renal dialysis, in vitro fertilisation and transplantations are covered by the state budget or other dedicated funds. The most important category of excluded services is long-term care. Uninsured individuals have to pay directly for medical services and goods, unless they visit an emergency centre in a life-threatening situation.

There are flat co-payments with no exemptions for medicines

Patients have to pay flat user charges for most services. Children and some statutory categories are exempted and the user charge for a GP visit is lower for pensioners. The NHIF covers a proportion of the reference price of medicines on the positive drug list and patients, in addition to covering the complement as well as the difference between the reference and the actual price, also pay a dispensing fees. There are no exemptions from co-payments for medicines which account for some three-quarters of OOP costs. Patients also pay for excluded services and informal payments.

Bulgaria's social health insurance system is highly centralised

The Ministry of Health is responsible for the overall organisation of the health system and policy formulation. The National Health Insurance Fund (NHIF) is the core purchaser in the system, operating through 28 Regional Health Insurance Funds. The benefit basket is set by the Ministry of Health, while tariffs and reimbursement procedures are specified in the National Framework Contract and negotiated on an annual basis between the NHIF and health provider organisations.

The over-reliance on hospital care has not been overcome

Primary care is provided by independent GPs who work in solo or groups practices and are paid for mainly on a capitation basis. Patient can freely choose their GP which are supposed to act as gatekeepers, and have to operate within a maximum number of referrals to outpatient specialists and inpatient services. Considerable regional variation exists in the density of GPs and the number of enlisted patients per GP which results in access problems. The hospital system on the other hand comprises a very large number of facilities, all contracted by the NHIF and funded through case base payments. Many facilities are small and underused and the system is fragmented but the number inpatient discharges is exceedingly high.

The number of physicians is above the EU average, but there are fewer nurses and midwives

Bulgaria has a relatively high number of doctors, with 405 practising physicians per 100,000 population in 2015, above the average in EU countries. The number of nurses and midwives per 100,000 population was 483 in 2015, which is below the EU average. The low numbers of graduates entering the health workforce has been a long-standing concern. Moreover, many professionals go abroad due to low recognition and low pay at home.

Policy Developments

Structural reforms to contain costs and integrate care are in their early stages

Improving the efficiency of the health care sector has been the focus of several recent reforms. Since 2015, there have been plans to allow regional branches of the NHIF to selectively contract hospitals if the capacity exceeds population needs as defined by National and Regional Health Maps. The introduction of Health Technology Assessment (HTA) in 2015 is expected to increase the effectiveness of pharmaceutical spending. HTA is currently applied for medicines belonging to new International Non-proprietary Name groups, but has yet to be used systematically on all pharmaceuticals. Furthermore, changes to the "Law on Health" in 2015 introduced the concept of integrated care in Bulgaria. This law established a new type of health care provider, integrated social and health service centres for children with disabilities, with the intention to move away from hospital-centred delivery of care.

A recent attempt to reform the benefit package was partially struck down in court

In 2016, an attempt was made to split the benefit package into two parts: basic and complementary. The basic part would have covered prevention, diagnosis and treatment of major diseases and conditions that cause death and disability, and maternal and child health – in accordance with health priorities listed in the National Health Strategy "Health 2020". The complementary part would have included treatment services which could be postponed without the immediate risk of a patient's condition deteriorating, such as hip replacement surgery. In 2016, the Constitutional Court rejected this proposal as unconstitutional.

Recent efforts focus on strengthening health promotion and prevention

Bulgaria has recently scaled up health promotion and prevention efforts. In accordance with EU Directives, a smoking ban in public places was introduced in 2012 and the National Prevention Programme (2014–20) focuses attention on early detection of non-communicable diseases, especially for cardiovascular diseases (CVD). This is supported by a budget increase in 2017, earmarked for early detection and screening. Providers are incentivised to participate in screening, examination and prophylaxis. The NHIF receives additional funding to pay for the screening of uninsured individuals.

JAF Health Results

Most health outcomes in Bulgaria are considerably worse than the EU average, while only few are improving

In 2015, life expectancy at birth (74.7) and at 65 (16) are considerably worse than the EU average for both women and men, while life expectancy at 65 for wom-

en is improving more than the EU average in the previous three years. The infant mortality rate is considerably worse than the EU average, but is improving considerably more than the EU average in the past three years. Child mortality (for 1-14 year-old) is also considerably worse than the EU average (2013 data). In 2014, potential years life lost for both women and men and amenable mortality are considerably worse than the EU average. Moreover, amenable and preventable mortality are worsening considerably more than in other EU countries in the past three years. Inequality in general health as measured by the gap between the bottom and the top income quintile in the share of people who perceived their general health as good/very good and bad/very bad are worse than the EU average, while the second is also worsening more than the EU average in the last three years. These variables are identified as health challenges.

Access: Unmet need for medical care due to distance is worse than the EU average, but it is improving as, in general, unmet need

In 2016, unmet need for medical care due to distance is worse compared to the EU average, although it is improving relatively more in the last three years. Unmet need for medical care, in particular due to costs, and inequality in unmet need by income group are improving considerably more than the EU average in the last three years and are now around the EU average.

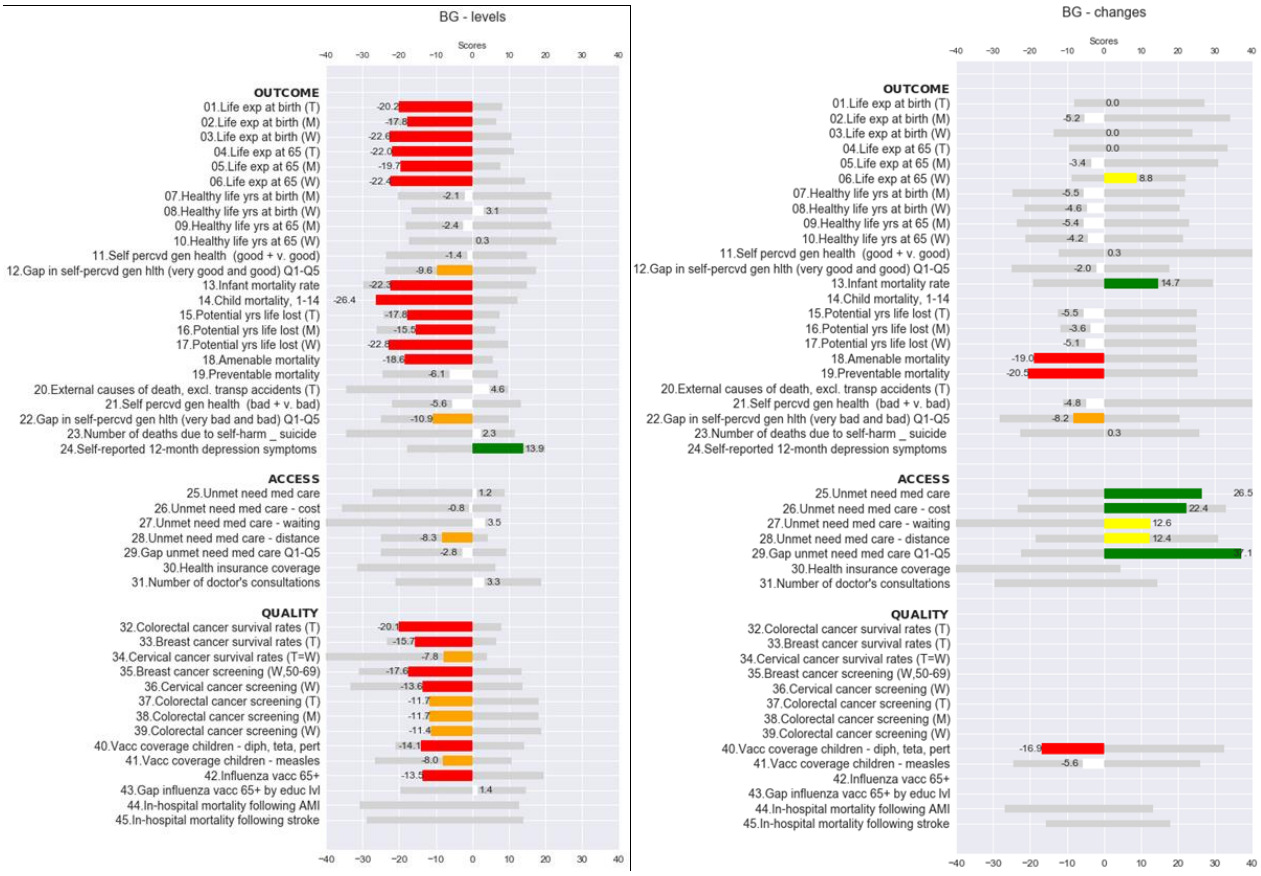
Quality: The quality of healthcare is worse or considerably worse than the EU average and there are signs of a worsening of prevention

Data on the quality of healthcare in Bulgaria are relatively limited, also due to the lack of time series. In 2014, colorectal cancer screening, for both women and men, is worse compared to the EU average., while the screening for breast and cervical cancer are considerably worse than the EU average. In 2007, survival rates for colorectal and breast cancer were considerably worse than the EU average, while survival rates for cervical cancer was worse than the EU average. In n 2015, the vaccination coverage rates of children for DTP and measles are, respectively, considerably worse than the recommended 95% threshold. Moreover, the vaccination coverage rates of children for DTP shows a considerably negative development over the last three years. The influenza vaccination rate for over 65 (2.4% in 2014) is also considerably worse than the EU average.

Non-health determinants: most lifestyle indicators are worse than the EU average, in particular for smoking, diet and physical activity, while some are better (obesity among women and alcohol use among young)

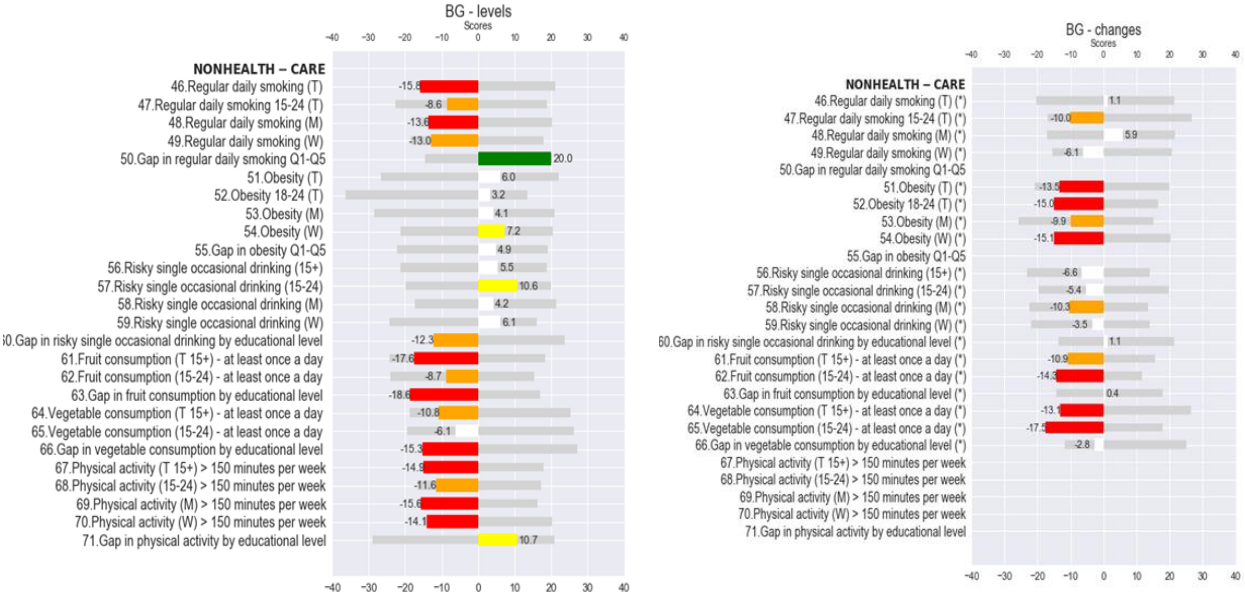
In 2014, the smoking rate, especially among men, the consumption of fruit and physical activity (among both men and women) are considerably worse than the EU average. Younger people have a less unhealthy lifestyle, but are still in a worse situation than their EU peers. Among young people, the smoking rate, fruit consumption and physical activity are worse that the EU average (while they are considerably worse for adults), while vegetable consumption is not an issue for young. While inequality in alcohol use, fruit and vegetable consumption (as measured by the gap between high and low educated) are worse and considerably worse than the EU average, inequality in smoking (as measured by the gap between the bottom and the top income quintile) and physical activity (as measure by the gap between educational groups) are, respectively, considerably better and better than the EU average. Obesity and alcohol use among men are around the EU average but are worsening compared to the EU average change.

Figure 5 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 6 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Croatia

With GDP per capita and health expenditure below the EU average and the rate of poverty and social exclusion described above, health outcomes in Croatia are generally worse than average. In particular, life expectancy and healthy life years at 65 are considerably worse than the EU average and they are not improving. The population is aging faster than the EU average, as well as the projected increase of public health expenditure. The situation of non-health determinants is mixed with some inequalities and young people generally have a healthier lifestyle than the overall population. Overall, access to healthcare is good. The health system is based on compulsory social insurance, with the government covering contributions for some vulnerable groups, and the scope of services is wide. However, there is a challenge in the geographical distribution of healthcare, with shortages of health workers in rural areas and some islands, emigration of health workers and a considerably higher-than-average unmet need due to distance. The government adopted a Strategic Plan for Human Resources in Health Care for the period 2015-2020.

Resources, Coverage and Organisation of the Health System

Croatia spends less on health care compared to other EU countries

Health spending in Croatia was below the EU average in 2015, both when measured per capita (1,245 pps) and as a share of GDP (7,37%). However, health spending is expected to rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 1.7 percentage points in Croatia, which is considerably above the EU average (0.9%) . Croatia spends less on long-term care (0.2% of GDP) compared to other EU countries. Otherwise, the spending structure does not differ notably from the EU average.

Public spending on health is mainly channelled through compulsory health insurance

In Croatia, the proportion of compulsory insurance funding (74.4% of current health expenditure in 2015) is higher and the proportion of government outlays (2.4%) lower than in the EU. The remaining spending is made up of households' out-of-pocket payments (15.2%) and voluntary prepayment schemes (8%), with the latter being slightly above the EU average.

The Croatian health system provides broad coverage through compulsory social health insurance

The Croatian Health Insurance Fund (CHIF) provides broad compulsory coverage to all residents and contracts services from providers, who operate under state, county, or private ownership. Compulsory coverage of the CHIF is mainly financed by income-related contributions payable by the working population and the state budget finances coverage of vulnerable groups, such as children (up to 18 year-old), regular students (up to 26 year-old), people with 100% impairments, and people with low income. In addition to compulsory coverage, the CHIF also offers voluntary insurance for patients to cover use chargers.

According to the Health Care Act, all Croatian citizens have the right to health care and all persons with residence in Croatia and foreigners with permanent residence permits must be insured in the compulsory health insurance scheme, unless an international agreement on social insurance states otherwise.

Scope of services covered is wide with few exemptions

Under compulsory health insurance Croatian residents are entitled to a broad benefit package that includes primary, specialist and hospital care, the use of medicines on the CHIF lists, dental care and some other specific health care. Some health services are explicitly exempted from compulsory coverage, such as treatments outside the established standards of the right to health care from CHIF, experimental therapy, aesthetic surgery (except for severe diseases or disorders like breast reconstruction after mastectomy, aesthetic reconstruction of congenital malformations, and cosmetic reconstruction after severe injury), surgical treatment of obesity except for pathological obesity (body mass index >40). Pharmaceutical coverage is defined around two positive lists: the basic one, for medicines provided free of charge, and the supplemental list which requires co-payments.

Cost-sharing applies to most services but vulnerable groups are exempt

While certain health care services (e.g., laboratory tests within primary care, drugs on the basic list, etc.) are fully covered compulsory health insurance generally covers only about 80% of the costs of most services included in the benefit package (this also applies to acute health care in hospitals). The remaining costs are borne by the insured person either through complementary health insurance or out-of-pocket (OOP) payments. Complementary health insurance is voluntary and is purchased individually from either the CHIF or a private insurer. All cost-sharing is capped at HRK 2000 (approximately EUR 264) per episode of illness in secondary or tertiary care. Overall, the depth of coverage has been reduced since the early 2000s, however,

voluntary complementary health insurance can be purchased to cover user charges, with the exception of co-payments for pharmaceuticals on the supplemental list. Vulnerable population groups are entitled to the complementary health insurance offered by the CHIF and their contributions are covered by the state budget.

The Ministry of Health is the steward of a health system organised at the county level with the Croatian Health Insurance Fund contracting health providers

The Ministry of Health is responsible for health policy, planning, evaluation, public health programmes, and regulation. As the sole insurer in the mandatory health insurance system, the CHIF contracts services from health care providers and plays a key role in defining which services are covered. It also sets performance standards and prices; pays sick leave compensation, maternity benefits and other allowances; and is the main provider of complementary voluntary health insurance. Local governments own and operate most public primary and secondary care facilities, and are responsible for planning, coordinating and managing health services at the county and municipal level.

Primary care is contracted via public-private partnerships while secondary care is mainly public

Primary care is mostly provided by private providers, contracted through concessions (public-private partnerships introduced in 2009), which often operate in health care facilities rented from local governments. All insured citizens must register with a general practitioner or a paediatrician, also including PHC gynecologists for women's health care and doctors of dental medicine, whom they can choose and change once per calendar year. A referral from a primary care physician is needed to access specialised ambulatory care, although patients in some cases avoid this by accessing emergency services directly. Specialist and hospital care are predominantly delivered in public facilities owned by local governments, while tertiary hospitals are owned by the central government. Primary care physicians are paid through a combination of capitation and fee-for-service with the possibility of additional payments based on performance. Hospitals are paid through a comprehensive prospective case-adjusted payment system, based on diagnosis-related groups (DRGs).

The numbers of doctors and nurses in Croatia are close to EU averages

In 2015, there were 319 doctors per 100, 000 population, close to the EU average, and 623 nurses per 100,000 population, slightly below the EU average. In 2016, the number of doctors and nurses per 100,000 population increased to, respectively, 323 and 633 (Source: Health Manpower Registry from Croatian Institute of Public Health, 2017). Yet, these figures mask geographical disparities, with most health workers based around the capital Zagreb and other county seats and shortages in rural areas and the islands off the Adriatic coast. Furthermore, with the country's accession to the EU, in 2013, and comparably low salaries in the health sector, emigration of health professionals has become an issue. Croatia has started to address these concerns through increasing enrolment quotas and attempts to encourage young people to study medicine, dental medicine and other health studies (nursing, midwifery, medical laboratory diagnostics, physiotherapy, radiological technology).

Policy Developments

Addressing gaps in health workforce planning and management

In May 2015, the government adopted the Strategic Plan for Human Resources in Health Care 2015-2020. The plan seeks to address important gaps in the way human resources in health care are organised, trained and managed, as well as to tackle the negative effects of outward migration of health workers following the country's accession to the EU. The main priority is to design and implement a management information system for the health workforce, which would aggregate and harmonize different data collected by various institutions under a National Registry. The system would facilitate the identification of current and future gaps in the supply, distribution and skillset of health workers. Other measures included in the plan address working conditions and regulation of roles and professions (e.g., task shifting).

Integrating and standardising health information in Croatia is a top priority under the National Health Care Strategy 2012-2020

The National Health Care Strategy 2012-2020 sets out the overall vision, priorities and goals for the Croatian health system. A top priority in this strategy is the development of e-health for which the following measures have been identified: developing systems to monitor and analyse health data and support decision making (business intelligence); improving and modernising existing health information systems; developing joint procurement across the health system (including the information technology infrastructure); integrating telemedicine with emergency and other medical services; standardising and certifying health information systems (especially with regard to interoperability); training health workers and managers to use information and communication technologies; increasing the budget for health information technologies; and regulating e-health. The priority is in line with e-Croatia

2020, a national strategy to move towards electronic provision of public services.

Improvements in health care quality and efficiency but delays in implementing certain key reforms

Improving the quality, efficiency, and sustainability of hospital service delivery is another priority laid out in the National Health Care Strategy 2012-2020. To that effect, the National Plan for the Development of University Hospital Centres, University Hospitals, Clinics and General Hospitals aims to rationalise the structure and activities of health care institutions. Basic hospitals should retain four main inpatient activities (internal medicine, surgery, paediatrics, and obstetrics and gynaecology) while for other services different models of functional integration would be put in place. Additional objectives include the development of day surgery, the re-profiling of acute care beds into chronic and palliative care beds, and the accreditation of hospitals. As of April 2017, good progress had been made on reducing the number of acute care beds, establishing sentinel surveillance schemes in hospitals with surgery wards, and increasing the share of elective surgeries performed on an outpatient basis. However, other aspects of the reforms, including the reorganisation of hospitals, the implementation of accreditation, and joint/centralised procurement of drugs, medical supplies and devices, were delayed and hospital arrears continued to be a problem.

JAF Health results

Health outcomes in Croatia are worse than the EU average, especially the life expectancy and healthy life years at 65

In 2015, life expectancy and healthy life years at 65 are considerably worse than EU average. Healthy life years at 65 are also deteriorating considerably more than the EU average in the last 3 years. Life expectancy (74.4 years for men and 80.5 for women in 2015) and healthy life years at birth are worse than the EU average. In 2014, amenable and preventable mortality, and number of deaths due to self-harm or suicide in Croatia were worse than the EU average. Infant mortality rate increased more than average in the last 3 years. Self-perceived general health as good/very good and bad/very bad are, respectively, worse and considerably worse than the EU average, while both are improving considerably in relative terms. Inequality in self-perceived health (as measured by the gap between income quintiles) is worse than the EU average, although the gap in self-perceived general health as bad/very bad is improving considerably. These variables are identified as a health challenge.

According to national estimates, life expectancy in 2016 increased by 0.9 years for women and by 0.6 years for men (Source: population by age and sex – mid-year estimate, average age of population and life expectancy , Croatian Central Bureau of Statistics, July 2017).

Access: The geographical dimension of access is a challenge

Unmet need for medical care due to distance is the highest in the EU28, while it was improving more than in other countries in the last three years.

Quality: Data on quality are limited for Croatia but reveal a shortcoming in vaccination coverage rates of children

Data on the quality of healthcare are limited for Croatia, due to availability and short time series.

In 2015, the vaccination coverage rates of children for DTP and measles are below the recommended 95% threshold and decreasing more than the EU average (especially for DTP) in the past three years.

In 2007, cancer survival rates, in particular for colorectal and breast cancer, were worse than the EU average

Non-health determinants: The situation regarding lifestyle is mixed, with young generally having a healthier lifestyle with the exception of smoking habits

Data on risk-factors based on EU surveys are limited for Croatia compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

In 2014, the smoking rate among young and women are worse and considerably worse, respectively, than the EU average. Obesity among men is worse than the EU average, while among young it is better than average. Physical activity in both men and women is worse than the EU average. Alcohol use among women is better than the EU average. Fruit consumption among young and vegetable consumption are considerably better than the EU average.

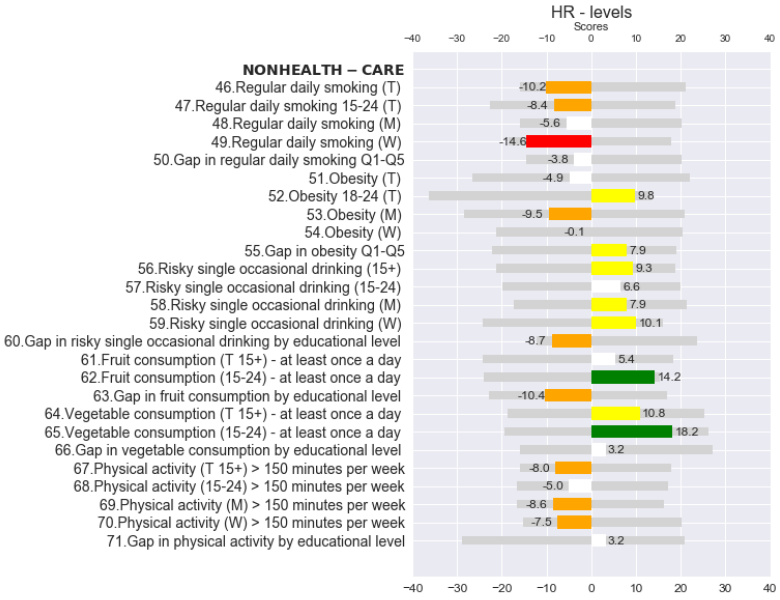
Some inequalities in lifestyle are observed

The gap in fruit and alcohol consumption between high and low educated are worse than the EU average. On the other hand, the gap in the obesity rate between income groups is better than the EU average.

Figure 7 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 8- JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



CYPRUS

With a younger than average population, health outcomes in Cyprus are around or better than the EU average. Self-perceived general health is identified as a good outcome. However, in recent years some health outcomes, such as preventable mortality, are deteriorating more than in the EU. With a below EU average health spending per capita and a considerably lower than average expenditure on prevention, indicators on prevention, including specific vaccinations and cancer screenings (e.g. colorectal, cervical), are worse than the EU average or are deteriorating and are identified as health challenges. Lifestyle is generally good compared to the EU average. However, some lifestyle behaviors among young, such as smoking and physical activity, are worse than those of their EU peers. Smoking is also worse than the EU average and inequalities in some risk-factors are worsening in the last years. While self-reported unmet need is relatively low in Cyprus and improving, access to healthcare is not universal (but public healthcare is available to low income households) and the contribution of out-of-pocket payments to health expenditure is the second highest in Europe (with public user charges relatively low). After several delays, the new national health system has been finally agreed in 2016 and the implementation of the new system is expected to be fully completed in 2020.

Resources, Coverage and Organisation of the Health System

Health spending is lower than in other EU countries

Health spending per capita in Cyprus (1,590 pps) was lower than the EU average in 2015, and in contrast to most other EU countries spending had tended to decrease in recent years. Expenditure also represented a lower share of GDP (6.8%) than the EU average. However, health spending is expected to rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 public health spending as a share of GDP is projected to increase by 0.3 percentage points in Cyprus, which is lower than the EU average (0.9%)8. Compared to other EU countries, Cyprus spent less on long term care (0.2% of GDP in 2015). It also spent considerably more on rehabilitative care (6.4% of health spending), more on curative care (57.2%), less on administration (1.5%) and considerably less on prevention (0.7%) than EU countries on average.

Out-of-pocket is the largest source of funding in the health system

In 2015, 42.3% of health spending was channelled through government outlays, around the EU average. By contrast, the proportion of health expenditure funded through compulsory insurance (0.3%) was considerably lower than in other EU countries. Household out-of-pocket payments were the largest source of funding in the system (43.9% of total spending), considerably higher than in other EU countries and voluntary schemes represented 12.2%, higher than the EU average.

Publicly provided care is available to the population below a given income level, while non-beneficiaries can either access public care for a fee or pay for care in the private sector

Cyprus does not provide universal coverage to its resident population. Citizens and permanent residents below a determined income level can use health services provided by a wholly-integrated National Health System with minimal user charges. The system is mostly tax financed but some groups, for instance civil servants, have to pay contributions. Non-beneficiaries, which represents around a quarter of the population, must pay public services according to fee schedules set by the Ministry of Health or seek – and privately finance - care from the private sector. Around 20% of the population has group or individual private insurance but the contribution of voluntary health insurance to financing care remains relatively limited.

The public benefit package is comprehensive but limited funding leads to long waiting times in the public sector

The public benefits package is comprehensive, with some dental services excluded. When services are either unavailable in the public sector or there are long waiting lists, the Ministry of Health can subsidise care provided to beneficiaries (based on income and need) either in the private sector or, more rarely, abroad. Capacity and resource constraints in the public sector lead to long waiting lists for some medical procedures and diagnostics. For this reason, a significant portion of the population prefers using private services for outpatient consultations and routine procedures, but turns to the public sector for more complex or costly services such as major emergencies.

Public user charges remain relatively low

Prior to 2013, user charges for public sector beneficiaries were minimal. However, since then, user charge levels have increased and new charges have been introduced. Public services now generally require some form of out-of-pocket payment. Beneficiaries pay EUR 3 for a visit to a general practitioner, EUR 6 for a visit to

[8] For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

a specialist, and EUR 10 for emergency department visits. That last rate also applies non-beneficiaries who are otherwise charged full prices for services. For diagnostics and inpatient care, however, non-beneficiary expenditure is capped to a means-tested maximum share of household annual income. There are almost no copayments on drugs in the public sector and the Ministry of Health manages a budget which can be used to partially reimburse some drugs which are only available in the private sector. Prescriptions made in the private sector are paid out-of-pocket.

The Ministry of Health runs the public sector

The public system is highly centralized and almost every aspect related to planning, organization, administration, financing, and regulation is under the responsibility of the Ministry of Health. It is exclusively financed by the state budget, with services provided through a network of public hospitals and health centres directly controlled by the Ministry of Health. Most regulations in the health system (e.g., concerning pharmaceuticals, private providers) were revamped in the context of the country's accession to the EU. Overall, health workers and medical technology are poorly allocated between the public and private sectors and the private sector's activity – beyond safety standards – is minimally regulated.

Service delivery is mixed but access to private services is mostly funded out-of-pocket

The public sub-system is highly centralized. Facilities at all levels have no financial autonomy and are staffed by civil servants. Private providers set their own fee schedule. Public primary care services are delivered in health centres as well as hospital outpatient departments. There is no gatekeeping mechanism or formal referral system between primary and specialist care in the public sector, except for certain specialties.

Cyprus has an average number of doctors but fewer nurses than other EU countries

In 2015, there were 358 practicing physicians per 100,000 population (which is around the average in Europe) and practicing 553 nurses and midwives, which is below average. The increase in the number of physicians in Cyprus had been considerably stronger than in other EU countries in recent years. The majority of physicians, dentists and pharmacists work in the private sector whereas the majority of nurses are employed in the public sector.

Policy Developments

Progress is being made towards establishing a universal coverage system

After three decades of delays, recent steps have been taken towards implementation of a new national health system providing universal access to care. Under the new system, a Health Insurance Organisation would cover the entire population and purchase services from public and private providers. The legal foundation for this new system was agreed by Parliament in 2001. However, full implementation has been continuously delayed due to, among other reasons, uncertainty regarding the costs, contribution rates, and financial and administrative autonomy of public hospitals and involvement of private insurers. The reform programme and timetable were finally agreed by the major parties and the President in July 2016, and parliamentary approval on a package of necessary laws, including on setting contribution and copayment rates, followed a year later. A contract for an IT system to support the new health system has been issued, and implementation of the new system is expected to be fully completed in 2020.

As part of this package, major service delivery reforms will be implemented

Service delivery reforms are an inherent part of this reform package and key to ensuring the new system's financial sustainability. First, public provider's autonomy must increase to allow them to contract with the Health Insurance Organisation and compete with the private sector. In June 2017, the Parliament approved a bill to provide financial and administrative autonomy to public hospitals. There are also plans to strengthen public primary care and establish gatekeeping, although the details are not known.

Notable efforts have also been made to obtain value for money in the pharmaceutical sector

Health Technology Assessment has not played a major role in determining the benefits package. In the public system, medicines are procured via tenders, where the bidder offering the lowest price wins the right to supply the entire market for 2 years. This has the potential to lead to low prices, presuming there is no monopoly producer. Private sector medicine prices are determined using external reference pricing. Generic substitution is required in the public sector, although in the private sector there are no incentives for doctors and pharmacists to prescribe generics. There are also clinical guidelines to discourage overprescribing, although no formal auditing system is in place to monitor compliance. Future plans in this area include the establishment of an autonomous medicines agency tasked with regulating medicines (Cyprus National Reform Programme, 2017).

JAF Health Results

Health outcomes in Cyprus are around or better than the EU average, but some indicators are deteriorating in the past three years

Heathy life years at 65 for men, potential years of life lost (for both men and women) and preventable mortality show a negative development compared to the EU average in the past three years, although levels (in 2015 and 2014) are still around the EU average. These variables are identified as health challenges. On the other hand, self-perceived general health as good/very good and bad/very bad are better than the EU average and show, respectively, a considerably positive and a positive development compared to the EU average over the past three years. Self-perceived general health is identified as a good health outcome.

A number of other indicators show a considerably positive (such as life expectancy at birth for men and at 65 for women) or positive (such as infant mortality) development in relative terms over the past three years.

Access: The number of consultations per doctor is better than the EU average and decreasing in relative terms

In 2015, the available indicators do not show any specific challenge in access, in particular related to self-reported unmet need for medical care, which is also improving compared to the EU average in the last three years. In 2014, the number of doctor's consultations is relatively low and shows a slight reduction in the last three years. However, the number of doctors' consultations for Cyprus refers to the public sector only.

Quality: The vaccination coverage rate of children for measles is a health challenge, as well as some cancer screenings

In 2015, the vaccination coverage rate of children for measles (90%) is below the recommended 95% threshold, although it shows a considerable positive development compared to the EU average change over the past three years. In 2014, the proportion of persons (aged 50-74) reporting to have undergone a colorectal cancer screening test in the past two years is worse than the EU average for both women and men and it is improving less than at the EU level. The share of persons (aged 20-69) reporting to have undergone a cervical cancer screening test in the past three years is decreasing from 2008, although it is still around the EU average. These indicators are identified as health challenges.

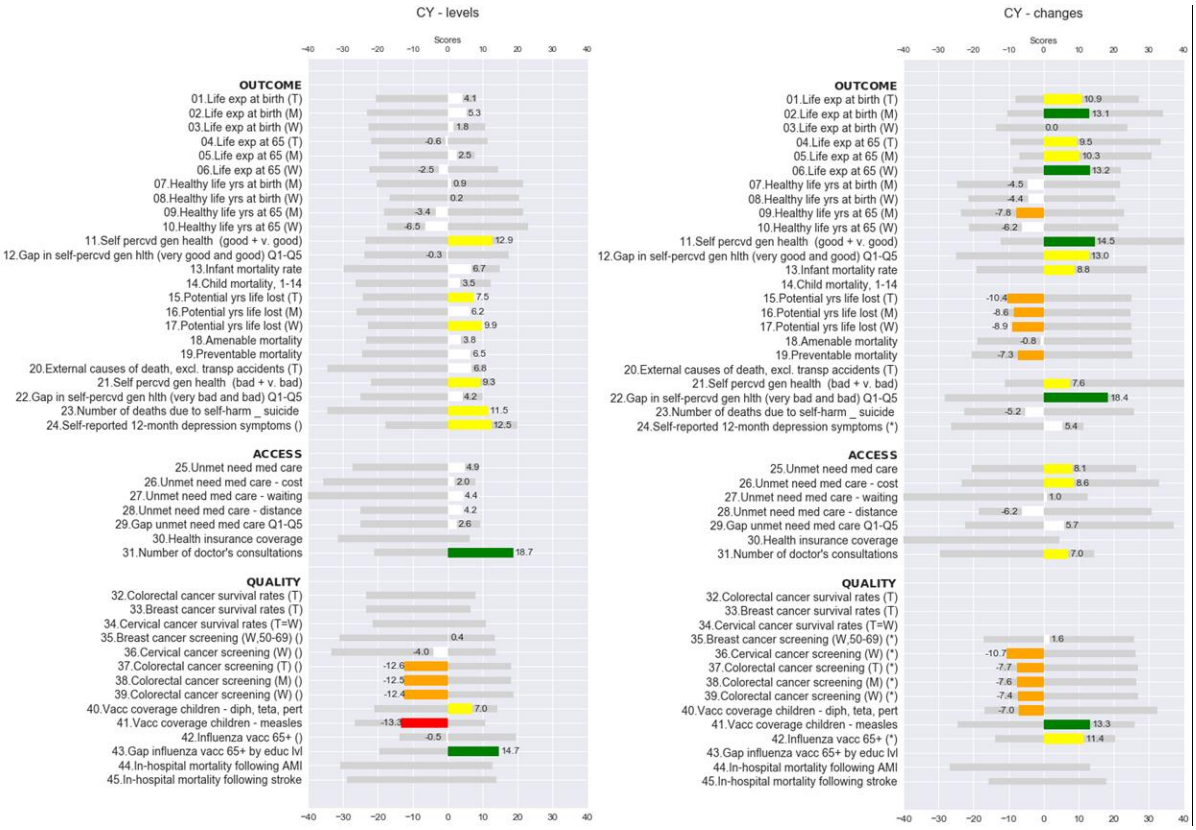
As regards vaccination coverage for DTP and polio, according to the last immunization survey performed by the Ministry of Health in 2015, the rate remains quite high i.e. 97.1% for the first 3 doses of the vaccine. This compares favorably to the 95% recommended threshold and remains constant across the years.(no statistical significance to the previous coverage rate assessed in 2012).

Non-health determinants: Lifestyle is generally good, while smoking is worse than the EU average, as well as some behaviors among young, and inequalities in some other risk-factors are worsening

In 2014, lifestyle indicators are generally good, with the obesity rate (especially among women) and alcohol use (especially among men), respectively, better and considerably better than the EU average and improving. These variables are identified as good health outcomes. On the other hand, the smoking rate, including among young, is worse than the EU average and it is considerably worse that the EU average among men. Inequality in alcohol use and in vegetable consumption between low a higher educated are, respectively, worse than the EU average and around worsening from 2008. These variables are identified as health challenges.

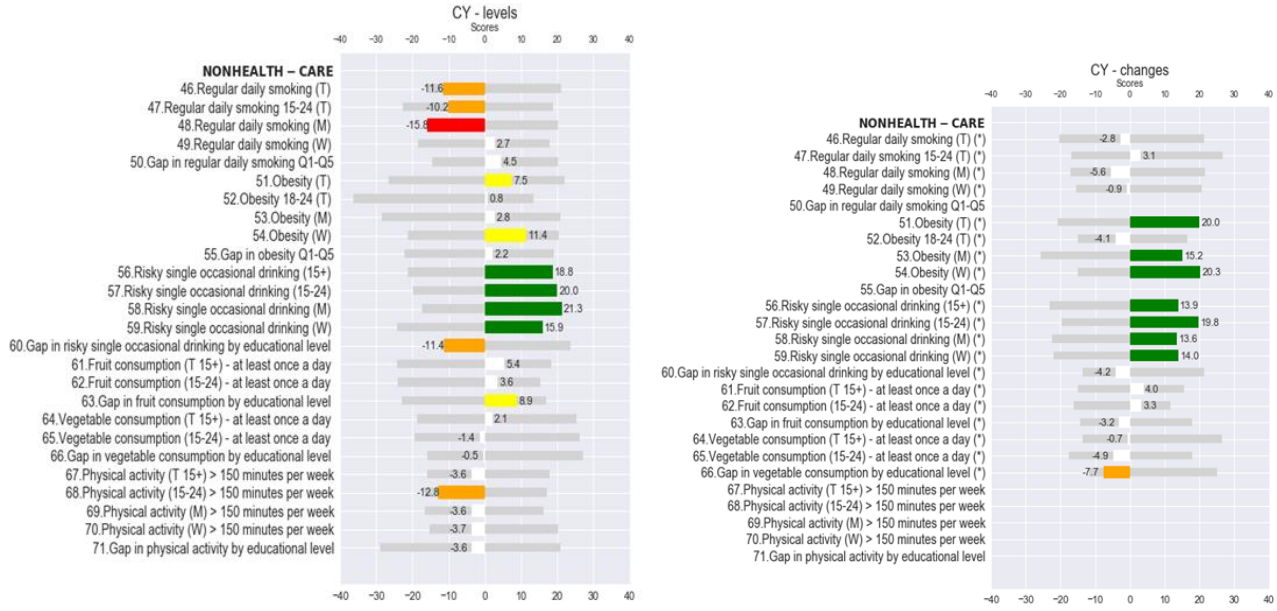
Physical activity among young is worse than the EU average.

Figure 9 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 10 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

CZECH REPUBLIC

With a level and structure of health spending similar to other EU countries, some health outcomes in the Czech Republic are worse than the EU average, such as life expectancy for women and at 65 for men. In a context of increasing attention paid by the Czech government to improving the quality of care, indicators on quality are generally good. In particular, indicators on prevention for children and women are better than the EU average. The only exception is influenza vaccination for older people, which is lower than the EU average. While the health system is mostly based on compulsory health insurance contributions, the state pays contributions on behalf of almost 60% of the population. Indicators on the access to healthcare are generally good, while unmet need due to distance is worse than the EU average, although low in absolute terms. In 2017, some measures were taken to upgrade the health workforce, including by improving training programs for nurses which suffered a decline in recent years. Inequality is a challenge in some dimensions, namely in self-perceived health and in fruit and vegetable consumption. Obesity, especially among men, and diet, specifically the consumption of vegetable, are identified as health challenges. Obesity among young is improving, while the Czech government initiated actions plans on nutrition and obesity, in particular among children.

Resources, Coverage and Organisation of the Health System

The level and structure of health spending is similar to other EU countries

In 2015, health spending in the Czech Republic was around the EU average when measured as spending per capita (1,992 pps) and slightly below average when measured as a share of GDP (7.2%). Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 1.0 percentage points in the Czech Republic, which is comparable to the EU average (0.9 percentage points) . In 2015, ,the spending structure did not differ notably from the EU average. Only expenditure for rehabilitative care (4.4% of CHE) was slightly above the EU average.

Compulsory health insurance plays a larger role than in other EU countries

In the Czech Republic, compulsory health insurance represented 70.4% of total health spending in 2015, which is higher than the EU average and government outlays accounted for 12.0%, slightly below the EU average. The remaining spending was made up of households' out-of-pocket payments (14.8%), which were slightly below the EU average, and voluntary schemes (2.8% of total spending), around the EU average.

Competing insurers provide statutory coverage to virtually all residents and pay providers

A statutory health insurance system covers all permanent residents and is operated by seven (as of 2014) competing health insurers which are quasi-public self-governing bodies. Compulsory, wage-based SHI contributions are the main source of health care financing in the Czech Republic, but the state pays contributions on behalf of almost 60 % of the total population (the so-called "state-insured"), mostly economically inactive including children, students, pensioners, women on maternity leave, people on parental leave, the unemployed, asylum seekers and etc. People are free to select their insurance fund and to ease the financial burden of health insurance funds with higher-risk beneficiaries and to lower the potential for risk selection, SHI contributions are redistributed among the funds according to a risk-adjustment scheme. The health insurance funds serve as the main purchasers of health care services in the Czech health system.

The benefit basket is broad and co-payments limited

The benefit basket is uniform, particularly generous and includes home nursing care, medical aids and devices, and spa treatment in 2017. Some services are excluded either implicitly (voluntary abortion) or explicitly (cosmetic surgery, acupuncture). Pharmaceuticals, medical aids and dental aids may only be reimbursed if they are on a positive list. Otherwise, they must represent the only available option for a given patient. Cost-sharing is required for pharmaceutical products but in order to protect vulnerable groups, there are ceilings for out-of-pocket payments.

The Ministry of Health regulates the system while health insurance funds manage coverage

The Ministry of Health serves as the main administrative and regulatory body while self-governing health insurance funds administer the collection of contributions and provide benefits-in-kind to the insured. The Ministry of Health also owns all university hospitals and some psychiatric institutions while regional authorities own several hospitals, including ambulatory (outpatient) care providers. For public health, the main actors are the National Institute of Public Health (NIPH), two institutes of public health (SZÚ a ZÚ) and 14 regional public health authorities (KHS), which are all directly under and managed by the Ministry of Health. As to long-term care, the Ministry of Health sets standards for health care providers and Ministry of Labour and

Social Affairs sets standards for social care providers, and offices under the Ministries conduct quality evaluations.

Service delivery is predominantly private for primary care and mixed for hospital care

Ambulatory care, both primary and specialist care, is provided predominantly by self-employed doctors in solo practice in health centres owned by municipalities and privately-owned polyclinics. General Practitioners (GPs) are reimbursed mainly through combination of capitation and fee-for-services. Specialist ambulatory care is paid on a fee-for-service basis. Hospitals are owned either by ministries, regional authorities, private sector or churches, and Diagnosis Related Groups (DRGs) are the main payment mechanism for inpatient care. Patients are free to see any specialist ambulatory care without referral and value this freedom highly, but a referral is needed for inpatient care except for medical emergency.

The density of physicians and nurses is around the EU average but the number of nurses decreased recently

In the Czech Republic, there were 369 practicing physicians per 100,000 population in 2013 and 841 nurses and midwives in 2015, both around the average of the EU. In recent years, the number of nurses and midwifes had tended to decrease. The problem in the remuneration of inpatient nurses has been addressed in the past three years with rapid raises of 10% a year. Since this year, nurses serving in shift receive extra remuneration in addition to general raises. These policies are meant to stabilize the workforce in Czech hospitals and provide competitive remuneration to both the outpatient sector and also other parts of the economy (notably the pharmaceutical industry). Concerns are growing about the distribution of the health workforce, the aging of physicians and the increasing tendency of younger ones to seek out better working conditions abroad. Many effective measures to remedy this situation can be envisaged, but an increased production of graduates in general medicine from all Czech medical faculties is undoubtedly a priority. This measure must not be postponed, because its effect will become evident at least 6 years later (if additional years necessary for specialist training are not considered). A long-term increase in the number of graduates from medical faculties will not only replenish the needed staff capacity, but also make the physician population younger. Furthermore, the Ministry of Health would like to reduce the administrative burden of physicians and nurses and to develop a legal protection of healthcare professionals.

