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Sustainability

Delegations will find attached the Commission's Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability- Country Documents.

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Joint Report on Health Care and Long-

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Sustainability- Country Documents

prepared by the European Commission (DG ECFIN)

and the Economic Policy Committee (AWG)

EUROPEAN ECONOMY

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The Economic Policy Committee (EPC) together with the Ageing Working Group (AWG), in cooperation with Commission services (Directorate-General for Economic and Financial Affairs) carried out an analysis of health care and long-term care systems in the EU.

This is the second part of the Joint Report on Health Care and Long-term Care Systems and Fiscal

Sustainability (European Economy, Institutional Paper 037, Volume 1, October 2016). This part of the report describes the health care and long-term care systems of all EU Member States on a country basis and presents the related policy challenges.

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1. HEALTH **CARE** SYSTEMS

1.1. AUSTRIA

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General context: Expenditure, fiscal sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population

Austrian GDP per capita has been among the

highest in the European Union over the last

decades and in 2013 amounted to 33,192 PPS,

compared to the EU27 average of 27,880 PPS. The

global financial and economic crisis has pushed

the Austrian economy into a deep recession with

economic growth slowing down from 3.4% in 2007 to -4.1% in 2009. Following the swift recovery of the pre-crisis GDP level during 2011, growth has remained sluggish but has recently shown signs of picking up. Correspondingly the more recent numbers indicate a slow but stable GDP growth at 0.9% in 2015, expected to further increase to more than double the rate in 2015 at 1.7% and 1.6% in 2016 and 2017 respectively (1). Fiscal consolidation to bring government revenues and spending into line in the coming years may have some consequences for the health care sector through consolidating current measures to improve its efficiency.

In terms of population, the Austrian population was around 8.5 million in 2013, slowly increasing over the last decade (8.1 million in 2003). It is projected to further increase by 1.2 million from 2013 to 2060, reaching 9.7 million.

Total and public expenditure on health as % of GDP

Total expenditure on health is one of the highest in the EU: 11.0% of GDP in 2013, slightly increasing over the last decade (10.3% in 2003). This is above the EU average of 10.1% in 2013. Public

expenditure on health amounted to 8.4% of GDP in 2013, putting Austria on the high end of the European spectrum, above the EU average of 7.8 %. When measured in per capita terms, in 2013 Austria was among the highest in terms of total expenditure (3,821 PPS vs. the EU average of 2,988) and public spending (2,895 PPS vs. 2,208 PPS).

(1) European Commission (2016), European Economic Forecast Winter 2016.

Expenditure projections and fiscal sustainability

As a result of ageing, health care expenditure is projected to increase by 1.3 pps of GDP (that is higher than the EU average foreseen of 0.9 pps

When taking into account the impact of nondemographic drivers on future spending growth

(AWG risk scenario), health care expenditure is expected to increase by 2.0 pps of GDP from now until 2060, higher than the average (EU level: 1.6) (2).

Over both the medium and the long run, sustainability risks appear for Austria. These are primarily related to the strong projected impact of

age-related public spending (mainly healthcare and

long-term care, but pension spending trend is significantly above the EU average as well) (3).

Health status

The period 1980 –2010 saw a sharp rise in life expectancy, which grew by approximately one year every five years for women, and even more quickly for men (4). The Austrian population lives longer than the average EU citizens: life expectancy at birth of both women (83.8 years) and men (78.6 years) was higher than the EU averages of 83.3 and 77.8 years in 2013 (5).

Healthy life years, although with minor fluctuations, have remained quite stable during the past decade (6) and in 2013 this amounted to 60.2 years for women (compared to 61.5 years in the EU) and 59.7 years for men (compared to 61.4 years in the EU). Infant mortality of 3.1‰ (2013) is still slightly below the EU average of 3.9‰ (7).

As in most other European countries, in Austria non-communicable diseases remain the leading causes of morbidity and mortality. During the period 1995-2010, diseases of the circulatory system have been the most important cause of

(2) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(3) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

(4) HiT (2013).

(5) Data on life expectancy and healthy life years is from the Eurostat database.

(6) A break in series exists between 2003 and 2004, so the marked decrease in 2004 has likely a strong methodological component.

(7) Data on infant mortality is from the OECD database.

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death, both for men and women. However, a significant reduction in the standardised rates of these conditions was achieved during this period.

Although a reduction in the second most common cause of death, malignant neoplasms (cancer), was also achieved, their incidence did not fall as much as diseases of the circulatory systems. Of particular significance within the group of malignant growths are the smoking related cancers. This is the case for both men and women. Breast cancer also plays

a significant role for women. Age-standardised cancer incidence rates are just under the average of the EU member states (8).

In terms of lifestyle-related risk factors, Austria can be classified in the middle of the EU countries.

While percentage of obese population (12.4% in 2006, latest recorded), and percentage of regular smokers (22.9% in 2008) are slightly lower than currently on average in the EU (15.5% and 22% respectively), alcohol consumption (11.9 litres per capita in 2011) is somewhat higher than the corresponding figure for the EU in that year (10 litres). In Austria, 15-year-old males, together with their contemporaries in Poland and Lithuania, show the highest increase in obesity. Traditionally, the provisions of social insurance law were strongly oriented towards a curative approach, but a series of legislative initiatives have been set up in the last decade, in order to enhance the approach to health promotion and prevention (9). Underlying data - and the projections hereafter - suggest that the authorities could continue their efforts to improve population life-styles.

System characteristics

The Austrian health care system has a complex

structure based on the federalist structure of the Austrian state. The regulatory responsibility for the health care sector lies with the federal government, with the exception of the system of hospitals. Concerning the latter, the Federal Republic enacts only basic laws, while their implementation and enforcement is under the responsibility of the states ("Bundesländer"). Social insurance providers are supposed to be self-governing bodies, which implies that they have important (8) HiT (2013).

(9) See for instance the Health Promotion Act of 1998, which established the Healthy Austria Fund, and the adoption in 2005 of the "New Preventive Check-up". regulatory functions, especially concerning outpatient health services (10).

System financing: taxed-based or insurancebased
The Austrian health system is financed from a mix of sources. In 2013, 75.8 % of expenditure was public, while 24.2% came from private sources. As for public spending, about 60% comes from health insurance contributions, while about 40% is financed from taxes, mainly general tax revenue; these proportions have remained pretty stable.
Revenue collection mechanism (tax/social

security contributions/premium)

Mandatory health insurance is based on mandatory

contributions paid by all employed people. The

contributions amount to a maximum of 7.65% of

the contribution basis (generally wage), and they

are mostly equally divided into two parts paid by

employer and employee, respectively (11). A

statutory 'maximum contribution basis' puts a

ceiling on the wages used for the calculation of the

contributions. In 2016 this ceiling amounts to EUR

4,860. The contributions are collected and

administered directly by the health insurance

funds.

Social security funds are the main source of

financing in the health system, accounting for

more than 50% of current health expenditure (12).

The financing of acute hospital care is partially

budgeted and is carried out according to

performance-related criteria within the framework

of yearly budget. The states, which are owners of

the hospitals, not only cover investment and

maintenance costs, but also contribute to the

current expenditure of the hospitals. Hospital debts

are also covered at federal level by the states.

(10) See also Austria - asisp Annual Report 2009.

(11) [http://www.selbsthilfeoesterreich.](http://www.selbsthilfeoesterreich.at/fileadmin/upload/doc/aktuelles/SVaktuell_2013-33_Neue_Betr%C3%A4ge.pdf)

at/fileadmin/upload/doc/aktuelles/SVaktuell_

2013-33_Neue_Betr%C3%A4ge.pdf.

(12)

[http://www.euro.who.int/ data/assets/pdf file/](http://www.euro.who.int/data/assets/pdf_file/0017/233414/HiT-Austria.pdf)

0017/233414/HiT-Austria.pdf, HiT Austria (2013).

In the quantification of this share as 50%, expenditure on longterm

care is excluded from total current health expenditure.

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Since 2013 Austria imposes a constraint on public spending on health via the budget process (13). The reform includes financial targets and the introduction of a budget cap on public expenditure on health (expenditure containment path). Over the period until 2016, the increase in public health

expenditure (excluding long-term care) will be gradually aligned with the expected average nominal growth of gross domestic product (plus 3.6% per year). In total it was agreed to contain expenditures by EUR 3.43 billion until 2016 by the regional governments (EUR 2.058 billion) and the

social insurance institutions (EUR 1.372 billion).

The finances for public health expenditure, mainly via the social insurance system, are raised and used in a decentralised manner; they are not subject to any budget-setting process, but rather result from the health insurance funds' obligation to ensure that services are in accordance with the current provisions of social insurance law (14).

Nevertheless, the health expenditure has remained stable over the last decade, as seen in the in the part covering general country statistics.

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions

As mentioned earlier, the Austrian health system has a complex structure based on the federalist structure of the Austrian state, with a multitude of relevant decision makers (15). Nevertheless, the level of expenditure in administering such a complex system remains about the EU average (16). Public (0.22%) and total (0.38%) expenditure on health administration and health insurance as a percentage of GDP is slightly below or about the EU average (0.27% and 0.47%

respectively in 2013), and so are public and total

expenditure on health administration and health

(13) Austria scored 0 out of 6 in the 2010 OECD scoreboard

due to the soft budget constraint.

(14) See HiT 2013.

(15) Irrespective of the reforms of 2005 (The 2005 Health

Reform), which were aimed at improving integrated

planning by the introduction of a Federal Health Agency, a

Federal Health Commission and a Structural Healthcare

Plan at the national level and of State Health Funds and

Health Platforms at the state level (Austria, ASISP Annual

Report 2009).

(16) Of course, we have to take into account the important share

of the health expenditure as a % of GDP, and the GDP per

capita itself.

insurance as a percentage of current health

expenditure (2.8% and 3.8% vs. 3.5% and 4.9% in

2013).

Health care insurance is provided by a number of

health insurance funds. They are decentralised

institutions, based on the self-management model.

The Central Association of Social-Insurance

Institutions coordinates the management of the

specific institutions. Insured individuals do not

have free choice of health insurance fund. They are

assigned a given fund according to the region in which they live or occupational group (e.g. salary and wage earners, farmers, civil servants, specific funds for miners, railway employees, etc.) they belong to. Given that the coverage of individual funds is clearly specified, and the funds cannot choose their members according to risk selection or any other criterion, there is no competition between them. However, individual institutions have a large degree of freedom in establishing their administrative procedures.

Coverage (population)

About 99 % of the Austrian population are covered by the social health insurance, organised as a compulsory insurance for people in gainful employment. The insurance contribution covers also dependent members of the family (their share amounts to about one third of the total number covered by the statutory health insurance), while the persons without insurance may have access to the health care system via means-tested social insurance.

Treatment options, covered health services

The benefits guaranteed by the social health insurance system include both in-kind and cash

benefits and do not depend on the level of contributions. Further, all health insurance funds are supposed to provide all necessary services. Still, the bundle of "necessary services" is not explicitly defined by law, which may lead to some variations between the funds.

Role of private insurance and out of pocket co-payments

Since an individual person apart from members of selected self-governed professions has no right to opt out from the statutory insurance, private health

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insurance serves predominantly as a supplement to the former and covers additional costs for treatment in private hospitals or serves as an insurance for daily benefits.

Hospitalised patients in standard class accommodation pay a fee of around EUR 11 per day for a maximum of 28 days per year. This fee is collected directly by hospitals. Here again, individuals who already pay a deductible as well as those in need of social protection are exempted from this regulation. The co-payment for

dependants of those insured is slightly higher (between 12 and EUR 19/day depending on the hospital) (17).

Private expenditure (e.g. patient co-financing and voluntary private health insurance) (18) represented around 24.2% of the total health expenditure in 2013, ranging between 23.5% and 25.4% throughout the decade. It is slightly above the EU average of 22.6% in 2013. Out-of-pocket spending accounts for 15.8% of total current health spending (slightly above the EU average of 14.1 % in 2013) and has registered a small but steady reduction since 2004 (17.9%) (19). The share of private health insurance expenditure amounted to 4.5% in 2012. The respective shares of public and private expenditure in the total health expenditure, as well as the specific out-of-pocket part, have remained quite constant over the last decade (20).

Types of providers, referral systems and patient choice

Patients who are insured in the mandatory social health insurance system, as well as their family members, are provided with E-Cards being certificates of entitlement to health services. For each accounting period, which is usually 1 or 3

months – depending on the insurance fund - a

patient can choose one general practitioner (GP)

(17) Source: HIT and sozialversicherung.at.

(18) This would be excluding Non-profit institutions serving

households and corporations other than health insurance,

source: OECD; (function: total current expenditure. No

possibility to split private sector for the function of total

expenditure).

(19) Note that since 2008, prescription charges are limited to

2% of the income for patients suffering from chronic

diseases.

(20) Austria scored about 6 out of 6 on the breadth, 6 in the

scope and around 5.5 on the depth of basic coverage

according to the 2010 OECD scoreboard.

and one specialist, for any specialty (21), by means

of his/her personal E-Card, which has replaced the

former health vouchers. For the issue of an E-Card,

a lump sum (22) deductible is paid. He/she can also

switch the contract physician with the agreement

of the health insurance fund (23).

A large share of primary care is provided by selfemployed

physicians who predominantly work in

individual practices. Patients have also direct

access to outpatient clinics which are run by both

the social health insurance schemes and by private

individuals. Outpatient care is mostly based on contractual relationships between individual private providers and insurance funds, but a large share of patients also opt for outpatient departments of publicly run hospitals.

Hence, private practices are run by self-employed physicians, about half of which are general practitioners and half specialists. The number and regional distribution of self-employed physicians is specified in the "location plan" drawn up by the health insurance funds and the Medical Chamber in order to avoid imbalances in the provision of

care. However, there are large differences between rural and urban areas.

Only around 47% of physicians (including dentists) in private practice have a contract with one or more health insurance fund. They exercise to some extent a gatekeeper function as they can control patients' flows by referrals. This is the case when several physicians are consulted in one accounting period or when hospital treatment is required. The other 53% private physicians who do not hold a contract with a health insurance fund do not require E-card intervention and mostly apply much higher fees, whereas their services are

reimbursed for four fifths of the fee which the health insurance funds would pay for a "contracted physician".

The number of practising physicians per 100,000 inhabitants (499 in 2013) is above the EU average (344 in 2013) and showing a consistent increase since 2003 (411). The number of GPs per 100,000 inhabitants (77 in 2013) is slightly below the EU

(21) For up to 3 specialists by period.

(22) EUR 10.85 in 2016.

(23) According to the OECD, the level of choice of provider in Austria had a score of 2.7 out of 6 in 2010.

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average (78.3 the same year), and has remained roughly stable during the past decade (75 in 2003).

This figure, paired with the high number of practicing physicians, suggests that the Austrian

health care system is currently hospital centred.

The number of practicing nurses per 100,000 inhabitants (787 in 2013) is below the EU average (837) having increased throughout the decade, from a level of 720 in 2003 (24). Still, there have been concerns about inequalities in the supply

structure between the states and also between urban and rural areas. In addition, staff issues may be reinforced by the fact that as many as 57.51% of all physicians were more than 45 years old in 2012 and many will retire in less than 10 years. These elements suggest that a comprehensive human resources strategy may be necessary in order to ensure that the skill mix stays in favour of a primary care oriented provision, without excessive recourse to it, and face regional disparities and staff ageing.

Hospital care is, according to the law, the responsibility of the states. The Federal Hospitals Act (KAKuG) stipulates that each state is obliged to ensure the availability of inpatient care for people who require it. The states establish the structure of inpatient acute care in quantitative and qualitative terms according to the specifications set out in health planning (HIT 2013). As such, inpatient care is predominantly provided by the public entities. A minor share is also organised by the private non-profit-making providers, who operate according to the public law and by private

profit-making hospitals (25). Hospitals which are subject to public law are obliged to admit and provide services to all patients, but are entitled to receive state subsidies for their day-to-day operations. On the contrary, private for-profit providers have the right to refuse patients, but must finance their operations on their own.

The management structure of the hospital sector changed considerably over the first half of the decade of 2000s, as public hospitals have been assigned operating companies which act according (24) Data for density of health personnel is taken from the OECD database. As this figure includes only nurses employed in hospitals, the actual number may be underestimated.

(25) 72.5% of acute care beds are in publicly owned hospitals, 18.8% in not-for-profit privately owned hospitals and 8.7% in for-profit ones.

to the private law. A similar change has taken place in the case of private non-profit making companies.

The empirical data suggest the overutilisation of the hospital care in Austria. The number of available acute care beds (535 per 100,000

inhabitants in 2013), although somewhat lower than a decade before (604 per 100,000 in 2003) is 50% higher than the respective amount in the European Union (356). At the same time, even if the curative care average length of stay of 6.5 days is about the EU average in 2013, the number of inpatient discharges per 100 inhabitants (26.6) is the highest in the EU, more than 50% higher than the EU average of (16.5). Consistently, the number of day-case discharges is lower than average (6,595 in Austria vs. 7,031 in the EU in 2013). Sectoral fragmentation, which also creates the bias towards hospital care, is a long standing weakness of the Austrian health care system. Therefore, it seems essential to improve the cost efficiency of the hospital care, by reducing the number of beds and replacing acute care stays with day-case treatments or outpatient treatment.

The physicians who operate their private outpatient practice are reimbursed by the insurance funds according to a mixed fee system, which combines lump-sum payment for basic services with fee-for-service for more complex treatments. The level and structure of payment is established in regular

negotiations between health insurance funds and the Medical Chamber and varies heavily across funds and specialties. In practice, specialists who execute more complicated or technical tasks (in the areas such as radiology or laboratory analysis) are paid almost exclusively according to a fee-for-service scheme, while general practitioners receive proportionately more often flat rate payments per basic case, which are accompanied by basic practice allowances and fees for home visits. The level of the flat rate fees for basic services varies according to specialty and state. In some states, in order to distribute the general budget more equally among the physicians, it is calculated on a decreasing scale, depending on the number of E-Card certificates invoiced per provider and per accounting period.

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About 50% (26) of specialists work exclusively in hospitals and are paid salaries, which vary across states. They can also treat private patients in public hospitals and earn additional incomes from these practices.

Hospitals are paid differently depending on the type of expenditure. Investment and capital costs are borne by the owners and operating companies. The ongoing operating costs are estimated prospectively based on the modified, activity-oriented diagnosis-related groups (DRGs). The units of calculation are points, whose value is established retrospectively at the level of the state by dividing the fixed budget by the number of points performed during the accounting period. In the DRG system two types of payments exist: the nationally uniform DRG core area and the DRG fund control area, which can vary according to the state. Health insurance funds also participate in the funding of hospitals by transferring a fixed share of their resources (about 35%) to the states' hospital funds.

In the core area, procedure- and diagnosis-oriented case groups form the basis for awarding points for an inpatient stay. A nationally uniform number of points is allocated for stays in a number of selected specialised units (intensive care, geriatric care, psychiatric day care, etc.), while special rules apply for stays which are longer or shorter than the

predefined bounds. Financing in the fund control area can be modified by the individual states, which gives them an opportunity to take into account different structural criteria (e.g. hospital type, staff, equipment, state of hospital buildings, utilisation of capacities, quality of accommodation, etc.) when distributing financial resources among the hospitals.

The activity-related hospital financing DRG system was introduced in 1997. The main effect of this measure was a shortening of the average length of stay, but also increased hospitalisations and a shift towards high scoring diagnoses (27).

(26) Hofmarche, M., Quentin, W. Austria: Health system review. Health Systems in Transition, 2013; 15(7): 1– 291.

(27) As a result, the OECD score for remuneration incentives to raise the volume of care in Austria is 3 out of 6.

The market for pharmaceutical products
Expenditure on pharmaceuticals (28) is below the EU average both when measured as % of GDP (1.2% vs. 1.44% in 2013), and when calculated as percentage of total current health expenditure (11.9% vs. 14.9% in 2013).

Austria applies external price referencing when establishing maximum price for reimbursed

pharmaceuticals. The price of drugs, taking into account ex-factory and wholesale price level, is included in the Reimbursement Code - or "EKO" ("Erstattungskodex"), in place since 2005 - and cannot be higher than the EU average price, as established by the Pricing Committee.

All reimbursable pharmaceuticals are explicitly listed in a list annexed to the Austrian Social Insurance Law. The cost-sharing mechanism takes the form of a flat rate fee paid for each prescription by all patients, apart from socially disadvantaged people (in particular elderly pensioners with an income below a certain threshold and persons with communicable diseases) who are exempted.

Moreover, a ceiling on prescription fees (Rezeptgebührenobergrenze) was introduced in 2008. Patients have to pay the flat rate prescription fee until it exceeds the threshold of 2% of their annual net income. Patients pay out-of-pocket for over-the-counter and non-reimbursable pharmaceuticals, but in some precisely determined circumstances, they can apply for individual reimbursement, which requires an ex-ante approval of the head physician.

Rational prescribing is ensured through the

Economic Prescription Guidelines published by the Main Association of Social Security Institutions (MASSI) in 2004. These guidelines encourage doctors to prescribe the most economical pharmaceutical out of several therapeutically similar alternatives (29). Health (28) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 (pharmaceuticals and other medical nondurables) in the OECD System of Health Accounts. Note that this SHA-based estimate only records pharmaceuticals in ambulatory care (pharmacies), not in hospitals. Data is taken from the OECD database.

(29) Vogler, S., Schmickl, B., Zimmermann, N., Short PPRI / PHIS Pharma Profile Austria 2013. Vienna: Pharmaceutical Pricing and Reimbursement Information (PPRI) / Pharmaceutical Health Information System (PHIS).

<http://whocc.goeg.at/Literaturliste/Dokumente/CountryInfo>

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funds also monitor the prescribing patterns of GPs and specialists who are under contract with them, and provide them with information leaflets and

newsletters (30).

Use of Health Technology Assessments and

cost-benefit analysis

A national Health Technology Assessment (HTA)

strategy was published in 2010, establishing

common goals of the major decision-makers in the

health-care sector and creating a framework for

expanding the use of HTA. The evaluation of

health technologies as an instrument to support or

to control their dissemination and use or to help

define policies is increasingly referred to by the

public health insurances and hospitals. Several

academic institutions (31) are carrying out full

Health Technology Assessments. At the same

time, within the reimbursement institutions (health

insurances, hospitals) some form of evaluation

reflecting the institution's perspective is

increasingly implemented. Health Technology

Assessment as an instrument for health technology

regulation is nowadays often being used: for

coverage and fee-setting in the private practices of

the outpatient sector; to establish a positive list of

the pharmaceuticals that are covered by the public

health insurance scheme; as a controlling

instrument in hospitals for obvious inefficient

practice styles; as planning or reimbursement tool

for new surgical interventions; by the medical

community for professional training and education.

eHealth, Electronic Health Record

In 2012 the Austrian parliament passed a law to

strengthen eHealth in the Austrian health care

system by introducing the Electronic Health

Record (ELGA).

The Electronic Health Record (ELGA) is an

information system that offers personalised health

data to the individual citizens and to their health

rmationReports/Short_PPRI_PHIS_Pharma_Profile_Austri

a_2013_final.pdf.

(30) Vogler, S.; Zimmermann, N., (2013), 'How do regional

sickness funds encourage more rational use of medicines,

including the increase of generic uptake? A case study

from Austria', Generics and Biosimilars Initiative Journal

(GaBI Journal) 2/2:65-75.

(31) Currently: LBI-HTA, GÖG, Donau-Uni Krems, Med-Uni

Graz, UMIT.

service providers (hospitals, pharmacies, general

practitioners, specialists, etc.). Doctors can access

individual medical exams, prescriptions and other

relevant health information independently from

location and time in order to support their

decisions and diagnoses.

ELGA aims to raise quality of care and thus patient safety. It also helps to avoid duplication of medical exams and ensures the information flow between health care providers' crosslinking interfaces.

Patients are generally free to opt out of ELGA, but also have the right to ban only certain information within the portal or even a single health care provider from usage. Patients will also be able to check who is accessing their individual record.

Access to ELGA is limited to health care providers. Private companies, health insurers or employers are strictly banned from accessing the health records. The functionalities of ELGA will be implemented stepwise.

Health and health-system information and reporting mechanisms

In the past few years, great efforts have been made to build and expand information systems in the health care system with the principal aim of increasing transparency. A series of national guidelines on the systematic documentation of

services and costs, particularly in inpatient care,

were recently issued or refined.

Health promotion and disease prevention

policies

As introduced, some socio-economic risk factors could translate into an important burden of disease and financial costs. This is why the authorities have emphasised somewhat health promotion and disease prevention measures in very recent years.

Currently, public and total expenditure on prevention and public health services as a share of GDP (0.15% and 0.19% in 2013) are close, though slightly below, to EU average (0.19% and 0.24% in 2013). The figures are below average when measured, as a % of total current health

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expenditure (2.0% vs. 2.5% and 1.9% vs. 2.5% in 2013) (32).

Transparency and corruption

Since 2008, anti-corruption legislation has aimed to increase transparency in the formation of waiting lists and to minimise the incentive to make and solicit informal payments but were relaxed

slightly again in 2009 (HiT). Doctors have to abide by the medical association's code of conduct (33), which regulates in this context the cooperation between doctors and pharmaceutical industry regarding attendance at conferences, acceptance of gifts or professional samples. Patients have the possibility of complaint; there are ombudspersons and patients advocates in charge.

Improving transparency within the health care system is also a major target of the health reform 2013. The target includes improvement of information systems on the organisation of the system, on providers and services, on the "best point of service" for patients according to their needs, and on the quality of treatments. Equal attention is paid to measures that contribute to the improvement of health literacy of the population and of communication skills of health care providers. Transparency is also improved by the obligation to publish major reform documents and evaluation reports.

Recently legislated and/or planned policy reforms

In order to address the major challenge (fragmentation) of the Austrian health system the

Ministry of Health started a reform process in December 2010 by drawing the roadmap for a health reform in the next years. The key element of the reform is a cooperative “governance by objectives” approach for achieving targets which will guarantee better coordination within the system.

With the reform of the Austrian Internal Stability

Pact, agreement was reached to limit health

(32) Data on expenditure on prevention and public health services was taken from OECD.

(33) <http://www.aerztekammer.at/>.

documents/10431/19066/%C3%84rztlicher+Verhaltenskodex+konsolidierte+Fassung/4ce3afe0-57d0-4cc4-923a-0dab81fe045f?version=1.0&t=1387379387000.

expenditure growth. In the context of the health system reform plan (2013-2016) the different layers of government agreed to limit public health expenditure growth from 2016 onwards so that it remains in line with expected average nominal GDP growth.

Major elements of the health reform are: 1) the creation of institutional capacity for the effective realisation of the “governance by objectives”

approach, 2) enhanced primary care capacity, 3)

standardisation of care processes, 4) monitoring of

health indicators and 5) the definition of

accounting standards to better enable adherence to

the budget cap.

The reform also includes financial targets and the

introduction of a budget cap on public expenditure

on health (expenditure containment path). Over the

period until 2016, the increase in public health

expenditure (excluding long-term care) will be

gradually aligned with the expected average

nominal growth of gross domestic product (plus

3.6% per year). In total, it was agreed by the

regional governments (EUR 2.058 billion) and the

social insurance institutions (EUR 1.372 billion) to

contain expenditures by EUR 3.43 billion until

2016.

Thus, a contract between the federal government,

social insurance and the states was signed to

formalise both health and financial targets

("Bundes-Zielsteuerungsvertrag"). The contract is

divided into four key areas (1) the structure of

provision, (2) the process of care, (3) outcome and

health targets and (4) financial targets. The key

areas define 26 operative objectives together with actions and target measures. The contract will be updated in 2016 including adapted financial targets and a new budget cap.

In order to raise institutional capacity the “Federal Target-Based Governance Commission” has been established in 2013 as a new cooperative decisionmaking body. Since 2013 the “Federal Health Commission” together with the “Federal Target-Based Governance Commission” is responsible for steering and controlling the Austrian health care system. At the state level, nine “Provincial Target-Based Governance Commissions” were established in order to ensure “governance by objectives”. Based on the standards of the federal contract, also the “Provincial Target-Based Governance

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Commissions” set up contracts between states and the social insurance funds to concretise the federal targets at the state level.

It is promising that the states’ healthcare expenditure, having for many years exhibited a rate of growth above that of other levels of

government and above nominal GDP growth, has

been much better controlled in recent years.

According to the monitoring reports, most of the

federal states reached their financial targets in

recent years.

Nevertheless, given that the estimated average

nominal GDP growth of 3.6 % proved to be

optimistic compared with the growth observed

since 2013, expenditure caps will have to be

revised downwards. As a consequence, compliance

may turn out to be more difficult in the future, not

least against the background of the full effects of

an ageing population.

Challenges

A range of reforms have been implemented in

recent years – or are still in the process of gradual

implementation – implying substantial structural

changes, with a focus on more integrated nationwide

planning, assuring and improving the quality

of the health system, and ensuring financial

sustainability of the health care system. As the

analysis above has shown, the main challenges for

the Austrian health system currently are as

follows:

- To continue increasing the efficiency of health

care spending in order to adequately respond to

the rising expenditure pressures over the

coming decades, which is a risk to the medium

and long-term sustainability of public finances;

- To explore if current cost-sharing could be

adjusted to discourage overuse/ encourage

better use of more effective and cost-effective

services – e.g. use of primary care rather than

specialist care, and notably more health

promotion and disease prevention activities

(e.g. vaccination);

- To correct the misalignment between revenue

generation and spending, currently

characterised by a high level of

decentralisation, to improve coordination at

sub-federal level and increase efficiency in the

provision of health care and reduce

unnecessary costs;

- To continue to develop a comprehensive

human resources strategy that tackles

spatial/regional disparities – inequalities

between the states and between urban and rural

areas – and that ensures sufficient numbers of

staff in general and in the future in view of

population ageing;

- To tackle the excessive degree of

hospitalisation, one of the major drivers of the

high spending, deriving from the fragmentation

of competencies between different government

levels, where states and local governments are

both involved in providing hospital services,

while out-patient care is provided by social

security services, and the consequent weak

incentives to shift care from hospitals to

outpatient settings;

- To control more effectively the use of specialist

and hospital care, by strengthening primary

care as a gatekeeper and fostering the

coordination of care between primary,

secondary and hospital care. To this end, to

strengthen/improve the referral system and

ensure reimbursement of health care providers

delivers the incentives to pursue efficiency

goals;

- To improve the cost-efficiency within

hospitals, ensuring that care is provided in the most clinically appropriate and cost-effective way, for example by maximising the

proportion of elective care provided on a day case basis, day-of-surgery admission and containing unnecessary hospitalisation;

- To monitor and adapt, as necessary, the functioning and competences of the “Federal Target-Based Governance Commission” and the “Federal Health Commission” with a view to give room to further improve, cost control, quality management and efficiency. To monitor how the work of these governing bodies is aligned with fiscal targets established for health

care spending, as well as with national public health goals;

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- To improve data collection, especially in some crucial areas such as resources and care utilisation; to improve the patient information system;
- To foster the wide use of Health Technology

Assessment and information and

communication technologies in health care;

- To further enhance health promotion and disease prevention activities, promoting healthy life styles and disease screening given the most recent pattern of risk factors (smoking, alcohol, cardiovascular diseases).

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Table 1.1.1: Statistical Annex – Austria

Source: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 231 242 253 266 282 292 286 295 309 317 323 9289 9800 9934

GDP per capita PPS (thousands) 31.0 31.9 31.7 32.8 33.4 33.1 30.9 32.0 32.6 33.4 33.2 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 0.4 1.9 1.7 3.1 3.4 1.1 -4.1 1.5 2.5 0.4 -0.2 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 2.4 3.2 1.6 1.1 3.8 3.4 2.1 1.1 0.1 2.5 -0.8 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 10.3 10.4 10.4 10.2 10.3 10.5 11.2 11.1 10.9 11.1 11.0 10.4 10.1 10.1

Total current as % of GDP 9.8 9.9 9.9 9.7 9.7 10.0 10.5 10.5 10.2 10.4 10.1 9.8 9.6 9.7

Total capital investment as % of GDP 0.5 0.5 0.6 0.5 0.5 0.5 0.6 0.7 0.6 0.7 0.9 0.6 0.5 0.5

Total per capita PPS 2650 2805 2915 2992 3172 3343 3478 3561 3633 3796 3821 2828 2911 2995

Public as % of GDP 7.7 7.8 7.9 7.7 7.8 8.0 8.5 8.4 8.3 8.4 8.4 7.8 7.8

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Public current as % of GDP 7.4 7.5 7.5 7.5 7.5 7.7 8.1 8.1 7.9 8.0 7.7 7.9 7.7 7.7

Public per capita PPS 1848 1953 2033 2120 2238 2374 2444 2499 2780 2879 2895 2079 2218 2208

Public capital investment as % of GDP 0.3 0.3 0.4 0.3 0.3 0.3 0.4 0.3 0.4 0.4 0.7 0.2 0.2 0.1

Public as % total expenditure on health 74.6 74.7 75.3 75.6 75.8 76.4 76.2 75.5 76.5 75.9 75.8 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 14.8 14.1 15.2 15.5 15.4 15.8 15.6 15.5 15.4
15.3 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 98.0 98.0 98.0 98.5 98.7 98.8
98.8 98.8 99.9 99.9 99.9 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 16.3 17.9 17.8 17.4 17.3 16.9 17.0 17.2
16.9 16.7 15.8 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 8.1 8.1 8.2 8.3 8.3 8.3 8.3 8.4 8.4 8.4 8.5 502.1 504.5 506.6

Life expectancy at birth for females 81.5 82.1 82.2 82.8 83.1 83.3 83.2 83.5 83.8 83.6 83.8 82.6 83.1 83.3

Life expectancy at birth for males 75.9 76.4 76.6 77.1 77.4 77.7 77.6 77.8 78.3 78.4 78.6 76.6 77.3 77.8

Healthy life years at birth females 69.6 60.4 60.1 61.0 61.4 59.9 60.8 60.8 60.1 62.5 60.2 : 62.1 61.5

Healthy life years at birth males 66.2 58.3 58.2 58.7 58.7 58.5 59.5 59.4 59.5 60.2 59.7 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 71 56 54 52 48 47 45 43 96 97 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.5 4.5 4.2 3.6 3.7 3.7 3.8 3.9 3.6 3.2 3.1 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 3.44 3.45 3.46 3.42 3.38 3.48 3.66 3.65 3.57 3.66 3.44 3.13 2.99 3.01

Day cases curative and rehabilitative care : 0.03 0.03 0.04 0.04 0.05 0.05 0.05 0.05 0.07 0.07 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.49 2.43 2.47 2.41 2.44 2.43 2.63 2.59 2.53 2.55 2.55 2.29 2.25 2.24

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Pharmaceuticals and other medical non-durables 1.35 1.34 1.33 1.32 1.34 1.38 1.33 1.31 1.27 1.27 1.20 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.44 0.45 0.41 0.41 0.41 0.42 0.45 0.44 0.44 0.44 0.43 0.31 0.31 0.32

Prevention and public health services 0.17 0.20 0.20 0.19 0.19 0.19 0.19 0.19 0.18 0.18 0.19 0.25 0.25 0.24

Health administration and health insurance : 0.43 0.41 0.39 0.39 0.41 0.43 0.42 0.41 0.42 0.38 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.94 2.97 3.00 2.98 2.96 3.06 3.24 3.24 3.17 3.27 3.01 2.73 2.61 2.62

Day cases curative and rehabilitative care : 0.03 0.03 0.04 0.04 0.05 0.05 0.05 0.05 0.07 0.07 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.69 1.69 1.72 1.69 1.71 1.72 1.85 1.81 1.77 1.78 1.80 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.91 0.91 0.89 0.88 0.91 0.94 0.90 0.88 0.87 0.86 0.83 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.19 0.20 0.18 0.18 0.18 0.19 0.20 0.19 0.19 0.19 0.20 0.13 0.12 0.13

Prevention and public health services 0.15 0.17 0.17 0.17 0.17 0.16 0.16 0.16 0.16 0.15 0.15 0.25 0.20 0.19

Health administration and health insurance 0.22 0.24 0.25 0.22 0.23 0.24 0.25 0.25 0.24 0.23 0.22 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.1.2: Statistical Annex - continued – Austria

Source: EUROSTAT, OECD and WHO

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Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative **care** 35.1% 34.8% 35.1% 35.1% 34.7% 35.0% 34.7% 34.8% 34.9% 35.2%
34.1% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative **care** : 0.3% 0.3% 0.4% 0.4% 0.5% 0.5% 0.5% 0.5% 0.7% 0.7% 1.8% 1.9%
1.9%

Out-patient curative and rehabilitative **care** 25.4% 24.5% 25.0% 24.7% 25.1% 24.4% 25.0% 24.7% 24.7% 24.5%
25.3% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 13.8% 13.5% 13.5% 13.6% 13.8% 13.9% 12.6% 12.5% 12.4%
12.2% 11.9% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 4.5% 4.5% 4.1% 4.2% 4.3% 4.2% 4.2% 4.2% 4.3% 4.2% 4.3%
3.2% 3.3% 3.3%

Prevention and public health services 1.7% 2.0% 2.0% 2.0% 2.0% 1.9% 1.8% 1.8% 1.8% 1.7% 1.9% 2.6% 2.6%
2.5%

Health administration and health insurance : 4.3% 4.2% 4.0% 4.0% 4.1% 4.1% 4.0% 4.0% 4.0% 3.8% 4.2% 4.3%
4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative **care** 39.9% 39.8% 40.0% 40.0% 39.7% 39.8% 39.9% 40.1% 40.1% 40.7%
39.1% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative **care** : 0.4% 0.4% 0.5% 0.5% 0.6% 0.6% 0.6% 0.7% 0.9% 0.9% 2.0% 2.1%
2.3%

Out-patient curative and rehabilitative **care** 22.9% 22.6% 22.9% 22.7% 22.9% 22.4% 22.8% 22.4% 22.4% 22.1%
23.3% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 12.3% 12.2% 11.9% 11.8% 12.2% 12.2% 11.1% 10.9% 11.0%
10.7% 10.7% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 2.6% 2.7% 2.5% 2.5% 2.4% 2.5% 2.5% 2.4% 2.4% 2.4% 2.6%
1.6% 1.6% 1.6%

Prevention and public health services 2.0% 2.3% 2.3% 2.3% 2.3% 2.1% 2.0% 2.0% 2.0% 1.9% 2.0% 3.2% 2.7%
2.5%

Health administration and health insurance 3.0% 3.2% 3.3% 3.0% 3.1% 3.2% 3.1% 3.1% 3.0% 2.9% 2.8% 1.4%
3.5% 3.5%

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Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 1.35 1.59 1.62 1.68 1.77 1.80 1.84 1.86 1.86 1.91 1.92 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.9 0.9 0.9 0.9 0.9 : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants 2.7 2.9 3.0 3.0 3.0 3.0 2.9 3.0 2.9 3.0 3.0 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.1 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.1 0.1 0.1

Proportion of the population that is obese : : : 12.4 : : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : : : 23.2 : 22.9 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 12.4 12.1 12.2 12.5 12.5 12.0 11.7 12.1 11.9 : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 411 420 432 445 454 460 469 480 484 490 499 329 335 344

Practising nurses per 100 000 inhabitants 720 713 718 727 738 752 761 767 775 783 787 840 812 837

General practitioners per 100 000 inhabitants 75 76 76 77 77 77 77 78 78 78 77 : 78 78.3

Acute hospital beds per 100 000 inhabitants 604 596 588 583 581 575 568 560 554 546 535 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 6.7 6.7 6.7 6.7 6.8 6.9 6.9 6.9 6.9 6.8 6.8 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 26.6 27.4 27.3 27.7 27.9 28.1 27.8 27.6 27.3 27.0 26.6 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 4,132 4,294 4,487 4,834 5,113 5,457 5,501 5,690 6,018 6 ,348 6,595 6368 6530 7031

Acute care bed occupancy rates 85.0 88.0 86.0 87.0 87.0 87.7 86.9 86.2 85.5 82.7 80.2 72.0 73.1 70.2

Hospital curative average length of stay 7.2 7.2 7.0 6.9 6.8 6.8 6.7 6.6 6.6 6.5 6.5 6.5 6.3 6.3

Day cases as % of all hospital discharges 13.5 13.5 14.0 14.8 : 16.2 16.5 17.1 18.0 19.0 19.9 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 6.9 7.2 7.6 7.9 8.2 8.2

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AWG risk scenario 6.9 7.4 7.9 8.5 8.8 8.9

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 8.5 8.8 9.3 9.6 9.7 9.7

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

14.3 3.1

1.3 0.9

2.0 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

1.2. BELGIUM

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

With EUR 393 billion (2013), the Belgian share in the EU economy is some 4%. GDP per capita is with 30,340 PPS in 2013 above the EU average of 27,900 PPS. Economic growth decelerated in 2015, and it is projected to remain stable at 1.3% in 2016 to then increase to 1.7% in 2017 (34).

The population of the constitutional monarchy has increased during the past decade, from 10.4 million in 2003 to 11.2 in 2013. Over the decades

to come, the Belgian population is projected to continue to increase significantly, from 11.2 million in 2013 to 15.4 million in 2060 (35). This projected increase in population is much higher than that of the EU (37.7% vs 3.1%).

Total and public expenditure on health as % of GDP

Total expenditure on health, as a percentage of GDP, has steadily increased during the past decade, from 9.7% in 2003 to 11.2% of GDP in 2013 (36). Total expenditure in PPS is with 3549 higher than the EU average (2988 PPS per capita).

Public expenditure, after reaching a plateau at around 8.0% from 2009 to 2012, displays in 2013 a slightly wider gap with respect to the EU average than the past years (0.7% in 2013 vs 0.4% in 2011 and less than 0.1% in 2009).

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health **care** expenditure is projected to increase by 0.1 pps of GDP, below the average growth level expected for the EU of 0.9 pp of GDP, according to the AWG (34) European Commission (2016), European Economic Forecast Winter 2016.

(35) Eurostat 2013 Population Projections – Main Scenario.

Note that this number is considerably higher than the current (March 2016) Belgian national projection of 13.0 million in 2060.

(36) WHO Total Health Expenditure (Series 6710). Note that the AWG projection is based on Current Health Expenditures (10.2 % of GDP) as reported in the System of Health Accounts.

reference scenario (37). When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 0.5 pps of GDP from now until 2060, still lower than the average (EU level: 1.6).

From a sustainability point of view, the country faces both medium and short term challenges, driven by the high initial debt-to-GDP ratio and, especially over the long term, by projected cost of ageing (38).

Health status

With 83.2 and 78.1 years for women and men respectively, life expectancy at birth is in Belgium similar to the EU average in 2013 (83.3 and 77.8 respectively). The years spent healthy are, with 63.7 for women and 64 and for men, higher than the EU average (61.5 and 61.4, respectively).

Infant mortality, which represents the ratio of the number of child deaths under one year of age per 1000 live births, has declined to 3.5. This declining trend is noted throughout the whole of the EU, which averages around 3.9 in 2013.

System characteristics

System financing, revenue collection

mechanism, coverage and role of private

insurance and out of pocket co-payments

The responsibility for the regulation and financing of the compulsory health insurance lies with the federal government. It also creates the programmes and normative framework for the hospitals. In addition it governs the rules for recognition of providers and organises the registration of pharmaceuticals and their price and determines the rules for financing of healthcare infrastructure (such as costly medical equipment). At federal level, decisions are also made regarding which products and services can be benefitted from under the system.

The compulsory health insurance is combined with a mostly private system of health care delivery,

(37) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(38) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

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based on independent medical practice, free choice of physician and predominantly fee-for-service payment.

Financing for the healthcare insurance is obtained through employee and employer contributions and through a contribution from the state budget from the general taxation, complemented with alternative financing by earmarked taxes derived from VAT income. The budget for the system is fixed and is adjusted to inflation and, on top of that, according to a legally inscribed real growth

norm. Between 2004 and 2012, the health **care** budget was allowed to grow by 4.5% per year (since 2004), after adjustment for inflation.

However, the actual expenditures were growing slower on average, which, together with the aim of controlling public expenditure, has led to a

downward revision of the growth norm in the wake of the financial crisis. The norm was set to 2% in 2012 and 3% in 2013 and 2014. After the change in government in 2014 and the austerity policy it set out to pursue, the growth norm was set to 1.5% from 2015 onward.

Citizens contribute financially to the healthcare system according to their employment situation, their statute (preferential reimbursement or not) (39), the type of service they request and on the basis of the amount of user charges they have already paid during that year. Users of healthcare services will participate in health-care financing by paying a certain fixed amount of the cost of a service, with the third-party payer covering the balance of the amount. In 2001, Belgium introduced a system of maximum billing. The system has been designed as a structural measure to find a compromise between social protection of the weakest groups in society on the one hand and individual responsibility on the other hand. Thanks to this scheme, each household (both with high and low incomes) has, according to the family's net taxable income, an annual out-of-pocket ceiling for

all necessary health care expenses. The ceiling has a minimum and a maximum height.

Almost the whole population (> 99%) is covered for a very broad benefits package. Since January

(39) To qualify for preferential reimbursement the patient has to belong to a socioeconomically vulnerable group and have an income below a certain limit. In addition, patients with certain medical conditions or chronic diseases are exempted from cost-sharing.

2008, there is no longer any difference between health insurance coverage in the general scheme and the scheme for the self-employed, as the latter now includes the coverage of minor risks.

A large majority of the population hold voluntary health insurance (both complementary and supplementary), covering for example single room accommodation for hospitalised patients. These insurances are being provided by both the sickness funds and private for profit insurance companies.

Private health insurance is relatively limited in importance, as it represents between 4 and 4.5% of total health expenditure in 2013 (40), and covers mostly inpatient expenditure, even when larger coverage (ambulatory care and dental care) also exist.

Private expenditure (patient co-financing and voluntary insurance) in Belgium is higher than the EU-average (around 24.2% of total expenditure). This share used to be higher, but the share of public expenditure in the total has increased from 2003 to 2013 from 73.1% to 75.8%, closer to the EU average of 77.4%. Out-of-pocket expenditure alone, however, displays at 19.9% in 2013, a wider gap with respect to EU.

Administrative organisation

The compulsory health insurance is executed through six private, not-for-profit national associations of sickness funds and one public sickness fund. It is their major responsibility to reimburse health service benefits. The sickness funds are members of the National Institute for Health and Disability Insurance (NIHDI-RIZIVINAMI).

Since 1995 a trend has started to make Belgian sickness funds more financially accountable for their expenses made. They act collectively in their negotiations with health care providers.

The public expenditure in 2013 on healthcare administration and health insurance is in Belgium with 0.3% close to the EU average of 0.27% of

GDP.

(40) <http://ec.europa.eu/eurostat/web/health/healthcare/>

data/database (SHA).

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Treatment options, covered health services

The services that are covered by compulsory

health insurance, which is characterised as a fee-for-

service system, are described in the nationally

established fee schedule (more than 8000

services), the so called 'nomenclature'.

Types of providers, referral systems and patient

choice

National planning sets various targets and

accreditation norms that institutions must follow.

Access to professions is regulated by law. The

Belgian health system is mainly based on the

principles of equal access and freedom of choice.

All residents have to register to a Bismarckian type

of public compulsory health insurance

(sickness funds) which offers a very broad benefits

package (a positive list of goods and services is

defined at the central level).

Belgium has a well-developed system of primary

care. The service is provided through independent

general practitioners (GPs, or "family doctors").

Some GPs provide their services in group

practices. There are relatively many GPs in

Belgium, compared to other EU Member States

(112 vs 78.3 in the EU respectively per 100,000

inhabitants). The Belgian government aims at a

strengthening of the role of the GP, for example in

the treatment of chronic diseases. The current

apparent over capacity could facilitate that shift.

Specialist outpatient care is provided

predominantly in hospital outpatient departments

and at times in private group practices.

Day care and inpatient treatment is provided in

hospitals. Two thirds of the hospital acute beds are

owned by private not-for-profit hospitals. The rest

of the hospitals are publicly owned. The number of

acute care beds per 100 000 inhabitants (396 in

2013), while showing a reduction, is still above the

even faster decreasing EU average (356). Overall

there are compared to the EU average not so many

physicians per inhabitant in Belgium (295 per

100,000 compared to 344) (41). The amount of

(41) Note that the actual figures may be underestimated as

Belgium limits the count to physicians with a minimum amount of activity, whereas other countries count all physicians who have had at least one patient contact per year.

practising nurses per 100,000 inhabitants in Belgium on the other hand is higher than in the average EU level (932 in BE and 812 in the EU in 2011).

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Two systems of payment are implemented, the first one is a reimbursement system (for outpatient/

ambulatory care) and the second one is a thirdparty payer system where the patient pays only the

co-insurance or the co-payment (for inpatient care and pharmaceuticals). The third-party payer system is gradually being further enlarged and

implemented also in ambulatory care.

Most health care professionals are self-employed and are paid on a fee-for-service basis (publicly and readily available), with the patient partly reimbursed (generally at a rate of 75%) afterwards.

Indeed, less than 1% of the physicians working in hospitals are employees. Nurses are mainly salaried in comparison. To avoid competition between services from hospitals or from officebased specialists, the same national negotiated fee is imposed. However, when working in hospitals, the specialists allow the institutions to retain a proportion of the fees as compensation for the space, equipment, staff and additional services. The government sets the fees for GPs and specialists every two years following a bargaining process with all the concerned parties. Only noncontracted physicians can set their fees freely even if the contracted can, in some specific cases like activity outside core time for example, charge higher fees. The same principle applies to dentists, pharmacists and self-employed nurses. In Belgium the remuneration gap is particularly large between GPs and specialists with GPs earning three times less than specialists even if some efforts have been made recently to decrease this gap. A possibility has been created for GPs to receive compensation/pay for the management of chronic diseases.

Inpatient care is covered by the third-party payer

system. The patient pays a co-payment while the bulk of the cost is directly paid by the sickness fund to the hospitals. For the hospitals' running

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costs, a national budget (42) is set annually and paid to the hospitals via the sickness funds with an aim to make the hospitals accountable for their operations by means of financial rewards or fines.

Hospitals are paid on a combination of (43):

“common services” (about 25%) based on surface area, number of cases, number of patient days etc.,

“clinical services” (about 47%) based on volume and type of activity, intensity of nursing services and other activity indicators, and “legally required services” (general surgeon, hospital hygiene,

registry keeping, quality policy and monitoring,

hospital pharmacy) (about 14%) and other smaller

items. Hospital activity is very high, with hospital inpatient discharges slightly below the EU average

(15.8 vs. 16.4 per 100 inhabitants in 2011) but

more than compensated by substantially higher

than average (more than double) number of day

case discharges (15,149 vs. 6,530 in 2011). Day

case surgery has increased significantly in the last decade and the percentage of surgical procedures conducted as day cases in 2011 (48.9%) is much above the EU average during the same year (28.7%). From 1982, the "number of days" for an inpatient stay is subject to restrictions (pathology weighted) to discourage hospitals to extend stays for financial reasons. Despite that kind of control procedure, Belgium had for long time a hospital average length of stay above the EU average, though having decreased through the past decade. The average is currently 7.1 vs 6.3 days in the EU in 2011.

One of the key advantages of the Belgian system is that the precise price setting (flat rate) avoids unexpected fees for the patient. However, in hospitals, the patient's out-of-pocket contribution per day of hospitalisation may vary if there are additional costs for a single room, nonreimbursable products or non-publicly contracted physicians. Recent legislation however, obliges hospitals to provide a cost estimate of the treatment to the patient at the admission.

(42) This budget only covers about 50% of the hospitals' operational costs. The other half is financed by fee-forservice

payments by the NIHDl and patient out-of-pocket
(or private insurance) payments (mainly physicians' fees
and drugs).

(43) CM 2013, De organisatie en financiering van de
ziekenhuizen. CM Informatie nr. 253 (info fiche) [also
available in French].

The market for pharmaceutical products

Pharmaceuticals are exclusively distributed
through community pharmacies and hospital
pharmacies and their establishment is strictly
regulated since 1973.

Total expenditure in Belgium on pharmaceuticals
as a percentage of GDP has over the last few years
quite closely matched the EU average, going from
1.8 to 1.46% of GDP (44) (2013), with a EU
average of 1.44 in 2013.

About 2500 pharmaceuticals are reimbursable in
Belgium. The initial price of reimbursed drugs is
based on clinical performance, economic
evaluation and cost of existing treatments, and
looking at the average EU price. The amount
reimbursed is determined by the pharmaceutical
category that reflects the social importance of the
drug, pharmacotherapeutic criteria and price
criteria. The patient pays only the nonreimbursable

amount as a co-payment to the pharmacy. Authorities also use reference pricing whereby the reimbursement level of a drug is based on the prices of drugs that have the same active ingredient.

The sickness funds negotiate as a cartel with the drug companies on reimbursement rates under the supervision of the central government. The central government can also as an extreme measure oblige pharmaceutical firms to pay a special tax when expenditures on pharmaceuticals are too high (a sort of payback system). However, the main policy instruments to stem (public) cost increases during the last decade have been price regulation and increases in co-payments.

Since 2001, the use of generics has been stimulated by introducing lower co-payments for the users and lower reimbursement levels for branded drugs when generics are available.

Generic drugs must be at least 30% cheaper than originators. Doctors are encouraged to prescribe generic medicines through prescription quotas.

Pharmacists are encouraged to provide the generic drug when available, for some categories of drugs,

(44) Expenditure on pharmaceuticals used here corresponds to

category HC.5.1 in the OECD System of Health Accounts.

Note that this SHA-based estimate only records

pharmaceuticals in ambulatory care (pharmacies), not in hospitals.

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the substitution is compulsory (providing the patient with the cheapest or generic variant with the same active molecule of a prescribed drug).

Information on generics is provided to health professionals and to the public.

Authorities promote rational prescribing by physicians through compulsory guidelines and prescription quotas, complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines. They also promote education and information campaigns for patients.

Despite the success of the measures introduced so far, research (45) suggests that there is scope for further cost savings, which suggests progress towards the wider adoption of more cost-effective solutions should be pursued.

Use of Health Technology Assessments and

cost-benefit analysis

The Belgian Health **Care** Knowledge Centre has played a major role in conducting and gathering information on health technology assessment since 2003. Health technology assessment information has been used to define guidelines and determine coverage and level of reimbursement of new procedures, new medicines and new high-cost equipment.

eHealth (e-prescription, e-medical records)

Belgium has established a public institution for eHealth with the law of August 28 2008. The organisation's mission is 'to optimise the quality and continuity of health **care** provision and patient safety and to streamline administrative procedures by means of mutual electronic services and data exchange between all health **care** actors, while guaranteeing information security and respecting patient privacy (46).

The mission translates into a number of tasks, such as the development of software platforms for safe

(45) Cornelis, K., Het geneesmiddelenbeleid inzake goedkopere geneesmiddelen in België, Brussels, September 2013;

<http://www.cm.be/binaries/CM-253->

Geneesmiddelen_tcm375-130001.pdf.

(46) See <https://www.ehealth.fgov.be/nl/over-het-ehealthplatform/>

wetgeving/wet (only available in Dutch and French).

information exchange between health professionals

and between **care** providers and administrative services (the Federal Public Service for Health, Food Chain Safety and the Environment, the National Institute for Health and Disability Insurance, etc.) and managing and coordinating the ICT-related, organisational, functional and technical aspects of data exchange related to electronic patient records and electronic prescriptions. The organisation also acts as a 'trusted third party' for coding, anonymising and linking data requested by academic or public or private sector researchers.

Health and health-system information and reporting mechanisms

Monitoring and data collection has been widely

implemented in the Belgian health-**care** system.

Dedicated databases like Pharmanet, NMDS (47) or

HDS (48), allow the control of the medical practice of individual physicians (volume of activity, prescription activity) and whether it complies with treatment guidelines. It also enables among other things the monitoring of health problems and the epidemiological situation or the effectiveness and quality of hospital care. The global set of data is very wide even if the collection of data about voluntary private health insurance or about care and nursing homes could be improved. The performance of the Belgian health care system is monitored continuously and reported periodically (49).

Health promotion and disease prevention policies

In Belgium, the communities and partially the federal state are responsible for prevention, promotion and education on health. In 2013, public expenditure on prevention and public health services reached 0.32% of GDP, which is above the EU average (0.19%). The most recent health promotion campaigns included: healthy eating, organ donation, deadly accident prevention, abuse of antibiotics, promotion of vaccinations and

breast and cervical cancer screening.

(47) Nursing Minimum Data Set.

(48) Hospital Data Set.

(49) See: Vrijens et al. 2016, De performantie van het Belgische

gezondheidssysteem - Rapport 2015. KCE Rapport 259A

(Dutch and French).

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Transparency and corruption

In 2008 Belgium signed the 'Tallinn Charter' on

'Health Systems for Health and Wealth' at a

ministerial conference in Estonia organised by the

World Health Organisation European Office. One

of the commitments of the signing member states

was to 'promote transparency and be accountable

for health system performance to achieve

measurable results'. This commitment has fuelled

an ongoing policy debate in Belgium regarding the

best ways to improve the transparency of health

care provision. This debate focuses mainly on

using transparency to improve informed patient

choice and quality of service. One example of this

approach is to measure and publicise hospital

performance indicators. The feasibility of this idea

is currently being tested in Flanders as part of the 'Flemish Indicators Project'. Participating Flemish hospitals measure a number of performance or quality indicators on a voluntary basis and decide whether they publish the results online. Many of them also conduct patient satisfaction surveys on a regular basis (50).

A recent government bill has been approved aimed at improving the transparency of medical costs charged to patients. The bill aims to improve the disclosure of the details of the medical interventions and the associated full costs, both for the patients (co-payments and supplements) and for the health insurance funds (reimbursements).

Hospitals will have to provide patients with detailed information on expected costs before they are admitted.

Recently legislated and/or planned policy reforms

The main change in health care policy legislated in the recent years concerns the devolution of responsibilities (and shifts in associated budgets) for a number of health care tasks from the federal to the regional level (Flanders, Wallony and

Brussels) as a consequence of the 6th Reform of the State. The reform was signed into law on January 31 2014 and became effective on July 1 2014. While the transferred responsibilities mainly (50) See

[https://www.zorg-engezondheid.](https://www.zorg-engezondheid.be/Beleid/Kwaliteit/Welke-ziekenhuizenmeten-hun-kwaliteit-met-VIP%C2%B2/)

[be/Beleid/Kwaliteit/Welke-ziekenhuizenmeten-hun-kwaliteit-met-VIP%C2%B2/](https://www.zorg-engezondheid.be/Beleid/Kwaliteit/Welke-ziekenhuizenmeten-hun-kwaliteit-met-VIP%C2%B2/) (only available in Dutch).

concern care for the elderly (see country document

on long-term care), some may be classified as

acute care expenditures. A few notable examples

are geriatric hospital services, revalidation,

mobility aides, prevention and the maximum

billing (MAB) payments. The total budget shift

from the federal to the regional level is estimated

to be approximately 3.4 billion euros in 2015,

almost 12% (400 million euros) of which will be

(acute) health care expenditures (51). At the time of

writing there is no information available as to how

the regional authorities will manage their new

responsibilities, including if and how they may

change the rules that govern the use of services

and the associated public expenditures.

Consequently, the current Belgian projections at the national level assume that the regionalised health care expenditures will evolve according to the same mechanisms that pertained at the federal level.

Ongoing efforts to improve the performance of the

Belgian health care system are detailed in the annual Policy Notes of the Minister responsible for

public health and health care. The most recent

Policy Note, issued in November 2014 (52),

discusses a government bill aimed at improving

the accessibility of health care, the continuing

integration of chronic care, the execution of the

eHealth platform and the strengthening of primary

care. Planned structural reforms envisage the

reform of hospital financing, the expansion of

mental health care services and a stronger focus on

evidence-based medicine.

An important recent policy reform concerns the

pharmaceutical industry. The Minister of Health

and Social Affairs has signed a 'Pact for the

Future' with the Belgian pharmaceutical sector,

aimed at improving the accessibility to innovative therapies while containing pharmaceutical spending. The agreement provides a framework that combines cost containment with measures to stimulate innovation, especially in the area of orphan drugs. In order to achieve this, a multi-year budget aimed at providing perspective and

(51) RIZIV, Budget 2016. Technical estimates for 2015-2016 (internal document).

(52) See

[http://www.deblock.belgium.be/sites/default/files/articles/2014_11_25_Beleidsnota%20Gezondheidszorg_54K058800](http://www.deblock.belgium.be/sites/default/files/articles/2014_11_25_Beleidsnota%20Gezondheidszorg_54K0588007.pdf)

7.pdf.

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predictability of the revenues of the sector has been agreed.

Challenges

The analysis above shows that a number of reforms have been implemented over the years, aiming to improve the quality and efficiency of

care delivery, and which Belgium should continue to pursue. The main challenges for the Belgian

health system are as follows:

- To continue increasing the efficiency of health

care spending, promoting quality and

integrated care as well as a focusing on costs in

view of the relatively high spending on health

care as a share of GDP and increasing health

care expenditure over the coming decades,

which will accompany the high projected

demographic growth;

- To ensure that the recent responsibilities of the

regional governments and the management of

the budgets they have acquired with the recent

reform of the state are well coordinated

horizontally, with other regions, and with

decisions at the federal level to avoid

duplications and inefficiencies;

- To further the efforts in the area of

pharmaceuticals considering additional

measures to improve the rational and costeffective

prescribing and usage of medicines,

such as information and education campaigns,

the monitoring of prescription of medicines and

incentivising the uptake of generics, as already

successfully implemented in the past years. The policies could help improving population health and improving access to cost-effective new medicines while generating savings to the public payer;

- To strengthen the role of primary care as a gatekeeper by expanding the current incentives in place, both for doctors and patients, to contain direct access to specialist care, for instance, by making referrals compulsory. To make use of high capacity of GPs to support patients in their management of chronic conditions as envisaged;
- To monitor the issue of financial access, in light of the high level of co-payment, while ensuring that enough incentives to discourage over-consumption of health care services are preserved;
- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes, focussing in the areas of voluntary private health insurance and on care and nursing homes, so that regular performance assessment can be conducted and used to

continuously improve access, quality and

sustainability of care;

- To further enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening.

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Table 1.2.1: Statistical Annex – Belgium

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 283 299 311 327 345 354 349 365 379 387 393 9289 9800 9934

GDP per capita PPS (thousands) 29.8 30.1 30.3 30.5 31.1 30.4 28.9 30.2 30.5 30.7 30.3 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 0.4 2.8 1.2 2.0 2.1 0.2 -3.5 1.5 0.9 -0.8 -0.3 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 4.2 3.1 0.9 1.3 2.5 3.5 3.4 0.6 1.4 1.8 2.4 3.2 -0.2
-0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 9.7 9.7 9.7 9.6 9.6 9.9 10.7 10.6 10.6 10.9 11.2 10.4 10.1 10.1

Total current as % of GDP 9.7 9.1 9.0 8.9 9.0 9.4 10.1 9.9 10.1 10.2 10.2 9.8 9.6 9.7

Total capital investment as % of GDP 0.0 0.6 0.6 0.7 0.6 0.6 0.5 0.7 0.5 0.7 0.9 0.6 0.5 0.5

Total per capita PPS 2365 2507 2594 2684 2825 2975 3114 3207 3296 3428 3549 2828 2911 2995

Public as % of GDP 7.1 7.2 7.1 7.0 7.0 7.4 8.1 7.9 8.0 8.2 8.5 8.1 7.8 7.8

Public current as % of GDP 7.1 7.0 6.9 6.8 6.8 7.2 7.8 7.7 7.8 7.9 8.0 7.9 7.7 7.7

Public per capita PPS 1688 1807 1869 1911 1995 2172 2304 2343 2495 2578 2690 2079 2218 2208

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Public capital investment as % of GDP 0.0 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.3 0.5 0.2 0.2 0.1

Public as % total expenditure on health 73.1 73.9 74.0 73.0 72.5 74.6 75.8 75.0 75.7 75.2 75.8 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 13.7 14.0 13.3 13.8 14.1 14.5 14.5 14.6 14.8 14.7 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 99.0 99.0 99.0 99.0 99.0 99.5 100.5 101.5 98.8 99.0 99.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 21.8 20.9 20.8 21.9 22.3 21.1 20.0 20.8 20.0 20.4 19.9 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 10.4 10.4 10.4 10.5 10.6 10.7 10.8 10.8 11.0 11.1 11.2 502.1 504.5 506.6

Life expectancy at birth for females 81.1 81.9 81.9 82.3 82.6 82.6 82.8 83.0 83.3 83.1 83.2 82.6 83.1 83.3

Life expectancy at birth for males 75.3 76.0 76.2 76.6 77.1 76.9 77.3 77.5 78.0 77.8 78.1 76.6 77.3 77.8

Healthy life years at birth females 69.2 58.4 62.3 63.2 63.9 64.1 63.7 62.6 63.6 65.0 63.7 : 62.1 61.5

Healthy life years at birth males 67.4 58.9 62.4 63.0 63.5 63.4 63.9 64.0 63.4 64.2 64.0 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 63 60 58 54 53 52 50 : 100 99 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.1 3.9 3.7 4.0 3.9 3.8 3.5 3.6 3.4 3.8 3.5 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.68 2.60 2.47 2.49 2.53 2.66 2.87 2.81 2.86 2.94 2.93 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.05 0.05 0.05 0.02 0.02 0.04 0.05 0.07 0.07 0.07 0.07 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.64 1.66 1.69 1.29 1.31 1.24 1.40 1.38 1.41 1.44 1.49 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.80 1.56 1.55 1.48 1.51 1.53 1.61 1.55 1.56 1.49 1.46 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.15 0.16 0.15 0.15 0.15 0.17 0.21 0.21 0.21 0.21 0.23 0.31 0.31 0.32

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Prevention and public health services	0.19	0.08	0.14	0.09	0.10	0.16	0.16	0.11	0.11	0.12	0.32	0.25	0.25	0.24
Health administration and health insurance	0.56	0.54	0.56	0.56	0.51	0.52	0.55	0.54	0.55	0.54	0.37	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative <u>care</u>	2.24	2.18	2.09	2.02	1.99	2.10	2.24	2.18	2.23	2.27	2.28	2.73	2.61	2.62
Day cases curative and rehabilitative <u>care</u>	0.05	0.05	0.05	0.02	0.02	0.04	0.05	0.07	0.07	0.07	0.07	0.16	0.16	0.18
Out-patient curative and rehabilitative <u>care</u>	1.44	1.47	1.51	1.14	1.16	1.12	1.27	1.23	1.25	1.28	1.32	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.90	0.93	0.92	0.86	0.88	0.97	1.04	1.03	1.03	1.01	0.97	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.09	0.09	0.09	0.09	0.09	0.09	0.10	0.10	0.10	0.10	0.11	0.11	0.13	0.12
Prevention and public health services	0.19	0.08	0.14	0.09	0.10	0.16	0.16	0.11	0.11	0.12	0.32	0.25	0.20	0.19
Health administration and health insurance	0.45	0.44	0.46	0.46	0.41	0.42	0.45	0.44	0.44	0.42	0.30	0.11	0.27	0.27
EU- latest national data														

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.2.2: Statistical Annex - continued – Belgium

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 27.8% 28.6% 27.4% 27.9% 28.1% 28.4% 28.3% 28.4% 28.2% 28.8%
28.6% 31.8% 31.3% 31.1%

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Day cases curative and rehabilitative care 0.5% 0.6% 0.5% 0.2% 0.2% 0.5% 0.5% 0.7% 0.7% 0.7% 0.7% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative care 17.0% 18.2% 18.7% 14.4% 14.6% 13.2% 13.8% 14.0% 13.9% 14.1%
14.6% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 18.7% 17.1% 17.2% 16.6% 16.8% 16.3% 15.9% 15.7% 15.4%
14.6% 14.3% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 1.5% 1.7% 1.7% 1.7% 1.7% 1.8% 2.1% 2.1% 2.1% 2.1% 2.2%
3.2% 3.3% 3.3%

Prevention and public health services 2.0% 0.9% 1.6% 1.0% 1.1% 1.7% 1.6% 1.1% 1.1% 1.2% 3.2% 2.6% 2.6%
2.5%

Health administration and health insurance 5.8% 5.9% 6.2% 6.3% 5.7% 5.6% 5.4% 5.5% 5.4% 5.3% 3.6% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 31.8% 31.3% 30.1% 29.8% 29.4% 29.1% 28.6% 28.4% 28.7% 28.6%
28.6% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 0.7% 0.7% 0.7% 0.3% 0.3% 0.6% 0.6% 0.9% 1.0% 0.9% 0.9% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative care 20.4% 21.1% 21.8% 16.8% 17.1% 15.5% 16.2% 16.0% 16.1% 16.1%
16.6% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 12.8% 13.4% 13.3% 12.7% 13.0% 13.4% 13.3% 13.4% 13.2%
12.7% 12.2% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 1.2% 1.3% 1.3% 1.3% 1.4% 1.3% 1.3% 1.3% 1.3% 1.3% 1.4%
1.6% 1.6% 1.6%

Prevention and public health services 2.7% 1.1% 2.0% 1.3% 1.5% 2.2% 2.0% 1.4% 1.4% 1.5% 4.1% 3.2% 2.7%
2.5%

Health administration and health insurance 6.4% 6.3% 6.6% 6.8% 6.0% 5.8% 5.7% 5.7% 5.6% 5.3% 3.8% 1.4%
3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants 0.68 0.70 0.70 0.71 0.75 : : : : : 1.0 1.1 1.0

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Angiography units per 100 000 inhabitants 1.5 1.4 1.4 1.4 1.3 : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants 3.1 3.2 3.9 4.0 4.2 : : : : : 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.1 : : : : : : : 0.1 0.1 0.1

Proportion of the population that is obese : 12.7 : : : 13.8 : : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 27.0 23.7 20.3 22.0 22.0 18.9 : : : : 18.9 23.2 22.4 22.0

Alcohol consumption litres per capita 11.0 11.0 10.9 10.7 10.2 10.6 10.4 10.6 9.8 9.8 : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 286 287 287 289 291 292 292 291 291 293 295 329 335 344

Practising nurses per 100 000 inhabitants : 854 865 878 885 895 905 910 932 951 : 840 812 837

General practitioners per 100 000 inhabitants 119 119 118 118 116 115 114 112 111 111 112 : 78 78.3

Acute hospital beds per 100 000 inhabitants 451 447 440 434 428 424 418 411 405 399 395 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 7.8 7.2 7.2 7.1 7.2 7.5 7.6 7.4 7.4 : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 16.0 15.9 16.1 15.8 15.7 15.9 15.9 : 15.8 15.9 : 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 9,335 9,979 10,497 10,773 11,359 12,554 12,832 : 15,149 15,546 : 6368 6530 7031

Acute care bed occupancy rates 76.0 75.0 75.0 74.0 74.0 74.0 78.1 78.2 78.0 78.4 : 72.0 73.1 70.2

Hospital curative average length of stay 7.5 7.4 7.7 7.2 7.1 7.1 7.2 7.2 7.1 7.0 : 6.5 6.3 6.3

Day cases as % of all hospital discharges 36.9 38.5 39.5 40.5 41.9 : 44.7 : 48.9 49.5 : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 6.0 5.9 5.9 6.1 6.1 6.1

AWG risk scenario 6.0 6.0 6.1 6.3 6.5 6.5

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

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Population projections until 2060 (millions) 11.2 11.9 12.9 14.0 14.8 15.4

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

37.7 3.1

0.1 0.9

0.5 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

Bulgarian GDP per capita is currently one of the lowest in the EU with 12,800 PPS in 2014. The global financial and economic crisis has had a strong impact on the Bulgarian economy that resulted in a strong contraction of the economic growth. The recovery has been slow over 2010-13, reflecting partially global economic headwinds.

Population was estimated at 7.3 million 2013. It has been decreasing in past years mainly to due emigration. According to Eurostat projections, total population is projected to decrease from

around 7.2 million in 2015 to 5.5 million in 2060.

Total and public expenditure on health as % of

GDP

Total expenditure (53) on health as a percentage of

GDP (7.6% in 2013, latest available data) has

remained stable over the last decade (from 7.6% in

2003) and is below the EU-average (54) of 10.1%

in 2013. Throughout the last decade, public

expenditure has decreased as % of GDP: from

4.7% in 2003 to 4.2% of GDP in 2011 (EU: 7.7%

in 2013). Public spending as a share of GDP is one

of the lowest in the EU.

When expressed in per capita terms, also total

spending on health at 990 PPS in Bulgaria in 2013

was far below the EU average of 2,988 in 2013. So

was public spending on health care: 587 PPS in

2013 vs. an average of 2,208 PPS in 2013. Overall,

Bulgaria devotes relatively few resources to health

care.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care

expenditure is projected to increase by 0.4 pps of

(53) Data on health expenditure is taken from OECD health data

and Eurostat database. The variables total and public

expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(54) The EU-averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units and units of staff where relevant. The EUaverage

for each year is based on all the available

information in each year.

GDP, below the average growth expected for the

EU of 0.9 pps of GDP, according to the "AWG

reference scenario". When taking into account the

impact of non-demographic drivers on future

spending growth (AWG risk scenario), health care

expenditure is expected to increase by 1.1 pps of

GDP from now until 2060 (EU: 1.6) (55).

Despite the deficit in the structural primary

balance and the debt to GDP ratio being on an

increasing trend, no sustainability risks appear

over the medium-term thanks to the very low

starting level of the debt ratio. In the long-term,

Bulgaria appears to be at medium risk because of

the unfavourable initial budgetary position slightly

compounded by the age-related expenditures on

health care and long term care (56).

Health status

Life expectancy at birth (78.0 years for women and 71.1 years for men in 2014) is one of the lowest in the EU, while healthy life years (66.6 years for women and 62.4 years for men in 2013) are above the respective EU averages (83.6 and 78.1 years of life expectancy in 2014, 61.5 and 61.4 in 2013 for the healthy life years). Mortality rates, which are thought amenable if appropriate and timely care is delivered, are also high (391 in Bulgaria vs. 128 deaths in the EU per 100 000 inhabitants). The infant mortality rate of 7.3‰ is very high compared to the EU average of 3.7‰; in 2013, having gradually fallen over the last decade (from 12.3‰ in 2003).

As for the lifestyle of the Bulgarian population, the data indicates a high proportion of regular smokers (29.2% in 2008), being above the EU average of 22.0%. The proportion of the obese population is below EU level of 13.4% (EU: 15.5%), while the alcohol consumption is at EU level.

System characteristics

Overall description of the system

The health system is a system of compulsory health insurance with contributions from

(55) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(56) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

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employees and contractual relationship between

the National Health Insurance Fund (NHIF) as

purchaser of services and healthcare providers.

NHIF acts as a single buyer of health services and

runs the mandatory health insurance for the

Bulgarian citizens. NHIF is separated from the

structure of the public healthcare system and

having its own governing bodies. The mission of

the NHIF is to provide free and equal access for

the insured persons to medical **care** for a defined

package of health services and the free choice of a

contracted provider.

Coverage

A system of mandatory social health insurance

provides coverage for the residing population.

The majority of the population takes part in the health insurance system. The share of the people without health insurance payments for 2014 amounts to approximately 7 % (516 753 people), while the structure of insured is as follows: 45% insured by the employer, 4% self-insured and approximately 44% insured by the state.

According to the data of the "Civil Registration and Administrative Service Directorate General" (GRAO) until the end of 2014 approximately 1,630,000 people who have their permanent address in Bulgaria had foreign residence and are not legally obliged to take part in the obligatory health insurance system.

The 2015 amendments to the Health Insurance Act (State Gazette, Vol. 72/18.09. 2015, Vol. 79/13.10.2015, Vol. 98/15.12.2015) led to recovery of the health insurance rights of 195,726 Bulgarian citizens for the second half of 2015.

All children aged 0-18 and all retired people have their health coverage provided by the state. People without incomes receive social assistance from the Social Assistance Agency. Long-term unemployed people without incomes and real estate have the right to get their hospital treatment paid for by the

Fund of the Ministry of Labour and Social Policy

on the basis of their property status proven. This

fund amounts to BGN 5 mln per year.

All women in Bulgaria have the right to receive

free of charge health services for giving birth,

regardless of their health insurance status.

Similarly, all pregnant women have access to free

health care services, regardless of their health

insurance status. The access to emergency medical

care is free for all, regardless of health insurance

status.

Administrative organisation and revenue

collection mechanism

The National Health Insurance Fund (NHIF) pools

the compulsory social health insurance wage-related

contributions of employed individuals and

the general tax revenue allocated by the

government which covers for the contributions of

the non-working population (pensioners,

unemployed, people taking care of disabled

members of the family, people with right to social

welfare, etc). The NHIF carries out the financing

of the healthcare network through its 28 regional

authorities (regional health insurance funds). The

NHIF contracts health services from general practitioners (GPs), specialists in outpatient departments, medical laboratories, dentists and hospitals for the insured population and provides for medication and medical devices.

Bulgaria has a mixed system of health care

financing. The Bulgarian health care system is financed from three main sources: compulsory health insurance contributions, general taxation, and household private expenditure.

Role of private insurance and out of pocket co-payments

While the state provides free, universal access to emergency health care, private expenditure plays an important role in financing health care in Bulgaria. In 2013, public expenditure accounted for only 59.3% of total health expenditure (EU: 77.4%) and out-of-pocket expenditure was at the very high level of 39.6% of total health expenditure. The role of private insurance is very limited.

Out-of-pocket payments take three main forms: direct payments, cost-sharing and informal

payments. Direct payments in Bulgaria include payments for specialist services without a GP referral, payments to the providers without a contract with the NHIF, or payments not covered within benefit package. Cost-sharing applies as a flat mandatory fee for visits to a GP, a specialist or a health diagnostic laboratory covered by the

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NHIF and for hospital stay (57). Cost-sharing also applies to outpatient medicines, except for treatment of chronic diseases. A large number of patients report making informal payments (58).

In mid-March 2016 the Council of Ministers adopted amendments to the ordinance on the implementation of the right of access to medical

care. It defines the terms and conditions under which the insured persons will be reimbursed by NHIF services.

It forbids hospitals to ask additional payments from mothers with children up to seven years of

age, in case they stay in the hospital with their child. If the case requires extra care that the

hospital cannot provide, children up to 18 years of

age will be accompanied free of charge. In case of a need of hospitalisation, companions of disabled people who cannot be self-served will have the right for free of charge stay in the hospital.

A patient has the right for an elective hospital admission within two months. Patients who wish to pay for faster admission may do so, but this should not change the order of already planned admissions. The admission list of patients is published on the web site of the NHIF and monitored by the interested persons. Admissions are registered electronically via eHealth tools by the NHIF and can be verified by the respective patient.

The ordinance prohibits hospitals to require patients or their relatives to make any donations, i.e. informal payments, during the hospitalisation, as well as one month before and after it. The ordinance does not allow patients to pay extra for activities funded by the NHIF.

Types of providers, referral systems and patient choice

Primary care is provided by GPs working in

private practices, group practices and in outpatient

departments. The citizens have free choice of GPs,

whom they can change once every six months.

(57) According to the new text in the Health Social Insurance

Act, Ar. 37, the amount of cost-sharing is not connected

already to the minimum wage, but on yearly basis is

defined by a Decree of the Council of Ministers.

(58) 'Study on corruption in the healthcare sector',

HOME/2011/ISEC/PR/047-A2, October 2013.

GPs are being legally assigned the function of

gatekeepers, referring patients to the specialists

and hospitals. Facilities which provide specialised

ambulatory care include individual or group

practices for specialised medical care within:

separate medical subfields; health centres;

diagnostic consultation centres (containing at least

10 physicians in various specialities); laboratory

and image diagnosis centres; or individual medical

and diagnostic or technical laboratories.

The density of physicians in Bulgaria exceeds the

average density in the EU. In 2013, there were 398

practising physicians per 100 000 inhabitants,

compared to 344 in EU. However, Bulgaria has a

low number of general practitioners (63 per 100

000 inhabitants vs. 78 in 2013 in the EU). The

number of nurses per 100 000 inhabitants (447 in 2013) is much below the EU average of 837. The availability and quality of health services varies across the country and needs substantial improvements in non-urban areas. The ill-defined skill-mix together with an unequal distribution of physicians across the regions affects the provision and use of primary care, resulting in bottlenecks and limiting the effectiveness of the system and leading to strong inequities in access to health care, although patients profit from traveling to cities where access to care is easier.

Hospital care in Bulgaria is provided by public and private health establishments.

Similarly to the number of physicians, hospital capacity exceeds EU averages. In 2013, the number of acute care beds was 524 compared to 356 per 100 000 inhabitants in the EU. The number of acute care beds is also increasing contrary to the general trend in the EU. The number for all hospital beds (incl. long-term care beds) in Bulgaria is also higher than the EU

average (Bulgaria: 681, EU: 526 per 100 000

inhabitants). Further reducing hospital capacity,

optimising bed occupancy rates and bed turnover

rates, increasing the number of day case surgery

and outpatient cases, and concentrating high-tech

complex care in a few facilities (centres of

excellence) are perhaps areas where further

improvements can be made.

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Treatment options, covered health services

There is a defined basket of services that has to be

delivered to the whole population covered. An

ordinance adopted by the MoH regulates the scope

of the specific medical activities in the package

paid with funds from NHIF. The outpatient care is

included entirely in the basic package. For primary

care the basic package includes provision of health

information, promotion, prevention, diagnostics

and therapeutic activities. They aim at completing

the provision of necessary medical care and

services and to protect and improve the health of

patients and their families. The focus is put on

health education about risk factors regarding socially significant illnesses and damages from unhealthy habits as well as on promoting positive health habits.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Health care providers are mainly reimbursed retrospectively on a per-case and per-capita basis. Actual payment rates are agreed in the contract with the NHIF beforehand.

Primary health care providers are reimbursed by the NHIF on a contractual basis according to the National Framework Contract. The contracts are based on monthly per-capita payments per insured person on the patient list. They also may include additional payments for additional procedures, such as preventive health, immunisation, regular medical check-up, dispensary treatment and observation. Moreover, those working in sparsely populated and remote areas receive an additional per-capita remuneration combined with periodic balancing. Outpatient specialists are paid on a fee-for-service basis with different rates depending on the service provided.

Hospitals receive funding mainly through casebased payments (or payments per clinical pathway), based on a single flat rate per pathway combined with global budgets. The flat rate is calculated according to the cost of medical activities, auxiliary services provided to patients and up to two outpatient examinations following the patient's discharge. The terms, conditions and the procedure for monitoring, analysis and control on the implementation of medical care providers, as well as of the volumes and the total value of the services provided, shall be defined in the National Framework Agreement for Medical Activities. In case such an agreement is not concluded the decision should be taken by the NHIF Supervisory Board.

A disproportionally high share of public health care spending is spent on inpatient curative and rehabilitative care (61% in Bulgaria in 2008 versus 35% in the EU in 2009 and 34% in the EU in 2013), while a low share of spending is allocated to outpatient care (12% in Bulgaria in 2008 versus 22% in the EU in 2009).

The institutions which are financed from the state

budget (mainly state psychiatric hospitals and

health and social care children's homes) follow

different procedures and are paid per diem by the

Ministry of Health.

The mechanisms for paying staff employed in

inpatient care institutions vary according to the

type of the institution and, generally, combinations

of various payment methods are used. In the public

inpatient sector, health personnel are mostly

salaried with additional performance-related

bonuses. In private hospitals, payment mechanisms

are directly negotiable between the employer and

the employees under labour contracts for different

personnel categories.

The market for pharmaceutical products

Medicines to be reimbursed by the NHIF are listed

on the Positive Drug List, grouped under the

anatomical-therapeutic-chemical code. The

products included in the list are both trade names

and international non-proprietary names (INN) by

dosage forms and are reimbursed in 25-100%.

Medicines on the list are reimbursed based on

reference pricing (maximum value per unit of

substance). An independent National Council for

prices and Reimbursement decides on reimbursement. This body is under direct supervision of the Council of Ministers.

Bulgaria has no explicit legislation regarding generics, but has a policy to promote them. GPs may prescribe pharmaceuticals covered by the National Health Insurance Fund.

In 2015 the Ministry of Health adopted changes in the regulations on the pricing of medicines. The

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new provisions are intended to limit the copayment by patients to not more than 60% of the cost per package, based on the reference value of the medicinal product, which is the lowest value for the defined daily dose for a therapeutic course of treatment. This ensures that even if the patient is prescribed the most expensive product in the group, he/she will not pay more than 60% than he/she would have paid for the cheapest product (reference product).

Use of Health Technology Assessments and cost-benefit analysis

The adopted amendments to the health insurance

law in June 2015 initiated the following reforms.

An obligatory centralised negotiation of the discounts paid by NHIF for innovative medicines and products for cancer treatment is introduced, as well as a mechanism for health technology assessment for medicinal products. Health technology assessment is already a tool for decision-making. The HTA aims to provide information about the safety, clinical effectiveness and efficiency, as well as on the budgetary, social, legal and ethical impacts of the application of medicinal products in healthcare. The HTA is carried out also in the event of inclusion in the positive drug list of new innovative medicinal products.

eHealth, Electronic Health Record

A system of accreditation of medical facilities is being organised by the Ministry of Health with the participation of the NHIF, the Bulgarian physicians', dentists' and patients' associations. In addition, a system for medical audits and monitoring is being established by an executive agency, responsible for developing uniform criteria for assessing the efficiency and effectiveness of health care services. The use of information and

communication technologies (ICT) is growing in the Bulgarian health system.

The health portal of the National Health Insurance Fund enables the insured persons to review their emedical record online. The electronic service for reviewing the medical record is available to all citizens of the Republic of Bulgaria, who are (or were) health insured, as well as EU citizens who possess a European Health Insurance Card (59).

Some other e-services provided by NHIF include checking for GPs that have contracted with NHIF and medicines paid by NHIF. Additionally, there are electronic submissions of reports from the inpatient **care** sector to NHIF, electronic daily registers of hospitalised and discharged patients, electronic checks of validity of health insurance cards, verification of health insurance status, etc.

Health promotion and disease prevention policies

Resources directed to prevention and health promotion policy are low due to the overall low level of health spending.

In 2014 the national assembly endorsed the National Health Strategy 2014-2020

(<http://dv.parliament.bg/>) and an action plan for its

implementation. According to the strategy the main direction of government's policy is to increase the part of spending devoted to prevention. In early 2015 the government adopted the "Objectives for Health 2020". The document formulates national goals in the field of improving health status of population as a factor for sustainable growth and defines long-term priorities of the country in the health sector. Based on the analysis of the health status of the population in Bulgaria, the concept defines several national health goals by 2020, including reduction of child mortality, the improvement of health status among economically active groups and an increase in life expectancy.

Bulgaria still has untapped potential to achieve better health of the population and prevent most of the diseases and premature mortality, respectively.

There is a potential to increase the high levels of premature mortality by a stronger focus on health promotion and disease prevention policies, e.g. by changing unfavourable life styles.

(59) Users may access this electronic service through the home

page, located at: <https://pis.nhif.bg/main/>. In order to access

his/her e-medical record online the insured person should possess Qualified Electronic Signature or should obtain an Unique Access Code from his/her Regional Health Insurance Fund.

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Recently legislated and/or planned policy reforms

As far as future strategic objectives are concerned,

according to the National Health Care Strategy

(2014-2020) there are eight basic priority areas

guiding future health system change. These

address the following areas: 1) Ensuring a reliable

system of health provision and access to quality

medical care and health services through better

medical standards and life-long learning for health

care personnel; 2) Introducing a single integrated

information system through the development of

eHealth; 3) Streamlining of financial management

by integrating e-system of financial and nonfinancial

reporting in real time is adopted by NHIF

and all health providers contracted with NHIF; 4)

Strengthening and modernising the system for

emergency medical care, e.g. via raising salaries of the personnel, easy access to medical specialisation and establishing medical standards for good practices; 5) Regional policy with particular emphasis on supporting the medical facilities in remote and small regions of the country; 6) Effective functioning of the mother, child and school health. A special emphasis is laid on the health education at school and to the prevention services performed by the GPs; 7) Sustainable development of human resources with a focus on medical specialisation staff and continuous training; 8) Reorientation of the health system towards prevention and the prevention of socially significant diseases.

Recent reforms in the healthcare system envisage the splitting of the current coverage package into three packages — basic, additional and emergency.

The reform officially establishes waiting lists and introduces the possibility for voluntary health insurance for those who do not want to wait for services provided under the additional package.

With the latest amendments to the law on medical treatment facilities from December 2015, the National Assembly adopted the National Health

Map, which will determine and plan the needs of the population for health services access to outpatient and hospital care on geographical principles. The changes also provides for the formation of complex multidisciplinary centres for children with disabilities and chronic illnesses and people with rare diseases. Thus in the hospitals with active care these patients will be serviced in one place.

In 2016, in accordance with the changes in the law on health insurance adopted in December 2015, the NHIF will apply new mechanisms for the implementation of control activities, which will reduce opportunities for fraud and abuse in the health insurance system. The employees of the NHIF and the controllers will carry out unexpected controls over the execution of contracts with the medical and / or dental care executors, prepayment control of the provided medical and / or dental care services and ex-post control.

Challenges

The analysis above shows that a range of reforms have been implemented over the years to increase

the efficiency in the sector while trying to improve

the access to care. However, there may be room for improvements in a number of areas. The main

challenges for the Bulgarian health care system are as follows:

- To guarantee the universality of health care coverage, by spreading coverage rights to the social groups previously excluded; improve regulation of the health services market to limit the size of informal health care payments and reduce the role of out-of-pocket payments in total expenditure as a highly regressive method of financing. These would contribute to reduce the inequalities in access to and quality of health care among social groups and regions.
- To improve the basis for more sustainable and efficient financing of health care in the future (e.g. considering additional sources of general budget funds), aiming at a better balance between resources and spending, as well as between the number of contributors and the number of beneficiaries. This can reduce the size of private payments and reduce

inequalities in the access and quality of care

and its distribution between population groups

and regional areas.

- To continue to enhance and better distribute

primary health care services to improve

effectiveness and efficiency of health care

delivery. In the future, the effective

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implementation and usage of the recently

deployed eHealth tools, including electronic

patient records, can help ensuring effective

referral systems from primary to specialist care

and improving care coordination between types

of care.

- To increase the primary care staff supply by

implementing a comprehensive human

resources strategy that adjusts the training of

doctors to ensure a balanced skill-mix, that

avoids staff shortages and that motivates and

retains staff to the sector, especially in view of

migration. In addition, consider enhancing

financial and institutional incentives for GPs to provide adequate levels of services to patients based on quality indicators, performance-based reporting and payment bonuses.

- To increase health system efficiency by the shifting excessive capacity and activity of acute inpatient care towards ambulatory and outpatient care services, and strategically directing more resources towards providers of lower levels of care.