The issue of remuneration has already been addressed in answers to other questions. Successive waves of pay raises in recent years have contributed to workforce stabilization. The long term sustainability of health workforce is a separate issue and the eventual decrease of number of GPs in particular seems unavoidable. As a result, higher concentration and efficiency of primary care provision should be pursued.

Policy Developments

Efforts are made to address growing issues in public health

The public health sector has seen significant reforms in recent years. From an administrative point of view, the largest change was the merger in 2012 of 14 public health institutes into two institutes of public health. The Strategic Document on Public Health of 2012 set long-term goals to expand traditional public health to include non-communicable diseases. Health promotion has gained importance over the last few years through the implementation of policies to address behavioural and social health determinants. In particular, the Czech Republic has taken on the WHO´s strategies when developing Health 2020 – National Strategy for the Protection and Promotion of Health and Disease Prevention, followed by action plans on nutrition, preventing and treating obesity, promoting physical activity, on health-risk management (tobacco, alcohol, prevention of high-risk group of children, reducing health risks from the living and working environment, managing infectious diseases, developing health screening programs, on quality of health care, on education of medical and non-medical staff, on eHealth development, on development of health literacy and indicators of the health status of the population. The same principles were embodied in the government strategic framework Czech Republic 2030. Tobacco control legislation was strengthened in 2017 (later than in most countries).

The need to improve the financial stability of the system has driven some reforms over time

The health financing system is unstable and over time different reforms have attempted to improve the situation. For instance, some restrictions have been put in place on the benefit basket. User fees were introduced starting in 2007, but were subsequently removed. A new risk distribution mechanism between funds will start operating in 2018. In addition to the number of clients, age and sex, the system will incorporate pharmaceutical consumption-based indicators which adjust for chronic diseases.

Increasing attention is being paid to improving quality of care

Safety legislation in 2011 fostered a wave of provider accreditation for institutions meeting minimal technical requirements, patient care standards, human resources management, quality and safety management,

and process assessment requirements. More recent advances in the area of quality and safety assurance include the adverse event reporting system and the introduction of sectoral safety targets for all health care providers. In 2012, maximum waiting times were established for several procedures, although there is little waiting time information, and it is not typically available to patients when they choose a hospital. To upgrade health workforce and its quality, in 2017, training programmes for doctors and nurses are also improved. With regard to data infrastructure, the national eHealth programme aims to tackle the current lack of interoperability between health-related data system and will also support the collection of information on quality of care which is currently lacking.

Since 2014, the new central system for adverse event reporting has been operated under the Institute of Health Information and Statistics supervision. Data about adverse events are monitored according the uniform methodology from 80 healthcare providers in a 3-years pilot study. Since 2018, there will be an obligation to report adverse events on central level from all inpatient healthcare facilities. In 2017, pilot study among home care agencies is also carried out.

There has been a significant development in increasing the efficiency of healthcare facilities data collection system thanks to the approval of the amendment of the Act on Health Services (372/2011 Coll.). The amendment allows us to implement system for monitoring of health care quality, contributes to the improvement of healthcare reimbursement and prescribes implementation of health registries that will allow us to significantly reduce the data collection burden. The National Registry of Reimbursed Health Services has been established within the scope of the ESF project "Development of the Technological Platform of the National Health Information System". The registry is operated in cooperation with the health insurance companies and will contain most of the production and reimbursement data collected from the healthcare providers. Due to the broad scope of the collected data, the registry will be used to validate or even replace many current data collections within the National Health Information System and will naturally become the main data source for production of performance indicators, namely those quantifying the volume of provided health service.

JAF Health Results

Life expectancy for women and at 65 for men, as well as inequality in self-perceived health are worse than the EU average

In 2015, life expectancy at birth for women (81.6 years) and life expectancy at 65 (both for women and men) are worse than the EU average. Healthy life years at 65 for men shows some negative development (only +0.1 years in the last three years) compared to the EU average change, although it is around the EU average. Inequality in self-perceived general health (as good/very good and bad/very bad) between income groups are, respectively, considerably worse and worse than the EU average. Moreover, the gap in the share of people who perceive their health as good/very good shows a negative development in the previous three years. These variables are identified as health challenges.

In 2014, potential years of life lost, amenable and preventable mortality are improving more than the EU average, while they are around the EU average.

Access: Unmet need for medical care due to distance is worse than the EU average

In 2015, unmet need for medical care due to distance is worse than the EU average, although it concerns a small share of the population (0.3%).

The past several years have seen increasing tension regarding the accessibility of care in remote/border/rural areas. Elderly doctors (both in outpatient, primary care and inpatient care) are retiring without being replaced with younger colleagues. This leads to greater concentration of care in large cities, where the density of doctors and services is actually increasing.

Several policies have been implemented to counter this trend. Firstly in the area of primary care, which is arguably most important in remote regions, a subsidy program has been designed to cover the costs of setting up new primary practices for providers willing to move to the remote regions. Providers in remote areas where the availability of care is threatened are also motivated by greater level of reimbursement from health insurance funds. Since health insurance funds are the ultimate guarantors of availability of care, it is up to them to design policies and reimbursement motivations that will attract providers to remote regions.

As for inpatient providers, regional and remote hospitals can expect greater increases in reimbursement than large providers (with higher reimbursement base rates). This should guarantee fair competition in healthcare labour market.

Furthermore, the recently implemented new health insurance redistribution system (PCG) does not intentionally include regional aspects. This rewards health insurance funds that have wide network of contracted providers rather than a concentrated one in metropolitan areas. In large cities where the demand of care is greater (arguably due to larger supply), health insurance funds are not compensated for insuring patients with this increased demand (ceteris paribus demographic and chronic factors). This should lead to lower

reimbursement of providers in cities to counterbalance higher demand. And in turn, lower reimbursement of metropolitan providers should discourage further concentration of care.

And lastly, the effort to keep out-of-pocket expenditure to health providers at a bare minimum prevents rent-seeking of providers, which would be otherwise incentivized to move to metropolitan areas where purchasing power of population is greater and they could more easily gain profits by leveraging it using OOP payments. We can for example see that in the area of dental care, where the share of out-of-pocket payments is the greatest, the concentration of care and provider mobility is also the greatest, resulting in decreasing availability of dental care in remote regions.

As for the assessment of efficiency and impact of said policies, it is still too early to tell. Most of these have been designed in recent years or are planned for the next year, therefore there is little evidence regarding their efficacy so far. We monitor some demand for subsidies to new providers in rural areas, but we cannot analyse if the policy is effective in attracting new providers or if we subside providers who would set up new regional practice even without the subsidy (this not being a randomised control trial policy).

In 2013, number of doctor's consultations is considerably higher than the EU average.

High number of consultations is perceived as both a source of inefficiency and a sign of high availability of care. In a recent OECD health system characteristics survey (HSCS, 2017) the Czech healthcare system received maximum scores for scope of coverage (with increasing trends regarding actual levels of coverage), patient choice among providers on one hand, and minimal scores for scope of out-of-pocket payments and gate-keeping on the other. With these characteristics, it is understandable that Czech system generates such a high volume of doctor consultations. These characteristics are generally seen as a point of strength rather than weakness of the Czech healthcare system. If self-reported data on consultations to the physicians are considered (data from the European Health Interview Survey, population aged 15+), the position of the Czech Republic is very close to the EU average. During the last month only about 42 % of all respondents consulted a doctor.

Non-health determinants: Obesity and diet, as well as inequalities in fruit and vegetable consumption, are a challenge in the Czech Republic

The obesity rate, especially among men, and vegetable consumption are worse than the EU average. Inequalities in fruit and vegetable consumption between educational groups are worse than the EU average. The obesity rate is considerably improving among young. As mentioned above, the Health 2020 national strategy addresses lifestyle challenges and includes support for physical activity, good nutrition and eating habits, prevention of obesity, food safety and development of health literacy.

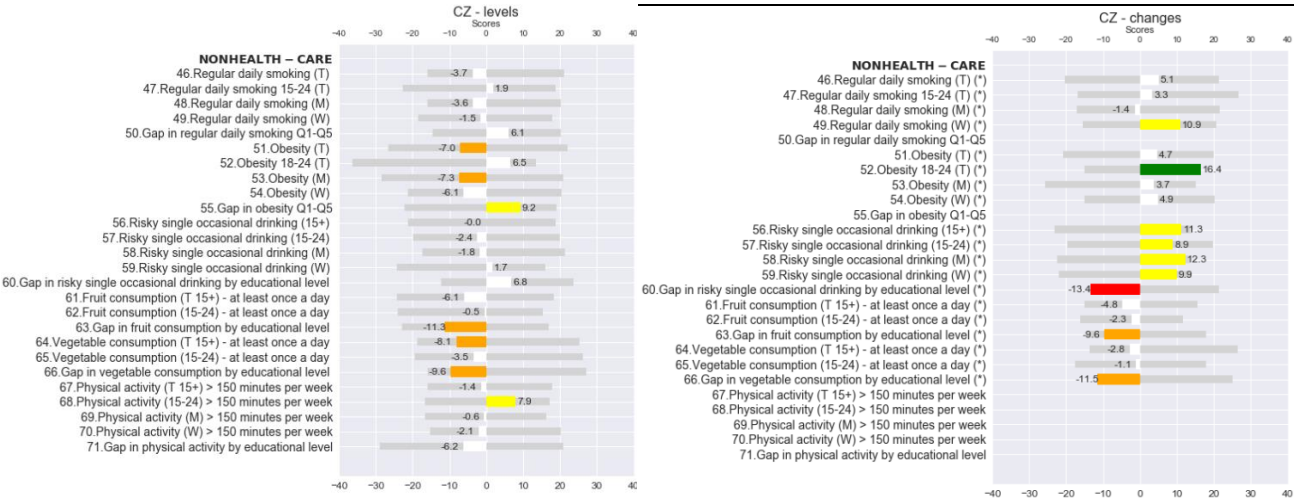
Quality: The indicators in the quality dimension are generally good, with the exception of influenza vaccination for over 65 year-old

Influenza vaccination rate for over 65 year-old (15.5% in 2014) is worse than the EU average and it identified as a health challenge. However, in 2015 was adopted an amendment of the Public Health Insurance Act, which included an amendment point: “the paid service is pneumococcal vaccination to an approved vaccine schema for those over 65 years of age”. On the other hand, the vaccination coverage rate of children for DTP (99% in 2015) is identified as a good health outcome. Similarly, cancer screening for women (in particular for cervical and colorectal cancer) are considerably better than the EU average in 2014.

Figure 11 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 12 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Denmark

With health expenditure higher than the EU average, health outcomes in Denmark are around average. Life expectancy for women is increasing, but their healthy life years are decreasing in the last years. While the number of nurses and midwifes is around the EU average, infant mortality is increasing more that at the EU level. Vaccination coverage rates of children are also a challenge in Denmark, as they are below standards. Other indicators on the quality of healthcare are around or better than the EU average. Denmark has a universal decentralised healthcare system, mostly financed by government sources, with a comprehensive package of services and no cost-sharing for primary care and hospitals. In a context of care integration and coordination, the number of doctors' consultations is better than in other EU countries. While access healthcare is generally around the EU average, unmet need for medical care due to distance is worsening in the last years. There are also some inequalities between different population groups. In particular, the gap in self-perceived general health as bad between the bottom and the top income quintile is widening in the last years and inequality in vegetable consumption is considerably worse than the EU average. In terms of risk-factors, risky alcohol consumption is an issue in Denmark, while smoking and physical activity are better than the EU average. Reducing risky behaviours has been on the agenda in Denmark.

Resources, Coverage and Organisation of the Health System

Health spending in Denmark is above the EU average

Health spending in Denmark is above the EU average when measured on a per capita basis (3,494 in pps in 2014) or as a share of GDP (10.4%). Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.9 percentage points in Denmark, equal to the EU average. At 2.8% of GDP in 2014, Denmark spent considerably more on long-term care than most other EU countries. Otherwise, the spending structure did not differ notably from the EU average.

In Denmark, the proportion of government outlays (84.2%) is considerably higher than in the EU and there is no compulsory insurance. The remaining spending is made up of households' out-of-pocket payments (13.8%) and voluntary schemes (2%), both lower than in most other EU countries.

The health system in Denmark is decentralised, and mainly financed through general taxation

The highly decentralised Danish health system is tax-financed with universal coverage for all residents, and health services are delivered by a mix of public and private providers. In addition to the central government, five regional health authorities and 98 municipalities (local authorities) have different responsibilities for the delivery of services, and purchase of services from private providers. The regions are primarily financed by the central government (app. 75%), and secondarily by municipal co-financing. The municipalities are primarily financed through taxes (app. 71%), and secondarily through central government grants and other schemes.

Grants made from the central government are adjusted for social and demographic factors.

At the national level, the Parliament, the Ministry of Health, the Danish Health Authority, the Danish Medicines Agency, and the Danish Patient Safety Authority are responsible for the general regulation, planning, and supervision of health services, including cost-control mechanisms. These authorities also have important roles in supervising health personnel, developing quality management programme, planning the location of specialist services, approving regional hospital plans, and approving mandatory "health agreements" between regions and municipalities to coordinate service delivery. The regions are, amongst other things, responsible for the treatment of patients, operation of hospitals, and supervision of general practitioners and specialists. Municipalitities however, while municipalities are responsible for disease prevention, health promotion, rehabilitation, home care and long-term care amongst other things.

The Danish population enjoys access to a comprehensive package of services

All registered Danish residents are entitled to a comprehensive package of services while non-residents only receive acute care treatment. A voluntary, privately funded initiative by Danish doctors provides access to care for irregular migrants and visitors. The initiative is supported by the Danish Red Cross and Danish Refugee Aid (Commonwealth Fund, 2015).

Publicly financed health care includes all primary, specialist, hospital, preventive, mental and long term care services. National law and guidelines stipulate that regions make the decisions about the prioritisation of health services and new medical treatments. The "medicines council" established in 2017, is responsible for evaluating the cost-effectiveness of new pharmaceuticals, and provides guidance for regional decision-making. Residents have the right to seek treatment

anywhere in the country if their home region does not provide a service delivered elsewhere (in these cases, the home region needs to cover the expenses of treatment). Furthermore, a guarantee ensures that residents who are not examined or treated within 30 days after being referred by their GP, have the right to seek medical examination or treatment at private or foreign hospitals.

There is no cost-sharing for primary care services and hospitals

In Denmark, publicly financed services are mostly free of charge at the point of use. However, to varying degrees, user charges are required for outpatient visits to psychologists, chiropractors and physiotherapists, as well as for prescriptions, hearing aids, cosmetic treatments and dental care. Patients with high annual expenses for medicines dispensed from pharmacies (over DKK 3 390 or EUR 455)) receive 85 % reimbursement for all drug costs. On behalf of their patients, physicians are also able to apply for a raised reimbursement if the patient is in need of more expensive synonymous medicine (e.g. if the patient is allergic to the additives in the cheap alternative), or apply for full reimbursement if the patient is terminally ill. Patients with expenses exceeding DKK 3 955 or EUR 530 annually, receive full reimbursement of their expenses.. Retirees and people receiving incapacity benefits with personal assets less than DKK 84 300 or EUR 11 300, are able to receive an additional health allowance that covers expenses for medicine, dental treatment, listening aids, physiotherapy, podiatry, psychological treatment and chiropractic treatment. Most complementary voluntary insurance (for drugs and dental care) is provided by a not-for-profit organisation, while supplementary insurance (providing expanded and faster access to private providers) is often provided as an employment benefit. Although 38 % of the population has these types of complementary or supplementary coverage, they only cover a small part of total health expenditure.

Service delivery is mainly private in primary care and public in secondary care

General Practitioners (GPs) work predominantly in private solo practices, and act as gatekeepers for access to hospital services as well as other specialists. Nearly all Danish GPs are independent professionals working on a contractual base with the regional authorities, and are commissioned to provide primary care services either from their own facilities, or (less often) renting space from a publicly run local health care clinic. GPs are paid through a mix of capitation from the regions and fee-for-service. Capitation is composed of a basic fee based on the annual patient numbers as well as a performance element. Hospital service delivery is mainly public. Regions decide on budgeting mechanisms, generally using a combination of fixed-budget and activity-based funding based on diagnosis-related groups (DRGs), with the fixed budget making up the bulk of the funding.

Denmark has a considerably higher number of nurses and midwifes, while the number of physicians is around the EU average

In 2014, Denmark had 366 practising physicians per 100,000 population (around the EU average), but this number had increased less in recent years than in other EU countries. The number of nurses and midwives, however, was considerably higher than in most other EU countries (at 1,702 per 100,000 population) and had increased more in recent years than in the EU

Policy Developments

Denmark is promoting care integration and coordination

Various measures have been introduced by regions and municipalities to promote greater care integration and cooperation. Hospitals, for example, use outreach teams for home visits after hospital discharge. Municipal units have also been established within hospitals to facilitate follow-up care after hospital discharge. Some municipalities created “Health Houses” where general practice, allied health personnel and office-based specialist services are provided at one site. These multi-specialties facilities focus on care for chronic patients. In such models, GPs are encouraged to act as a care coordinator.

The new three-year agreement between the Organisation of General Practitioners and Danish Regions (concluded in September 2017) also aims at improving care coordination for patients with type 2 diabetes, COPD and cancer by strengthening GP follow-up after hospital discharge. A quality assurance programme will be introduced, and an electronic pathway program will be implemented for patients with type 2 diabetes, COPD and lower back pain. The agreement also strengthens the efforts to prevent hospital admissions, and establishes easier access to home-based care for vulnerable and chronic patients. Furthermore, a dedicated action plan for diabetes patients was agreed upon in 2017, which will improve early detection of type-2 diabetes, including by strengthening the monitoring children, young adults and vulnerable groups.

Denmark is improving care provision for elderly patients

A national action plan for elderly patients with complex care needs was launched in 2016. The Action Plan entails 1.2 billion DKK of extra funding for 2016 to 2019 and 300 million DKK annually from 2020 onwards. The overarching objective is to enhance the capacity of municipal health services to improve care quality for elderly and focus on early detection and intervention.

Acute care functions in the municipalities will be enhanced to reduce hospital overcrowding.

Reducing risky behaviours is on the agenda in Denmark

In Denmark, the municipalities are by Danish Health Law required to promote healthy living, and the Danish Health Authority is tasked with formulating recommendations regarding healthy diet, reduction of alcohol consumption, increasing physical activity, and reducing tobacco usage.

Following several EU tobacco Products Directives, Denmark has introduced health warnings on cigarette packages and also increased taxation of tobacco products. Beyond this, Denmark continues to implement a range of programmes to reduce tobacco consumption including tobacco cessation programmes and public awareness campaigns through mass media.

Denmark also implemented national strategies to promote physical activity and better nutrition, and to tackle the rising rates of obesity. In addition, 11 "prophylactic packages" were published in 2012 which aim at helping the municipalities in reducing alcohol consumption and smoking, increase physical activity, and combat mental illness etc. In regards to alcohol consumption, the government financially supports two partnerships to help achieve this target : (i) the "Partnership for a responsible alcohol culture" which involves industry stakeholders and focuses on compliance with age limits on the sale of alcohol and on initiatives to change the alcohol culture in bars; (ii) the "Partnership for youth and alcohol" which involves municipalities and civil society organisations with the aim to reduce underage drinking by initiating local activities for young people in collaboration with local authorities and civil society.

JAF Health results

Health outcomes are around the EU average, with an increase in life expectancy for women and a decline in their healthy life years in the last years

Healthy life years at birth for women is deteriorating over the past three years and it is worse than the EU average in 2015. Although the infant mortality rate and the gap in self-perceived general health as bad/very bad by income group are still around the EU average, they show negative developments compared to the EU average change in the past three years. These variables are identified as health challenges.

While life expectancy at 65 for women are considerably improving in the last three years and their remaining healthy life years are better than the EU average, healthy life years for women (both at birth and at 65) are decreasing more than the EU average change in the same period.

Access: Unmet need for medical care due to distance is worsening in the last years

While unmet need for medical care (including due to distance) is around the EU average in 2015, unmet need due to distance (0.1%) is worsening more that at EU level in the past three years. The number of doctor's consultations (4.4 times) is lower than the EU average and keep decreasing in the last three years (4.7 times in 2012).

Quality: Vaccination coverage rates of children are below standards

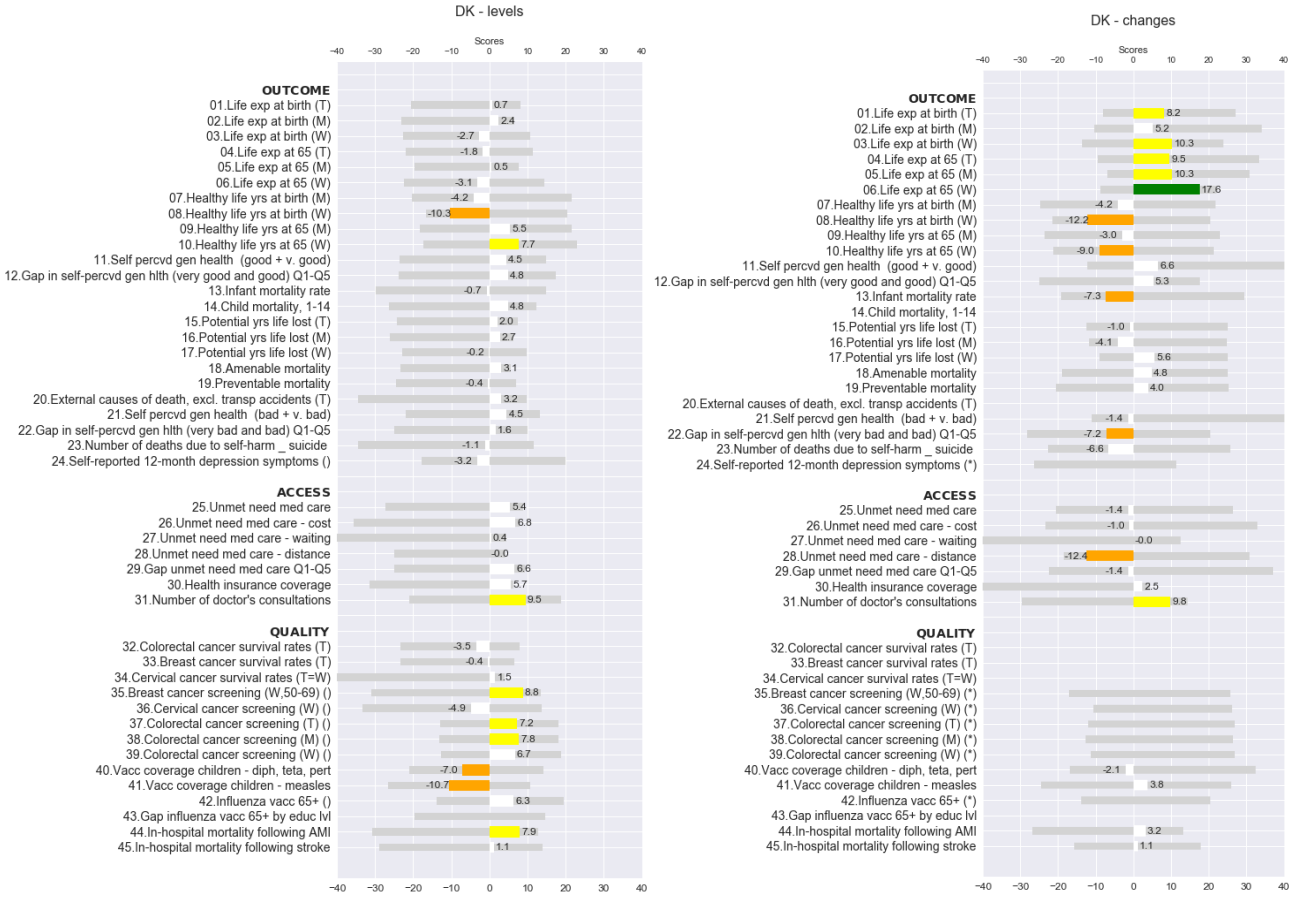
In 2015, the vaccination coverage rate of children for DTP (93%) and measles (91%) are below the recommended 95% threshold and are identified as health challenges in Denmark.

Other quality indicators are around or better (e.g. for specific cancer screenings) than the EU average.

Non-health determinants: While smoking and physical activity are better than the EU average, the risky alcohol consumption is an issue

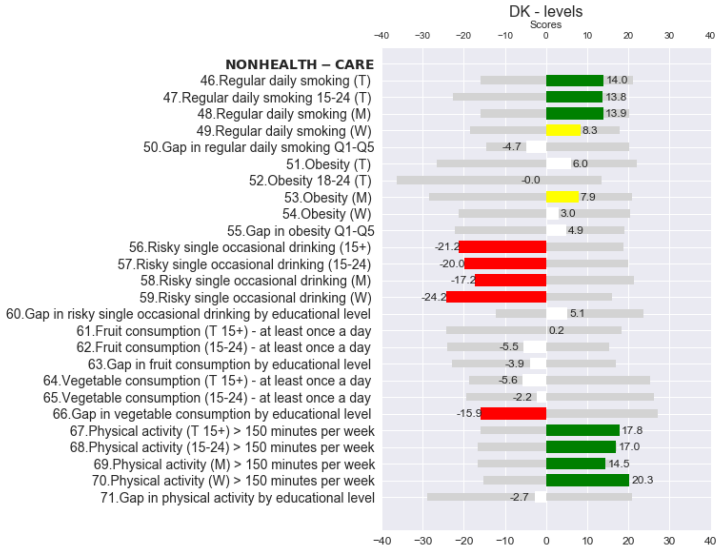
Data on risk-factors based on EU surveys are limited for Denmark compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

Figure 13 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 14 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



ESTONIA

With a below EU average expenditure for healthcare, health outcomes in Estonia are generally worse or considerably worse than average, although most are improving. Most indicators in the JAF Health quality domain are worse than the EU average, including about prevention, while a few are improving. In particular, indicators on prevention (e.g. cancer screenings, vaccination coverage rates of children) show a worse than average performance. However, public programs for certain cancer screenings (e.g. colorectal) have recently been introduced. Estonia is internationally recognized for developing E-health services, with the aim of improving care quality and efficiency. The worse than average performance in terms of lifestyle indicators, which include some inequalities, stresses the need for better prevention. The government is discussing some measures to tackle unhealthy lifestyles, such as increasing taxes on unhealthy products. Healthcare financing is mostly insurance based and aims at providing universal coverage. Nevertheless, the government has decided to increase public spending on health starting from 2018. However, access to healthcare is a challenge. A relatively large proportion of the population (6%) remains uncovered. Estonia reports the highest level of unmet need for medical care in the EU and this rate is also increasing over time. Unmet need is mostly due to long waiting time for some specialised services. Workforce shortages in some areas of care (including in hospitals) contribute to explaining long waiting times and, recently, the government started to take some measures to increase healthcare spending and personnel. The rationalization of the hospital sector through the shift towards ambulatory care can have an impact on waiting time.

Resources, Coverage and Organisation of the Health System

Health spending in Estonia is below the European average

Health spending in Estonia is below the EU average when measured on a per capita basis (1,458 in pps in 2015) or as a share of GDP (6.5%). Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.6 percentage points in Estonia, which is comparable to the EU average (0.9%)[9].

Compared with the EU average, Estonia spends relatively less on long-term care and more on curative and rehabilitative care. While around the EU average, administrative expenditure had been declining faster than across the EU over the three preceding years.

The majority of public spending is financed by social insurance

In Estonia, funding by compulsory insurance represents 64.9% of current health expenditure, which is slightly higher than on average in the EU and the proportion of government outlays, at 10.8% of current expenditure, is slightly lower than in the EU. Starting from 2018 healthcare spending of government is increasing with a contribution on behalf of pensioners. Households' out-of-pocket payments are around the EU average (22.8%), while voluntary schemes represent only 1.6% of current health spending, below the EU average.

[9] For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

The insurance-based health system aims at providing universal access to care

The Estonian Health Insurance Fund (EHIF) aims to provide universal access to health services and contracts public and private providers to that effect.

Enrolment is compulsory, based on residence and financed by an earmarked social payroll tax paid by the employed. In 2016, 94% of the population was covered by the mandatory health insurance and this proportion has been stable in the last 6 years. The exact status of the uninsured is unclear but it is believed that these are predominantly young men who are economically inactive or working abroad.

The range of services covered by the EHIF is relatively broad, but rationing through waiting times occurs.

The public benefit package to be financed by the EHIF is outlined in the 2002 Insurance law and further specified through government acts. It includes preventive and curative health services, pharmaceuticals and medical devices, as well as prevention and health promotion programmes. Partial coverage for dental care is also included and has been extended to the entire population as of July 2017. While entitlements include a relatively broad range of services, limited funding constrains the supply of those services, contributing to long waiting times for some specialised services.

However, users do have to pay out-of-pocket expenses for most goods and health care services

In Estonia, the health insurance act allows co-payments for patients and sets some limit. Patients incur no charge for a visit to the family doctor but pay EUR 5 for home visits or specialist consultations, EUR 2.50 per day for a hospital stay (up to 10-day max), and EUR 9.75 for inpatient nursing care. For prescription-only

pharmaceuticals delivered on an outpatient basis, the general reimbursement level is 50% of the price for listed pharmaceuticals. Yet, higher reimbursement rates of 75%, 90% and 100% exist and apply for some diseases and indications (e.g. cancers, syphilis, and diabetes), prescriptions for chronic diseases and some patients groups, such as children and pensioners. There is also a co-payment of EUR 2.50 per prescription not depending on the rate of reimbursement. Out-of-pocket spending also includes payments for services that are not in the benefits package or are made to non-contracted providers. Altogether, co-payments for medicines and dental care account for 74% of out-of-pocket spending.

The Ministry of Social Affairs and its agencies are responsible for planning, administration, regulation and financing of the health system

The Ministry of Social Affairs is the steward of the health system and is supported by several agencies including the National Institute for Health Development, the Health Board, the State Agency of Medicines and the Health and Welfare Information Systems Centre. They are responsible for the development of national health care policies and legislation, supervision of compliance with legal acts, collection and analysis of health information and the registration of health care professionals and licensing of health care facilities. The Estonian Health Insurance Fund is responsible for contracting with health care providers, paying for healthcare services, reimbursing pharmaceutical expenditure and paying for temporary sick leave and maternity benefits.

Service delivery is mainly private in primary care and public in secondary care

In Estonia, the primary care system is well developed with independent family physicians acting as the first level of contact and gatekeepers to secondary care. Family physicians are responsible for providing a core package of services to their patient-list. Since 2006, age-adjusted capitation, fee-for-service payments and basic allowances have been complemented by a quality bonus system. The overarching aim is to expand the role of family physicians and to improve the management of chronic conditions. Hospital service delivery is mainly public. A diagnosis-related group system was implemented in 2004, complementing fee-for-service payments.

The availability of human resources is comparable to the EU average, but shortages are anticipated

In 2016, the numbers of physicians (352.6 practicing physicians per 100,000 population) and nurses and midwives (677.0) are similar to the EU average. The number of nurses and midwives, however, had been declining in Estonia in recent years, in contrast to most other EU countries. The proportion of health personnel working in hospitals (in FTE) is below the EU average (931.3 per 100,000 population) and has decreased considerably in recent years.

Policy Developments

E-health services have been developed to increase care quality and efficiency

Estonia has invested in e-health and is internationally recognised for its innovations. Most health care providers keep an electronic health record for patients and all health care providers are responsible for sending data on patient health and service provision to the central health information system. The system also allows e-consultations, digital referrals and e-prescriptions – virtually all prescriptions are electronic and pharmacists increasingly sell on-line. Several new applications are under development, including an electronic immunisation passport, a central digital registration system for outpatient care and, since 2016, a facility to provide access to claims and costs. The use of the platform is intense with 4.5 million enquiries from the patient portal to the e-health system in the first 4 months of 2017.

Addressing risk factors is on the policy agenda in Estonia

In accordance with several EU directives, the government increased excise taxes on cigarettes (2006–17), and introduced a smoking ban in public spaces, public transport and workplaces (2007), picture warnings on tobacco products (2016) and a ban on smoking areas in buildings (2017). The Green Paper on Tobacco Policy established by the government also aims at reducing the attractiveness of tobacco products, promoting a smoke-free environment and curbing the black market. Other key measures introduced by the government include the 'sober and healthier' programme started in 2004 to raise awareness about alcohol-related harm. Since 2018 Estonia adopted policies to further limit alcohol advertising and introduce sales restrictions. Estonia is currently at the end of process developing the Green Paper on nutrition and physical activity which aims to set goals on reducing health problems arising from dietary choices and lack of physical activity. Furthermore, Parliament is also discussing a tax on sugar-sweetened beverages to tackle obesity, which is growing sharply, especially among the young.

Shifting care toward outpatient care has been a priority in Estonia

The rationalisation of the hospital sector, coupled with the development of family medicine centred primary care, is a stated priority in Estonia. Many small hospitals have merged or turned into ambulatory (or outpatient) clinics, nursing and rehabilitation facilities, hospi-

tals and social services providers. In addition, since 2014, regional hospitals are encouraged to network with general hospitals to share skills and medical resources and to support access to specialist care in smaller hospitals. By 2018, two such networks coordinated by the North Estonian Medical Centre and Tartu University involved six general hospitals. Plans to further strengthen family medicine are also under development including the development of new multi-practitioners multidisciplinary primary care centres.

Measures are taken to avoid workforce shortages

Shortages in the health workforce in Estonia have been emerging as a result of professional ageing and inadequate training volumes and contribute to extend waiting times in some areas of care. To further develop nursing care, the government recently decided to increase the nurses training places from 400 in 2016 to 517 in 2020 (2018 – 501 nurse students, 2019 – 501 nurse students). The government also finances the project "health workers back to health care system" (in 2018 is project for doctors). Recent changes have also enabled more substitution by increasing the role of nurses and midwives in health system organisation.

JAF Health Results

Health outcomes in Estonia are generally worse or considerably worse than the EU average, although most are improving

Life expectancy for men is worse than the EU average. In 2015, life expectancy for a boy at birth is 73.2 years (9 years less than for a girl) versus 77.9 for the EU. However, life expectancy (at birth and at 65) is improving considerably for all and especially for men. Healthy life years (at birth and at 65) are worse than the EU average, especially for men who have considerably lower values but the figure increased in 2016 reaching to 56.5 years. A 65 year-old men can expect to live 5.3 years without disability versus an EU average of 9.4 years. The self-perception of general health (as good/very good and bad/very bad) is considerably worse than the EU average, as well as inequality in self perceived general health (as measure by the income quintile gap) which is not improving Among the bottom income quintile 34.1% declare to be in very good or good health against 75.2% in the top income quintile. Potential years of life lost are considerably worse than the EU average, especially for men (for women are worse than the EU average), but they are improving considerably with respect to the average change in EU countries (for women they are also improving). In 2014, amenable and preventable mortality (234.6 and 325.3, respectively, per 100000 population aged 0-74) are worse than the EU average and the first is improving more than the EU average. The number of deaths due to self-harm/suicide is worse than the EU average and increasing considerably more than the EU average. These variables are identified as health challenges. On the other hand, infant mortality rate is identified as a good health outcome, as it is better than the EU average and considerably improving in relative terms.

In 2013, child mortality (20.1 per 100 000 child aged 1-14 years) is considerably worse than the EU average, as well as external causes of death (excluding transport accidents). However, in 2016 child mortality decreased to 12.6 death cases among 1-14 year olds per 100 000 child aged 1-14 years (Estonian Death Registry). Similarly, latest data for external causes of death (excluding transport accidents) in 2016 show a reduction (59.7 according to the Estonian Death Registry).

Access: The highest level in the EU of unmet need for medical care and the relatively low health insurance coverage signal a challenge in access to healthcare

In 2015 Estonia has the highest level of unmet need for medical care in the EU (12.7%), which is mostly due to waiting time. This share is also increasing considerably in the last 3 years with respect to the EU average. Unmet need due to distance is considerably worse than the EU average, but still small in absolute terms (0.7%) and relatively improving in the last 3 years. Health insurance coverage is also lower than the EU average (94.3%). In general, access to healthcare is identified as a health challenge.

Quality: Most indicators in the JAF Health quality domain are worse than the EU average, including about prevention, while a few are improving

In 2014, breast cancer screening (for women aged 50-69) is considerably worse than the EU average, while cervical cancer screening (for women aged 20-69) is worse than the EU average but improving considerably with respect to the EU average change. In 2013, in-hospital mortality following ischemic stroke is worse than the EU average, but improving considerably with respect to the EU average change. The vaccination coverage rate of children for DTP is lower than the recommended 95% threshold (93% in 2015). Influenza vaccination for over 65 year-old is not included in national vaccination programs and it is considerably worse than the EU average. These variables are identified as a health quality challenge.

The breast cancer survival rate in Estonia for 2014 (relative survival rate for years 2010-2014) was 79% and for cervical and colorectal cancer respectively 67% and 55%. In 2007 the survival rates for colorectal and breast cancer were worse and considerably worse, respectively, than the EU average. However, colorectal cancer screening for both men and women remains worse than the EU average in 2014, this is as expected as Estonia started its public screening program for colorectal cancer in 2016, with only 6.5% of people

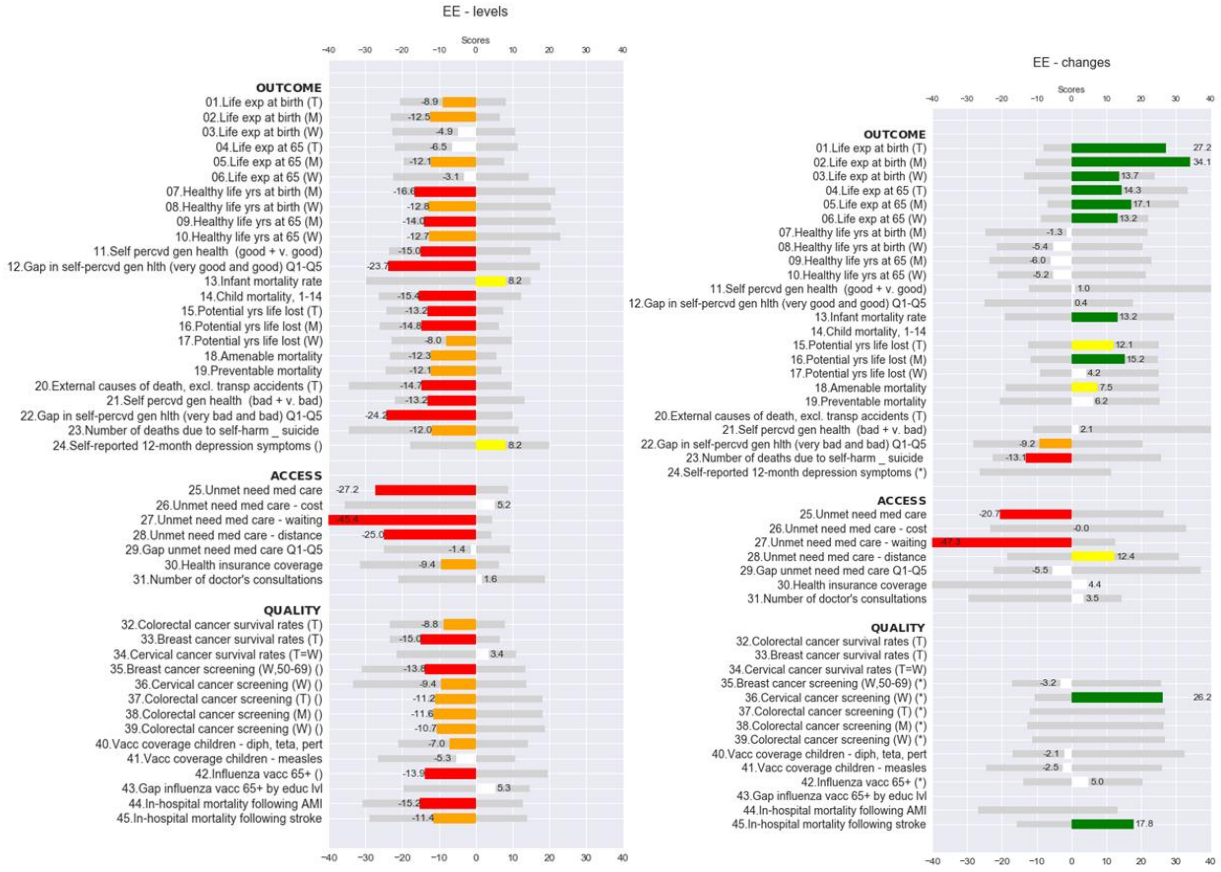
aged 50-74 reporting to have undergone a test in the past two years.

Non-health determinants: Lifestyle indicators are worse than the EU average in most areas, such as in alcohol use and especially for obesity among women

In 2014, obesity (19.7% of the population) is worse than the EU average and among women (20.8%) is considerably worse than the EU average. The smoking rate of men and young are worse than average, while for the first is considerably improving from 2008 compared to the EU average change. Fruit consumption (including among young) is worsening from 2008, although it is still around the EU average. Inequality in fruit consumption between lower and higher educated is worse than the EU average, but is improving considerably more than average.

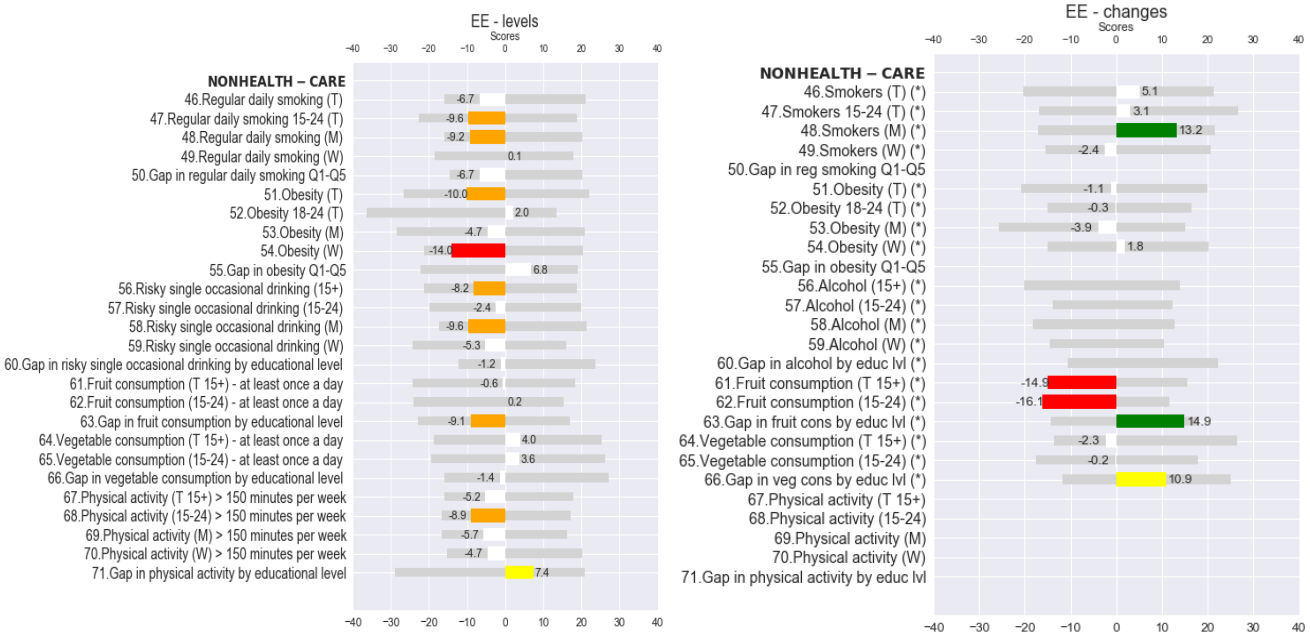
In 2014, alcohol use among men is than the EU average. The share of people reporting to have had a risky single occasional drinking in the past year is 52.7% compared to an EU average of 40.1%. However, data on alcohol use in 2008 are not available for Estonia. The smoking rate and physical activity of young Estonian (15-24 year-old) are worse than their EU peers. According to the Estonian national dietary survey the situation on obesity is worrisome also among children, as 13.9% of 6-9 year-old and 13.2% 10-13 year-old are obese.

Figure 15 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 16 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

FINLAND

With an average health spending per capita, health outcomes in Finland are around the EU average with life expectancy improving considerably more than average. However, healthy life years at birth, especially for women, are worse than the EU average. Finland also has a higher number of nurses and midwifes than the EU average and a considerably lower infant mortality rate. The quality of healthcare is generally good, with a few exceptions. With a higher than average spending on prevention and public health, some lifestyle indicators are better than the EU average (e.g. smoking) while others are worse (e.g. alcohol use). In a context of rapid aging, public healthcare is open to all residents and increasingly supplemented by occupational and private insurance, which offer a faster access to healthcare mostly to working age people in higher socio-economic groups. Unmet need for medical care due to waiting list is identified as a challenge, as it is considerably worse than the EU average. Wide-range reforms are being discussed in Finland, with the main aim of improving coordination and reducing expenditure.

Resources, Coverage and Organisation of the Health System

Health spending per capita is around the EU average, but spending on long-term care and prevention is higher

Health spending per capita in Finland, which stood at 2,885 pps in 2014, was around the EU average. Health spending measured as a share of GDP (9.5%) was also similar to the EU average, but had increased more in recent years than in other EU countries. Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and a rise in incomes: between 2013 and 2060 the percentage of GDP spent on health is projected to increase by 0.7 percentage points in Finland, which is comparable to the EU average (0.9%). Finland spends 1.7% of GDP on long-term care, which is slightly above the EU average. However, this share has somewhat eroded in recent years, thus growing less than in other countries. Spending on prevention and public health services is also higher than on average in the EU, at 3.3% of total health expenditure. Finland spends relatively less on administration (1.6%) than most other EU countries.

The share of government outlays is higher than across the EU but out-of-pocket expenditure are around the average

In Finland, the proportion of government outlays (62.2%) is higher than in the EU, while the proportion of care funded through compulsory insurance (13.2%) is lower. The remaining spending is made up of households' out-of-pocket payments (19.1%, similar to the EU average) and voluntary schemes (5.5%). In contrast to other EU countries, the share of out-of-pocket payments in health spending has decreased in recent years.

The health system is mostly decentralised and service delivery predominantly public

In Finland, until 2020 when the Regional Government together with Health and Social Services Reform is implemented municipalities finance and deliver the bulk of health services, which are thus public, while the National Health Insurance (NHI) mostly provides pharmaceutical coverage and partially reimburses private services.

Access to public healthcare is open to all residents and coverage supplemented by additional public and private financing schemes

Municipalities finance and organise, for the residents of Finland, the provision of primary care and hospital care. The NHI – which is funded by compulsory insurance contributions and state transfers – is responsible for the financing of outpatient medications, health care-related travel costs, and sickness and maternity allowances for all permanent residents in the country. Certain population groups (irregular migrants, tourists, temporary visitors from non-EU countries) are not covered, but are entitled to essential emergency care. The NHI also partially funds the occupational health care schemes employers have to offer their employees (approximately one-third of the total population) and reimburses a proportion of care patients purchase privately. A growing share of the population (now 15%) also has duplicate, complementary and/or supplementary private health insurance, mainly to cover the cost of private services and outpatient drugs not covered by the NHI. Occupational health care and private health insurance offer wider provider choice but mainly cover people from higher socioeconomic groups and working people.

Co-payments for services can be extensive

User fees in the form of co-payments are quite extensive, as charges apply to most municipal health care services, including primary and emergency care. A cap of EUR 691 per person per year applies to user charges for public health services. For prescribed medicines, patients pay the first EUR 50 in a given year. Above this deductible, most drugs are reimbursed at a 40% rate (others can obtain a special reimbursement level of 65 % or 100 %), but out-of-pocket spending is capped at EUR 605 per year. Some services are free of charge

(e.g. outpatient primary and dental care for children, visits to maternal and child health clinic, occupational health care services), and people with certain diseases and disabilities are also exempted from payments. People who purchase private services pay out-of-pocket and can seek partial reimbursement by the NHI.

Central and local institutions are involved in health care governance

At the national level, the Ministry of Social Affairs and Health is responsible for developing and implementing health reforms and policies, and it extensively relies on a network of expert and advisory bodies in its work. The statutory National Health Insurance (NHI) scheme is run by the Social Insurance Institution and accountable to Parliament. Over 300 municipalities are responsible for the organisation and provision of health and social care services with some autonomy in the planning and steering of these services. Municipalities also jointly administer 20 hospital districts. Åland Islands have an autonomous status and administer the health and social welfare services by themselves.

Health care services are mainly provided by public providers

Primary care is offered in public health centres and (for employees) in occupational health units. Public health centres are financed out of the municipality budgets and staff salaried. They commonly include General Practitioner (GP)-run inpatient units, largely for chronic and long-term care patients. Secondary care (including specialised outpatient care, inpatient care and day surgery) is mainly provided by public hospitals organised in municipality-owned hospital districts. Hospital payment methods are not uniform across district. Tertiary care is delivered in five university hospitals. Finland has few private hospitals, but private provision of specialist outpatient care is much more common. Patients need a referral to access specialist care, except for emergency cases.

Finland has a high number of nurses and midwifes

In 2014, Finland had 321 practising physicians per 100,000 population, which is around the EU average. The number of nurses and midwives, however, was considerably higher, at 1,508 per 100,000 population. The roles of some nurses have expanded greatly with new functions such as patient case managing, consultations and prescribing, although the actual number of nurses practising in these expanded roles still remains relatively low.

Policy Developments

Wide-ranging reforms are being proposed in Finland

A major reform currently under discussion in Finland aims to establish a less decentralised health and social care system -at the regional (county) level. The overarching goal is to curb expenditure growth through cost savings. The main proposed changes include transferring responsibility for the organisation and provision of health and social care services from municipalities to 18 newly created regional governments (counties); moving from a multi-payer towards a single-payer system, financed through general taxation; and improving the provision of services by introducing a purchaser-provider split and provider competition, extending freedom of choice for patients, strengthening service integration and continuity of care, and centralising emergency care and certain specialist services.

Finland is strengthening primary care and care coordination through eHealth

One important challenge in Finland is to strengthen access to and efficiency in primary care and promote greater coordination among primary care providers and hospitals. To this end, Finland has invested substantially in eHealth. It introduced a nationwide harmonised electronic patient record, the national Patient Data Repository (referred to as KANTA). This information system includes all public and private health care providers. It also includes mandatory electronic prescription and a health portal allowing citizens to review their own information. Since September 2016, these electronic patient records cover the entire population.

Finland has implemented several policies to control pharmaceutical spending

In 2009, reference pricing was introduced and since then reimbursement for pharmaceuticals has been based on the price of the cheapest substitutable product plus a small premium. Hence, if patients choose a product whose retail price exceeds the reference price, they need to pay the share above the reference price. Pharmacists are obliged to dispense the cheaper product and replace the prescription by a generic medicine if available. Finland also introduced several policies to reduce inappropriate prescribing including treatment guidelines complemented by the monitoring of prescribing patterns, as well as education and information campaigns on the prescription and use of medicines.

JAF Health Results

Most health outcomes in Finland are around the EU average, while healthy life years at birth among women are worse than the EU average and infant mortality considerably better

In 2015, the life expectancy at both birth (81.6) and 65 (20.2) are around the EU average, while their developments over the last three years are considerably better or better than the EU average. Healthy life years at birth is worse than the EU average, especially among

women. These variables are identified as health challenges. Although the share of people who perceive their health as good/very good shows a considerable positive development in the last three years, inequality between income groups is worse than the EU average. On the other hand, the share of people who perceive their health as bad/very bad is better than the EU average. Infant mortality rate is considerably better than the EU average and it is identified as a good outcome.

In 2013, the number of external causes of death, excluding transport accidents, is worse than the EU average. The number of deaths due to self-harm or suicide improved more that the EU average in the past three years and is now around the EU average. In 2014, the self-reported 12-month depression symptoms is worse than the EU.

Access: unmet need for medical care due to waiting time is a challenge

While unmet need for medical care due to cost (0.1%) is better than the EU average in 2016, unmet need due to waiting time (4%) is considerably worse than the EU average[10]. In 2014, the number of consultations per doctor is lower than the EU average.

Quality: the quality of healthcare is generally good, with the exception of colorectal cancer screening

In 2013, in-hospital mortality following stroke (at 5.1% in 2013) is considerably better than the EU average and it is identified as a good health outcome.

In 2014, colorectal cancer screening (both for women and men) is worse than the EU average. The pilot study on colorectal cancer screening 2004-2014 is currently discontinued, since the effect on mortality was much smaller than expected On the other hand, breast cancer and cervical cancer screening are better than the EU average.

Non-health determinants: Smoking rate and physical activity are considerably better than the EU average, while alcohol use and fruit consumption are worse

Data on risk-factors based on EU surveys are limited for Finland compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

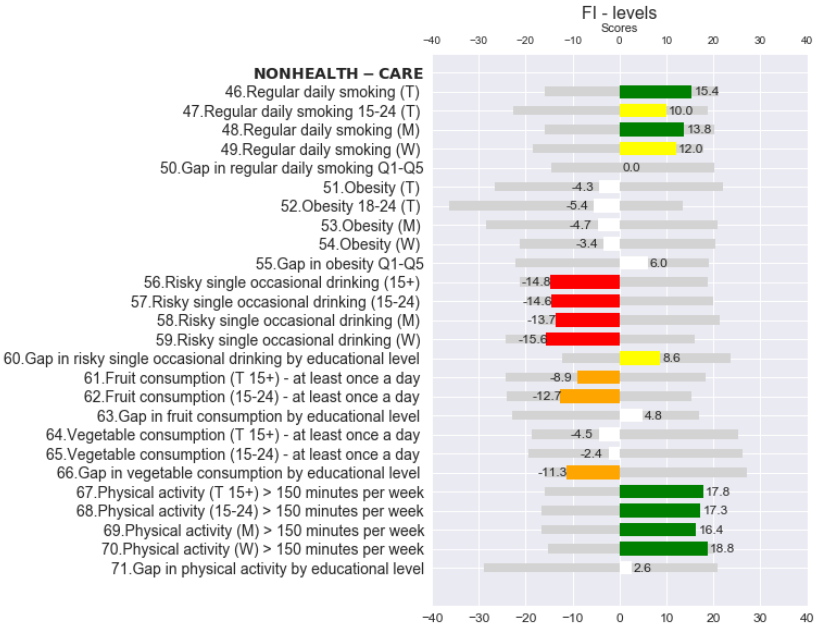
In 2014, the smoking rate (especially among men) and physical activity are considerably better than the EU average. On the other hand, the consumption of alcohol is considerably higher than the EU average. The consumption of fruit is worse than the EU average, as well as the gap in vegetable consumption between high and low educated people.

[10] However, the 2016 data is still provisional and in 2015 there was a break in the series for Finland.

Figure 17 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 18 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



France

With a relatively high health expenditure and good socio-economic context, France has good health outcomes, especially for the life expectancy of women, and a good access to healthcare. While expenditure for health is projected to increase at the same pace as the EU average, the French population is aging faster and some risk factors, including for young, are worse. The smoking rates of young and women are considerably worse than the EU average. Inequalities in lifestyle are also worse than the EU average, in particular for smoking and obesity. The deteriorating trend of obesity signals this issue as a health challenge. Recent interventions try to address the challenge of obesity among children. Prevention among children, in particular concerning the vaccination against measles, represents a health challenge in the quality dimension.

Resources, Coverage and Organisation of the Health System

Health spending is high in France and projected to increase at the same pace as the EU average

Health spending per capita in France is higher than the EU average (3,339 in pps in 2014) and considerably higher and rising if measured as % of GDP (11.1% in 2014), largely a consequence of sluggish economic growth in recent years. Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.9 percentage points in France, the average level across the EU11. In terms of structure, France stands out due to relatively high administrative expenditure on health (6% of current health spending), half of which relates to private supplementary insurance. Spending on curative and rehabilitative care (55%) is around the EU average.

The financing structure is characterised by the prominent role of social insurance.

In France, the share of compulsory contributory insurance in the financing of health expenditure is larger than the EU average (75% in 2014, SHA data) and the share of government schemes correspondingly lower. Yet, altogether, public spending on health is around the EU average.

The historically work-based statutory health insurance scheme has shifted to a universal coverage one since 2000

In France, all legal residents are covered by statutory health insurance (SHI), an entitlement to the wider social security system. The SHI scheme initially offered coverage based on professional activity and was contingent on contributions but is now based on residence and more than half financed by earmarked taxes (notably the contribution sociale généralisée, CSG).

The French health care basket is relatively broad in terms of goods and services covered

Medical goods and services covered include hospital care and treatment delivered in public and private institution, outpatient care provided by GPs, specialists, dentists and midwives and all other services prescribed by doctors (diagnostic and medical procedures, laboratory tests, pharmaceutical products, medical appliances, and health care related transport).

However, the depth of public coverage is uneven, with cost-sharing applying to most goods and services

A complex system of co-payments and deductibles applies to most good and services, but patients with specific diseases can be exempted from co-payments for the care and medicines related to their illness. Overall, hospital care is ultimately well covered (92% of the related expenditure was publicly funded in 2015). For outpatient care, in general, the reimbursement rate ranges between 70% of the statutory tariff for consultations with doctors and dentists to 60% for services provided by medical auxiliaries and laboratory tests. These rates can be reduced in the absence of a referral from the "preferred doctor"; patients are encouraged to register with a "preferred doctor" who is generally a primary care physician acting as a gatekeeper. The SHI also does not cover extra-billing amounts over statutory tariffs. Overall, around 66% of ambulatory care is publicly funded. The majority of outpatient pharmaceuticals are reimbursed at a 65% rate but non-substitutable or expensive drugs are reimbursed 100% and for drugs that have been assessed as having a low effectiveness only 15% (Service Médical Rendu). Overall 70% of ambulatory medicine expenditure is reimbursed.

In France, patients have traditionally paid for ambulatory health services at the point of use and are then reimbursed by the social health insurance and by their voluntary health insurance. This can constitute a financial barrier to access to health care for certain population groups. For this reason, the French authorities started to universalise third-party payment at the point of use, a reform whose implementation is still in progress.

[11] For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

Voluntary Health Insurance (VHI) plays an important role in France

VHI provides complementary insurance for co-payments and better coverage for medical goods and services poorly covered by SHI. It finances approximately 14% of total health expenditure, which is considerably higher than the EU average and covers about 95% of the population. Out-of-pocket (OOP) payments account for 7% of total health expenditure in 2015, considerably lower than the EU average and this proportion had been decreasing in the three previous years.

Health policy, regulation and management of the health system are split between the central government and the SHI with an increasing role being delegated to the regions. The State (parliament, government and various ministries), defines general policies for the health sector, organizes the health system, determines the operating conditions of the SHI and sets its annual target budget (known as ONDAM). The statutory health insurance (SHI) manages its budget, negotiates with health professionals, proposes the basket of services admitted to reimbursement and can modify reimbursement rates within the limits defined by the state.

Since the mid-1990s, reforms have aimed to devolve some state responsibilities to the regional level, in particular for planning. In 2010, most existing regional institutions were merged in 2010 into a single regional health agency (ARS), under the responsibility of the ministry of health, to ensure that health care provision meets the needs of the population.

Services delivery is mixed

Primary and secondary ambulatory care is provided mainly by self-employed doctors, dentists and medical auxiliaries (including nurses and physiotherapists) and, to a lesser extent, by salaried staff in hospitals and health centres.

GPs have taken on an increasing role in the coordination of care with the introduction in 2004 of the "preferred doctor" scheme that provides incentives to people to visit their GP prior to consulting a specialist. The patient now is required to choose a primary GP ("preferred doctor") and to seek a referral from them for specialist services (otherwise, the consultation's reimbursements of medical consultations are lowered). Acute specialized care is provided by a diverse range of public, private for profit and non-profit hospitals. The hospital sector has traditionally occupied a central place in the French health system. Over the past decade, progress has been made to shift care away from the expensive inpatient sector to day care and outpatient care outside hospitals. Medicines are dispensed by self-employed pharmacists.

The availability of human resources is average but their distribution uneven

In 2015, the ratio of the number of physicians per population was around average, and it had increased more slowly than the EU average in the preceding three years. National data suggest that the number of nurses and midwives per population is also average. Further, the density of nurses and midwives has increased faster in France than on average in the EU 15 between 2010 and 2014. The proportion of health personnel working in hospitals (in FTE) is higher than the EU average.

The density of health care professionals is variable between geographic areas in France, in particular for specialist doctors. In 2015, the density of doctors was more than three times higher in urban than in rural areas (4.5 doctors per 1 000 population in urban areas vs 1.4 in rural areas).

Policy Developments

In recent years, various initiatives have sought to address the lack of coordination and continuity of care in the health system.

New modes of organisation such as multi-disciplinary care homes and hospital at home have been developed

These include the gatekeeping system and provider networks to offer multidisciplinary care to patients with complex needs. The development of multi-disciplinary health homes which group self-employed health professionals has also been encouraged in France since 2007 particularly in rural areas. The reduction in length of stay in hospital is partly due to the expansion of the "hospitalisation at home" programme (known as Programme d'Accompagnement du Retour à Domicile, PRADO) from 2010, which has been designed among other things to reduce delayed hospital discharges.

The development of coordination structures among providers is being further encouraged at the local level

The "Loi de modernisation de notre système de santé", adopted in January 2016, aims at rationalising the supply of physical and human resources to bring efficiency and quality gains. On the hospital side, the plan is to develop "Groupements hospitaliers de territoires" (GHT) to improve cooperation between hospitals within a defined geographical area. In July 2016, 135 GHTs were created to improve health care accessibility through greater communication and collaboration between 850 French hospitals. Regarding ambulatory care, the law plans the development of "Communautés professionelles territoriales de santé". The aim is to improve multidisciplinary practice between a range of health and social care professionals. This is expected to improve coordination at the interfaces between vari-

ous parts of the health care system and between health care, social care and long-term care. While it is too early to assess the impact of such Communautés professionelles territoriales de santé, they are intended to better meet the needs and improve the quality of care of the chronically ill population.

Programs to tackle obesity have been in place since 2001 and trends have stabilised but socio-economic inequalities remain high

A national programme for health nutrition (PNNS) has aimed to tackle obesity and overweight in France since 2001. Trends have stabilised but children of manual workers are still much more likely to be overweight (22%) or obese (6%) than children of executives (13% and 1% respectively). Addressing social inequalities has become a major objective of this programme with its renewal in 2011. Additional measures to reduce the prevalence of obesity and promote healthy life-styles were included in the 2016 law to modernise the French health system, notably restrictions of the distribution or sale of unlimited volumes of soft drinks and the possibility for "preferred doctors" to prescribe physical activities adapted to patients with long-term conditions. France also plays an important role in the coordination of the "joint action on nutrition and physical activity" (JANPA) – a programme that aims to contribute to halting the rise of overweight and obesity in children and adolescents in Europe by 2020

JAF Health results

Health outcomes are generally good in France

In 2015, life expectancy of women at 65 (23.5 years) is considerably better than the EU average and it is identified as a good health outcome. In 2015, life expectancy at birth for women and life expectancy at 65 for men are better than the EU average.

The number of deaths due to self-harm/suicide is around the EU average, and has decreased faster than the EU average over the last three years (from 16.68 per 100000 inhabitants to 14.13). Nevertheless it remains an area of concern in France, which is the reason why a national observatory of suicide was created in 2013.

The self-perceived level of good and very good general health is also better than the EU average (2014). All other JAF outcome variables are around the EU average and their developments over the last three years are similar to the EU average according the latest available data.

Access: Data on access dimension is around the EU average

In 2014, the number of doctors' consultations is around the EU average but has been decreasing between 2011 and 2014 (from 6.8 consultations in 2011 to 6.3 in 2014, per 1000 inhabitants), whereas it has been slightly increasing on average over the 18 MS for whom data are available. The other JAF access indicators are around the EU average and their developments over the last three years are similar to the EU average from the latest available data. 1.2% of the population reported unmet need for medical care in 2015 (a drop from 2.8% in 2014), while the gap between the top and the bottom income groups is small as compared to EU average.

Quality: Indicators on quality are generally better than the EU average, with the exception of vaccination coverage rate of children for measles

The vaccination coverage rate of children for measles is lower than the 95% threshold (at 91% in 2015) and it is identified as a health challenge. While the evolution of the first dose vaccination against measles, mumps and rubella is rather stable, the second dose vaccination is increasing. In 2014, the first dose vaccination was at 90.6% and the second dose at 76.8%[12]. In 2013, in-hospital mortality following AMI was around the EU average. In 2015 the fatality rate following heart attack is 5.6% (down from 7.9% in 2005) in France versus an EU average of 7.4% (down from 10.2% in 2005).

The colorectal cancer screening (51.4% in 2014) is considerably better than the EU average (both for women and men) and increasing. It is identified as a good outcome. National screening program for colorectal cancer has been extended to the whole French territory in 2008-2009, leading to an increase in the screening rate between 2008 and 2014[13]. National data from the screening program (Santé Publique France) show a slight decrease from 2011-2012 to 2013-2014, partly because some screenings were delayed before the introduction of a new test.

In 2014, cervical cancer screening is better than the EU average, although JAF data show an increase smaller than the EU average in the last three years. Estimations of the coverage rate based on reimbursement data (EGB-Cnamts, exploitation by Santé Publique France) show a slight decrease in coverage rate since 2008[14]. An experimentation for an organized screening program was conducted in 2010-2012, and will be implemented on the whole territory as part of the "Plan cancer 2014-2019".

Breast cancer screening is better than the EU average, with 87% of women 50-69 year-old covered. The de-

[12] Source: DREES in health quality and efficiency program (PQE), 2017 - http://www.securite-sociale.fr/Indicateurs-Objectifs-Resultats-Maladie-Partie-2,5222.
13 See DREES; "L'état de santé de la population en France », 2017, pages 230-233.
14 Ibid, pages 234-235.

velopment of this share was similar to that in other EU countries. National data from the screening program (Santé Publique France) shows a stability of breast cancer screening program participation between 2008 and 2014[15]. According to health care reimbursement data (Cnamts), 56% of women aged 50 to 74 received a breast cancer screening over the last two years, a slight decrease from 2007-2008 when that share was close to 60%[16].

National cancer register data (Francim) and civil register data (RNIPP, Insee) have been used to estimate 5 years survival rates for people diagnosed with cancer between 2005-2010, and between 1989-1993. Over this period, survival rates have improved for most cancers, including breast cancer (from 80 % to 88 %), colon and rectum cancers. However, survival rates for cervical cancer has been decreasing[17].

The vaccination coverage rate of children for DTP is above the 95% threshold (98% in 2015) and the influenza vaccination of over 65 is higher than the EU average (55.3%). The other JAF quality indicators are around the EU average and do not show developments over the last three years different from the EU average from the latest available data.

Non-health determinants: Risk-factors among young are an issue in France and some inequalities are worse

The obesity rate is around the EU average (14.7%) but has increased faster than in countries for which data is available on average (considerably for young people) between 2008 and 2014. National data confirms an increase in obesity rate among adults aver the recent years, although at a slower pace since 2000 than before. Obesity rates among children seem to have stabilised since 2000[18]. The gap in obesity between the bottom and top income groups is worse than the EU average. Fruit consumption among young (15-24 year-old) is worse than the EU average (38.2% in 2014) and it is identified as a health challenge. However, the gap in fruit consumption by educational level is negligible and it is identified as a good outcome.

The gap in regular smoking between income groups and the smoking rate of young people (22.2%) are, respectively, considerably worse and worse than the EU average. The smoking rate among women in 2014 is worse than the EU average (18.3%). According to national survey data, in 2014, 29% of adults aged 18-75 years old smoke daily (versus 22% of people over 15 according to EHIS data). After decreasing for several decades, the occasional smoking rate has increased between 2005 and 2010 and was then stable between 2010 and 2014. The daily smoking rate among 18-75 years old also increased between 2005 and 2010, but then decreased between 2010 and 2014 (from 29,7% to 28,6%), due to less frequent daily smoking women[19]. Physical activity among young people (38.1% in 2014) is worse than the EU average.

The other JAF non-health determinants indicators are around the EU average and do not show developments over the last three years from the latest available data.

[15] DREES; "L'état de santé de la population en France », 2017, pages 228-229. Among women 50-74.

[16] Ibid. The reimbursement data doesn't allow to differentiate perfectly between a mammography intended for screening and a mammography intended for diagnostic or follow-up.

[17] DREES; "L'état de santé de la population en France », 2017, pages 222-227.

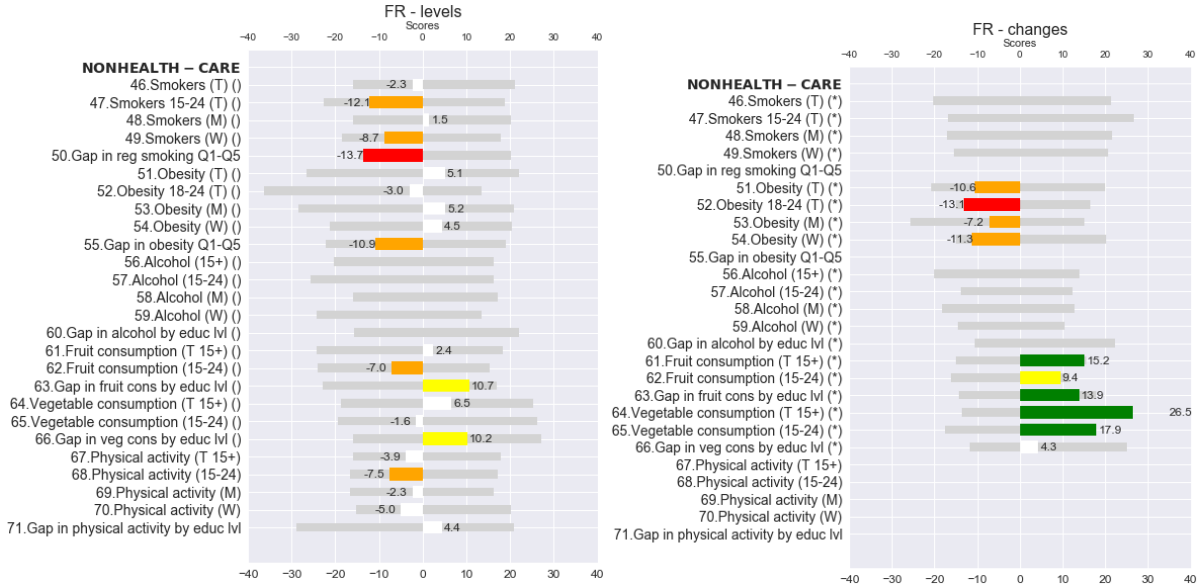
[18] DREES; "L'état de santé de la population en France », 2017, pages 123-149.

[19] DREES; "L'état de santé de la population en France », 2017, pages 123-149.

Figure 19 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 20 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

GERMANY

Germany has the highest health expenditure (in % of GDP) in the EU and a higher than average expenditure on administration (although on a declining path). Healthcare expenditure is mostly financed by mandatory public (SHI) or private (PHI) insurance. The two systems are operated by a large number of entities: 100 funds for SHI and 40 companies for PHI. Health insurance in nearly universal, while a small share of residents (0.2%) has no insurance. This share may include people such as on low income or self-employed with difficulties in paying SHI contributions or PHI premiums. Within SHI, the depth of coverage is broad and co-payments limited by caps based on patients' income. Unmet need for medical care, as a measure of access to healthcare, is better than the EU average. With a higher number of health employees than average and measures taken to improve the availability of care in rural areas, Germany has an average performance in terms of health outcomes with few exceptions. Healthy life years, in particular for women, are identified as a good health outcome, while life expectancy is not improving as much as in other countries and self-reported depression is worse than the EU average. Indicators on the quality of care are generally good in Germany, with the exception of influenza vaccination for elderly, which is worsening in the last years. A new institute has recently been founded for enhancing quality assurance and transparency. In terms of risk-factors, the situation in Germany is better than the EU average for smoking, while the rising obesity rate among young is a challenge. Health promotion is on the German political agenda and recent initiatives address dietary habits and obesity, in particular among children and adolescents.

Resources, Coverage and Organisation of the Health System

Health spending in Germany is considerably higher than in most European countries

In 2015, health spending per capita in Germany (4,113 pps) was considerably higher than on average across the EU and had increased substantially more than in other European countries in recent years. As a share of GDP, health spending, at 11.2%, is the highest in the EU. It is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.6 percentage points in Germany, which is lower than the EU average (0.9 percentage points) . In 2015, Germany spent more on long-term care (1.8% of GDP) than most EU countries and the share had increased faster than in other countries in recent years. At 4.8% of total health spending, administrative spending was substantially above the average, but unlike many other countries, the share has gone down in recent years. Otherwise, the spending structure did not notably differ from the EU average.

Compulsory health insurance plays a larger role than in most EU countries

In Germany, compulsory health insurance represented 77.9% of total health spending in 2015, which is higher than the EU average, and government outlays accounted for 6.6%, below the EU average. The remaining spending was made up of households' out-of-pocket payments (12.5%), which were below the EU average, and voluntary schemes (3.0% of total spending), around the EU average. The share of compulsory insurance spending had increased faster in Germany than in most other EU countries in recent years, while the opposite was true for out-of-pocket payments.

Mandatory coverage is provided though a mixed insurance system which funds access to predominantly private service providers

Since 2009, health insurance coverage has been mandatory for residents in Germany and most people (88% of the population) are covered by the social (public) health insurance (SHI) system. The rest of the population is predominantly covered by the private health insurance (PHI) system (operated by around 40 companies), which is open to specific population groups allowed to opt out of SHI system: employees over a specific income-threshold, civil servants and the self-employed. Additional schemes exist for policemen and asylum seekers. Service providers are mostly private. They typically sign collective agreements with the group of SHI funds which operate in their regions or in some cases at the federal level.

Competing funds provide the social health insurance coverage

The SHI system is operated by more than 100 competing health insurance funds. Within the SHI system, contributions are wage-related and shared between employers and employees, with the federal government making transfers on behalf of the economically inactive population. A risk-equalisation mechanism redistributes social contributions between SHI funds to counterbalance differences in the risk profiles of their insured populations. To enhance competition between the health insurance funds, each sickness fund can charge an additional income-related contribution fee directly to its members, who are free to switch insurance funds. Insurance premiums payable for coverage in the PHI system are calculated based on the health-risk of the individual. Long-term care coverage is a separate scheme organised along the same principles.

Coverage is near universal

Although insurance coverage is legally mandated, it is estimated that about 0.1 % of the population did not have insurance in 2015 (Mikrozensus 2015 of the Federal Statistical Insurance Authority). Lapses in coverage do only occur, when individuals do not cooperate with SHI and contribute to administrative necessities. On the other hand, unpaid PHI premiums or SHI contributions do not lead to exclusion from the insurance but to reduced benefits. While undocumented migrants (theoretically) have a right to health care often fail to do so because of language barriers or because they are afraid of legal consequences.

The benefits basket is broad and copayments limited

SHI covers a broad benefits package and individual SHI funds may include additional services for their insured. In contrast to many other countries the German benefits package also includes dental care, dental prostheses and orthodontics – although with considerable user charges. The benefits basket includes all licensed prescription drugs, i.e. there is no positive list of covered pharmaceuticals. Within the SHI system, copayments mainly apply to pharmaceuticals and inpatient care. They are capped at 2% of a patient's gross annual income (1% for chronic patients). Benefit packages in the PHI system depend on individual insurance policies. Federal law only stipulates a minimum package. There is also a significant variation with regards to copayments. People can opt for reduced monthly premiums in exchange for a higher deductible. Copayments for services in the long-term care scheme are considerable.

Self-governing bodies play a decisive role in the German health system

The federal government defines the overall legal framework for the system, while the regulatory details are specified in directives issued by the Federal Joint Committee – the highest self-governing decision-making body in the country. The Federal Joint Committee consists of representatives of associations of SHI funds, physicians and dentists, hospitals, and three independent members. It takes decisions on SHI benefits, reimbursement systems and quality assurance. The states (Bundesländer) supervise self-governing bodies at state level and are responsible for hospital planning and investments. The Federal Insurance Offices supervises SHI funds at the federal level while the Federal Financial Supervisory Authority is responsible for the monitoring of private health insurers.

Service delivery is predominantly private

Ambulatory care, both primary and specialist care, is provided predominantly by self-employed doctors in private solo and group practices. For patients covered under the SHI system, individual physicians are paid fee-for-service within a budget capped at practice level but some preventive services remain uncapped. For PHI patients, they are also paid fee-for-service, but in this case fees are not capped and tariffs are generally higher than for SHI patients which can lead to preferred treatment of PHI patients. Hospitals can be under public, private or not-for-profit ownership and Diagnosis Related Groups (DRGs) are the main payment mechanism for inpatient care. Patients can freely choose their GP and can see any ambulatory specialist without referral. However, SHI funds give financial incentives to those patients who participate in a voluntary gate-keeping system.

Germany has more physicians and nurses than many other EU countries

In Germany, there were 414 practicing physicians and 1,363 nurses and midwives per 100,000 population in 2015, both above the average of the EU and considerably more so for nurses. The numbers of physicians and nurses have both increased more in Germany (and considerably more for nurses and midwifes) than in most other EU countries in recent years.

Policy Development

Prevention and health promotion are on the political agenda

There has been considerable activity at the political level to improve prevention and health promotion in Germany. The recent Act to Strengthen Health Promotion and Prevention regulates vaccination policy and expands health check-ups. SHI funds and long-term care funds invest substantial resources into health promotion in children's day-care facilities, schools, the work environment and long-term care facilities. The National Action Plan 'IN FORM' aims to achieve lasting improvements in dietary and exercise habits in Germany by 2020 for the whole population with a focus on children and adolescents. In addition, the Federal Ministry of Health established a funding priority to promote research in the field of childhood obesity.

Several reforms have targeted health care quality and transparency of quality of care

A new Institute for Quality Assurance and Transparency in Health Care (IQTIG) was founded in January 2015 to make health care quality more transparent for patients. Quality assurance in Germany has traditionally been split between the ambulatory sector and the inpatient sector. Public reporting of hospital quality has existed for many years but information on quality in ambulatory care remains largely unavailable. The IQTIG - in behalf of the Federal Joint Committee (the highest decision-making body of the joint self-government of physicians, dentists, hospitals and health insurance funds) - is charged with harmonising the existing separate programs for quality assurance in ambulatory and

hospital care. In addition, IQTIG will develop quality indicators that can support quality-based planning of hospital capacities, and other indicators for a planned introduction of pay-for-performance for hospitals.

Several reforms have aimed to improve availability of services in rural areas

National data show that some rural areas, particularly in the Eastern Länder, face an acute shortage of physicians, and several recent reforms have addressed potential access problems. For example, the 2015 Healthcare Strengthening Act enables municipalities to set up health centres and allows hospitals in under-served areas to provide outpatient care. In addition, physicians working in under-served areas receive financial incentives.

Future sustainability of long-term care is on the political agenda

Three recent Long-Term Care Strengthening Acts have considerably expanded the benefits package for the long-term care insurance. This was coupled with an increase in insurance contribution rates by 0.5 percentage point. Part of this increase (0.1 percentage point) is used to create a long-term care precaution fund to stabilise future contributions after 2035. However, the sustainability of long-term care insurance depends strongly on future demographic developments and migration, which are difficult to predict.

JAF Health Results

Healthy life years, in particular for women, are better than the EU average and improving, while life expectancy is not improving as much as in other countries and self-reported depression is worse than average[20]

Life expectancy at birth (78.3 years for men and 83.1 for women) and at 65 are not improving as much as the EU average, although their levels are still around average in 2015. Inequality in self-perceived general health as good/very good by income group (as measured by the gap between the first and the fifth income quintile) is worse than the EU average. These variables are identified as a health challenges. On the other hand, healthy life years for women (67.5 years at birth and 12.3 at 65) are identified as good health outcomes, as they are better than the EU average and improving considerably more over the past three years.

Self-reported 12-month depression symptoms is worse than the EU average in 2014. However, in societies with advanced de-stigmatisation and de-tabooing of mental illnesses and with a broadly developed psychiatric-psychotherapeutic care and help system, as is the case in Germany, there are statistically more reports of depressive complaints than in other countries (Thom et al., 2017). Healthy life years for men are also good (65.3 years at birth and 11.4 at 65).

Access: Unmet need for medical care is better than the EU average, while the number of doctor's consultations is considerably higher

Unmet need for medical care due to costs, waiting time or distance (0.5% in 2015) is better than the EU average, with healthcare utilisation as measured by the number of doctor's consultations is considerably higher than the EU average (9.9 times in 2014).

Quality: Indicators on quality are generally good in Germany, while the influenza vaccination rate for elderly is worsening

The influenza vaccination rate for over 65 year-old (47.5% in 2014) is around the EU average, but it is decreasing since 2008 and is identified as a health challenge. Although colorectal cancer screening is decreasing from 2008, the level is still considerably better than the EU average (31.3% among 50-74 year-old in 2014). It should be noted that a negative colonoscopy means that further screening (including faecal occult blood test as measured in the EU Health Interview Survey) would not be necessary during the next 10 years. This may even at least partially explain the negative trend, as it seems likely that in 2014 more people in Germany have had a negative colonoscopy in the last 10 years compared to 2008 and were therefore not recommended to take a faecal occult blood test. The remaining indicators of the quality domain are generally good.

Non-health determinants: While the situation on smoking is better than the EU average, the rising obesity rate among young is a challenge

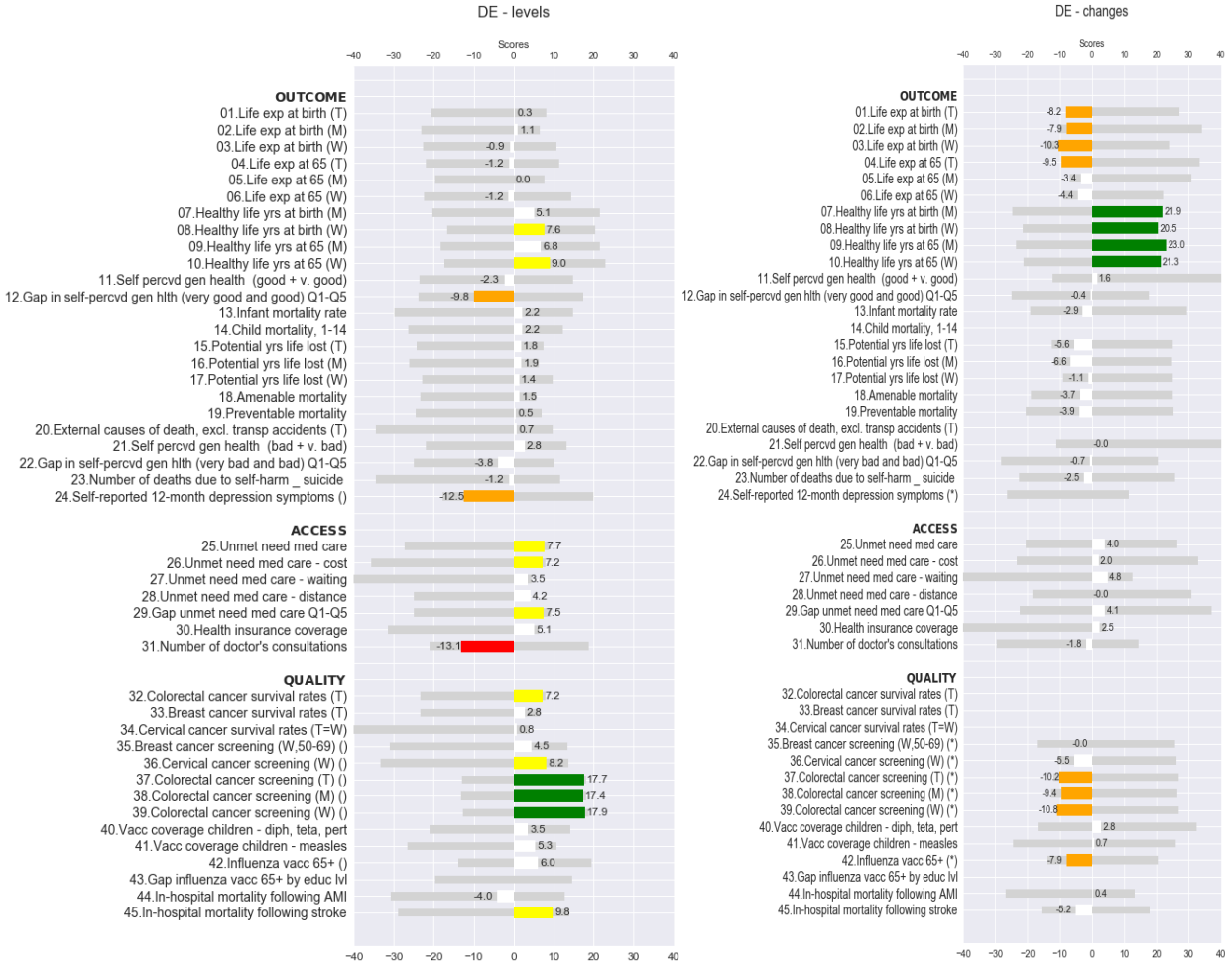
Data on risk-factors based on EU surveys are limited for Germany compared to other EU countries, due to the lack of data on alcohol use, fruit and vegetable consumption in the 2008 wave of the European Health Interview Survey.

The obesity rate among young is deteriorating from 2008 and it is identified as a health challenge, although the share in 2014 is still around the EU average. On the other hand, regular daily smoking, including among young, is a good health outcome in Germany, as it is better than the EU average and it shows a considerably positive development.

Alcohol use (especially among women) and vegetable consumption (including among young) are considerably worse than the EU average, while physical activity is considerably better than the EU average.

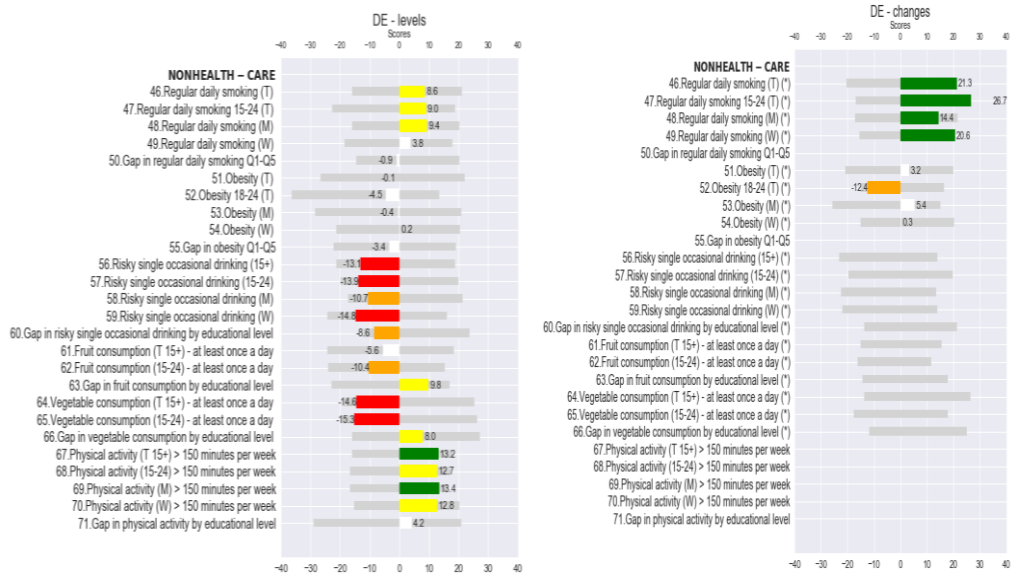
[20] The outcome indicators are only partly dependent on health system's factors, mostly they are influenced by a lot of factors outside the system (such as nutrition, life-style, etc.). Therefore, the "outcome" dimension reflects the health status of the population and it is not directly an assessment of the health system's performance.

FIGURE 21 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 22- JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Greece

In a context of far-reaching reforms aimed at increasing the cost-efficiency of the Greek health system, health expenditure declined considerably in recent years and expenditure per capita is below the EU average. Health expenditure is projected to increase as in other EU countries, also due to the aging of the population, which is a bigger concern in Greece than in other EU countries. Several reforms have been taken by the Greek government to drastically reduce healthcare and pharmaceutical spending and to improve cost-efficiency. Expenditure on prevention is considerably below the EU average. While vaccination coverage rates are good for both children and older people, colorectal cancer screening is worse than the EU average. The recently launched Primary Care Plan places greater emphasis on health prevention and promotion, while strengthening the integration of care. In the last years, Greece also witnessed a deterioration in some health outcomes (such as preventable mortality), although levels are still around the EU average. In particular, infant mortality worsened considerably, while the availability of nurses and midwives decreased in the last years and is considerably below the EU average. Access to healthcare has been challenging in Greece. In 2015, Greece has the second highest level of unmet need for medical care in the EU, especially due to costs. The level of out-of-pocket expenditures for healthcare is considerably higher than the EU average and considerably increasing, as well as unmet need for medical care. Inequality in access to healthcare between income groups is also considerably worse than the EU average and considerably increasing over the last years. After the financial crisis revealed that a system based on a strong link between employment status and health insurance coverage could not adequately protect people in times of crisis, leaving 14% of the population without coverage in 2015 (from 0% in 2012), a new legislation was recently finalized introducing universal access to healthcare. In terms of risk-factors, Greece perform relatively well, with the exception of physical activity and the smoking rate, which is nonetheless considerably improving.

Resources, Coverage and Organisation of the Health System

Health spending per capita in Greece is below the EU average and declined considerably in recent years

In 2015, health spending in Greece was below the EU average when measured on a per capita basis (1,639 in pps) and around the EU average when measured as a share of GDP (8.4%), but while it had increased in many EU countries, it had been considerably declining in Greece over the three preceding years. This is the result of measures taken under the first Economic Adjustment Programme (EAP) which foresaw a ceiling on health spending that aimed at reducing overall public sector spending in exchange for emergency lending by the IMF, the EU and the ECB during the financial crisis.

Yet, health spending is expected to rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 1.3 percentage points in Greece, which is similar to the EU average (0.9%) .

At 0.2 % of GDP, Greece spent less on long-term care than most other EU countries in 2015 and considerably less for prevention and public health spending (1.3% of health expenditure).