- To consider additional measures to improve the rational prescribing and usage of medicines, such as information and education campaigns, the monitoring of prescription of medicines and a more explicit policy on incentivising the uptake of generics. The policies could help improving population health, reducing the high level of out-of-pocket payments and improving access to cost-effective new medicines by generating savings to the public payer.

- To continue improving the systems for data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted.

Promote the use of ICT in the gathering,
storage, use and exchange of health
information.

- To gradually increase the use of costeffectiveness

information in determining the

basket of goods and the extent of cost-sharing.

- To foster public action in the area of health

promotion and disease prevention on the basis

of the defined public health priorities (diet,

smoking, alcohol, lack of exercise) and given

the recent pattern of risk factors.

- To operationalise, implement and adapt as

needed the National Health Care Strategy

(2014-2020), with a view of increasing

ownership of the strategy by all stakeholders of

the health system.

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Table 1.3.1: Statistical Annex – Bulgaria

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 19 21 24 27 33 37 37 38 41 42 42 9289 9800 9934

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GDP per capita PPS (thousands) 10.7 11.1 11.4 11.8 12.1 12.1 11.1 11.3 11.0 11.2 11.3 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 6.4 7.3 6.9 6.8 7.0 6.7 -5.0 1.1 4.4 1.2 1.4 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 9.0 3.5 6.9 0.7 5.8 9.2 -1.5 6.0 6.3 -2.7 4.3 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 7.6 7.3 7.3 6.9 6.8 7.0 7.2 7.6 7.7 7.4 7.6 10.4 10.1 10.1

Total current as % of GDP 7.4 7.1 7.1 6.8 6.5 6.6 7.1 7.5 7.7 : : 9.8 9.6 9.7

Total capital investment as % of GDP 0.2 0.2 0.2 0.1 0.3 0.4 0.2 0.0 0.1 : : 0.6 0.5 0.5

Total per capita PPS 412 447 515 557 663 781 813 869 968 952 990 2828 2911 2995

Public as % of GDP 4.7 4.4 4.5 3.9 4.0 4.1 4.0 4.2 4.2 4.2 4.5 8.1 7.8 7.8

Public current as % of GDP 4.5 4.3 4.3 3.8 3.7 3.7 3.8 4.2 4.2 : : 7.9 7.7 7.7

Public per capita PPS 240 253 291 296 334 457 405 457 529 536 587 2079 2218 2208

Public capital investment as % of GDP 0.2 0.2 0.2 0.1 0.3 0.4 0.2 0.0 0.1 : : 0.2 0.2 0.1

Public as % total expenditure on health 62.1 60.7 60.9 57.0 58.3 58.5 55.3 55.7 54.7 56.3 59.3 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 13.6 13.5 12.9 11.6 10.5 11.7 10.1 12.6 12.6 12.9 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance : : : : : : 77.0 77.0 : 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 38.1 39.2 38.9 42.7 42.6 42.6 44.4 43.1 44.5 42.5 39.6 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 7.7 7.7 7.7 7.6 7.6 7.5 7.5 7.4 7.4 7.3 7.3 502.1 504.5 506.6

Life expectancy at birth for females 75.9 76.2 76.2 76.3 76.6 77.0 77.4 77.4 77.8 77.9 78.6 82.6 83.1 83.3

Life expectancy at birth for males 68.9 69.0 69.0 69.2 69.5 69.8 70.2 70.3 70.7 70.9 71.3 76.6 77.3 77.8

Healthy life years at birth females : : : 71.9 73.9 65.7 65.9 67.1 65.9 65.7 66.6 : 62.1 61.5

Healthy life years at birth males : : : 66.2 67.1 62.1 62.1 63.0 62.1 62.1 62.4 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 204 194 210 210 209 201 189 191 364 391 : 64.4 128.4 :

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Infant mortality rate per 1 000 live births 12.3 11.6 10.4 9.7 9.2 8.6 9.0 9.4 8.5 7.8 7.3 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.70 2.66 2.87 2.64 2.54 2.72 : : : : 3.13 2.99 3.01

Day cases curative and rehabilitative care : 0.00 0.00 0.00 0.00 0.00 : : : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.07 1.00 0.97 0.87 0.84 0.82 : : : : 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 2.73 2.54 2.44 2.49 2.29 2.33 : : : : 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.11 0.13 0.08 0.11 0.17 0.10 : : : : 0.31 0.31 0.32

Prevention and public health services 0.26 0.28 0.22 0.24 0.26 0.29 0.25 0.32 0.29 : : 0.25 0.25 0.24

Health administration and health insurance 0.10 0.09 0.10 0.10 0.08 0.07 0.10 0.10 0.15 : : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.49 2.38 2.51 2.23 2.15 2.27 : : : : 2.73 2.61 2.62

Day cases curative and rehabilitative care : : 0.00 0.00 0.00 0.00 : : : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care 0.59 0.59 0.56 0.49 0.47 0.46 : : : : 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.74 0.60 0.54 0.52 0.47 0.43 : : : : 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.02 0.01 0.00 0.00 0.00 0.00 : : : : 0.13 0.12 0.13

Prevention and public health services 0.26 0.26 0.20 0.21 0.24 0.27 0.23 0.28 0.27 : : 0.25 0.20 0.19

Health administration and health insurance 0.10 0.10 0.11 0.10 0.07 0.07 0.09 0.09 0.14 : : 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

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EU- latest national data

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Table 1.3.2: Statistical Annex - continued – Bulgaria

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 36.6% 37.3% 40.3% 39.1% 39.1% 41.2% : : : : 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : 0.0% 0.0% 0.0% 0.0% 0.0% : : : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 14.5% 14.0% 13.6% 12.9% 12.9% 12.4% : : : : 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 37.0% 35.6% 34.3% 36.8% 35.2% 35.3% : : : : 16.3% 16.2%
14.9%

Therapeutic appliances and other medical durables 1.5% 1.8% 1.1% 1.6% 2.6% 1.5% : : : : 3.2% 3.3% 3.3%

Prevention and public health services 3.5% 3.9% 3.1% 3.6% 4.0% 4.4% 3.5% 4.2% 3.8% : : 2.6% 2.6% 2.5%

Health administration and health insurance 1.4% 1.3% 1.4% 1.5% 1.2% 1.1% 1.4% 1.3% 2.0% : : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 55.5% 55.9% 58.8% 58.8% 58.9% 61.2% : : : : 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : 0.0% 0.0% 0.0% 0.0% : : : : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care 13.1% 13.8% 13.1% 12.9% 12.9% 12.4% : : : : 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 16.5% 14.1% 12.6% 13.7% 12.9% 11.6% : : : : 10.0% 13.9%
12.5%

Therapeutic appliances and other medical durables 0.4% 0.2% 0.0% 0.0% 0.0% 0.0% : : : : 1.6% 1.6% 1.6%

Prevention and public health services 5.8% 6.1% 4.7% 5.5% 6.6% 7.3% 6.0% 6.7% 6.5% : : 3.2% 2.7% 2.5%

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Health administration and health insurance 2.3% 2.4% 2.6% 2.6% 1.9% 1.8% 2.4% 2.2% 3.4% : : 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants : : 0.27 0.31 0.31 0.31 0.40 0.42 0.63 0.74 0.73 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : 0.6 0.6 0.7 0.7 : : 1.0 1.0 1.1 0.9 0.9 0.8

CTS per 100 000 inhabitants : : 1.6 1.7 1.9 2.2 2.7 3.0 2.9 3.2 3.4 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : : : : 0.0 0.0 0.0 0.1 0.1 0.1

Proportion of the population that is obese : : : : : 11.5 : : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : : : : 39.7 29.2 : : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 10.6 10.6 10.1 10.0 10.2 10.5 10.2 10.2 9.7 : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 360 352 364 365 364 360 369 375 386 391 398 329 335 344

Practising nurses per 100 000 inhabitants 379 383 404 410 421 424 421 426 430 439 447 840 812 837

General practitioners per 100 000 inhabitants 69 69 68 67 65 63 65 64 64 67 63 : 78 78.3

Acute hospital beds per 100 000 inhabitants 483 470 491 475 489 499 508 508 499 511 524 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : : 19.9 20.0 20.9 21.7 23.4 25.0 26.1 27.3 30.0 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : : : : : : : : 6368 6530 7031

Acute care bed occupancy rates : : : : : 70.1 : : : : : 72.0 73.1 70.2

Hospital curative average length of stay : : : : : : : : 6.5 6.3 6.3

Day cases as % of all hospital discharges : : : : : : : : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 4.0 4.2 4.4 4.5 4.5 4.4

AWG risk scenario 4.0 4.5 4.9 5.2 5.3 5.2

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 7.3 7.0 6.5 6.1 5.8 5.5

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-24.8 3.1

0.4 0.9

1.1 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

1.4. CROATIA

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

Croatia, independent country since 1991 and

member of the European Union since 2013, has a

population of 4.3 million, roughly 0.8% of the EU

population. After a long spell of contraction,

growth picked up over the course of 2015, marking

it the first year of positive growth (1.8%) since

2008. Overall, real GDP is expected to grow by

2.1% in 2016 and 2017. (60) In current prices the

GDP of Croatia has been increasing fast from 2003

to 2008, from EUR 31 to EUR 48 billion. Since 2008 it decreased to EUR 43 billion. GDP per capita was in 2013 with 15,200 PPS well below the EU average of 27,900 PPS.

The population in 2013 is 4.3 million and, according to Eurostat 2013 projections, total population in Croatia is projected to decrease in 50 years with some 13.1% to 3.7 million in 2060.

Total and public expenditure on health as % of GDP

Total health expenditure was at 7.3% of GDP in 2013, lower than the EU average of 10.1%. Public expenditure on health as a percentage of GDP (5.8%) remains under the EU average (7.8%), but is still higher than neighbouring Hungary. At the same time, the share of health in public expenditure is very large with 20.1%, recorded in 2012, of total government expenditure, where the EU average is 14.9%. With some 80% the share of public expenditure in total expenditure on health was in 2013 higher than the EU average of 77.4%.

When expressed in per capita terms, total spending on health at 1,100 PPS in 2011 was significantly under the EU average in the same year (2,904 PPS) and it is below the latest figure (2,988 in 2013). So

is public spending on health: 880 PPS in 2013 vs.

an average of 2,208 PPS in the EU in 2013.

(60) European Commission (2016), European Economic

Forecast Winter 2016.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care

expenditure is projected to increase by 1.7 pps of

GDP, at the average growth level expected for the

EU of 0.9 pps of GDP, according to the "AWG

reference scenario". (61) When taking into account

the impact of non-demographic drivers on future

spending growth ("AWG risk scenario"), health

care expenditure is expected to increase by 2.7 pps

of GDP from now until 2060 (EU: 1.6). Overall,

the country faces high medium-terms risks from a

debt sustainability analysis perspective due to the

high debt-to-GDP ratio and the unfavourable initial

budgetary position (62).

Health status

Life expectancy at birth for both women and men

is respectively 81 years and 74.5 years and is,

although having increased during the decade;

below the EU average (83.3 and 77.8 years

respectively). Similarly healthy life years at birth

for both sexes are with 60.4 years (women) and 57.6 years (men) slightly lower than the EU average (61.5 and 61.4 respectively), the biggest gaps in both indicators being recorded for males. Infant mortality has gradually declined to 4.1 per 1000 live births in 2013, but is still higher than the EU average of 3.9.

System characteristics

Overall description of the system

Since 1990, Croatian health care went through a series of reforms that have helped to transform the once fragmented and highly decentralised health system, inherited from former Yugoslavia and battered by five years of war, into a health care system that maintains the principles of universality and solidarity.

The system of health care in Croatia is based on mixed financing (with predominant public financing, nearly 85%) and provision by public and private health services providers. Health care is financed from mandatory contributions

(61) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(62) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

Health **care** systems

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(approximately 91%) as well as from taxes and copayments

and private insurance. Also a share of

compulsory car insurance premiums is part of the

healthcare budget.

Health **care** is contracted by the Croatian Health

Insurance Fund (HZZO), counties (20) and the

City of Zagreb and beneficiaries. Rates of

contributions for the mandatory health insurance

were in May 2012 reduced from 15% to 13% of

gross salary (measure implemented with the aim of

increasing competitiveness of the economy)., but

the government has decided that this measure will

be revoked in 2014. (63) 0.5% contribution is paid

as a special contribution to cover costs of

occupational injuries.

Two basic rights arising from the compulsory

basic health insurance include in-kind benefits

(right to health protection) and cash benefits (e.g.

compensation for sick leave, travel expenses (64),
etc).

Coverage

The average number of insured persons in 2015
was 4,325,852, which is 0.45 % less than in 2014,
when an average of 4,345,435 insured persons was
recorded.

The average number of active insured persons
(paying the full premium of 15% of the gross
salary) was, in 2014, 1,466,654, which is 1.24%,
higher, with 17,917 additional individuals
recorded, than in 2014 (in which the number was
1,448,737). (65)

It is estimated that only 1/3 of the population is
liable to pay health care contributions, while the
remaining population includes pensioners (who
pay a reduced healthcare premium), insured
persons' family members, unemployed (health
(63) Act on Amendments of the Contributions Act, OG, No.
41/14).

(64) Insured persons are entitled to claim reimbursement of
travel expenses if they used health services at a contracted
health facility or physician which is more than 50 km
distant from their residence, provided they are not able to
obtain the same treatment in the place of their residence.

However, complicated rules of reimbursement do not allow

for a full reimbursement of costs in all cases.

(65) Source: Croatian Health Insurance Fund Annual Report for

2015, <http://cdn.hzzo.hr/wpcontent/>

uploads/2016/04/lzvjesce_o_poslovanju_hzzo_za_

2015_godinu.pdf.

contribution 5% of the prescribed base amount,

paid from the state budget) and other inactive

persons.

46.77% (685,988) of active insured persons are

women and 53.23% or 780,666 persons are men.

Furthermore, 1,061,553 pensioners were registered

in 2015, which is slightly higher than in 2014

(1,058,751 recorded pensioners). The number of

farmers has decreased by 13.08% over the period,

with an average of 21,845 as opposed to 25,131

farmers recorded last year during the same period.

(66) Other categories of insured (which comprises

the unemployed, insured abroad - pensioners,

students and high school students, persons

incapable of independent life and work, etc.)

increased by 29.44% in 2015. (67)

Administrative organisation and revenue

collection mechanism

Contributions are paid on the monthly contribution base, which represents the salary or other income from employment paid by employer and subject to income tax or income from self-employment, which is calculated as the product of monthly contribution base and a coefficient depending on the nature of self-employment. Health contribution on pensions above average net wage is paid in the amount of 3%.

In 2008 the efficiency of the sector was increased through the introduction of public procurement of medication, centralised procurement of medical equipment, better supervision of transfers to households, reorganisation of emergency medical services, use of eHealth tools in primary health

care and introduction of national waiting lists.

Diagnoses related groups (DRGs) replaced the unpopular PPTPs in 2009 and allowed for more refined case-groupings.

(66) Source: Croatian Health Insurance Fund Annual Report for

2015, [http://cdn.hzzo.hr/wpcontent/](http://cdn.hzzo.hr/wpcontent/uploads/2016/04/lzvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf)
[uploads/2016/04/lzvjesce_o_poslovanju_hzzo_za_](http://cdn.hzzo.hr/wpcontent/uploads/2016/04/lzvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf)
[2015_godinu.pdf](http://cdn.hzzo.hr/wpcontent/uploads/2016/04/lzvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf).

(67) Source: Croatian Health Insurance Fund Annual Report for

2015, http://cdn.hzzo.hr/wpcontent/uploads/2016/04/lzvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf.

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Role of private insurance and out of pocket

co-payments

Patients have to pay co-payments for medicines

which are on a complementary list of medicines,

even if they have complementary insurance.

Complementary insurance is a part of voluntary

insurance. Patients without complementary health

insurance have to pay additional fixed amount of

HRK 10 (EUR 1.50) per prescription and HRK 10

(EUR 1.5) for GP check-up.

They also have to pay 20% of hospital

expenditures with the maximum amount of

approximately EUR 260 per invoice (for

treatments, medical tests, hospital bed).

With the Healthcare Reform of 2008, the share of

the population excluded from paying co-payments

was reduced. At the same time, the HZZO offered

a complementary health insurance (CHI), which

would cover these co-payments. (Voncina, 2012).

The total number of insured persons in supplementary health insurance was in 2015 2,597,831. 1,623,799 of insured persons pay supplementary policy by themselves. The costs of supplementary health insurance policy for 974,032 insured persons are covered from the state budget (these categories include persons with 100% disability, organ donors, blood donors, pupils and students under 26 years, as well as persons below the minimum income threshold). (68)

HZZO provides the supplementary health insurance at a yearly loss (EUR 23 million in 2012). Nevertheless, the HZZO reduced the price of supplementary policy to HRK 70 (EUR 9) for all insured persons in September 2013. With this measure, HZZO hoped to retain the majority of 2,370,000 insured persons and beat the competitors in the market. The largest private insurer in Croatia, Osiguranje, offered their supplementary policies at a price of HRK 75, and with the opening of the market after Croatia joined the EU; additional private insurance companies have announced their interest in this segment. HZZO is currently holding around 98% of the market in

(68) Source: Croatian Health Insurance Fund Annual Report for

2015, http://cdn.hzzo.hr/wpcontent/uploads/2016/04/lzvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf.

supplementary insurance (Bodiroga-Vukobrat, 2013).

Private voluntary insurance is still a luxury for Croatian citizens, since only about 1.19% of citizens have a private health insurance policy. The 1993 Law allowed opting-out of the public insurance system and acquiring substitutive insurance with private insurers. This was abolished in 2002.

Types of providers, referral systems and patient choice

The number of practising physicians per 100,000 inhabitants (303 in 2013) is slightly below the EU average (344 in 2013), showing an increase since 2003 (244). The number of GPs per 100,000 inhabitants (54 in 2013) is below the EU average (78.3 the same year), and has remained roughly stable since 2009. The number of practising nurses per 100,000 inhabitants (621 in 2013) is well below the EU average (837) despite having increased throughout the decade, from a level of 470 in 2003. (69)

Teaching hospitals, clinical hospital centres and state institutes of public health are state owned.

Health centres, polyclinics, general and special hospitals, pharmacies, institutions for emergency

medical aid, home care institutions and county institutes of public health are county-owned.

During 2002, health centres began the process of merging through which their number was reduced from 120 in 2001 down to 49 in 2014. Out of 73

hospital institutions and sanatoriums, ten special hospitals and five sanatoriums were privately

owned. By the end of 2014, there were 5,399

private practice units (doctors' offices,

laboratories, private pharmacies, private physical

therapy practices and home care services)

registered. (70) The majority of primary health care

general practitioner (GP) offices located in health

centres were since 1991 privatised, and the

remaining ones were left under county ownership

(Bodiroga-Vukobrat, 2013).

(69) Data for density of health personnel is taken from the

OECD database. As this figure includes only nurses

employed in hospitals, the actual number may be

underestimated.

(70) Croatian Institute of Public Health, Croatian Health Service

Yearbook 2014, http://www.hzjz.hr/wpcontent/uploads/2015/05/ljetopis_2014.pdf.

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Treatment options, covered health services

As the main purchaser of health services, the

HZZO also plays a key role in the definition of

basic health services covered under statutory

insurance, the establishment of performance

standards and price setting for services covered by

the HZZO (Vončina et al., 2006).

With 1.8 hospitals and 549 hospital beds per

100,000 inhabitants, Croatia is in line with older

EU Member States and does not have excess

hospital facilities like many other countries in

Central and Eastern Europe. However, the

Croatian hospitals have inadequate medical

technology and equipment. Comparing the number

of MRI scans, mammograms and CT scans per

100,000 inhabitants reveals that Croatia is in the

lower ranking within the EU. In addition, regional

coverage varies and regional differences persevere,

since many capacities are unequally distributed

and concentrated in metropolitan areas. Roughly half of the healthcare budget is being spent in hospitals (Bodiroga-Vukobrat, 2013).

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Hospitals were financed directly from the state budget (based on the contract concluded with the HZZO), while all other payments are effectuated through the HZZO. Clinical medical institutions received during the year the maximum amounts to perform clinical and specialist medical care and at the end of the year the work performed and the allocated means are harmonised. Since 2015, HZZO is out of state budget. This means that all hospitals and primary care providers are financed from HZZO budget. The treatment of acute patients is paid to clinical medical institutions according to diagnostic-therapeutic groups (DTS), or according to day of clinical (hospital) treatment (DBL) for chronic diseases. Additional coverage is provided for particularly expensive medicines and certain complicated procedures. In the year 2015, 24,069 beds have been contacted, of which 12,617 are for acute care, 1,324 for long-term care, 6,357

beds for chronic diseases and 3,771 day care beds,

with an increase in the number of the latter from

the previous year (15,940 acute, 3,033 day care

and 5,898 beds for chronic diseases and physical

therapy). The average monthly hospital limit in

2015 was HRK 664,907,700, increased from

576,573 million in 2014 (71). Depending on the

structure, the majority of hospital expenses cover

employees' wages (56.67% in 2010, 57.38% in

2011).

In 2015, the average number of waiting days for all

diagnostic procedures was 147 with 178,344

orders waiting (decreased from 166 with 189,540

orders in 2014); the average number of days for

therapeutic procedures was 253 with 42,791 orders

(down from 267 with 44,822 in 2014), and the

average number of days for first examination was

102 with 128,847 orders (lower than 111 with

125,236 orders recorded the previous year).

In 2014 there were 77 hospital institutions and

treatment centres in Croatia: 5 clinical hospital

centres, 7 clinical hospitals and clinics, 20 general

hospitals, 33 special hospitals and treatment

centres, 1 hospice, 10 general wards and 1 out-ofhospital

maternity ward.

In 2014, Croatian hospitals treated 742,452 people

(744,188 in 2013). The care included hospital stays

for childbirth, abortion, and hospital rehabilitation.

According to individual reports on treated patients

(excluding childbirth, abortions and rehabilitation),

the number of patients treated in Croatian hospitals

in 2014 was 578,569 (577,565 in 2013).

The number of beds (expressed per 1,000

population) in all hospital-type institutions in 2014

was 5.89 (in 2013 it was 5.86). By bed structure

per 1,000 inhabitants in 2014, there were 4.07

acute beds (1.80 in general hospitals and 2.31 in

teaching hospitals). For chronic and subacute

patients, 1.82 beds per 1,000 inhabitants were

available.

In Croatian hospitals, in 2014 there were 6,536,737

days of hospital treatment. In other words, the

average length of treatment per stay was 8.80 days

(against the 1990 average length of treatment of

15.37 days). Average length of treatment in

general hospitals has been reduced from 12.3 days

in 1990 to 6.80 days in 2014. The average length

of stay in teaching hospital centres, teaching

hospitals and clinics was reduced from 12.05 to

(71) Network of Public Health Services (Official Gazette, No 101/12, 31/13, 113/15).

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7.34 days and in special hospitals from 34.83 to 23.36 days. (72)

It is recognised that a reduction of existing inefficiencies in hospital management is required in the short run in order to decrease the debt and arrears of the hospitals. Reconsidering the model of financing of hospitals seems inevitable in the long run. To this end, the Hospital Master Plan, which is the National plan of development of clinical hospital centres, clinical hospitals and general hospitals in Republic of Croatia for 2015.- 2016, has come into force since March 2015. (73)

The World Bank supports the preparation of the plan, and provided funds to hire French consultancy firm Conseil Santé to assist with the writing of the plan.

The market for pharmaceutical products

Out of the total expenditure by HZZO, pharmaceuticals accounted for a share of 14.1% in 2002 (Vončina, 2006). In 2011, there were 16

licensed pharmaceutical manufacturers in Croatia.

Domestic manufacturers held 20% of the market

share by value produced and 33% by volume

produced (Ministry of Health and Social Welfare,

2011). The major domestic pharmaceutical

companies are Pliva, Belupo and Jadran Galenski

Laboratorij.

The HZZO is a purchasing monopoly. It controls

drug prices and it has enforced price reductions in

the market. The access of new drugs to the market

used to take two to three years. However, the 2003

Drugs Law introduced a new Agency for Drugs

and Medical Products and set out a shorter, more

ambitious time frame for registration (210 days for

ready-prepared drugs).

The Drug Reference Price System was introduced

in 1999 in an attempt to contain pharmaceutical

expenditure. To further rationalise costs for drugs,

the HZZO has introduced risk-sharing, pay-back

and cross-product agreements with pharmaceutical

companies. In addition, according to the new

model, whenever both an off-patent and a generic

are available, generics are preferred, unless there

(72) Source: Croatian Institute of Public Health, Croatian

uploads/2015/05/ljetopis_2014.pdf.

(73) [http://narodnenovine.](http://narodnenovine.nn.hr/clanci/sluzbeni/2015_03_26_544.html)

[nn.hr/clanci/sluzbeni/2015_03_26_544.html](http://narodnenovine.nn.hr/clanci/sluzbeni/2015_03_26_544.html).

are specific medical indications to the contrary

(Vončina, 2006).

To curb the volume of prescriptions, the HZZO has imposed annual caps on the number of prescriptions per beneficiary and limited the number of drugs per prescription, which, however were not successful as the number of prescriptions actually increased over time. The HZZO reviews prescribing practices but does not include them as part of performance indicators for payments.

Overspending by individual GPs is, however, subject to financial punishment of up to 10% of monthly capitation. The punishments are enforced (Vončina, 2006).

Pharmaceuticals covered by the HZZO are classified into two lists: the positive list entirely covered within the MHI scheme, and the supplementary list with medicines covered in part by the MHI scheme and in part by OOP payments.

Medicines are free of charge if they are on the positive list, regardless of the patient's situation

(age, financial status, inpatient or outpatient

setting, etc.). There is a prescription fee for all reimbursable medicines of HRK 10 (approximately EUR 1.5) per prescription. Private health insurance schemes do not cover medicines.

Use of Health Technology Assessments and cost-benefit analysis

In accordance to the Act on Quality of Health **Care** and Social Welfare (Official gazette, no 107/07, 124/11), the Agency for Quality and Accreditation in Health **Care** and Social Welfare is in charge for health technology assessment (HTA). However this is optional and not mandatory. Regrettably, HTA in Croatia is rather “underused” and “underdeveloped”. The HZZO is playing a big role in HTA decisions and, through its “Drugs Committee” and “Medical Devices Committee”, it is responsible for the appraisal and gives a recommendation to the Board of the HZZO, which then makes the pricing and reimbursement decision. The HZZO can make a request to the Agency for Quality and Accreditation in Healthcare and Social Welfare – HTA Department to conduct an assessment. The Ministry of Health is involved in the HTA process, when it comes to

legislation. As a member state, Croatia is also taking part in EUnethTA and is represented in some of the work groups of the network.

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The World Bank identifies HTA and use of protocols as a field for improvement (Bodiroga-Vukobrat, 2013).

eHealth, Electronic Health Record

Information and eHealth strengthening is the first priority identified in the 2012 National Health

Care Strategy. The aim would be the integration

and standardisation of health information and

equalisation of the level of informatisation in the

health **care** system as a whole, the further

establishment of Electronic Health Records, to

improve the use of statistical information to

support decision making and establishing a

reporting and warning system. It is the aim of the

Government of Croatia to improve, modernise and

maintain the existing information systems in health

care.

Health promotion and disease prevention

policies

The Government of Croatia confirms in the

National Health Care Strategy that it needs to increase its focus on the prevention of disease, for which it needs to gradually increase the share of preventive programmes and activities in the health

care budget. The primary focus in prevention must be on the biggest health problems of the Croatian population – chronic non-infectious diseases, malignant tumours, injuries, mental disorders and risk behaviours, including smoking, misuse of alcohol and drugs, physical inactivity and poor nutritional habits. The broad ambitions of the government would need to be translated in to concrete actions.

Recently legislated and/or planned policy reforms

The focus of reforms that were implemented between 2006 and 2013 was the financial stabilisation of the health care system. The key reform, implemented between 2008 and 2011, contained a number of measures: diversification of public revenue collection mechanisms through the

introduction of new mandatory and complementary health insurance contributions; increases in co-payments; and measures to resolve accumulated arrears. Other important reforms included changes in the payment mechanisms for primary and hospital care; pharmaceutical pricing and reimbursement reform; and changes to health

care provision (e.g. emergency care reform).

The launch of many of these reforms was not difficult, as for many of them policy options were not publicly discussed and no comprehensive implementation plans were developed. However, as a result, many of them soon faced serious implementation problems and some were only partially implemented.

Planned reform activities for 2014–2016 will mainly be directed at achieving cost–effectiveness in the hospital sector. (74)

(74) Republic of Croatia has regulated healthcare by Health

Care Protection Act ("Official Gazette", 150/08., 155/09., 71/10., 139/10., 22.11., 84/11., 154 / 11., 12.12., 70/12., 144/12., 82/13., 159/13., 22/14.), Compulsory Health Insurance Act ("Official Gazette" No. 80/13 ., 137/13.) and Voluntary Health Insurance Act ("Official Gazette", 85/06.,

150/08., 71/10.).

Health Protection Act: regulates principles and procedures

of health care, rights and obligations of persons in the use

of health care services, social welfare holders for

population health, content and organisational forms of

health activities and supervision of the performance of

health care activities.

Compulsory Health Insurance Act: regulates compulsory

health insurance in the Republic of Croatia, the scope of

the right to health care and other rights and obligations of

the insured persons, acquiring and financing terms and

manners of, as well as rights and obligations of compulsory

health insurance, including the rights and obligations of the

contracting entities for the implementation of health care

from the compulsory health insurance. Under this Act the

Directive 2011/24 / EC of the European Parliament and of

the Council of 9 March 2011 is transposed into national

legal system and the application of patients' rights in crossborder

healthcare (OJ L 88, 4 4th, 2011).

Voluntary Health Insurance Act : regulates types,

conditions and manners of implementation of voluntary

health insurance (voluntary, supplementary and private

health insurance).

National Strategy for the Development of Health (2012-

2014) which sets the direction of development of the

Croatian Health **Care** ("Official Gazette" No. 116/12.), and

laws governing the conduct of certain medical procedures.

All those laws include provisions of the acts of the

European Union, such as Transplantation of Human

Organs for the Purpose of Medical Treatment Act

("Official Gazette" No. 144/12), Medically Assisted

Reproduction ("Official Gazette" No. 86/12), Application

of Human Tissues and Cells Act ("Official Gazette" No.

144/12).

The organisation itself, as well as conditions for carrying

out certain health activities are regulated by following

laws: Medical Practice Act ("Official Gazette", no. 121/03

and 117/08.), Medical- Biochemical Activities Act

("Official Gazette" No. 121/03 and 117/08.), Dentistry Act

("Official Gazette", 121/03. 117/08., and 120/09),

Pharmacy Act ("Official Gazette", 121/03. 142/06., 35/08.,

and 117/08), Nursing Act ("Official Gazette", 121/03.

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Based on the National Reforms Program for 2016

adopted by Croatian Government in April 2016,

spending control, rationalisation and optimisation

of costs should ensure a high level of health protection. This should be achieved through changes of the health insurance system, through a reform of emergency medicine, the reorganisation of the hospital network, the rationalisation and reorganisation of hospital non-medical services, a reform of primary health care, further development and implementation of the joint public procurement procedure, and through the stricter control of drug prescriptions and the informatisation of the health system. (75)

Joint hospital procurement

While initially the health care sector was largely unaffected by the austerity measures implemented in response to the financial crisis, since 2012 (after the new centre-left government took office), it has faced more pressure to rationalise health care costs. One of the measures that were meant to achieve significant savings was the implementation of a joint hospital procurement programme for public hospitals.

Public hospitals, which previously procured all medical products and other goods individually, were directed to form joint purchasing bodies for

items that account for the largest share of expenditure, such as medicines, medical devices and energy. A decentralised approach was adopted, whereby a number of hospitals were assigned to procure categories of goods for all participating hospitals. Hospitals that had previously achieved best value for money for certain procurement categories were selected to be the central purchasers. Central procurement was launched for 15 groups of goods and services in October 2012. Despite substantial opposition from manufacturers and retailers, a number of joint procurement tenders have been successfully concluded. So far, the reform is proving to be successful in reducing 117/08., 57/11.). Health **care** in the Republic of Croatia is also regulated by other regulations which are adopted under the basis of the specified laws.

(75) Source: National Reforms Program for 2016,

<https://vlada.gov.hr/UserDocsImages//Sjednice/2016/17%20sjednica%20Vlade//17%20-%201a.pdf>.

prices and achieving savings, and in standardising the quality of procured goods.

Sanation of public hospitals

The problem of **poor** hospital finances has

persisted over many years and in the last 15 years;

there were more than 10 cases where hospitals had to be financially reorganised in the short term (Bodiroga-Vukobrat, 2013). In 2012, the Act on Sanation(76) of Public Institutions was adopted, mainly with the aim of improving the finances of heavily indebted county-owned hospitals. It enabled temporary centralisation of the hospital management, and it was conceived as one of the measures aimed at reducing the overall public debt and improving the efficiency of the public sector (measures were also undertaken in other sectors).

In April 2013, the government adopted decisions on the financial reorganisation of nine State-owned clinical hospitals at a cost of HRK 1.9 billion (EUR 0.25 billion) and an additional 25 health care facilities (mostly county-owned hospitals) at a cost of HRK 1.13 billion (EUR 0.15 billion) (Bodiroga-Vukobrat, 2013). The measure is to be applied to all hospitals whose expenditures exceeded revenues at the end of 2013. However, both the hospitals and the HZZO continue to generate new debts (and at the same time both the State budget for health care and co-payments have been

reduced). Problems with poor hospital management also persist due to the political designation of hospital directors and managers.

During 2013 and 2014 total amount of sanation was HRK 3.5 billion (EUR 0.461 billion). (77)

Other reforms

Some of reforms that were introduced between 2006 and 31 December 2013 were encouraged by previous experiences (for example, the introduction of a prospective case-adjusted hospital payment system, based on DRGs, was encouraged by evidence on efficiency gains (76) The word “sanation” refers to the act of healing. In the context of the Croatian health care system it means restoring the financial position and improving management.

(77)

[https://vlada.gov.hr/UserDocsImages/Sjednice/2016/272%](https://vlada.gov.hr/UserDocsImages/Sjednice/2016/272%20sjednica%20Vlade/272%20-%201.pdf)

[20sjednica%20Vlade/272%20-%201.pdf](https://vlada.gov.hr/UserDocsImages/Sjednice/2016/272%20sjednica%20Vlade/272%20-%201.pdf).

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reported since the implementation of the payment per therapeutic procedure (PPTP) schedule in

2005) (Bodiroga-Vukobrat, 2012), most measures had not been tested before.

The Government Programme for the 2011–2015

Mandate recognised that citizens have over the years become increasingly burdened with health

care financing and the focus has been shifted to patient-oriented health policy, maintaining

solidarity between the healthy and the ill, the rich

and the poor, and the young and the elderly. This is to be achieved through a number of measures, such

as the reorganisation of emergency medical care,

primary health care and hospitals; education of human resources; more emphasis on preventive measures; and the shortening of waiting lists.

The large number of changes that have been introduced and the speed of their implementation have resulted in insufficient preparation of some measures, delays and problems with implementation. Nevertheless, several reforms (the pharmaceutical pricing and reimbursement reform; the 2013 payment mechanisms reform; and also the EMS reform) seem to have been successfully implemented.

According to the Hospital Master Plan, in 2015

reorganisation of hospitals was initiated. In the last

quarter of 2015, the Network of Public Health

Services was changed which implied a

reclassification of hospitals beds from acute beds

to palliative, chronic, prolonged and day-care beds.

The full implementation of the Master Plan,

including the reshaping of the hospital network,

will start by the end of 2016. (78)

Challenges

A range of reforms have been implemented in

recent years – or are still in the state of gradual

implementation. They imply substantial structural

changes, with a focus on controlling the growth of

health expenditure and improving efficiency and

quality. The main challenges for the Croatian

health care system are as follows:

(78) Source: Convergence Program of Republic of Croatia for

2016-2019,

[https://vlada.gov.hr/UserDocsImages//Sjednice/2016/17%20](https://vlada.gov.hr/UserDocsImages//Sjednice/2016/17%20sjednica%20Vlade//17%20-%201b.pdf)

[0sjednica%20Vlade//17%20-%201b.pdf](https://vlada.gov.hr/UserDocsImages//Sjednice/2016/17%20sjednica%20Vlade//17%20-%201b.pdf).

- To continue increasing the efficiency of health

care spending in order to adequately respond to

the increasing health care expenditure over the

coming decades. To this end, to strengthen the existing public procurement system.

- To improve the basis for more sustainable and

efficient financing of health care (e.g.

considering additional sources of general

budget funds), aiming at a better balance

between resources and spending, and

diminishing the reliance on retroactive

government transfers to cover deficits by health

care providers and of regressive financing;

- To increase efficiency in hospital productivity

by adjusting the way providers are

remunerated, including staff wages, thereby

containing the issue of deficits and arrears, the

elimination of which is lagging behind. To this

end, to further the efforts in the introduction of

activity-based systems as a driver of costefficiency.

- To explore how current financing schemes

could be adjusted to a mix of capitation-based

reimbursement and of activity/quality linked

incentives, to increase efficiency and quality in

the delivery of services at all levels of care

(primary and specialist care) and notably to

encourage more health promotion and disease

prevention activities (e.g. vaccination).

- To optimise the configuration of the hospital system (including capacity, staff and service mix) to tackle existing regional differences and obstacles to access to services. To design and implement a policy of human resources management based on improved training and on achieving a skill mix consistent with a primary-care based system.

- To improve data collection, especially in some crucial areas such as resources and care utilisation; to improve the patient information system promoting the development and utilisation of eHealth tools as envisaged by the 2012 National Health Care Strategy, which can help ensuring effective referral systems from primary to specialist care and improving care coordination between types of care.

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- To consider additional measures to improve the

rational prescribing and usage of medicines,
 such as information and education campaigns,
 the monitoring of prescription of medicines and
 a more explicit policy on incentivising the
 uptake of generics. The policies could help
 improving population health, reducing the high
 level of out-of-pocket payments and improving
 access to cost-effective new medicines by
 generating savings to the public payer.

- To gradually increase the use of costeffectiveness

information in determining the
 basket of goods and the extent of cost-sharing,
 increasing the use of HTA currently underused
 and underdeveloped, possibly making it a
 compulsory step and strengthening the role of
 the Agency for Quality and Accreditation in

Health **Care** and Social Welfare.

- To further enhance health promotion and
 disease prevention activities, promoting healthy
 life styles and disease screening given the most
 recent pattern of risk factors (such as, for
 instance alcohol consumption).

- Implementing the Health **Care** Strategy (2012-
 2020), with a view of increasing ownership of
 the strategy by all stakeholders of the health

system.

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Table 1.4.1: Statistical Annex – Croatia

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 31 33 37 40 44 48 45 45 45 44 43 9289 9800 9934

GDP per capita PPS (thousands) 15.1 15.6 15.9 16.3 17.3 17.0 15.1 14.9 15.3 15.4 15.2 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 5.4 4.1 4.2 4.9 5.1 2.1 -6.8 -2.0 0.1 -1.9 -0.5 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita : 7.5 9.5 5.5 12.7 5.6 -1.7 -0.5 -12.8 -2.6 0.5 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 6.4 6.7 7.0 7.0 7.5 7.8 8.2 8.4 7.3 7.2 7.3 10.4 10.1 10.1

Total current as % of GDP : : : : : : 7.1 7.0 7.3 9.8 9.6 9.7

Total capital investment as % of GDP : : : : : : 0.2 0.2 0.0 0.6 0.5 0.5

Total per capita PPS 678 755 854 936 1098 1226 1232 1242 1100 : : 2828 2911 2995

Public as % of GDP 5.3 5.4 6.0 6.0 6.5 6.6 7.0 7.2 5.7 5.8 5.8 8.1 7.8 7.8

Public current as % of GDP : : : : : : 5.5 5.6 5.8 7.9 7.7 7.7

Public per capita PPS 558 613 733 799 947 1037 1048 1070 865 872 880 2079 2218 2208

Public capital investment as % of GDP : : : : : : 0.2 0.2 0.0 0.2 0.2 0.1

Public as % total expenditure on health 82.3 81.2 85.8 85.3 86.2 84.6 85.1 86.1 78.6 80.1 80.0 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure : : : : : : 20.1 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance : : : : : : 100.0 100.0 : 99.7 99.7 98.7

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Out-of-pocket expenditure on health as % of total expenditure on health 16.7 18.2 13.4 13.4 12.5 14.5 13.7 13.8
13.4 12.8 12.5 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 502.1 504.5 506.6

Life expectancy at birth for females 78.1 78.8 78.8 79.3 79.2 79.7 79.7 79.9 80.4 80.6 81.0 82.6 83.1 83.3

Life expectancy at birth for males 71.0 71.8 71.7 72.4 72.2 72.3 72.8 73.4 73.8 73.9 74.5 76.6 77.3 77.8

Healthy life years at birth females 0.0 : : : : : 60.4 61.7 64.2 60.4 : 62.1 61.5

Healthy life years at birth males : : : : : 57.4 59.8 61.9 57.6 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 157 145 149 142 144 136 132 125 268 249 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 6.3 6.1 5.7 5.2 5.6 4.5 5.3 4.4 4.7 3.6 4.1 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 1.96 1.87 1.56 3.13 2.99 3.01

Day cases curative and rehabilitative care : : : : : 0.19 0.19 0.24 0.18 0.18 0.19

Out-patient curative and rehabilitative care : : : : : 1.72 1.71 1.70 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables : : : : : 2.04 2.04 2.38 1.60 1.55 1.44

Therapeutic appliances and other medical durables : : : : : 0.16 0.15 0.14 0.31 0.31 0.32

Prevention and public health services : : : : : 0.14 0.16 : 0.25 0.25 0.24

Health administration and health insurance : : : : : 0.18 0.20 : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : : : : 1.78 1.72 1.44 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : 0.18 0.18 0.23 0.16 0.16 0.18

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Out-patient curative and rehabilitative care : : : : : 1.33 1.35 1.37 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables : : : : : 1.25 1.28 1.60 0.79 1.07 0.96

Therapeutic appliances and other medical durables : : : : : 0.07 0.07 0.07 0.13 0.12 0.13

Prevention and public health services : : : : : 0.13 0.15 : 0.25 0.20 0.19

Health administration and health insurance : : : : : 0.16 0.18 : 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.4.2: Statistical Annex - continued – Croatia

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 27.7% 26.6% 21.4% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : : : : : 2.7% 2.7% 3.3% 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : : : : : 24.3% 24.3% 23.4% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables : : : : : 28.8% 29.0% 32.7% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : : : : : 2.3% 2.1% 1.9% 3.2% 3.3% 3.3%

Prevention and public health services : : : : : 2.0% 2.3% : 2.6% 2.6% 2.5%

Health administration and health insurance : : : : : 2.5% 2.8% : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

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Inpatient curative and rehabilitative care : : : : : 32.2% 30.7% 24.7% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : : : : 3.3% 3.2% 3.9% 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care : : : : : 24.1% 24.1% 23.5% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables : : : : : 22.6% 22.9% 27.4% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : : : : 1.3% 1.3% 1.2% 1.6% 1.6% 1.6%

Prevention and public health services : : : : : 2.4% 2.7% : 3.2% 2.7% 2.5%

Health administration and health insurance : : : : : 2.9% 3.1% : 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants : : : : 0.70 : 0.72 : 0.98 1.06 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : 0.5 : 0.6 : 0.6 0.7 0.9 0.9 0.8

CTS per 100 000 inhabitants : : : : 1.4 : 1.6 : 1.6 1.6 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.0 : : : : 0.0 : 0.1 : 0.1 0.1 0.1 0.1 0.1

Proportion of the population that is obese : : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 27.4 : : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 12.3 11.7 10.5 10.6 11.4 10.9 11.0 10.7 10.6 : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 244 250 250 253 266 266 267 278 284 299 303 329 335 344

Practising nurses per 100 000 inhabitants 470 479 483 492 503 522 511 531 542 568 621 840 812 837

General practitioners per 100 000 inhabitants : : : : : 55 50 51 53 54 : 78 78.3

Acute hospital beds per 100 000 inhabitants 338 342 338 339 340 341 336 352 350 357 357 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita : 7.6 6.9 6.4 6.4 6.0 6.4 6.1 6.0 6.9 6.1 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 14.5 14.8 15.1 15.9 16.0 15.9 15.7 14.8 15.3 14.9 15.1 16.6 16.4 16.5

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Day cases discharges per 100 000 inhabitants 309 315 298 332 319 1,863 3,076 4,538 5,487 6 ,704 7,949 6368 6530 7031

Acute care bed occupancy rates 91.0 90.0 88.0 87.0 86.0 84.9 83.1 75.2 76.7 77.3 73.7 72.0 73.1 70.2

Hospital curative average length of stay 8.4 8.2 7.8 7.6 7.5 7.3 7.4 7.2 7.2 6.9 6.9 6.5 6.3 6.3

Day cases as % of all hospital discharges 2.1 2.1 1.9 2.0 1.9 10.5 16.4 23.5 26.4 31.0 34.5 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 5.7 6.8 7.1 7.3 7.4 7.5

AWG risk scenario 5.7 7.0 7.6 8.1 8.4 8.4

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 4.3 4.2 4.1 4.0 3.8 3.7

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-13.1 3.1

1.7 0.9

2.7 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

GDP per capita is currently below EU average with 21,900 PPS in 2013 (EU: 27,900). The population was estimated at 0.9 million in 2013. According to Eurostat 2013 projections, total population is projected to increase from around 0.9 million in 2013 to 1.1 million in 2060. The economic crisis hit Cyprus hard and resulted in a significant drop in GDP and employment. Since 2013, Cyprus has been implementing an Economic Adjustment Programme agreed with the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF) covering the period 2013-2016. The Programme aims to address the financial, fiscal and structural challenges facing the economy. This includes key fiscal-structural reforms in the economy as a whole including in the health sector.

Total and public expenditure on health as % of GDP

Total expenditure on health has been increasing in the past decade. However, due to high economic growth until 2008, expenditure as a percentage of GDP (7.4% in 2013) was relatively moderate and below the EU average of 10.1% in 2013. When expressed in per capita terms, also total spending

on health at 1,749 PPS in 2013 was below the EU average of 2,988 in 2013. So was public spending

on health care: 3.4% of GDP in Cyprus in 2013 vs. 7.8% of GDP in the EU; and 743 PPS in Cyprus vs. an EU average of 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.3 pps of GDP, below the average growth level expected for the EU of 0.9 pps of GDP, according to the "AWG reference scenario". (79) When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health

care expenditure is expected to increase by 0.6 pps of GDP from now until 2060 (EU: 1.6). Overall, (79) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

projected health care expenditure increase is expected to add to budgetary pressure, contributing to the risk for long-term sustainability of public finances.

Health status

Life expectancy at birth (85.0 years for women and

80.1 years for men) was above EU average levels of 83.3 and 77.8 years in 2013. The same is true for healthy life years with 65.0 years for women and 64.3 years for men in Cyprus versus 61.5 and 61.4 in 2013 in the EU. The infant mortality rate of 1.6‰ was below the EU average of 3.9‰ in 2013, having fallen throughout the last decade.

As for the lifestyle of the Cypriot population, data indicates a high proportion of regular smokers (25.9% in 2008), being above the EU average of 22.0. The proportion of the obese population is at the EU level at 15.6% (EU: 15.5%), and the alcohol consumption is below EU level. The proportions of population smoking, being obese as well as the average alcohol consumption seem relatively unchanged over the last decade.

System characteristics

Overall description of the system

The Cypriot health system is made up of two uncoordinated sub-systems of similar size: a public one and a separate private one. The public system is highly centralised and planning, organisation, administration and regulation are the responsibility of the Ministry of Health (MoH). It is mainly financed by the state budget, as well as by

contributions to health insurance from civil servants and civil servant pensioners, with services provided via a network of public hospitals and health centres directly controlled by the MoH.

Public providers' employees have the status of civil servants and are salaried employees.

The current system has led to an unequal distribution of services and inequities in access to

care. Also, prices, capacity, and care quality in the private sector are to a large extent unregulated.

There is no implemented coherent framework matching separate provision of public and private healthcare services, leading to inadequate and ineffective coverage. On the one hand, driven by the economic crisis, the increase in demand for

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public health care services has led to an overburdened public healthcare sector. This resulted in high waiting times for selected consultations, surgical procedures and diagnostic tests, and potentially also to a decrease in the quality of care.

The over-capacity of private health care providers

is exacerbated. This led to wasteful allocative

inefficiencies in total health care resources in

Cyprus.

To address these inefficiencies and to ensure

efficiency gains in the mid-term, the Cypriot

authorities are pursuing to implement a dual

strategic reform program; Firstly, it aims to raise

resilience of the system and to improve the access

to quality health care in Cyprus with the

autonomisation of public hospitals, thereby

enacting the relevant bill. Public hospitals financial

autonomy can facilitate the improvement of access

to quality health care and foster it, thereby

administering their own budgets based on available

resources. The public hospitals' autonomisation

should lead to normalisation of admissions and

length of stay as well as the appropriate utilisation

of infrastructure, staff as well as the efficient use

of hospitals' properties.

Secondly and following the public hospitals

autonomy, Cyprus is envisaged to implement a

National Health Insurance Scheme (NHIS). The

main goals of NHIS are: (i) ensuring universal

healthcare coverage; (ii) pooling the public and

private financing; (iii) overcoming the fragmentation of provision of uncoordinated private and public care; (iv) improving system organisation and monitoring; (v) improving access to and quality of care.

Coverage

Citizens below a determined income level used to be free health care beneficiaries of the Public Health System (around 80% of the population), while the rest of the population (non-beneficiaries) paid according to fee schedules by the MoH. As from 1.8.2013 new fees and co-payments were set that reduced the share of free health care beneficiaries to around 70% of the population. The envisaged introduction of the NHIS is expected to increase coverage to the whole population, since every inhabitant should be covered under a family doctor to guide him through the system. As demand exceeds significantly the supply for free public health care services, long waiting lists for some specialties create barriers to access for those services. For this reason, a part of the population uses the private services for outpatient

consultations and routine procedures, using the public sector for more costly services.

Administrative organisation and revenue collection mechanism

The public health care budget is financed by the state. In addition, a contribution-based health care scheme is implemented for civil servants, and there are co-payments defined for beneficiaries and nonbeneficiaries

of public health care services. The public health sub-system is highly centralised.

Most decision-making processes are centralised.

Public hospitals form part of an integrated system of civil service and ministerial control management, such that managerial decisions are taken outside of the hospitals.

Role of private insurance and out of pocket co-payments

The public health care system has since long been criticised for failing to effectively cover the population leading to inadequate and ineffective coverage. The latter is associated with the fact that around 50% of people eligible for free public health care opt to visit the private sector and pay

out-of-pocket (mostly for ambulatory care services) to avoid long waiting times. As a result, the share of private and out-of-pocket in total health expenditure (53.7% and 46% in 2013, respectively) is the largest in the EU (EU average: 23% and 14% in 2013, respectively). The population non eligible for free public health care services is to some degree covered by private health insurance schemes, although the domestic private health insurance industry is still at an infant stage.

Types of providers, referral systems and patient choice

As stated above, public and private provision coexist. Public primary care is provided in hospital outpatient departments, urban and rural health centres and sub-centres. Public dental care is provided in public dental clinics. Public general hospitals offer specialist outpatient care and district hospitals and Specialist Centres such as the Health care systems

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of Neurology and Genetics offer outpatient and

inpatient hospital care. Private health services

include a variety of specialists and dentists who

provide their services in their own facilities,

typically in the largest urban areas.

The total number of practising physicians per 100

000 inhabitants (322 in 2013) is below the EU

average (344 in 2013). The number of general

practitioners (GPs) per 100 000 inhabitants is not

known with certainty, but in the past it has been

below the EU average (41 per 100 000 inhabitants

in 2003). At the moment, besides some form of

referral in the case of public provision, there is no

formal referral system from primary to specialist

and hospital care. With NHIS, national authorities

want to establish a system of family doctors and

strengthen the referral system from primary care to

specialist doctors and other providers. In other

words, all inhabitants would register with a family

doctor, who would act like a gatekeeper referring

patients to specialist and other providers.

Cyprus has seen a reduction in the number of acute

care beds per 100 000 inhabitants in the last

decade (320 in 2013 vs. 394 in 2003) and their

number is below the EU average (356 in 2013).

About half of the beds are publicly owned. The

future number of acute care beds will depend on

the combination of the possible reorganisation of

public hospitals as a result of the NHIS

implementation with optimal use of effective

modern technologies at hospitals such as day-care

and laparoscopic services, the availability of

follow-up care and the availability of long-term

care services. With the planned autonomisation the

public hospitals shall be turned into independent

and autonomous units that can compete with

private providers on an equal basis to establish

contracts with the purchasing authority (Health

Insurance Organisation - HIO).

Treatment options, covered health services

The benefit package is explicitly defined and is

comprehensive.

Price of healthcare services, purchasing,

contracting and remuneration mechanisms

Currently, doctors in the public sector are paid a

salary, while in the private sector they are paid on

a fee-for-service basis with unregulated fees.

Public sector remuneration is determined by the central government. The private sector fees are determined by the free market and depend on reputation of each specific doctor, although an indicator of private sector fees is set by the Medical Council. At the moment there is no activity or performance related payment in the public sector. With the implementation of the NHIS, family doctors' (FDs) reimbursement shall entail a 3-tier payment: (i) An age-adjusted capitation (per number of patients), (ii) an activity based reimbursement, depending on doctor activities regarding preventive medicine practices, chronic disease management, and (iii) a performance related reimbursement that will be tied to, among others, the use of the electronic HIO IT system, referral and prescribing behaviour. The details of how this will be implemented are in the process of being finalised. A uniform reimbursement policy is to be applied to both public and private sector providers.

Specialists' outpatient services will be reimbursed on a fee for service basis (per activity). As regards specialists' inpatient services in hospitals, these will be incorporated into the DRG to which each

case will be assigned. It is expected that with its introduction, the DRG system will promote the containment of inpatient expenditure through the increased transparency concerning clinical data and costs. In addition, as the HIO will treat the public and private sectors exactly the same, it is expected that, through the competitive environment which will be created, an improvement in hospital efficiency and quality of service provided will occur.

Currently the annual MoH budget includes a specific hospital budget allocated to each hospital according to need, primarily on a historical basis adjusted to inflation. As a result, there are no incentives for cost-awareness and control from the part of the public providers. In addition, when looking at hospital activity, inpatient and day case discharges are much lower than the EU average (respectively 7.8 discharges per 100 inhabitants vs. 16.5 in the EU and 1,672 day case discharges vs. 7,031 in the EU per 100 000 inhabitants). This suggests that there is room to increase hospital activity. It also suggests that as a result of hospital inefficiency patients waiting times are increased.

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The market for pharmaceutical products

In the private sector, pharmaceutical care is provided through registered private pharmacies and financed with out-of-pocket payments. The prices of imported pharmaceuticals are set through external price referencing. A 3% mark-up is added to the external reference price (ERP) to cover the cost of importing pharmaceuticals. Furthermore, a reduction of 8.5% is applied for products with a whole sale price greater than EUR 10. The price set is the wholesale price. The wholesale prices include the wholesale margins and the distribution costs. The Pharmacy margins reach 37% on wholesale price for the medicines of EUR 0 – 50, 33% for the medicines of EUR 50,01 – 250,00 and 25% for the medicines of > EUR 250,00. The price revisions only apply to medicines with wholesale prices greater than EUR 10,00. Pharmacists also receive a flat fee of EUR 1,00 per prescription. A 5% VAT is added to the net price.

The external price referencing is also applied for setting the prices of imported generics, in case the corresponding originators are not included in the

price list. In general, the price of the generics cannot exceed 80% of the price of the original branded product marketed in Cyprus. For locally manufactured generics, the ex – factory price is set on the basis of the production cost plus a mark-up of 20%, in cases where the originator is not included in the price list. Along with the imported generics, local manufactured generics should not exceed 80% of the original product included in the price list. Price revisions take place annually. A recalibration of the pricing method is performed semi-annually.

There are no lists of medicines (positive or negative) in the private sector as pharmaceutical

care is not reimbursed. Prescribing habits of private doctors are not monitored, although the authorities often issue guidelines and recommendations for the correct use of medicines to the prescribing physicians.

In the public sector pharmaceutical care is provided through public pharmacies and it falls under the Pharmaceutical Services of the Ministry of Health. It is block-funded by the Ministry of Finance. For the supply of medicines a public

procurement method is used. Pharmaceutical care

is provided to eligible patients, according to the

Medical Institutions and Services General

Regulations.

Pharmaceuticals provided to the eligible patients

are included in the Hospital Formulary which

provides contemporary information about

medicines available from public hospitals and

health care centres. In the past years, a co-payment

scheme has been implemented which enables

doctors to prescribe a limited number of drugs not

included in the approved list, but available in the

private sector. The medicines in the co-payment

scheme are partly reimbursed by the Government.

The amount reimbursed is based on the price

difference between the price of the co-payment

drug and the price of the corresponding available

drug on the list of approved drugs.

In order for a new product to be added to the

Hospital Formulary, a formal pharmaceutical

request form has to be submitted by a specialist

physician practising in a public hospital. Generics

and generic substitution are used widely in the

public sector. The use of generics provides high

cost savings in the public sector. Conversely, the

use of generics in the private sector is limited. One of the reasons for this is the fact that pharmacists are not allowed to substitute original pharmaceutical products for generic medicines.

Furthermore, the promotion of generic medicines is still limited, and the Cypriot government does not provide any incentives for doctors and pharmacists.

A general reform of the pricing and reimbursement system is expected due to the introduction of the NHIS. This reform will unify the pharmacy market under common pricing and reimbursement rules.

Use of Health Technology Assessments and cost-benefit analysis

The government currently builds up its HTA capacity. For pharmaceuticals, the criteria for inclusion of a pharmaceutical in the List of

Approved Pharmaceuticals include: productspecific criteria (e.g. medical and therapeutic value, safety, lack of alternative therapies); economic criteria (e.g. cost effectiveness, budget

impact); patient-specific criteria (e.g. age, sex, chronically or terminally ill patients); and diseasespecific criteria (e.g. severity of illness, special

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medical needs). The Drugs Committee assesses all of the above criteria.

eHealth, Electronic Health Record

At the current moment, there are major deficiencies in the system in terms of IT health solutions, since an Integrated Health Information System (IHIS) is currently used only in 2 hospitals (in Nicosia and Famagusta) and some health centres. However, the Ministry, as part of an ambitious health sector reform program that requires universal access for all public sector health providers to an IHIS and their routine use of it, now seeks an enhanced IHIS. This would incorporate the enhancements and/or amendments required to support the reform process, to expand in all the public hospitals and health centres all over Cyprus.

The main objective is to provide a functional interoperable solution that will ensure electronic data exchange of patient records with other EU countries, the extension, in the future, of services to the Cyprus private healthcare sector, implementation of the further National Health

Insurance System (NHIS) reform and other major

Cyprus health care initiatives that involve

development of electronic data exchange.

On the other hand, in view of the implementation

of the NHIS, the Health Insurance Organisation

(HIO) has prepared the technical requirements for

a total solution for the Information Technology

(IT) System. Currently, the tenders submitted for

the procurement of the NHIS IT system are being

evaluated by the HIO. A full electronic system

shall be implemented for submitting claims and

issuing prescriptions, lab orders and referrals. This

shall be based on electronic enrolment of

beneficiaries and healthcare providers which will

take place in parallel to the development of the IT

system. Other systems such as Electronic Patient

Records, data mining & analytics and disease

management system shall be implemented in

addition.

A high degree of interoperability and data

interchange between the two systems will be

required, since public sector hospitals and health

centres will be service providers to the HIO.

Health promotion and disease prevention

policies

Authorities do not particularly emphasise health promotion and disease prevention, which is visible for the relatively low level of expenditure. Total expenditure on prevention and public health services as a share of GDP and as share of total current health expenditure are below the EU average (0.1% of GDP and 1.4% of total current health expenditure in Cyprus versus 0.2% and 2.5% in the EU, respectively). Prevention is expected to increase with the introduction of the NHIS and the concept of the Family Doctor since the design includes the provision of incentives for specific preventive and screening activities.

Recently legislated and/or planned policy reforms

Health sector reforms gained some momentum under the Economic Adjustment Programme. A Memorandum of Understanding on Specific Economic Policy Conditionality (MOU) attached to this economic adjustment programme included fiscal and structural measures intended to “control the growth of healthcare spending, strengthen the sustainability of the health sector's funding structure and improve the efficiency of public healthcare provision”.

Specific measures were intended to increase the availability of publicly financed health services, to initiate processes to improve the quality of care in public provision of health services and to increase revenue for the health sector. These included: (a) a revision of exemptions from user charges and the introduction of a new contribution of 1.5% on the gross salary or pension for active and retired civil servants; (b) a 30% increase in user charges for publicly provided health services for 'nonbeneficiaries' and the introduction of new user charges (co-payments) and increased user charges for higher levels of care; (c) financial disincentives for using emergency care in non-urgent situations; financial disincentives in the form of co-payments to minimise medically unnecessary laboratory tests and use of pharmaceuticals; (d) MOU measures provided for the restructuring and autonomisation of public hospitals, the restructuring of the Ministry of Health, Associated Facilities/ Organizations and the Health Insurance Organization (HIO). They provided also for the Health care systems

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implementation of the National Health Insurance

Scheme,

In addition, the MOU measures included the

development and implementation of the

information technology infrastructure for the

NHIS, the review of income thresholds for free

access to health care, the creation of evidencebased

protocols for laboratory tests and prescribing

medicines, the establishment of a system for health

technology assessment (HTA), the preparation of

new clinical guidelines for the management of

high-cost diseases, the introduction of coding for

diagnosis-related groups (DRGs) in both public

and private hospitals to provide the basis for a

future payment mechanism, shadow-budgeting for

public hospitals, and periodic reviews of various

other measures (using HTA to define the scope of

publicly covered services, user charges policy and

the introduction of income-related contributions

earmarked for the NHIS), introduction of working

time flexibility, definition of a basket of publicly

covered (reimbursable) medical services and

establishment of a system of family doctors to

refer patients to other levels of care, etc.

The current planning of the comprehensive reform

of the healthcare sector is soon to be completed

and besides the Autonomization of Public

Hospitals, will include the modernisation of

Primary Healthcare, the eHealth, the establishment

of University Clinics, the set up of National

Medicines Organisation and the introduction of

National Health System that will serve as a

capitalisation tool for the rest of the reforms and

boost citizens with high level healthcare services,

in a single market, without public – private

boundaries, with the patient in the centre, able to

choose healthcare provider. The NHIS will be

developed and implemented based on the

fundamental principles of free choice of provider,

social equality and solidarity, financial

sustainability and universal coverage. The current

planning consists of having the original 2013

NHIS bill serving as the basis for NHIS

legislation. The NHIS will be based on a single

payer system.

Challenges

The analysis above has shown that the major

reforms with regard to increasing the efficiency of

the health system are outstanding. The main challenges for the Cypriot health system are as follows:

- To continue increasing the efficiency of health

care spending in order to adequately respond to

the increasing health care expenditure over the coming decades that is a risk to the long-term sustainability of public finances. This could be achieved by implementing a universal NHIS ensuring equal access, financial sustainability

and quality health care, through which a number of other challenges can be tackled as follows:

- To ensure universal coverage and the pooling of financing to the sector, currently nonexistent.
- To address the inefficiencies related to the

fragmentation of care provision characterised by separate public and private provision that do not make part of a whole coherent framework.

- To implement a comprehensive reform of the public hospital sector increasing their managerial capacity and legal ability for autonomous decision making within a strategic framework of public health policies aiming at:

an increase of hospital output, an improvement

of the provision of after-hours primary care

services, and the creation of integrated

networks of public primary health care centres

working in a coordinated fashion with public

hospitals.

- To reorganise and promote public hospitals

autonomy through the relevant bill so as to

ensure equal competition between private and

public health providers and ease failure of

coordination between the public and the private

sector leading to duplication and waste of

resources.

- To focus on enhancing primary health care

services and to implement a comprehensive

reform of the primary health care centres to

improve efficiency and care coordination

between types of care and to encourage patients

to first make use of primary care vs. specialist

care vs. hospital care.

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- To define a comprehensive human resources

strategy to ensure a balanced skill-mix that

allows a strong primary **care** sector to develop.

- To continue to improve data collection and

monitoring of inputs, processes, outputs and

outcomes including putting IT-systems into

place in every public hospital.

- To make systematic use of cost-effectiveness

information, as planned, in determining the

basket of goods and the extent of cost-sharing.

- To foster health promotion and disease

prevention activities, promoting healthy life

styles and disease screening given the pattern

of risk factors (smoking, alcohol, obesity,

circulatory system diseases).

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Table 1.5.1: Statistical Annex – Cyprus

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 13 14 15 16 17 19 18 19 20 19 18 9289 9800 9934

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GDP per capita PPS (thousands) 24.5 25.6 26.4 27.0 27.6 27.9 26.3 26.0 24.5 23.3 21.9 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 0.6 2.9 2.4 2.4 2.9 1.0 -4.5 -1.3 -2.1 -3.9 -5.8 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 12.6 -3.3 1.6 1.0 -0.9 15.0 2.6 -2.9 1.9 -6.2 -5.3 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 6.8 6.4 6.4 6.3 6.1 6.9 7.4 7.3 7.6 7.4 7.4 10.4 10.1 10.1

Total current as % of GDP 6.2 6.0 6.0 6.0 5.9 6.7 7.2 6.4 6.6 6.7 6.8 9.8 9.6 9.7

Total capital investment as % of GDP 0.6 0.4 0.4 0.3 0.2 0.2 0.2 0.8 0.9 0.7 0.6 0.6 0.5 0.5

Total per capita PPS 1359 1378 1442 1510 1563 1882 1934 1914 1988 1883 1749 2828 2911 2995

Public as % of GDP 3.1 2.8 2.7 2.7 2.6 2.9 3.1 3.5 3.6 3.4 3.4 8.1 7.8 7.8

Public current as % of GDP 2.8 2.5 2.5 2.6 2.6 2.8 3.1 3.1 3.2 3.1 3.2 7.9 7.7 7.7

Public per capita PPS 500 486 511 566 565 615 733 814 831 782 743 2079 2218 2208

Public capital investment as % of GDP 0.3 0.3 0.2 0.1 0.0 0.1 0.1 0.4 0.4 0.4 0.3 0.2 0.2 0.1

Public as % total expenditure on health 45.1 43.8 41.8 42.4 42.6 41.4 42.4 47.7 46.8 46.5 46.3 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 7.6 7.3 7.0 7.3 7.0 7.1 7.1 7.1 7.3 7.2 : 14.8 14.9 :
:

Proportion of the population covered by public or primary private health insurance : : : : : : 83.0 83.0 : 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 47.7 49.9 50.1 48.6 49.1 51.3 49.9 46.3 46.5 47.2 46.4 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 0.7 0.7 0.7 0.7 0.8 0.8 0.8 0.8 0.8 0.9 0.9 502.1 504.5 506.6

Life expectancy at birth for females 81.2 81.8 80.8 82.0 82.1 82.9 83.5 83.9 83.1 83.4 85.0 82.6 83.1 83.3

Life expectancy at birth for males 76.8 76.5 76.5 78.1 77.6 78.2 78.5 79.2 79.3 78.9 80.1 76.6 77.3 77.8

Healthy life years at birth females 69.6 : 58.2 63.4 62.8 64.5 65.3 64.2 61.0 64.0 65.0 : 62.1 61.5

Healthy life years at birth males 68.4 : 59.8 64.2 63.1 63.9 64.8 65.1 61.6 63.4 64.3 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* : 57 55 63 54 49 45 46 103 104 : 64.4 128.4 :

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Infant mortality rate per 1 000 live births 4.1 3.5 4.6 3.1 3.7 3.5 3.3 3.2 3.1 3.5 1.6 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 1.93 1.77 1.76 1.84 1.79 2.32 2.55 1.94 1.99 1.93 1.96 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.09 0.09 0.09 0.10 0.09 0.16 0.17 0.22 0.22 0.22 0.20 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.56 1.55 : : : : 2.03 2.09 2.13 2.17 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.39 1.32 1.31 1.28 1.24 1.24 1.28 1.13 1.17 1.18 1.23 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.14 0.14 0.14 0.13 0.13 0.16 0.14 0.13 0.13 0.14 0.13 0.31 0.31 0.32

Prevention and public health services 0.04 0.04 0.03 0.04 0.04 0.04 0.04 0.10 0.09 0.09 : 0.25 0.25 0.24

Health administration and health insurance 0.12 0.10 0.10 0.10 0.09 0.11 0.11 0.09 0.10 0.09 : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 1.53 1.37 1.35 1.44 1.40 1.71 1.88 1.43 1.46 1.38 1.41 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.02 0.02 0.02 0.03 0.02 0.02 0.03 0.11 0.11 0.10 0.11 0.16 0.16 0.18

Out-patient curative and rehabilitative care 0.35 0.34 0.33 0.34 0.33 0.38 0.41 0.69 0.71 0.70 0.73 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.34 0.27 0.30 0.28 0.28 0.30 0.32 0.31 0.33 0.31 0.35 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.01 0.01 0.01 0.01 0.13 0.12 0.13

Prevention and public health services 0.03 0.03 0.03 0.03 0.03 0.03 0.03 0.10 0.09 0.09 : 0.25 0.20 0.19

Health administration and health insurance 0.21 0.20 0.19 0.19 0.19 0.22 0.24 : : : : 0.11 0.27 0.27

EU- latest national data

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Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.5.2: Statistical Annex - continued – Cyprus

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 31.0% 29.6% 29.4% 30.5% 30.4% 34.8% 35.6% 30.1% 30.0% 29.0%
28.8% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 1.4% 1.5% 1.5% 1.7% 1.5% 2.4% 2.4% 3.4% 3.3% 3.3% 2.9% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative care 25.1% 25.9% : : : : 31.5% 31.5% 32.0% 31.9% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 22.3% 22.1% 21.9% 21.2% 21.1% 18.6% 17.9% 17.5% 17.6%
17.7% 18.1% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 2.3% 2.3% 2.3% 2.2% 2.2% 2.4% 2.0% 2.0% 2.0% 2.1% 1.9%
3.2% 3.3% 3.3%

Prevention and public health services 0.6% 0.7% 0.5% 0.7% 0.7% 0.6% 0.6% 1.6% 1.4% 1.4% : 2.6% 2.6% 2.5%

Health administration and health insurance 1.9% 1.7% 1.7% 1.7% 1.5% 1.6% 1.5% 1.4% 1.5% 1.4% : 4.2% 4.3%
4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 55.4% 55.0% 54.4% 55.6% 54.9% 61.1% 61.0% 46.6% 46.3% 45.2%
44.6% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 0.7% 0.8% 0.8% 1.2% 0.8% 0.7% 1.0% 3.6% 3.5% 3.3% 3.5% 2.0%
2.1% 2.3%

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Out-patient curative and rehabilitative care 12.7% 13.7% 13.3% 13.1% 12.9% 13.6% 13.3% 22.5% 22.5% 23.0% 23.1% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 12.3% 10.8% 12.1% 10.8% 11.0% 10.7% 10.4% 10.1% 10.5% 10.2% 11.1% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.3% 0.3% 0.3% 0.3% 1.6% 1.6% 1.6%

Prevention and public health services 1.1% 1.2% 1.2% 1.2% 1.2% 1.1% 1.0% 3.3% 2.9% 3.0% : 3.2% 2.7% 2.5%

Health administration and health insurance 7.6% 7.9% 7.5% 7.2% 7.6% 7.7% 7.7% : : : 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 0.28 0.41 0.66 0.65 0.89 1.64 1.86 1.93 2.00 1.97 1.97 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.4 0.4 0.8 0.8 0.8 0.8 0.7 0.7 0.8 0.8 0.8 0.9 0.9 0.8

CTS per 100 000 inhabitants 1.5 1.8 2.0 1.9 3.6 3.5 3.3 3.3 3.2 3.2 3.2 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.1 0.1 0.1

Proportion of the population that is obese 12.3 : : : : 15.6 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 23.9 : : : : 25.9 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 9.3 9.5 8.7 8.4 8.6 9.3 8.5 8.7 8.9 : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 260 266 261 252 273 280 284 292 300 304 322 329 335 344

Practising nurses per 100 000 inhabitants 425 439 409 450 458 450 471 476 487 475 492 840 812 837

General practitioners per 100 000 inhabitants 41 : : : : : : : : : 78 78.3

Acute hospital beds per 100 000 inhabitants 394 385 345 344 346 349 351 334 330 324 320 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 1.9 2.1 2.1 2.0 2.1 2.1 2.3 2.3 2.3 2.4 2.4 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 6.7 6.8 6.6 6.5 7.5 6.5 7.5 7.8 8.0 8.1 7.8 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 562 571 632 701 749 701 935 1,574 1,437 1,505 1,672 6368 6530 7031

Acute care bed occupancy rates 73.0 80.0 84.0 79.0 76.0 88.2 84.7 84.2 90.9 75.8 74.4 72.0 73.1 70.2

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Hospital curative average length of stay 5.5 5.8 6.0 5.8 5.3 5.5 5.7 5.4 5.3 5.6 5.7 6.5 6.3 6.3

Day cases as % of all hospital discharges 8,3 8,4 8,7 9,7 9,1 9,7 11.1 16.9 15.3 15.7 17.7 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 3.0 3.1 3.1 3.3 3.3 3.3

AWG risk scenario 3.0 3.1 3.3 3.5 3.6 3.6

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 0.9 0.9 0.9 1.0 1.0 1.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

29.5 3.1

0.3 0.9

0.6 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population;

GDP per capita (21,600 PPS in 2013) is lower than

the EU average (27,900 PPS). The Czech Republic

recorded high real GDP growth before 2009, above

the EU average, throughout the decade. As a result of the global economic crisis, real GDP growth was -5.1% in 2009 followed by positive growth rates in 2010 and 2011 and negative growth rates in 2012 and 2013. Current population stands at 10.5 million people and has been fairly stable throughout the decade. The population is projected to increase to 11.1 million by 2060.

Total and public expenditure on health

Total expenditure on health as a percentage of GDP (7.2% in 2013) is below the EU average (10.1%). It has increased from 6.7% in 2006 but it is lower than that registered in 2009. Public expenditure on health as a percentage of GDP is below the EU average (CZ: 6.0% vs. EU: 7.8%).

In 2013, total (1,535 PPS) and public (1,279 PPS) per capita expenditure were lower than the EU average in (2,988 PPS and 2,208 PPS).

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to increase by 1.0 pp of GDP ("AWG reference scenario"), above the average increase of 0.9 pps for the EU. When taking into account the impact of non-demographic drivers on future spending

growth ("AWG risk scenario"), health care expenditure is expected to increase by 1.7 pps of GDP from now till 2060 compared to the EU average of 1.6 pps (80). Overall, projected health

care expenditure poses a risk to the medium and long-term sustainability of public finances. Over the long run, medium sustainability risks appear for the Czech Republic. These risks derive

primarily from the projected impact of age-related public spending (notably health care and

(80) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

pensions), compounded by the slightly

unfavourable initial budgetary position. (81)

Health status

Despite showing an improvement, the health status of the Czech population lags slightly behind the EU average. While showing a consistent increase, life expectancy (81.3 years for women and 75.2 years for men in 2013) is still below the EU average (83.1 and 77.6 years of life expectancy in 2013). However, healthy life years are above the respective EU averages (64.2 years for women and 63 years for men in 2013 vs. EU average of 61.8

and 61.6 respectively). Amenable mortality rates show a consistent decrease over the decade but are still fairly high (187 deaths per 100 000 inhabitants in CZ vs. 128 in the EU). Infant mortality is below the EU average (2.6‰ vs. 3.9‰).

System characteristics

System financing

The Czech health care system is a compulsory social health insurance (SHI) system with universal coverage. Entitlement to coverage is based on permanent residence rather than SHI contributions, and each person must be covered either through a SHI, a foreign social insurance system or a private health insurance.

The SHI system plus contribution from the state budget comprise 83% of total health expenditure.

Stage budget contribution is devoted to capital investments in facilities directly managed by the Ministry of Health (teaching hospitals, specialised

health care, research and postgraduate education facilities) or by regional authorities (regional and municipal hospitals), as well as to public health services (training costs of medical personnel, variety of health promotion and disease

prevention, medical research, postgraduate

education, etc.).

In 2013, mandatory SHI contributions account for

76% of revenues of the SHI system. The remaining

24% comes from the State contributions for certain

groups of economically inactive people (children,

(81) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

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students, women or men on parental leave,

pensioners, unemployed, imprisoned and asylum

seekers). SHI contributions take the form of a

payroll tax split between employers and

employees; self-employed must contribute a fixed

percentage of their profits. Contributions of

employed people amount to 13.5% of gross

monthly wages, with employees paying 4.5% and

employers 9%. The state-financed contributions

represented 870 CZK in 2016 for every

economically inactive person monthly. These

revenues for the Czech health system are therefore

set by law; they consist in a fixed amount of money, occasionally adjusted – "valorised".

Next, SHI contributions are redistributed among the funds according to a risk-adjustment scheme

based on age and gender. The VZP is the largest fund, covering approximately 59% of the population in 2013. It was the first one created in 1992, covering at that time 100% of the market.

However, it is supposed to have the worst riskstructure of the members, as funds established later have been taking over mainly younger and healthier part of the population.

Private spending includes mainly three categories of expenditures: out-of-pocket payments for over-the-counter pharmaceuticals and some dental procedures; co-payments on medical aids and prescription pharmaceuticals, whose price exceeds the reimbursement amounts; and user fees for prescription pharmaceuticals and medical services.

Private expenditure accounted for 17% of total health expenditure in 2013. This amount is still among the lowest in the EU, well below the average of 23%. Although available, voluntary

health insurance plays a minor role in health care financing (less than 1% of health expenditure in

2012), which is mainly due to the broad range of benefits available under the SHI schemes.

Administrative organisation

SHI is assured by health insurance funds (in 2013

there were 7 of them, down from 27 in the mid-

1990s), which are quasi-public, self-governing

bodies that act as payers and purchasers of care.

Patients can change their choice of a fund once

every 12 months. Funds are obliged to accept all

applicants and not allowed to make risk selection.

Even if the state has been decentralised (end of

1992) – and therefore competencies given to

regional authorities beside the state level – the

level of expenditure in administering such a

system does not seem high, though its share in the

total health expenditure has slightly increased in

recent years. Public and total expenditure on health

administration and health insurance as a

percentage of GDP, both 0.2% in 2013, are both

below the EU average (0.3%).

Coverage of services, types of providers,

referral systems and patient choice

The range of coverage includes "any medical

treatment delivered with the aim of maintaining or

improving an individual's health status". In

practice the benefits are rationed at the point of use by the provider, based on four factors: the negative lists of procedures and services excluded from reimbursement; the positive lists of approved pharmaceuticals, medical aids and dental aids that may be reimbursed (together with the depth of coverage); the annual negotiation process between health insurance funds and health care providers resulting in establishment of specific conditions of reimbursement attached as amendments to the existing long-term contracts between them; the List of Health Services, being a fee schedule of the rationed benefits updated annually by the Ministry of Health.

Primary care is provided by physicians working in private practices or in health centres and polyclinics. Currently 95% of services are provided in private – mainly individual – practices. Polyclinics and health centres are usually private legal entities, which additionally offer ambulatory specialist care. Sometimes health centres are owned by the municipalities, and primary care physicians pay a rent for the use of the facilities.

Patients register with a primary care physician of their choice and can switch to a different doctor once every three months. The gatekeeper role of general practitioners (GPs) is limited. The physicians can refer patients to specialists, but the direct access to the latter is neither institutionally restricted nor economically discouraged. The patients frequently use this option in practice, circumventing the physicians and addressing directly the specialists. The referral is, however, obligatory for admissions to secondary inpatient

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care (except for emergency cases). Moreover, visits to the dentists and gynaecologists are always direct and without referral.

Secondary care services are provided by private practice specialists, hospitals and specialised inpatient facilities. Following a series of reforms in the 1990s, formerly state-owned hospitals are currently owned and managed by a wide range of entities: ministries, regions and municipalities, private entities and churches.

Empirical evidence suggests a deficit of GPs and an overutilisation of secondary and tertiary care in comparison with primary care. The number of practising physicians (369 per 100 000 inhabitants) and nurses (799 per 100000 inhabitants) slightly exceeded or was at the EU averages in 2013 (344 and 837 respectively). However, the number of GPs is lower than the EU average (63 vs. 78 per 100 000 in 2013).

On the other hand, these figures suggest relatively easy access and possibly excessive use of inpatient care. All indicators, although falling over the last years, still exceed significantly respective figures for the entire EU on average: number of acute care beds (437 vs. 356 per 100 000 of population in 2013), number of inpatient hospital discharges (19.5 vs. 16.5 per 100 inhabitants in 2013) and average length of stay in acute care hospitals (6.6 vs. 6.3 days in 2013). Those figures, together with the data on the share of hospital day case in total discharges (3.2% in the Czech Republic vs. 30.4% in the EU in 2013), may suggest an inadequate allocation of resources between acute health care

on the one hand and outpatient care on the other hand, only partially explained by the reimbursement system (see below).

Purchasing and contracting of health care

services and remuneration mechanisms;

Health insurance funds conclude long-term contracts with the providers, for five or eight years.

Only the framework of such contracts is defined by law. They include necessary conditions for

providing health care, general payment mechanisms, conditions for ending the contract, other rights and obligations of both sides, but do not include specific conditions of reimbursement, which are subject to annual negotiations.

GPs are paid according to a system of risk-adjusted

capitation fees, accounting for age, but not gender

of the patients. The number of patients per physician is subject to a limit above which the

payment is reduced. However, some services (such

as preventive examinations and visits to patients'

homes, accounting in 2011 for approximately 30%

of physicians' income) are still paid on the fee-for-service basis.

Ambulatory care specialists are reimbursed using a

digressive fee-for-service system, based on the List of Health Services. This List defines the number of points for each service and the threshold of the amount of services up to which providers are fully reimbursed. In case the limit is exceeded, the value of points is reduced. The financial value of the point is bargained annually between insurance funds and provider organisations.

Payments to hospitals are very diverse. Mainly, the system of prospective global budgets is used. The budget's level is based on the amount of services provided during the relevant period of the previous year and the sum of points from the "List of Health Services". A growing number of cases are paid on the basis of diagnosis-related groups (DRGs) system: each year an updated version of the list of relative weights is published and the base rate is set. This system is supplemented with flat fees per insured person which are applied according to the thresholds based on the amount of services provided during the previous year.

The market for pharmaceutical products, the use of Health Technology Assessment and cost-benefit analysis

Public and private pharmaceutical expenditure

accounts for 20% of total current health expenditure, which is slightly more than the EU average (14.9% in 2013). The pharmaceutical reimbursement system is based on reference pricing, whereby the basic reimbursement level for each reference group of substitutes is set at the price of the least expensive of those in the entire EU. Also maximum ex-factory prices for pharmaceuticals are based on international benchmarking, and the group of reference countries includes eight EU Member States (Estonia, France, Italy, Lithuania, Hungary, Portugal, Greece and Spain). The combined maximum amount of mark-ups by pharmacies and

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wholesalers is set by the Ministry of Health. The system is regressive, with maximum surcharges being reduced in line with growing ex-factory prices.

In order to constrain pharmaceutical expenditure, health insurance funds are allowed to introduce pharmaceutical budgets for each provider and impose penalties in case of overspending.

eHealth (e-prescription, e-medical records)

and information and reporting mechanisms;

The information and communication technologies

are still not sufficiently spread in the Czech health

system. Health technology assessment of

treatments and procedures is practically not

available due to the lack of technical infrastructure.

For the same reason, the information on patients

owned by the health insurance funds is not

efficiently used in practice.

The use of electronic medical records is being

currently developed with a number of projects

allowing physicians to share patient information

between physicians and with the concerned

patient. Information systems are broadly used for

reimbursement and accounting purposes, and the

use of web pages is being increasingly spread

among health insurance funds, health care facilities

and physicians. A system of mandatory eprescriptions

was approved to be effective from

January 2015, but now it is in the process of

improvement.

Although the country lacks a unified system for

assessing the quality of health services, the

providers in some sectors of care (mainly those under direct responsibility of the Ministry of Health) are more and more frequently assessed via surveys, patient satisfaction questionnaires and accreditations.

The government aims to ensure secure sharing of important health and economic information, thereby achieving improved quality, comfort,

security and transparency of the health care system. Computerisation allows professionals and patients to make the right decisions based on correct information. Full use of modern communication technologies will contribute to a

better and more cost-effective care. In this context, the aim is to create a working government strategy to ensure standards necessary for the development and sustainability of eHealth and to oversee their implementation.

Health promotion and disease prevention policies

The need to improve health status further through promotion and prevention activities is a policy priority. The government intends to support the implementation of health promotion projects aimed at promoting and optimisation of physical

activity among the general public and specific target groups. It will also support health promotion projects aimed at achieving changes in eating habits and increasing health literacy, especially among children and the youth. It will also focus on reducing the health risks of the living and working environment and reducing health risk behaviour, in particular regarding protection against addictive substances. The government will also promote the prevention of infectious diseases, particularly through measures aimed at antimicrobial resistance and vaccination programs. Currently, total and public expenditure on prevention and public health services as a % of GDP (0.2% and 0.1%, latest data) are below the EU average (0.2%).

Recently legislated and/or planned policy reforms

A number of measures aimed at improving the cost-effectiveness and governance of the health

care sector, based on the priorities in the Government's manifesto and the National Strategy for Health 2020, are in various stages of implementation. In order to provide for a better hospital financing system, the 'diagnosis-related group' project formally commenced in January

2015. However, its outcomes will only be used for financing in 2018 at the earliest. Conversely, fees in the outpatient sector were eliminated in 2015, leading to an increase in the consumption of services.

The introduction of centralised public procurement for selected pharmaceuticals was launched in 2015 and the Commission for Accessing the Placement of Medical Devices also became operational. A complete and compulsory disclosure of contracts between health insurers and providers entered into force in 2016, which should increase the transparency of the Czech health care system and

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boost competition among health care providers. In addition, the government implemented the cancellation of cost-sharing fees for hospital care in 2014, as well as the abolishment of fees for outpatient services and prescriptions in 2015. Short-term measures include the reduction of the health insurance companies' reserve fund by

a half, i.e. from the current 1.5% to

0.75%. Through this measure, health care has received an additional budget allocation in 2014. In 2014, the government also submitted a proposal to reduce the overhead costs of health insurance companies.

As far as future policy changes are concerned, the Government intends to strengthen the activities leading to a more equitable distribution of funds among health insurance companies. Redistribution of health insurance funds should be influenced by other parameters (e.g. PCG, Pharmacy Cost-Based Groups) to enable more equitable distribution of funds among health insurance companies and thus

improve the quality of care for chronically ill patients. In this context, as of 2016 at the moment the Government handed over to parliament a proposal for changing the respective law (592/1992). Additionally, selected public hospitals will be transformed into non-profit entities, with the aim of enhancing management of key hospitals in the country. There are also plans to replace the non-transparent process of determining the reimbursement of medical devices with a new system.

The government aims also at strengthening, through legal measures, the state supervision of health insurance flows and over the functioning of the health insurance companies. The government will introduce a transparent system of quality indicators for comparing and publishing of quality of health care in individual health care facilities, so that these are accessible to both patients and specialists.(82) Competencies between the Ministry of Health and the National Reference Centre shall also be specified.

The government's commitment to effectively define the process of entry of new technologies into the health system still continues. A

(82) The authorisation will have to be embedded in the amendment to the Act No. 372/2011 Coll. on Health Services.

methodology has been established within the project of implementation of health technology assessment (HTA), which should ensure that new technologies, which are to be covered by the public health insurance system, bring adequate and documented counter value. It is necessary to decide on the form of the institutional arrangements for HTA and the manner of its

inclusion in the process of determining the extent

of medical care covered by public health

insurance. In 2017 the usability of the

methodology will be tested further as well as its

eventual deployment via a law.

Challenges

The analysis above has shown that many reforms

are ongoing, aiming mainly at an improved

efficiency of the health system via costcontainment

and more market-oriented solutions,

and its results are yet to be evaluated. The main

challenges for the Czech health system are as

follows:

- To continue increasing the efficiency of health

care spending in order to adequately respond to

the increasing health care expenditure over the

coming decades, which is a risk to the longterm

sustainability of public finances.

- To clearly define a basic package of the health

care services which are covered from the

general insurance (i.e. to have a more explicit

definition of SHI benefits).

- To develop a comprehensive human resources

strategy that tackles spatial/regional disparities

in health care accessibility (physicians' density, waiting times).

- To enhance primary care provision and tackle the excessive use of specialist and hospital

care, in particular with a referral system to

specialist care either through financial incentives or by making it compulsory; to promote use of GPs' services, by strengthening organisational and financial incentives for both doctors and patients; to foster the coordination

of care between primary, secondary and

hospital care in order to reduce redundant and duplicated medical examinations and laboratory tests, doctor visits and unnecessary

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drug prescriptions; to monitor the impact of the abolishment of patient cost-sharing at different

levels of care, especially with regard to avoidable use of services.

- To improve the cost-efficiency within

hospitals, ensuring that care is provided in the most clinically appropriate and cost-effective way, by implementing the new DRG based financing system, by increasing the proportion of elective care provided on a day-case basis and day-of-surgery admissions; to consider reducing the high number of acute care bed capacity.

- To further develop the equitable financing system of insurance system in order to minimise patient selection, improve fairness in financing, and reduce fiscal risks.

- To implement the e-prescription tool for pharmaceuticals, improving the rational prescription and use of medicines and enhancing access to cost-effective medicines, while generating savings to payers.

- To introduce a system of quality indicators for comparing and publishing of quality of health

care in individual health care facilities, that should be accessible to patients and clinicians.

- To foster the use of centralised procurement procedures for pharmaceuticals, but also for

other medical and non-medical goods,
generating savings to payers, while ensuring
access to high-quality products in the health
system.

- To ensure a greater and more systematic use of
health technology assessment to achieve
decisions, for example about the SHI coverage
or reimbursement rates.
- To foster health promotion and disease
prevention activities, promoting healthy life
styles and disease screening given the pattern
of risk factors (smoking, alcohol, obesity,
circulatory system diseases).