The share of government outlays and funding by compulsory insurance are around the EU average, while out-of-pocket expenditures are considerably higher and considerably increasing

In 2015, the proportion of funding by government outlays (30.3% of health expenditure) and the proportion of compulsory insurance (28.8%) in Greece were both around average for the EU. Funding from compulsory insurance had been decreasing much more in Greece than in the rest of the EU. At the same time, households' out-of-pocket payments (35.5%) were considerably higher and had been increasing considerably more than in other EU countries. At 1.6% of current health expenditure, funding from the rest of the world was also considerably above the EU average and increasing.

The mixed health system in Greece has seen some drastic reforms in recent years

The Greek health care system is mixed, with the parallel existence of Social Health Insurance (SHI) and a National Health System (NHS), and services are delivered by a mix of private and public providers. While until 2010, social health insurance was provided by a series of occupation-based social-security funds, it is now managed by the National Organisation for the Provision of Health Services (EOPYY) created in 2011. EOPYY is mainly financed from contributions of employees and employers and acts as the main purchaser of public and private health services. In parallel, tax-financed NHS services are delivered by public facilities.

Universal access to health care was established in 2016 after substantial coverage reduction at the peak of the financial crisis

Outside of treatment in the NHS system (mainly primary care in rural health care centres and outpatient and emergency treatment at public hospitals) which can be access by all residents, coverage used to be linked to employment status through the SHI system or employ-

ees and their families. The economic downturn starting in 2009 led to nearly a quarter of the population loosing coverage. After several unsuccessful attempts, a new legislation in 2016 established a package of care accessible to all uncovered citizens and legal residents which includes ambulatory care, hospital care in the network of NHS public health care facilities and access to pharmaceuticals.

While the public benefits package has been harmonized direct out-of-pocket payments are substantial

The SHI benefits package was standardised when EOPYY was established. Previously, the different occupation-based SHI funds had their own contribution rates and benefits packages, resulting in fragmented and unequal access to services. Today, the public benefits package is broader and dental services have been recently added.

Yet, out-of-pocket payments are substantial in Greece. Co-payments are levied on diagnostic and laboratory tests, outpatient medicines and for visits to private providers contracted by EOPYY. Exemptions apply for certain conditions and vulnerable groups, such as those with low incomes or suffering from chronic diseases. Direct payments, rather than copayments, constitute the bulk of out-of-pocket payments. This can be explained, for example, by waiting lists for services in the public sector; extra billing from several providers; monthly thresholds on the number of physician consultations that are publicly covered which may force patients to seek primary care in private settings. Moreover, informal payments to bypass waiting lists or to have access to "better care" are widespread.

The Ministry of Health and Social Solidarity is the steward of the health system, but other bodies participate in the governance and regulation of the public health care system

The health system in Greece is highly centralised with the Ministry of Health and Social Solidarity being the steward of the health system. It is responsible for the overall planning and implementation of the national health strategy. It sets, for example, national priorities, allocates resources and regulates health professionals and it is supported by a range of councils and other bodies in the governance and regulation of the public health care system. Although recent plans aimed to transfer more power to regional health authorities, involvement of regional and local governments in health care planning, organisation, and provision is very limited.

There is no well-established primary care sector in Greece, and service delivery is split between public and private providers

So far, Greece has not had a well-defined primary care sector. The vast majority of physicians are specialists with only a small minority (around 6 %) being GPs or family medicine physicians. In addition, the majority of public health centres, rural surgeries and private doctors' offices do not provide generalist or preventive care or act as gatekeepers but rather deliver specialised ambulatory services. Physicians contracted in ambulatory settings are paid on a fee-for-service basis. Service delivery in Greece is very hospital-centred with services provided by a mix of public and private hospitals. A DRG payment system is currently being implemented to ensure more effective reimbursement of hospitals.

The availability of nurses and midwives in Greece is considerably below the EU average

The number of nurses and midwives in Greece is considerably below the EU average. In 2015, there were 345 nurses and midwives per 100,000 population, and it has decreased more than across the EU in recent years. A hiring freeze was imposed on public sector employees in 2010 and halted the steady growth in the health care workforce that characterized the period prior to the crisis. It has led to a 15 % decrease in staff employed in hospitals.

Policy Developments

A formal primary care sector is being established

The Primary Care Plan, launched in 2017, aims to establish a formal primary care sector as point of first contact to the health system and to place greater emphasis on primary prevention and health promotion activities. Regional health authorities are expected to co-ordinate primary care services. The Plan also implies the establishment of a gatekeeping system with patients being required to register with their local clinic. It is foreseen that primary care facilities will be staffed by multidisciplinary teams, including doctors, nurses and social workers, to promote greater integration of care.

Far-reaching reforms have been implemented to increase cost-efficiency in the wake of the financial crisis

The Greek government has taken a number of measures to drastically reduce public spending on health as part of the emergency lending conditions. To tackle high pharmaceutical spending, Greece introduced prescription guidelines, coupled with a compulsory electronic prescription system. Generics consumption has been promoted through compulsory prescribing by active substance, mandatory generic substitution in pharmacies and use of generics in NHS hospitals. Greece also introduced reference pricing for branded drugs based on the three lowest EU prices and setting a maximum pricing level for generics.

In the hospital sector, structural reforms were implemented in 2013 to improve transparency, reduce the cost of supplies and change the hospital payment system. These measures consisted of, for example, improving information technology and introducing a double-entry accounting system, along with the annual publication of audited balance sheets; introducing all-day access to hospitals and extending working hours of outpatient offices; and using a new centralised procurement system to rationalise public purchasing of medical supplies and devices. To improve public purchasing of services from private providers, a claw-back mechanism has been introduced to require private providers to return any expenditure above EOPYY's budget ceiling.

JAF Health results

Some health outcomes are deteriorating in the last years, in particular infant mortality, although levels are still are around the EU average

Infant mortality rate worsen considerably in the last years, although in 2015 the level is still around the EU average. Heathy life years at 65 for men, preventable mortality, and self-perceived general health as bad/very bad shows negative developments in the past three years, although their level in 2015 is still around the EU average. These variables are identified as health challenges.

Most of the other outcomes indicators are around the EU average and some better, while life expectancy at 65 for women shows a considerably positive development compared to the EU average change over the past three years.

Access: In 2015, access to healthcare in Greece is generally considerably worse than the EU average, unequally distributed and worsening

Health insurance coverage rate in Greece (86%) was the lowest in the EU in 2015, considerably declining from 100% in 2012. The share of people who reported unmet need for medical care is considerably worse than the EU average (12.3% versus 3.2% in the EU28 in 2015). The main reason for unmet need is cost: 10.9% of people declare they had unmet need for medical care as it was too expensive, which is considerably worse than the EU average (2%) and considerably worsening. The second reason is distance: declared by 0.3% of the population, which is also worse than the EU average (0.1%). The share of unmet need is increasing considerably more than the EU average in the last three years. Moreover, inequality in access to healthcare as measured by the gap in unmet need between the bottom and the top income quintile is considerably worse than the EU average and considerably worsening in the last three years. Access to healthcare and inequality in access are identified as health challenges in Greece.

Quality: While vaccination rates are identified as good health outcomes, colorectal cancer screening is identified as a health challenge

Colorectal cancer screening (for both women and men) is, worse than the EU average in 2014 and it is identified as a health challenge. On the other hand, the influenza vaccination rate for over 65 year-old (51.4% in 2014) and the vaccination coverage rate of children for DTP (99% in 2015) are identified as good health outcomes, as they are, respectively above the EU average and considerably improving and above the recommended 95% threshold.

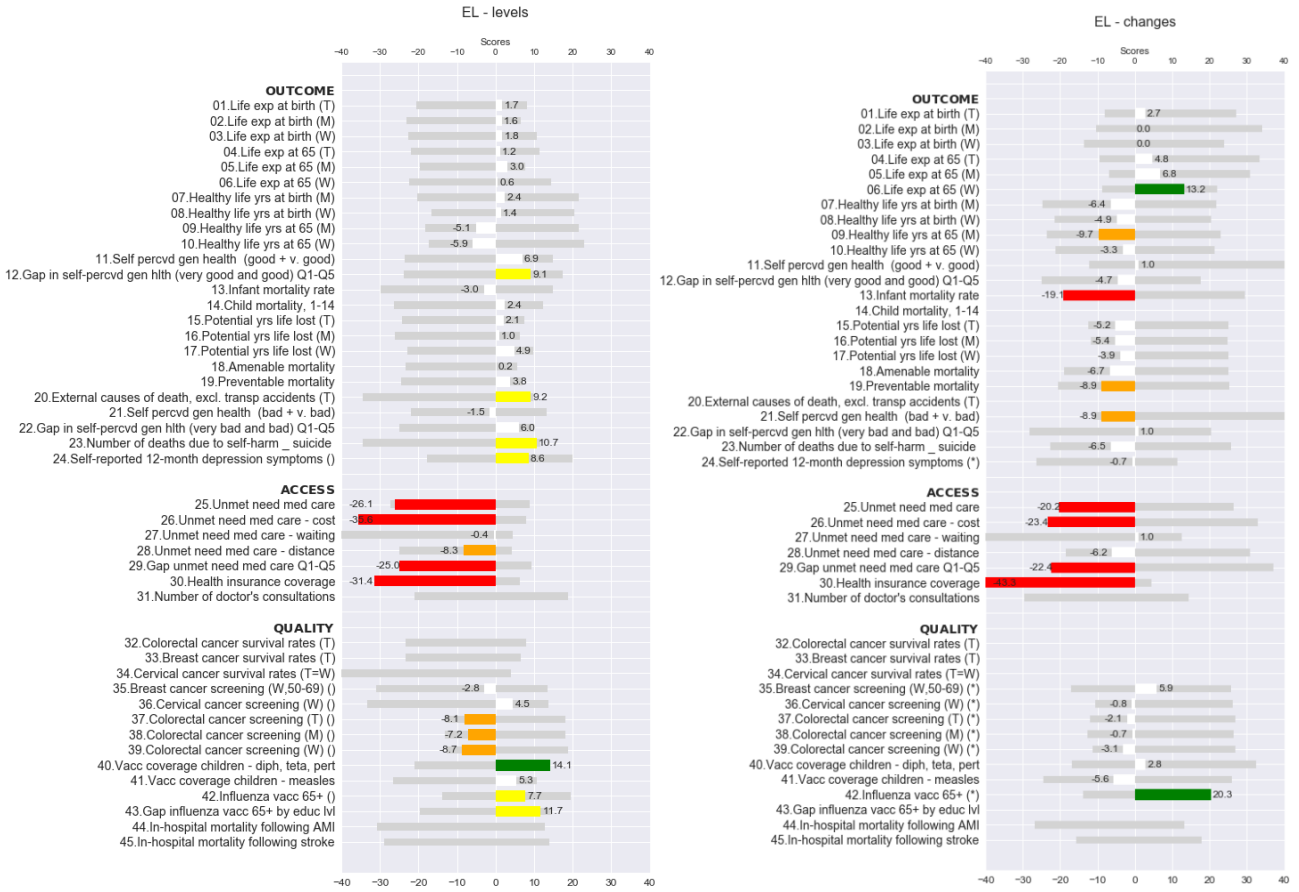
The vaccination coverage rate of children for measles (97%) is also above the recommended 95% threshold in 2015.

Non-health determinants: most variables on lifestyle are good and show positive developments, while smoking rand physical activity are worse than the EU average

Although indicators on smoking are improving (considerably more than the EU average among women), regular daily smoking in 2014 is still considerably worse (especially among women) than the EU average and it is identified as a health challenge. On the other hand, alcohol use among women, fruit consumption among young, and vegetable consumption are better than the EU average and show positive developments over the past three years. The gap in vegetable consumption between high and low educated groups is considerably better than the EU average. These variables are identified as good outcomes.

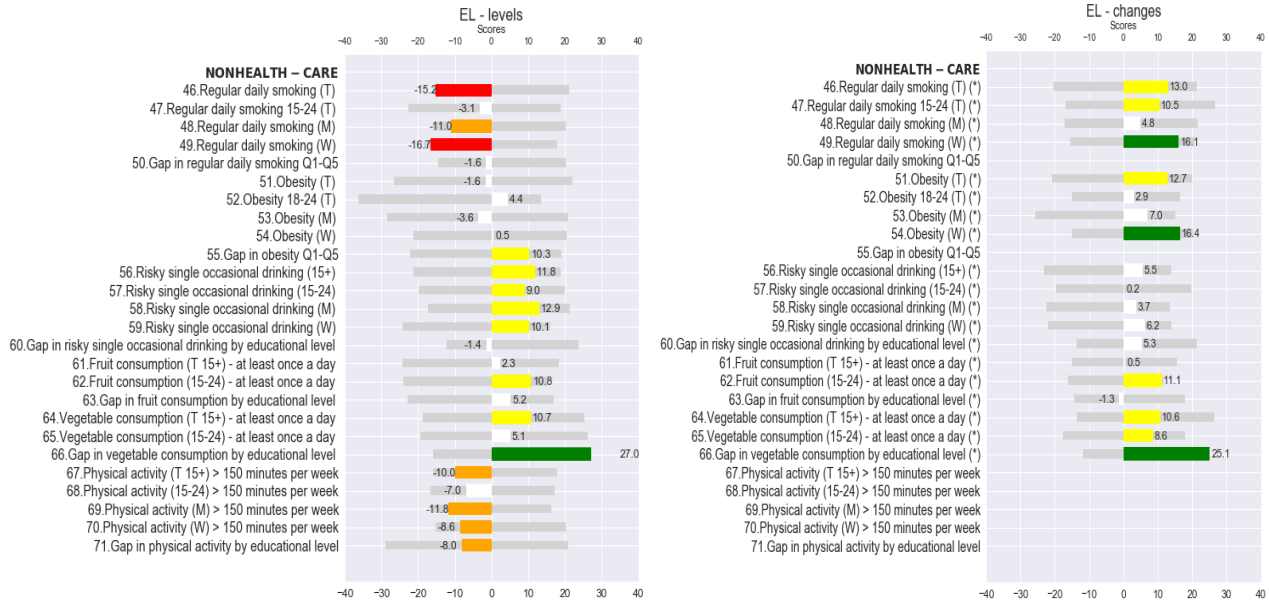
In 2014, physical activity rates among female and male adults are worse than the EU average, as well as inequality in physical activity between educational groups.

Figure 23 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 24 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

HUNGARY

With GDP and health spending per capita below the EU average, most health outcomes in Hungary are considerably worse than average. However, a few outcomes are improving in 2015, namely the potential years of life lost and the suicide rate. The available indicators on the quality of healthcare show an average performance, with some exceptions for indicators on prevention, an area for which expenditure decreased more than average between 2011 and 2014. In 2014, the screening for colorectal cancer for men was worse than the EU average, while the year after the vaccination coverage rates of children were better than average. In 2015, the legislation tried to strengthen primary care with an emphasis on prevention. Some risk factors are worse than the EU average, such as smoking and obesity, although alcohol use is considerably better. The government took some initiatives to address unhealthy diet. Health expenditure is mostly financed by social insurance contributions (58%), followed by out-of-pocket payments (28%) and to a smaller extent by government schemes (9%). Although social health insurance is compulsory, the 5% of uncovered population remains a challenge of the Hungarian health system. In a context where doctors emigrate to other EU countries, the number of physicians increased less than the EU average, although this number is still around average. The government took a number of measures to improve the retention of health professionals, including salary increases.

Resources, Coverage and Organisation of the Health System

Health spending per capita is below the EU average

In 2015, health spending per capita in Hungary was below the EU average (1,532 in pps). When measured as a share of GDP, Hungary spends 7.2% (down from 8% in 2005) for health compared to an EU average of 9.9%. Unlike most other EU countries, health spending measured as a share of GDP had been declining over the three preceding years. Yet, health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.8 percentage points in Hungary, which is comparable to the EU average (0.9%).

At 0.3% of GDP, Hungary spent less on long-term care than most EU countries. In 2015, expenditures for administration (2.1% of current health expenditure), for prevention and public health (2.7%) and for curative care (50.3%) are around the EU average. Unlike other EU countries, spending on prevention and public health had been declining in recent years, while curative care expenditures had been increasing much more in Hungary than in the EU on average.

Public health spending is mainly financed by compulsory health insurance

In Hungary, the proportion of funding by compulsory health insurance (55.6% in 2015) is around the EU average, while the proportion of government outlays (11.1%) is lower than in other European countries. Considering the sum of the contributions from compulsory health insurance and government outlays, Hungary has the sixth lowest expenditure (67%) in the EU. Households' out-of-pocket payments (29.0%) is just above the EU average. Although the share of voluntary schemes is around the EU average (4.2%), it has been declining considerably more in Hungary than in other EU countries in recent years.

Hungary's social insurance system covers 95% of the Hungarian population and health services delivery is very hospital-centered

The National Health Insurance Fund (NHIF) is the sole payer in the compulsory insurance system and health services are provided by a mix of public and private providers but still very hospital-centered. The NHIF is mainly financed through contributions and an earmarked health care tax. Although coverage should be universal, the insurance status of about 5 % of the population was unclear in 2015, mainly because of unpaid insurance contributions. Still, necessary care cannot be denied to patients who have not paid their contributions.

The publicly funded benefit package is comprehensive but not exhaustive

The benefit package is decided at the central level by the Parliament and the Ministry of Health and defined by a positive list for pharmaceuticals and a negative list for medical procedures. Since 2004, inclusion of new technologies (pharmaceuticals, procedures, and medical devices) in the benefit package is based on the best available evidence with particular focus on Health Technology Assessments. Although the benefit basket is rarely subject to downward adjustments, few technologies have been added to the benefit basket since the financial crisis.

Out-of-pocket payments in Hungary take the form of cost-sharing, direct payments and informal payments

Cost-sharing is required for medical goods (including pharmaceuticals), dental prostheses and some health care services (treatment in sanatoria, long-term chronic care and some hotel services in hospitals) with co-payments for pharmaceuticals being most important. Cost-sharing is also required when patients fail to fol-

low specific health care pathways and seek specialist care without a referral from a family doctor. People seeking care from providers outside the social health insurance system or for services outside of the defined limits of the benefit package must cover all costs out of pocket. Additionally, informal payments to physicians are a common practice to get quicker access and better quality care.

The central government plays a dominant role in the Hungarian health system

The central government has almost exclusive power to formulate strategic direction and to issue and enforce regulations. It exercises strict control over revenue collection, determines the benefit package, sets budgets, allocates financial resources and engages in contracting and payment. In 2017, the National Institute of Health Insurance Fund Administration – which administers the NHIF - was integrated into the Ministry of Human Capacities and renamed as part of the ongoing centralisation process. Another important agency is the National Healthcare Service Centre, the leading organisation for health provision. Its responsibilities include hospital planning, licensing of medical professionals, implementation of national strategies and communication with international research organisations.

The provision of primary care is up to municipalities, while secondary care is the responsibility of the central government

In Hungary, municipalities have to guarantee access to primary care and can choose to provide it through salaried doctors or contracted physicians. The latter is more common with family doctors working independently in publicly-owned practices. Remuneration is mostly capitation-based with additional fixed payments (based on the size and location of practice). A performance bonus payment system was introduced in 2009 to drive improvement in care quality. Patients can freely choose their family doctor, who acts as a gatekeeper and refers patients to secondary care. Responsibility for secondary care lies with the central government (hospitals are publicly owned). Inpatient services are reimbursed according to the DRG-based prospective payment system, except for a few high cost interventions reimbursed on a case basis. Despite efforts to reduce hospital capacity and activity, the Hungarian health system remains very hospital-centred.

The availability of human resources is comparable to the EU average, but the number of physicians increases at a slower rate

The number of physicians, nurses and midwives in Hungary is similar to the EU average. In 2015, there were 310 practicing physicians per 100,000 population and 664 nurses and midwives per 100,000 population. The number of practicing physicians, however, has increased less than across the EU in recent years. Since its accession to the EU in 2004, emigration of doctors is a key policy concern in Hungary.

Policy Developments

Recent government initiatives address antimicrobial resistance

Over the past 15 years, Hungary has strengthened its national strategies to fight antimicrobial resistance (AMR). Hungary has established a National Bacteriological Surveillance System (2001), and a web-based National Nosocomial Surveillance System (2004). In 2009, the Ministry of Health published a decree providing a legal framework to all existing infection and AMR control activities in the country, and broadened their scope in terms of pathogens and infections under surveillance as well as the number of hospitals and laboratories providing surveillance data. The country is working to develop and implement a comprehensive national strategic action plan for AMR as recommended by the European Commission.

To improve health of the Hungarian population a number of public health measures have been taken

To support health promotion and disease prevention 61 health promoting offices (HPOs) were established via EU funds in the 2007-2013 period in particular in socio-economically disadvantaged regions) with a key focus on promoting healthy lifestyle including regular physical exercise and healthy diet, raising awareness and improving the uptake in cervical and breast cancer screening. Nearly 200,000 people participated in community health promotion and health education programmes and the establishment of additional HPOs with further EU funding is planned in 2018.

Additional measures have been taken to promote healthy lifestyle

The Act on Healthcare adopted in 2011 and related decrees set the background for comprehensive health promotion and disease prevention at school. Key elements include healthy diet, everyday physical activity, and physical and mental health development.

In 2011, a Public Health Tax was introduced to encourage healthy diet. The tax, which applies to specific food products high in sugar, salt or caffeine, was complemented by regulation to limit the trans-fat content of food products and to redefine the nutritional requirements for public catering. Impact assessments indicate that consumers responded to the tax by choosing cheaper, often healthier products and reduced their intake of unhealthy foods.

Cancer screening and some vaccinations were strengthened to improve disease prevention

Hungary is financially supported by EU Structural Fund to improve the quality and accessibility of organized cancer screenings. In this context, a public health screening system was established in Hungary to support early diagnosis of certain types of cancer but comparably low screening rates and substantial inequalities in access question the effectiveness of these programmes in the past. The 2017-18 Public Health Action Plan of the National Public Health Strategy tries to address these issues, for example by:

setting up mobile screening stations to visit mainly small underdeveloped territories, with some of them providing digital mammography screening on spot and others offering health counselling and cervical screening; and by the the expansion of colorectal cancer screening to ensure the coverage of the target population of 50-70 year-old women and men.

In September 2014, human papillomavirus (HPV) vaccine was introduced as a free, non-prescription vaccine, and about 75% of the 7th grade girls were vaccinated.

Efforts have been made to retain health professionals in Hungary

Hungary has introduced a number of measures to improve retention of health professionals. In 2011, the residence scholarship programme was created, which offered a raise in salary to medical resident doctors who made a commitment to work in the public sector while obtaining their specialisation. In the past six years, there also have been periodic salary increases for health workers in publicly financed establishments, particularly for medical doctors, and it is expected that salaries will be increased again in the last quarter of 2017.

Primary care reform has been a consistent focus of reform

A central element of the Semmelweis plan, the sector-wide reform of 2011, was the reinforcement of primary care, with improved care coordination between providers, use of multidisciplinary polyclinics and the standardisation of patient pathways for chronic disease management. However, the reform process focussed on the hospital sector, leaving the primary care reform as a secondary priority, so the latter was not fully developed when the reform period came to an end. Recent legislation in 2015 tried to strengthen primary care again by redefining GPs' tasks (with a particular emphasis on disease prevention), promoting community practices and Health Promoting Offices, and revising payment schemes.

The first Health System Performance Assessment has been carried out

The first system-wide Health System Performance Assessment (2013-2015) was been published in June 2017, to assess, among others, the health status of the population, mortality indicators, the accessibility and quality of health care services. The report also analyses health care expenditures and the long-term sustainability of the healthcare system.

JAF Health Results

Most health outcomes in Hungary are considerably worse than the EU average, while potential years of life lost and suicide rate are improving

In 2015, life expectancy at birth (75.7 years) and at 65 (16.6 years) are considerably worse than the EU average, for both man and women. Healthy life years (at birth and at 65) are worse than the EU average, except at birth for women.. Potential years life lost (in particular for women) and number of deaths due to self-harm/suicide are considerably worse than the EU average, although they are improving considerably more than the EU average change. Amenable and preventable mortality are considerably worse than the EU average, but also show a positive development compared to the EU average in the past three years. These variables are identified as health challenges.

Access: Health insurance coverage is relatively low

In 2015, health insurance coverage is worse than the EU average, with 5% of the population uncovered. In 2014, the number of doctors' consultations is considerably higher than the EU average.

Quality: Indicators on quality are generally around the EU average, with the vaccination coverage rates of children as positive exceptions and colorectal cancer screening for men as a negative exception

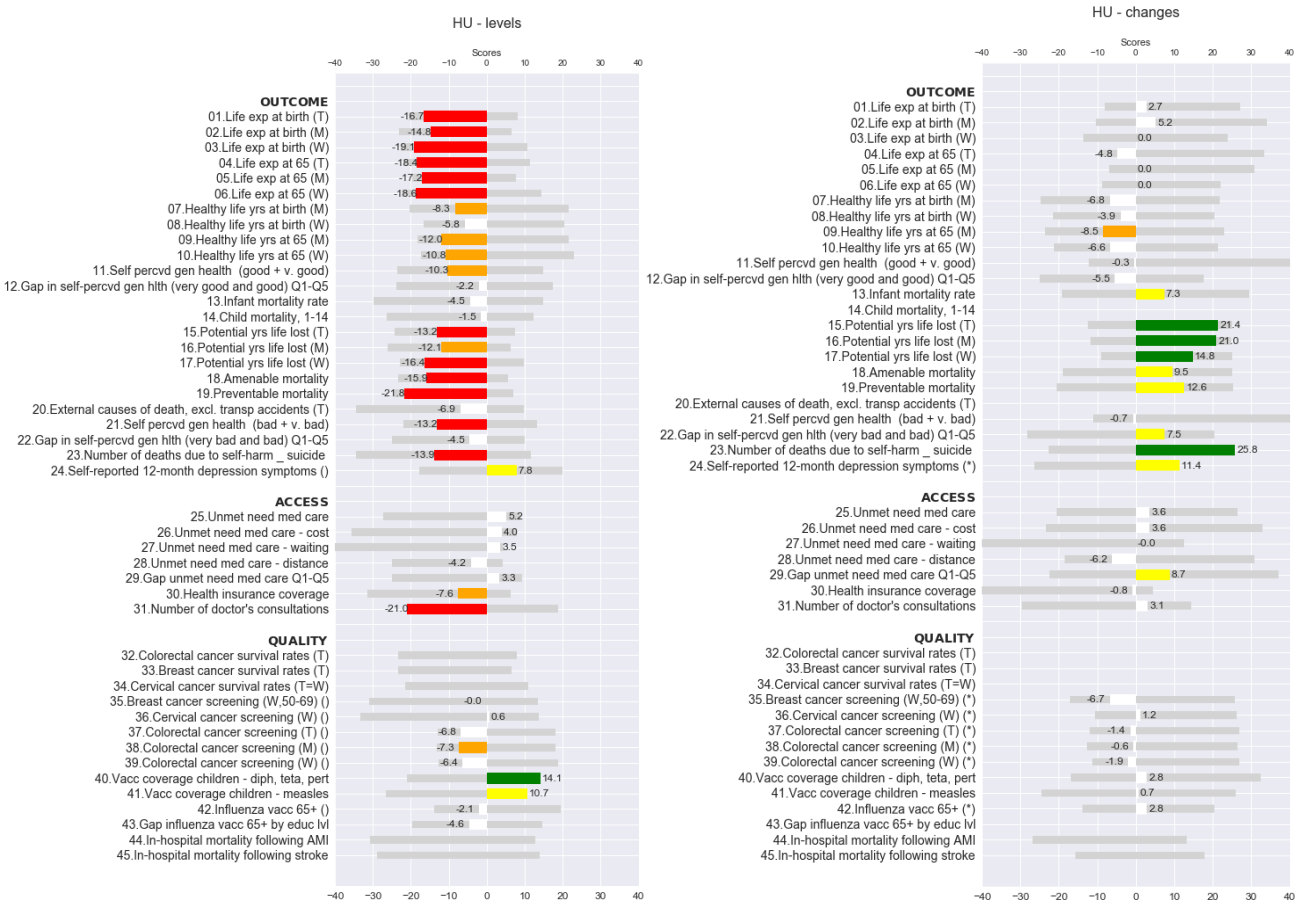
In 2015, the vaccination coverage rate of children for DTP (99%) is considerably above the 95% recommended threshold and it is identified as a good health outcome.

Also the vaccination coverage rate of children for measles is above the 95% recommended threshold. In 2014, the screening for colorectal cancer among men is worse than the EU average.

Non-health determinants: Alcohol use is considerably better than the EU average, while the smoking and the obesity rates are worse than the EU average

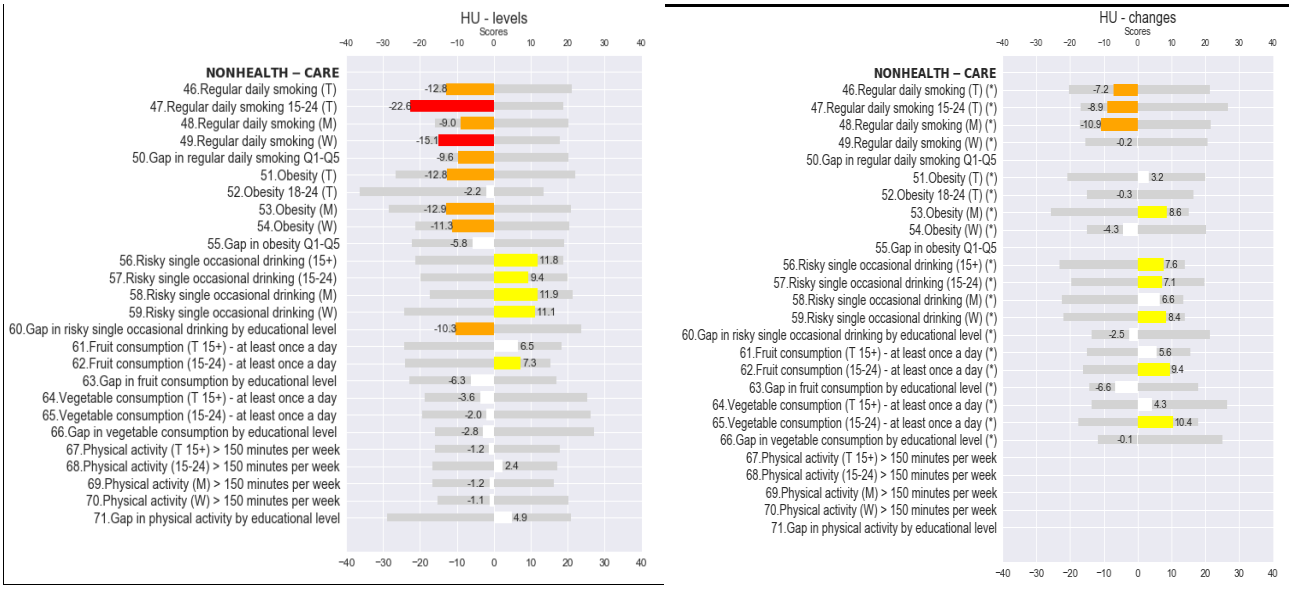
The daily smoking rate of men is worse than the EU average and considerably worse than average among young and women. The obesity rate (except among young) is worse than the EU average, although it is improving more than the EU level among men. Inequality in risky single occasional drinking (as measured by the gap between low and high educated) is worse than the EU average.

Figure 25 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 26- JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

IRELAND

With GDP and health spending per capita above the EU average and a younger population than other EU countries, health outcomes in Ireland are generally around or better than the EU average. However, inequality in self-perceived general health is worsening. The quality of healthcare is similar to other EU countries, while the vaccination coverage rate of children for measles is below standards. The Irish health system lacks universal coverage for primary care and co-payments can be substantial for people without the Medical or GP Visit cards, while voluntary health insurance plays an important role. The lack of universal coverage, as well as the "two-tier" financing system, poses some challenges for the implementation of an effective integrated care model. The Parliamentary commission established in 2016 suggested a re-orientation towards a single-tier system with universal access. In terms of risk-factors, obesity, especially among young and children is an issue in Ireland. As part of the Healthy Ireland Framework, measures to address this have recently been taken with the "Healthy Weight for Ireland – Obesity Policy and Action Plan 2016- 2025".

Resources, Coverage and Organisation of the Health System

Health spending per capita is above EU average and Ireland spends more on long term care than most EU countries

Health spending per capita in Ireland is higher than the EU average (3,489 in pps in 2015) but around the EU average when measured as a share of GDP (7.8%). Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 1.2 percentage points in Ireland, which is comparable to the EU average (0.9%). With 1.8% of GDP, Ireland spends more on long-term care than most EU countries. Otherwise, the spending structure does not differ notably from the EU average.

The share of government outlays stands at 70% with voluntary schemes playing an important role in Ireland

In Ireland, the proportion of direct funding by government schemes (69.7%) is higher and the proportion of compulsory insurance considerably lower than in the EU (0.3%). The remaining spending is made up of households' out-of-pocket payments (15.2%), which is slightly below the EU average and voluntary prepayment schemes (14.9%) which plays a considerably bigger role in Ireland than in most other EU countries.

A national health system provides some access to all residents

Large segments of the health care service delivery system are publicly financed and accessible to all residents, but coverage is uneven and private insurance is used by many to gain faster access to private care.

The Irish health system lacks universal coverage for primary care

All residents are entitled to receive a range of health services in the public system (e.g., inpatient and outpatient treatment in hospitals, pharmaceuticals), although there are notable variations in coverage. Visits to GPs are only covered for the 47 % of the population who qualify either for Medical Cards (mainly based on means-test) or GP Visit Cards (based on a more generous means-test and universally available for children under 6 years and senior citizens above the age of 70).

Co-payments can be quite substantial

Cost-sharing plays a major role in paying for health services in Ireland, particularly for those who do not hold a Medical Card. Acute inpatient care requires a co-payment (EUR 80 per day), capped at EUR 800 per year, as do visits to emergency and outpatient departments (EUR 100). Co-payments on prescribed medicines are also applied and capped at EUR 134 per household per month. For Medical Card holders, cost-sharing is basically limited to a EUR 2 charge per pharmaceutical prescribed up to a ceiling of EUR 20 per month. GPs set their own prices and a visit costs on average more than EUR 50 for those without Medical Card or GP Visit Card.

Voluntary Health Insurance (VHI) plays an important role in Ireland

Due to important gaps in the public benefit basket – particularly for those without Medical Card, and long waiting times because of capacity limitations, having voluntary private health insurance is important for many people in Ireland. Currently, around 45.3% of the population have predominantly duplicate coverage for private care in both public and private hospitals, as well as for quicker access for hospital outpatient consultations but private insurance can also cover some of the cost of GP visits, dental care and other services.

The Department of Health and the Health Service Executive are the main actors in the system

The Department of Health provides strategic leadership and allocates the health budget, which goes mainly to the Health Service Executive (HSE). The HSE has operational responsibility for care provision in public hospitals, health centres and a range of community and social care services. It also purchases service from private providers, particularly for primary care.

Service delivery is predominantly private for primary care and public for secondary care

GPs are mainly self-employed and are paid to provide public services on a weighted capitation basis plus additional fees for special services such a vaccination. They are paid on a fee-for-service basis for all patients who do not have either a Medical Card or a GP Visit Card.

Referrals are required to access specialist outpatient services in the public system. People with voluntary health insurance (or who are otherwise able to pay) obtain faster access to diagnostics and hospital treatments, even from public providers. Hospital service delivery is mainly public and activity-based funding has been introduced recently.

The number of physicians is below the EU average

Compared to other EU countries, Ireland has a relatively low number of doctors and high number of nurses. Nursing numbers in Ireland not only include nurses providing care for patients, but also those working as managers, educators, etc. There were 288 practicing physicians per 100,000 population in 2015, below the average in EU countries. Ireland has raised the number of students entering medical education since 2010 which has already led to a strong increase in the number of new medical graduates, though a significant proportion of these are from abroad and leave Ireland following graduation. The proportion of health personnel working in hospitals (in FTE) is around the EU average (1,124 per 100,000 population) and has increased slightly in recent years.

Policy Developments

Improving care integration and developing of disease management programmes is on the agenda in Ireland

To overcome the existing care fragmentation in Ireland the Health Service Executive is currently developing five integrated care programmes with an in implementation foreseen over the next two to five years. Clinically-led, multi-disciplinary care models will target older people, the prevention and management of chronic diseases and children and maternity care. In the area of chronic disease management, the Health Service Executive is developing programmes focusing on diabetes, chronic pulmonary disease, asthma, heart failure and atrial fibrillation. Yet, the implementation of effective integrative care models in Ireland faces some challenges, in particular due to its "two-tier" financing system, the absence of universal health coverage as well as the lack of integration of different state agencies and the lack of electronic health records.

Addressing public health issues has been a major focus of recent government initiatives

In 2013, the "Healthy Ireland" agenda was adopted as a general framework to improve population health and wellbeing around four broad goals: a) increasing the proportion of people who are healthy at all stages of life; b) reducing health inequalities; c) protecting the public from threats to health and wellbeing; d) creating an environment where every sector of society can play their part. Some of the key measures to be introduced by the government as part of the agenda include setting a minimum unit price for alcoholic beverages under the Public Health (Alcohol) Bill to bring down alcohol consumption (the Bill has yet to be adopted by parliament) and introducing plain packaging for cigarettes in 2017 as part of the Public Health (Standardised Packaging of Tobacco) Act. Under the Healthy Ireland Framework, the Irish Government has approved and published policies and action plans to tackle risk-factors such as obesity, drug, tobacco and alcohol use, to promote physical activity, sexual health and positive aging and to provide additional supports for children and young people. More specifically, the Healthy Ireland Framework includes the National Physical Activity Plan - Get Ireland Active and a Healthy Weight for Ireland – Obesity Policy and Action Plan 2016- 2025, which were launched in 2016 to tackle obesity and promote physical activity.

Future reforms will most likely aim at a major overhaul of the Irish health system

There is a broad consensus in Ireland that the health system requires fundamental changes to better serve the needs of the population and deliver value for money. A Parliamentary Committee on the Future of Healthcare was established in 2016 to outline a reform agenda for the next ten years. In its final report, the Committee suggests a re-orientation of the Irish health system towards a single-tier system with universal access based on need. (Oireachtas 2017).

The Sláintecare Implementation Strategy, prepared in response to the Parliamentary Committee report, was approved by government in July 2018. It ,provides the framework for the implementation of a system-wide reform programme aiming to provide care in the right place, at the right time, by the right person and always on the basis of need and not ability to pay.

JAF Health Results

While the share of people perceiving their health as good is considerably better than the EU average, inequalities in self-perceived health are worsening

In 2015, inequality between income groups in self-perceived general health (as good/very good and as bad/very bad) is deteriorating in the past three years and it is identified as a health challenge. On the other hand, self-perceived general health as good/very good is considerably better than the EU average and is identified as a good health outcome.

Self-perceived general health as bad/very bad is also better than the EU average, but shows a negative development in the last three years. In general, life expectancy is improving compared to the EU average and healthy life years are better than average. In 2014, the indicator of self-reported 12-month depression symptoms is considerably worse than the EU average, but the time series is limited.

Access: Indicators on access are around the EU average

The agreed indicators on access provide information on the average level of unmet need for medical care across income groups (and by reason) and on the gap between the poorest and the richest quintile. In 2015, all these indicators are around the EU average.

Quality: Indicators on quality are around the EU average

All quality indicators are around the EU average. However, the vaccination coverage rate of children for measles (93%) is below the recommended 95% threshold.

Non-health determinants: while smoking and some inequalities in lifestyle are better than the EU average, obesity in particular among young and women is considerably worse

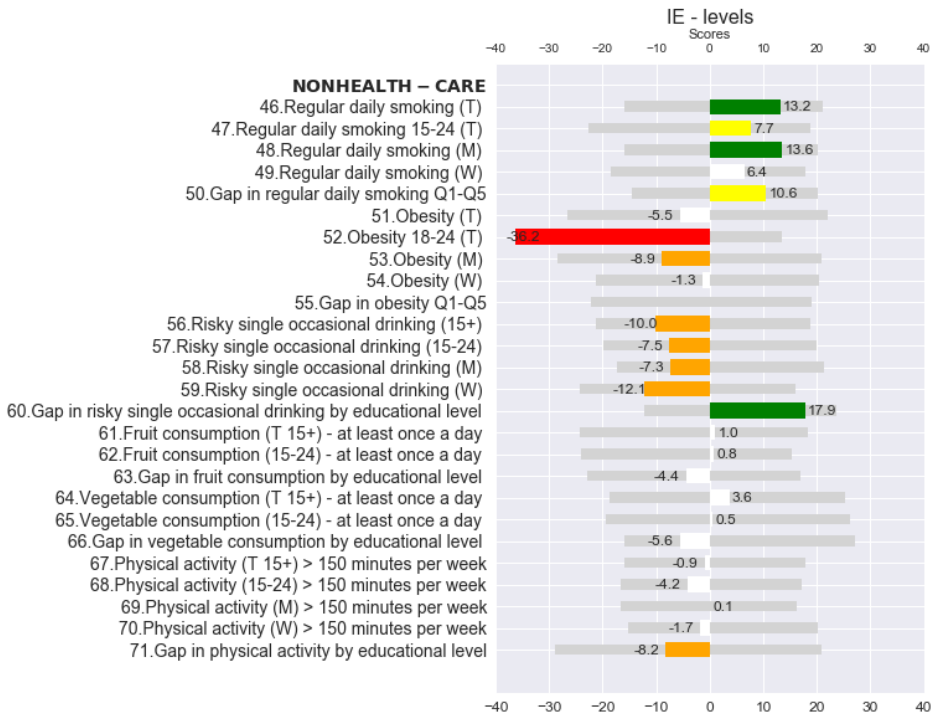
Data on risk-factors based on EU surveys are limited for Ireland compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

In 2014, the obesity rate in particular for young people in the age group 18-24 was considerably worse than the EU average. Obesity rate among men, risky single occasion drinking and the gap in physical activity between educational groups are worse than the EU average. On the other hand, daily smoking rate, especially among men, is considerably better than the EU average. Inequality in smoking rate by income groups and in risky single occasion drinking by educational groups are better than the EU average.

Figure 27 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 28 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



ITALY

With an above average expenditure for healthcare, a continuous investment on prevention, mostly tax-financed universal coverage and a general good lifestyle, health outcomes in Italy are around or better than the EU average. However, new challenges are emerging in access to healthcare and vaccination coverage rates of children. The share of unmet need for medical care due to costs is considerably worse than the EU average, increasing and unequally distributed, with almost one out of six persons among poorest households declaring unmet need for medical care. The combination of regional differences in the organization of healthcare, including the level of co-payments for outpatient specialist visits, and the recent introduction or increase of these co-payments may contribute to explaining the high level and increasing trend in unmet need for medical care. While the government has recently addressed the challenge of the low vaccination coverage rates of children, no measures have been taken to effectively guaranteeing access to healthcare for all.

Resources, Coverage and Organisation of the Health System

Health spending is on par with EU countries with long term care spending growing more slowly

Health spending per capita in Italy is on par with other EU countries both in absolute terms (2,459 pps in 2015) and when measured as a share of GDP (9%). Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.7 percentage points in Italy, which is comparable to the EU average (0.9%)[21]. Spending on long-term care (0.9% of GDP) was around the EU average. Italy spends considerably more on prevention (4%) than many other EU countries, while spending on administration (1.9%) is below the EU average. Otherwise, the spending structure does not differ notably from the EU average.

The share of government financed health expenditure is considerably above the EU average

In Italy, the proportion of direct funding by government schemes (74.6%) is considerably higher and funding by compulsory insurance (0.3%) much lower than in the EU. The remaining spending is made up of households' out-of-pocket payments (22.8%) which is around the EU average and voluntary prepayment schemes (2.3%) which play a smaller role in Italy than in other EU countries.

The tax-funded Italian National Health Service provides near universal coverage

Financed mainly through national and regional taxes, the regionally-organised Italian National Health Service automatically covers all citizens and foreign residents, although important regional differences in funding and cost-sharing pose a challenge for access to services.

Scope of services covered by the National Health Service is wide but there are exemptions

The central government sets a list detailing the health care goods and services available to the population through public funding known as essential levels of care. Services such as dental care and orthodontics are not included in the national benefits package but dental care is covered for children under 15 years and vulnerable groups (e.g., low-income patients). Services not included in the essential levels of care can be provided if financed by regions.

Cost-sharing applies to some services with levels of co-payments set at regional level

Flat co-payments are levied on outpatient specialist visits referred by a GP (without a referral, the full cost has to be paid), on diagnostic procedures, and on medicines with full or partial reimbursement. Regions determine the levels of co-payments. In an effort to reduce wasteful spending and public deficits, the majority of regions introduced or increased co-payments on pharmaceuticals in 2012, as well as user fees for emergency services that are deemed inappropriate. Some groups, such as people over 65 or pregnant women, are exempted from these user fees.

The Ministry of Health is the steward of a highly decentralised National Health Service

The Italian National Health Service is organised regionally, with the central government sharing responsibility for health care with the country's 19 regions and two autonomous provinces. At the national level, the government exercises a stewardship role, controls and distributes the tax-financed health budget, and defines the essential levels of care. Regions are responsible for the organisation, planning and delivery of health services through local health authorities, and enjoy substantial autonomy in how they structure their health systems within the general framework established nationally.