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Table 1.6.1: Statistical Annex – Czech Republic

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 88 96 109 124 138 161 148 156 164 161 157 9289 9800 9934

GDP per capita PPS (thousands) 18.5 19.0 20.0 21.2 22.3 21.3 19.9 20.6 21.6 21.5 21.6 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 3.8 4.7 6.5 6.7 5.2 2.0 -5.1 2.2 2.0 -1.1 -1.0 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 4.2 1.3 7.0 3.0 2.5 6.7 9.2 -3.3 3.0 -0.4 -5.1 3.2 -0.2 -0.4

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Expenditure on health* 2009 2011 2013

Total as % of GDP 7.1 6.9 6.9 6.7 6.5 6.8 7.9 7.4 7.5 7.6 7.2 10.4 10.1 10.1

Total current as % of GDP 6.9 6.7 6.7 6.5 6.3 6.7 7.6 7.2 7.4 7.4 6.9 9.8 9.6 9.7

Total capital investment as % of GDP 0.3 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.1 0.1 0.3 0.6 0.5 0.5

Total per capita PPS 1071 1132 1211 1255 1332 1448 1615 1536 1573 1589 1535 2828 2911 2995

Public as % of GDP 6.4 6.2 6.1 5.8 5.6 5.6 6.6 6.2 6.3 6.3 6.0 8.1 7.8 7.8

Public current as % of GDP 6.1 5.9 5.8 5.6 5.3 5.5 6.4 6.0 6.2 6.2 5.8 7.9 7.7 7.7

Public per capita PPS 883 931 970 1005 1043 1111 1252 1196 1324 1334 1279 2079 2218 2208

Public capital investment as % of GDP 0.3 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.1 0.1 0.2 0.2 0.2 0.1

Public as % total expenditure on health 89.8 89.1 87.3 86.8 85.3 82.6 83.7 83.7 84.1 84.0 83.3 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 14.8 16.2 16.0 16.4 16.8 16.8 17.2 17.8 18.1
17.5 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0
100.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 10.0 10.4 10.7 11.3 13.2 15.7 14.6 14.9
14.7 15.0 15.7 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 10.2 10.2 10.2 10.2 10.3 10.3 10.4 10.5 10.5 10.5 10.5 502.1 504.5 506.6

Life expectancy at birth for females 78.6 79.1 79.2 79.9 80.2 80.5 80.5 80.9 81.1 81.2 81.3 82.6 83.1 83.3

Life expectancy at birth for males 72.0 72.5 72.9 73.5 73.8 74.1 74.3 74.5 74.8 75.1 75.2 76.6 77.3 77.8

Healthy life years at birth females : : 60.0 59.9 63.3 63.4 62.7 64.5 63.6 64.1 64.2 : 62.1 61.5

Healthy life years at birth males : : 58.0 57.9 61.4 61.3 61.1 62.2 62.2 62.3 62.5 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 154 132 128 119 97 94 95 88 193 187 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 3.9 3.7 3.4 3.3 3.1 2.8 2.9 2.7 2.7 2.6 2.5 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

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Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.36 2.18 2.11 2.08 1.95 2.00 2.28 2.17 2.20 2.16 2.05 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.07 0.07 0.07 0.08 0.08 0.12 0.11 0.12 0.13 0.13 0.13 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.49 1.50 1.49 1.51 1.59 1.75 2.12 2.05 2.13 2.16 2.12 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.73 1.71 1.72 1.52 1.40 1.39 1.69 1.48 1.50 1.59 1.39 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.22 0.22 0.23 0.22 0.23 0.24 0.21 0.22 0.22 0.21 0.20 0.31
0.31 0.32

Prevention and public health services 0.12 0.14 0.12 0.14 0.14 0.18 0.17 0.18 0.17 0.15 : 0.25 0.25 0.24

Health administration and health insurance 0.20 0.24 0.23 0.22 0.23 0.24 0.25 0.24 0.24 0.23 0.24 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.31 2.14 2.06 2.04 1.90 1.94 2.17 2.08 2.12 2.05 1.97 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.07 0.07 0.07 0.08 0.08 0.12 0.11 0.12 0.13 0.13 0.13 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.37 1.35 1.33 1.36 1.39 1.43 1.69 1.71 1.79 1.84 1.82 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 1.31 1.31 1.30 1.08 0.92 0.86 1.21 0.94 0.94 1.02 0.86 0.79 1.07
0.96

Therapeutic appliances and other medical durables 0.09 0.09 0.09 0.09 0.09 0.08 0.07 0.07 0.08 0.08 0.08 0.13
0.12 0.13

Prevention and public health services 0.13 0.12 0.10 0.12 0.12 0.20 : : 0.14 0.13 0.14 0.25 0.20 0.19

Health administration and health insurance 0.17 0.21 0.20 0.20 0.20 0.22 0.23 0.22 0.22 0.21 0.24 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.6.2: Statistical Annex - continued – Czech Republic

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 34.5% 32.6% 31.5% 32.0% 30.9% 30.1% 29.9% 30.0% 29.9% 29.1%
29.5% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 1.0% 1.0% 1.0% 1.2% 1.3% 1.8% 1.5% 1.6% 1.7% 1.7% 1.8% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative care 21.8% 22.5% 22.3% 23.3% 25.2% 26.3% 27.8% 28.3% 28.9% 29.1%
30.5% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 25.3% 25.6% 25.7% 23.4% 22.2% 20.9% 22.1% 20.4% 20.4%
21.4% 20.0% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 3.2% 3.3% 3.4% 3.3% 3.6% 3.6% 2.8% 3.0% 2.9% 2.9% 2.9%
3.2% 3.3% 3.3%

Prevention and public health services 1.8% 2.1% 1.8% 2.2% 2.2% 2.7% 2.2% 2.5% 2.3% 2.0% : 2.6% 2.6% 2.5%

Health administration and health insurance 2.9% 3.6% 3.4% 3.4% 3.6% 3.6% 3.3% 3.3% 3.3% 3.1% 3.5% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 37.7% 36.1% 35.5% 36.4% 35.6% 35.5% 34.2% 34.5% 34.4% 33.0%
33.8% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 1.1% 1.1% 1.2% 1.3% 1.6% 2.2% 1.8% 1.9% 2.1% 2.0% 2.2% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative care 22.3% 22.8% 22.9% 24.3% 26.0% 26.2% 26.6% 28.4% 29.0% 29.6%
31.3% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 21.4% 22.1% 22.4% 19.3% 17.2% 15.8% 19.1% 15.6% 15.2%
16.4% 14.8% 10.0% 13.9% 12.5%

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Therapeutic appliances and other medical durables 1.5% 1.6% 1.6% 1.6% 1.6% 1.5% 1.1% 1.2% 1.3% 1.2% 1.3% 1.6% 1.6% 1.6%

Prevention and public health services 2.1% 2.0% 1.7% 2.1% 2.2% 3.7% : : 2.3% 2.1% 2.4% 3.2% 2.7% 2.5%

Health administration and health insurance 2.8% 3.5% 3.5% 3.5% 3.8% 4.1% 3.6% 3.7% 3.5% 3.4% 4.0% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 0.24 0.28 0.31 0.38 0.44 0.50 0.57 0.63 0.69 0.69 0.74 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.5 0.5 0.6 0.6 0.7 0.8 0.8 0.8 0.7 0.8 0.8 0.9 0.9 0.8

CTS per 100 000 inhabitants 1.3 1.3 1.2 1.3 1.3 1.3 1.4 1.4 1.5 1.5 1.5 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.0 0.0 0.0 0.0 0.0 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1

Proportion of the population that is obese : : : : 17.1 : 21.0 : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 27.2 25.4 24.3 23.4 24.0 21.8 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 13.0 13.2 13.2 13.0 13.4 13.3 13.2 12.7 12.7 12.8 12.5 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 353 352 356 357 357 356 358 360 364 367 369 329 335 344

Practising nurses per 100 000 inhabitants 797 810 809 805 800 794 806 808 803 806 799 840 812 837

General practitioners per 100 000 inhabitants : : 73 72 71 71 71 70 70 70 70 : 78 78.3

Acute hospital beds per 100 000 inhabitants 557 540 534 525 518 508 499 488 470 456 437 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 13.0 13.1 13.2 13.0 12.6 11.4 11.2 11.0 11.1 11.1 11.1 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 21.1 21.5 21.5 20.8 20.6 20.2 20.0 19.7 19.4 19.3 19.5 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 305 312 343 364 378 440 439 466 524 5 85 642 6368 6530 7031

Acute care bed occupancy rates : : 78.0 : : : 75.3 73.8 72.8 73.1 73.9 72.0 73.1 70.2

Hospital curative average length of stay : : 7.1 : : : 7.1 7.0 6.8 6.6 6.6 6.5 6.3 6.3

Day cases as % of all hospital discharges 1.4 1.4 1.6 1.7 1.8 : 2.1 2.3 2.6 2.9 3.2 27.8 28.7 30.4

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Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 5.7 5.9 6.2 6.5 6.6 6.7

AWG risk scenario 5.7 6.1 6.7 7.1 7.4 7.5

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 10.5 10.7 10.8 10.9 11.1 11.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

5.4 3.1

1.0 0.9

1.7 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

GDP per capita is currently well above EU average

with 32,100 PPS in 2013 (EU: 27,900). The

economic crisis hit Denmark relatively hard and

resulted in a significant drop in employment.

However, the economy has gained traction in

2013. Population was estimated at 5.6 million

2013. It has been slowly increasing in past years.

According to Eurostat 2013 projections, total population is projected to increase from around 5.6 million in 2013 to 6.5 million in 2060.

Total and public expenditure on health as % of GDP

Total expenditure on health as a percentage of GDP (10.6% in 2013) has increased over the last decade (from 9.5% in 2003), although down from a peak of 11.1% of GDP in 2010, and is above the EU average (83) of 10.1% in 2013. Throughout the last decade, public expenditure has increased as % of GDP: from 8.0% in 2003 to 9.1% of GDP in 2013 (EU: 7.8%). When expressed in per capita terms, total spending on health at 3,551 PPS was above the EU average of 2,988 in 2013. So was public spending on health care: 3,031 PPS vs. an EU average of 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.9 pps of GDP, at the average growth level expected for the EU of 0.9 pps of GDP, according to the "AWG

reference scenario". When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health

care expenditure is expected to increase by 1.9 pps of GDP from now until 2060 (EU: 1.6). (84)

Overall, projected health care expenditure increase is expected to add to budgetary pressure. However, (83) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

(84) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

currently no sustainability risks appear for Denmark over the long run. This risk-free outlook derives primarily from a relatively limited unfavourable contribution of the initial budgetary position and from the different contributions to

age-related public spending balancing each other out in the long-term. (85)

Health status

Life expectancy at birth (82.4 years for women and

78.3 years for men) is around the EU averages of 83.1 and 77.6 years in 2013. With 59.1 years for women and 60 years for men, healthy life years are below the averages in the EU (61.8 and 61.6, for women and men). (86) The infant mortality rate of 3.5‰ is below the EU average of 3.9‰ in 2013.

As for the lifestyle of the Danish population, the data indicates an average number of regular smokers (17% in 2013), being below the EU average of 22%, having declined in the past years.

The proportion of the obese population was below EU level at 13.4% in 2010 (EU: 15.5% in 2013), and alcohol consumption is slightly below the EU level.

System characteristics

Overall description of the system

Denmark has a universal, tax-based decentralised health care system. The five Regional Authorities are responsible for hospital and psychiatric care funding as well as for establishing collective agreements with providers of ambulatory care, while 98 local authorities are in charge of mainly rehabilitation and health promotion and disease prevention policies.

Coverage

The system provides full population coverage.

Primary, specialist and hospital **care** are free at the point of use for most services. Children, senior citizens, those with certain medical conditions and

(85) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf

(86) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and Eurostat database.

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disabilities and those who have reached an upper limit for out-of-pocket payments are exempted from cost-sharing.

Administrative organisation and revenue collection mechanism

The budget for public spending in the health sector is decided by the Parliament on the basis of (yearly) budget agreements between the government and the local authorities. The

financing of the system comes from central and local taxes (regions are not allowed to levy taxes). State funding is distributed to the regions and 98 local authorities via block grants. Part of the funding attributed to the regions, including local authorities funding, is activity-related, an element that came into place in 2002, and revised in 2007 and 2012. Today, around 20 percent of the funding of the regions is activity-related, within an overall framework with fixed spending caps set by Parliament.

The funds to be allocated to hospitals, GPs and specialist, within the agreed overall budget, are determined by the regional authorities. Funds for remuneration of medicines are earmarked. The Ministry of Health, through the National Health Board, provides guidelines and regulation (the overall legal framework) for care provision, supervises care delivery and sets public health priorities. It is, however, for hospitals to define the remuneration of other health staff, for regions to plan hospital capacity and equipment and for the regions and local authorities to pay providers for the delivery of care (regions buy curative care,

local authorities pay for promotion, prevention,

rehabilitation, children dental care).

Role of private insurance and out of pocket

co-payments

33 % of the population buys supplementary private

insurance (to cover the services not covered by

public provision/funding) and 40 % buys

complementary health insurance to cover costsharing.

In 2013, private expenditure and out-of-pocket

expenditure were 14.6% and 12.8% of total health

expenditure, below the EU averages (22.6% and

14.3%).

Types of providers, referral systems and patient

choice

Primary care is provided by general practitioners

(GPs) working in private group practices and

outpatient specialist care is provided in private

individual practices. They receive almost all of

their income from services paid by the regions.

Most hospitals are owned by the regions (about

97% of all hospital beds are public) and hospital

doctors are employees of the regions. In general,

providers are paid by the regions on the basis of

contractual arrangements with relevant unions.

The density of physicians in Denmark is at the average density in the EU. In 2012, there were 362 practising physicians per 100 000 inhabitants, compared to 344 in EU in 2013. The number of general practitioners is below the EU average (69 per 100 000 inhabitants vs. 78 in the EU). The number of nurses per 100 000 inhabitants (1,630 in 2009) is much above the EU average of 837.

Authorities have put strong efforts to use primary

care vis-à-vis specialist and hospital care.

Residents have to register with a GP and there is a

compulsory referral system from primary care to specialist doctors i.e. GPs act like gatekeepers to

specialist and hospital care.

Regional authorities decide on hospital capacity and equipment capacity. Hospitals have autonomy to recruit medical staff and other health professionals, within the budget set by the regional authorities and within pay scales set by the agreements between the regional authorities and the unions. Private hospitals are free to establish and expand their capacity in compliance with quality and safety requirements. In 2010, the

number of acute care beds was 287 compared to 356 per 100 000 inhabitants in the EU in 2013.

The average length of stay of hospital inpatients is one of the lowest in the EU, such that with low capacity, Denmark still achieves high discharge rates (15.4 discharges in Denmark versus 13.5 in the EU per 100 inhabitants).

Treatment options, covered health services

The benefit package is not explicitly defined but the health interventions provided are based on clinical effectiveness.

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Price of health care services, purchasing, contracting and remuneration mechanisms

Outpatient and inpatient specialists in hospitals are paid a salary. GPs are paid a mix of a capitation and a consultation fee by the regional authorities, within an overall spending cap for GP's set by agreement with the relevant organisations. GP's performance based payment includes a variety of fees for different kinds of consultation, including advice on prevention. General fiscal consolidation also involves more focus on monitoring and

control of activity and spending in private practise

(GP's etc.).

Regional authorities decide how hospitals are paid

in combination of prospective global budgets and

activity-related payments based on diagnosis-related

groups (DRGs). DRG weights are defined

at central level with hospital remuneration methods

and negotiation of rates taking place at regional

level.

The market for pharmaceutical products

The authorities have implemented some policies to

control expenditure on pharmaceuticals. There is

no direct price regulation although the government

and the industry have agreed on a scheme for price

reductions for medicines used in hospitals. The

regional authorities have also, according to the

budget agreement for 2011, established a new

committee to establish a better coordination

between the regions on recommended use of

expensive medicines in hospitals to ensure use of

the most cost-effective medicines and at the same

time establish a potential for lower prices through

procurement.

The authorities also apply reference pricing on

reimbursed medicines, whereby the maximum

reimbursement level of a medicine is the lowest price of the products in each group of products, defined on the basis of same active ingredient, form and strength and package size (with some deviation allowed). There is a positive list of reimbursed products which is based on health technology assessment information when available.

Authorities promote rational prescribing of physicians through treatment guidelines complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines. Authorities monitor the general consumption of prescribed medicines closely.

Generic substitution is normally defined as a right or an obligation of pharmacists to substitute a cheaper (generic) medicine with the same active ingredient(s) for another, usually a brand medicine.

Generic substitution is obligatory in Denmark. A public webpage indicates which products can replace each other to help pharmacists and consumers choose.

Use of Health Technology Assessments and cost-benefit analysis

Comprehensive data, including comparable information on physician and hospital activity and care quality (clinical outcomes, use of appropriate processes) and on patient's experience and satisfaction with the care obtained through surveys is publicly available. Authorities also encourage providers' self-assessment and want to conduct regular comparisons with health care activity in other countries and develop further statistics on areas such as waiting times and choice.

The Danish Centre for Evaluation and Health Technology Assessment and various regional resource centres conduct and gather information on health technology assessment which is used to define coverage of new medicines, new high-cost equipment and new procedure as well as their level of reimbursement and respective clinical guidelines. Existing clinical guidelines and practice protocols are coupled with financial incentives and the monitoring of physician activity to encourage compliance with those guidelines.

eHealth, Electronic Health Record

Under the National IT Strategy for the Danish

Health Care Service authorities have been introducing a number of ICT and eHealth solutions to allow for nationwide electronic exchange of medical data, including the patient electronic medical records and e-prescribing to support and render the referral system and care coordination more effective, reduce medical errors and increase cost-efficiency. A system with a full overview of all medical records of a patient from GP's, hospitals etc. is now fully operational in the hospitals and GP's and was implemented in the

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local municipalities in 2015. A system with a full overview of all records of a patient was fully implemented in 2013.

Health promotion and disease prevention policies

Authorities have strongly emphasised health promotion and disease prevention measures in recent years. Promotion and prevention are seen by authorities as a means to ensure long-term sustainability of the health budget. Total and public expenditure on prevention and public health

services as a % of GDP were above the EU average.

Recently legislated and/or planned policy reforms

A number of initiatives aimed at improving the transparency on quality and results, patient rights, psychiatry, cancer care for children and public

health care are in various stages of implementation:

- Transparency reform – greater focus on quality and results. The aim is to create greater and more systematic knowledge about quality and best practice, as well as achieving better management of the health care and longterm

care system based on improvements in the overall health of the population, a high level of patient involvement and lower expenditure per capita. Large funds have been transferred to building a national platform for valid and up to date health data. The accessible health data should provide a platform for transparency and dissemination of best practice as well as management and priorities in the health care

sector on the basis of key goals and results.

- The right to assessment and identification of needs and to treatment of somatic and psychiatric patients. The rights aim to secure a short and effective diagnosing and treatment of all patients. Under current rules patients have the right to assessment and identification within 1 month and the right to treatment within 1 month for serious illness and 2 months for less severe disease. The Government has introduced a bill for a new right to assessment and identification of needs and to treatment. If the capacity of the public hospital cannot ensure that a given treatment or assessment can be initiated within 1 month, patients will have the right to extended free choice of hospital. The new right is expected to take effect on 1 October 2016.

- Massive prioritising of the psychiatry. The parliament has agreed to invest 2.2 billion DDK in the psychiatry over the period 2015-2018. This means a massive development of capacity, professionals and facilities and environment to secure an ambitious lift of the psychiatry in terms of quality and equal and

fast diagnosis and treatment of the patients.

- Partnerships to reduce the use of force. In

2014 Finance Act, it was agreed to set a target

that the use of force in the psychiatric health

services should be reduced by 50 per cent. A

permanent grant has been allocated to form

partnerships with the regions to meet the target.

For instance, the funds may be spent on

regional initiatives on patient involvement,

competency development and dissemination

and implementation of methods that have

proven successful based on national and

international experience.

- Stronger health care agreements. Five health

care agreements have been made for 2015-

2018 – one for each region. They include new

mandatory key action areas and specific

objectives. Across the boundaries of key action

areas, the health care agreements have a focus

on inequality in health and active involvement

of patients and their relatives. The aim with the

five health care agreements is to ensure

coherence and coordination of efforts in the

patient care that goes on across hospitals,

general practice and municipalities so that each patient and citizen receives a treatment that is consistent and of high quality at the lowest effective cost.

- National quality goals. The Government, Danish Regions and Local Government Denmark will set ambitious goals for the quality of the Danish health care in spring 2016. The national goals will set a framework for the continuous improvement of quality and efficiency. The national goals will be supported

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by a number of local goals and activities, which shall lead to local improvements. The national goals are part of a national programme to improve the quality and efficiency in the health

care system in Denmark. Beside the national goals, the quality programme consist of e.g. quality improvement teams, a national leadership programme and enhanced patient involvement and empowerment.

In addition, the Danish government has identified a

number of future priorities for health. Thus, the government will present a cancer plan which aims at reducing interregional differences in treatment and outcomes and the national cancer mortality rate. Moreover, the government will present a national plan targeting elderly patients. The plan will aim to improve the general conditions for the patients and reduce overcrowding in the hospitals. The third priority targets enhancements in quality, coherence and cost-effectiveness, which are the keywords in order to maintain a resilient and sustainable health care system in the future. With an ageing population and increasing demand for health care services it is crucial to map and spread best practices and secure a coherent health care system so that high-quality health care services are carried out as cost-effective as possible. Finally, the government has initiated work on a comprehensive plan to strengthen integrated care, including extended responsibility of the GP's for the care of elderly or chronically ill patients. The aim is a more cost-effective treatment of this group, which is expected to grow significantly

over the coming years, and at the same time

securing a better quality of care closer to the patient.

Challenges

The analysis above shows, that a wide range of

reforms have been implemented over the years.

Denmark should continue to pursue such reforms.

In this regard the main challenges for the Danish

health care system are as follows:

- To continue increasing the efficiency of health

care spending, promoting quality and

integrated patient packages as well as a

focusing on productivity and costs in view of

the relatively high spending on health care as a

share of GDP and increasing health care

expenditure over the coming decades, due to

population ageing and non-demographic

factors.

- To continue strengthening the integrated health

care system, such that general practitioners,

municipalities and hospitals work closely

together to give citizens a coordinated package

of treatment.

- To implement and monitor the effectiveness of the plans to foster quality and access to psychiatric care, while ensuring the high value for money for current investments.
- To implement the reform on transparency of results to inform best practice and contribute to faster diagnosis, treatment and care of the best quality.
- To continue the consolidation of the administrative reform and the new decisionmaking structure that resulted from it, ensuring coherence of responsibilities.
- To continue to focus on a balanced mix of skills in all parts of the health sector, for instance for nurses to handle tasks in private practice and acute wards, and on a clear referral system, to ensure an effective use of resources.

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Table 1.7.1: Statistical Annex – Denmark

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

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GDP, in billion Euro, current prices 193 202 213 226 233 241 230 242 246 253 255 9289 9800 9934

GDP per capita PPS (thousands) 31.3 32.5 32.3 33.5 33.9 33.1 30.8 31.9 32.4 32.3 32.1 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 0.1 2.1 2.1 3.1 1.2 -1.4 -6.2 0.9 0.7 -0.7 0.0 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 8.2 3.8 3.2 4.7 1.9 0.5 5.7 -2.5 -1.2 0.3 -3.3 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 9.5 9.7 9.8 9.9 10.0 10.2 11.5 11.1 10.9 11.0 10.6 10.4 10.1 10.1

Total current as % of GDP 9.1 9.3 9.3 9.5 9.6 9.8 11.0 10.7 10.5 10.6 10.4 9.8 9.6 9.7

Total capital investment as % of GDP 0.4 0.4 0.4 0.5 0.4 0.4 0.4 0.4 0.4 0.4 0.2 0.6 0.5 0.5

Total per capita PPS 2491 2654 2819 3026 3139 3288 3511 3543 3527 3645 3551 2828 2911 2995

Public as % of GDP 8.0 8.2 8.3 8.4 8.4 8.6 9.8 9.4 9.3 9.4 9.1 8.1 7.8 7.8

Public current as % of GDP 7.7 7.7 7.8 7.9 8.0 8.2 9.3 9.0 8.9 9.0 8.8 7.9 7.7 7.7

Public per capita PPS 1957 2066 2196 2345 2452 2587 2772 2825 3008 3127 3031 2079 2218 2208

Public capital investment as % of GDP 0.4 0.4 0.4 0.5 0.4 0.4 0.4 0.4 0.4 0.4 0.3 0.2 0.2 0.1

Public as % total expenditure on health 84.5 84.3 84.4 84.7 84.4 84.7 85.1 85.1 85.3 85.8 85.4 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 12.9 13.0 13.6 14.1 14.8 15.0 15.1 14.6 14.4 14.5 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 14.6 14.9 14.7 14.5 14.6 14.1 13.7 13.7 13.3 12.9 12.8 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 5.4 5.4 5.4 5.4 5.4 5.5 5.5 5.5 5.6 5.6 5.6 502.1 504.5 506.6

Life expectancy at birth for females 79.8 80.2 80.5 80.7 80.6 81.0 81.1 81.4 81.9 82.1 82.4 82.6 83.1 83.3

Life expectancy at birth for males 75.0 75.4 76.0 76.1 76.2 76.5 76.9 77.2 77.8 78.1 78.3 76.6 77.3 77.8

Healthy life years at birth females 60.9 69.0 68.4 67.2 67.4 60.8 60.4 61.4 59.4 61.4 59.1 : 62.1 61.5

Healthy life years at birth males 63.0 68.3 68.4 67.7 67.4 62.4 61.8 62.3 63.6 60.6 60.4 : 61.7 61.4

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Amenable mortality rates per 100 000 inhabitants* 80 76 72 71 63 60 58 : 119 115 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.4 4.4 4.4 3.5 4.0 4.0 3.1 3.4 3.5 3.4 3.5 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.55 2.58 2.62 2.69 2.72 2.86 3.24 3.12 3.02 3.03 2.89 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.43 2.47 2.50 2.54 2.50 2.58 2.93 2.82 2.94 3.04 3.02 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 0.84 0.83 0.80 0.82 0.85 0.81 0.84 0.82 0.73 0.69 0.70 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.39 0.40 0.39 0.40 0.40 0.40 0.43 0.40 0.38 0.38 : 0.31 0.31
0.32

Prevention and public health services 0.21 0.21 0.21 0.20 0.21 0.21 0.25 0.25 0.24 0.24 0.26 0.25 0.25 0.24

Health administration and health insurance 0.12 0.12 0.12 0.12 0.15 0.14 0.16 0.15 0.15 0.26 0.25 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.40 2.40 2.42 2.48 2.50 2.63 2.98 2.88 2.76 2.78 2.67 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.92 1.94 1.98 2.03 1.97 2.06 2.35 2.25 2.38 2.49 2.42 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.47 0.46 0.45 0.45 0.46 0.44 0.45 0.43 0.36 0.32 0.28 0.79 1.07
0.96

Therapeutic appliances and other medical durables 0.18 0.18 0.18 0.18 0.19 0.19 0.21 0.20 0.18 0.19 : 0.13 0.12
0.13

Prevention and public health services 0.21 0.21 0.20 0.19 0.20 0.20 0.24 0.24 0.23 0.23 0.25 0.25 0.20 0.19

Health administration and health insurance 0.09 0.09 0.09 0.09 0.12 0.11 0.12 0.12 0.11 0.21 0.21 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.7.2: Statistical Annex - continued – Denmark

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 27.9% 27.9% 28.1% 28.5% 28.5% 29.3% 29.3% 29.2% 28.8% 28.6% 27.8% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 26.6% 26.7% 26.8% 26.9% 26.2% 26.4% 26.5% 26.4% 28.1% 28.7% 29.1% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 9.2% 9.0% 8.6% 8.7% 8.9% 8.3% 7.6% 7.7% 7.0% 6.5% 6.7% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 4.3% 4.3% 4.2% 4.2% 4.2% 4.1% 3.9% 3.7% 3.6% 3.6% : 3.2% 3.3% 3.3%

Prevention and public health services 2.3% 2.3% 2.3% 2.1% 2.2% 2.1% 2.3% 2.3% 2.3% 2.3% 2.5% 2.6% 2.6% 2.5%

Health administration and health insurance 1.3% 1.3% 1.3% 1.3% 1.6% 1.4% 1.4% 1.4% 1.4% 2.5% 2.4% 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 31.3% 31.0% 31.0% 31.3% 31.2% 32.0% 31.9% 31.9% 31.1% 30.8% 30.4% 34.6% 34.1% 34.0%

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Day cases curative and rehabilitative care 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% : : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care 25.1% 25.1% 25.4% 25.6% 24.6% 25.1% 25.2% 24.9% 26.8% 27.6%
27.6% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 6.1% 6.0% 5.8% 5.7% 5.7% 5.4% 4.8% 4.8% 4.1% 3.5% 3.2%
10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 2.3% 2.3% 2.3% 2.3% 2.4% 2.3% 2.3% 2.2% 2.0% 2.1% :
1.6% 1.6% 1.6%

Prevention and public health services 2.7% 2.7% 2.6% 2.4% 2.5% 2.4% 2.6% 2.7% 2.6% 2.5% 2.9% 3.2% 2.7%
2.5%

Health administration and health insurance 1.2% 1.2% 1.2% 1.2% 1.5% 1.3% 1.3% 1.3% 1.2% 2.3% 2.3% 1.4%
3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants 0.91 1.02 : : : : 1.54 : : : : 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : : : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants 1.4 1.4 1.4 1.6 1.8 2.1 2.4 2.8 2.9 : 3.8 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : 0.2 0.4 0.4 0.4 0.5 0.6 : 0.5 : 0.6 0.1 0.1 0.1

Proportion of the population that is obese : : 11.4 : : : : 13.4 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 28.0 26.0 26.0 25.0 24.0 23.0 19.0 20.9 : : 17.0 23.2 22.4 22.0

Alcohol consumption litres per capita 11.5 11.3 11.3 11.1 11.1 10.8 10.2 10.4 10.1 9.0 9.2 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 308 322 331 338 340 346 350 356 360 362 : 329 335 344

Practising nurses per 100 000 inhabitants 1358 1399 1439 1448 1429 1489 1556 1586 1598 1630 : 840 812 837

General practitioners per 100 000 inhabitants : : : : : : 68 68 69 69 : : 78 78.3

Acute hospital beds per 100 000 inhabitants 339 326 315 309 299 292 286 287 253 : 247 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 7.9 4.4 4.5 4.5 4.5 4.6 4.6 4.6 4.8 4.7 4.6 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 16.4 16.4 16.5 16.5 15.5 15.2 15.4 : : : : 16.6 16.4 16.5

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Day cases discharges per 100 000 inhabitants 3,999 4,259 4,470 4,755 4,729 4,793 5,383 : : : 6368 6530 7031

Acute care bed occupancy rates : : : : : : : 72.0 73.1 70.2

Hospital curative average length of stay 3.6 3.4 3.5 : : : : : 6.5 6.3 6.3

Day cases as % of all hospital discharges 19.7 20.6 21.4 22.4 23.0 : 25.8 : : : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 8.1 8.5 8.8 8.9 9.0 9.0

AWG risk scenario 8.1 8.8 9.4 9.7 10.0 10.0

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 5.6 5.8 6.1 6.3 6.4 6.5

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

16.5 3.1

0.9 0.9

1.9 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

Estonia is the smallest of the Baltic States. GDP

per capita (17.8 thousand PPS in 2013) is much below the EU average of 27.9 thousand PPS, although it has more than doubled since 1998 (7.2 thousand PPS).

Population was estimated at 1.3 million 2013.

According to Eurostat 2013 projections, total population is projected to decrease from around 1.3 million in 2013 to 1 million in 2060.

Total and public expenditure on health as % of GDP

Total expenditure on health (87) as a percentage of GDP (5.7% in 2013) is well below the EU average (88)(10.1%), having significantly increased since 2003 (4.9%) but decreased since 2009's peak of 6.9%. Public expenditure on health as a percentage of GDP (4.5%) is also much below the EU average (7.8% in 2013), but is still significantly higher than in 2003 (3.8%). The low and rather constant ratios may be partly explained by the very high GDP growth: prior to the crisis Estonia registered one the highest GDP growth in the EU reaching a double-digit output growth. Indeed, total (1200 PPS in 2013) and public (934 PPS in 2013) per capita expenditure actually increased since 2008. However, they are still considerably lower

than the EU average (2988 PPS and 2208 PPS respectively in 2013) and remains one of the lowest in the EU. Note though that the share of public expenditure in total expenditure on health is relatively high (77.9%, above the EU average of 77.4% in 2011).

Expenditure projections and fiscal sustainability

Public expenditure on health care is forecast to increase by 0.6 pps by 2060 according to the 2015 (87) Data on expenditure for Estonia is taken from WHO health for all database and Eurostat.

(88) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units or units of staff where relevant. The EU average for each year is based on all the available information in each year.

Ageing Report reference scenario. Under the risk scenario this could go up by 0.9 pps of GFP.

Overall, for Estonia no significant short-term risks of fiscal stress appear at the horizon, though some variables (namely, the change in the share of nonperforming loans) point to possible short-term challenges.

No sustainability risks appear over the long run due to contained projected ageing costs and a close

to neutral initial budgetary position.

Health status

Life expectancy (81.7 years for women and 72.8 years for men) and healthy life years (57.1 years for women and 53.9 years for men) are below the EU average and, particularly for men, amongst the lowest in the EU.⁽⁸⁹⁾ The large difference in male and female life expectancy in Estonia is also explained by differences in avoidable mortality. Specifically, cardiovascular diseases and external causes account for 30% and 26%, respectively, of deaths among men under-65 years, while accounting for only 22% and 14%, respectively, among women. Men's life expectancy shows a consistent increase from 1995 onwards but suffered a significant decline in the early 1990s, a period of substantial economic and political transition. In contrast, infant mortality has fallen from 7 per 1000 live births in 2003 to 2.1 in 2013, falling below the EU average (3.9). It should also be noted that Estonia has an amenable mortality rate per 100,000 inhabitants that is, at 132, only slightly above the EU average of 128.4 for 2012. Mortality rates associated with ischaemic heart disease and more generally,

diseases of the circulatory systems are some of the EU highest, as are the death rates due to suicide, injuries and road traffic accidents. The incidence rate of tuberculosis is high as is the incidence rate of lung cancer for men. Estonia also registers a relatively high proportions of people that smoke regularly: 26% of adults in 2012 versus an EU average of 22%. Alcohol consumption, at 11.8 litres per capita is also one of the highest, compared with a EU average of 9.8. In 2010, 16.9% of the population was obese. These values (89) Data on life expectancy and healthy life years is from the Eurostat database.

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on the health status of the population deserve attention and action to protect population health outcomes and reduce the burden of disease.

System characteristics

Overall description of the system

The system is financed primarily through mandatory contributions (earmarked payroll tax on employees and self-employed) and through taxation revenues that pay for ambulance and

emergency care and health promotion and disease prevention.

Health expenditure funding comes from social insurance contributions (earmarked payroll tax) plus government taxation, out-of-pocket contributions, private insurance and financial contributions from the rest of the world. An issue of concern is that funding is strongly based on employment-related contributions but the share of non- contributing individuals such as children and pensioners is almost half of the insured. The authorities recognise the narrow revenue base, strongly based on wages (notably in the context of ageing) and there is the intention to enlarge the revenue base for the sector to ensure the long-term sustainability of the sector financing.

Coverage

The Estonia Health Insurance Fund (EHIF)

purchases and reimburses care for about 93.6% of the population based on residence and group membership (e.g. unemployed, children, pensioners, full time carers). 6% of the population are still uninsured and have access to emergency

care only.

Administrative organisation and revenue

collection mechanism

The EHIF establishes contracts with care providers, including General Practitioners (GPs).

However, access to primary care is considered to be very good. Cost-sharing also appears to encourage greater use of primary care services vis-à-vis specialist and inpatient care, which can be cost-effective.

Nevertheless, different measures of the reform of the sickness insurance regime may have important, if not reverse effects in the future. For instance, EHIF compensations are only paid now from the 9th sickness day. Before that, the employer has to cover the costs. While some informal payments exist in the health sector, they do not appear to be widespread or significant in magnitude.

Moreover, the authorities acknowledge long delays for specialist consultations and inpatient care.

They have therefore established centrally managed waiting lists and additional resources to services with the longest lists.

The EHIF (which has four regional branches but

acts as one purchaser of care) uses its budget to establish contractual arrangements with providers, remunerate doctors, and reimburse medicines.

There is an overall budget constraint defined annually for public spending on health which is quite detailed and transparent. Expenditure cannot exceed revenue. However, revenue and expenditure do not necessarily have to match in each financial year, as the EHIF has some accumulated reserves (around 1% of GDP) and could in principle use those to finance expenditure.

In practice though, expenditure has indeed followed the same pattern as revenue. Therefore, when for example the budget has run out, hospitals may in theory postpone surgical interventions for the following year or else the patient has to pay for the full cost. However, in practice such cases are extremely rare.

Role of private insurance and out of pocket co-payments

Cost-sharing applies to home and outpatient visits, hospital stays and medicines, though pensioners and children below 16 have lower out-of-pocket payment. Adult dental care and plastic surgery are not covered by the EHIF. The share of private

expenditure on health in total health expenditure (22.13% in 2013) is slightly below the EU average (22.64%). Out-of-pocket expenditure constitutes about 18.9% of total health expenditure (13.2% in 1998, 25.1% in 2006) and stands above the EU average (14.1% in 2013). From the point of view of access, a smaller share of private expenditure than that of its Baltic neighbours and the way costsharing is applied across services may ensure

better access to basic health care services in Estonia than in Latvia and Lithuania. Out-ofHealth

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pocket expenditure may still pose barriers to access to low income groups and uninsured (authorities do acknowledge that socioeconomic differences have an impact in the use of health services).

While some informal payments exist in the health sector, they do not appear to be widespread or significant in magnitude.

Types of providers, referral systems and patient choice

Primary care is provided by self-employed family practitioners (FPs, equivalent to GPs) and nurses or by family practitioner group practices (owned by family practitioners). Ambulatory specialist

care is provided in health care centres, hospital outpatient departments and specialists' own practices. Inpatient hospital care is provided in regional, central, general or local hospital (state or municipally owned). Outpatient and inpatient providers establish contracts with the EHIF.

Access to primary care is considered to be very good due to the high numbers of general practitioners (GPs), the ability to see the GP within 3 days, and a 24-hour free primary care counselling phone line. Cost-sharing also appears to encourage greater use of primary care services vis-à-vis specialist and inpatient care, which can be cost-effective.

Authorities acknowledge long delays for specialist consultations and inpatient care. They have therefore established centrally managed waiting lists and additional resources to services with the longest lists.

The total number of practising physicians per 100 000 inhabitants has been fairly stable during the last decade (328 in 2013), slightly under the EU average (344). Data on the physician skill/mix indicates that the number of general practitioners (GPs) per 100 000 inhabitants (79 in 2013) has increased steadily since 2003 (66) is above the EU average (78.3) as part of the authorities' long term effort to improve primary care provision. This has resulted in a relatively good access to primary care to the insured population. The number of nurses (617 in 2013) per 100 000 inhabitants is significantly below the EU average (837). Estonia may have suffered from staff migration to other EU countries where qualified health staff was needed and wage levels were higher. There is also a problem of ageing of the workforce, in 2013 – 77.2% of all physicians had more than 40 years of age (including age groups: 40-49; 50-59; 60+) To retain staff the authorities had increased wages in the sector prior to the crisis but this trend was reversed with the economic crisis to improve fiscal balances. However, there have been further wage increases since 2011, leading to significant wage

increases for doctors (60%) and nurses (57%) between 2006 and 2012. However, if there is no political will to increase total public spending on health care, salary increases will need to be covered by efficiency gains of hospitals and other health care organisations, as well as a limited increase in OOP payments.

Note that the authorities have put strong efforts to concentrate medical training, emphasise primary

care training of doctors and nurses and bring training in line with EU law, and to start developing human resources planning in the sector.

Since the early 1990s, national authorities have made a significant and successful effort to enhance

primary care provision and to strengthen the referral system from primary care to specialist doctors and the gatekeeping role of FPs (to reduce the unnecessary use of specialist and hospital

care). All inhabitants have to register with a FP, who acts as family doctor and as a gatekeeper referring patients to other specialists and hospital

care. Patients can choose their FP and choose the specialist after referral.

Estonia has seen a large reduction in the number of acute care beds per 100 000 inhabitants in the last decades, and its number is now only slightly above the EU average (337 vs. 356 in 2013). Bed occupancy rates have stayed relatively constant and, at 69.4%, are slightly below the EU average at 70.2% in 2013.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Payments systems have evolved much over the years and consist of a mix of remuneration types.

GPs receive a mix of capitation, base fee, distance fee for remote practices, fees for defined services and bonus payments for health promotion, disease

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prevention and disease management activities.

This mixed system intends to render primary care more attractive and to provide incentives for

primary care provision including some health promotion, disease prevention activities and

disease management. All other staff is remunerated on a salary basis.

Hospital average length of stay (5.5 days in 2013) is under the EU average (6.3 days), having significantly decreased from 7.3 in 2001. The proportion of hospital surgery done as day cases was 29% in 2011, a significant increase from 4.3% in 2001, close to the EU average of 30.4%.

Hospitals remuneration is a mixed of activitybased payment using DRGs (diagnosis related groups), fee-for-services and bed-days. Further reliance on prospective payment on the basis of DRGs was planned. Although significantly improved and based on complex criteria, the basis for establishing contracts between the EHIF and the various providers could perhaps be further improved in the long run to favour cost-effective interventions when health technology assessment is applied more regularly.

The market for pharmaceutical products Total (1.1%) and public (0.6%) expenditure on pharmaceuticals (90) as a percentage of GDP are below the EU average (1.44% and 0.96% respectively in 2013) and have been basically constant since 2003 (even since 1999, earliest

available data). Public expenditure on pharmaceuticals is close to the EU average (13.1% compared to 12.5% in 2013). This suggests that policies regarding pharmaceuticals have been fairly successful at controlling pharmaceutical expenditure.

Imported medicines now come from Western Europe rather than the former Soviet Union, which resulted in a large increase in prices. In order to control overall expenditure the authorities have implemented a large number of policies. The initial price decision is based on a) international prices, as well as b) economic evaluation and c) the cost of existing treatments. In addition, authorities

(90) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 in the OECD System of Health Accounts.

Note that this SHA-based estimate only records

pharmaceuticals in ambulatory care (pharmacies), not in hospitals.

implement 1) price-volume agreements, together with 2) reference pricing, whereby the maximum reimbursement level of a prescribed drug is based on the second lowest price of existing drugs that

have the same active ingredient and form, and 3) the definition of positive lists (as much as possible based on economic evaluation). The authorities also implement prescriptions guidelines and monitor prescription patterns of physicians who get feedback once a year. These policies have been very useful in controlling pharmaceutical expenditure growth. Perhaps the authorities could explore if these policies, which currently apply only to reimbursable pharmaceuticals, could be extended to non-reimbursable medicines especially in the context of high out-of-pocket payments.

Use of Health Technology Assessments and cost-benefit analysis

Estonia has a Health Technology Assessment Centre that conducts health technology assessment. It was at first funded mainly from Structural Funds (01.02.2012-30.08.2015), and it will in the future be getting its budget from the state. The authorities and professional associations are developing treatment guidelines to harmonise and rationalise medical practices.

Data management and eHealth (eprescription,

e-medical records)

Digital prescription was launched in 2010 and by

2012 most prescriptions were written

electronically. Individuals can access their own

medical data by using their electronic ID cards via

the patient's portal.

Data has substantially improved in recent years.

Information on activity and services is collected by

the EHIF and the Ministry of Social Affairs on a

routine yearly basis. Providers are obliged to

provide annual data reports according to national

standards. This information is used for contracting

purposes and allocation of funds. The Hospital

Network Development Plan is used to make

projections of hospital activity and future hospital

capacity needs and thus hospital licensing and

hospital service regulation (and helped

adjusting/reducing hospital capacity over the

years). There are other plans for other services.

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Health promotion and disease prevention

policies

The government has approved the Public Health

Development Plan for 2009-2020 with the

objective of continuously improving the health

status of the population: increasing average life

expectancy at birth, increasing healthy life years

and reducing socio-economic inequalities in

health. This plan denotes a recent much stronger

concern with health promotion and disease

prevention. Total and public expenditure on

prevention and public health as a % of GDP

(0.17% and 0.16% in 2013) are below the EU

average (respectively 0.32% and 0.19%).

However, public (2.2%) expenditure on prevention

and public health as a % of the total public

expenditure on health is in fact slightly higher than

the EU average in 2013, denoting the authorities'

emphasis to improve life-styles and disease

prevention.

Transparency and corruption

The Estonian health system is perceived to be

transparent and featuring little corruption. The latest health sector corruption survey (University of Tartu, 2011) concluded that the role of informal payments is marginal; 2% of patients acknowledged having paid informally to obtain faster access to care and about 3% to have paid after getting the treatment. Overall, informal payments do not appear to be widespread or significant in magnitude. This may be because of the introduction of formal co-payments in 2002 or because of the generally low level of corruption and informal payment practices.

Recently legislated and/or planned policy reforms

In order to improve the access to health care, the Estonian authorities have adopted the following measures: for 2016, Estonia has increased the Health Insurance Fund budget by 6.4 % compared to 2015, and the budget for nursing services by 12 %. These changes cover wage increases and an increase in the number of health professionals trained. Estonia plans to invest 207,6 million euros

into primary care and into developing regional hospital network competency centres in 2014-2020 to extend and increase the share of primary healthcare services and deliver specialised medical care in a more efficient way and tackle alcohol abuse and addiction.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, many quite successfully (e.g. the development of a strong primary care system that patients can easily access and which can contribute to control cost and ensure the cost-effectiveness of the systems; the development of data collection and monitoring of inputs, processes, outputs and outcomes use for decision-making), and which Estonia should continue to pursue. The main challenges for the

Estonian health care system are as follows:

- To improve, as acknowledged by the authorities, the basis for more sustainable and enhanced financing of health care in the future (e.g. considering additional sources of general

budget funds), with a better balance between resources and demand, between the number of contributors and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources are brought into the sector it is important that they do not remain fragmented but are pooled together, maintaining the strong pooling mechanisms in place today.

- To define a comprehensive human resources strategy to ensure a balanced skill-mix, avoid staff shortages and motivate and retain staff within the sector in view of ageing and migration.
- Increasing insurance coverage to the uninsured population, while improving access, could also decrease the unnecessary use of emergency care services (currently the only services to which uninsured individuals have access).
- To continue the efforts to gather and make more use of cost-effectiveness information in

determining the basket of goods and the extent

of cost-sharing.

- To continue to work on public health priorities

defined in the 2009-2020 Plan and continue to

enhance health promotion and disease

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prevention activities, i.e. promoting healthy life

styles and disease screening given the recent

pattern of risk factors (diet, smoking, alcohol,

lack of exercise, obesity).

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Table 1.8.1: Statistical Annex – Estonia

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 9 10 11 14 16 17 14 15 17 18 19 9289 9800 9934

GDP per capita PPS (thousands) 16.5 17.4 18.4 19.1 19.4 17.9 15.4 16.1 17.1 18.1 17.8 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 8.2 6.6 9.2 10.4 7.5 -4.0 -14.0 3.3 8.7 4.5 2.2 -4.8 1.4 -0.1

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Real total health expenditure growth (% year-on-year) per capita 10.9 11.4 6.7 10.4 10.5 12.7 -1.7 -5.8 0.3 5.6 -0.7
3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 4.9 5.1 5.0 5.0 5.2 6.1 6.9 6.3 5.8 5.9 5.7 10.4 10.1 10.1

Total current as % of GDP 4.9 5.1 5.0 5.0 5.1 5.8 6.7 6.3 5.8 5.7 5.9 9.8 9.6 9.7

Total capital investment as % of GDP 0.0 0.0 0.0 0.0 0.1 0.3 0.3 0.1 0.1 0.2 -0.2 0.6 0.5 0.5

Total per capita PPS 457 532 606 732 909 1089 1069 1016 1064 1166 1200 2828 2911 2995

Public as % of GDP 3.8 3.9 3.9 3.7 3.9 4.7 5.2 5.0 4.6 4.6 4.5 8.1 7.8 7.8

Public current as % of GDP 3.7 3.9 3.8 3.6 3.9 4.6 5.2 5.0 4.6 4.5 4.6 7.9 7.7 7.7

Public per capita PPS 347 397 458 525 674 804 792 781 844 918 934 2079 2218 2208

Public capital investment as % of GDP 0.0 0.0 0.0 0.1 0.0 0.2 0.0 0.0 0.0 0.1 -0.1 0.2 0.2 0.1

Public as % total expenditure on health 76.8 75.5 76.7 73.3 75.6 77.7 75.3 78.8 79.2 78.8 77.9 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 11.8 11.8 12.2 12.5 12.6 13.1 12.5 13.1 13.3
12.9 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance : 94.1 94.3 95.0 95.9 95.6 95.6
95.6 92.9 93.7 93.6 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 20.6 21.5 20.5 25.4 22.2 20.5 21.2 18.7
17.8 18.4 18.9 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 1.4 1.4 1.4 1.4 1.3 1.3 1.3 1.3 1.3 1.3 1.3 502.1 504.5 506.6

Life expectancy at birth for females 77.2 78.0 78.2 78.6 78.9 79.5 80.3 80.8 81.3 81.5 81.7 82.6 83.1 83.3

Life expectancy at birth for males 66.4 66.7 67.6 67.6 67.5 68.9 70.0 70.9 71.4 71.4 72.8 76.6 77.3 77.8

Healthy life years at birth females : 53.8 52.4 53.9 54.9 57.5 59.2 58.2 57.9 57.2 57.1 : 62.1 61.5

Healthy life years at birth males : 50.0 48.3 49.6 49.8 53.1 55.0 54.2 54.3 53.1 53.9 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 161 143 136 128 105 90 79 74 152 132 : 64.4 128.4 :

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Infant mortality rate per 1 000 live births 7.0 6.4 5.4 4.4 5.0 5.0 3.6 3.3 2.5 3.6 2.1 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 1.42 1.56 1.66 1.51 1.54 1.77 1.90 1.79 1.65 1.53 1.51 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.05 0.08 0.09 0.09 0.10 0.12 0.13 0.12 0.11 0.12 0.13 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.25 1.14 1.03 1.12 1.20 1.34 1.55 1.57 1.42 1.60 1.74 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.20 1.30 1.20 1.18 1.11 1.25 1.63 1.38 1.25 1.12 1.11 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.11 0.13 0.14 0.18 0.17 0.19 0.16 0.16 0.13 0.16 0.18 0.31
0.31 0.32

Prevention and public health services 0.10 0.11 0.12 0.13 0.14 0.16 0.16 0.17 0.16 0.19 0.17 0.25 0.25 0.24

Health administration and health insurance 0.21 0.18 0.15 0.14 0.13 0.13 0.14 0.13 0.13 0.11 0.13 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 1.36 1.45 1.51 1.40 1.40 1.66 1.81 1.72 1.57 1.50 1.49 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.05 0.08 0.09 0.09 0.10 0.12 0.13 0.12 0.11 0.11 0.12 0.16 0.16 0.18

Out-patient curative and rehabilitative care 0.93 0.85 0.83 0.82 0.95 1.12 1.33 1.24 1.16 1.16 1.18 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.54 0.60 0.53 0.48 0.47 0.54 0.67 0.67 0.61 0.60 0.60 0.79 1.07
0.96

Therapeutic appliances and other medical durables 0.04 0.05 0.06 0.06 0.06 0.08 0.08 0.09 0.08 0.08 0.10 0.13
0.12 0.13

Prevention and public health services 0.09 0.08 0.09 0.10 0.11 0.15 0.14 0.15 0.13 0.17 0.16 0.25 0.20 0.19

Health administration and health insurance 0.21 0.18 0.17 0.13 0.13 0.13 0.14 0.13 0.13 0.12 0.12 0.11 0.27 0.27

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EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.8.2: Statistical Annex - continued – Estonia

Source: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 29.1% 30.6% 33.3% 30.4% 30.3% 30.5% 28.6% 28.5% 28.7% 26.8%
25.7% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 1.0% 1.5% 1.8% 1.8% 2.0% 2.0% 2.0% 1.8% 1.9% 2.1% 2.1% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative care 25.6% 22.4% 20.6% 22.5% 23.6% 23.1% 23.3% 25.0% 24.7% 28.0%
29.6% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 24.6% 25.5% 24.0% 23.7% 21.9% 21.5% 24.5% 22.0% 21.7%
19.6% 18.9% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 2.2% 2.6% 2.8% 3.6% 3.4% 3.2% 2.4% 2.5% 2.3% 2.8% 3.1%
3.2% 3.3% 3.3%

Prevention and public health services 2.0% 2.2% 2.4% 2.6% 2.8% 2.8% 2.4% 2.7% 2.8% 3.3% 2.9% 2.6% 2.6%
2.5%

Health administration and health insurance 4.3% 3.5% 3.0% 2.8% 2.6% 2.2% 2.1% 2.1% 2.3% 1.9% 2.2% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

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Inpatient curative and rehabilitative care 36.4% 37.7% 39.5% 38.6% 36.2% 36.5% 34.8% 34.6% 34.1% 33.3% 32.6% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 1.4% 2.0% 2.3% 2.4% 2.6% 2.6% 2.5% 2.3% 2.4% 2.5% 2.6% 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care 24.9% 22.1% 21.7% 22.6% 24.5% 24.6% 25.6% 24.9% 25.2% 25.8% 25.7% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 14.4% 15.6% 13.9% 13.2% 12.1% 11.9% 12.9% 13.5% 13.2% 13.3% 13.1% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 0.9% 1.4% 1.7% 1.7% 1.6% 1.7% 1.6% 1.9% 1.8% 1.8% 2.1% 1.6% 1.6% 1.6%

Prevention and public health services 2.4% 2.1% 2.4% 2.8% 2.8% 3.3% 2.7% 3.0% 2.8% 3.8% 3.5% 3.2% 2.7% 2.5%

Health administration and health insurance 5.6% 4.6% 4.3% 3.7% 3.4% 2.8% 2.7% 2.6% 2.7% 2.7% 2.7% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants : : 0.22 0.37 0.52 0.82 0.75 0.82 0.97 0.98 1.14 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : 0.4 0.4 0.4 0.7 0.7 0.7 0.7 0.8 0.8 0.9 0.9 0.8

CTS per 100 000 inhabitants : : 0.7 0.7 1.1 1.5 1.5 1.6 1.6 1.7 1.9 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : 0.0 0.1 0.1 0.1 0.1 0.1 0.1 0.2 0.2 0.1 0.1 0.1

Proportion of the population that is obese : : : : 18.0 : 16.9 : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : 32.8 : 27.8 : 26.2 : 26.2 : 26.0 : 23.2 22.4 22.0

Alcohol consumption litres per capita 11.6 13.2 13.1 13.4 14.7 14.2 11.9 11.4 11.6 12.2 11.8 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 316 321 317 319 326 333 327 322 326 328 328 329 335 344

Practising nurses per 100 000 inhabitants 621 631 633 632 640 640 613 608 618 617 617 840 812 837

General practitioners per 100 000 inhabitants 66 68 69 69 70 72 72 73 74 74 79 : 78 78.3

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Acute hospital beds per 100 000 inhabitants 434 421 379 389 376 381 357 342 349 355 337 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 6.2 6.2 6.3 6.4 6.6 6.6 6.3 6.1 6.4 6.3 6.4 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 18.5 18.7 17.8 18.2 18.3 18.3 17.5 17.4 17.4 17.3 17.1 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 2,939 3,076 3,886 4,814 5,916 6,061 5,921 6,080 6,852 8,044 7,021 6368 6530 7031

Acute care bed occupancy rates 67.0 69.0 69.0 71.0 72.0 70.1 68.2 70.8 71.0 69.1 69.4 72.0 73.1 70.2

Hospital curative average length of stay 6.4 6.2 6.0 5.9 5.9 5.7 5.6 5.5 5.5 5.6 5.5 6.5 6.3 6.3

Day cases as % of all hospital discharges 6.8 8.1 12.2 14.2 16.2 16.8 25.3 25.8 28.2 31.8 29.0 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 4.4 4.6 4.8 5.0 5.0 5.0

AWG risk scenario 4.4 4.8 5.3 5.6 5.7 5.7

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 1.3 1.3 1.2 1.2 1.1 1.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-17.2 3.1

0.6 0.9

1.3 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, Finland had a GDP per capita of 27.9 PPS

(in thousands), very similar to the EU average.

Population was estimated at 5.4 million in 2013.

According to projections, total population in

Finland is projected to increase from around 5.4

million in 2013 to 6.2 million in 2060.

Total and public expenditure on health as % of

GDP

Total expenditure (91) on health as a percentage of

GDP (9.4% in 2013) has increased over the last

decade (from 7.4% in 2001, although it has been

relatively flat since 2009), below the EU average

(92) of 10.1% in 2013. Public expenditure has

increased, though to a smaller extent: from 5.3% in

2001 to 7.1% of GDP in 2013. It is also below the

EU average of 7.8% in 2013. According to the

authorities, the main factors explaining the growth

of health expenditure are the increased costs of

specialised care and pharmaceuticals.

When expressed in per capita terms, total spending

on health at 2,951 PPS in Finland is below the EU

average of 2,988 in 2013, while public spending on

health care is slightly higher: 2,221 PPS vs. an

average of 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health

care expenditure is projected to increase by 0.7 pps

of GDP, below the average growth expected for

the EU (0.9) (93), according to the Reference

Scenario. When taking into account the impact of

(91) Data on health expenditure is taken from OECD health data

and Eurostat database. The variables total and public

expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(92) The EU averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units and units of staff where relevant. The EU

average for each year is based on all the available information in each year.

(93) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

non-demographic drivers on future spending

growth (AWG risk scenario), health care

expenditure is expected to increase by 1.3 pps of

GDP from now until 2060 (EU value: 1.6).

High risks appear in the medium term from a debt

sustainability analysis perspective due to the

relatively high stock of debt at the end of

projections (2026), and the sensitivity to possible

shocks to nominal growth, interest rates and the

government primary balance. Jointly simulated

shocks to growth, interest rates and the primary

balance point to an 80% probability of a debt ratio

in 2020 greater than in 2015. Finland faces

medium sustainability risks over the long run.

These are primarily related to the unfavourable

initial budgetary position compounded by the

projected impact of age-related public spending

(notably healthcare and long-term care). (94)

Health status

Life expectancy at birth (84.1 years for women and 78.0 years for men in 2013) is close to the respective EU averages (83.3 and 77.8 years of life expectancy in 2013). (95) However, healthy life years, at 56.2 years for women and 57.3 years for men, were below the EU averages of 62.1 and 61.5 in 2012. The infant mortality rate of 1.8‰ is lower than the EU average of 3.9‰; in 2013, having gradually fallen over most of the last decade (from 3.2‰ in 2001), although it has been relatively flat since 2010, until it fell finally below 2‰ in 2013.

As for the lifestyle of the Finnish population, the data indicates a constant fall in the proportion of the regular smokers (from 23.8% in 2001 to 15.8% on 2013), below the EU average of 22.0 in 2013).

Over the same period the proportion of the obese in the population has increased (from 11.4% in 2001 to 16.6% in 2011). Alcohol consumption has increased since 2001, when it was 8.9 litres per capita, to 9.0 in 2013, although still below the peak of 10.5 in 2007 and the 2013 EU average of 9.8.

(94) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(95) Data on health status including life expectancy, healthy life

years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and

Eurostat database.

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System characteristics

Coverage

Finnish municipalities and their co-operation

networks are required to provide social and health

care services, including essential public health

services and actions, to their resident citizens.

The provision of health care by the municipalities

is complemented by the Finnish statutory health

insurance, which covers the entire population, and

includes both medical care insurance and earned

income insurance.

KELA, the Social Insurance Institution of Finland

is in charge of health insurance. This insurance reimburses patients for tests and treatments prescribed by private doctors and dentists as well as for any charges paid according to statutory reimbursement rates. Costs in excess of the statutory reimbursement rate are paid by patients.

The insurance is financed 50/50 from taxation and contributions. Contributions to this insurance are deducted from the taxable income, benefits and/or pension of the insured.

Earned income insurance covers other benefits such as allowances for sickness, rehabilitation, special care, and maternity/paternity.

Administrative organisation and revenue collection mechanism

From a financial point of view, the Finnish health

care system has three main parts: municipal health

care services (primary and specialised health services), private health services and occupational health services.

An integrated but decentralised system of

municipal health care services, funded on the basis of taxes (central and local taxes and for a small part client fees), provides full population coverage.

On the basis of legal provisions (harmonised legislation and guidelines), the 320 municipalities (in 2013, compared to 415 in 2008) are responsible for providing or funding a wide range of health services (including health promotion, disease prevention and rehabilitation) for their residents (still less than 10 000 in the majority of

municipalities). Primary care is provided by individual municipalities or by groups of municipalities whereas the specialised health care is organised through federations of municipalities.

In 2014, 50% of the population used the services of a GP and 68% GP or other services of the multiprofessional municipal public health centres.

This is coupled with a compulsory national medical insurance (run by KELA, the Social Insurance Institution) covering all residents (96), financed through the state (50 55%) and the insured (50 45%). This covers part of patients'

expenditure on outpatient drugs, transportation

costs but also part of private health care (mainly

outpatient visits and ambulatory care in big cities).

Use of private health services represented 5.9% of

total health expenditure in 2013. In addition,

employers provide/buy occupational health

services predominantly preventive and first aid

care, but also basic outpatient care for common

illnesses in the case of larger companies. The role

of compulsory occupational health care is

significant, as it covers around one third of the

total population. Supplementary private health care

insurance is available but has only a minor role. In

2013, the share of primary and occupational health

services was 17.3% and that of specialised care

38% of total health expenditure.

Role of private insurance and out of pocket

co-payments

Preventive and promotive services are mostly free

of charge and used widely. However, users pay an

out-of-pocket fee for the use of ambulatory and

hospital services, including laboratory tests and scans. The maximum fees are set by central government every six months. Users are further protected by an annual ceiling, above which they are able to use of all municipal health services without further fees.

Most municipal health services (primary, outpatient specialist care, hospital day case and inpatient care, dental care, physiotherapy) involve a fee at the point of use. Children and those who have reached an upper limit for out-of-pocket payments are exempted from cost-sharing. Use of child clinics, including vaccinations, and maternity services is free of charge. The occupational health care is free of charge to the employee. Under the

(96) This is a part of the national health insurance scheme that covers both the medical insurance and the sickness and parenthood allowances scheme.

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national medical health insurance the cost-sharing

applies to pharmaceuticals and many private health

care services (see the previous paragraph).

Eyeglasses and contact lenses are, for example, not

funded or provided by local or state authorities.

Reimbursement for pharmaceutical outpatient

prescriptions is calculated as a percentage of the

medicine's reference price. Patients enjoy a fixed

deduction due to any travel expenses as well as the

cost of prescribed medicines. Again, an annual

ceiling is set on the maximum amount that patients

pay for prescriptions and travel expenses.

11.4% of the population buys supplementary

private insurance (to cover the services not

covered by public provision/ funding) and 11.5%

buys complementary health insurance to cover

cost-sharing. If cost-sharing is fully covered by

private insurance it may lose the ability to reduce

overconsumption and/or encourage some services

more than others, although complementary

insurance is taken by a relatively small share of the

population.

In 2013, private expenditure and out-of-pocket

expenditure were 24.7% and 18.5% of total health expenditure and therefore above the EU average (22.6% and 14.1%). Both have fallen since their 2001 values of 27.8% and 21.6%.

To improve access and reduce the waiting times for primary care, legislation was introduced which establishes the right to immediate access to health centres by phone or a visit during working hours and evaluation of the person's health care needs within 3 working days. To reduce waiting times for hospital surgery, which was seen as a problem in Finland, legislation provides that a non-urgent referral must be assessed within 3 weeks and hospital treatment provided within 6 months.

When this is not possible, patients can be treated in another hospital district or in the private sector at the authorities' expenses. In many areas there are phone services and web pages in place to help patients access the system. Waiting times have seen a reduction since these systems have been implemented. Some hospital districts provide online data on waiting times. In addition, the

National Institute for Health and Welfare publishes

general statistics on waiting times.

Types of providers, referral systems and patient

choice

Primary care is provided by general practitioners

(GPs) in municipal public health centres while

outpatient specialist care is provided in outpatient

hospital departments. In larger cities the public

health centres also provide outpatient specialist

services. Federations of municipalities form

hospital districts (20 districts in total excluding the

Åland Island) and own public hospitals. About

89% of all hospital beds are public. The 20

hospital districts are further grouped into 5 tertiary

care regions around universities with medical

schools. Private provision, often through group

practices, mostly concerns outpatient specialist and

simple ambulatory services, and typically takes

place in urban areas. Private physicians can,

however, refer patients to public hospitals. Of

physicians, 70% work in the public and 30% in the

private sectors. Of all physicians working in the

public sector, 24% work also on a part time basis

in the private sector outside office hours. The

proportion of GPs who work in the public health

centres and have a private practice outside office

hours is 12%.

The number of licensed physicians per 100 000

inhabitants in Finland is, at 302 in 2013, far below

the EU average of 344 in that year. It has increased

continuously since 2001. The number of general

practitioners (GPs) per 100 000 inhabitants was

120 in 2013, above the EU average of 78.3. The

number of nurses per 100 000 inhabitants (1412 in

2012) was far above the EU average of 829.

Authorities acknowledge shortages of staff in some

specialties and in some geographic areas. A

shortage of GPs in certain municipalities may

explain longer waiting times to see a GP. Staff

supply is regulated in terms of quotas for medical

students but not in terms of the location of

physicians. The GP shortage has been addressed

by redistribution of professional responsibilities in

primary care between physicians and public health

nurses. The effectiveness of this measure is unclear

at this stage.

Authorities have made some efforts to use primary

care vis-à-vis specialist and hospital care. While

residents are free to contact a GP, there is in

municipal health care a compulsory referral system

from primary care to specialist doctors i.e. GPs act

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like gatekeepers to specialist and hospital care.

However, in some areas, shortages in GPs may

have led to perceived long waiting times for GP

visits and therefore led to unnecessary visits to

specialists or emergency departments.

Choice of GP, specialist and hospital is allowed

but limited. Increasing patient choice is, in fact, a

priority of national authorities.

The number of acute care beds per 100 000

inhabitants (281 in 2013) is well below the EU

average of 356 for that year. It has consistently

decreased in recent times (341 in 2003) and stands as one of the lowest in the EU. There appears to be no regulation in terms of increases in hospital capacity or equipment capacity. Hospitals have autonomy to recruit medical staff and other health professionals. Private hospitals are free to establish and expand their capacity in compliance with quality and safety requirements.

Treatment options, covered health services

The Ministry of Social Affairs and Health defines general policy guidelines and regulation, but there is not a defined basic benefit package. The Council

for Choices in Health Care at the Ministry of

Social Affairs and Health provides

recommendations on which treatments and other health technologies methods are included in the range of health services provided by public funding in Finland.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Public sector physicians (GPs and specialists) are paid a salary. The pay scale for medical staff and other health professionals is set at national level.

The labour unions negotiate with the Commission for Local Authority Employers over salaries. The Government does not have a role in this procedure. Physicians are not eligible to receive bonuses regarding their activity or performance, although a small share of the salary of dentists and primary care physicians is paid following a fee-for-service principle. Of physicians 70% work in the public and 30% in the private sectors. Physicians who work in the public sector may also practice in the private sector based on the approval of the (public) employer. Of all physicians working in the public sector, 24% work also on a part time basis outside their office hours in the private sector. The proportion of GPs who work in the public health centres and have a private practice outside office hours is 12%. This is considered to be a measure to increase access.

The municipalities remunerate the hospital districts for their services. In most hospital districts some type of payment per case basis using DRGs is in use. Hospital remuneration methods are negotiated

at local level.

When looking at hospital activity, inpatient discharges (1,731 per 100 000 inhabitants in 2013) are above the EU average (1,649) while the number of day case discharges, at 5,323 in 2013, is below the EU average of 7,031. The proportion of surgical day case discharges amongst all procedures conducted was 23.5% in 2013, being below the EU average (30.4%). Acute average length of stay (6.8 days in 2013) is below the EU average (6.3 days in 2013).

The market for pharmaceutical products

The authorities have implemented a large number of policies to control expenditure on pharmaceuticals. Initial price is based on clinical performance, economic evaluation, the cost of existing treatments and international prices (NL, BE, ES, IE, IS, UK, IT, AT, EL, LU, NO, PT, FR, SE, DE, and DK). The government has used price freezes and cuts and there is a positive and a negative list of reimbursed products which is based partly on health technology assessment information when available. Authorities promote

rational prescribing of physicians through treatment guidelines complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines. The structure of co-payments changed in 2006 so that the co-payment is now a share of the medicine's cost rather than a fixed amount for any "visit" to the pharmacy, which appears to have encouraged patients to buy excessive quantities of medicines. There is an explicit generics policy. Prescription by active element is in place although its application is rare. Nevertheless, pharmacies are obliged to dispense the cheaper product and replace the prescription by a generic medicine if available. Generics face a fast track registration and lower registration fees. Patients aware of the generic substitution appear to

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request cheaper medicines and electronic systems allow doctors (and therefore the patients) to access

the prices of medicines when prescribing medicines. Generic substitution is particularly important when patients have to incur a large share of the cost. In April 2009, reference pricing was introduced. The reimbursement is based on the reference price that is the price of the cheapest substitutable product plus a small premium. If the patient chooses a product whose retail price exceeds the reference price, he/she must pay the share above the reference price. Both generic substitution and reference pricing systems have had notable downward effects on the pharmaceutical expenditure. Authorities (through KELA, the Social Insurance Institution) monitor the general consumption of prescribed medicines closely and evaluate the budgetary impact of generic substitution.

Pharmaceutical spending as a proportion of current health spending fell from 16.9% in 2005 to 13.9% in 2013. It is below the EU average of 14.9% for that year. Pharmaceutical spending remained on the same level in 2014, but increased 5% in 2015.

eHealth, Electronic Health Record

The coverage of electronic patient records has been 100 % in Finland for many years now. Finland has also introduced a nationwide harmonised electronic patient record (Patient Data Repository), an electronic prescription, a citizens' health portal (My Kanta pages) and a national medicine record (Pharmaceutical Database). These initiatives have been a part of the National Archive of Health Information –project (Kanta).

The electronic prescription is in use by both public and private organisations and the coverage is in public organisations nearly 100 %. Electronic prescription is mandatory as of 1.1.2017. All public organisations are connected to the Patient Data Repository and private organisations are starting to participate in 2016. This allows sharing of data between healthcare providers securely and with patient consent. Citizen's health portal enables patients to inspect their electronic prescriptions and health records, log data, give consent and denials and make advanced directives (e.g. living will). The national medicine record

provides regularly updated information for physicians and pharmacies about e.g. the cost, reimbursement eligibility and substitutability of pharmaceuticals. Modernisation of electronic health record systems and other health/hospital/patient access systems is moving forward. Finland also has a national eHealth - strategy for information management and ICT development.

Health and health-system information and reporting mechanisms/ Use of Health

Technology Assessments and cost-benefit analysis

Finland has an extensive information management and statistics systems and comprehensive data is gathered on physician and hospital activity and quality and health status. Hospital benchmarking data is available allowing for costs and efficiency comparisons. Existing clinical guidelines and practice protocols are coupled with the monitoring of physician activity and feedback to physicians (for example on their prescription behaviour) to encourage compliance with those guidelines.

Through surveys, authorities are planning to

collect information on patient's experience and

satisfaction with the care obtained. They also want

to make information publicly available.

The Centre for Health Economics (CHESS) at the

National Institute for Health and Welfare

undertakes high-quality health economics research

on issues relevant for health policy. CHESS

focuses on quality and efficiency of health

services, financing and provision of health services

and evaluation of health services system. The

Finnish Office for Health Technology Assessment

(Finohta) produces, supports and coordinates

health care technology assessment in Finland. It

disseminates assessment results and experiences,

both national and international, within the health

system. The Pharmaceuticals Pricing Board

confirms the reimbursement (including the level of

reimbursement) and a reasonable wholesale price

for pharmaceuticals.

The Parliament, the Government through the

Ministry of Health, and municipalities set public

health priorities in terms of outcomes and the

reduction of health inequalities. For example, a shared project of the National Institute for Health and Welfare and the Finnish Institute of Occupational Health (the TEROKA project) aims aimed to develop information on health

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inequalities and to promote the reduction of inequalities. As section 1 suggests there are indeed a number of risk factors that can translate into an important burden of disease and financial costs. Authorities have strongly emphasised health promotion and disease prevention measures in recent years as well as emphasising the important contribution other policy areas can make to improve the health of the population ("Health in all Policies"). Recent legislation will define more explicitly the promotion and preventive services to be provided at municipal level. Promotion and prevention are seen by authorities as a means to ensure long-term sustainability of the health

budget: they reduce the development of disease;

the need for care; and, the consequent need for funding.

Public expenditure on prevention and public health services as a % of GDP was above the EU average 0.28% vs. 0.19% in 2013. This was also the case as a % of total current health expenditure (4.3% vs. the EU average of 2.5% in 2013).

Recently legislated and/or planned policy reforms

On April 5 2016 the Finnish Government published its detailed position, which will guide the drafting of legislation on three interconnected reforms: (1) the reform of the organisation of health and social services, (2) the reform relating to freedom of choice and multisource financing, and (3) the regional government reform, i.e. the establishment of 18 independent counties governed by elected county councils.

The goals of these reforms are to (1) reduce the currently forecasted public finance sustainability gap by EUR 3 billion by 2030, (2) guarantee equal access to high quality services everywhere in the

country and (3) reduce health inequities.

The health and social reform is based on a clientcentred integration of health and social services as the key measure for narrowing health and wellbeing disparities, improving the effectiveness of the services in an equal manner and bringing cost savings. A single strong organiser, county, will be responsible for services, steering, official activities, evaluation of regional impact, costeffectiveness and quality services as well as supporting the users' freedom of choice. Freedom in the choice of choice of services, the details of which are decided later in the legislative process, will enable users themselves to make choices between the providers.

The county will have a single budget and a single financial management and it will produce the necessary health and social services itself or together with other counties, or it may rely on private or third sector in the provision of services.

Counties will be financed by the central government and the current multisource financing

will be simplified. The relevant perspectives of European Union law and the realisation of fundamental rights will be taken into account in the legislative drafting.

Counties will ensure that the organisation and provision of services are genuinely separated and performed by different organisations (legal persons). Freedom of choice will significantly promote competition in the provision of services.

Integration of information systems will increase information flows between different providers.

Consequently, the integration of service chains will improve. Essential public health functions, including health promotion and disease prevention, will be ensured.

The decision entails a major shift of paradigm and will require additional planning to that already carried out at earlier phases of the reform preparations. The requisite constitutional assessment of different funding alternatives will be carried out as a part of the drafting of the new legislation. The government bills on the reform will be passed to the Parliament in 2016 and 2017,

and enacted in 2019. Improved cost management will be a key principle when preparing legislation and implementing the reform. Successful and skilful change management will be a prerequisite for achieving the targets and thus will receive particular attention during the reform implementation.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. to reduce waiting times, to improve hospital efficiency, to improve data collection and monitoring, to control pharmaceutical expenditure), and which Finland

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should continue to pursue. The main challenges for the Finnish health care system are as follows:

- To ensure greater coherence between the sources of financing so that they reinforce equity and efficiency in the system.

- To ensure consistency in the provision of health care by different municipalities, ensuring equity of access and costeffectiveness.
- To enhance primary care provision by increasing the numbers and spatial distribution of GPs and nurses and by rendering referral system to specialist care more effective.
- To consider whether it is worth introducing some element of performance related payment physicians' remuneration (e.g. through the use of mixed payment schemes) to encourage health promotion, disease prevention and disease management activities or the treatment of vulnerable populations and increase outpatient output and render primary care more attractive. More generally, to ensure sufficient numbers of staff in view of ageing of staff and population.
- To increase hospital efficiency by increasing the use of day case surgery and increasing the supply of follow-up care for long-term care

patients so as to reduce the unnecessary use of

acute care settings for long-term care patients.

In addition, measures pursued in recent years

should be consolidated to reduce duplication

and improve efficiency and quality in the

hospital sector (e.g. concentration and

specialisation of hospitals within regions).

- To ensure a greater use of health technology

assessment to determine new high-cost

equipment capacity as well as the benefit

basket and the cost-sharing design across

medical interventions as is currently done with

medicines.

- To further enhance health promotion and

disease prevention activities i.e. promoting

healthy life styles and disease screening given

the recent pattern of risk factors (diet, smoking,

alcohol, obesity) in various settings (at work, in

school).

- To tackle the increased waiting times found in

some areas, especially by distributing

healthcare staff more efficiently.

- To track the sustainability of the healthcare

system and ensure that the medium and longterm

risks are accounted for. All the potential

cost-drivers should be considered and dealt

with.

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Table 1.9.1: Statistical Annex – Finland

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 152 158 164 173 187 194 181 187 197 200 203 9289 9800 9934

GDP per capita PPS (thousands) 27.0 28.9 29.3 30.4 32.1 31.7 28.3 29.2 29.6 29.0 27.9 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 1.8 3.8 2.6 4.0 4.9 -0.2 -9.0 2.9 2.3 -1.5 -1.8 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 6.4 4.6 5.3 2.9 1.1 3.2 0.4 0.9 1.8 0.0 1.5 3.2 -0.2
-0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 8.2 8.2 8.4 8.3 8.0 8.3 9.2 9.0 9.0 9.1 9.4 10.4 10.1 10.1

Total current as % of GDP 7.8 7.9 8.1 7.9 7.6 7.9 8.7 8.6 8.5 8.7 8.6 9.8 9.6 9.7

Total capital investment as % of GDP 0.4 0.4 0.4 0.4 0.4 0.4 0.5 0.4 0.4 0.4 0.8 0.6 0.5 0.5

Total per capita PPS 1983 2088 2217 2295 2382 2544 2611 2633 2746 2817 2951 2828 2911 2995

Public as % of GDP 5.9 6.0 6.2 6.3 6.0 6.2 6.9 6.7 6.7 6.8 7.1 8.1 7.8 7.8

Public current as % of GDP 5.6 5.7 5.9 5.9 5.7 5.9 6.5 6.3 6.3 6.5 6.5 7.9 7.7 7.7

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Public per capita PPS 1314 1400 1489 1556 1614 1721 1751 1766 2047 2113 2221 2079 2218 2208

Public capital investment as % of GDP 0.3 0.3 0.3 0.4 0.3 0.3 0.4 0.4 0.3 0.3 0.6 0.2 0.2 0.1

Public as % total expenditure on health 72.8 73.3 73.8 74.9 74.4 74.5 74.8 74.2 74.5 75.0 75.3 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 12.9 13.1 13.7 14.0 13.9 14.2 14.1 14.2 14.3 14.5 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 21.9 21.4 21.0 20.1 20.4 20.1 19.9 20.6 20.1 19.6 18.5 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 5.2 5.2 5.2 5.3 5.3 5.3 5.3 5.4 5.4 5.4 5.4 502.1 504.5 506.6

Life expectancy at birth for females 81.9 82.5 82.5 83.1 83.1 83.3 83.5 83.5 83.8 83.7 84.1 82.6 83.1 83.3

Life expectancy at birth for males 75.1 75.4 75.6 75.9 76.0 76.5 76.6 76.9 77.3 77.7 78.0 76.6 77.3 77.8

Healthy life years at birth females 56.5 53.1 52.5 52.8 58.0 59.5 58.6 57.9 58.3 56.2 : : 62.1 61.5

Healthy life years at birth males 57.3 53.3 51.7 53.2 56.8 58.6 58.2 58.5 57.7 57.3 : : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 70 64 62 60 57 54 54 51 114 115 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 3.1 3.3 3.0 2.8 2.7 2.6 2.6 2.3 2.4 2.4 1.8 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.28 2.20 2.21 2.12 2.00 1.99 2.32 2.31 2.39 2.43 2.49 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.12 0.10 0.11 0.10 0.10 0.10 0.10 0.11 0.11 0.12 0.13 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.01 2.16 2.24 2.34 2.28 2.47 2.66 2.67 2.71 2.80 2.79 2.29 2.25 2.24

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Pharmaceuticals and other medical non-durables 1.29 1.32 1.35 1.22 1.19 1.23 1.30 1.25 1.20 1.21 1.20 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.21 0.21 0.21 0.22 0.21 0.20 0.22 0.22 0.22 0.21 0.21 0.31 0.31 0.32

Prevention and public health services 0.39 0.40 0.43 0.43 0.43 0.45 0.49 0.48 0.52 0.54 0.51 0.25 0.25 0.24

Health administration and health insurance 0.12 0.12 0.11 0.12 0.10 0.11 0.10 0.09 0.08 0.08 0.08 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.03 1.96 1.99 1.90 1.79 1.78 2.08 2.08 2.16 2.21 2.27 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.12 0.09 0.10 0.08 0.08 0.08 0.09 0.09 0.09 0.10 0.10 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.42 1.57 1.65 1.75 1.71 1.88 2.00 2.00 2.04 2.11 2.14 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.63 0.67 0.68 0.66 0.64 0.67 0.72 0.69 0.67 0.68 0.63 0.79 1.07 0.96

Therapeutic appliances and other medical durables : : : : : : : : : : 0.13 0.12 0.13

Prevention and public health services 0.23 0.24 0.26 0.27 0.28 0.28 0.29 0.28 0.31 0.32 0.28 0.25 0.20 0.19

Health administration and health insurance 0.19 0.18 0.17 0.18 0.16 0.16 0.15 0.14 0.12 0.13 0.12 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.9.2: Statistical Annex - continued – Finland

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Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 29.3% 28.0% 27.5% 26.8% 26.2% 25.2% 26.7% 27.0% 28.0% 28.1% 28.8% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 1.6% 1.2% 1.3% 1.2% 1.2% 1.2% 1.2% 1.2% 1.3% 1.4% 1.5% 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 25.9% 27.5% 27.8% 29.6% 29.9% 31.3% 30.6% 31.2% 31.8% 32.3% 32.3% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 16.6% 16.8% 16.8% 15.4% 15.6% 15.6% 15.0% 14.6% 14.1% 14.0% 13.9% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 2.7% 2.7% 2.6% 2.7% 2.7% 2.5% 2.5% 2.6% 2.5% 2.4% 2.4% 3.2% 3.3% 3.3%

Prevention and public health services 5.0% 5.1% 5.3% 5.4% 5.6% 5.7% 5.6% 5.6% 6.1% 6.2% 5.9% 2.6% 2.6% 2.5%

Health administration and health insurance 1.5% 1.5% 1.4% 1.5% 1.3% 1.4% 1.2% 1.1% 0.9% 0.9% 0.9% 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 36.1% 34.2% 33.7% 32.3% 31.7% 30.4% 32.2% 33.0% 34.1% 34.1% 35.1% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 2.1% 1.6% 1.7% 1.3% 1.4% 1.4% 1.3% 1.4% 1.5% 1.6% 1.6% 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care 25.3% 27.4% 27.9% 29.7% 30.3% 32.1% 31.0% 31.7% 32.2% 32.6% 33.0% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 11.2% 11.7% 11.5% 11.2% 11.3% 11.4% 11.1% 10.9% 10.6% 10.5% 9.7% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : : : : : : : : : 1.6% 1.6% 1.6%

Prevention and public health services 4.1% 4.2% 4.4% 4.6% 5.0% 4.8% 4.5% 4.4% 4.9% 4.9% 4.3% 3.2% 2.7% 2.5%

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Health administration and health insurance 3.3% 3.2% 3.0% 3.1% 2.8% 2.7% 2.3% 2.2% 2.0% 2.0% 1.9% 1.4%
3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants 1.30 1.40 1.47 1.52 1.53 1.56 1.57 1.86 2.02 2.16 2.21 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : 2.0 : 2.3 2.4 2.1 2.0 1.9 0.9 0.9 0.8

CTS per 100 000 inhabitants 1.4 1.4 1.5 1.5 1.6 : 2.0 2.1 2.1 2.2 2.2 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.1 0.1 0.1 0.1 : : 0.1 0.1 0.2 0.2 0.2 0.1 0.1 0.1

Proportion of the population that is obese 12.8 14.0 14.1 14.3 14.9 15.7 14.9 15.6 16.6 : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 22.2 23.0 21.8 21.4 20.6 20.4 18.6 19.0 17.8 17.0 15.8 23.2
22.4 22.0

Alcohol consumption litres per capita 9.3 9.9 10.0 10.2 10.5 10.3 10.0 9.7 9.8 9.2 9.0 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 256 259 263 268 269 272 283 299 299 301 302 329 335 344

Practising nurses per 100 000 inhabitants : 1213 1257 1315 1340 1314 1356 1386 1408 1412 : 840 812 837

General practitioners per 100 000 inhabitants : : : : : 102 113 117 115 120 : 78 78.3

Acute hospital beds per 100 000 inhabitants 341 338 334 327 320 311 304 302 296 292 281 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 4.2 4.2 4.3 4.3 4.2 4.3 4.2 4.3 2.8 2.7 2.6 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 20.8 20.5 20.1 19.6 19.0 18.8 18.4 18.2 18.0 : 17.3 16.6 16.4
16.5

Day cases discharges per 100 000 inhabitants 5,051 5,191 5,552 5,403 5,429 5,434 5,332 5,473 5,547 : 5,323
6368 6530 7031

Acute care bed occupancy rates : : : : : : : : : : 72.0 73.1 70.2

Hospital curative average length of stay 7.1 7.1 7.1 7.2 7.2 7.1 7.1 7.0 6.9 6.9 6.8 6.5 6.3 6.3

Day cases as % of all hospital discharges 19.5 20.2 21.6 21.6 22.2 22.4 22.4 23.2 23.6 : 23.5 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 7.8 8.1 8.4 8.5 8.5 8.5

AWG risk scenario 7.8 8.1 8.6 8.9 9.1 9.1

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 5.4 5.6 5.9 6.1 6.2 6.2

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

14.8 3.1

0.7 0.9

1.3 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, France had a GDP per capita of 28.1 PPS

(in thousands), slightly above the EU average of

27.9.

Population was estimated at 65.7 in million 2013.

It has increased in the previous decade and it is projected to increase further, although at a slower rate.

Total and public expenditure on health as % of GDP

Total expenditure (97) on health as a percentage of GDP (11.7% in 2013) has increased over the last decade (from 10.8% in 2003) and is slightly over the EU average (98) of 10.1% in 2013. Public expenditure has increased as well: from 8.4% in 2003 to 9% of GDP in 2013.

When expressed in per capita terms, total spending on health at 3353 PPS in France is above the EU average of 2988 in 2013. So is public spending on health care: 2600 PPS vs. an average of 2208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health care expenditure is projected to increase by 0.9 pps

of GDP, in line with the average growth expected

for the EU (99), according to the "AWG reference

scenario". When taking into account the impact of

non-demographic drivers on future spending

growth (AWG risk scenario), health **care**

expenditure is expected to increase by 1.6 pps of

(97) Data on health expenditure is taken from OECD health data

and Eurostat database. The variables total and public

expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(98) The EU averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units and units of staff where relevant. The EU

average for each year is based on all the available

information in each year.

(99) I.e. considering the "reference scenario" of the projections

(see The 2015 Ageing Report at

http://ec.europa.eu/economy_finance/publications/europea

n_economy/2015/pdf/ee3_en.pdf).

GDP from now until 2060 (in line with the EU

average).

Overall, for France no significant short-term risks

of fiscal stress appear at the horizon, although

some variables point to possible short-term

challenges.

Risks appear, on the contrary, to be high in the

medium term from a debt sustainability analysis

perspective due to the still high stock of debt at the

end of projections (2026) and the high sensitivity

to possible macro-fiscal shocks.

No significant sustainability risks appear over the

long run, under the no-fiscal policy change

baseline scenario, notably thanks to pension

reforms implemented in the past.

Health status

Life expectancy at birth (85.6 years for women and

79 years for men in 2013) and healthy life years

(64.4 years for women and 63 years for men) are

above the respective EU averages (83.3 and 77.8

years of life expectancy in 2011, 61.5 and 61.4 in

2013 for the healthy life years). (100) An infant

mortality rate of 3.6‰; is lower than the EU

average of 3.9‰; in 2011, having gradually fallen

over most of the last decade (from 4.2‰; in 2003).

System characteristics

Coverage

The French system is a social health insurance system in which all legal residents have to register with the public health insurance program (sickness insurance funds) and provides universal population coverage. The universal coverage is given, first, on the professional/ occupational basis and secondly, since 2000, on the basis of residence.

The system is based on the principles of solidarity and the guarantee of financial protection against life's contingencies for everyone. The basic (though comprehensive in scope) social health insurance system had three dominant schemes –

(100) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and Eurostat database.

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the general health insurance scheme, the

agricultural scheme and the national insurance fund for self-employed non-agricultural workers – brought together under the National Union of Sickness Insurance Funds (UNCAM) since 2004. These funds are not allowed to define the benefit basket, the level of coverage or premiums, and risk-equalisation is in place. In addition to the basic social insurance scheme (financed by social security contributions and taxation), more vulnerable households (i.e. with a yearly income below EUR 8,645 for a single person in 2015, EUR 15,560 for a 3-person household) (101) benefit from free complementary sickness insurance – "Complementary Universal Health Coverage" (CMUC), an effort by authorities to improve access to health insurance and therefore to health care by those more vulnerable groups. In order to avoid a threshold effect, if the income exceeds the threshold to the limit of 35%, the government finances a part of the premium paid by the insured for complementary insurance. More and more people are also covered by private voluntary health insurance. 96% of the population

is covered by complementary (to cover for patients' cost-sharing for public goods and services) and supplementary (to cover the services not covered by public provision/ funding) voluntary health insurance by individual initiative (57%) or in the context of employment (43%).

Administrative organisation and revenue collection mechanism

The Parliament and the central government set the level of taxes and social contributions financing basic health insurance. The Parliament also sets the total public budget for health and by type of care.

The central government determines resource allocation across the regions and the payment methods of hospitals. Fees are defined in agreements negotiated between public health insurance funds and physicians unions. While the State plays the steering role in administering the system, some decentralisation has been introduced during the 1990's to give more responsibilities to regional authorities in the planning and financial resource allocation for hospitals.

(101) See the official website of the CMU fund: www.cmu.fr.

This system involves a strong collaboration between the entities of the system. The legitimacy of the social partners in the management of the health insurance funds and their role with regard to the role of the state was, for example, one of the questions that have been raised often in the past.