Service delivery is mainly private in primary care and mainly public for secondary care

21 For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

Primary care is provided by self-employed physicians, paid through a mix of capitation and fee-for-service. People are required to register with a General Practitioner (or a paediatrician up to the age of 14), who receives financial incentives to act as a gatekeeper and care coordinator. Specialist and hospital care are predominantly delivered by public providers (such as local health units, and district and regional hospitals) as well as accredited private providers. The majority of hospitals are paid by DRG, combined with global budgets for a few activities, such as teaching. While the Ministry of Health sets reference payment rates for hospital and outpatient care, regions have substantial autonomy in adjusting these tariffs.

Italy has fewer nurses and slightly more doctors compared to other EU countries

Italy has a number of doctors (384 per 100,000 population) which is slightly above the EU average, but in contrast to most other EU countries, the rate has decreased in recent years. The number of students admitted to and graduating from nursing schools has increased substantially over the past 15 years, yet the number of nurses (570 per 100,000) is still below the EU average. The role of nurses is currently being strengthened in Italy, especially with regard to the management of chronic patients and the introduction of nurse-led professional groups in primary care.

Policy Developments

The national benefits package is updated and a new National Vaccination Plan developed

In January 2017, the government approved an updated version of the publicly financed benefit package – the essential levels of care which was developed on the basis of epidemiological and demographic needs. The list of services was extended to include new vaccinations and neonatal screenings. An updated list of chronic and rare diseases are exempt from cost-sharing. Whether the essential levels of care are actually being delivered to the population is also monitored more closely following a strengthening of the eHealth and health information infrastructure in recent years. Alongside the updated benefits package, the new National Immunisation Plan 2017-2019 seeks, among other things, to provide free vaccinations for specific age groups and populations at risk; to eradicate measles, polio and rubella; and to promote patient literacy regarding the benefits of vaccination. Following a measles outbreak in 2016-2017, the government has made 12 vaccinations compulsory for children attending school. Parents refusing to comply can be fined.

Progress in tackling smoking among teenagers and obesity in children but challenges remain

The Italian government has taken steps to tackle two pressing public health problems: smoking among teenagers, and overweight and obesity in children. Policies have targeted smoking for the past 15 years, including a 2012 ban on smoking in all public and work places, and stronger restrictions on tobacco consumption for minors. Brand-free cigarette packaging was introduced in 2016, targeting teenagers in particular, among whom smoking rates remain high.

The surveillance system "Okkio alla salute" has monitored children in elementary schools throughout Italy for the last 10 years. While the latest statistics indicate the prevalence of obesity has gone down, notable regional differences remain in the availability of gyms in schools, initiatives for the promotion of healthier eating habits, and the percentage of schools that offer lunch (below 50 % in the south compared to 90 % in the north).

Building momentum on efficiency, care integration and coordination

Since 2016, several regions have introduced new organisational models and health service delivery processes while others have merged local health authorities into larger entities (one of the measures of the Balduzzi Decree, adopted in 2012). The overall aim of these reforms is to achieve efficiency gains and improve quality of care through economies of scale and better organisational integration. In that vein, the Balduzzi Decree also promoted the formation of voluntary group practices in primary care, moving away from the predominant model of solo GP practices to group and team-working models, better equipped to address patients with complex needs.

More recently, the 2014 Pact for Health went a step further towards care integration, requiring regions to establish "primary care complex units" comprising GPs, specialists, nurses and social workers. There has also been a move away from institutional long-term care towards home care, and regional efforts to set up chronic care and disease management programmes for high-burden conditions such as diabetes (Donatini, 2017). These new organisational models seek to promote continuity of care while reducing the inappropriate use of emergency services.

JAF Health Results

Health outcome are around or better than the EU average

No challenges are identified for health outcomes, which are generally around the EU average or better (such as life expectancy at birth and potential years of life lost for women, number of deaths due to self-harm/suicide).

Access: unmet need for medical care due to costs is considerably worse than the EU average, it is unequally distributed and worsening

Despite universal health coverage, the share of people who reported unmet need for medical care is worse than the EU average (7.2% versus 3.2% in the EU28 in 2015). The main reason for unmet need are costs: 6.5% of people declare they had unmet needs for medical examinations or treatment as being too expensive, which is considerably worse than the EU average (2%). The share of unmet needs is increasing more than the EU average in the last 3 years. Moreover, the gap in unmet need between the bottom and the top income quintile is considerably worse than the EU average, with 15.2% declaring unmet needs in the first quintile versus 1.4% in the fifths quintile. The gap in unmet need is also worsening in the last 3 years with respect to the average change in the EU. Access to healthcare and inequality in access are identified as health challenges.

Quality: The vaccination coverage rates of children are a challenge

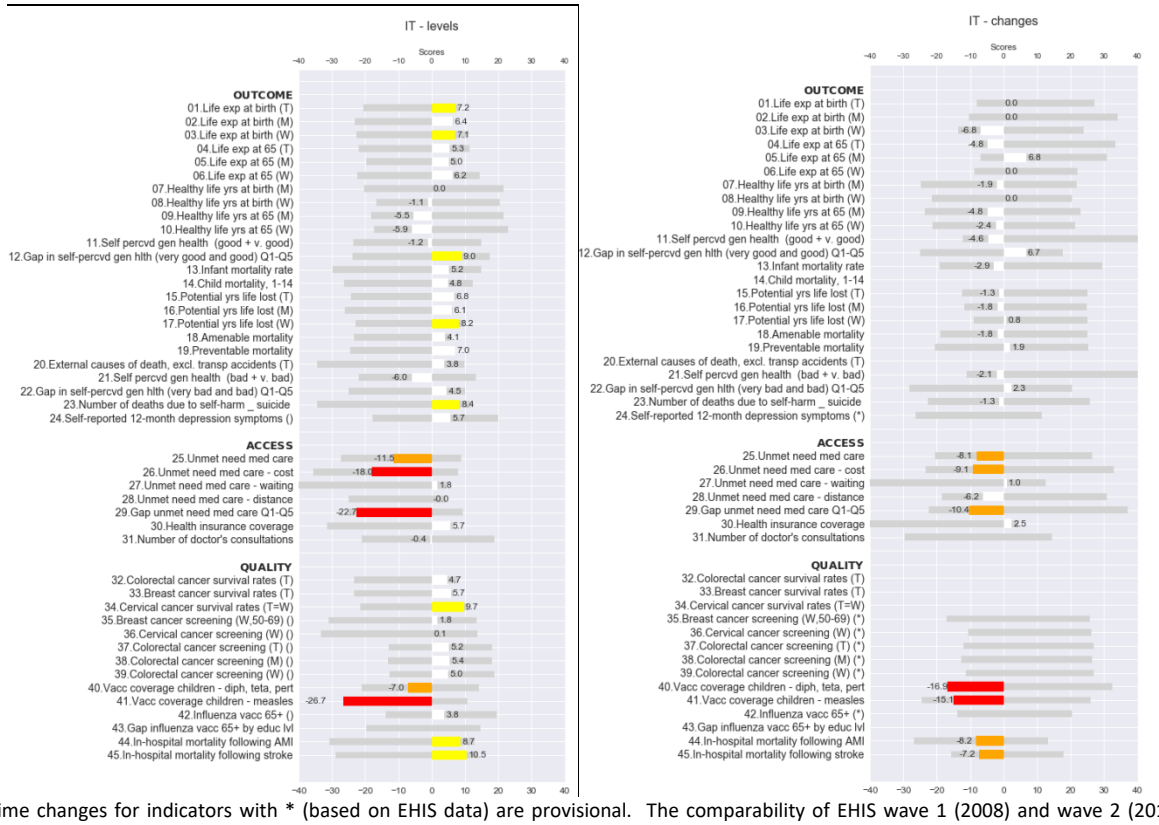
In 2015, the vaccination coverage rate of children for measles is considerably worse than the recommended 95% threshold (85%) and is decreasing considerably with respect to the average change in the EU in the last 3 years. The vaccination coverage rate of children for DTP is lower than the recommended 95% threshold (93%) and is also worsening in the last 3 years.

Non-health determinants: Lifestyle is generally better or considerably better than the EU average, with the exception of physical activity and inequality in alcohol use

Data on risk-factors based on EU surveys are limited for Italy compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

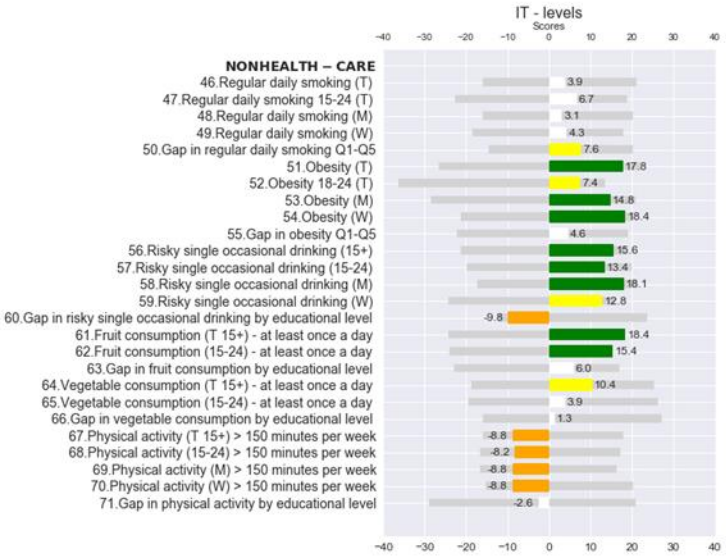
Physical activity for men, women, adults and young are worse than the EU average. The gap in alcohol use by educational level is worse than the EU average. The other lifestyle variables are generally better or considerably better than the EU average in 2014.

Figure 29 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 30- JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



LATVIA

With limited financial and physical resources dedicated to healthcare, health outcomes in Latvia are worse or considerably worse than the EU average. However, these challenges are showing strong signs of improvement in the last years, with recent reforms also allocating more resources for the healthcare of vulnerable groups and for workers in the health sector. Some areas in the quality dimension (e.g. cancer care) still need to be improved. With a relatively low level of GDP per capita, risk-factors remain worse than the EU average. Risk-factors is also deteriorating, a recent trend observed in other EU countries. Due to high out of pocket payments access to medical care is limited and unequal. Health care system is universal in Latvia, but the depth of coverage is limited. A recently adopted law will shift the current universal health system towards a two-tier system linking the right to accessing the full healthcare service basket to insurance contributions. Residents will have a differential access to healthcare depending on whether they will pay social insurance contributions, or voluntarily opt-in or fall into one of the categories for which the state will pay insurance contributions (e.g. children and pensioners). These people will have access to a full healthcare service basket, while other residents will have access to a minimum basket.

Resources, Coverage and Organisation of the Health System

Health spending in Latvia is low and projected to increase as in Europe

Health spending per capita in Latvia is below the EU average (991 pps in 2014). If measured as a share of GDP, health expenditure in Latvia is considerably below the EU average (5.5% in 2014). Yet, health spending is expected to rise in the future due to a number of factors, including population ageing, technological progress and rising incomes: between 2013 and 2060 the share of public spending on health in Latvia is projected to increase by 0.6 percentage points of GDP, around the average level across the EU (+0.9 percentage points)[22]. At 0.3% of GDP, spending on long-term care in Latvia is also below the EU average.

In terms of the structure of health spending, Latvia spends less on administration (2%) than the EU average. Spending on curative and rehabilitative care (49%) is slightly below the EU average (55%). On the other hand, spending on pharmaceuticals in Latvia is higher.

Public health spending in Latvia is comparably low with out-of-pocket spending playing an important role

Only 60% of total health spending in Latvia is paid out of public sources, compared with almost 80% in the EU as a whole (in 2014). Public spending is entirely financed through direct outlays by government since a social health insurance scheme based on contributory payments does not exist in Latvia. Nearly all of the remaining spending is made up of households' out-of-pocket payments (39%). This share is among the highest across the EU and considerably above the EU average of 15%. This is the result of limitations in the breadth and depth of public coverage for health care services. Informal payments are also more frequent in Latvia than many EU countries[23]. Voluntary health insurance plays only a marginal role compared to many other EU countries. Its share of total health spending (1%) is below the EU average.

Universal coverage in a tax-financed health system

The Latvian health system is mainly tax-financed providing coverage for the entire population via a publicly-funded benefit package. However, patients are exposed to substantial user charges and direct payments.

The scope of goods and services covered is comparably limited

Services provided by physicians and institutions that have contractual agreements with the National Health Service (NHS) are publicly covered. The benefit package is defined by "positive lists" (for pharmaceuticals, and for certain preventive, diagnostic and therapeutic interventions) and "negative lists" (exclusion of certain services, such as dental care for adults, rehabilitation with some exceptions, and sight- and hearing-correction aids also with some exceptions). Compared to other European countries, the scope of the benefit package in Latvia is relatively limited, and was reduced after the economic crisis in 2008 to help contain health spending during a period of fiscal consolidation. However, the benefit package has recently been expanded again for instance with the inclusion of transcatheal aortic valve implantation for patients and liver transplantation for adults, positron emission tomography services for patient with certain oncological diagnosis. As well improved the provision of diagnostics and consultation for patients with rare disease by introducing the specialized rare disease cabinet, and improved diabetes patients care by introducing services of training cabinet. Additionally, efforts have been made to improve the timeliness of access to some vital services

22 For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

23 Transparency International (2013).

particularly in oncology. For instance, since 2016, patients with a suspected cancer diagnosis are expected to be examined in a specialised institution within 10 working days of receiving a referral from their family doctor. Since 2017, the course of treatment must also be decided within a month of the first specialist.

Limited depth in public coverage lead to a high out-of-pocket spending

In general, access to health services in Latvia, including GP visits, specialist visits, hospital stays and pharmaceuticals, requires cost sharing in the form of user charges. If treatment is sought outside of the NHS system or secondary care providers are consulted without referral, patients have to bear the full cost of services. Both the limitations in the scope of services covered and lack of depth of coverage contribute to the high share of out-of-pocket spending in Latvia, in particular for pharmaceuticals.

The government introduced a number of supplementary measures to protect particularly vulnerable groups from catastrophic health spending. After the financial crisis in 2009, a reduced cap on out-of-pocket payments was introduced for lower-income groups as part of the Safety Net and Social Sector Reform Programme which lasted until 2012.

Today, other protection mechanisms limit user charges to a certain degree. Some health services such as emergency medical services, annual health check-ups by GPs, vaccination against diphtheria for adults, and specific screening services are exempt from cost-sharing. Additionally, the regulation on health care organisation and financing stipulates an exemption from user charges for a total of 18 statutory categories of vulnerable patient groups including children under 18 years, persons in need, persons with disabilities, asylum seekers, and people receiving inpatient palliative care.

Responsibility for health policy, regulation and management is split between the Ministry of Health and the NHS

The Latvian health system is characterised by tax-financed health care provision, a purchaser–provider split and a mix of public and private providers. The system is the result of more than 25 years of transformation since the independence of the country in 1991. After undergoing several reforms, a National Health Service (NHS) type system was established in 2011. The two main actors in the health system are: (1) the Ministry of Health, which is responsible for developing national health policies and for the overall organisation and functioning of the health system, and (2) the NHS, which implements health policies and purchases the bulk of publicly-financed health services.

Service delivery is mixed with gatekeeping at the primary care level

Providers contracted by the NHS tend to be predominantly private in the case of primary care; public and private in the case of secondary care, with public ownership concentrated mainly at the municipal level; and exclusively public in the case of tertiary care, with ownership concentrated at the national level.

Almost all Latvians are registered with a primary health care (PHC) provider who acts as the main point of entry into the health care system and as the gatekeeper for secondary ambulatory and hospital care. In rural areas (in which about a third of the population lives), physician assistants or midwives still provide a considerable proportion of primary care. A patient with a referral from a PHC provider can freely choose any ambulatory or inpatient care provider under contract with the NHS. Some specialists can be accessed directly without a referral, under certain conditions (e.g. access to a paediatrician for children). In 2016, the requirement that only specialists (not PHC providers) can refer patients for certain highly specialised diagnostic and laboratory examinations was introduced in an attempt to rationalise expenditures.

PHC providers are paid using a mix of capitation, fee-for-service (FFS), fixed practice allowances, bonuses, and include a pay-for-performance scheme (P4P). The latter was introduced in 2013, and targets prevention, the treatment of chronic conditions, efficiency gains, and the diversity of PHC services. Secondary ambulatory providers are mostly paid by flat-rate fees for defined episodes of illness, with additional FFS payments for preventive, diagnostic and therapeutic interventions. Since 2010, hospitals have been paid through global budgeting adjusted by numbers and types of patients treated. The implementation of a payment scheme more explicitly based on DRGs started in 2015.

Availability of nurses and midwives in Latvia is below the EU average

In 2015, the ratio of practicing physicians in Latvia stood at 320 per 100,000 population – around the EU average. This figure has been relatively stable in Latvia in recent years, while it has gone up in general across the EU. The number of practicing nurses and midwives relative to the size of the population in Latvia (489 per 100,000 population) was lower than the EU average and has been declining over the three preceding years.

The density of health professionals varies between regions in Latvia. To promote the recruitment of medical staff in underserved areas, new resident admission requirements for government-financed medical education were introduced giving priority in training to those applicants who commit to working within a regional municipality and/or state medical institution outside

the capital after the completion of their residency program. Further measures to encourage working outside of Riga, supported by EU funds from the 2014-2020 perspective, will facilitate the recruitment of staff outside of the capital, including the possibility for some specialists to retrain and return to the labour market.

Low remuneration has been identified as an important obstacle in the recruitment of staff for medical institutions, in particular for positions at middle and lower level. To tackle this problem, the Ministry of Health has allocated additional funding to remunerate medical staff. Wages for low pay grades have been increased by approximately 7% (EUR 10 million in 2016; EUR 5.8 million in 2017). Additional funding of EUR 85.3 million to increase remuneration of medical staff will be made available in2018. This will lead to significant wage increase for doctors (44%), nurses and midwives (38%), and for medical and patient care support staff (24%).

Policy Developments

Improving care coordination at the primary care level has become an important policy goal in Latvia

In addition to assuring access to care for low-income households, the Social Safety Net programme, introduced in 2009, also included measures that aimed to shift care away from hospitals towards more coordinated care at the community level. This refers to the provision of home care services for chronic patients, day care services for patients with mental illnesses, the financing of additional nurses in primary care and the establishment of a family doctor telephone advisory service. To increase the accessibility of health care services, the 2017 budget for health care was raised by EUR 50 million (6.5%) compared to 2016. EUR 34.3 million of this increase is earmarked for activities to decrease waiting times for out-patient services, to improve the accessibility to diagnostics, to treat malignant tumours and to reimburse pharmaceuticals for specific conditions.

Recent reforms aim to improve the general access to medical care, care quality and the efficiency of the system, including by allocating more targeted resources

Latvia has started to implement a number of health care reforms with the aim of ensuring the sustainable development of the health care system while improving access. Reforms are expected to cover many areas of the health system including infrastructure requirements and mapping of service providers, the remuneration of health workers, an improvement of the selection process of the publicly funded health care providers (strategic purchasing including the benefit basket), the establishment of a health care quality system, a further development of the existing eHealth system, the reorganization of subordinate institutions which are under the responsibility of the Ministry of Health.

A recently adopted law will shift the current universal health coverage towards a two-tier system linking access to the full healthcare service basket to insurance contributions

In December 2017 the Latvian government adopted a health financing law which introduces state health insurance system with two service baskets (a full and a minimum).. The full healthcare service basket is linked to state health insurance. The right to state health insurance (full basket) is reserved to people who paid compulsory social insurance contributions, which are increased by 1% in 2018. There would be a voluntary opt-in for those who want to have access to full basket, by paying voluntary health insurance contributions. Health insurance payments for those who will not be insured automatically will amount 1% of the minimum monthly salary in 2018 (3% in 2019, 5% in 2020). . The state will contribute on behalf of specific groups including children, pensioners, registered unemployed and other statutory categories. The minimum basket available to all residents includes emergency care, maternity care, family doctor services, medicines and medical devices as well as the treatment of selected diseases (tuberculosis, mental health).

JAF Health Results

Health outcomes in Latvia are often considerably worse than the EU average, although objective measures show strong signs of improvement

In 2015, healthy life years at birth and at 65 are considerably worse than the EU average (for both women and men) and are identified as a health challenge. Life expectancy at birth (74.8 in 2015), preventable mortality and the number of deaths due to self-harm / suicide are considerably worse than the EU average, but show some positive developments compared to the average trend in the EU over the last three years. Life expectancy at 65 for both men and women, potential years of life lost for both men and women and amenable mortality are also considerably worse than the EU average, but show a considerable positive development. All these indicators are identified as health challenges. The share of people who perceived their general health as good/very good and bad/very bad are considerably worse than the EU average and are identified as health challenges. In general, the level remains considerably worse than the EU average and it is identified as a health challenge.

Child mortality (1-14) (23/100 000 in 2013) and external causes of death (excluding accidents) are considerably worse than the EU average. The gap in the share of people who perceive their general health as bad/very bad between the lowest and the highest income group is considerably higher that the EU average.

Access: The limited and unequal access to healthcare is improving as well in the last years

Unmet need for medical care (8.2% in 2016) represents a health challenge in Latvia, as it remains worse than EU average, although it shows a considerable positive development over the last three years. Unmet need for medical care in Latvia is mostly explained by costs and distance. Inequality in access to medical care, as measured by the gap between the bottom and top income quintile, is considerably worse than the EU average but improving considerably.

The number of doctors' consultation is around the EU average but shows a positive development.

Quality: The quality dimension is not as challenging as other areas in Latvia, but it does not show either clear signs of improvement

Breast cancer screening is worse than the EU average. Although cervical cancer screening is around the EU average, it decreased from 2008, in a period in which the survival rate for cervical cancer was already worse than the EU average (2007 data). The influenza vaccination rate for over 65 (3.9% in 2014) is worse than the EU average. These indicators are identified as health challenges in the quality domain.

In-hospital mortality following AMI and stroke are considerably worse than the EU average (2013). Survival rates for colorectal and breast cancer are considerably worse than the EU average (2007 data), although colorectal cancer screening is around the EU average. However, the vaccination coverage rates of children for DTP and measles show a considerable positive development over the last three years and meet the 95% threshold.

Non-health determinants: Indicators about lifestyle are worse than the EU average, including inequality in alcohol consumption. With the exception of the smoking rate of, the situation is worsened by the negative development of most of these indicators

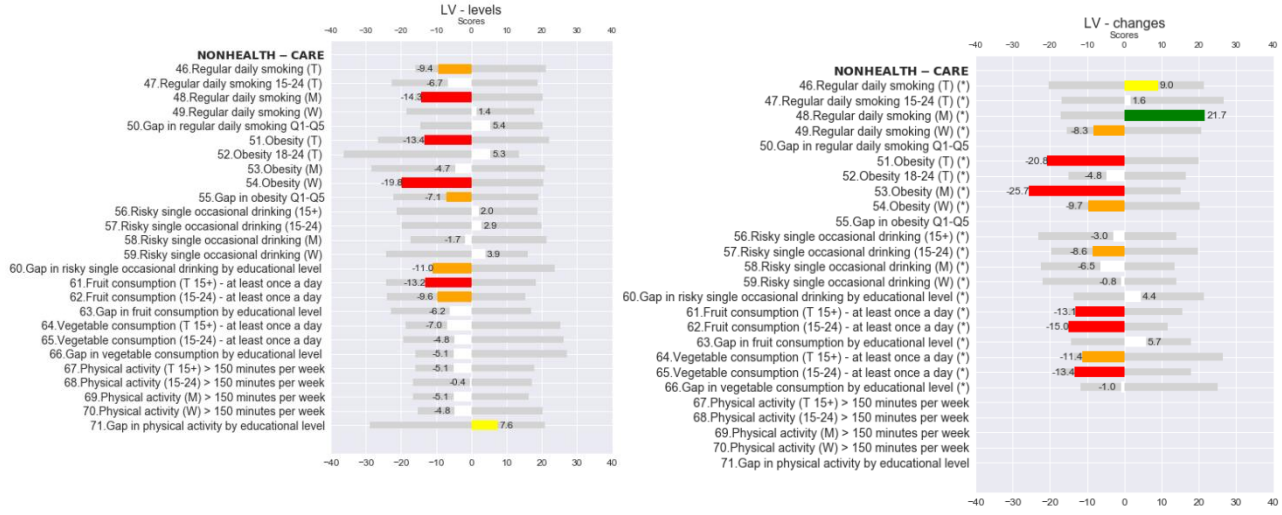
In 2014, the obesity rate among women (22.7%), alcohol use among men (31.4%) and fruit consumption among adults (39.8%) are considerably worse than the EU average. The gap in obesity between high and low income quintile and alcohol use between high and low educated and fruit consumption among young (15-24 year-old) are worse than the EU average. The smoking rate among men (36%) is considerably worse than the EU average, but shows a considerable positive development from 2008. Although the share of smokers among women is around the EU average, it shows a negative development from 2008 compared to the EU average change. The obesity rate for men is around the EU average, but shows a considerable negative development compared to the average increase in the EU. Vegetable consumption among young people is worse the EU average and shows a relative negative development, while among young people is around average but shows a considerable negative development. These indicators are identified as health challenges.

Physical activity, including among young, is around the EU average (only 2014 data available).

Figure 31 - JAF Health profile charts for main dimensions (standardised scores), levels (left bar) and 3-year changes (right bar)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 32 - JAF Health profile charts for non-health determinants (standardised scores), levels (left bar) and 3-year changes (right bar)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

LITHUANIA

With a high rate of poverty and social exclusion and a health spending below average, most health outcomes in Lithuania are considerably worse than the EU average, while only around half are improving. Lithuania has the lowest life expectancy at birth for men in the EU, with smoking among men worse than average, while Lithuania's alcohol policy is becoming more restrictive. Expenditure on prevention is below the EU average and some indicators on prevention (vaccinations, cancer screening) show a worse than the average performance. The Lithuania health system is mostly based on compulsory social insurance, with an estimate of 2-4% of the population uninsured (although their exact status is not clear). The level of government expenditure for healthcare is below the EU average and the level of out-of-pocket payments for pharmaceuticals is relatively high. Lithuania recently adopted pharmaceutical guidelines to promote the rational use of medicines and the reduction of out-of-pocket spending. The number of consultations per doctor is higher than the EU average and increasing, despite the number of physicians is considerably above the average. Unmet need for medical care due to distance is worse than average and identified as a challenge.

Resources, Coverage and Organisation of the Health System

Health spending in Lithuania is below the European average

Health spending in Lithuania is below the EU average when measured on a per capita basis (1,483 in pps in 2015) or as a share of GDP (6.5%). Health spending is expected to rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.1 percentage points in Lithuania, considerably more slowly than the EU average (0.9%) .

In 2015, Lithuania spent 1.9% of current health expenditure on prevention, which is below average, but the proportion had been rising more rapidly than in the EU in previous years. The spending structure was otherwise comparable to the EU average although the proportions dedicated to curative and rehabilitative care had been decreasing in comparison to the EU average in previous years.

The majority of public spending is financed by social insurance

In Lithuania, in 2015, the proportion of funding by compulsory insurance (57.0% of current health expenditure) was around average for the EU while the proportion of government outlays (9.9%) was lower. Households' out-of-pocket payments (32.1%) were higher and had been increasing more rapidly than in the EU, while voluntary schemes represented only 1.0% of current health spending, below the EU average.

The insurance-based health system aims at providing universal access to care

The National Health Insurance Fund (NHIF) provides quasi-universal coverage to the population and contracts public and private providers. The principle of universality in the Lithuanian Compulsory Health Insurance System is understood as an arrangement where all permanent residents and those temporary residing and legally working foreigners as well as they family members are obliged to pay compulsory health insurance contributions, and upon an occurrence of an insured event are entitled to receive healthcare services compensated from the budget of the Compulsory Health Insurance Fund. Compulsory enrolment is financed by a mix of contributions and per-capita payments from the state budget on behalf of the economically inactive population. People who do not pay compulsory contributions and are not insured by State must cover the cost of treatment personally. It is estimated that between 96% and 98% of the population is covered. The exact status of the uninsured is unclear, but they could be people who reside and pursue economic activity abroad without declaring officially about the movement of their residence to another country (and for this reason they could still be counted in the reference population of permanent Lithuanian residents for the estimation of health insurance coverage).

The range of services covered by the NHIF is relatively broad but out-of-pocket payments for medical goods are high

Urgent health care is provided for all residents. The insured are entitled to a broad range of personal health services defined rather loosely. There are no co-payments for primary care and referred services. A positive list indicates which pharmaceuticals are reimbursed. For ambulatory pharmaceuticals, reimbursement rates range between 50 and 100% depending on the type of disease covered (with the majority covered at 80 or 100%) and reimbursement can be tied to specific indications. The reimbursement rate applies to a reference price and patients who purchase higher priced pharmaceuticals have to pay the difference. The relatively high out-of-pocket payments are thus predominantly expended on medical goods, but can also include payments for services that are not in the benefits package, or are made to non-contracted providers. To reduce the prices of medicines is one of the priorities of the 17th Government of the Republic of Lithua-

nia. The Programme of the Government of the Republic of Lithuania foresees several measures which are aimed to promote the rational use of medicines by encouraging the use of generics and biosimilars instead of patented medicines; providing information campaign for patients about rational use of medicines, including non-prescription medicines, control of prescription only medicines sales in pharmacies, decreasing patients' co-payments for reimbursed medicines, ensuring better access of medicines for people with very low incomes. To decrease the co -payments for reimbursed medicines, the Governmental Decree on reimbursed price calculation was amended and came into force on 1st July 2017. After the implementation of new provisions, the co-payment for reimbursed medicines decreased about 20 percent[24].

The Ministry of Health is the main steward of the health system

The Ministry of Health (MoH) formulates health policy and regulation but has also a more direct managerial role, from actively governing the NHIF, e.g., by representation in its board, to managing large hospitals. The MoH is supported by a number of specialised agencies, including the State Health Care Accreditation Agency, which is also in charge of HTA and the States Medicines Control Agency.

Service delivery remains dominated by a large mostly public hospitals sector but outpatient service delivery is increasingly mixed

Primary care is provided in either municipality-owned or private facilities. Private providers tend to work in small practices and covered around 30% of the population in 2015. Insured people are free to register with the primary care provider of their choice. Primary care providers receive a capitation, with additional fees for delivering preventive services, and a small pay-for-performance component. Specialist outpatient care is delivered through the outpatient departments of hospitals or polyclinics, as well as by private providers. Hospitals, which are for the most part owned by the state or municipalities, are paid by DRG but volumes are capped. In the fast developing day care and day surgery segment, private providers, although they are still few and small, receive around 10% of the amount contracted by the NHIF. They also provide around half of diagnostic and interventional imaging services contracted by the NHIF.

The number of physicians is relatively high compared to the EU average

In 2015, the numbers of physicians (434 practicing physicians per 100,000 population) was considerably higher than the EU average, but the number of nurses and midwives (798 per 100,000 population) was average.

Policy Developments

Lithuania's alcohol policy is becoming more restrictive

Health features as a prominent inter-sectoral priority across Lithuania's strategic planning documents, and the health strategy emphasises the importance of tackling health determinants and reducing inequalities. In particular, Lithuania is stepping up its efforts to tackle the exceptionally high alcohol consumption. In 2017, alcohol taxes increased and Parliament adopted new restrictions including a ban on alcohol advertising, the extension of the age for buying and consuming alcoholic beverages from 18 to 20 years, and restriction of selling hours. In the new legislation, retailers would be responsible for controlling the age of buyers, and local governments given increased authority to limit and control sales hours in both shops and restaurants.

The on-going consolidation of the hospital sector is now supported by measures to improve the quality of care

The consolidation of the hospital sector has been a long-standing government priority but remains a challenge. Two recent initiatives aim to support this agenda by organising and concentrating service delivery to increase quality. First, contracting for surgery and maternity by the NHIF is now limited to those hospitals that provide more than a minimum volume of services. Second, standardised pathways have been introduced for stroke and some myocardial infarctions. Following an initial assessment, and depending on severity, patients are directed by emergency services either to the regional hospital, to one of six regional stroke treatment centres, or to one of five cardiology centres established by the program. They receive an initial treatment and can be later transferred to a facility closer to their home. The new specialised centres offer effective but previously under-developed services.

National pharmaceutical guidelines provide an explicit direction for pharmaceutical health policy

As many other countries, Lithuania struggles to balance considerations of access and sustainability when it comes to pharmaceutical products. For the first time in 2017, the Ministry of Health has adopted national pharmaceutical guidelines which set explicit policy priorities. These include the promotion of the rational use of medicines and reductions in out-of-pocket spending through increases in the take-up of generics and bio-similars as well as reductions in prices.

[24] Based on data from NHIF available at: http://www.vlk.lt/veikla/veiklos-sritys/kompensuojamieji-vaistai/Statistika.

JAF Health Results

Outcomes: Men in Lithuania have the lowest life expectancy in the EU and most health outcomes are considerably worse than the EU average, while only around half are improving

In 2015, life expectancy at birth (stand at 74.6) and at 65 (stand at 17.1) are considerably worse than the EU average. Lithuania records the lowest life expectancy at birth for men in the EU (69.2), although it shows a positive development compared to the EU average change in the last three years. Life expectancy at 65 and healthy life years (at birth and at 65) for women are relatively better compared to men, but still worse than the EU average. However, healthy life years show a negative development compared to the EU average change in the past three years. Self-perceived general health as good/very good and bad/very bad are considerably worse than the EU average, while the latter is improving considerably in relative term. Inequality in self-perceived health (as measured by the gap between income quintiles) is also worse than the EU average While the gap in self-perceived general health as bad/very bad is improving in comparative terms in the last three years, the self-perceived general health as good/very good is worsening considerably compared to the EU average change. In 2014, potential years life lost (for both women and men), amenable and preventable mortality are considerably worse than the EU average, but they are improving considerably in the past three years. Lithuania also report the highest number of deaths due to self-harm/suicide in the EU, although it is improving more than average in the last three years. Infant mortality is around the EU average, but it is deteriorating more than the EU average in the last three years. These variables are identified as health challenges.

Child mortality (among 1-14 year-old) and external causes of death excluding transportation accidents are, respectively, worse and considerably worse than the EU average.

Access: unmet need for medical care due to distance and the number of doctor's consultations are worse than the EU average, while the latter is also worsening

In 2015, unmet need for medical care due to distance (0.3%) is worse than the EU average. In 2014, the number of doctor's consultation it is higher than the EU average and considerably increasing compared to the EU average in the last three years.

Quality: Some indicators on prevention (vaccination, cancer screening) are worse than the EU average

Data on the quality of healthcare are limited for Lithuania. In 2015, the vaccination coverage rates of children for DTP is below the recommended 95% threshold and it identified as a health challenge.

In 2007, the survival rates of colorectal and breast cancer were considerably worse than the EU average. In 2014, the screening of breast cancer (among women 50-69) is still worse than the EU average. The share of over 65year-old declaring to have had an influenza vaccination (5.2%), based on the EHIS data, is also worse than the EU average. The ECDC provides data on vaccination coverage rates for older people based on the administrative method, which corresponds to reported routine immunisation data, i.e. registry system of doses administered. According to these data, the vaccination coverage rate for over 65 year-old in Lithuania is 22.1%[25], against a median value in Europe of 41.8%[26]. The vaccination coverage rate of children for measles is below the recommended 95% threshold.

Non-health determinants: Some aspects of lifestyle are a concern, especially for men and to a lesser extent for young, with some inequalities in diet

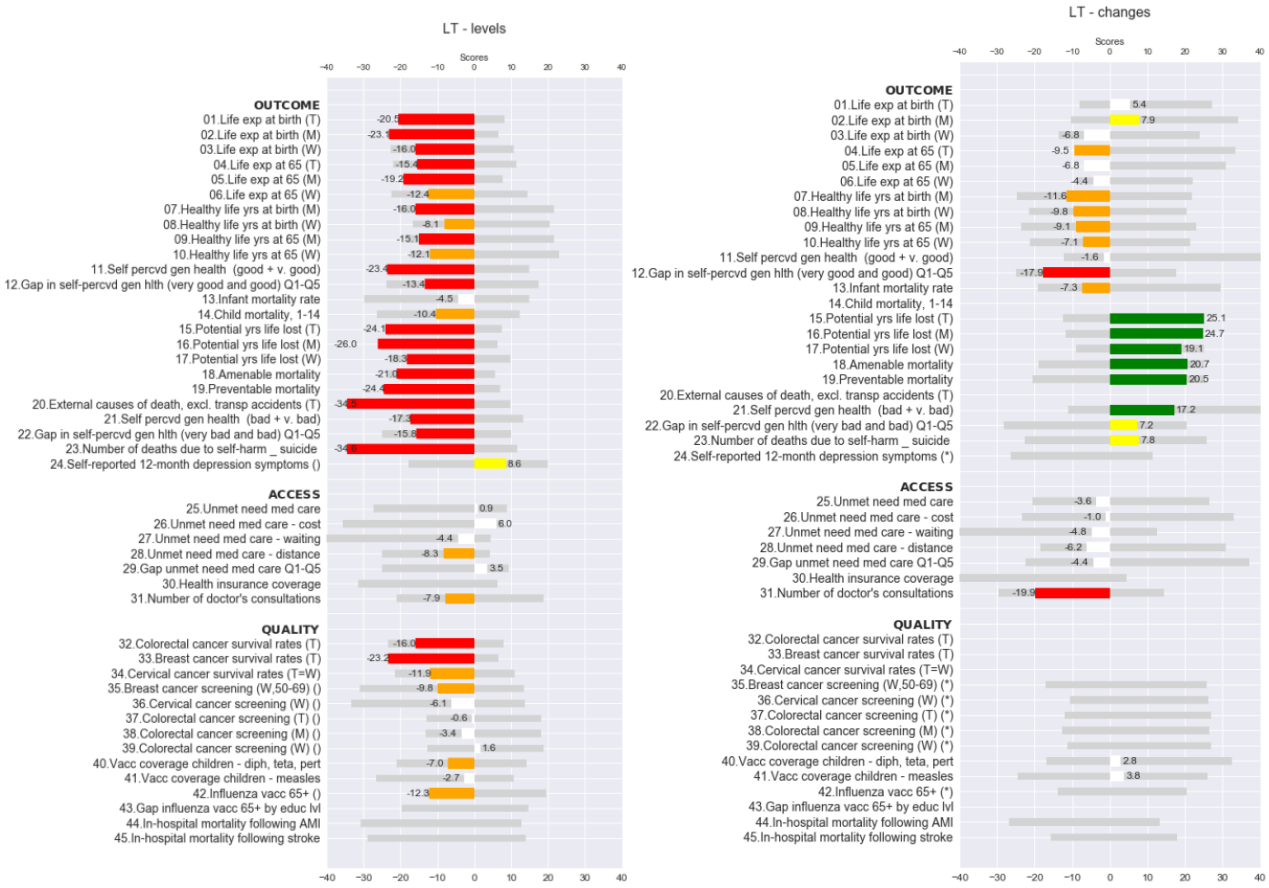
Data on risk-factors based on EU surveys are limited for Lithuania compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

In 2104, the smoking rate (33.6%) among men are worse than the EU average, while the smoking rate among women (9.2%) is considerably better than the EU average. On the other hand, the obesity rate among women is worse than the EU average, while that of men and young are better than average. The physical activity rate among adults (women and men) is worse than the EU average, but not for young. Vegetable consumption among young (15-24 year-old) is better than the EU average and, in general, young have a healthier lifestyle. While inequality between high and low educated is worse than average for diet (fruit and vegetable consumption) and considerably better for physical activity.

[25] These data may include double counting.

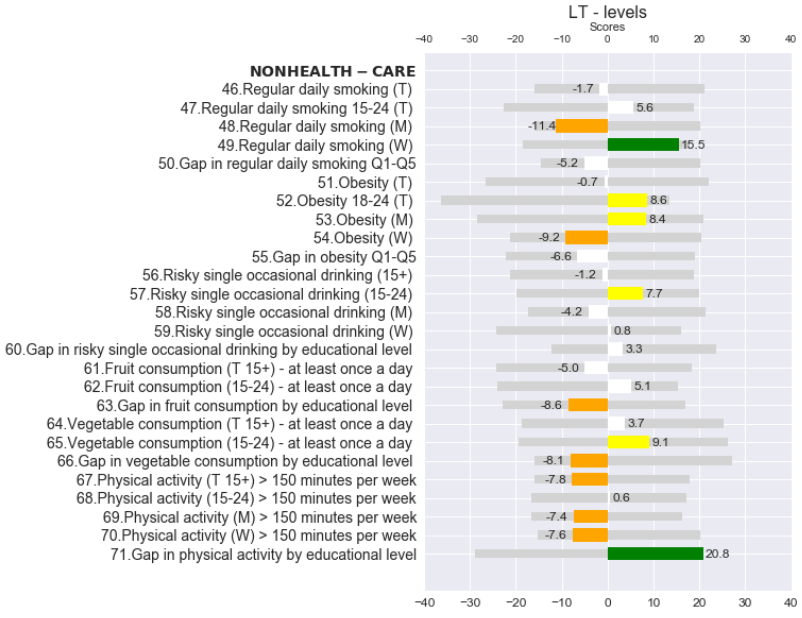
26 Source: European Centre for Diseases Prevention and Control (2017) TECHNICAL REPORT "Seasonal influenza vaccination in Europe. Vaccination recommendations and coverage rates in the EU Member States for eight influenza seasons 2007–2008 to 2014–2015", available at: https://ecdc.europa.eu/sites/portal/files/documents/influenza-vaccination-2007%E2%80%932008-to-2014%E2%80%932015.pdf

Figure 33 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 34 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



LUXEMBOURG

With the highest health expenditure per capita in the EU, health outcomes in Luxembourg are generally around the EU average. However, indicators on mental health signal an issue in this area, as Luxembourg has a relatively high level of depression, while the suicide rate is increasing. Other health outcomes are worsening in the last years, namely healthy life years (while life expectancy is increasing) and self-perceived general health, as well as its divide by income groups. In terms of quality, vaccination coverage rates of children are good, while in-hospital mortality rates following AMI and stroke are not improving as in other EU countries. Recently, Luxembourg set-up its first National Antibiotic Plan to tackle antimicrobial resistance. Healthcare insurance is universal in Luxembourg. The largest share of health expenditure is financed by compulsory health insurance, and the benefit package is relatively generous. Cost-sharing applies to most services, but they are capped depending on annual income. This, together with the use of complementary voluntary insurance, explains the relatively low level of out-of-pocket payments compared to other EU countries. Although the availability of care depends on recruitment from abroad, there are no specific issues in the access dimension. In terms of risk-factors, alcohol consumption and inequality in regular smoking by income groups are worse than the EU average. A number of measures have been taken in recent years to address public health issues and, in particular, on alcohol consumption and smoking, as well as suicide and depression.

Resources, Coverage and Organisation of the Health System

Health spending as a share of the GDP is below the EU average even though Luxembourgers spend much more on health per capita than other EU countries

Health spending per capita in Luxembourg (4,131 pps) is the highest in the EU in 2015. Luxembourg spends less than the EU average when health spending is measured as a share of GDP (6.1%), although in proportion to national consumption (e.g. measure as a share of GNI) it would be higher. Health spending is expected to rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 0.5 percentage points in Luxembourg, which is below the EU average (0.9%). In terms of structure, in 2015, Luxembourg spent considerably more on long-term nursing care (23.5% of health spending) than other EU countries. Administrative spending (4.3%) was also higher than in the EU although the proportion allocated to this had gone down in recent years. Spending on curative (48.7%) and rehabilitative care (4.2%) were average, but their share had declined in the previous three years.

Public spending on health is mainly channelled through compulsory health insurance

In 2015, 72.9% of health spending was channelled through compulsory health insurance, above the EU average. By contrast, the proportion of health expenditure funded through government outlays (9.1%) was lower than the EU average, but has increased more than in other countries in recent years. The remaining spending was made up household out-of-pocket payments (10.6%), below the EU average, and voluntary schemes (7.4%), around the EU average. The share of the latter, however, had increased in recent years.

Generous coverage is provided through compulsory social health insurance

A single-payer social health insurance fund (CNS) provides universal health coverage and either pays service providers or reimburses patients afterwards. Revenues of CNS come from contributions by employees and employers but transfers from the government are also substantial (40%).

Coverage is universal and benefit package more generous than in neighbouring countries.

In 2015, 95.2% of the population were covered by health insurance. The rest were mostly working either for the European Commission or abroad and thus covered by foreign schemes. Absence of coverage is not considered to be an issue in Luxembourg. Compulsory health insurance entitles the insured population to a very broad benefits package, which covers more services than those in neighbouring countries, in particular for dental care and prosthesis.

Cost-sharing applies to many services with voluntary health insurance used to offset co-payments

With the exception of some clearly defined services such as chemotherapy, child vaccinations, and medicines for certain conditions, most goods and services, including doctor's consultations, pharmaceuticals and hospitalisation require some level of cost-sharing for patients. This can refer to flat user fees, a ceiling on the annual amount covered, or a percentage of costs reimbursed (with rates varying between services). Co-payments are capped at 2.5% of annual gross income. More than half of the population has complementary voluntary health insurance to offset these co-payments. This explains why the share of out-of-pocket payments in Luxembourg is below most other EU countries.