Over time, the balance tends to shift towards increasing state intervention. However, the division of responsibilities between the central government and the regions remains unclear in certain areas and could, therefore, benefit from further clarification to avoid conflict relations between the state authorities and the health insurance funds and improve the efficiency in running the health sector.

The number of actors involved in decision making may partly explain why public expenditure on health administration and health insurance as a percentage of GDP (0.36%) and as a % of current health expenditure (0.67%) is above the EU average (respectively 0.27% and 0.47%), amongst the highest in the Union in 2013. This shows that

there is perhaps scope to reduce administrative costs and improve the general management of the sector despite current efforts. The setting up of the Regional Health Agency (ARS), in 2010, can certainly contribute to enhance the efficiency in running the health sector. For instance, the ARS aims at improving care coordination between outpatient and inpatient care and at optimising the regional health care supply.

In France, a non-mandatory national health care spending target (ONDAM) is voted each year by the Parliament as part of the social security budget law (Loi de financement de la sécurité sociale – LFSS). Compliance with this target has been met for the 5th year in a row in 2014 (with an undershooting of the target by EUR 0.3 bn) and, according to the warning committee's report of 6 October 2015, the 2015 target is also likely to be respected.

This is mostly explained by restrained growth in outpatient care spending, in particular reductions

in pharmaceutical prices (detailed in the Lois de financement de la Sécurité sociale - LFSS) and measures to promote generic medicines. These measures include the implementation of incentive payments for general practitioners, specialists and pharmacists in 2012 (Rémunération sur objectifs de santé publique – ROSP) with prescribing

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targets. Patients were also given a larger incentive to accept the substitution for generic drugs with the “tiers payant contre générique” measure: patients have to wait to be reimbursed the cost of their prescription from the Social Insurance if they do not wish to be dispensed the generic.

Although the ONDAM is not a budgetary ceiling, several monitoring and tracking levers, strengthened recently (especially after the 2010 Briet report) are used to ensure it continues to be respected. First, spending is monitored closely by an independent “warning committee”, composed of 3 experts whose role is to give, three times a

year, an opinion on progress towards the target and on the risks of overshooting. Second, there has been a gradual reduction of the warning threshold (amount above which the government must take corrective measures to ensure compliance with the target) from 0.75% of the target in 2010 to 0.7% in 2011, then to 0.6% in 2012 and finally to 0.5% in 2013. Finally, in late 2010, a monitoring committee co-chaired by the ministers of Health and Budget was implemented. This committee is assisted by a statistical group in charge of reviewing the data monthly in order to come up with propositions to curb spending and ensure compliance with the target. The committee overviews the implementation of the spending cuts decided along with the level of the target. It is in charge of monitoring the regulation strategy in the case of an overshooting of the target and of preparing the construction of the target the following year.

Role of private insurance and out of pocket co-payments

Cost-sharing applies to most goods and services, especially primary care and specialist consultations, laboratory tests, pharmaceuticals, eyeglasses and contact lenses, dental care and dental prostheses. Pregnant women, those with certain severe medical conditions, those with an income below a defined threshold, those on social assistance. Victims of accidents at work are exempted from cost-sharing. The private voluntary complementary health insurance increases the rate of reimbursement, reducing the discrepancy between the actual amount paid by patients and the amount they are reimbursed by their social health insurance fund. Voluntary insurance decreases this discrepancy to greatest extent for prostheses, drugs, optical and dental care. In doing so, complementary health insurance reduces the ability of cost-sharing to control overconsumption as it renders users less cost-aware. As a result, the authorities implemented a ticket, and a “deductible”: the patient has to pay EUR 1 for each physician visit and each biomedical analysis,

EUR 0.50 per drug box, EUR 0.50 on each paramedical procedure and EUR 2 for each medical transport. In the same time, government encourages with fiscal incentive “responsible contracts” that don’t cover the deductible part in order to limit health sector inflation. As a result the deductible is usually not covered by complementary health insurance.

Private expenditure (patient co-financing and voluntary private health insurance) represented around 22.5% of the total health expenditure in 2013, i.e. a small increase since 2003 (22%), but still below the EU average (22.6% in 2013). Out-of-pocket spending accounts for a small part of private expenditure (7.4% of total health spending which is a small share in the EU context – EU average of 14.1% in 2013) and having remained relatively constant since 2003.

Types of providers, referral systems and patient choice

The French system is strongly characterised by freedom of choice and unrestricted access for patient, and by free practice of professionals on the

basis of accreditation. The primary and secondary health care delivery relies then on an easily accessible combination of public and private supply. Providers are organised in two groups: the health institutions that include hospitals, nursing homes and laboratories, which provide most of the inpatient care and employ mainly salaried health professionals (102); and the generally selfemployed professionals such as general practitioners (GPs), specialists, dentists, nurses, and pharmacists who provide outpatient care.

Primary care is provided by self-employed physicians and other professionals mostly in private individual practices. This is also the case for specialist outpatient services, although sometimes these also work in private clinics. Day case and inpatient care is provided in hospitals.

(102) The net salary of a full-time employed doctor in hospital is very close to the one earned by a self-employed GP.

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Hospitals are organised in three categories: the public sector, the not profit and profit-making private sector, the latter is mainly concentrated on surgical procedures.

In 2013, the number of practising physicians per 100 000 inhabitants was 310 (slightly below the EU average of 344). The number of general practitioners was 155, far above the EU average of 78.3. Finally, the number of practising nurses per 100 000 in 2013 (940) was above the average EU number (837).

It should be noted that there are differences in the supply of physicians across regions as, while total supply is regulated, the location of physicians is not. The *numerus clausus* system was introduced in 1971 in order to regulate access to health professions. Indeed, a ministerial decree sets annually the number of places available for each health qualification and research units. This policy has resulted in the stabilisation of doctors' numbers but some specialities, such as anaesthesiology,

gynaecology or obstetrics have been reported to need more professionals. The same problem, which might become more severe in the near future, concerns other specialities and nurses working in hospitals. On the one hand, specific incentives could be developed to promote and encourage staff to work in some specialities currently in shortage. On the other hand, geographical disparities could be reduced. More generally, the human resources strategy needs to tackle staff and population ageing in the future. In this view, some financial incentives have been granted since 2006 to physicians who settle in areas where there is a lack of supply of physicians.

The lack of coordination between primary, specialist and hospital care has been one major problem of the health care system, potentially leading to unnecessary use of specialist and hospital care and the duplication of procedures resulting in higher expenditure. To improve the situation, referring GP and provider networks were implemented as from July 2005. The patient

chooses and registers with a general practitioner at

the social health fund. The patient is free to change

general practitioners but has to report any change.

If necessary, the GP plays the role of gatekeeper

and sends his patient to a specialist who will

report, with the authorisation of the patient, any

relevant information to the GP in order to followup

and coordinate the care (103). The patient has to

face financial penalties applied to the

reimbursement rate by the national sickness fund,

if he/she doesn't designate his/her preferred GP

and does follow a referral procedure. Around 90%

of the insured patients have designated a preferred

doctor so far. Patients are also free to choose a

specialist and a hospital.

Each patient has his own medical card called

"Carte Vitale" which transmits all the transactions

to the health fund where he is registered.

However, plans to put prescriptions,

reimbursements and information on the health

status on the card have not been implemented.

Therefore, it does not contain any medical

information and cannot be used for care

coordination. Since 2011, a new individualised

medical record (Dossier medical personnalisé,

DMP) has also put in place aiming to improve care

coordination.

The central government evaluates via the High

Authority for Health (HAS) the best medical

practices and promotes compulsory life-long

medical education. It sets a package of

recommendations and targets after consulting with

funds and professionals such as for drug

prescriptions (generics, right prescription) which

each physician is advised to follow. Penalties

could be issued if non-compliance to the

recommendations is frequent, serious or costly for

the health system. Such procedures are likely to

have a positive effect on doctors' prescribing

behaviour and efforts should continue in that

direction.

France has a number of acute care beds per

100,000 inhabitants (335 in 2013) below the EU

average in that year (356). These results reflect

efforts made during the 1980's and 1990's to
 reduce the number of hospitals beds as well as the
 average hospital length of stay (see further below).

Finally, pharmaceuticals are exclusively
 distributed by approximately 23,000 pharmacies
 and their establishment is regulated by a numerus
 clausus taking into account the size of the
 population and a distance factor.

(103) Gynaecology, ophthalmology, stomatology and psychiatry
 are out of that procedure.

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Treatment options, covered health services

There is a common basket of services of the
 National Health System that has to be delivered to
 the whole population covered.

Price of healthcare services, purchasing,
 contracting and remuneration mechanisms

Two payment systems have been implemented, the
 first one is a reimbursement system (ambulatory
care) and the second one is a third-party payer

system where the patient pays only the coinsurance

or the co-payment (inpatient care and pharmaceuticals).

Outpatient primary and specialist care doctors are generally self-employed and paid on a fee-for-service basis paid by the patient at the consultation and partly reimbursed at a later stage by their social health insurance. The fees are fixed and negotiated between physicians' unions and the public health insurance funds under contracts signed for every four or five years. Medical practitioners and clinics, which are not under contract, have to display their prices. Almost no reimbursement is given by the statutory health insurance to patients visiting professionals not under contract.

Hospital inpatient doctors are mostly salaried employees of the hospitals, with the salary scale defined at central level. For hospital day care or inpatient care, a third-party payer system is generally used whereby the patient pays only the co-insurance or the co-payment.

The amount paid by the patient and not taken in charge by the compulsory insurance is called "ticket modérateur". An average of 70% of the cost of a visit to a GP is thereby refunded, from 80% to 95% for a surgery, 95% for childbirth, 70% for xrays, dental care and 60% for nursing at home among others. Under certain conditions such as some chronic disease or care requiring hospital stay of at least 30 days (104) or beneficiaries of the CMUC, individuals could be entitled to a 100% reimbursement of medical and hospital costs. Hospitals are remunerated on a payment per case/ (104) Although it should be noted that the 100% reimbursement in this case is only applied from the 31st day and patients pay a 20% "ticket modérateur" the first 30 days. DRG basis. (105) Hospitals are legally autonomous and manage their own budgets. Since 2009, they have autonomy to recruit their own medical staff. The number of inpatient discharges is below the EU average (15855 vs. 16402 per 100 000 inhabitants in 2011) but this is related to many policies that have been put in place in order to

encourage methods of providing care that are alternative to hospitalisation such as day care surgery or hospitalisation at home. Among others, extension of hospital's capacity via a theoretical exchange rate of one acute bed for two "non-acute" beds is possible. Day cases as % of all hospital discharges are, at 37%, well above the EU average (29.3% in 2011). This share has fallen since the peak of 38.6% in 2008, but up to that point it had increased significantly from 28.4 in 2001.

Hospital average length of stay (5.2 days in 2011) has been slightly decreasing (5.6 days in 2001) and is lower than the EU average of 5.8 days in 2011.

The market for pharmaceutical products

The central government regulates the production and distribution of pharmaceuticals and any drug must obtain a formal authorisation to be sold.

International price reference is used and based on manufacturing price in DE, ES, IT, and UK. The initial price is also based on the clinical performance and cost of existing treatments.

About 4900 pharmaceuticals are reimbursable in France, which represents approximately one half

of the drug presentations available. The list of reimbursable drugs is established by ministerial ordinance and will contain only drugs having a sufficient medical service rendered (SMR). (106)

The amount reimbursed will depend on various criteria such as the effectiveness, the side effects, the place in the therapeutic process, the seriousness of the condition, the properties of the drug and its importance for public health. According to the SMR, the reimbursement rate for prescribed drugs is chosen between four rates (100%, 65%, 30%, and 15%). In order to control final spending on reimbursable products, the central government sets

(105) The OECD score for remuneration incentives to raise the volume of care in France is about 4.5 out of 6 as a result of the use of activity related payment elements in physician and hospital remuneration.

(106) For a period of five years before revaluation.

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the prices on producer's side, after bargaining with

the drug's committee and the laboratory involved.

In order to promote the use of generic drugs, the pharmacists have been financially encouraged to offer their clients generic drugs where this is possible. In such cases, an equivalent profit margin is guaranteed.

Generics also face a fast-track registration and automatic price setting (60% of the price of the brand name drug). Authorities promote rational prescribing of physicians through prescription guidelines, complemented with monitoring of prescribing behaviour and feedback, and education and information campaigns on the prescription and use of medicines. They also promote education and information campaigns for patients. Physicians receive feedback on their prescription behaviour in comparison with that of colleagues and in relation to some sort of national contract/ priorities established between the doctors and the social health insurance funds. Doctors are visited by delegates of the social insurance, who provide them with information on rational prescribing.

Use of Health Technology Assessments and

cost-benefit analysis

Quality of care, especially in hospitals, is a major

matter of concern to public French authorities. To

improve it, from 1996, the central government

decided that all health care institutions must be

accredited to provide treatment by the Haute

Autorité de Santé (HAS). An evaluation procedure

is then done on several dimensions such as quality

of care, information given to the patient, medical

records, general management and risk prevention

strategies. The HAS publishes afterward the

accreditation reviews. Perhaps performance

monitoring in the sector could be further improved

by publishing more routine and comparable

information on the activity and quality of providers

(clinical outcomes, use of appropriate processes,

patients' satisfaction and patient experience),

which can support choice of provider while help

identifying good practices and areas for

improvement through peer reviews for example.

Health technology assessment information has

been used to define guidelines and determine coverage of new procedures, new medicines and new high-cost equipment, the level of reimbursement of new procedures and new medicines, and to develop guidelines for high-cost equipment. The benefits package is defined on the basis of clinical effectiveness.

eHealth, Electronic Health Record

The government has the ambition to develop eHealth. The implementation of a medical personal data folder has been ongoing for years but will enter a second phase now.

The government is opening administrative data on reimbursements to researchers. Related to patient privacy, it can sometimes be merged with medical data. That should improve medical products surveillance.

Health promotion and disease prevention policies

The Ministry of Health, on the basis of the overall framework established by the parliament, is responsible for defining priority areas for national programmes in the field of health promotion and

disease prevention. The main priorities include

cancer, pain control and anti-smoking campaigns.

Public health objectives are set in terms of process,

outcomes and the reduction of health inequalities.

Public expenditure on prevention and public health

services as a % of GDP (0.22%) is slightly below

the EU average of 0.24% in 2013, and as a

percentage of public current health expenditure

(2%) is below the EU average of (2.5%).

As for the lifestyle of the French population, the

data shows that the proportion of regular smokers

has increased slightly (from 23.4% in 2004 to

24.1% in 2012), above the EU average of 22%.

Over the same period the proportion of the obese

in the population has increased (from 9.4% in 2001

to 12.9% in 2010), while alcohol consumption

shows a reduction from 13.5 litres per capita in

2003 to 11.4 litres in 2013 (still above the EU

average of 9.8).

Recently legislated and/or planned policy

reforms

Recent policy response

The success in not overshooting the planned expenditure increase in 2013 has led government to propose a reduction of the national health

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spending target for 2014 by EUR 800 million (the 2014 target initially set at EUR 179.1 billion was brought down to EUR 178.3 billion) in the rectified social security budget bill. Furthermore, it was decided that EUR 10 billion would be achieved through health insurance savings, and the national health target budget increase would be set at respectively 2.1%, 1.75% and 1.75% for the 2015-2017 time period. These economies relative to the higher planned expenditure should stem from the implementation of the national healthcare strategy, which promotes greater efficiency in expenditure through structural reforms such as the streamlining of treatments, development of outpatient care, improving the share of generic drugs consumed and reducing their prices (along

with other drug policies).

Recent policy changes adopted

From January 2016 collective complementary

insurance is compulsory for all employees of the private sector.

New regulations and fiscal incentives for

"responsible contracts" have been implemented in

order to limit health price inflation due to

complementary insurance coverage.

The "Loi de modernisation de notre système de

santé" has been promulgated in January 2016. It

rationalises the offer by care providers: for

hospitals with the GHT ("groupements hospitaliers

de territoire") and for ambulatory care and

coordination between inpatient and outpatient care

("Communautés professionnelles territoriales de

santé"). Health care accessibility has also been

improved by the direct payment to doctors ("tiers

payant") of the reimbursement of social security

funds.

Challenges

The analysis above has shown that a range of

reforms has been implemented in recent years to a

very large extent successfully, which France

should continue to pursue. For example,

improvements in access to health insurance for

those most vulnerable, improvements in hospital

efficiency, improved data collection and

monitoring and better control of pharmaceutical

expenditure, greater use of primary care and

improvements in care coordination from primary

to secondary care. The main challenges for the

French health care system are as follows:

- To reinforce human resources strategies to avoid a shortage of physicians in the future as a result of staff and population ageing. This can be done by pushing up *numerus clausus* ceilings according to projected needs. To improve geographical access to doctors especially between urban and rural areas through incentives system directed at doctors, especially primary care staff.

- To continue efforts to implement costcontainment policies in a system characterised

by fee-for-service payment of doctors and

unrestricted freedom of choice for patients.

These include continuing to encourage a more

rational and coordinated use of care through

greater use of primary care and more effective

referrals from family doctors to steer demand

to other types of care and organise appropriate

and cost-effective channels of treatment. Even

if patients' financial contributions have already

been implemented, it may also be worth

exploring if cost-sharing can be further

adjusted to encourage the use of more costeffective

interventions.

- To continue to promote generic

pharmaceuticals by extending reference pricing

schemes.

- To continue to improve the general governance

of the system, through strategies to rationalise

administrative procedures, therefore enhancing

the global system's efficiency and quality.

Possible areas include: increasing the financial

responsibility of the funds, clarifying

responsibilities of the various actors in the system, and improving accountability, perhaps through greater use of systems of rewards and fines.

- To improve data collection and comparability in order to evaluate more thoroughly the activity and quality of providers and the overall system. Possible indicators include preventable hospitalisations, readmission rates, mortality post-hospital, complication during and post operation, prescription mistakes (recommended by OECD). Public comparisons and peer

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reviews can help providers identify areas for improvement and good practices.

- To enhance health promotion and disease prevention activities, i.e. promoting healthy life styles.

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Table 1.10.1: Statistical Annex – France

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 1637 1711 1772 1853 1946 1996 1939 1998 2059 2087 2117 9289 9800 9934

GDP per capita PPS (thousands) 26.7 27.1 27.6 27.9 28.6 27.8 26.5 27.4 27.9 27.8 28.1 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 0.2 1.8 1.1 1.8 1.7 -0.6 -3.6 1.2 1.5 -0.5 -0.3 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 2.6 3.1 1.5 1.1 1.0 0.6 2.5 0.8 1.2 0.3 0.1 3.2 -0.2
-0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 10.8 10.9 10.9 10.9 10.8 10.9 11.6 11.6 11.5 11.6 11.7 10.4 10.1 10.1

Total current as % of GDP 10.4 10.5 10.5 10.4 10.4 10.5 11.2 11.1 10.7 10.8 10.9 9.8 9.6 9.7

Total capital investment as % of GDP 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.8 0.8 0.7 0.6 0.5 0.5

Total per capita PPS 2517 2664 2748 2832 2935 3030 3113 3179 3251 3306 3353 2828 2911 2995

Public as % of GDP 8.4 8.5 8.5 8.4 8.4 8.4 9.0 9.0 8.9 9.0 9.0 8.1 7.8 7.8

Public current as % of GDP 8.2 8.2 8.3 8.2 8.1 8.2 8.7 8.7 8.4 8.5 8.6 7.9 7.7 7.7

Public per capita PPS 1852 1951 2014 2065 2142 2199 2279 2317 2515 2557 2600 2079 2218 2208

Public capital investment as % of GDP 0.2 0.2 0.3 0.3 0.3 0.3 0.3 0.3 0.5 0.5 0.4 0.2 0.2 0.1

Public as % total expenditure on health 78.0 77.9 78.0 77.6 77.6 77.3 77.5 77.6 77.3 77.3 77.5 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 14.2 14.4 14.6 14.5 14.4 14.3 14.3 14.5 14.7
14.7 : 14.8 14.9 :Proportion of the population covered by public or primary private health insurance 99.9 99.9 99.9 99.9 99.9 99.9
100.9 101.9 99.9 99.9 99.9 99.7 99.7 98.7

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Out-of-pocket expenditure on health as % of total expenditure on health 7.4 7.3 7.4 7.7 7.6 7.9 7.8 7.7 7.8 7.8 7.4
14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 62.3 62.3 62.8 63.2 63.6 64.0 64.4 64.7 65.0 65.3 65.6 502.1 504.5 506.6

Life expectancy at birth for females 82.7 83.8 83.8 84.5 84.8 84.8 85.0 85.3 85.7 85.4 85.6 82.6 83.1 83.3

Life expectancy at birth for males 75.7 76.7 76.7 77.3 77.6 77.8 78.0 78.2 78.7 78.7 79.0 76.6 77.3 77.8

Healthy life years at birth females 63.9 64.3 64.6 64.4 64.4 64.5 63.5 63.4 63.6 63.8 64.4 : 62.1 61.5

Healthy life years at birth males 60.6 61.5 62.3 62.8 62.8 62.8 62.8 61.8 62.7 62.6 63.0 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 51 47 46 43 40 40 39 37 81 79 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.2 4.0 3.8 3.8 3.8 3.8 3.9 3.6 3.5 3.5 3.6 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 3.41 3.37 3.35 3.32 3.27 3.29 3.50 3.48 3.05 3.08 3.10 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.52 0.60 0.61 0.62 0.61 0.63 0.69 0.69 0.70 0.72 0.74 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.80 1.79 1.79 1.77 1.75 1.76 1.85 1.84 2.04 2.08 2.11 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.82 1.84 1.84 1.81 1.80 1.80 1.88 1.85 1.73 1.69 1.65 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.42 0.43 0.44 0.44 0.45 0.47 0.50 0.51 0.53 0.54 0.56 0.31
0.31 0.32

Prevention and public health services 0.23 0.23 0.23 0.22 0.23 0.23 0.27 0.23 0.23 0.23 0.22 0.25 0.25 0.24

Health administration and health insurance 0.73 0.71 0.69 0.67 0.65 0.64 0.67 0.67 0.67 0.68 0.67 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

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Inpatient curative and rehabilitative <u>care</u>	3.19	3.14	3.12	3.06	3.01	3.03	3.22	3.20	2.84	2.86	2.89	2.73	2.61	2.62
Day cases curative and rehabilitative <u>care</u>	0.49	0.56	0.57	0.57	0.57	0.59	0.64	0.64	0.65	0.66	0.69	0.16	0.16	0.18
Out-patient curative and rehabilitative <u>care</u>	1.15	1.14	1.12	1.11	1.10	1.10	1.15	1.16	1.17	1.19	1.42	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.26	1.28	1.29	1.26	1.25	1.21	1.27	1.25	1.19	1.16	1.15	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.14	0.14	0.15	0.15	0.16	0.17	0.18	0.19	0.20	0.20	0.21	0.13	0.12	0.13
Prevention and public health services	0.15	0.16	0.16	0.15	0.16	0.16	0.19	0.15	0.15	0.15	0.15	0.25	0.20	0.19
Health administration and health insurance	0.44	0.42	0.41	0.39	0.37	0.37	0.38	0.37	0.36	0.36	0.36	0.11	0.27	0.27
EU- latest national data														

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.10.2: Statistical Annex - continued – France

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative <u>care</u>	32.9%	32.2%	31.9%	31.9%	31.6%	31.4%	31.3%	31.3%	28.5%	28.5%	28.4%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative <u>care</u>	5.1%	5.7%	5.8%	5.9%	5.9%	6.0%	6.1%	6.2%	6.5%	6.6%	6.8%	1.8%	1.9%	1.9%

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Out-patient curative and rehabilitative care 17.4% 17.1% 17.0% 17.0% 16.9% 16.8% 16.6% 16.5% 19.0% 19.2%
19.3% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 17.6% 17.6% 17.5% 17.4% 17.4% 17.2% 16.8% 16.6% 16.1%
15.6% 15.1% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 4.1% 4.1% 4.2% 4.3% 4.4% 4.5% 4.5% 4.6% 4.9% 5.0% 5.2%
3.2% 3.3% 3.3%

Prevention and public health services 2.2% 2.2% 2.2% 2.1% 2.2% 2.2% 2.4% 2.1% 2.1% 2.1% 2.0% 2.6% 2.6%
2.5%

Health administration and health insurance 7.1% 6.8% 6.6% 6.4% 6.3% 6.1% 6.0% 6.0% 6.3% 6.3% 6.1% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 39.1% 38.1% 37.8% 37.5% 37.1% 37.1% 36.9% 36.8% 33.8% 33.6%
33.6% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 6.0% 6.8% 7.0% 7.1% 7.1% 7.2% 7.3% 7.4% 7.7% 7.8% 8.0% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative care 14.1% 13.8% 13.6% 13.6% 13.6% 13.5% 13.2% 13.3% 13.9% 14.0%
16.5% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 15.4% 15.5% 15.6% 15.5% 15.4% 14.8% 14.5% 14.4% 14.2%
13.6% 13.4% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 1.7% 1.7% 1.8% 1.9% 2.0% 2.1% 2.1% 2.2% 2.3% 2.4% 2.5%
1.6% 1.6% 1.6%

Prevention and public health services 1.8% 1.9% 1.9% 1.8% 2.0% 2.0% 2.2% 1.7% 1.8% 1.8% 1.8% 3.2% 2.7%
2.5%

Health administration and health insurance 5.4% 5.1% 4.9% 4.7% 4.6% 4.5% 4.4% 4.3% 4.3% 4.2% 4.2% 1.4%
3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants 0.32 0.39 0.48 0.52 0.55 0.61 0.64 0.70 0.75 0.86 0.94 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.8 : : : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants 0.8 0.9 1.0 1.0 1.0 1.1 1.1 1.2 1.3 1.3 1.5 1.8 1.7 1.6

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PET scanners per 100 000 inhabitants : 0.0 0.0 0.0 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1

Proportion of the population that is obese : 9.4 : 10.5 : 12.2 : 12.9 : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : 23.4 : 25.9 : 26.2 : 23.3 : 24.1 : 23.2 22.4 22.0

Alcohol consumption litres per capita 13.5 13.2 12.2 12.4 12.2 11.9 11.8 11.9 12.0 11.8 11.4 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants : : : : : : : 307 308 310 329 335 344

Practising nurses per 100 000 inhabitants 743 763 785 804 791 819 847 876 901 910 940 840 812 837

General practitioners per 100 000 inhabitants 164 165 165 164 163 162 160 159 156 156 155 : 78 78.3

Acute hospital beds per 100 000 inhabitants 381 374 369 362 358 352 349 346 343 339 335 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 7.4 7.0 7.0 6.8 6.8 6.7 6.7 6.7 6.8 6.7 6.4 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 16.6 16.5 16.4 16.3 16.1 16.1 16.0 15.9 15.8 15.7 15.6 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 8,224 8,722 9,629 10,205 9,378 9,287 9,158 9,297 9,541 9 ,731 9,982 6368 6530 7031

Acute care bed occupancy rates 75.0 75.0 74.0 74.0 74.0 74.2 74.4 75.0 75.0 : : 72.0 73.1 70.2

Hospital curative average length of stay 5.6 5.5 5.4 5.3 5.3 5.2 5.2 5.2 5.1 : : 6.5 6.3 6.3

Day cases as % of all hospital discharges 33.1 34.6 37.0 38.6 36.8 36.8 36.3 36.9 37.6 38.2 39.0 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 7.7 8.0 8.3 8.6 8.7 8.6

AWG risk scenario 7.7 8.2 8.7 9.2 9.4 9.4

Note: *Excluding expenditure on medical long-term care component.

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Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 65.7 67.8 70.5 72.9 74.4 75.7

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

15.1 3.1

0.9 0.9

1.6 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, GDP per capita (31,700 PPS) in Germany

was one of the highest in the EU. GDP grew with

positive rates from 2010 onwards, after a record

negative growth rate in 2009. Current population is

estimated at 82.0 million. Over the decades to

come, the German population is projected to shrink

significantly from 82 million in 2013 to 70.8

million in 2060.

Total and public expenditure on health as % of

GDP

Total expenditure on health was one of the highest

in the EU at 11.3% of GDP in 2013 (EU: 10.1%).

Public spending on health was at 8.7% of GDP

(EU: 7.7%). Spending relative to GDP was quite

constant between 2003 and 2008, with a sharp

increase due to falling GDP in 2009, and has

stayed on this level in 2013. In 2012, 15.7% of

total government expenditure was channelled

towards health spending (EU: 14.9%). In per

capita terms, total (3,742 PPS) and public spending

(2,860 PPS) are well above the respective EU

averages (2,988 PPS and 2,208 PPS).

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health **care**

expenditure is projected to increase by 0.6 pps of

GDP, below the average growth level expected for

the EU (0.9 pps of GDP), according to the "AWG

reference scenario".(107) When taking into account

the impact of non-demographic drivers on future

spending growth (AWG risk scenario), health **care**

expenditure is expected to increase by 1.3 pps of

GDP from now until 2060 (EU: 1.6). Overall,

projected health care expenditure increase is

expected to add to budgetary pressure. However,

no sustainability risks appear over the long run as

the favourable initial budgetary position would

(107) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

mitigate the projected increase in age-related

expenditure. (108)

Health status

Life expectancy at birth is 78.6 years for men and

83.2 years for women, being one of the highest in

the EU (EU: 77.6 for men and 83.1 for women).

Healthy life years are, however, below the EU

average (57.0 vs. 61.8 years and 58 vs. 61.6 years),

but due to limited cross-country comparability of

the healthy-life years indicator these results have

to be treated with caution. Amenable mortality

rates, i.e. deaths that should not occur with timely

and effective care, are well below EU average.

Infant mortality is at the level of 3.3‰ (EU:

3.9‰).

System characteristics

System financing, revenue collection

mechanism, coverage and role of private

insurance and out of pocket co-payments

The German health **care** system provides universal

coverage. Insurance is compulsory and provided

by either statutory (SHI) (around 90% of the

population) or private health insurance (PHI). The

membership in the SHI is mandatory for

employees with gross income not exceeding a

legally defined threshold, covering in most cases

also the spouses and children of the insured

without additional contributions. High-earners

with a monthly income exceeding a specified

threshold, the self-employed and civil servants

have to contribute towards a private insurance.

SHI provides a standardised benefits package.

Premiums are income dependent but do not

dependent on individual health risks. In contrast,

PHI premiums depend on the individuals' health

risks and not on income. The benefit package is

based on an insurance contract and co-insurance of

family members requires additional premiums.

Once covered by PHI, the possibility to switch

back to SHI is restricted.

SHI is predominately financed through labourincome-

dependent contributions accompanied by a

(108) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eejp/pdf/](http://ec.europa.eu/economy_finance/publications/eejp/pdf/ip018_en.pdf)

ip018_en.pdf.

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complementary government subsidy. Since 2009, a

National Health Fund (Gesundheitsfonds) is

responsible for pooling contributions paid at a

uniform rate set by the Federal government. From

January 2015 on, the uniform contribution rate is

set at 14.6% (7.3% and 7.3% paid by employers

(pensioners) and employees (pension fund),

respectively. Yet, the SHIs may charge additional

surcharges if expenses do not cover expenditures.

The introduction of additional surcharges increases

competition between SHIs (see explanation of the SHI health financing reform below).

The collected contributions are pooled and complemented by a federal tax subsidy. They are allocated then to the individual sickness funds in the form of: (i) a uniform basic lump-sum per person insured, (ii) payments adjusted for risk, gender, invalidity, age and morbidity from 80 chronic and serious illnesses; and (iii) additional funds to cover other standard expenditure (e.g. administrative costs).

In 2016, the SHI was composed of 116 sickness funds, which are non-profit public law corporations and financially and organisationally independent bodies. The number of SHI funds has decreased from over 1.123 in 1992, mainly as a result of reforms aimed at strengthening the competition among health-care insurers. There is an obligation for sickness funds to insure anybody who is entitled to SHI. A risk adjustment mechanism redistributes funds across SHI funds to better reflect actual morbidity costs.

In 2012, the SHI bore 57% of total health expenditure. Other social insurance schemes bore another 10.7%, the PHI 9.3%, public authorities 4.8% and employers 4.3%. Private out-of-pocket payments amount to 12.9% of total health expenditures (EU: 14.3%). Conversely, private expenditure was slightly above the EU average of 23.2% (EU: 22.6%). Since 2004, patients need to provide certain co-payments limited to 2% of an annual household income, respectively to 1% for the chronically ill. The quarterly fee paid by patients for medical treatment (Praxisgebühr) was abolished at the beginning of 2013 on the grounds that it was ineffective.

The health reform (GKV-Finanzstruktur- und Qualitätsweiterentwicklungsgesetz), coming into force in January 2015, promotes a quality-based competition among health funds. Its main elements are the following. The general contribution rate was decreased from 15.5% in 2010 to 14.6%, while freezing the contribution rate paid by employers at 7.3%. The 0.9% employee's

contribution surcharge was abolished. Health funds received greater financial autonomy due to the lowering of the uniform contribution rate and the introduction of health insurance fund-specific, income-related surcharges to cover expenditures exceeding risk-adjusted allocations. A full revenue compensation scheme for the income-related surcharges was introduced to avoid incentivising risk selection.

Administrative organisation

The responsibility for the system is shared between national and regional level (Länder). At the national level the legal framework for both tiers of the insurance system is set. The Länder are responsible for organising medical education, planning inpatient capacities and financing capital investments in hospitals. Large sections of the German health care system are shaped through contracts between the SHI-funds and various health care providers.

A special feature in the regulation of medical services of the German health care system is the

important role, alongside that of the legislature, played by the self-governing bodies of service providers and health insurance funds. In the statutory health insurance system the major decision-making body is the Federal Joint Committee (G-BA). It is formed by the national associations of doctors and dentists, the German Hospital Federation and the National Association of Health Insurance Funds. Thus, the G-BA determines the benefit catalogue of the SHI as well as on binding collective regulations on the quality of health care services.

Treatment options, covered health services

SHI covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, physical therapy, prescription drugs, medical aids, rehabilitation, hospice and palliative care, pregnancy care, maternal leave and sick leave compensation. SHI preventive services include regular dental check-ups, child check-ups, basic

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immunisations, check-ups for chronic diseases,

and cancer screening at certain ages. All

prescription drugs—including newly licensed

ones—are covered unless explicitly excluded by

law (mainly so-called lifestyle drugs) or pending

evaluation. While the broad contents of the

benefits package are legally defined, specifics are

decided upon by the Federal Joint Committee.

Types of providers, referral systems and patient

choice

Primary care is provided by private for-profit

physicians, most of whom run individual practices,

and about 25% share a practice. The majority of

doctors are accredited for SHI. They can also take

private patients and charge them higher prices.

Traditionally, the German health-care system does

not have a gate-keeping system and the patients are

free to choose any doctor under a contract with

their sickness fund. SHI operates with collective

contracts covering provision by all doctors of a certain region. There is no affiliation to a single sickness funds. Additionally, there is also the option for selective contracts for a range of services or specific care models. More recently, patients are encouraged to choose a family doctor. The number of physicians has grown constantly over the recent decade: from 337 per 100000 inhabitants in 2003 to 402 in 2013, above the EU average of 344. Over the same period of time, the number of general practitioners has stayed constant at 66 per 100000 between 2003 and 2013 (EU: 78). The number of nurses is at 1248 per 100000 in 2013, remaining well above the EU average of 837. Total and public expenditure on outpatient care as a % of current health expenditure were at the EU average (around 23%). Germany has the highest per-capita hospital beds for curative (acute) care in the EU: 529 beds per 100 000 inhabitants in Germany compared to 356 in the EU. Obviously, access to inpatient care is high. This is despite a constant decline of hospital

bed capacity in the past, driven by a decrease in the average length of stay, which still remains above the EU average. Contrary to the general trend in the EU, the number of hospital inpatient discharges is rising from 21.9 in 2003 to 24.4 in 2013 per 100 inhabitants (EU: 16.5 in 2013). At the same time, the level of day case discharges is very low with 656 discharges per 100 000 inhabitants in Germany, versus 7,031 discharges in the EU. The low number of day case discharges is a consequence of the disintegrated system of care, which basically limits the room for providing day case treatments in German hospitals. Public inpatient care accounts for roughly 32% of public expenditure on health in Germany compared to 34% in the EU. High expenditure levels may be a sign of a modern hospital system providing highquality services. They may, also, reflect hospital centrism, an overprovision of inpatient services, a focus on costly high-technology treatments and an undervaluation of (cheaper) ambulatory care services (at the same level of quality of care).

Price of healthcare services, purchasing,
contracting and remuneration mechanisms

Physicians and other health professionals working
in hospitals or institutions for nursing care or
rehabilitation are paid salaries. Public and nonprofit
providers usually pay public service tariffs
to their employees, while private, for-profit
providers may pay lower or higher wages or
additional payments to their employees. Services
provided by the ambulatory care providers, as well
as by private physicians, dentists, pharmacists,
midwives and other health professionals are subject
to predetermined price schemes or price ranges.

Medical billing is based on the standard schedule
of fees (Einheitlicher Bewertungsmaßstab - EBM).

It is the fee schedule that applies to outpatient care
and, in the form of fees-for-service or flat rates,
comprises all services that panel doctors can bill
for reimbursement by the statutory health
insurance funds. Patients covered by PHI pay outof-
pocket on a fee-for-service basis. Doctors may
charge higher fees for private patients – based on a

medical fee schedule for private patients.

Hospital expenditures are financed using two different mechanisms. Investment is financed by the regions (Länder), mainly through regional taxes, while recurrent expenditure (thus, mainly cost of care) is reimbursed by the SHI-funds and PHI. Recurrent expenditures of acute hospitals are reimbursed by the SHI-funds according to the Diagnosis-Related Group (DRG) system, with some exceptions.

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The market for pharmaceutical products

Until 2011, prices of medicines were mainly determined by internal reference pricing for generics and therapeutic substitutes. Internal reference prices are price limits on certain pharmaceutical substance groups. The G-BA specifies the groups of active ingredients. The National Association of Health Insurance Funds sets the reference prices, considering that enough

medicines are available at that price. Patients have to bear the price difference for any drug whose price exceeds the reference level. This sets strong incentives to producers not to set prices above the reference price. In contrast, prices of newly invented drugs were unilaterally set by the producer.

Since 2011, the AMNOG obliges producers to verify the additional therapeutic benefit of new patented medicines. If an additional benefit is proven, the National Association of Statutory Health Insurance Funds negotiates the price for the medicine with the pharmaceutical company. If an additional benefit is not proven, new active pharmaceutical ingredients are subject to reference pricing. If this is not possible the price must not be higher than the price of the therapy standard.

AMNOG aims at ensuring fair prices that balance the interests of both, the statutory health insurance as well as the pharmaceutical companies. As a further cost-containment measure, the SHIAmendment Law (in force since August 2010) introduced a mandatory discount of 16% on

pharmaceuticals and freeze of prices of pharmaceuticals until 2013. With the 13th and 14th SGB V-Amendment Law (in force since December 2013 respectively April 2014) the price freeze was extended until 2017 and while the mandatory discount of 16 % ran out by the end of 2013, there is still a remaining mandatory discount of 7 % (16 % for generics). However, the prize freeze does not apply for medicines that have been subject to internal price referencing and it is not relevant for medicines that have a negotiated price after the AMNOG-procedure.

Pricing policies are supplemented by financial incentives and the monitoring of prescription patterns of physicians vis-à-vis prescription guidelines and prescription targets.

Use of Health Technology Assessments and cost-benefit analysis

Health Technology Assessment (HTA) is increasingly used in Germany to inform healthcare decision-making. Quality and efficiency are two deciding factors in maintaining the

performance of the German health care system. To

achieve this aim, it is important to examine

objectively the advantages and disadvantages of

medical services for patients. This is the

responsibility of two German Institutes: the

German Agency for Health Technology

Assessment (DAHTA), which runs the HTA

information system and the Institute for Quality

and Efficiency in Health Care (IQWiG). IQWiG is

an independent scientific institute that investigates

the benefits and harms of medical interventions for

patients.

eHealth (e-prescription, e-medical records)

One of the most important eHealth projects in the

German health care system is the adoption of an

eHealth card and a telematics infrastructure. The

eHealth card is meant to contribute to better

medical care provision, to improve communication

among all of the parties involved and ensure

greater efficiency in health care processes. To this

end, the application possibilities for the eHealth

card are to be expanded step by step, whereas the

eHealth card has been distributed to the ca. 70

million publicly insured persons in Germany by

almost 100%.

A new act on eHealth, which came into force in

December 2015, accelerated the deployment of the

applications to the eHealth card, setting clear

deadlines and further specifications to the

entrusted company (Gematik). In addition the act

on eHealth set out further incentives with regard to

telemedicine as well as supporting interoperability.

Gematik is responsible for the national telematics

infrastructure and the applications of the eHealth

card and supported by the self-administration. The

act on eHealth also supported Gematik's continued

work to support interoperability on the EU-level.

As set out in the act on eHealth, from 2018

onwards patients in Germany can choose to have

the relevant emergency data stored on their health

card. Also an electronic medication plan is planned

to be available by 2018, including a verification of

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drug treatment safety among care providers. The Electronic Patient Health Records, which will be on the one hand managed by health professionals, but also on the other hand through a so called electronic patient folder manageable by the patients, are to be introduced by beginning of 2019. The design of the German telematics infrastructure fulfils the highest of safety standards: there are clear rights of access and the accessing of data by physicians is recorded. Medical data is encrypted. At all times, patients have control over their data and decide whether and which medical data may be stored and who is entitled to read them.

Health and health-system information and reporting mechanisms

The planning of measures on health care provision is based on a range of information and research made available by various actors at the federal, state and corporatist levels. For example, the Federal Association of Sickness Funds and the Federal Association of SHI Physicians are obliged

by law to provide and publish statistics on their financial performance and activities and about the structure of their membership. Additionally, these and other stakeholders are financing health services research, health policy research and publish related reports and statistics. A large number of health statistics is published by the Federal Statistical Office. An Advisory Council on the Assessment of Developments in the Healthcare System reports every two years to the Federal Ministry of Health on current developments in the health care system.

Health promotion and disease prevention policies

Health promotion and disease prevention activities have received more emphasis than in other countries in the EU, as seen by its pattern of expenditure. Total and public expenditure on prevention and public health services as a % of total current health expenditure were well above the EU average. The German Preventive Health

Care Act (Präventionsgesetz) has given a further

boost on health prevention. SHI-funds are obliged to provide more disease prevention and health promotion activities especially in the settings and spend more money in this sector (See section 3).

Transparency and corruption

The task of supervising whether doctors, dentists, pharmacists and psychotherapists fulfil their professional obligations is incumbent on the specific professional organisations and the professional disciplinary tribunals. Professional obligations include the observance of specific prohibitions regarding inadmissible business relations and forms of cooperation, or relations that are prone to corruption, with other benefit and care providers. Statutory disclosure obligations apply, for example, to fees and remuneration received within the framework of surveys and observational non-interventional trials in the context of medicinal products supply. The health insurance funds, together with the panel doctors' associations and/or the associations of the other care providers, are responsible for verifying the observance of the

rules applicable in the statutory health care system

regarding the cost-effectiveness of care provision

and the mathematically and factually accurate

settlement of claims for benefits and services by

the care providers. Furthermore, offices

responsible for combating misconduct in the

statutory health insurance have been set up at all

health insurance funds and panel doctors'

associations as well as their associations at Land

and federal level.

Recently legislated and/or planned policy

reforms

The increase in the elderly population will result in

a greater need for health and long-term care

benefits. The federal government addresses these

challenges in its recent reforms to the health care

system and has implemented several structural

health care reforms to strengthen competition in

the health care system in order to improve

efficiency in health care provision. A sustainable

funding for health care provision was emphasised

in particular as part of this process.

The "Reform of the Market for Pharmaceutical Products" (AMNOG) in 2011 was a far-reaching structural reform that aimed at curbing expenditure growth of medicines. The AMNOG obliges producers to verify the additional therapeutic benefit of new patented medicines. The AMNOG also allows for the possibility of price negotiations for patented medicines instead of unilateral price setting by the producers.

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The health financing reform (Act on the further development of the Statutory Health Insurance System's Financial Structure and Quality), which came into force in January 2015, promotes qualitybased competition among providers and health funds. Health funds received greater financial autonomy due to the lowering of the uniform contribution rate and the introduction of health insurance fund-specific, income-related surcharges

to cover expenditures exceeding risk-adjusted allocations. The idea behind the surcharges is to foster competition among statutory health funds. Through increasing the financial autonomy of health funds and by implementing a consistent quality focus in health care provision, the costeffectiveness of public spending should be improved. At the same time, freezing the share of employers' health insurance contributions at 7.3% aims at containing wage related costs.

The establishment of an Institute for Quality Assurance and Transparency in the healthcare sector (IQTIG), as specified in the "Act to Further Develop the Financial Structure and Quality of the Statutory Health Insurance System", strengthens competition in terms of quality in the statutory health insurance system. The aim is for patients to have a set of transparent criteria which they can use to ascertain which specific hospitals offer the best quality for a specific treatment, for instance. Over the medium to long term, a better quality of service leads to the more efficient use of resources.

Better in-patient treatment, in turn, will mean fewer complications and re-admissions, and thereby less subsequent expenditure. Higher quality in health care leads, in the medium to long term, to a more efficient use of resources and to greater sustainability in the German health care system.