Cross-border working and seeking treatment abroad are important in Luxembourg

A feature that sets Luxembourg apart from other countries is the extent to which cross-border workers and Luxembourgish residents seek care abroad – for different reasons. In 2013, 16% of patients insured with the CNS sought care abroad. This refers on the one hand to cross-border workers who seek care mostly in their country of residence. A second group comprises Luxembourgish residents who seek specialised health services that are unavailable in Luxembourg (e.g. paediatric cancer care, organ transplant). They are treated in neighbouring countries and in general the CNS is very generous in pre-authorising care abroad.

The Ministry of Health, the Ministry of Social Security and the Ministry of the Family are the main actors in the health system

The Ministry of Social Security and the Ministry of Health are jointly responsible for health system governance, with the Ministry of the Family contracting and regulating long term care. The Ministry of Health develops health policy and legislation, organises care delivery, authorises large hospital investments and directly co-finances public health programmes. The Ministry of Social Security is responsible for social policy and oversees public institutions (such as the CNS) funding health care, sickness leave and long term care.

Service delivery is mainly private in primary care and mixed for secondary care

Primary care is provided in private solo practices, as is the majority of outpatient specialist care (with some provision in public and private hospitals). Patients do not have to register with a general practitioner and are free to access specialist services directly. Hospital care is delivered by public and not-for-profit hospitals. Nearly all doctors in the country are self-employed and paid by fee-for-service, irrespective of where they practice. Only few physicians working in hospitals are salaried and even then, the CNS pays the hospital a fee-for-service for all the medical services they provide. All other hospital services (e.g., hospital stays, nursing services) are financed from global budgets based on the number of patient days and allocation formulas for specific hospital services.

Luxembourg has fewer doctors and more nurses compared to other EU countries

Compared to other EU countries, in 2015 Luxembourg has a relatively lower number of doctors (291) and a higher number of nurses (1,227) per 100,000 population. The country relies heavily on recruitment of both doctors and nurses from abroad, partly due to the lack of tertiary education in Luxembourg. This creates a strong dependency on neighbouring countries and competition for scarce health professionals.

Policy Developments

Addressing public health issues has been a major focus of recent policies

Luxembourg has national action plans for a number of public health issues. In 2014 Luxembourg launched the first National Cancer Plan 2014-2018. Building on previous policies to tackle tobacco smoking, and in accordance with EU directives, Luxembourg's Anti-Tobacco Plan 2016–2020 includes public awareness campaigns and tax increases starting from 2018. Only recently, in June 2017, has the government raised the legal age for purchasing tobacco products to 18. In 2012–14, the government established several small-scale programmes to fight excessive alcohol misuse among young adults through awareness-raising activities which are part of the National Action Plan 2015–2019 in the fight against drugs and related addictions. A national alcohol strategy is currently under development. Faced with a growing prevalence of HIV infection, the government has set up public health campaigns and expanded screening centres and low-threshold testing for HIV as part of the national HIV Action Plan 2012–2015. The new action plan for 2017-2021 is currently being developed.

Tackling antimicrobial resistance with the first National Antibiotic Plan 2018-2022

Given the link between antibiotic consumption and antimicrobial resistance, the Ministry of Health and the Ministry of Agriculture, Viticulture and Consumer Protection have started to develop the first ever National Antibiotic Plan. To be adopted by the end of 2017, the plan aims to reduce the emergence, development and transmission of antimicrobial resistance in Luxembourg.

Setting the building blocks for a health information system

The Health Reform Law of 2010 sought to equip the CNS with a standardized accounting system for hospital services and a new e-health infrastructure. A new agency, the National Agency for Shared Information in Health, was set up to oversee the creation of a national platform for e-health services. Operational since 2014, the National eSanté Platform facilitates the sharing of health information with, and between, health professionals, in a secure manner and with privacy controls. The shared health record, adopted in 2015 in a pilot phase for a subgroup of patients, seeks to empower patients to make informed choices by giving them access to all available information on their health

status and treatment options, as well as providers the opportunity to access all relevant information. Another initiative, the Carte Sanitaire, provides structured information on all Luxembourgish hospitals and the services they provide. It has been used for planning and is considered a key step towards systematically compiling information on hospital utilization and standardizing hospital procedures.

JAF Health Results

Health outcomes in Luxembourg are around the EU average, with the exception of the relatively high level of depression, while some outcomes are worsening in the last years

In 2015, healthy life years (63.7 at birth for men and 60.6 for women) are around the EU average. However, they are worsening in the last three years, especially for women they are declining considerably more than the EU average change. Similarly, infant mortality[27], the number of deaths due to self-harm/suicide and self-perceived general health as bad/very bad are around the EU average, but they are worsening in the last years. Inequality in self-perceived general health as bad/very bad by income group (as measured by the gap between the first and the fifth income quintile) is considerably worsening compared to the EU average in the past three years, although it is still around average in 2015. These variables are identified as health challenges.

While healthy life years are worsening, life expectancy (for both men and women) is improving in the last years. Self-reported 12-month depression symptoms are worse than the EU average in 2014.

Access: indicators on the access dimension are around the EU average

The agreed indicators on the access to healthcare are all around the EU average.

Quality: While vaccination coverage rates of children are good, in-hospital mortality rates following AMI and stroke are not improving as in other EU countries

The vaccination coverage rate of children for DTP (99% in 2015 is considerably above the recommended 95% threshold and it is identified as a good health outcome. On the other hand, the rates of in-hospital mortality following AMI and stroke (around the EU average in 2012), had a negative development compared to the EU average change since 2009.

Non-health determinants: Alcohol use and inequality in regular smoking are an issue in Luxembourg

Data on risk-factors based on EU surveys are limited for Luxembourg compared to other EU countries, specifically as Luxembourg did not participate in the 2008 wave of the European Health Interview Survey.

In 2014, alcohol use is worse than the EU average. Inequality in regular daily smoking by income[28] (as measured by the gap between the first and the fifth income quintile) is considerably worse than the EU average. On the other hand, regular daily smoking, physical activity[29] and inequality in fruit and vegetable consumption by educational level are better than the EU average.

[27] The increase in infant mortality may not be reliable due to the small number of cases.

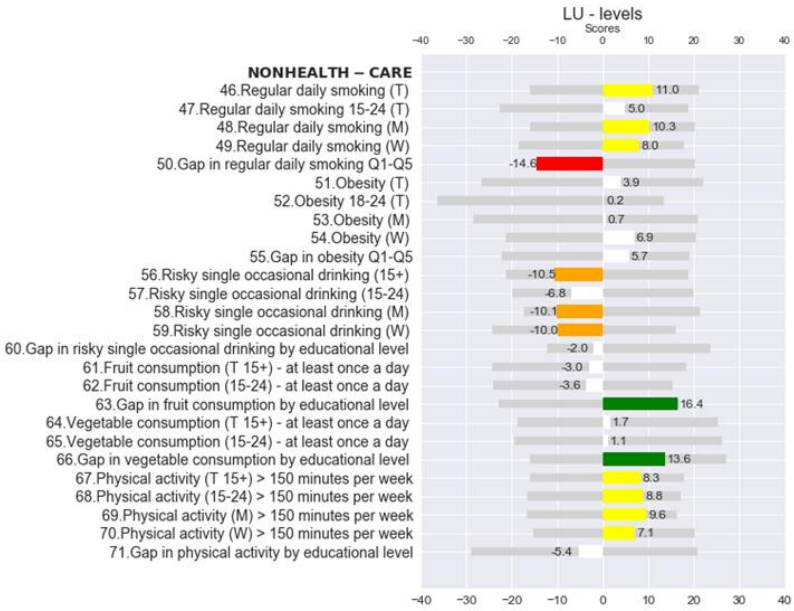
[28] To be noted that 14.2% of the survey participants didn't answer to the income question.

29 More than 20% of the survey participants did not answer to this question.

Figure 35 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 36 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



Malta

With a moderate budget on health expenditure, Malta has generally good health outcomes. A notable exception to good health outcomes is infant mortality, which is explained by the legislative context (abortion is illegal, including for serious congenital anomalies). Most indicators on quality are comparable to other EU countries, with a few weak areas (vaccination coverage of children for measles, in-hospital mortality following AMI/stroke). The nearly universal health system generally guarantees a good access to healthcare. A key challenging dimension is represented by non-health determinants, in particular obesity and related risk factors. This could be explained by the relatively high share of low educated people. While recent reforms aim at addressing some of the identified challenges (e.g. on lifestyle), further pressure are expected on the sustainability of the system, also due to the rapid ageing of the Maltese population.

Resources, Coverage and Organisation of the Health System

Health spending in Malta is below the EU average, but projected to increase considerably,

Recent data on health expenditure is not available from national sources but WHO estimates indicates that on a per capita base, current spending stood at 2,255 pps compared 2,797 pps across the EU. This corresponds to 8.4% of GDP, one and a half percentage points below the EU average of 9.9%. This rate has decreased over the last years, indicating that economic growth in Malta has been outpacing growth in health spending. Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 2.1 percentage points in Malta, more than double the increase seen across the EU (+0.9 percentage points)[30].

While the share of government financed health expenditure is considerably below the EU average

In Malta, WHO estimates suggest that the share of public spending in total health expenditure (69%) is significantly below the EU average (79%) but has grown steadily from an historic low in 2010. As a result, out-of-pocket spending in Malta was comparably high (28.7%) in 2015, nearly double the EU average (15.3%).

The Maltese health system is tax-based and nearly universal

Malta has a tax-financed National Health Service (NHS) characterised by a predominant public provision of hospital services and a mix of public and private provision of primary care and outpatient specialist services.

The Maltese health system provides practically universal coverage to residents for a comprehensive basket of health services.

Health services provided from the public sector are not subject to cost-sharing. Public coverage is however means-tested for a few services, including elective dental care, optical services and some formulary medicines. Access to free pharmaceuticals is also provided to patients with chronic conditions. Patients are sent overseas only for highly specialised care required for treating rare diseases or for interventions not currently carried out in Malta. The substantial amounts of out-of-pocket payments are thus primarily for pharmaceuticals and for patients who choose to consult GPs and specialists in the private sector.

The Ministry of Health is the main actor in the system and responsible for health system governance, regulation, service provision and financing.

Three important advisory or regulatory bodies in the Maltese health system include the Council of Health which advises the ministry on public health issues; the Health Policy and Strategy Board which is composed of senior officials from the different directorates within the ministry and which supports policy development and its implementation, and the Advisory Committee on Health Benefits defining the content of the benefits package.

Service delivery is predominantly public

The NHS is the key provider of health services in Malta, with the private sector complementing public service delivery, particularly for outpatient care. The Catholic Church and voluntary organizations are also involved in the provision of long-term and chronic care service. In primary care, public clinics operate on a walk-in basis and services are provided by different GPs on duty. Many patients prefer to visit the private GPs which provide around two-third of services. A gatekeeping system is in place in the public sector but bypassed by those who seek care privately. Hospital service delivery is mostly public.

The availability of physical resources in the system is around the EU average, but increasing relatively more than in other EU countries

The human and physical capacities available in the health sector in Malta to cope with health needs of the population are around those seen in other EU countries. The number of practicing doctors is 379 per

30 For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

100,000 population in 2015, around the EU-average and it has increased considerably compared to other EU countries in recent years. The number of practicing nurses and midwifes (840 per 100,000 population) is around the EU average, but shows a considerable relative increase in recent years. In 2015, hospital employment (in FTE) is considerably higher than the EU average and has increased faster than average in the three preceding years.

The development of e-health started in 2012 with the introduction of a web-based portal though which patients with e-ID cards can set-up appointments in the public sector and share medical records with physicians of their choosing. The development of e-prescription and electronic patient records in the primary health care sector are the next priories as funding become available.

Policy Developments

Recent initiatives and reforms have aimed at strengthening governance and public health, and sought to decentralise the system's management

Recent policy initiatives and reforms in Malta aimed at strengthening governance by actively setting health system objectives and monitoring and evaluating performance. The National Health Systems Strategy for 2014-2020 was adopted in September 2014. It sets out a number of key objectives to address the challenges faced by the health system, namely: responding to changes in health care demand triggered by population ageing and epidemiological trends; increasing equitable access, availability and timeliness of care; improving quality of care; and ensuring the financial sustainability of the system.

In the past 5 years, a series of initiatives have sought to address the growing prevalence of overweight and obesity among children and adults. The Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act (2016) sets up an advisory council composed of representatives from sectors outside health to ensure a health-in-all policies approach. A national cervical cancer screening programme was introduced in May 2016.

Additional initiatives have also sought to decentralise management. For instance, a number of primary care centers and peripheral clinics are now housed by local councils. More significantly, in 2017, the responsibility for managing three hospitals has been transferred from the Ministry of Health to an international profit-making health care organization for 30 years through a public-private partnership.

JAF Health Results

While health outcomes are generally good in Malta, infant mortality and inequality in self-perceived health are identified as challenges

In 2015, infant mortality rate is considerably worse than the EU average and it is identified as a health challenge. This rate also increased over the last three years. This is mainly ascribed to the fact that pregnancies with a serious congenital anomaly of the fetus are not terminated, as abortion is not a legal option in Malta including in these cases. As a result, the babies born with these anomalies have a high risk of dying in their first year, which contributes to explaining the high infant mortality rate in Malta compared to other EU countries in which abortion is a legal option. The number of deaths due to self-harm/suicide shows a considerable increase in the last three years. Similarly, potential years of life lost for men are identified as a health challenge, due to its relative negative trend over the last three years. The share of people who perceived their health as bad/very bad is considerably better than the EU average, while the gap between income groups in the share of people who self-perceived their general health status as good/very good is worse than the EU average. Healthy life years at birth and at 65 for both men and women have been identified as a good health outcome, as they are considerably higher than the EU average.

Life expectancy is around the EU average but shows considerable positive improvement. Child mortality and external causes of death (excluding transport accidents) are better than the EU average. Potential years of life lost are around the EU average. However, while they show some relative negative development for men they show a considerable relative positive development for women. Amenable mortality shows a considerable positive development over the last three years.

Access: Access to healthcare is not an issue in Malta

Unmet need for medical care is around the EU average, at 0.8% in 2015.

Quality: While most indicators in the quality dimension are around the EU average, in-hospital mortality is worse than average and the vaccination rate of children for measles remains below standards

In 2015, the vaccination coverage rate of children for measles (89%) is below the 95% threshold and declined by 4 percentage points since 2012..In 2016, the data reported for the vaccination of children for measles improved and are back to the 2012 value (93%), but coverage remains below the recommended threshold.

In-hospital mortality following stroke and AMI are worse than the EU average (data refer to 2013). Be-

tween 2008 and 2014, breast cancer screening shows a considerable positive development.

Non-health determinants: Non-health determinants represent a key challenging dimension in Malta, in particular for obesity

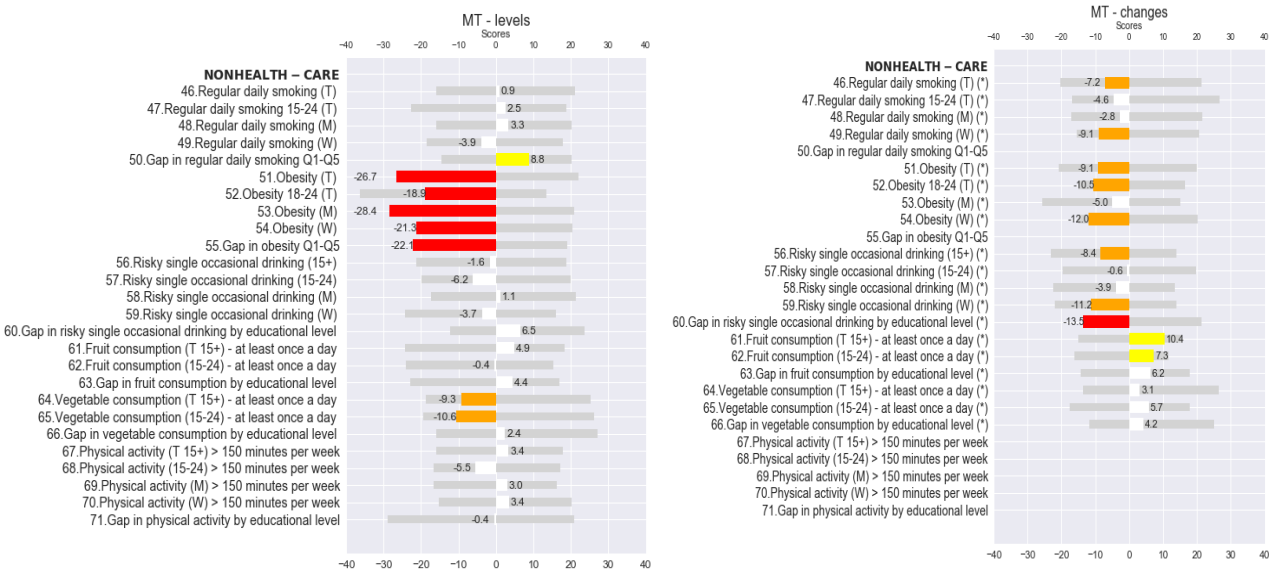
The obesity rate, including for young, is considerably worse than EU average, with a rate as high as 27.2 for men in 2014. Obesity is identified as a major health challenge, as it also shows a relative negative development over the last years. Vegetable consumption is worse than the EU average and it is identified as a health challenge. The smoking rate of women is around the EU average, but it is identified as a health challenge as it is on an increasing trend with respect to the EU average trend. Alcohol use among women is worsening compared to the EU average change.

However, the gap in regular smoking between the top and bottom income group is better than the EU average. Fruit consumption shows a relatively positive development over the period 2008-2014.

Figure 37 - JAF Health profile charts for main dimensions (standardised scores), levels (left bar) and 3-year changes (right bar)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 38 - JAF Health profile charts for non-health determinants (standardised scores), levels (left bar) and 3-year changes (right bar)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

NETHERLANDS

The Netherlands has the third highest expenditure per capita on health in the EU, including LTC, while expenditure for curative care is slightly lower than the EU average. In the last years, a number of reforms contained the growth in health expenditure. Health outcomes are generally around the EU average, with the exception of healthy life years at birth for women which are worse. A number of health outcomes (in healthy life years, potential years of life lost and the suicide rate) are worsening in the last years compared to the EU average change. The Dutch health system is mostly financed by compulsory insurance (premium paid by adults for mandatory private insurance and income-dependent employer contribution) and works through competing health insurance companies, while administrative costs are higher than the EU average. Available indicators on the access to healthcare are generally good, with near-universal coverage and low levels of unmet needs for medical care. With a higher than average expenditure on prevention, some indicators on the take-up of prevention measures (vaccination coverage of children and specific cancer screenings) are deteriorating, as in other EU countries, or worse than the EU average. The hospital-based indicator on quality "mortality following stroke" is identified as a good outcome. While lifestyle is generally good in the Netherlands, with a few weaknesses, such as inequality in regular smoking. In the last years, some measures have been taken by the Dutch government to address inequalities in risk factors.

Resources, coverage and organisation of the health system

Health and long-term care spending are substantially higher than in the EU

Health spending in the Netherlands is considerably higher than the EU average when measured per capita (3,857.1 pps in 2015) and as a share of GDP (10.6%). Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 1.0 percentage points in the Netherlands, which is comparable to the EU average (0.9 percentage points). In 2015, the Netherlands spent considerably more on long-term care (2.6% of GDP) than most EU countries, while spending on curative care was around the EU average. Spending for health system administration[31] and prevention were also higher than the EU average, at 3.9% and 3.6% of health spending, respectively.

Health care is primarily funded through compulsory insurance

In 2015, 71.4% of total health spending in the Netherlands was paid through compulsory insurance, with almost ¾ of this financed by compulsory private insurance schemes. This share is higher than the EU average. Government outlays accounted for 9.3% of spending, below the average across EU countries. The remaining spending was made up of households' out-of-pocket payments (12.3%), which were also below the EU average, and voluntary schemes (7.0%), around the EU average.

[31] In SHA administrative expenditure includes spending related to the financing and governing of healthcare, but excludes administrative activities related to providing healthcare.

Competing health insurance companies covers nearly all residents for a broad range of medical and curative care

Coverage for medical and curative care is provided under a system of regulated competition as set out in the Health Insurance Act (Zvw). All residents are mandated to purchase insurance policies, which cover a broad range of the most common services. Adults pay a community-rated premium to their insurer (all children are covered from a government contribution), and an income-dependent employer contribution is transferred into a central fund, which is redistributed among insurers on a risk-adjusted basis. People with low income receive a tax subsidy to purchase insurance, the amount of which is linked to the deductible. Insurers must accept all applicants and are expected to contract providers based on quality, price and volume, although purchasing on the basis of quality is still in its infancy. Long-term medical care is financed through a single payer scheme (Wlz) based on income-dependent contributions and cost-sharing payments. Other health care services can financed by municipalities based on the Social Support Act (Wmo) or the Youth Act (Jeugdwet) or different levels of Government in relation to the Public Health Act (Wpg).

However, some residents default on their premium payments

A number of measures support near-universal enrolment (around 22,500 people were uninsured in 2016). For instance people who refuse insurance on religious ground can still obtain services under a specific scheme. Among non-permanent residents, irregular migrants have to pay their incurred health costs out-of-pocket. Registered refugees are covered by a special insurance policy for which they do not pay premiums or a deductible. It covers almost the same benefits as the usual system but restricts the choice of provider. People accumulating payment arrears is more of a

concern. In 2016, there were 277,000 defaulters, that is, people with a payment delay of at least six months (Statistics Netherlands, 2017). The latter figure has decreased substantially since 2014 when 325,810 people had such a payment delay, a consequence of a number of measures put in place to tackle this issue. For instance, people with a payment delay are placed under forced administration by a separate government agency to protect them from losing coverage.

Out-of-pocket payments primarily consist of a mandatory deductible and payments for excluded services

A mandatory deductible of EUR 385 (in 2017) applies to health expenses excluding GP care, maternity care, district nursing, and care for children under the age of 18 which can, however, be increased if people want to reduce their premium payments for insurance in return. Reimbursement for drugs is based on reference pricing and insurers may list preferred medicines, meaning that patients who use an alternative drug may have to pay the difference in costs or the total amount. Some insurers do not charge the deductible when the patient uses the company's preferred providers for certain medical services or pharmaceuticals. For residential long-term care, income-dependent cost-sharing is applicable, ranging from 0 to EUR 2,312 per month (2017). People also have to pay for services excluded from the benefit package, mostly dental care (for adults) and physiotherapy. In 2015, 84.1 % of the insured had additional voluntary health insurance, which typically covers these services (NZA, 2016).

The central government sets rules in health care markets and oversees their functioning

The central government acts as supervisor of the health insurance, purchasing and provision markets with respect to quality of care, accessibility of care and affordability, aided by watchdog agencies such as the Authority for Consumers and Markets (fair competition), Health Care Authority (supervision and price regulation) and the Health Care Institute (care quality standards and insurance package advice). The competences of the central government differ for the other schemes and have been changed following the 2015 reforms which saw a devolution of responsibilities to municipalities for social support and youth care. Responsibilities for public health services are shared between the central government, municipalities, the National Institute for Public Health and the Environment (RIVM), Public Health Services (GGD'en) and other organisations implementing public health services on the municipal level. They include services such as health promotion, screening and vaccination, and preventive youth consultations, which are described in the Public Health act (Wpg).

Health care services are provided mainly by private providers

Primary care is provided by private providers contracted by health insurers. GPs typically work in group practices with other health professionals and are paid by a combination of fee-for-service, capitation, bundled payments for integrated care, and pay-for-performance. Specialised care is provided mainly by public or not-for-profit hospitals and they are paid through a case-based payment mechanism. Specialised care requires referral from a GP and patients have a free choice of hospital. Health insurers may financially incentivize patients with insurance policies that do not reimburse all available providers to stay within a preferred network of providers by selectively contracting providers on the basis of quality and costs.

The number of physicians and nurses relative to the population are around the EU average

The Netherlands had 347 practising physicians per 100,000 population in 2015 and 1,054 nurses and midwives per 100,000 population in 2014, both around the EU averages. Professionals in primary care increasingly work in larger organisational settings (such as primary health care centres) and in multidisciplinary teams. Community pharmacists increasingly work in structured collaboration with GPs in their catchment area. Task shifting has led to new occupations, such as practice nurses, nurse practitioners, nurse-specialists (who can also prescribe medicines) and physician assistants.

Policy Developments

Cost containment has been on the agenda in the Netherlands

Cost control has been a long-standing concern and was one of the main reasons for the 2006 health system reform which established managed competition in the insurance market and the long-term care reform of 2015 which introduced the new LTC scheme (Wlz) and devolved the responsibilities to finance and organise long-term care activities to municipalities and health insurers. Concerns for cost control were also the prime motivation for action taking when the financial crisis struck in 2009 and the Stability and Growth Pact criteria were breached in 2010. Since 2012, cost control has focused on: a) shifting costs from public to private sources (for example by increasing the compulsory deductible); b) shifting costs between various statutory sources in combination with cuts in budgets (most notably in the 2015 long-term care reform); c) substitution between different types of care: institutional care with home care and ambulatory care, and secondary care with primary care (particularly in mental and long-term care); d) increased focus on improving efficiency (e.g. tendering of generics) and eliminating fraud; and e) the use of broad sectoral agreements (with insurers

and providers) to curb costs. Taken together, these efforts have led to slowing growth in health expenditure in recent years in particular since 2012. Spending growth on long-term care has been in fact negative in 2015 and 2016. Yet, despite this progress, health spending is still among the highest in Europe but partly triggered by the comparably very high long-term care spending.

The Netherlands also aims to address public health issues

Policies seeking to reduce socioeconomic inequalities in health have been on the agenda in the Netherlands since the 1980s, with recent initiatives seeking to explicitly address inequalities in risk factors at the local level, such as Health in the City, a national programme introduced in 2014. A number of policies have been implemented to address smoking and the use of alcohol, including a smoking ban in offices in 2004, in pubs and restaurants in 2008 and measures to reduce teenage alcohol consumption in 2013. Furthermore, in 2011, a national policy paper ("Health Nearby") identified high body mass index, diabetes, depression, smoking, and harmful alcohol use as the main challenges and explored policies to promote more exercise and sports to tackle them. The "National Prevention Program" (NPP) acting as an umbrella for all activities related to prevention was launched in 2014 and is implemented by the central government, stakeholders, and other societal partners. Activities organized under NPP cover the domains school, work, living environment, healthcare, and health protection. One important element of this program is "All About Health" - a whole of society approach that fosters a societal movement for more health.

The Dutch health system tries to make patients a major actor

The reform in 2006 made patients a major market actor in the health system. They were expected to make well-informed decisions and, by doing so, influence quality in care. As a consequence, patient participation and patient choice have become important policy priorities. Since 1996, publicly financed health and social care providers have been obliged to have a representative client council. Furthermore, health insurers are required to involve patients in purchasing decisions. More recently, there have been efforts from the Ministry of Health (together with insurers) to make the choice of insurance policies simpler and improve the availability of quality data.

JAF Health Results

Healthy life years at birth for women are worse than the EU average, while some outcomes show a negative development tin the last years

In 2015, healthy life years at birth for women (57.2 years) is worse than the EU average. Healthy life years at birth for men and at 65 for women are around the EU average but shows negative developments in the past three years. Similarly, in 2014 potential years life lost for men and the number of deaths due to self-harm/suicide are around the EU average, but show negative developments in the last three years compared to the EU average (also in absolute term for the second indicator). These variables are identified as health challenges.

Access: The number of doctor's consultations increased in the last years, while indicators on access are generally good

The number of doctor's consultations increased considerably more than the EU average in the past three years, andself-reported unmet need for medical care is generally better than the EU average.

Quality: Some indicators on prevention (vaccination rates for DTP and specific cancer screening) are deteriorating or worse than the EU average, while in-hospital mortality following stroke is identified as a good outcome

The vaccination coverage rate of children for DTP is decreasing in the past three years, although in 2015 it still reaches the recommended 95% threshold. This variable is identified as a health challenge. On the other hand, in-hospital mortality following ischemic stroke is identified as a good outcome, as it is better than the EU average (in 2011) and improving.

Although the Dutch health system has a strong screening programme in place which aims at informing people about cancer screening, certain cancer screening rates are relatively low. In 2014, the proportion of women (aged 20-69) reporting to have undergone a cervical cancer screening in the past 3 years (in the European Health Interview Survey) is considerably worse than the EU average. According to the "Cancer screening in the EU" report (2017), the examination coverage rate for cervical cancer screening (64%) are well above the average for the available EU countries (30%). The discrepancy in these two data can be explained by a more limited target population in terms of age in the Netherlands (for 30 year-old and older with respect to 25 in most EU countries) and for the wider interval between screenings (5 years with respect to 3 in most EU countries). The proportion of women and men (aged 50-74) reporting to have undergone a colorectal cancer screening in the past 2 years is worse and worse than the EU average.

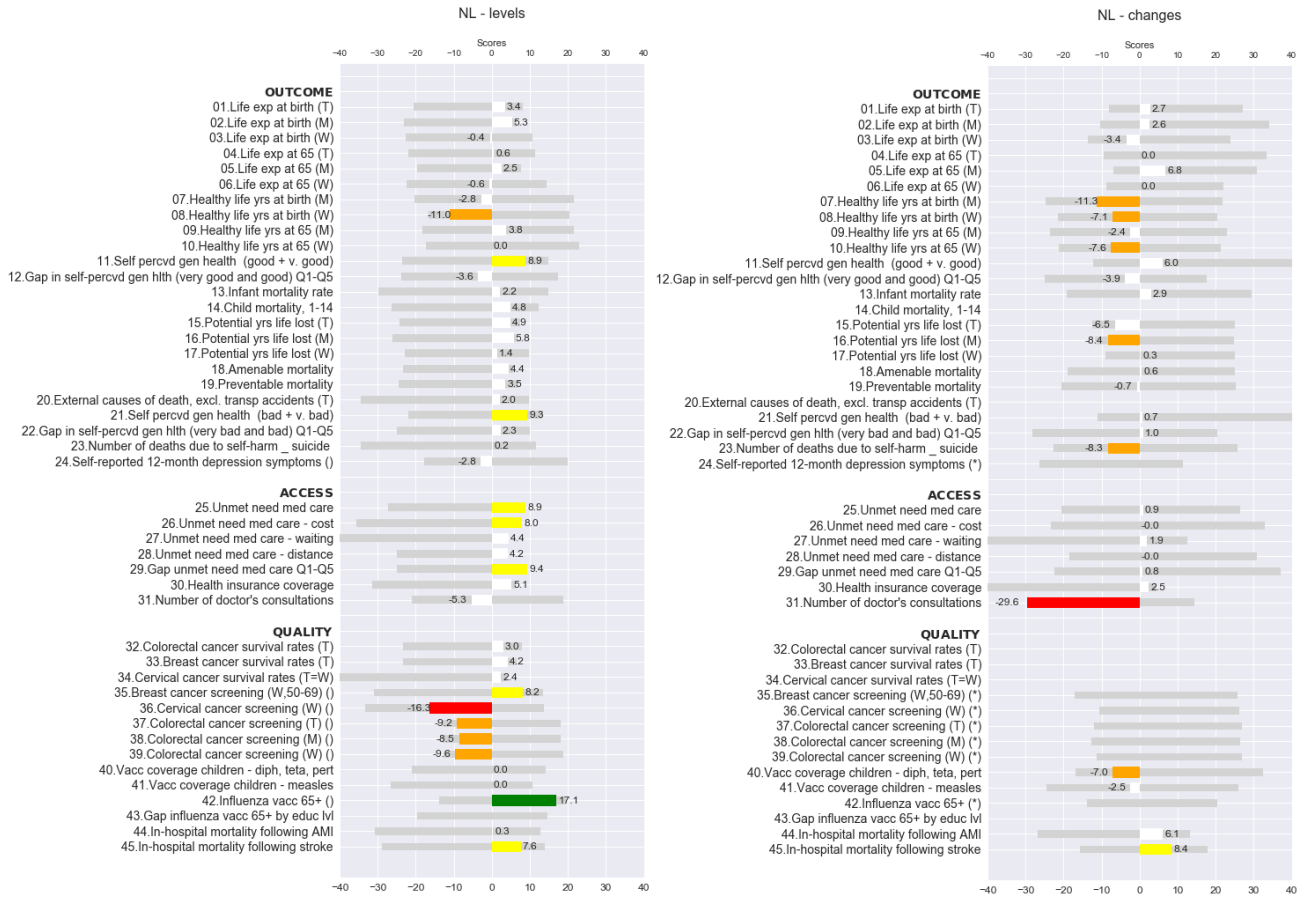
Non-health determinants: Data on risk-factors based on EU surveys are limited for the Netherlands but show weaknesses in fruit and vegetable consumption and inequality in regular smoking

Data on risk-factors based on EU surveys are limited compared to other EU countries, due to missing data in alcohol use, physical activity and in the 2008 wave of the European Health Interview Survey.

In 2014, fruit and vegetable consumption (both among adults and young) are considerably worse or worse than the EU average. Inequality in regular daily smoking by income (as measure by the gap between the first and the fifth income quintile) is worse than the EU average. On the other hand, the obesity rate among men is considerably better than the EU average.

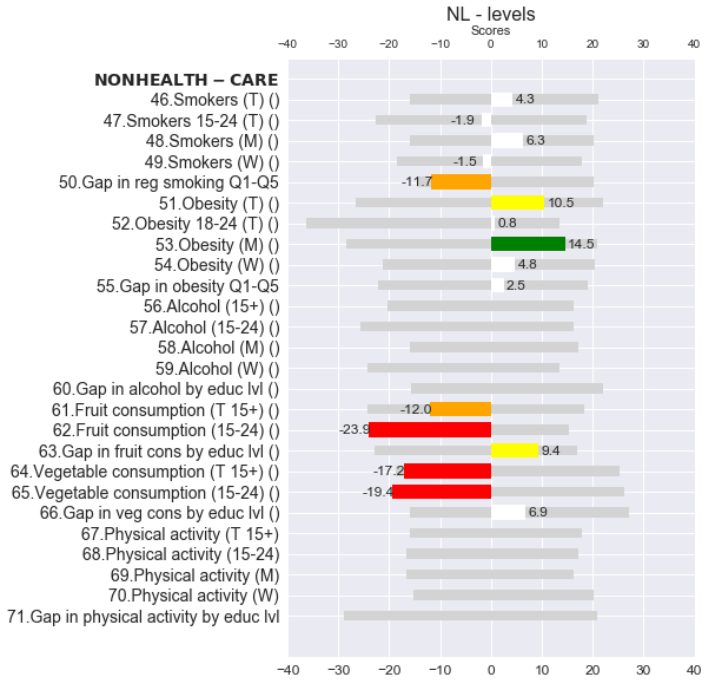
Although the Netherlands has a relatively high share of people consuming 5 portions or more of fruit and vegetables on a daily basis (25% against a EU average of 14%), it also has a relatively high share of people consuming 0 portions of fruit and vegetable on a daily basis (46% against 34% in the EU). Data from the Eurobarometer survey (2013) show that Dutch exercise or play sport more than in other EU countries. In 2013 58% of Dutch declare to do exercise or play sport with some regularity or regularly, against a EU average of 41%.

Figure 39 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 40 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



Poland

With GDP per capita below the EU average, health outcomes in Poland are generally worse than average, although most are improving. Poland also has a lower than average spending on health and a lower quality of healthcare. Poland faces a shortage of health professionals, including due to the emigration of physician in search of better working conditions. The government is proposing to increase salaries for medical staff, starting in 2017-2018. Access to healthcare is a challenge. Unmet need for medical care, in particular due to waiting time, is considerably worse than the EU average. Currently, public spending on health is mostly relying on social insurance contributions, while government outlays represent only a small share. Although social health insurance is compulsory, part of the population remain uncovered (as it is the case of informal and atypical workers). The government proposed the replacement of the National Health Fund by a tax-funded system and a commitment to increase public spending on health. As for lifestyle, physical activity and inequality in smoking are an issue. The adopted National Health Programme 2016-2020 aims to improve health status and reduce health inequalities, with physical activity and addiction prevention as priority areas.

Resources, Coverage and Organisation of the Health System

Health spending in Poland is below average

Poland spends less on health than the EU average both in per capita terms (1,299 pps in 2014) and when measured as a share of GDP (6.3%). Health spending is expected to rise due to a number of factors, including population ageing, technological progress and rising incomes: between 2013 and 2060 public spending on health as a share of GDP is projected to increase by 1.2 percentage points, which is comparable to the EU average (0.9 percentage points). Long-term care spending accounted for 0.4% of GDP in 2014, which is below the EU average. Otherwise, the spending structure does not differ notably from the EU average.

Public spending on health is mainly channelled through social health insurance

In Poland, the proportion of compulsory insurance funding (60.7% of current health expenditure in 2015) is around the EU average and the proportion of government outlays (9.3%) is lower than in the EU. Most of the remaining spending stems from households' out-of-pocket payments (23.3%, similar to the EU average) and voluntary schemes (6.8%, also around the EU average).

A social health insurance system with mixed service delivery

A single, mandatory social health insurance fund provides near universal coverage for publicly financed health services in Poland which contracts public and private providers in a service delivery system which remains hospital-centric.

Although mandatory, some gaps in coverage remain and some patients purchase services privately to avoid public sector waiting time

Social health insurance is mainly funded through mandatory health insurance contributions, payable entirely by the insured person and collected by the National Health Fund. Participation in the social health insurance scheme is mandatory for the vast majority of Polish citizens and legal residents with automatic entitlement for a number of population groups (e.g. children aged under 18, people with HIV and tuberculosis, people with mental health disorders). Nonetheless, social health insurance covers only 91% of the population with informal workers and those with some types of atypical work contracts not being covered. While entitlements includes a broad range of services, limited funding constrains the supply of publicly-funded services, resulting in long waiting times. Patients can obtain services faster by using private providers and paying themselves.

For pharmaceuticals public coverage is limited

Polish authorities explicitly define the medical procedures and pharmaceuticals covered in the benefit package under the social health insurance scheme. While most conventional medical procedures are included, the list of reimbursable drugs is narrow. High co-payments exist for reimbursed pharmaceuticals, whereas treatment by general practitioners, specialists or in hospitals is generally provided free-of-charge. The limitation in public coverage for pharmaceuticals results in high levels of out-of-pocket payments for medicines, which weighs more heavily on low-income households.

Many different bodies are responsible for organisation and governance of the system, posing a challenge for effective coordination

The Ministry of Health provides stewardship, policy directions and regulatory oversight and is supported by a number of advisory bodies, such as the Polish Agency for Health Technology Assessment. The National Health Fund is the main public purchaser and contracts with public and private health care providers for care delivery. Local governments at the regional (voivodeship), county (powiat) and municipal (gmina) levels are involved in health to a varying degree. They own and are accountable for the deficits of public service delivery

institutions. This mostly holds for some powiats, who own hospitals providing basic services in their territory, and voivodeships, who typically own a range of mostly higher-level facilities in the region. Local governments also have some responsibilities in health promotion and prevention. Additionally, voivodeships are responsible for ensuring the availability of services in the territory. However, this division of responsibilities across the different levels of government and levels of care is challenging for the coordination of services and the restructuring of the hospital sector.

Service delivery is predominantly private for outpatient care and public for hospital care

Primary care as well as specialised outpatient care is predominantly delivered by private providers. Primary care physicians are generally paid on a capitation basis and act as gatekeepers for specialist and hospital care – although direct access to certain specialities is possible (e.g. gynaecologists, psychiatrists, dentists). Hospital service delivery is mainly public and paid for on the basis of Diagnosis Related Groups (DRGs). Yet, a number of private hospitals are providing publicly funded services under contract with the National Health Fund, especially for specialties such as cardiac surgery where financial incentives for care provision are high. However from 1st October 2017 an important change to the system of contracting hospital care has come into effect with the introduction of the "hospital network". With this reform the core of hospital treatment was exempted from competitive contracting and concentrated in (mostly) larger, interdisciplinary hospitals belonging to one of six levels of the network. The practice of double employment, whereby physicians keep part-time salaried jobs in (mostly public) health care facilities and provide services privately to patients who pay out-of-pocket, is fairly widespread and poorly regulated.

Poland faces a shortage of health professionals

Poland has relatively low numbers of health professionals. In 2015, there were 233 practising physicians per 100,000 population, considerably below the EU average. The number of nurses and midwifes stood at 579 per 100,000 population, also less than in most other EU countries. Emigration of health professionals is a key policy concern in Poland, with physicians, in particular, looking for better remuneration, working conditions and career prospects abroad.

Policy Developments

An ambitious reform programme is likely to affect the organisation of the Polish health system

In 2016, the Polish Ministry of Health embarked on a far-reaching health reform programme aimed at improving access to care and care coordination, improving efficiency and reducing duplication of services. This agenda includes a commitment to increase public spending on health by about 35% over the next seven years. The most fundamental reform proposal is the abolition of the National Health Fund to be replaced by a tax-funded system controlled by the Ministry, with regional health authorities performing a range of financing, supervisory and planning functions. Other important proposals include the bundling of budgets across different types of care as a key lever to better link inpatient with outpatient services. The creation of multi-disciplinary health care teams aims to strengthen primary care and to improve care coordination across settings. To address health workforce shortages, the government is proposing to increase salaries for medical staff. Implementation of this ambitious reform programme is expected to begin in 2017-2018.

Addressing public health issues has been a major focus of recent government initiatives

In 2015, Poland passed for the first time an Act on Public Health which sets out specific public health activities, clarifies how they are financed and defines the responsible institutions. The Act identifies the National Health Programme as the key strategic document upon which public health policy in Poland will be based. The National Health Programme 2016-2020 aims to improve health status and reduce health inequalities around six priority areas: nutrition and physical activity; addiction prevention; mental health and well-being; environmental risks including work, habitation and education; healthy ageing; and reproductive health. More specifically, the programme is aiming to reduce by 2% the share of daily smokers by 2020, to halve the growth in obesity and diabetes rates by 2025, and to cut the number of alcohol abusers by 10% by 2025.

JAF Health Results

Health outcome in Poland are generally worse than in the EU countries, although most are improving

In 2015, life expectancy (at birth and at 65) is worse than the EU average for both women and men. However, life expectancy at birth for men is improving more than the EU average in the previous three years. Potential years life lost (both for women and men) are worse than the EU average, but show a considerable positive development in the last three years Self-perceived general health as good/very good and the number of deaths due to self-harm/suicide are worse than the EU average. Inequality in self-perceived general health as bad/very bad between income groups is worse than the EU average. These variables are identified as health challenges.

The indicator of self-reported 12-month depression symptoms is the only one better than the EU average. Amenable mortality shows a considerably positive

development in relative terms and it is now around the EU average.

Access: Health insurance coverage and unmet need for medical care due to waiting are identified as health challenge, although unmet need for medical care is improving

Access to healthcare is a challenge in Poland. In 2015, 8.7% of the population is not covered by public health insurance, which is considerably worse than the EU average[32]. Unmet need for medical care (7.3%) is worse than the EU average. In particular, unmet need due to waiting list (4.2%) and unmet need due to distance (0.4%) are, respectively, considerably worse and worse than the EU average. However, unmet need for medical care due to waiting time is improving in the last three years compared to other EU countries.

Quality: Most indicators on the quality of healthcare are worse than the EU average

Data on the quality of healthcare in Poland are limited, especially due to a lack of time series.

In 2014, influenza vaccination among over 65 year-old is worse than the EU average. In 2007, survival rates for colorectal and breast cancer were considerably worse than the EU average. Although breast and cervical cancer screening are around the EU average, they show negative developments between 2008 and 2014. In 2014, colorectal cancer screening (for both men and women) is still worse than the EU average. These variables are identified as health challenges. In 2015, the vaccination coverage rates of children are above the 95% recommended threshold.

In Poland the colonoscopy test is more commonly used than faecal occult blood test to detect the colorectal cancer. Data from the EHIS 2014 show that 8.9% of persons aged 15 and over have taken the colonoscopy test at least once in life.

Non-health determinants: While young people have a relatively healthy lifestyle, the low physical activity rate among the population and inequality in smoking are an issue

Inequality in fruit and vegetable consumption by educational level are identified as health challenges. While the first worsened from 2008, the second is worse than the EU average. On the other hand, fruit consumption among young is considerably better than the EU average and it is identified as a good health outcome.

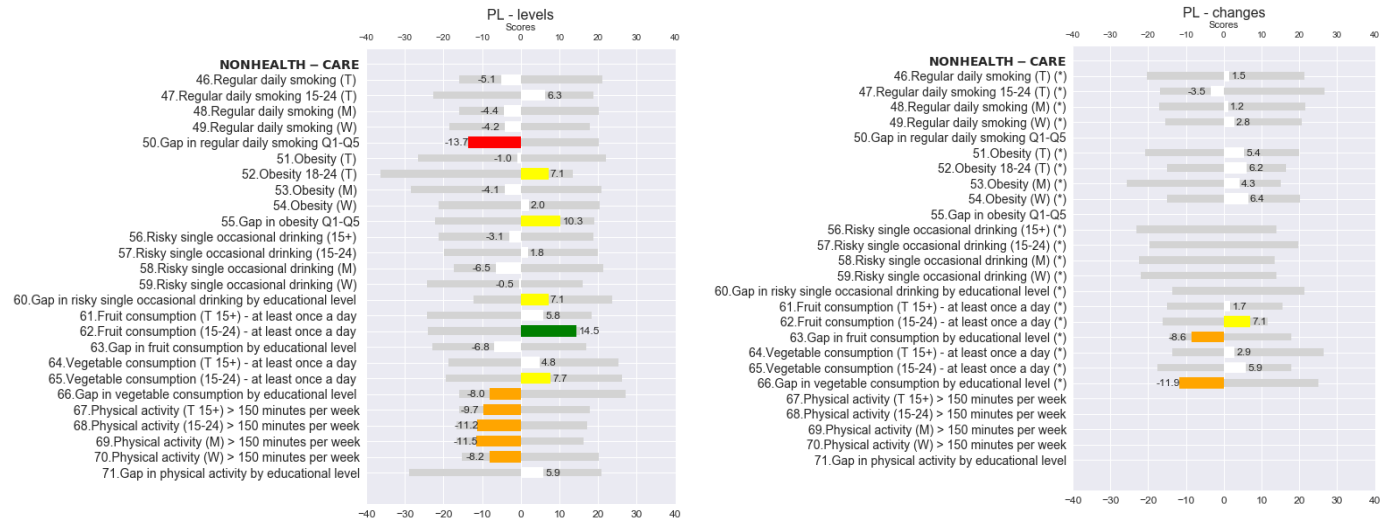
Physical activity of adults, young, women and men is worse than the EU average, but inequality by educational group is limited. The gap in the obesity rate by income groups is also limited and better than the EU average. The only aspect of lifestyle for which inequality is observed is smoking. Indeed, the gap in the smoking rate between high and low income groups is considerably worse than the EU average. Young generation have a healthier lifestyle. Although young do more physical activity than the adults, they do it less than in other EU countries. On the other hand, obesity, fruit and vegetable consumption among young Polish are better than the EU average.

32 Data on health insurance coverage should include both public and private insurance. For most EU countries, health insurance is mostly public and private insurance is often complementary, supplementary or duplicate (OECD, 2016).

Figure 41 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 42- JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

PORTUGAL

Portugal is aging faster than other EU countries and expenditure is projected to grow considerably more than the EU average. In the last years, Portugal took measures to enhance value for money in the pharmaceutical sector. Although health expenditure as a share of GDP is around the EU average, it decreased more than average in the last years and in terms of human resources the number of nurses is below the EU average. While life expectancy is improving compared to other countries, healthy life years, preventable mortality, the suicide rate and self-perceived general health are identified as health challenges. The developments of the first three indicators are also worsening in relative terms. Access to healthcare is guaranteed by a universal system with cost-sharing for most services, but with many exemptions for vulnerable groups. The healthcare system is mostly financed by government expenditure, with an important part of the population opting for additional insurance. With an expenditure for prevention below the EU average, indicators on prevention (including vaccination coverage rates of children and cancer screening) are better than average. While Portugal has a share of low educated people considerably higher than the EU average, lifestyle indicators are generally better than average, with the exception of physical activity and inequality in obesity.

Resources, Coverage and Organisation of the Health System

Health spending is on par with EU countries but projected to grow considerably faster

Health spending in Portugal was around the EU average in 2015, both when measured per capita (1,959 pps) and as a share of GDP (9.0%). But in contrast to most other EU countries, these numbers had tended to decrease or increase less than the EU average over the three preceding years. However, health spending is expected to rise due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 public health spending as a share of GDP is projected to increase by 2.5 percentage points in Portugal, which is considerably above the EU average (0.9%)[33]. Compared to other EU countries, Portugal spends less on administration (1.9% of health spending), prevention (1.8%) and long term nursing care (2.6%), but more on curative care (62%). In recent years, spending on prevention has decreased more in Portugal than in the rest of the EU.

Public spending on health is mainly channelled through government outlays

In 2015, 65% of health spending was channeled through government outlays, above the EU average. By contrast, the proportion of health expenditure funded through compulsory insurance (1.2%) was considerably lower than in other EU countries. The remaining spending is made up household out-of-pocket payments (27.7%) and voluntary schemes (6.1%), both around the EU average.

A tax-financed National Health Service provides near universal coverage

Tax-financed, centrally-planned and regionally-managed, the Portuguese National Health Service (NHS) provides theoretically universal coverage to all residents, with service delivery mainly by public providers. In addition, between a fifth and a quarter of the population gets additional insurance, either automatically through their employers (for some employees of the public or private sector) or through voluntary health insurance.

The scope of services covered by the National Health Service is wide but gaps exist

All resident of Portugal including migrants can obtain from the NHS a comprehensive package of services. While there are no explicit exclusions from the list of services covered by the NHS, coverage for dental care is very limited and is mostly paid for out-of-pocket. Some service such as diagnostic tests, renal dialysis, and rehabilitation are typically delivered by private provider contracted by the NHS. Long waiting times for specialist visits in NHS due to staff shortages are the reason why many patients seek care in the private sector. The earlier mentioned additional coverage schemes are mainly used to gain access to faster elective hospital treatment and ambulatory consultations and a larger choice of providers.

Cost-sharing applies to most services but many patients are exempt

For treatment in the NHS, fixed user charges exist for a wide range of services, including primary care visits, outpatient specialist visits, emergency visits, diagnostic tests and home visits. While there is no annual ceiling on co-payments, there are caps on user charges per episode of care. Certain services (e.g., diagnostic tests for hospitalised patients, dialysis, referred emergency care) are provided free of charge, and the majority of the population (60%) is exempt from user charges altogether. Exemptions apply to the poor under a defined income threshold, children, the unemployed, asylum seekers and refugees, and certain patient groups. Depth of coverage for pharmaceuticals is the lowest. Here, instead of fixed user charges, co-

33 For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

payments represent a share of total costs which varies depending on the therapeutic value of the drug, with pensioners only having pay a reduced rate and chronically ill patients being exempt from the cost in some cases.

The Ministry of Health and Regional Health Administrations are the main actors in the system

The Ministry of Health regulates, plans and manages the National Health Service, as well as regulates, audits and inspects private health providers. Health policy is implemented at the regional level by Regional Health Administrations, which manage population health, supervise public hospitals, and manage public primary care providers. The Regional Health Administrations coordinate all levels of health care following regionally set health plans and directions from the Ministry of Health. Staffing decisions within the National Health Service must be approved by the Ministry of Finance.

Service delivery is mainly public

Health services are delivered through a mix of public and private providers, with public provision dominant in the primary care and hospital sectors. Access to public hospital and specialist services is controlled by gatekeeping in primary care (patients must register with a general practitioner within their area of residence). Nearly all physicians in the NHS are salaried government employees but recently some performance elements have been included in the payment to staff working in newly created Family Health Units. Independent physicians that are contracted by the National Health Service to compensate for staffing shortages are paid by fee-for-service. Public hospitals are financed through an activity-based prospective payment model, based on negotiated contracts (called Contractos Programa) which involve diagnosis-related groups and case-mix adjustments, bundle payments for certain chronic conditions, as well as performance-based payments.

Portugal has more doctors and fewer nurses compared to other EU countries

Information from national data sources suggests that Portugal has more physicians and fewer nurses per 100,000 population than other EU countries. The prospect of better working conditions and more attractive salaries have led many doctors and, particularly, nurses to move abroad or join the private sector.

Policy Development

Reforms are targeting the pharmaceutical sector to enhance value for money

Various changes to pharmaceutical policies reflect evidence-based strategies to contain costs and maintain quality. These include changes to the reference price system and several waves of administrative price reductions (in 2005, 2007 and 2010). Changes have also been made to pharmaceutical co-payment rules and levels (2016). Finally there has been an increase in the use of economic evaluation before introducing new products, both in ambulatory care and hospitals (2015).

The National Commission of Pharmaceutical Products was established in 2013 to define a national list of pharmaceutical products and prescription guidelines. These guidelines are now produced and updated on a regular basis. Portugal is also developing health technology assessment (HTA) and applying it beyond pharmaceutical products. The Ministry of Health launched a new National System for Health Technology (SiNATS) in 2015 tasked with carrying out HTA for all public and private institutions that produce, market or use new technologies

Portugal is building on past reforms to promote integrated and coordinated care

A number of reforms have promoted more integration and coordination in the Portuguese NHS in the last 20 years. In 1999, Local Health Units were established, bringing together public hospitals and primary care providers under centralised management. In 2007, Family Health Units were created, comprised of teams of general practitioners and family nurses who have functional and technical autonomy. Also in 2007, the National Network of Integrated Continuous Care was introduced, with the objective of integrating health and social services for the elderly in need of long-term care. A year later, groups of primary health centres (ACES) were established to promote a better use of resources and management structures in primary care provision. In 2009, integrated disease management programmes were introduced for major chronic diseases including chronic renal disease and pulmonary hypertension. More recently, in April 2017, an Incentive Programme for Integration of Care was launched providing EUR 35 million in grants for projects seeking to integrate all levels of care. Throughout all these reforms, sophisticated monitoring and incentive structures were put in place.

Measures have been introduced to promote transparency and patient participation

Two new measures have been implemented recently to promote more transparency and patient participation in the NHS: the establishment of the National Health Council, and the creation of a new web portal for the NHS. The National Health Council is an

independent consultative body, working at arms-length from the Ministry to promote transparency and accountability, seeking a broad consensus on health policy. Among its 30 members are representatives of patients, health workers, municipalities, and universities. The new NHS web portal provides detailed and timely (often real-time) information on a wide range of indicators, including access, efficiency and quality. It also allows patients to access electronic health records and request medical appointments and medication renewals.

JAF Health Results

Healthy life years, self-perceived general health, preventable mortality and the suicide rate are identified as health challenges

In 2015, healthy life years are worse than the EU average (for women at birth is considerably worse) and they show considerably negative developments in the last three years. The share of people who perceive their health as good/very good and bad/very bad are considerably worse than the EU average, while inequality in self-perceived general health as bad/very bad between income groups is worse than the EU average. Although preventable mortality and the number of deaths due to self-harm/suicide are around the EU average in 2014, they are improving less than the EU average in the last three years. These variables are identified as health challenges.

In 2014, the self-reported 12-month depression symptoms is considerably worse than the EU average. Life expectancy at birth (81.3 years in 2015) is around the EU average, it improved more than the EU average over the last three years, especially for women.

Access: Indicators on access to healthcare is around the EU average

In 2015, unmet need for medical care (3%) is around the EU average. The number of doctor's consultations in Portugal is lower than the EU average.

Quality: Indicators on the quality of healthcare are better than the EU average

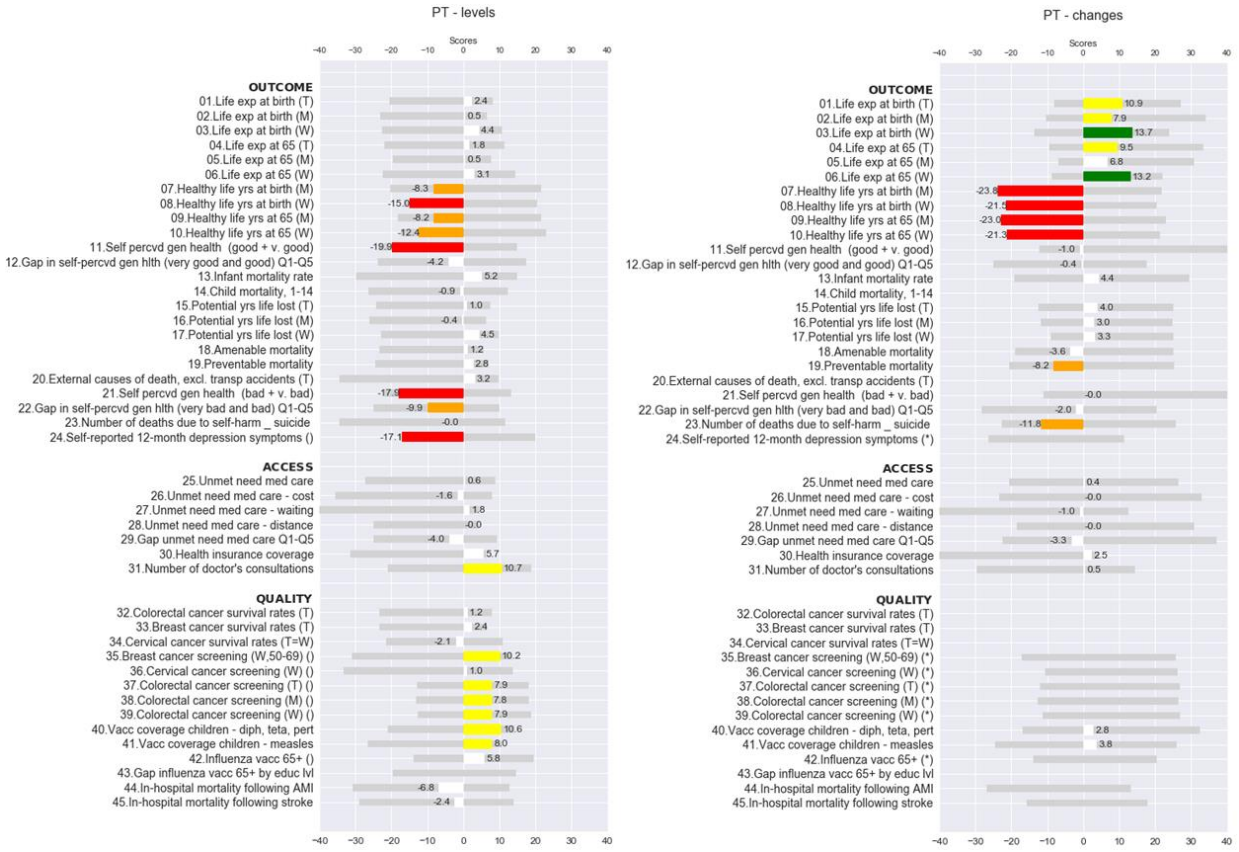
No health challenges are identified in the quality domain. Screening for breast and colorectal cancer are better than the EU average and the vaccination coverage rates of children for DTP and measles are above the recommended 95% threshold. The rest of the indicators are around the EU average.

Non-health determinants: Lifestyle is generally better than the EU average, with the exception of physical activity and inequality in obesity

Data on risk-factors based on EU surveys are limited for Portugal compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

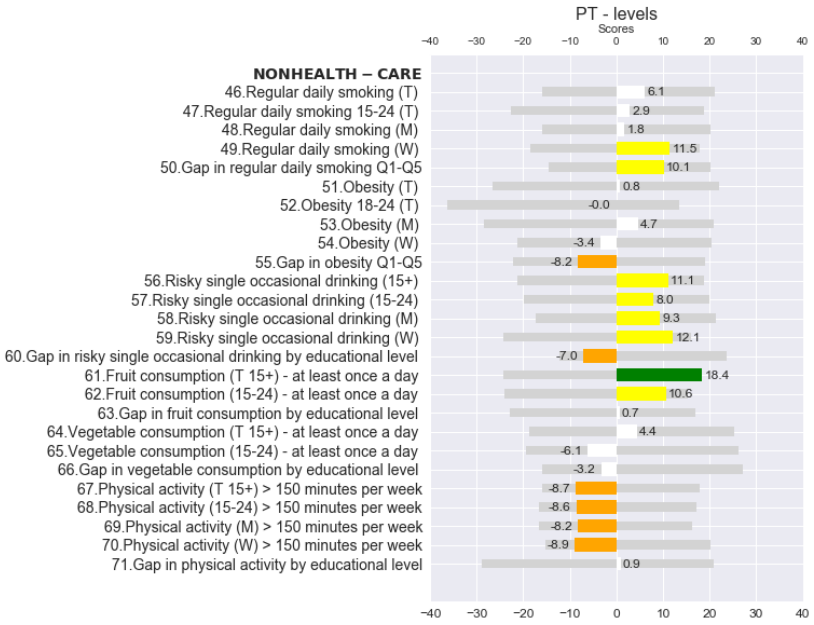
In 2014, physical activity for men, women, adults and young is worse than the EU average. The gap in obesity rate by income groups is worse than the EU average. On the other hand, indicators on alcohol use, smoking among women and inequality in smoking by income group and, especially, fruit consumption are better than the EU average.

Figure 43 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 44 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



ROMANIA

With GDP per capita below the EU average, the rate of poverty and social exclusion above average and the lowest health expenditure in the EU (in % of GDP), the health performance of Romania is poor, with one of the lowest life expectancies in the EU. While most health outcomes are improving, the quality dimension is generally worsening, including for prevention. The health system is mostly based on compulsory social insurance, while de facto covering only 86 % of the population. Some groups (such as self-employed, informal workers, unregistered unemployed, Roma with no identity card) remain uninsured and can only have access to a limited benefits package (e.g. emergency care). In this system, unmet need for medical care due to costs and to distance are considerably worse than the EU average. There are also shortages in the health workforce capacity. Overall, there is a challenge in the accessibility to healthcare, in particular related to coverage and to the availability of care. There are signs of improvement, in particular related to costs, and a government's commitment to increase health workforce capacity by improving working conditions. The weakness of the health insurance coverage system is not specifically addressed.

Resources, Coverage and Organisation of the Health Spending

Health spending per capita is considerably below the EU average

Health spending per capita in Romania, which stood at 865.1 pps in 2015 is considerably lower than the EU average, as is the health spending measured as a share of GDP (5.0%). Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and a rise in incomes: between 2013 and 2060 the percentage of GDP spent on health is projected to increase by 1.0 percentage points in Romania, which is comparable to the EU average (0.9%) . Romania spends only 0.3% of GDP on long-term health care, which is below the EU average. Spending on prevention and public health services is below the EU average at 2.1% of total current health expenditure.

The share of compulsory insurance is slightly above the EU average, with a comparably limited role of voluntary schemes

In Romania, the proportion of funding by compulsory insurance (64.5% of current health expenditure) is slightly higher and the proportion of government outlays (13.5%) slightly lower than in the EU. The remaining spending is made up of households' out-of-pocket payments (21.3%, similar to the EU average), and voluntary schemes (0.7%). The latter play a smaller role in Romania than in most other EU countries.

Coverage is provide by a Social Health Insurance which contracts providers

A single mandatory Social Health Insurance (SHI) fund provides a comprehensive package of benefits to those insured and patients receive care from a mixed, fairly fragmented and hospital-heavy service delivery system.

Population coverage is not universal in the Romanian health system

SHI is compulsory for all citizens, and contributions are paid by employers or and the insured person themselves. Yet, in practice the SHI covers only around 86.5 % of the population in 201534. Uninsured groups include people working in agriculture, self-employed or informal workers, unemployed who are not registered for unemployment or social security benefits; and Roma people who do not have identity cards and can therefore not enrol in the social security system.

While social insurance provides a comprehensive package of benefits, uninsured individuals have only a limited benefits package

All insured person have access to a comprehensive basic benefits package. Criteria for inclusion in the benefits package lack clarity but certain services are excluded (e.g. very expensive technologies and treatments deemed non-essential, such as cosmetic surgery or in vitro fertilisation). Uninsured individuals, have access only to a minimum benefits package, including emergency care, treatment of communicable diseases and care during pregnancy. When they access care, the may be liable to pay contributions and penalties retrospectively for up to six months.

Out-of-pocket expenses include co-payments, payments for services not covered by insurance, as well as substantial informal payments

Co-payment rates varying from 10 % to 80 % apply to pharmaceuticals as well as to rehabilitation services. In 2013, the government introduced co-payments for hospital care, charging patients up to EUR 2.50 per discharge, but with a range of exemptions. In addition to co-payments, out-of-pocket expenses in Romania include direct payments for services not covered by SHI, additional fees for services delivered by contracted private providers, as well as informal payments. The latter are thought to be widespread and substantial, but nevertheless difficult to estimate. However, the

[34] The percentage indicator is calculated using the average usual residence population 2015 and the insured population registered at the family doctors' offices at 31 December 2015.

government acknowledges this issue and introduced further penalties for those accepting money 'under the table' in 2014.

While care is contracted at the district level, the health system remains under strong centralised control

Romania's health system has remained highly centralised although implementation is largely decentralised at the level of 42 districts. The Ministry of Health provides overall stewardship, policy direction and regulatory oversight while locally, district authorities are responsible for service delivery and own public facilities. Similarly, the National Health Insurance House administers and regulates the SHI system but district-level branches contract care delivery with health providers.

Service delivery is fragmented and the hospital system remains large

Primary care is provided by family medicine physicians who usually operate in solo practices and receive a mix of age-weighted capitation and fee-for-service. Despite a formal gatekeeping role, direct access to a specialist is possible for certain conditions. Specialised ambulatory (or out-patient) care is paid on a fee for service basis and provided through a network of hospital outpatient departments, polyclinics, medical centres, and individual specialist physician offices. Inpatient care is provided by a large hospital network (including some private facilities) which is poorly distributed and organised. Hospitals receive mostly prospective payments based on a mix of payment methods, including the Romanian DRG system.

The number of physicians is below the EU average

Romania has a relatively low number of doctors, with 277 practising physicians per 100,000 population in 2015, below the average in EU countries. The number of nurses and midwives per 100,000 population was 658 in 2015, which is slightly below the EU average. This is despite steadily increasing numbers of nursing graduates and efforts to increase medical graduates after a decline from 2010 to 2013. These numbers are partly driven by substantial emigration of health workers (particularly after EU accession in 2007) and low public sector salaries.

Policy Developments

The National Health Strategy aims to improve public health, health services and the wider health system

The 2014–2020 National Health Strategy guides current and future health care reforms, and targets public health, health services and system-wide measures. Public health goals are to improve the health and nutrition of mothers and children; reduce communicable disease mortality and morbidity; and slow the growth in non-communicable diseases. The health services stream aims to ensure equitable access to high quality and cost-effective services, while system-wide measures address planning capacity and seek to strengthen it at the organisational level (national, regional, local), and for operational areas, such as cancer control, hospital services and human resources. There are also commitments to increase efficiency through eHealth and reduce inequities in access by developing the health care infrastructure. Implementation of the Strategy is one of the conditions for accessing new EU funding. Efforts are currently under way to operationalise the Strategy.

Romania is implementing policies to increase the health workforce capacity

A key government objective is to improve health workforce retention rates and respond to repeated strikes by health care professionals in 2015. There is a commitment to tackle the most common causes of dissatisfaction, including low salaries, limited recognition and career development opportunities and poor working conditions. The government has taken legal steps to increase publicly employed health professionals' salaries and pledged to improve working condition.

The health system is moving towards a more evidence-based approach

Health Technology Assessment started to develop in 2011 and has now become the main tool for compiling the list of reimbursable medicines, but other technologies (such as diagnostic procedures, surgical interventions, screening, etc.) are not yet being evaluated. There are plans to develop these methods as part of a World Bank project. In addition, the new National Authority for Quality Management in Health Care, established in 2015, is developing a quality assurance strategy and will expand the accreditation process from hospitals to all health care providers.

JAF Health Results

Health outcomes in Romania are generally worse or considerably worse than the EU average, although most are improving

In 2015, life expectancy at birth and at 65 are considerably worse than the EU average (for both women and men), but show some positive developments compared to the average trend in the EU over the last three years. Similarly, infant and child mortality, amenable and preventable mortality and potential years life lost are considerably worse than the EU average and show a positive trend compared to the EU average, especially the infant mortality rate. Healthy life years at birth and at 65 are worse than the EU average. These variables are identified as health challenges. On the other hand, in 2015 inequality in general health as

measured by the gap between the bottom and the top income quintile in the share of people who perceived their general health as good/very good is considerably better than the EU average and it is identified as a good health outcome. Inequality in self-perceive general health as bad/very bad is also better than the EU average.

In 2014, self-reported 12-month depression symptoms is better than the EU average.

Access: Unmet need for medical care due to costs and to distance are considerably worse than the EU average, while only the first is improving

Unmet need for medical care (6.5% in 2016) represents a health challenge in Romania, as it remains worse than EU average, although there was a considerable improvement over the past three years. In particular, unmet need for medical care due to costs and distance are considerably worse than the EU average. While unmet need due to costs shows a considerable improvement, unmet need due to distance is increasing more than the EU average. Inequality in access to healthcare is worse than the EU average. The number of doctors' consultation is around EU average but shows a negative development.

Quality: The health quality dimension is a challenge in Romania and it generally worsening

The availability of data on the quality of healthcare is limited for Romania.

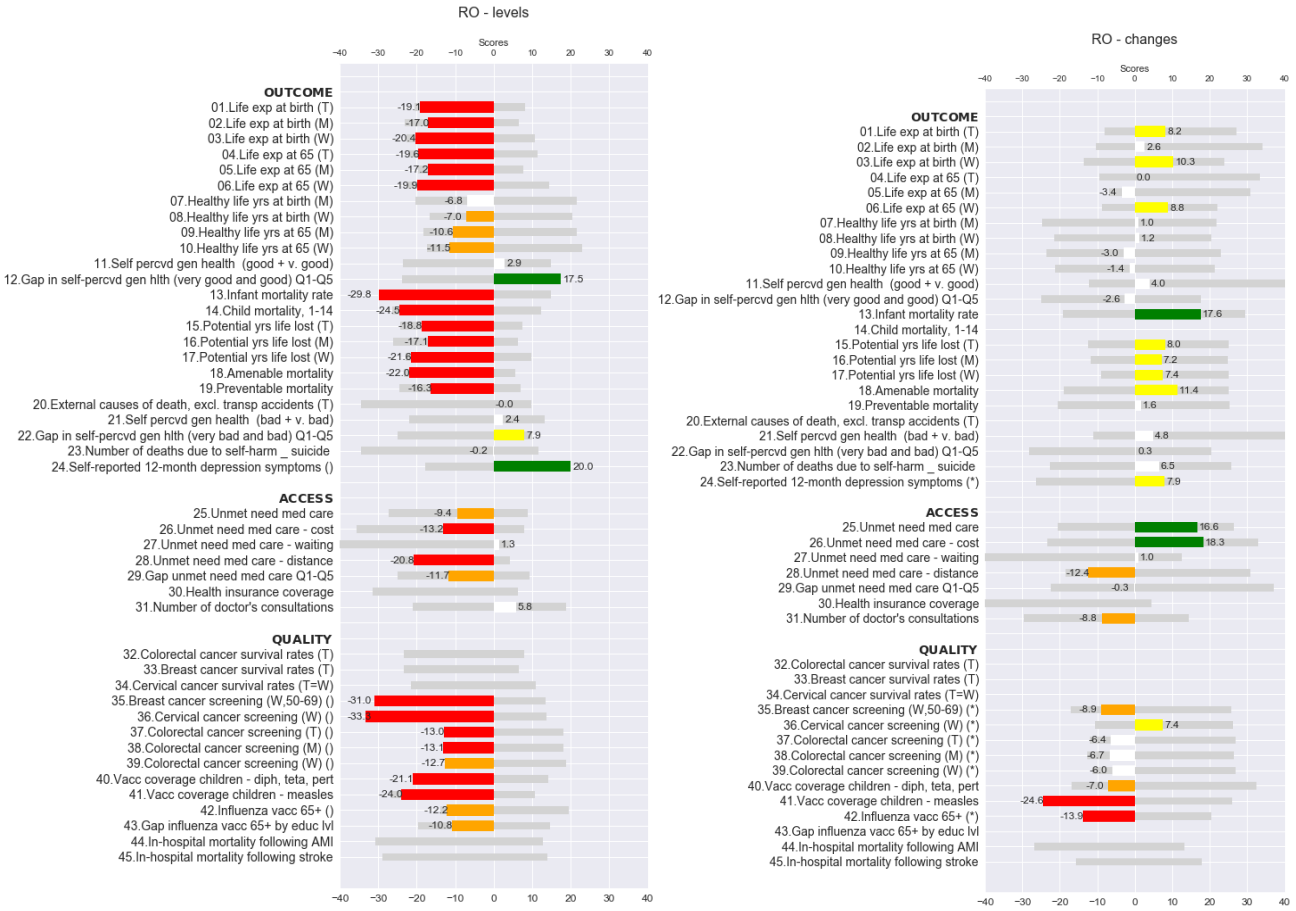
In 2014, cancer screening for breast, cervical, and colorectal are considerably worse than EU average. Cervical cancer screening shows a positive development, while breast cancer screening shows a negative development. In 2015, the vaccination coverage rates of children for DTP and measles are well below the 95% recommended threshold and show a negative trend (considerable for measles) over the last three years. The influenza vaccination rate for over 65 (5.5% in 2014) is worse than the EU average.

Inequality in the influenza vaccination rate between lower and higher educated is also worse than the EU average.

Non-health determinants: Most lifestyle indicators are worse than the EU average, while the smoking rate (except for men) and obesity are better

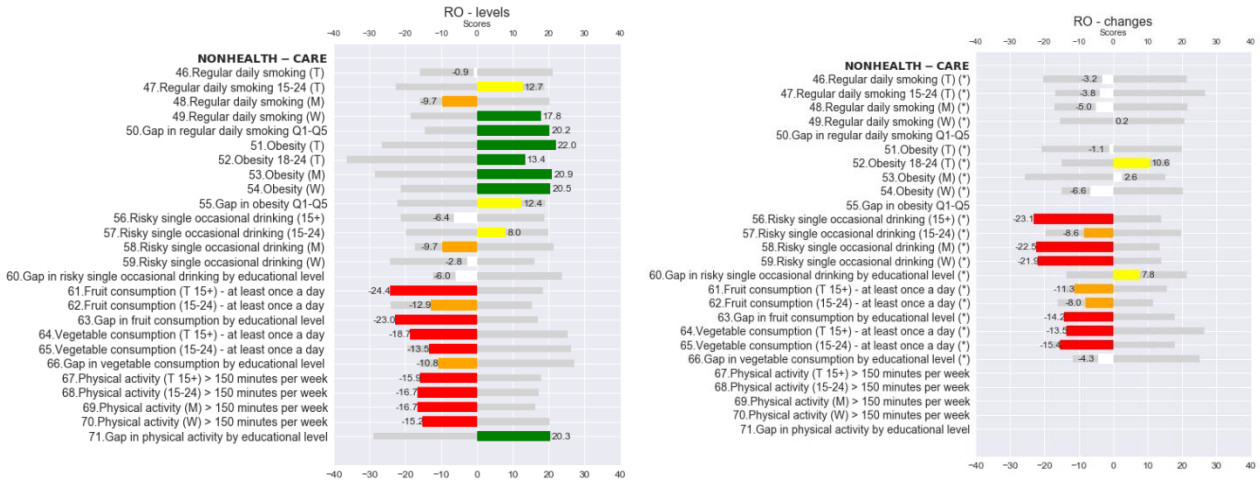
In 2014, the smoking rate among young and women are better than the EU average, as well as the obesity rate, while the smoking rate and alcohol use among men are worse. The consumption of fruit and vegetable consumption and physical activity are considerably worse than the EU average. Alcohol use among women and vegetable consumption are worsening from 2008. Fruit consumption among young is worse than the EU average. Inequality in lifestyle is generally better or considerably better than the EU average, with the exception of the gap in fruit and vegetable consumption between high and low educated which are, respectively, considerably worse and worse than the EU average.

Figure 45 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 46 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

SLOVAKIA

Although projected to grow substantially, health expenditure is below the EU average, while health outcomes are worse or considerably worse. However, some are improving, namely infant mortality, potential years of life lost and preventable mortality. In terms of prevention, influenza vaccination for old people is worse than the EU average, while the vaccination coverage rates of children and breast cancer screening are worsening in the last years. Slovakia has a universal health system, based on mandatory contributions as entitlement to healthcare benefits, while the government pays contributions for economically inactive individuals such as children, students, unemployed, pensioners and disabled. The indicator on health insurance coverage is worse than the EU average, with 6% of the population reported as being without a health insurance. People having a foreign health insurance as they are working or living abroad may be included among the uninsured. With a low number of health professionals, particularly GPs, and unequally distributed across regions, unmet need for medical care due to distance is worse than the EU average and it is also worsening in the last years. The Slovak population is much younger than in most EU countries, with most non-health determinants generally around the EU average. However, the trend is smoking and fruit consumption is worsening with respect to the EU average in the last years. Moreover, inequalities is some risk factors (alcohol use and fruit consumption) are an issue. While equity is on the agenda in the Slovak health system, addressing public health issues has not been a key priority for the central government.

Resources, Coverage and Organisation of the Health System

Health spending is below EU average expected to grow substantially

Health spending in Slovakia is below the EU average when measured on a per capita basis (1,531 pps in 2014) and a share of GDP (7.0%). However, health spending is expected to rise rapidly due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 2.0 percentage points in Slovakia, which is considerably above the EU average (0.9 percentage points) . In terms of structure, in 2014, Slovakia spent considerably less on long-term nursing care (0.3% of health spending) than other EU countries while the share of administrative cost (4.2%) was above EU average. A significant share of financial resources in Slovakia is dedicated to medical goods (35%), in particular pharmaceuticals.

Healthcare is mostly financed by compulsory insurance

In 2014, the proportion of funding by compulsory health insurance (76.2%) was above the EU average, while the proportion of government outlays (4.0%) was lower than in other European countries. The remaining spending was made up of households' out-of-pocket payments (18.0%), which was around the EU average and voluntary schemes (1.8%), which was lower than in most other EU countries.

Competing insurers provide statutory coverage and selectively contract service providers

The statutory social health insurance system is operated by three competing health insurers (one public, two private) which have to contract minimum sets of service providers to ensure access throughout the territory.

Slovakia has a universal health system, based on compulsory contributions as entitlement to benefits and on state subsidies

The Slovak social health insurance system applies to all residents, who can opt for the insurer of their choice, while people having insurance abroad are exempted. Compulsory health insurance is financed via contributions from employers and employees. Payment of contributions is compulsory and a condition for receiving health care benefits. If this obligation is violated, the insured are entitled only to emergency care and the health insurance company may require reimbursement of the costs. However, economically inactive individuals (such as children, students up to the age of twenty-six, unemployed, pensioners, persons taking care of children aged up to three years and disabled persons) are covered by the public health insurer with the government paying their contributions.

Actual coverage varies across the country

In practice, not all residents are covered by the SHI. People not covered by a Slovak health insurance may include residents living or working abroad covered by foreign schemes. Actual coverage however varies across the country since the supply of health workers is inadequate in some regions and districts, and in some instances there are simply not enough providers available to contract to ensure timely provision of services.

Basic benefit package is identical for all insurers

The three health insurers have to provide the same basic benefit package for their insured and they cannot refuse enrolment. Health insurers contract with providers through individual negotiations on quality, prices and volumes. To guarantee access to health care for

their insured across regions, health insurers are mandated to maintain a minimum network of providers in each region. To foster competition and prevent patient selection, a redistribution mechanism taking account of age, sex, economic activity and pharmaceutical consumption of the insured population partly mitigates differences in risk-profiles across the three insurance companies.

Direct payments and cost-sharing exist for a number of services

The Slovak Republic has a broad definition of what is included in the benefit package funded by health insurers. Some activities are explicitly excluded, for example, patient-requested anaesthesia, paternity tests, specialist visits without referral, treatment caused by substance abuse and most dentistry. Costs for these services have to be covered by patients themselves. In addition, user fees exist for prescription and emergency care and there are co-payments for pharmaceuticals and spa treatments. Treatment of "non-priority diseases" may also be subject to cost-sharing but in practice this does not frequently apply.

The Ministry of Health is the main actor in the health system and dual governance structures exist for long-term care

The Slovak Ministry of Health plays a central role in the governance of the health system including long-term care and its responsibilities include regulating health care delivery, assuring health care quality, managing national health programmes, and defining the benefit package and minimum provider network requirements for the three health insurers. The Health Care Surveillance Authority licenses health insurers, and monitors their financial situations, contracts with providers and quality of care provided. For social care which also includes long-term care, the Ministry of Labour, Social Affairs and Family is responsible for organisation and funding.

Primary care is provided mainly by private practices but care delivery remains hospital-centred

Primary care is provided by doctors predominantly working in private practices and General Practitioners (GPs) are remunerated based on capitation. In theory, referrals from GP or paediatricians are needed to access specialist care. However, there are still ways to bypass this referral system. In addition, GPs in the Slovak Republic have a relatively weak gatekeeping role due to their low number, limited rights to prescribe medicines and a lack of incentive for GPs and patients to stay within primary care (specialist visits are free after referral). As a result, 80 % of GP consultations lead to referrals to a hospital specialist which makes the Slovak health system very hospital-centred. Specialised ambulatory care is provided mainly by polyclinics attached to hospitals and providers are remunerated through a mix of capitation and fee-for-service payments. Inpatient care is provided in public or private hospitals which are paid through case-based payment, on a per diem basis, or fee-for-service depending on the intervention.

The number of health professionals, particularly GPs, is low and varies across regions

In 2015, there were 762 full-time equivalent health workers in hospital per 100,000 population and this was considerably lower than the EU average. Other data on human resources for health are not readily available but there is some imbalance in the distribution of health professionals across the country: in the capital region of Bratislava, the medical workforce per population is nearly twice as large as the national average while many rural areas face a limited availability of medical personnel which can impede access to care. This problem is particularly pronounced in primary care since there are much more specialists than GPs practicing in the country. Several steps have been taken recently to increase the number and strengthen the role of GPs, for example by redesigned medical training to include more practical elements and by putting a stronger focus on chronic disease management and health promotion.

Policy Developments

Slovakia implemented several reforms to contain costs and increase efficiencies in the health system

To promote efficient and effective information-sharing among providers, a new law on a national eHealth information system was adopted in 2013, although implementation is lagging behind. In the pharmaceutical sector, the positive list was modified and reference prices and regressive margins for prescribed drugs were introduced in 2012 to reduce high public pharma spending. In 2016, additional cost-saving measures were introduced, including reference prices for health care materials, a reduction of acute care beds in hospital and centralised procurement (OECD, 2017). A reform in 2012 improved the reallocation of public funds among health insurers by including pharmaceutical cost in the redistribution formula to compensate for the different risk-profiles for the individual insurer to foster competition and avoid risk-selection of patients.

Addressing public health issues has not been a key priority for the central government

The National Health Promotion Programme, adopted in 2014, includes some measures to reduce smoking (for example, smoking cessation programmes) and tackle other behavioural risk factors, with the objective to target socially disadvantaged communities and groups with high prevalence of risk factors (Smatana et al.,

2016). However, the central government has so far not yet prioritized prevention programmes and efforts to promote a healthy lifestyle and reduce risk factors have depended on the engagement of NGOs and the private sector.

Promoting equity is on the agenda in the Slovak health system

To assure equal access to health care among the population, policies were implemented to contain out-of-pocket payments among vulnerable groups, for instance by setting payment ceilings for prescribed pharmaceuticals and ambulance transport for people with chronic conditions as there is no payment cap otherwise. In 2015, the government also tightened the rules for additional charges that provider can bill for services outside the publicly funded benefit package. Moreover, in order to make health providers strictly follow cost-sharing and exemption rules, a new legislation in 2017 imposed penalties for providers not abiding by these rules.

JAF Health Results

Most health outcomes in Slovakia are worse or considerably worse than the EU average, while some are improving

In 2015, life expectancy (at 76.7 for total population at birth) and healthy life years (at birth and at 65) are considerably worse than the EU average, although life expectancy at 65 for women shows a positive development in the past three years compared to the EU average change. Similarly, infant mortality rate in 2015 and potential years of life lost in 2014 are worse than the EU average, while they also show positive trends in the past three years. Amenable and preventable mortality rate are considerably worse than the EU average, but only the last shows a positive development compared to the EU average in the previous three years. These variables are identified as health challenges.

Child mortality is considerably worse than the EU average.

Access: Health insurance coverage and unmet need for medical care due to distance are worse than the EU average

In 2015, health insurance coverage is worse than the EU average, with about 6% of the population uncovered. Although unmet need for medical care (at 2.1% in 2015) is around the EU average, unmet need due to distance (at 0.3% in 2015) is worse than the EU average and shows a negative trend in the past three years. These variables are identified as health challenges.

The number of doctor's consultation (at 11.28 in 2014) is considerably above the EU average.

Quality: The vaccination coverage rates of children and breast cancer screening are worsening

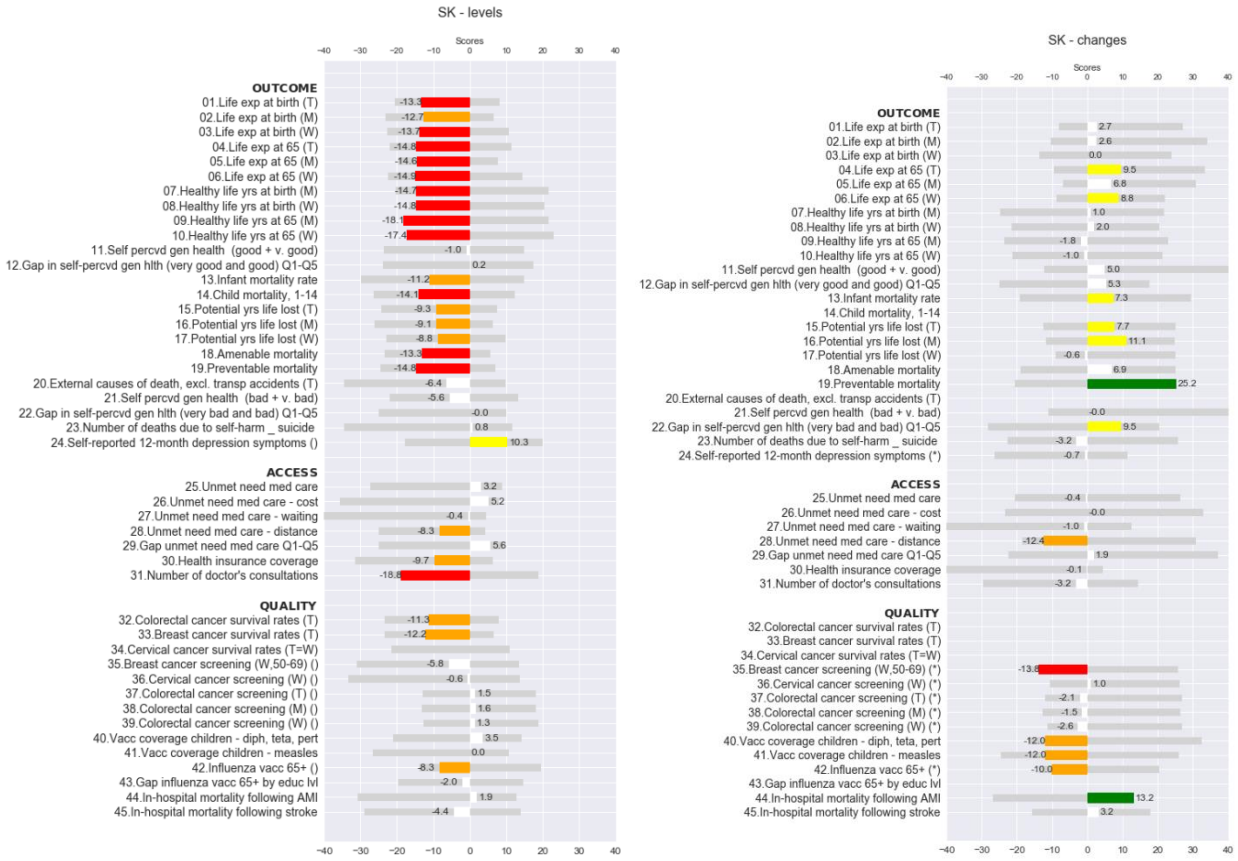
In 2015, the vaccination coverage rates of children for DTP (at 96%) and measles (at 95%) are around the 95% recommended threshold. However, they are decreasing in the past three years (they were at 99% in 2012). While breast cancer screening in 2014 is around the EU average, it shows a significant negative development compared to the EU average change. In 2014, the influenza vaccination rate for 65 year-old and older is worse than the EU average. These variables are identified as health challenges.

Other indicators on prevention are worse that the EU average, such as the survival rates for colorectal and breast cancer (in 2007).

Non-health determinants: Smoking and fruit consumption are worsening in the last years

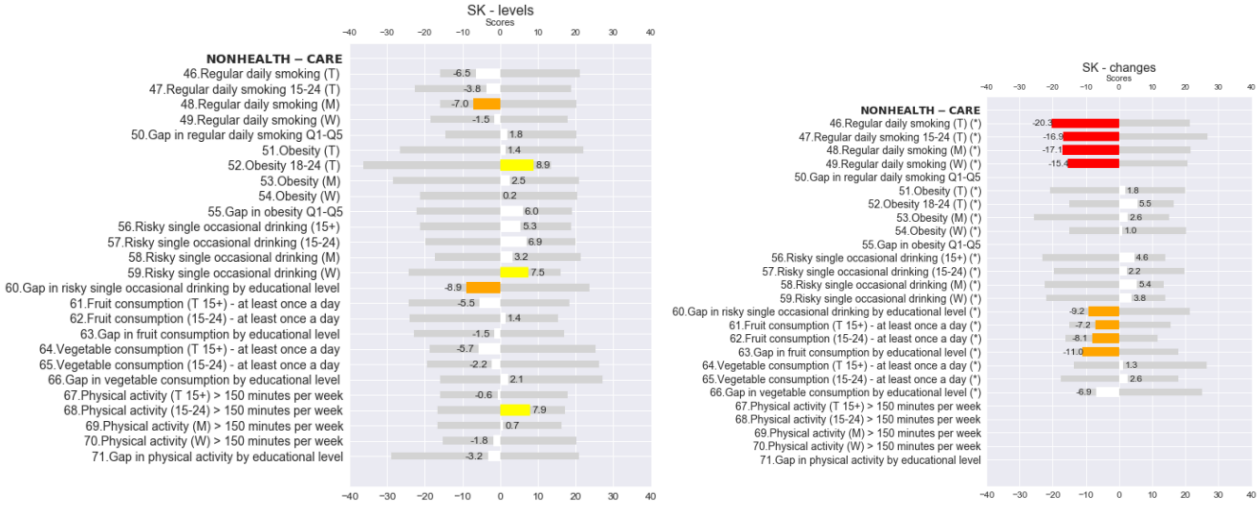
In 2014, the smoking rate among men is worse than the EU average, while for women and young is around the EU average but shows a significant negative development. Similarly, fruit consumption and inequality in fruit consumption by educational level are around the EU average, but show some negative development compared to the EU average change. Inequality in risky single occasional drinking between high and low educated is considerably worse than the EU average and worsening. These indicators are identified as health challenges.

Figure 47 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 48 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Slovenia

With an average GDP and health spending per capita, most health outcomes in Slovenia are around the EU average, except for a few. For instance, healthy life years at birth are worse than the EU average. Infant mortality is considerably better than the EU average,. The health system is mostly financed by compulsory health insurance, with a larger than average role of complementary and voluntary health insurance. According to the available indicators, access to healthcare is good, although the availability of physicians remains below the EU average with an unbalanced geographic distribution. Population is aging faster than in other EU countries and expenditure for healthcare is projected to increase by 1.2 pps between 2013 and 2060. Slovenia also has higher than average administrative costs. The new Health Care and Health Insurance Act which aims at addressing the challenges of the long-term stability of health system funding has not been finalised yet. As for the quality of healthcare, in-hospital mortality following stroke is identified as a health challenge, although it is improving. Some aspects of lifestyle are an issue such as obesity among men and poor and alcohol use among young. The Slovenian government has launched a number of policies and strategies to fight risk-factors, including obesity.

Resources, Coverage and Organisation of the Health System

Health spending per capita is around EU average but the share of administrative cost is higher

Health spending in Slovenia is around the EU average when measured on a per capita basis (1,999.7 pps in 2015) or as a share of GDP (8.5%). Health spending is expected to rise in Slovenia due to a number of factors, including population ageing, technological progress and rise in incomes: between 2013 and 2060 the share of public health spending in GDP is projected to increase by 1.2 percentage points in Slovenia, which is comparable to the EU average (0.9 percentage points) . Long-term care expenditures in 2015 represents 0.84% of GDP - this concerns only the health part of long-term care. If we account also the social expenditure of long-term care, the total expenditure is 1.26% of GDP Administrative costs represented 4.1% of health spending which was higher than in most EU countries. Otherwise, the spending structure does not differ notably from the EU average.

Slovenia spends considerably more on voluntary health insurance than most EU countries

In Slovenia, compulsory health insurance accounted for 68.7% of current health spending in 2015, which was higher than the EU average[35] and government outlays represented 3%, which was lower. Voluntary schemes accounted for 14.5% of health spending, playing a considerably bigger role in Slovenia than in most other EU countries. Households' out-of-pocket payments stood at 12.5% of health spending, lower than the EU average.

A single health insurance fund provides near universal coverage and contracts services providers, many of which are public

The Health Insurance Institute of Slovenia (HIIS) operates a compulsory health insurance system which virtually covers the entire population. The HIIS finances a range of municipal and other public providers as well as those private providers which have been granted concessions.

Nearly all residents are covered by compulsory health insurance

The compulsory insurance scheme whose funding relies almost exclusively on payroll contributions covers all permanent residents which are entitled to a broad range of health services. Overall, less than 1% of the population –mainly non-permanent residents- are not covered by the compulsory health insurance but entitled to emergency medical services.

Co-payments are high but covered by complementary health insurance for most of the population

The benefits package from compulsory health insurance is quite broad. Co-payments, however, are required for most health services including basic services and are not capped. These co-payments with compulsory insurance can range between 10% and 90%. For example, patients have to cover up to 10% of costs for some (e.g. 100% coverage for emergency medical treatment and emergency transport aid) urgent interventions and intensive therapy; 20% for specialist surgery, orthodontics and other aids; and 30 % for pharmaceuticals on the 'positive list' (with some exceptions) covered by the compulsory health insurance. Children and students up to the age of 26 as well as vulnerable groups are exempted from all co-payments. To cover these co-payments, 95%[36] of the population have complementary voluntary health insurance. In addition to that, there are also supplementary health

[35] The structure of the financing of healthcare systems varies widely across EU countries.

[36] Health Systems in Transition,Slovenia:Health System Review 2016, Vol. 18 No. 3 2016; Available at: http://www.euro.who.int/__data/assets/pdf_file/0018/312147/HiT-Slovenia_rev3.pdf?ua=1

insurances which include services that are excluded from the basic package, additional services in hospitals or can guarantee faster access to treatment.

The Ministry of Health is responsible for the governance of Slovenian health system as a whole

Governance and regulation are centralised within the Ministry of Health, (government is the founder of hospitals by law). Local governments, at the municipality level, are responsible for the organisation of primary care facilities, which they mostly own, including capital investment. They also grant concessions to private providers in their territory. The HIIS implements compulsory health insurance and is governed by an assembly composed of representatives of employers and the insured population. 10 regional branches of the HIIS are responsible for contracting service delivery.

Service delivery is mostly public

Primary care is mostly provided in community-level health care centres run by municipalities and by some private practices under concession (contract). Patients can freely select their GP but have to stick with their choice for at least one year. Primary care providers are paid through a combination of capitation and fee-for-service payments. Outpatient (or ambulatory) specialist care is provided on a fee-for-service basis by public hospitals, private outpatient specialist clinics and independent specialists. Inpatient care is provided mainly by public hospitals and covered (in theory) by fixed allocations and Diagnosis-Related Groups. However, in practice, hospitals are allocated budgets according to available resources and historical volumes. Slovenia operates a gate-keeping system, in which patients need a referral for an outpatient specialist or hospital consultation.

The physician density is below EU average and primary care doctors are not distributed equally across regions

Partly driven by immigration from neighbouring countries, the number of physicians has grown faster in Slovenia than in most other EU countries since 2012. Yet, in 2015 it was still below the average in EU countries (283 per 100,000 population), and challenges in access exist due to an unbalanced geographic distribution of primary care physician. The number of nurses and midwives (886 per 100,000 population) is around the average in the EU and has also been increasing faster than in other EU countries in recent years.

Policy Developments

Improving financial sustainability is on the agenda in the Slovenian health system

In 2016, the National Assembly of the Republic of Slovenia adopted a strategic framework for health system governance and development called the Resolution on the National Health Care Plan 2016–2025. Together with health promotion, optimizing health service delivery and improving health system performance, ensuring fiscal sustainability is one of the four priority areas under this plan. The new Health Care and Health Insurance Act is also proposed to address the challenges of the long-term stability of health system funding through measures that seek to diversify funding sources. In particular, the bill proposes an extended contribution base for compulsory insurance that takes direct and indirect income into account and unifies contribution rates across insured populations. The bill also envisages the abolition of the complementary voluntary health insurance scheme by 2019, and its replacement with an income-dependent contribution that will be more efficient to administer. So far, however, this Act has not been finalised due to political opposition and debate over legal specifications and the transfer of responsibilities.

Addressing public health issues has been a major focus of recent government initiatives

The Slovenian government has launched a number of policies and strategies such as the National Programme on Nutrition and Health Enhancing Physical Activity 2015–25 and the National Cancer Control Programme 2017-2021 to combat the rise in overweight and obesity and of hypertension and to reduce incidences of cancer. With regard to tobacco control, the 2014 reform on family medicine practices included strengthening prevention activities, screening, counselling and follow up of patients in smoking cessation programmes. Beyond the implementation of several EU Directives, new legislation on tobacco control adopted in 2017 includes comprehensive ban on all tobacco and related products advertising, promotion and sponsorship, including a display ban (mandatory from march 2018) on tobacco and related products at points of sale; the implementation of licencing for retailers of tobacco and related products and ban on selling to minors and using e-cigarettes and other tobacco related products in enclosed public places and workplaces, total ban on advertising, promotion and sponsorship of e-cigarettes and other tobacco related products. The new Act also made plain packing mandatory as of 2020 and banned smoking in all vehicles in the presence of minors. The strong legislation is a major development for tobacco control in the country, as well as in the south-eastern WHO European Region. By adopting this Act, Slovenia joins the group of countries around the world leading the enforcement of plain packaging, begun by Australia in 2012.

Slovenia continues to strengthen primary care and aims for better coordination in long-term care

The upgrading of family medicine practices in 2011 was an important government initiative to further

strengthen primary care. This includes 'model practices" in which designated registered nurses have the responsibility of screening for chronic disease risk factors, preventive counselling and care coordination. This new practice concept will be rolled out nationwide by the end of 2018 and should help to overcome the fragmentation of service organisation and to strengthen coordination between providers across different care levels. Problems are similar for long-term care where the currently debated Long-term Care Act aims to make care delivery more coordinated and to move away from institutional settings to more community and home care.

Improving efficiency in the health system is another key policy priority in Slovenia

The Ministry of Health has recently developed a new public procurement system, and mandatory centralised procurement of medicinal products and commonly used medical devices in public hospitals has been implemented. In 2017 an online application (registry) of a joint database of prices for medicinal products and medical devices was set up in order to promote efficient allocation of resources and enhanced transparency. The registry enables health-care institutions to get an insight into prices of medical supplies (medicinal products and medical devices) and their comparison.

JAF Health Results

Most health outcomes in Slovenia are around the EU average, while healthy life years at birth are worse and infant mortality rate considerably better

In 2015, healthy life years at birth are worse than the EU average for both women and men. Slovenia had faced a major drop in the year 2010 which was mostly explained with adopting the proposed wording of GALI questionnaire in combination with the influence of ongoing economic crisis. The number of deaths due to self-harm or suicide in 2014 is also worse than the EU average, although it improved more than the EU average over the past three years. These variables are identified as health challenges. On the other hand, infant mortality rate is considerably better than the EU average and it is identified as a good health outcome.

Infant mortality is better than the EU average. Inequality between income groups in self-perceived general health show a considerable positive development in the last three years. Life expectancy at both birth (80.9) and 65 (19.7) are around the EU average, while their developments over the last three years are better than the EU average change.

Access: Indicators on self-reported unmet need for medical care are good

In 2015, self-reported unmet need for medical care (0.2%) is better than the EU average. The gap in self-reported unmet need for medical care between the bottom and top income group is limited and better than the EU average.

Quality: In-hospital mortality following stroke is a health challenge

In 2012, in-hospital mortality following stroke (at 13.2% in 2012) is worse than the EU average, but it shows a considerable positive development in the past three years. While in-hospital mortality following stroke is identified as a health challenge in-hospital mortality following AMI (at 5.2% in 2013) is identified as a good health outcome because it is better than the EU average and it shows a positive trend in the past three years.

In 2014, colorectal cancer screening (both for women and men) is considerably better than the EU average, while influenza vaccination for over 65 year-old is worse than the EU average and the gap between high and low educated is considerably worse than the EU average.

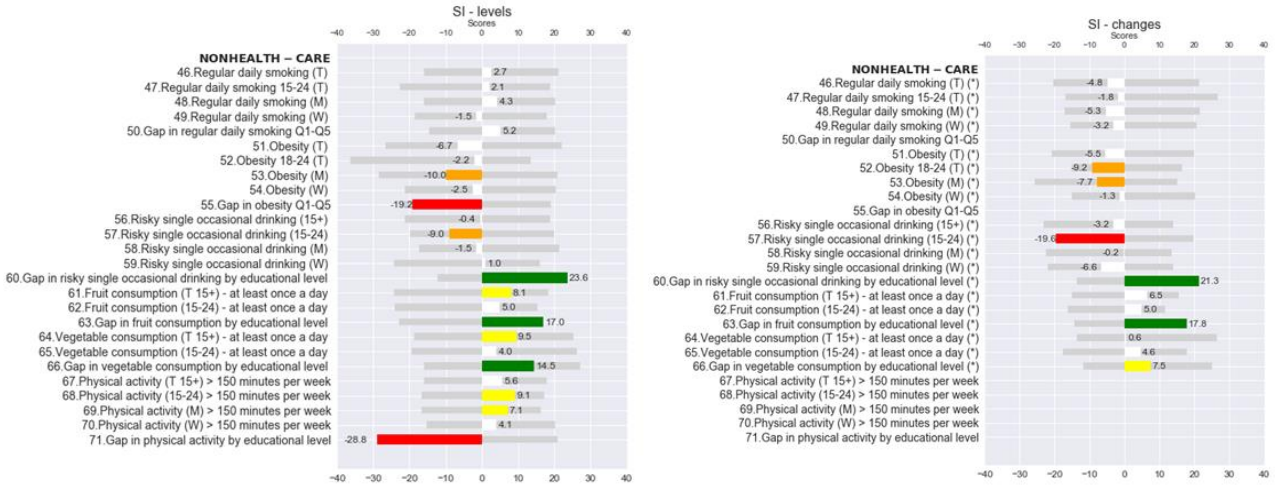
Non-healthcare determinants: Some aspects of lifestyle are an issue (e.g. obesity among men and poor and alcohol use among young)

In 2014, the obesity rate among men and alcohol use among young are worse than the EU average, while fruit and vegetable consumption and physical activity (especially among young and men) are better than the EU average. Obesity rate among young and men and risky single occasional drinking among young are identified as health challenges. Inequality in the obesity rate between income groups and physical activity between educational groups are considerably worse than the EU average. On the other hand, the gap in risky single occasional drinking, fruit and vegetable consumption by educational groups are limited and smaller than the EU average.

Figure 49 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 50- JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

SPAIN

With an around EU average level of health spending and a number of physicians slightly above average, health outcomes in Spain are around or better than the EU average, while healthy life years for women and the suicide rate are deteriorating. Expenditure for prevention is slightly lower than the EU average, while indicators on prevention (breast cancer screening, vaccination coverage rates) are generally good, with the exception of colorectal cancer screening which is worse than average. The decentralized health system is primarily funded from government sources, with service delivery mostly public and coverage is near universal. However, in 2012 universal coverage based on residency shifted towards an entitlement more closely linked to participation in the social security system, which excludes around 0.2% of the population, in particular unregistered immigrants. In the same year co-payments for pharmaceuticals were increased in response to the economic crisis. Overall, available indicators at national level do not highlight major problems in the accessibility to healthcare and the average level of unmet need is better than the EU average. Spain is one of the first EU countries to have developed an atlas of unwarranted variations in healthcare activities. In terms of lifestyle, Spain has a higher than average share of low educated people with some risk-factors worse than the EU average, in particular among women (smoking), young (vegetable consumption) and the poor (obesity), while alcohol use is better.

Resources, Coverage and Organisation of the Health System

The level and structure of health spending in Spain is comparable to most European countries

Spain's level of health spending is around the EU average both in per capita terms (2,320 pps in 2015) and when measured as a share of GDP (9.2%). Health spending is expected to rise due to a number of factors, including population ageing, technological progress and rising incomes: between 2013 and 2060 public spending on health as a share of GDP is projected to increase by 1.1 percentage points, which is comparable to the EU average (0.9 percentage points). Long-term care spending accounted for 0.8% of GDP in 2015, which is around the EU average. Spain spent slightly less on prevention than most EU countries (2.0% of total spending). Otherwise, the spending structure does not differ notably from the EU average.

Health spending in Spain is primarily funded from government sources

In Spain, government outlays represented 66.3% of total health spending in 2015, which is higher than the EU average and compulsory insurance accounted for 4.7%, which is lower. The share of government financing had come down in recent years. The remaining spending was made up of households' out-of-pocket payments (24.2%) and voluntary schemes (4.7%), both around the EU average.

The decentralised health system provides predominantly public services

The statutory National Health System (Sistema Nacional de Salud, SNS) is fully devolved to regional health ministries and covers virtually the entire population. The system is mostly tax-funded and service delivery is predominantly public.

Population coverage remains near universal despite a redefinition of the basis for entitlement following the economic crisis

Spain provides coverage for 99.9% of its population, including for civil servants who can opt out of the SNS and get coverage through private insurance instead. A common benefits package is defined at the central level for everyone covered under the SNS. Although the benefits package is comprehensive, coverage for certain types of services is limited – such as for long-term care, dental and optical services – with some regional variations. Regions may define a complementary benefits package providing specific services to their citizens that go beyond the common package. Following the economic crisis, the Royal Decree Law 16/2012 introduced the condition of "insured" as a necessary condition to access public healthcare. The Spain's National Health System (SNS) covers workers affiliated with social security, pensioners and recipients of social benefits, as well as their dependents. Non-insured legal residents with Spanish or EU/EEA citizenship are also granted the condition of "insured" if their income does not exceed the limit fixed by the law. The measures established in the decree therefore guarantee publicly funded universal healthcare coverage through the SNS for all Spanish citizens and for foreign citizens who are legal residents in Spain. The Royal Decree mostly affected foreign citizens in irregular administrative situations, as some of them are now excluded from full SNS coverage, while it provides full coverage for under-18s, pregnant women, and emergency care, as well as for all public health contingencies. Many regions took measures to limit the impact of these changes on coverage, but these measures were in turn legally challenged by the central Government and the situation remains in flux.

Co-payments for pharmaceuticals were increased in response to the economic crisis

Health care provision is generally free of charge at the point of delivery but important co-payments exists for pharmaceuticals. In addition to changing the basis for entitlement, the Royal Decree Law 16/2012 implemented a number of other emergency measures to ensure fiscal sustainability of the SNS. Most notably, this included an increase in co-payments for pharmaceuticals, which partly explains the rise in out-of-pocket spending in recent years. Different co-payment rates exist for pensioners and non-pensioners and for both groups payments are dependent on annual income. While a monthly ceiling of co-payments exists for pensioners, this is not the case for non-pensioners. Pensioners with an annual income of less than EUR 100,000 have to cover 10% of the pharmaceutical price with a monthly ceiling of EUR 8 to EUR 18. Above that they pay 60% with a ceiling of EUR 60. For non-pensioners co-payment rates are between 40-60% corresponding to three income bands. Certain population groups are exempt from cost-sharing, such as people on very low pensions and unemployed who do not receive unemployment benefits. Other important out-of-pocket payments refer to dental care.

Regions organise their own health services with the devolved health system being coordinated at the central level

The Spanish health system is devolved to the regional level, where 17 regional health ministries have primary jurisdiction over the organisation and delivery of health services within their territory. At the central level, the Ministry of Health, Social Services and Equality is responsible for basic health legislation, the definition of the common benefits package covered by the SNS as well as other strategic areas and performance monitoring. The inter-territorial Council of the SNS brings together the central and regional health ministries and has a coordinating role.

Service delivery is mostly public with a two-stage referral system closely controlling access to inpatient care

Primary care delivery is, to a great extent, public and most providers are salaried employees within the public sector. Primary health care centres are run by multidisciplinary teams composed of general practitioners, paediatricians, nurses and social workers. Some also include physiotherapists and dentists' surgeries and can provide basic laboratory and imaging services. Primary health care physicians act as gatekeepers and referral points to specialist care. Specialists can in turn refer patients to inpatient care which is provided mostly in public hospitals. Both specialists in ambulatory care and hospital doctors are typically salaried employees. Public hospitals are generally funded prospectively through negotiations between the hospital and the regional authority.

Physician numbers in Spain are slightly above the EU average

Spain's physician density (385 per 100,000 population) was slightly above the EU average in 2015, but the number had increased at a slower rate in the previous three years than in most other EU countries. The number of students entering medical education increased by over 50% between 2004 and 2014, in response to concerns about possible future shortages of doctors.

Policy Developments

Reducing unnecessary health interventions and regional variations in medical practice are important goals of Spanish health policy

In 2013, the Ministry of Health established the project "Commitment to Quality of the Spanish Scientific Societies". Its main goal is to reduce unnecessary health interventions by setting up a series of "do not do" (no hacer) recommendations. The Ministry worked together with the Spanish Society of Internal Medicine and the Guía Salud in coming up with recommendations targeting specific areas of health care. Moreover, Spain is one of the first EU countries to have developed an atlas to identify unwarranted variations in health care activities. The Spanish Atlas on Variations in Medical Practice is a bottom-up collaborative health services research project that aims to describe systematic and unwarranted variations in medical practice.

Several steps aimed at improving patient safety have been taken

Since 2005, the Spanish government has put in place various actions to improve patient safety. These include the promotion of a culture of patient safety among professionals and patients, implementing information systems to monitor patient safety incidents, implementing safe practices, promoting research and development on patient safety, and involving patients in the development of strategies related to patient safety. For example, a five-point checklist is now used in intensive care units to reduce catheter-related bloodstream infections. Spain also uses indicators to monitor the compliance of hospitals in reducing health care-associated infections through improved hand hygiene.

Spain adopted a national antimicrobial resistance (AMR) strategy to tackle this growing public health issue

In 2014, Spain introduced a four-year Strategic Action Plan to reduce the risk of antibiotic resistance – following the recommendation from the European Commission for EU Member States. The plan is structured around six priority areas for action: surveillance, research, prevention, control, training and communication – in both human and veterinary health. The overall

objective is to curb AMR by promoting a more rational use of antibiotics. At the international level, Spain is an active member of the Joint Programming Initiative on Antimicrobial Resistance and the Global Health Security Agenda – both initiatives aim to coordinate health policy strategies to address AMR

JAF Health results

Health outcomes in Spain are around or better than the EU average, while a few indicators are deteriorating

Heathy life years at birth for women, and number of deaths due to self-harm/suicide show a negative development compared to the EU average in the past three years, although levels (in 2015 and 2014) are still around the EU average. These variables are identified as health challenges.

Other health outcome indicators are around or better than the EU average.

Access: data on access at national level are around or better than the EU average

The available indicators at national level do not show specific issues on the access to healthcare.

In 2016, the average level of self-reported unmet need for medical care is better than the EU average.

Quality: Colorectal cancer screening is worse than the EU average, while others indicators on prevention are generally good

In 2014, colorectal cancer screening (both for women and men) is worse than the EU average. On the other hand, other indicators on prevention (breast cancer screening, influenza vaccination for over 65 year-old) are better than the EU average and the vaccination coverage rates of children are above the 95% recommended threshold.

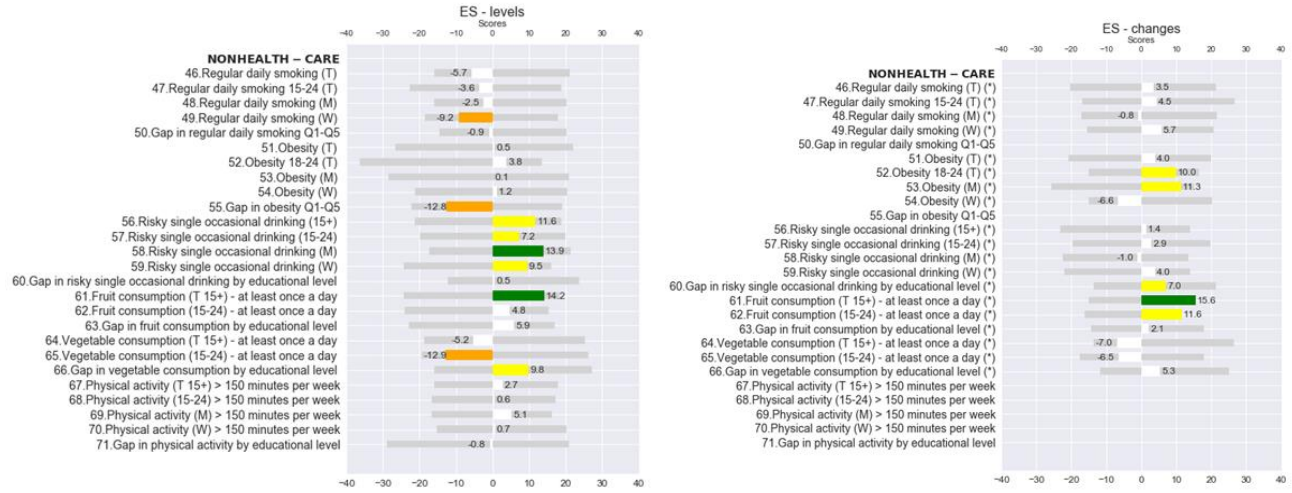
Non-health determinants: While alcohol use is better than in the EU, some risk-factors among women (smoking), young (vegetable consumption) and poor (obesity) are worse than average

In 2014, daily smoking among women, vegetable consumption among young and the gap in obesity rate between income groups are worse than the EU average. The first two indicators are identified as health challenges. On the other hand, risky single occasion drinking for men and fruit consumption are considerably better than the EU average. These variables are identified as good health outcome.

Figure 51 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 52 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

SWEDEN

With health expenditure as a share of GDP considerably higher than the EU average and a number of health employees higher than average, health outcomes in Sweden are good, with the exception of self-reported depression symptoms. In the last years, potential years of life lost are not improving as in other EU countries. The agreed JAF Health indicators on the quality of healthcare, including on prevention, are generally around or better than the EU average. Sweden has a universal healthcare system, mostly tax financed, with ceilings on co-payments and a guarantee for timely access to care. In terms of output, indicators on access to healthcare are around the EU average. In a context where the empowerment of patients has been at the heart of recent government initiatives, the number of doctor's consultations is higher than the EU average. However, service coverage and user charges vary across regions and some inequalities are observed between different population groups. In particular, the gap between people who perceive their health as good between the bottom and top income quintiles is increasing in the last years and inequality in alcohol consumption between low and higher educated people is considerably larger than the EU average. In this respect, recent public health efforts aim to tackle health inequalities between population groups.

Resources, Coverage and Organisation of the Health System

Sweden spends substantially more on health and long-term care than the EU average

In 2015, Sweden spent more on health per capita (EUR 3,835 pps in 2015) than the EU average. Health spending measured as a share of 11.0% of GDP was considerably above the EU. Health spending is expected to continue to rise due to a number of factors, including population ageing, technological progress and rising incomes: between 2013 and 2060 public spending on health as a share of GDP is projected to increase by 0.4 percentage points, which is below the EU average (0.9 percentage points). Long-term care spending accounted for 2.9% of GDP in 2015, which is considerably higher than the EU average (1.1%37). Administration accounted for a lower share of health spending in Sweden (1.7%) than for the EU on average (2.9%).

Health spending in Sweden is primarily funded from government sources

In 2015, 83.7% of Sweden's health spending came from regional government sources, which was considerably higher than in other EU countries and the only source of public funding. The remaining spending was made up of households' out-of-pocket payments (15.2%, slightly below the EU average of 22.5%38) and voluntary schemes (1.1%, below the EU average of 5.1%39).

A decentralised national health service provides universal coverage

In a regionally based national health service that raises revenues from central, regional and municipal taxes, regions and municipalities fund and provide a wide range of health services covering all of the resident population.

Population coverage is high but rules for service coverage and user charges vary across regions

Sweden's Health and Medical Services Act stipulates that health care shall be provided on equal terms for the entire population. This means that all residents are automatically entitled to publicly funded health services. Even though Sweden has a broad benefit package and a health care law with a strong focus on equity and needs-based health provision, the administrative structure with 21 autonomous regions leads to somewhat different service coverage rules across the country. Direct user charges (flat-rate payments) exist for nearly all types of services and goods, except for maternal and child health services provided in primary care settings. Apart from prescribed medicines and dental services, user charges are independently set at the regional level, leading to variations across the country. National ceilings for co-payments are in place, separately for health care services, prescription medicines, health-related transport and therapeutic appliances. Cost-sharing exemptions exist for children, adolescents, pregnant women and older people. Dentistry has separate and less generous coverage and no cap on cost-sharing.

Patients in Sweden benefit from free choice of provider and are guaranteed timely access to care

Free choice of primary care provider and freedom of establishment for accredited primary care providers are nationally mandated in Sweden. There is no formal gatekeeping in most regions and patients are free to contact specialists directly, though the structure of user charges incentivises patients to use primary care. Furthermore, a health care guarantee act stipulates maximum waiting times for a range of services. The act defines a "0–7–90–90" rule, which guarantees: same day contact with the health care system; seeing a GP within seven days; consulting a specialist within 90

37 The average is calculated on the available data for 22 Member States.
38 The average is calculated on the available data for 22 Member States.
39 The average is calculated on the available data for 22 Member States.

days; and waiting no longer than 90 days after being diagnosed to receive treatment. However, compliance with this waiting time guarantee varies largely across the country and no region has been fully able to meet these rules. Work is ongoing to strengthen the health care guarantee. Within three days, people should receive a medical assessment from legitimate healthcare professionals, tailored to their own needs.

Regions are responsible for funding and providing health services under the supervision of the central government

The responsibility for financing, purchasing and providing all individual health services in Sweden is decentralised to 21 regions and 290 municipalities. The municipalities are responsible for elderly care, home care and social care, while the regions are responsible for primary, psychiatric and specialist health care. The central government plays a regulatory and supervisory role through the Ministry of Health and Social Affairs together with relevant public agencies. It provides additional funding through general block grants, earmarked funding for outpatient pharmaceuticals and specific national programmes.

Most hospitals are publicly owned, but many primary care providers are private

In Sweden, there is a mix of publicly and privately owned health care facilities, but they are largely publicly funded. Highly specialised care, requiring the most advanced technical equipment, is concentrated in seven public university hospitals. There are also about 70 public hospitals at the regional level of which about two-thirds provide acute care on a 24/7 basis. In addition, Sweden has six private hospitals of different size and profile. Primary care is provided by over 1,100 primary care units, of which 42% are private, although the ownership structure differs widely between regions. The share of private primary care providers has increased rapidly in recent years.

The number of physicians and nurses is relatively high

Compared to other EU countries, Sweden has a relatively high number of physicians and nurses. In 2014, there were 419 practising physicians and 1,188 nurses per 100,000 population, both above the EU average40 (respectively, 341 and 734 per 100,000 population). Most physicians have a recognised specialisation, with almost one-quarter of them being specialists in general medicine.

Policy Developments

Empowering patients has been at the heart of recent government initiatives

Strengthening the position of patients and stimulating patient engagement has been high on the Swedish health policy agenda. On 1 January 2015, the Patients Act entered into force with the objective to empower patients, for example by extending patients' choice of provider through increased entitlements to services outside the home region, as well as increased information for patients.

Current efforts focus on ensuring equality and equity of care across all of Sweden

Despite the emphasis on equality and equity in the Swedish Health and Medical Services Act, the decentralised health system leads to regional differences in service access and outcomes. As a result, current discussions focus on how care provision could be reorganised to reach greater harmonisation between regions and reduce regional disparities across the country. To this end, a government committee has studied possible ways to concentrate highly specialised care to ensure quality and equality. Based on the committee's proposal, a new decision-making process for highly specialized care has now been adopted and efforts to concentrate the highly-specialized care are under way. Another example is the establishment of six regional cancer centres in 2011, which work across regions, in order to improve prevention and service coordination in cancer care.

Recent public health efforts aim to tackle health inequalities between population groups

A recent major public health effort is the 2014 declaration by the government to eliminate all avoidable health gaps between population groups within one generation. Towards this objective, a Commission for Equity in Health was established in June 2015. The Commission presented their report in June 2017, describing the importance of a broad approach across many sectors of society, beyond health care and health risk factors, to close health gaps in the population.

JAF Health Results

Inequalities in self-perceived health as good are increasing in the last years and potential years life lost are not improving as at EU level

Inequality between income groups in self-perceived general health as good/very good is deteriorating in the past three years, although its level is around the EU average in 2015. Similarly, potential years life lost (for both women and men) is improving less than the EU average change, although the level is around the EU average in 2014. These variables are identified as health challenges.

Healthy life years outcomes are considerably better than the EU average, while self-reported 12-month depression symptoms is worse than the EU average.

[40] The average is based on the available data for 18 Member States.

Access: Indicators on access are around the EU average, while the number of doctor's consultations is lower than the EU average

In 2014, the number of doctor's consultations (2.91 times) is considerably lower than the EU average. Other access indicators are round the EU average.

Quality: Indicators on the quality of healthcare are generally good

No health challenges are identified in the quality domain. Screening for breast cancer is considerably better than the EU average. In-hospital mortality following AMI and stroke were better than the EU average in 2013.

Non-health determinants: Risk-factors are generally better than the EU average, with the notable exception of inequality in alcohol use

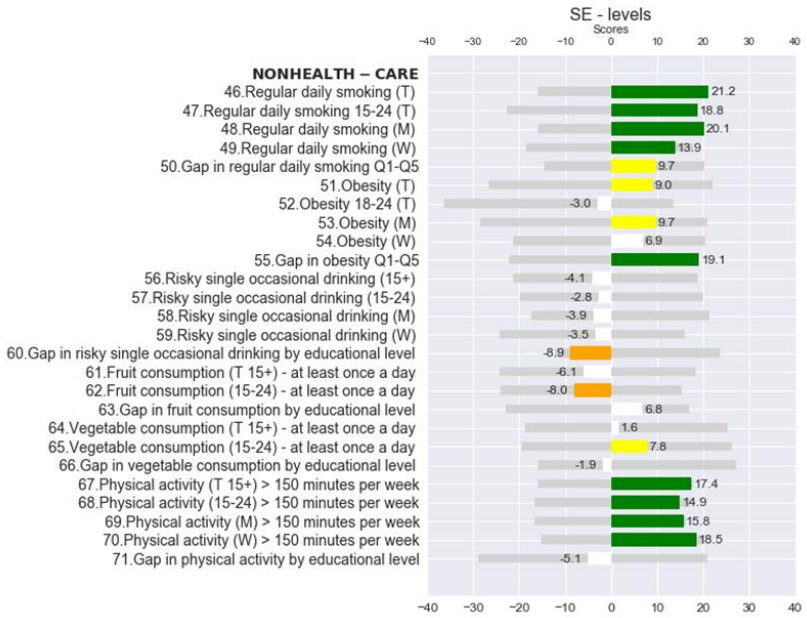
Data on risk-factors based on EU surveys are limited for Sweden compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

In 2014, inequality in alcohol use between low and high educated is worse than the EU average. On the other hand, regular daily smoking and physical activity are considerably better than the EU average.

Figure 53 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 54 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

United Kingdom

In the United Kingdom health spending per capita and health outcomes are both around the EU average. However, a number of health outcomes are deteriorating compared to the EU average change in the last years, including life expectancy and potential years of life lost. With spending on prevention higher than the EU average, some indicators on prevention (in particular colorectal cancer screening and influenza vaccination for older people) are better than average. Healthcare is universal and mostly funded by government outlays. Co-payments for NHS services are limited and coverage is very comprehensive, with some variation across devolved administrations. Indicators on access to healthcare are generally better than the EU average, in particular in terms of costs. The decline in the number of nurses and midwifes in the last years, with the risk of further reductions in the next years, is a concern for the future availability of care. In terms of non-health determinants, obesity and inequality in some risk-factors are an issue in the United Kingdom. Recent initiatives focused the integration of health and social care, as well as on cost control.

Health spending per capita is around the EU average, but spending on long-term care and prevention is higher

Health spending per capita is around the EU average, but spending on long-term care and prevention is higher

Health spending per capita in the UK, which stood at 2,910 pps in 2015, was around the EU average, but health spending measured as a share of GDP (9.9%) was above the EU average. Health spending is expected to further rise due to a number of factors, including population ageing, technological progress and a rise in incomes: between 2013 and 2060 the percentage of GDP spent on health is projected to increase by 1.3 percentage points in the UK, which is comparable to the EU average (0.9%)[41]. The UK spent 1.8% of GDP on long-term care in 2015, which is above the EU average. Spending on prevention is considerably higher than the EU average, at 5.2% of total health expenditure. Otherwise, the spending structure does not differ notably from other EU countries.

Healthcare expenditure in the UK is primarily funded through government outlays

In 2015, 79.5% of total health spending came from government outlays, which is considerably higher than in other EU countries. The proportion of care funded through compulsory insurance was considerably lower than on average in the EU, at only 0.1%. The remaining spending was made up of households' out-of-pocket payments (14.8%, slightly below the EU average), and voluntary schemes (5.6%, similar to the EU average).

The UK relies on National Health Services to fund and provide care

The United Kingdom is made up of four devolved health systems (England, Scotland, Wales, and Northern Ireland). The four nations have National Health Service (NHS) models, funded through taxes, which provide the population with comprehensive coverage, and where services are provided by a mix of private and public providers. The UK government allocates money for health care in England directly, and transfers block grants to the devolved administrations for all devolved services (including but not limited to health). Subsequently, Scotland, Wales and Northern Ireland set their own health budgets.

Population coverage is universal

The NHS provides universal access to comprehensive public services for those ordinarily resident in the United Kingdom. All persons who are not ordinarily resident in the United Kingdom or EU citizens must pay the full cost of any treatment provided. Although this was nominally the case in the past, coverage has been restricted in practice over recent years. Since April 2015, non-European Economic Area migrants must have 'indefinite leave to remain' (a special immigration status) before accessing free NHS hospital care and all users are expected to demonstrate entitlement. All asylum-seekers and refugees are entitled to register with a GP and receive free NHS hospital care; however, coverage for irregular migrants differs across the parts of the United Kingdom.

NHS coverage is very comprehensive with some variation across devolved administrations

There is no explicit list of benefits although there is a legal requirement for the system to deliver necessary health services and a commitment to patients' rights. In addition to primary and secondary care, the NHS covers district nursing, midwifery, health visiting, family planning and physiotherapy services, and free transport to hospital based on medical if required. To varying degrees, devolved administrations and local authorities make decisions about what services they will provide given budgetary constraints. Although the NHS provides largely comprehensive care, there are variations in coverage for some services and growing numbers of examples of local rationing, for example of in vitro fertilisation or elective surgery (termed 'the postcode lottery').

41 For the country and the EU, the increase in public health spending as a share of GDP refers to AWG reference scenario of EC (2015) for the period 2013-2060.

Co-payments for NHS services are limited but direct payment for long-term care can be substantial

For NHS services, out-of-pocket payments remain low and relate largely to prescription charges (mainly in England), cost of glasses and dental care. Some population groups are exempted from co-payments. Generally, this refers to children, pensioners over 65 and people with low income. Outside of NHS care, private spending on long-term care can be substantial. Local authorities are responsible for funding public long-term care but people above an asset-threshold have to cover most of the costs themselves.

The four countries are separate but all organise care based on a national health system

Each of the United Kingdom nations has its own advisory, planning and monitoring framework for its health system and its own public health agencies. Although the way in which services are organised and paid for has diverged, the NHS model applies in all four countries. Devolution means health boards in Scotland, Wales and Northern Ireland decide what treatments will be funded, while in England the 211 clinical commissioning groups make decisions about the services available to their local population – although highly specialist care is still commissioned nationally.

Primary care plays a central role in care provision

Throughout the UK, primary care is generally provided by teams of health care professionals in private practices, comprising GPs, nurses and therapists, and GPs have a gatekeeping role for specialist care. These practices are funded mainly by capitation, with fee-for-service for some additional activities and a relatively large performance component based on the Quality and Outcomes Framework (QoF). Most secondary care is provided by salaried specialist doctors in NHS hospitals. For inpatient care, local clinical commissioning groups pay hospitals based on activity at nationally determined tariffs. Tertiary care services for the most complex cases and rarer diseases tend to be delivered in facilities linked to medical schools. There has been a move to concentrate specialised care in fewer centres as a way of improving quality.

The number of physicians is below the EU average, and the number of nurses and midwives is decreasing

In recent years, the number of physicians in the UK has increased less than in other countries, and in 2015 the UK had 279 practicing physicians per 100,000 population, which is below the EU average. The number of nurses and midwives has decreased considerably more than in other EU countries, however, in 2015 there were 838 per 100,000 population which is similar to the EU average. There are a number of reasons for the decrease in nurses and midwives, including the introduction of language testing to qualify for registration. The NHS has been very reliant on the international recruitment of health workers in the past, hence there are concerns about future availability of health staffing once the United Kingdom leaves the EU.

Policy Developments

The integration of health and social care is a growing focus

Health and social care are divided in England, Scotland and Wales, where social care (including long-term care) is funded through local governments and mostly privately provided. In England, integration of health and social services is being pursued through the Better Care Fund (5.9 billion pounds sterling in 2016–17) and in a Greater Manchester pilot, which controls a unified budget. Efforts towards integration are also underway in Scotland. Northern Ireland is already pursuing an integrated approach.

Cost control, addressing variation and disease prevention are used to reduce the funding gap

A potential GBP 30 billion mismatch between resources and patient needs by 2020–21 has led the government to commit to extra funding for the NHS England for the next years. In addition, NHS England has three main approaches to generate efficiency gains: cost control by restricting pay rises for NHS staff and through the voluntary Pharmaceutical Price Regulation Scheme; addressing variations in treatment and cost by encouraging benchmarking and best practice; and fostering more appropriate use of services (managing people in the community) and tackling population health upstream (by improving health behaviours). Since 2015, England has encouraged a range of initiatives on new models of care, with 'vanguard' sites piloting new organisational forms and contracting arrangements to improve coordination and deliver more care outside hospital.

Purchasing and delivery models are currently moving away from competition-based markets

In 1990, a purchaser–provider split was introduced in the NHS, which charged local health authorities with commissioning care for their populations, and additional initiatives set out to foster privatised service delivery and internal competition. However, the most recent English policy position (2017's Next Steps on the Five Year Forward View) de-emphasises the role of markets and competition. It signals a scaling back of the purchaser–provider split in favour of new models of care that foster collaboration at local level. Scotland and Wales abolished the purchaser–provider split and have been less market-focused but also see targets and integration as important levers for higher quality, more cost-effective care.

JAF Health Results

Health outcomes in United Kingdom are around the EU average, but a number of outcomes are deteriorating in the last years

In 2015, life expectancy at birth (81 years) is around the EU average, but it shows a negative development compared to the EU average change over the past three years (both for women and men). Life expectancy at 65 for women, healthy life years at 65 for men and self-perceived general health as good/very good show negative developments in the past three years, although their levels in 2015 are still around the EU average. Similarly, potential years life lost among men is around the EU average in 2014, but it decreasing less than, on average, across the EU since 2011. These variables are identified as health challenges.

Access: Data on access dimension are generally better than the EU average

The available indicators do not show any challenge in the access domain. In 2016, unmet need for medical care due to cost (0.1%) is better than the EU average.

Quality: Indicators on the quality of healthcare are generally better than the EU average

No health challenges are identified in the JAF Health quality domain. Screening for colorectal cancer and the influenza vaccination rate for 65 year-old and older are, respectively, better and considerably better than the EU average.

Non-health determinants: Obesity and inequality in some risk-factors are an issue in the United Kingdom

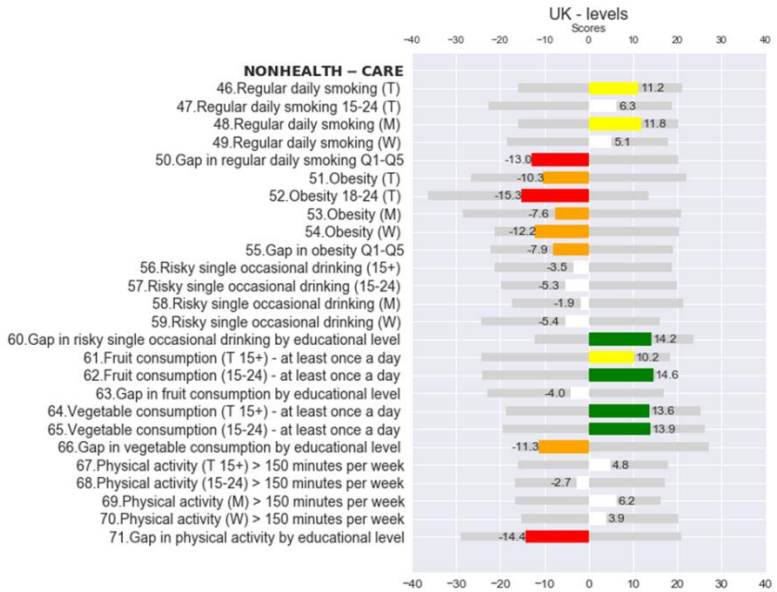
Data on risk-factors based on EU surveys are limited for the United Kingdom compared to other EU countries, specifically due to the lack of data in the 2008 wave of the European Health Interview Survey.

In 2014, the obesity rate (especially among young) is worse than the EU average. Inequality in risk-factors by income or educational groups is an issue in the United Kingdom. Indeed, inequality in regular daily smoking, obesity (as measured by the gap between the bottom and top income quintile), vegetable consumption and physical activity (as measured by the gap between low and high educated people) are worse or considerably worse than the EU average. On the other hand, fruit and vegetable consumption among young are considerably better than the EU average.

Figure 55 - JAF HEALTH PROFILE CHARTS FOR MAIN DIMENSIONS (STANDARDISED SCORES), LEVELS (LEFT BAR) AND 3-YEAR CHANGES (RIGHT BAR)

Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.

Figure 56 - JAF HEALTH PROFILE CHARTS FOR NON-HEALTH DETERMINANTS (STANDARDISED SCORES)



Notes: time changes for indicators with * (based on EHIS data) are provisional. The comparability of EHIS wave 1 (2008) and wave 2 (2014) is under assessment by Eurostat.