Representatives of the federal government and the Länder agreed for structural reform measures in the hospital sector that came into force in January 2016 (KHSG – Krankenhausstrukturgesetz). The aim is to boost the efficiency of hospital care – ranging from nationwide care provision to highend medical care – by improving the efficient use of resources. Important goals include strengthening the quality of care as a criterion, when it comes to hospital planning and the remuneration of services, and establishing a promotion programme for nursing homes. A structural fund will be set up to finance measures to improve existing care structures. To this end, a one-time disbursement of

500 million euros will be made from the liquidity reserve of the national health fund. This money will be used to finance projects proposed by the Länder, if the latter contribute an equal amount.

Thus, a maximum of 1 billion euros funding volume will be made available in order promote the reduction of excess capacity and the specialisation and concentration of hospital centres.

The federal government introduced a "Preventive Health Care Act" that entered into force in July 2015. At the core of this law is the strengthening of prevention and health promotion in the settings in which people live, for example in child day-care centres, schools, workplaces, neighbourhoods or in long-term care facilities. The intention is to achieve this through a much better fine-tuning of efforts undertaken by persons responsible for these settings at federal, Land and municipal level.

Expenditure by the health insurance funds on prevention and health promotion is to be almost doubled. The additional expenditure shall be offset

in the medium and long term by cost savings

achieved through avoided costs of diseases.

Additionally, early detection screening among

children, young persons and adults will continue to

be developed and important measures shall be

taken to close vaccination gaps.

In order to ensure a needs-based, universal and

easily accessible supply of medical care, the

federal government introduced the "Act to

Strengthen Care Provision in the Statutory Health

Insurance System" (Care Provision Strengthening

Act) that came into force in July 2015. The

primary objective of this law is to ensure a proper

supply of physicians both in the cities and in the

rural areas. The role of family doctors is to be

strengthened. The strain on doctors is to be

reduced by allowing them to delegate selected

medical services to qualified non-physician

personnel, for example, practice assistants.

Moreover, in the future, hospitals in underserved

areas will be able to assume more responsibility

for medical care. In order to promote innovative

care structures, to facilitate inter-sectoral

cooperation among health care providers and to

stimulate research on health care provision, an

innovation fund will be set up at the Federal Joint

Committee, endowed with EUR 300 million

annually – initially from 2016 to 2019.

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Telemedicine and digital technologies can provide

vital support in organising the supply of

healthcare. In order to make these advantages

available nationwide as soon as possible a new act

on eHealth was introduced by the federal

government and came into force in December

2015. The act on eHealth contains an overall plan

to accelerate the deployment of the telematics

infrastructure and the applications to the eHealth

Card such as electronic emergency data,

medication plan and electronic health records and

as well as to set out further incentives with regard

to telemedicine. Digital technologies are meant to

contribute to better medical care provision,

improves communication among all of the parties

involved and ensure greater efficiency in health

care processes (See above on eHealth: eprescription, e-medical records)

Challenges

The analysis above shows that a wide range of promising reforms has been implemented in recent years to strengthen financial sustainability, efficiency and quality of health care provision. The main challenges for the German health system are as follows:

- To continue increasing the efficiency of health

care spending, promoting quality and integrated care against the background of rising health care expenditure over the coming decades, due to population ageing and nondemographic factors.

- To improve further the coordination among

care providers and to reduce inter-sectorial borders between inpatient and outpatient care

and to promote new models of health care

delivery.

- To promote further telemedicine and digital

technologies in the health care sector for a

better medical care provision, for improving

communication among all of the parties

involved and to ensure greater efficiency in

health care processes.

- To enhance primary care provision through

promoting the number and the use of GPs'

services.

- To extend the possibilities of hospitals to

provide ambulatory and day care as well as to

transfer more health care services into the

ambulatory sector in order to reduce the

number of inpatient care treatments.

- To promote further the process of

modernisation and specialisation among

hospitals and to stimulate the further reduction

of excess capacities.

- To strengthen further the role of health

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promotion and disease prevention in the overall

health **care** system as well as in society in

general.

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Table 1.11.1: Statistical Annex – Germany

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 2220 2271 2301 2393 2513 2562 2460 2580 2703 2755 2821 9289 9800 9934

GDP per capita PPS (thousands) 26.9 27.8 28.8 30.1 31.3 31.3 28.6 30.8 32.1 32.1 31.7 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita -0.4 1.2 0.7 3.8 3.4 1.3 -4.9 4.2 3.3 0.5 0.2 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 2.6 -1.1 2.0 2.2 1.8 3.4 4.4 2.5 0.5 0.7 0.5 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 10.9 10.7 10.8 10.6 10.5 10.7 11.8 11.6 11.3 11.3 11.3 10.4 10.1 10.1

Total current as % of GDP 10.5 10.3 10.3 10.1 10.0 10.2 11.1 11.0 10.7 10.8 10.9 9.8 9.6 9.7

Total capital investment as % of GDP 0.4 0.4 0.6 0.5 0.5 0.5 0.6 0.6 0.6 0.5 0.4 0.6 0.5 0.5

Total per capita PPS 2814 2813 2889 2960 3066 3194 3378 3493 3564 3635 3724 2828 2911 2995

Public as % of GDP 8.6 8.2 8.3 8.1 8.0 8.2 9.0 8.9 8.6 8.6 8.7 8.1 7.8 7.8

Public current as % of GDP 8.3 7.9 7.8 7.7 7.6 7.8 9.3 9.2 9.0 9.0 9.2 7.9 7.7 7.7

Public per capita PPS 2065 2018 2070 2120 2197 2289 2426 2516 2726 2788 2860 2079 2218 2208

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Public capital investment as % of GDP 0.3 0.3 0.4 0.4 0.4 0.4 -0.3 -0.3 -0.3 -0.3 -0.5 0.2 0.2 0.1

Public as % total expenditure on health 78.5 76.8 76.6 76.4 76.4 76.4 76.8 76.7 76.5 76.7 76.8 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 14.4 14.0 14.3 14.6 14.9 15.2 15.1 15.0 15.5 15.7 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 99.7 99.8 99.8 99.8 99.8 99.9 99.9 99.9 99.8 99.8 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 11.4 12.8 12.7 12.9 12.8 12.6 12.3 12.3 12.3 12.2 12.9 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 82.5 82.5 82.5 82.4 82.3 82.2 82.0 81.8 81.8 81.8 82.0 502.1 504.5 506.6

Life expectancy at birth for females 81.3 81.9 82.0 82.4 82.7 82.7 82.8 83.0 83.2 83.3 83.2 82.6 83.1 83.3

Life expectancy at birth for males 75.8 76.5 76.7 77.2 77.4 77.6 77.8 78.0 78.4 78.6 78.6 76.6 77.3 77.8

Healthy life years at birth females 64.7 : 54.8 58.3 58.6 57.7 58.1 58.7 58.7 57.9 57.0 : 62.1 61.5

Healthy life years at birth males 65.0 : 54.5 58.7 59.0 56.4 57.1 57.9 57.9 57.4 57.8 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 69 63 60 56 52 51 50 47 102 99 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.2 4.1 3.9 3.8 3.9 3.5 3.5 3.4 3.6 3.3 3.3 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.93 2.91 2.85 2.81 2.71 2.75 3.04 3.02 2.97 3.00 3.03 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.07 0.07 0.08 0.09 0.10 0.10 0.11 0.11 0.10 0.10 0.11 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.46 2.46 2.32 2.29 2.26 2.32 2.54 2.50 2.46 2.47 2.50 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.57 1.48 1.58 1.52 1.53 1.56 1.70 1.65 1.53 1.53 1.54 1.60 1.55 1.44

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Therapeutic appliances and other medical durables 0.58 0.50 0.52 0.53 0.52 0.53 0.57 0.57 0.56 0.58 0.60 0.31 0.31 0.32

Prevention and public health services 0.35 0.34 0.35 0.35 0.37 0.38 0.41 0.39 0.36 0.36 0.34 0.25 0.25 0.24

Health administration and health insurance 0.67 0.66 0.66 0.63 0.60 0.61 0.67 0.67 0.65 0.64 0.61 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.63 2.60 2.55 2.52 2.43 2.46 2.91 2.89 2.85 2.88 2.91 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.07 0.07 0.08 0.09 0.10 0.10 0.11 0.11 0.10 0.10 0.11 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.84 1.73 1.61 1.59 1.56 1.59 2.04 2.00 1.96 1.97 2.05 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 1.17 1.05 1.17 1.14 1.16 1.19 1.42 1.36 1.26 1.24 1.26 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.33 0.28 0.27 0.26 0.26 0.27 0.29 0.28 0.27 0.28 0.29 0.13 0.12 0.13

Prevention and public health services 0.30 0.29 0.30 0.30 0.32 0.33 0.35 0.33 0.30 0.30 0.29 0.25 0.20 0.19

Health administration and health insurance 0.44 0.43 0.43 0.41 0.39 0.40 0.44 0.45 0.42 0.43 0.43 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.11.2: Statistical Annex - continued – Germany

Sources: EUROSTAT, OECD and WHO

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Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 27.9% 28.3% 27.8% 27.8% 27.2% 27.1% 27.3% 27.5% 27.8% 27.9% 27.7% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 0.7% 0.7% 0.8% 0.9% 1.0% 1.0% 1.0% 1.0% 1.0% 1.0% 1.0% 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 23.4% 24.0% 22.6% 22.7% 22.7% 22.9% 22.8% 22.7% 23.0% 23.0% 22.9% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 15.0% 14.4% 15.4% 15.0% 15.4% 15.4% 15.3% 15.0% 14.3% 14.2% 14.1% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 5.5% 4.9% 5.0% 5.2% 5.3% 5.2% 5.1% 5.2% 5.3% 5.4% 5.4% 3.2% 3.3% 3.3%

Prevention and public health services 3.3% 3.3% 3.4% 3.5% 3.7% 3.7% 3.7% 3.5% 3.4% 3.3% 3.1% 2.6% 2.6% 2.5%

Health administration and health insurance 6.4% 6.4% 6.4% 6.2% 6.0% 6.0% 6.0% 6.1% 6.1% 5.9% 5.6% 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 31.8% 32.8% 32.5% 32.7% 32.0% 31.7% 31.2% 31.4% 31.8% 32.0% 31.7% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 0.8% 0.9% 1.0% 1.2% 1.3% 1.3% 1.1% 1.2% 1.2% 1.1% 1.2% 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care 22.2% 21.8% 20.5% 20.6% 20.5% 20.5% 21.8% 21.7% 21.9% 21.9% 22.3% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 14.1% 13.3% 14.9% 14.8% 15.3% 15.3% 15.2% 14.8% 14.1% 13.8% 13.7% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 4.0% 3.5% 3.4% 3.4% 3.4% 3.4% 3.1% 3.0% 3.1% 3.1% 3.1% 1.6% 1.6% 1.6%

Prevention and public health services 3.6% 3.7% 3.8% 3.9% 4.2% 4.3% 3.7% 3.6% 3.4% 3.3% 3.2% 3.2% 2.7% 2.5%

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Health administration and health insurance 5.3% 5.4% 5.4% 5.3% 5.2% 5.2% 4.7% 4.9% 4.7% 4.7% 4.6% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants : : : : : : : : 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.6 0.7 0.7 0.8 0.8 : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants : : : : : : : : 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : : : : : 0.1 0.1 0.1

Proportion of the population that is obese 12.9 : 13.6 : : 15.8 14.7 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 24.3 : 23.2 : : 22.8 21.9 : : : 20.9 23.2 22.4 22.0

Alcohol consumption litres per capita 11.9 11.8 11.7 11.8 11.5 11.4 11.2 11.2 11.2 11.2 10.9 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 337 339 341 345 350 356 364 373 382 389 402 329 335 344

Practising nurses per 100 000 inhabitants 1095 1106 1123 1135 1151 1174 1204 1216 1229 1238 1284 840 812 837

General practitioners per 100 000 inhabitants 66 66 67 66 66 65 65 66 66 65 66 : 78 78.3

Acute hospital beds per 100 000 inhabitants 582 568 559 543 538 535 535 533 531 528 529 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 7.6 7.4 8.1 7.9 8.1 8.6 9.2 9.9 9.7 9.7 9.9 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 21.9 21.4 21.3 21.5 22.1 22.7 23.1 23.4 23.7 24.1 24.4 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 834 710 591 576 578 596 613 629 647 655 656 6368 6530 7031

Acute **care** bed occupancy rates 78.0 76.0 76.0 77.0 79.0 79.1 79.2 79.0 79.0 79.2 79.3 72.0 73.1 70.2

Hospital curative average length of stay 9.3 8.9 8.8 8.7 8.5 8.3 8.2 8.1 7.9 7.8 7.7 6.5 6.3 6.3

Day cases as % of all hospital discharges : : : 2.6 2.5 2.6 2.6 2.6 2.7 2.6 2.6 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 7.6 7.9 8.1 8.3 8.4 8.2

AWG risk scenario 7.6 8.2 8.5 8.9 9.1 8.9

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 81.3 80.6 79.7 77.7 74.5 70.8

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-12.9 3.1

0.6 0.9

1.3 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, Greece had a GDP per capita of 20,173

PPS, below the EU average of 27,900. Greece

continues to suffer the economic effects of the crisis, but there are signs that the economy may be improving. The recession in 2015 now appears to have been less severe than expected and economic growth is expected positive in the second half of 2016. Compliance with the conditionality of the third adjustment programme, easing of capital controls and confidence in the markets, is expected to lead to GDP growth of 2.7% in 2017 (109).

Population was estimated at 11 million in 2013.

According to Eurostat 2013 projections, total population in Greece is projected to decrease to 8.6 million in 2060, with a 22.5% decrease, which goes in the opposite direction of the EU as a whole, projected to increase on average by 3.1%.

Total and public expenditure on health as % of GDP

Total expenditure (110) on health as a percentage of GDP (9.8% in 2013) is just slightly below the EU average (111) of 10.1%. Public expenditure, at 6.8% of GDP (2013), shows a wider gap from the EU average of 7.8%.

When expressed in per capita terms, total spending

on health, at 1751 PPS in Greece is below the EU average of 2988 in 2013, having increased steadily from 1588 in 2003 until a peak of 2410 in 2008.

Public spending on health care was 1217 PPS vs. an EU average of 2208 PPS in 2013, having increased from 915 in 2003 to 1480 in 2009.

(109) European Commission (2016), European Economic Forecast - Winter 2016.

(110) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

(111) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

Expenditure projections and fiscal sustainability(112)

As a consequence of demographic changes, health care expenditure is projected to increase by 1.3 pps

of GDP, above the average growth expected for the EU (0.9) (113) according to the Reference Scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 2.1 pps of GDP from now until 2060 (EU1.6). (114)

Health status

Life expectancy at birth (84 years for women and 78.7 years for men in 2013) is above the respective EU averages (83.3 and 77.8 years of life expectancy) (115) and has increased slightly since the beginning of the crisis. Healthy life years, at 65.1 years for women and 64.7 for men are above the EU averages of 61.5 and 61.4 in 2013, but have fallen slightly since 2006. The infant mortality rate of 3.7‰; is below the EU average of 3.9‰; in 2013, having fallen since 2003. Amenable mortality was in 2011 163, well above the EU average of 128.4.

As for the lifestyle of the Greek population, the proportion of regular smokers at 38.9% of the population was above the EU average of 23.2%

(116) and the highest recorded in the EU. Alcohol

consumption, at 7.4 litres per capita, was lower

than the EU average of 10 in 2009.

(112) Greece is implementing the third adjustment programme

monitored by the EU, the IMF and the ECB. The

macroeconomic and budgetary prospects for Greece are

assessed more frequently than for the other Member States.

The time horizon covered by the forecasts for Greece is

also different than for the other Member States and assume

full implementation of the adjustment programme.

Projections based on the fiscal sustainability indicators S1

and S2 are therefore not included here.

(113) I.e. considering the "reference scenario" of the projections

(see The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

(114) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(115) Data on health status including life expectancy, healthy life

years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and

Eurostat database.

(116) The EU average value is recorded for 2009.

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System characteristics

System financing, revenue collection,

population coverage and role of private

insurance and out-of-pocket payments

A mixed system in terms of funding and service

delivery operates in Greece. A national health

service funded by taxation goes hand in hand with

a social health insurance system. A universal

health system (ESY) financed on the basis of

taxation was introduced in the early 1980s. The

mandate of ESY is to provide both primary and

secondary care. However, the actual provision of

services was characterised by an underdeveloped

primary care which resulted in exposing the

population to high private expenditure. In terms of

provision, public provision via ESY facilities goes

in parallel with private provision with a very large

number and type of private providers contracted by

EOPYY. Private provision expanded rapidly until

the eruption of the crisis (total health expenditure stood at about 9% for much of the second half of the 2000s, and roughly about 40% of it was private spending – mostly out-of-pocket payments, as private insurance remained limited).

Four decades after its establishment, the system had not developed into a typical fully-fledged national health service despite the legal reforms introduced over the 1990s and 2000s. Until the end of 2011, a highly fragmented (multiple funds), occupation-based health insurance system purchased goods and services in parallel and in supplement to the National Health Service.

Until the 2011 reform, when EOPYY (“the National Health Services Organisation”) initiated its activity, the employed population was enrolled in one of the large number of occupation based health insurance funds (the four biggest being IKA (employees), OGA (farmers), OPAD (civil servants) and OAEE (self-employed) and comprising about 80% of the population).

Contribution rates varied across funds and each fund provided its own package of health services

and goods. There was no risk-adjustment mechanism across funds to account for socioeconomic differences and differences in health conditions of each fund's members. The multiplicity of funding and the fragmentation in the system did not contribute to ensuring good care coordination or defining effective care paths and referral systems, and were instead a significant challenge to equity, efficiency and effectiveness (unequal access to services, unnecessary use of specialists and rapidly rising pharmaceutical expenditure). This was reflected in a diversity of service coverage by social insurance funds enhanced by the different ability of funds to access private services.

The crisis showed that the coverage available to the unemployed for health care benefits offered by social security funds was uneven across funds and largely temporary in the case of some professions. While some groups continued to have coverage two years after becoming unemployed (e.g. those insured with IKA), certain groups lost coverage

immediately (e.g. many of the self-employed professions). The coverage for those who became uninsured or those who could not afford their health insurance fees was limited to very low incomes (only those whose family income was below EUR 6,000 and held the so-called poverty booklet had access to the whole range of health care services for free).

Many Greek citizens lost their employment status and therefore the insurance status, losing their access to medicines, diagnostic tests and nonemergency primary and secondary care. Preventive

care such as vaccination, emergency care and care to chronic diseases was instead declared provided to everyone. Whether in practice access was provided to uninsured persons anyway, notably in terms of primary and hospital care under ESY, is unclear. (117)

The economic and sovereign crisis made health system reform a key priority and a major requirement of the rescue programme. The

merging of all public health insurance funds into a unified health fund (EOPYY), initiated with law 3918 of 2011 (and subsequent legislation), constitutes a major development in health insurance with the aim to equalise contribution rates and health care benefits across occupational groups, for those employed and their dependents. EOPYY became the fully-fledge purchaser of health and services, while ESY and private (117) According to several reports, the uninsured did continue to receive care unofficially from different health care providers especially NHS (ESY) providers, but this was left to the discretionary decision of providers and not necessarily done in a systematic manner.

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providers provide the necessary health goods and services. While the implementation of EOPYY has been an improvement so far, some challenges remain, notably the effective allocation of assets to EOPYY, the persistence of arrears in their

payments to public and private providers and the collection of contributions and the lack of a proper primary **care** network and service. Indeed, in parallel to the social health insurance reform, a reorganisation of ESY was adopted that has moved the primary **care** centres under EOPYY into the ESY structure and redrew the national map of primary **care** centres and hospitals and cut down/rearranged the number of clinics and functional beds with the aim to contain cost and rationalise structure and administration. However, the primary **care** network remains underdeveloped, as signalled by a density of GPs that is lower than half that of the EU average(118). In addition the authorities are currently developing policies to ensure a coherent and universal coverage of all residents and citizens independent of their occupational status, despite a recent set of measures aimed at establishing universal access to health **care** for Greek citizens.

The Greek government have recently passed several Ministerial Decrees to grant access to the

uninsured to Primary Health Care (December

2013), Secondary care and diagnostics (July 2014)

as well as pharmaceuticals (July 2014).

These laws have been adopted, but, based on

information from the authorities it seems as though

the government has not proceeded with full

implementation. Reportedly, there are over

2,000,000 people that are estimated to have no

health care coverage due to unemployment (of the

individual or of the household head upon whom

they depend) or due to discontinued payment of

contributions. Whereas it seems that uninsured did

receive free hospital care, although not full, free

access to pharmaceutical care was never

implemented. However, it is extremely difficult to

estimate the real level of access (119). Recently

passed legislation, the "Social Bill" of February

2016, tackles the issue of universal coverage,

(118) See section "Coverage of services, types of providers,

referral systems and patient choice".

(119) Recent figures provided by the OECD report a level of

coverage of 79% in 2013.

addressing the existing shortcomings (120) and

extends coverage to refugees and other vulnerable

groups in response to recent migration flows.

The share of private expenditure on health in total

health expenditure (30.5% in 2013) is far higher

than the EU average of 22.6%. Most is out-of-pocket

for private care or for private providers

with a contract with EOPYY. Out-of-pocket

expenditure constitutes about 26.4% of total health

expenditure, far above the EU average (14.1% in

2013). It has decreased since 2009 (37.9%), with a

particular sharp drop from 2008 to 2009 (down to

28.4%). To a large extent, this is due to

overconsumption and to higher than average prices

of healthcare goods and services. To tackle the

first issue, co-payments were revised upwards.

Hospital care is delivered free of charge in public

hospitals of the National Health System (ESY). As

for contracted private clinics the amount patients

contribute depends on the financing system (121):

For private clinics not contracted by EOPYY, full

charges apply.

A 15% co-payment for clinical tests when using private providers contracted by EOPYY, in tandem with 25% co-payment for a range of prosthetic devices, orthopaedic materials and respiratory devices, and a ceiling on consumables, such as diabetic test strips, injection needles etc. Costsharing also applies to pharmaceuticals (a share of the price of either 0%, 10% or 25%) depending on severity of condition.

At the same time existing exemptions from user charges for some groups have been made stricter (e.g. for the chronically ill persons exemptions are strictly related to their chronic illness).

Despite the increase registered in co-payment rates, parallel measures adopted to lower prices of goods, such as pharmaceuticals (122), and services,

(120) For instance removing the obligation for a committee to assess eligibility, which was reportedly hindering implementation in many cases.

(121) When Diagnosis-related Groups (DRGs) (Κλειστό Ενοποιημένο Νοσήλειο- KEN) apply, insured pay a 30% contribution. When daily fees apply, they pay a 10%

contribution.

(<http://www.missoc.org/MISSOC/INFORMATIONBASE/>

COMPARATIVETABLES/MISSOCDATABASE/compar

ativeTablesSearchResultTree.jsp, accessed 8 March 2016).

(122) See section "Coverage of services, types of providers, referral systems and patient choice".

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have lowered the basis on which the patients participation is calculated. However for policies to realise the full potential in terms of containing costs for patients, the joint effort of all stakeholders is essential.

Administrative organisation and revenue

collection mechanism

The Ministry of Health develops the national health policy strategy, defining public health and policy priorities, specifying the regulatory framework, defining the system organigram and providing the overall management of the health

care system as a whole. The Ministry of Health

through ESY provides goods and services to

residents and citizens of Greece.

EOPYY, the National Health Services

Organisation purchases the goods and services for

its insurees. At the moment the Social Security

Funds continue to collect health-related

contributions from those insured and submit them

to EOPYY. EOPYY then commissions providers

of health care, both public and private.

EOPYY and ESY are also funded from the State

general budget. The budget for ESY is defined

annually in Parliament when the general Budget is

approved. In recent years, authorities have

tightened the monitoring over the budget execution

of both ESY and EOPYY. The information system

has been strengthened and financial flows are

regularly followed up on both an accrual and cash

basis.

There are also seven Regional Health Authorities

and their role vis-à-vis the administrative regions

is under evaluation. Nevertheless, decision-making

remains highly centralised (which may actually

have helped with the implementation of cost

containment policies in recent times).

EPY is the centralised purchasing agency for the

Ministry of Health and tenders for and purchases

centrally medicines and medical devices. The

National Agency for Pharmaceuticals (EOF) is in

charge of developing and implementing pricing

and reimbursement policies, clinical and economic

evaluation. IDIKA, the IT agency for the Ministry

of Labour maintains the eHealth prescription

system and monitoring prescription together with

EOPYY who receives the data on a daily basis.

Coverage of services, types of providers,

referral systems and patient choice

ESY comprises primary and secondary specialist

and hospital care through a network of public

facilities. In some rural areas it is the main

provider of care. In Greece a mixed system of

service delivery by public and private providers

exists and there are a range of public and private

care providers. Public providers include the ESY

health centres plus the former health centres of

IKA that have come under EOPYY and that have now been moved under ESY and the outpatient and inpatient departments of public hospitals and public laboratories. Private providers either under a contract with EOPYY or paid out-of-pocket by the patients include a large variety of laboratories, diagnostic centres and hospitals from small to very large companies. EOPYY defines the services included in the statutory provision. The services provided by ESY are not necessary explicitly defined.

However, there is not a very clear distinction between primary and specialist care (what constitutes primary care is not explicitly defined) and a gate keeping/referral system is still lacking.

Residents do not have to register with a family doctor and first visit this prior to being referred specialist. Poor coordination between primary and secondary care is therefore a major predicament of health care in Greece. Addressing this shortcoming is a current policy priority. The re-modelling of the

primary health care system and of EOPYY aims to

help set up an effective referral/gate keeping

system. The amalgamation of most health

insurance funds under a single organisation

(EOPYY) also constitutes a significant step

towards improving primary care organisation and

provision. Similarly, the transformation of EOPYY

into a commissioner of health care rather than a

provider means that its former hybrid form as a

funding agency (for both primary and hospital

care) but also a provider of primary care services,

as well as a contractor of services to and buyer of

services from private providers – has been

rationalised. In 2014, all primary health care

centres of public nature have been grouped under

the common label of PEDY (National Primary

Healthcare Network). De facto, primary care

provision has remained inadequate as PEDY

provided primary care was not sufficient to cover

the population's needs. This led to access to

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primary care through EOPYY's contracted private providers, for those who could afford it and to lowquality service and long waiting lists for vulnerable groups.

The total number of practising physicians per 100,000 inhabitants (629 in 2013) is the highest in the EU and well above the EU average (344 in 2013) and has continuously increased since 2003 (474), both before and after the crisis. Data on the physician skill-mix indicates that the number of GPs per 100,000 inhabitants (32 in 2013) is below the EU average (78.3) although it registered an increase since 2005 (26) as part of the authorities' effort to improve primary care provision. The number of nurses (390 in 2013) per 100,000 inhabitants is far below the EU average (837 in 2013). The reported figures point at an oversupply of doctors and undersupply of nurses, which is indicative of an inefficient allocation of resources.

Greece had 399 acute care hospital beds per

100,000 inhabitants in 2011 (up from 382 in 2003), above the EU average of 360 for the same year. In addition, Greece displays higher than average rates of MRI units (2.42 vs EU 1.0), angiography units (1.1 vs EU 0.8) and CTS scanners (3.5 vs EU 1.6) per 100,000 inhabitants.

Purchasing, contracting and remuneration mechanisms

Remuneration is defined by the government. All

ESY doctors in primary or secondary care are paid

on a salary basis and directly by the Ministry of

Finance. Hospitals are allocated resources setting

the budget on the basis of historical and

prospective costs, but the authorities are

developing a Diagnosis-Related Group (DRG)(123)

system to be used for hospital remuneration. In

addition to the transfers from the Government,

hospitals generate their own revenue, though a

very limited share of the total (124), through special

services (e.g. individual private rooms) and from

privately insured patients in the so-called afternoon

practice.

There has also been progress in establishing a

DRG-based hospital payment system in order to

ensure effective reimbursement of hospitals. The

(123) Κλειστά Ενοποιημένα Νοσήλια (KEN) in Greek.

(124) The share is estimated not to exceed 10%.

first step was to develop KEN-DRGs, to define

standard patient cases and calculate the respective

hospital costs and use these to bill SSFs, private

insurance companies and private patients. Work is

still on-going but progress is currently uncertain.

Doctors in private practices are paid a fee for

service in the case of most diagnostics and

outpatient consultations and on the basis of a

"DRG-KEN" costing structure in the case of

private hospitals.

The market for pharmaceutical products, the

use of Health Technology Assessment and

cost-benefit analysis

Major developments in this area embrace higher

control over medical prescriptions (e-prescribing

and e-diagnosis systems), the development of

clinical protocols, new pricing rules for

pharmaceuticals and changes in procurement

processes.

A new pricing and regulation system was introduced in 2010. The price of drugs is set on the basis of the average price of the three lowestpriced markets in the EU. A drug-pricing observatory was established for this purpose and about 12,000 pharmaceutical products started being re-priced on the basis of the new system (a price list is set two times yearly). A number of drugs were also eliminated from the “positive list” of drugs (reimbursed drugs). Yet the pricing mechanism still requires adjustments so as to become more transparent and to reduce the number of complaints and potential confusion caused by several revisions of the same list.

Increasing the market share of generics and regulating their prices are also major objectives of past and current Greek governments. Eprescription and prescription by active substance (INN - International Non-proprietary Name) are now compulsory. The pharmacist is obliged to dispense the generic with the lowest price, but, according to evidence, this is not happening. If the

patient chooses the branded name instead, s/he has to pay 50% of the difference between the reference price and the actual price of the branded medicine (while lately the Ministry of Health raised this charge to the full price difference). Very recently, a further MD amended this mechanism to limit the patients' participation to 20 euros.

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The market penetration of generics remains limited. (125) Combining electronic prescription with compulsory use of prescription guidelines/protocols for physicians drawing upon the IDC10 (International Statistical Classification of Diseases and Related Health Problems) is another component of the on-going reform. This is attempted initially for the expensive medicines and those most widely used.

Interestingly, pharmaceuticals cost-containment occurred only in ambulatory care, while hospital drug expenditure has been rising (mostly due to the

transfer of dispensing of expensive drugs to hospital pharmacies). In parallel, centralised tenders and international e-auction procedures for hospital procurements were launched, but remain limited.

Containment of pharmaceuticals expenditure has been a top priority and has been carried out successfully to large extent in recent years plan (given the fact that drugs expenditure increased exceptionally fast during the 2000s). Significant cost-savings have so far been achieved through the introduction of e-prescribing and e-referral systems (initially on a pilot basis, but made progressively compulsory for all outpatient medical acts under ESY and EOPY – including drugs, referrals and diagnostics). Accompanying measures include: compulsory prescription guidelines and therapeutic protocols, incentives and obligations (for medical staff) to use generics, the regular revision of drugs' prices, the reduction of the profit margin for pharmacies, and the automatic clawback, which has preserved prices

and volumes from otherwise stricter necessary
downwards revisions. Also, the “positive list” of
drugs is periodically revised. Co-payments (for
pharmaceuticals, diagnostic tests and use of private
clinics) increased too, while exemptions have been
drastically reduced.

Prescription patterns by EOPYY doctors are
closely monitored through the web-based
application used for e-prescription and e-diagnosis.
Hence, real time information is available on a basis
on which detailed auditing on pharmaceutical
prescription and expenditure is carried out (on
volume and value, use of generics and off-patient

(125) The Role of Generic Medicines in Sustaining Healthcare

Systems: A European Perspective, IMS (2015).

drugs, on rebate etc.). Individual prescription
behaviour, in comparison to peers, is also
monitored and assessed (every month), and in the
case of non-compliance with guidelines, penalties
could be imposed on physicians. Nevertheless,
despite these significant innovations, major
stumbling blocks remain in performance terms,
due to resistance from main stakeholders, in

particular doctors and pharmacists.

eHealth (e-prescription, e-medical records)

and information and reporting mechanisms

Greece has an e-prescription system, run by

HDIKA that includes prescription for

pharmaceuticals, referrals and diagnostics. This

prescriptions' processing unit collects all the data

of prescribing, both the electronic prescriptions

and handwritten and scanned ones and has

developed a Business Intelligence system

producing both fixed reports as well as reports

generated ad-hoc.

In addition, a personal health insurance file is

being developed, containing data for all

hospitalisations, health services, materials and

diagnoses of a patient. The data are computerised

and the coverage is national. This will be further

enhanced by adding information on laboratory

exams recorder by diagnostic centres. Lastly, 3

registries of medicinal products have developed

(hepatitis C, chronic myeloid leukaemia and

multiple sclerosis) and an additional one is

expected during 2016.

These tools can help improving monitoring and control of prescription and consumption of services and goods and will render a future referral system and care coordination more effective, reducing the use of unnecessary pharmaceutical, specialist and hospital emergency care.

Health promotion and disease prevention policies in 2013, public and total expenditure on prevention and public health services as a % of GDP were lower than the EU average (0.10% and 0.10% vs. 0.24% and 0.19% in 2013), which also characterised recent years. Public and total expenditure on prevention and public health services as a % of current health expenditure (public and total, respectively) are, similarly, both

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below the EU average (1.1% vs. 2.5% and 1.7% vs. 2.5% in 2013).

Transparency and corruption

In past years, there have been reports of corruption in the system (126), in the form of bribery in medical service delivery (informal payments to obtain better services or to jump queues), procurement corruption (favouring of specific providers and putting obstacles to competition) and misuse of (high) level position. It is important to assess to what extent the measures addressing public procurement adopted so far have positive effects in this field and to design further improvements to completely eliminate corruption.

Furthermore, although there has been important progress in safeguarding the independence of hospital managers the last years, the system has not fully succeeded in isolating political interventions from decision making.

Recently legislated and/or planned policy reforms

In recent years, the authorities have taken several steps to improve health care delivery in Greece.

The creation of EOPYY was an important step in

improving equity in financing and access to care.

With EOPYY, contribution rates across professions and population groups were harmonised considerably (only those previously in OGA continued paying a lower amount and had access to a more limited set of benefits). The programme also included the introduction of centralised tendering of specific hospital supplies, which has led to significant savings, as the differences in prices paid by different hospitals have been eroded. However, the proportion of purchasing that is conducted through centralised tendering is still relatively low, indicating there is still scope to achieve further increases in efficiency.

These measures have also helped reduce fraud and waste. Improved budgeting and transparency, regular monitoring and e-prescription have made it easier to detect irregular behaviour. More reforms

(126) European Commission (2013), "Study on Corruption in the Healthcare Sector", Directorate-General Home Affairs.

can be undertaken in this direction, such as electronic queuing systems for referrals to

secondary care or, as mentioned in the paragraph

above, increases in centralised tendering.

Under the programmes, the Greek government has

undertaken measures yielding substantial savings

on pharmaceuticals in line with best international

practice:

- Setting up of an electronic prescription system

to enable control and monitoring of

prescription behaviour, as well as the

implementation of electronic prescription

guidelines.

- Pricing based on the three-lowest EU prices.

- Establishment of an evidence-based positive

list of drugs that are reimbursed by EOPYY.

- Promotion of generic medicines and reduction

of over-prescription and fraud by INN

prescribing.

- Establishment of an annual expenditure ceiling

and claw back system to enable control of

pharmaceutical expenditure.

- Establishment of pharmaceutical co-payments

from 25% to 10%, while setting up a list of

exemptions to ensure access.

As a result, public reimbursed expenditure on pharmaceuticals has gone from above 5bn at the start of the programme to a budgetary cost of about 2bn in 2014 and is legislated to remain at this level until 2017.

Until recently, public hospitals faced significant deficits. These deficits were addressed periodically through ad-hoc state subsidies derived from taxation revenues and often resulted in payment arrears to providers. The reasons were manifold and included delays in payment by SSFs combined with low statutory fees paid by SSFs for hospital services, in comparison to actual per diem costs, but also poor IT systems, poor budgeting and accounting systems combined with poor monitoring which led to a lack in transparency of financial and care activities carried by hospitals. In addition, an inefficient procurement of

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pharmaceuticals and medical supplies led to high prices and large variations in the prices paid by different hospitals. More generally, a proper incentive structure to deliver cost-effective services and stay within their budgets was absent.

Such incentives common in other Member States include a mix payment system and performance assessment mechanisms. More recently, improved IT and modern accounting systems have been established (accrual accounting has been introduced in addition to cash accounting), with balance sheets for all hospitals, unpublished for several years, now regularly published online.

Hospital funding and funding flows from various sources are now transparent and monitored on a regular basis and arrears have been significantly reduced.

Centralised purchasing has improved even if at slow speed with important savings, sometimes reaching more than 50% in price reduction paid for some medicines and medical supplies.

Performance indicators have been introduced in order to assess the performance of hospitals and

identify specific challenges.

Greece is currently implementing the third adjustment programme monitored by the EU, the IMF and the ECB. Several commitments have been formulated by the authorities and policies are being developed accordingly to meet the targets within the agreement.

In parallel, the authorities have formulated a plan to improve the system contained in the 100 Actions' Plan document. The document addresses several areas that need reforming based on three axes:

AXIS 1: ensuring universal access to quality care,

AXIS 2: transparent, inclusive and modernised health governance through an efficient and effective public administration

AXIS 3: fair and sustainable financing.

The proposed plan aims at the modernisation of the system and at improving quality and access while ensuring sustainability.

Recently, legislation was passed to update the existing legislation on the coverage of uninsured

Greek citizens to accommodate the incoming flows

of migrants. This legislation contained other

measures to improve the functioning of the

healthcare sector, such as a human resource

strategy to increase staff and re-qualify the existing

one to support the development of a primary health

care network over the territory.

In general, policies are being developed which

should support the goals of greater generics

penetration, more rational prescribing patterns,

rationalisation of healthcare expenditure,

promotion of higher transparency in the system,

elimination of waste, greater transparency and

elimination of corruption. In practice though,

progress is slow and uncertain in these areas.

Challenges

The analysis above shows that several reforms

have been implemented in Greece over the last five

years. However, the current incentives present in

the system are not necessarily conducive to the use

of cost-effective interventions, while individuals

pay a significant share of expenditure directly out

of their own pockets. On the basis of the analysis

the main challenges for the Greek health care

system are as follows:

- To continue increasing the efficiency of health

care spending, promoting quality and

integrated care as well as a focusing on costs,

to tackle the impact on spending due to

population ageing and non-demographic

factors. To this end, rationalise health care

expenditure by discouraging the overuse of

products and services. In addition to encourage

the use of generics, to improve hospital

management, to strengthen public procurement

and to further the efforts in the development of

protocols for treatment.

- To improve the basis for more sustainable and

efficient financing of health care in the future,

aiming at a better balance between resources

and spending. This can reduce the size of

private payments through enhanced coverage

and reduce inequalities in the access and

quality of care and its distribution between

population groups and regional areas. To tackle

the issue of arrears in payments by EOPYY.

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- Despite the observed progress in

pharmaceuticals expenditure, more efforts are

needed to ensure that spending stays within the

envelope and that spending targets are not

achieved just due to the implementation of

established cost-containment mechanisms

(clawbacks), for instance, increasing the

penetration of generics and the application of

therapeutic protocols.

- To reduce the excessive use of secondary

specialist and hospital care. To promote greater

efficiency in the hospital setting, including by

rationalising the use of resources to ensure all

capacity within public hospitals is utilised. To

this end, consider whether there is scope to

regulate the flows of patients towards private

providers by linking this possibility to a

threshold in terms of waiting time/local

capacity. In addition, consider adjusting the existing reimbursement schemes to increase efficiency and productivity in the delivery of hospital services.

- To implement a comprehensive strategy for primary health care over the territory, for it to act as a gatekeeper. To adjust staff training and the staff skill mix towards having more primary care doctors and nurses, correcting the current inefficient allocation of resources that sees an oversupply of doctors and an undersupply of nurses. It should be complemented with financial and non-financial incentives including the extent of cost-sharing to encourage the use of primary care versus specialist care.

Relatedly, authorities should improve followup care so as to reduce the unnecessary use of acute care settings for long-term care patients.

To this end, to make use of the existing eHealth tools.

- To improve governance (general coherence and

management) of the health care sector for

instance by clearer definition of strategic,

evidence-based objectives and by strengthening

technical expertise. To tackle the issue of

corruption and to eliminate waste.

- To enhance and continue data collection and

monitoring of inputs, processes, outputs and

outcomes so that regular performance

assessment can be conducted and used to

continuously improve access, quality and

sustainability of care. This includes efforts to

assess and publish evaluations of the quality of

care provided for example.

- To make more use of cost-effectiveness

information in determining the basket of goods

and the extent of cost-sharing to induce costeffective

behaviour.

- To enhance health promotion and disease

prevention activities i.e. promoting healthy life

styles and disease screening given the recent

pattern of risk factors (diet, smoking, lack of

exercise, obesity).

- To ensure access to primary and secondary

health care of the vulnerable groups,

particularly the uninsured. In that respect, close

monitoring of the respective costs will be

necessary, particularly those related to the

health needs of the refugee/migration flows in

order to disentangle the relevant budgetary

effects and seek for the appropriate EU

funding.

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Table 1.12.1: Statistical Annex – Greece

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 179 194 199 218 233 242 238 226 207 191 180 9289 9800 9934

GDP per capita PPS (thousands) 24.4 25.2 24.5 25.6 25.6 25.1 23.2 22.1 19.9 19.6 20.2 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 5.6 4.0 1.9 5.2 3.2 -0.4 -3.1 -4.7 -6.9 -6.7 : -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 3.6 1.1 13.4 6.2 3.8 2.8 -2.5 -11.3 -3.9 -11.7 : 3.2
-0.2 -0.4

Expenditure on health* 2009 2011 2013

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Total as % of GDP 8.9 8.7 9.7 9.8 9.8 10.1 10.2 9.5 9.8 9.3 9.8 10.4 10.1 10.1

Total current as % of GDP 8.2 8.0 9.0 9.0 9.1 9.8 10.0 9.3 9.7 9.2 9.2 9.8 9.6 9.7

Total capital investment as % of GDP 0.7 0.7 0.7 0.8 0.8 0.4 0.2 0.1 0.1 0.1 0.7 0.6 0.5 0.5

Total per capita PPS 1588 1671 1908 2099 2249 2410 2372 2096 1981 1739 1751 2828 2911 2995

Public as % of GDP : : : : : 7.0 6.3 6.6 6.2 6.8 8.1 7.8 7.8

Public current as % of GDP 5.1 4.8 5.6 5.7 5.6 5.8 7.0 6.3 6.6 6.2 6.0 7.9 7.7 7.7

Public per capita PPS 915 945 1111 1247 1302 1392 1480 1353 1336 1167 1217 2079 2218 2208

Public capital investment as % of GDP : : : : : 0.0 0.0 0.0 0.0 0.8 0.2 0.2 0.1

Public as % total expenditure on health : : : : : 68.4 66.7 67.4 67.1 69.5 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 11.6 12.1 13.7 13.4 13.1 12.6 12.2 13.0 11.9
10.8 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0
100.0 : : : : 79.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 34.3 35.2 34.8 32.9 34.6 37.9 28.4 29.4
28.8 28.8 26.4 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 10.9 10.9 11.0 11.0 11.0 11.1 11.1 11.1 11.1 11.1 11.0 502.1 504.5 506.6

Life expectancy at birth for females 81.8 82.0 82.3 82.6 82.5 83.0 83.3 83.3 83.6 83.4 84.0 82.6 83.1 83.3

Life expectancy at birth for males 76.5 76.6 76.7 77.1 76.9 77.5 77.5 78.0 78.0 78.0 78.7 76.6 77.3 77.8

Healthy life years at birth females 68.4 65.5 67.4 68.1 67.6 66.2 66.8 67.7 66.9 64.9 65.1 : 62.1 61.5

Healthy life years at birth males 66.7 63.9 65.9 66.5 66.0 65.6 66.1 66.1 66.2 64.8 64.7 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 123 117 110 104 97 92 86 79 163 166 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.0 4.1 3.8 3.7 3.5 2.7 3.1 3.8 3.4 2.9 3.7 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

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Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 3.66 3.43 3.84 4.25 3.81 3.13 2.99 3.01

Day cases curative and rehabilitative care : : : : : 0.06 0.05 0.06 0.03 0.03 0.18 0.18 0.19

Out-patient curative and rehabilitative care : : : : : 2.36 2.15 2.11 1.62 1.54 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.80 1.80 2.00 2.10 2.30 : 2.84 2.68 2.63 2.31 2.80 1.60 1.55
1.44

Therapeutic appliances and other medical durables : : : : : 0.24 0.21 0.22 0.18 0.14 0.31 0.31 0.32

Prevention and public health services : : : : : 0.13 0.13 0.13 0.11 0.10 0.25 0.25 0.24

Health administration and health insurance : : : : : 0.19 0.17 0.20 0.18 0.22 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : : : : 3.02 2.71 3.02 3.33 2.83 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : 0.06 0.05 0.06 0.03 0.03 0.16 0.16 0.18

Out-patient curative and rehabilitative care : : : : : 0.83 0.80 0.83 0.68 0.65 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables : : : : : 2.26 2.05 1.94 1.53 1.86 0.79 1.07 0.96

Therapeutic appliances and other medical durables : : : : : 0.17 0.15 0.16 0.12 0.10 0.13 0.12 0.13

Prevention and public health services : : : : : 0.13 0.10 0.10 0.25 0.20 0.19

Health administration and health insurance : : : : : 0.15 0.12 0.15 0.14 0.18 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.12.2: Statistical Annex - continued – Greece

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 36.5% 36.7% 39.7% 46.4% 41.6% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : : : : : 0.6% 0.6% 0.6% 0.3% 0.3% 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : : : : : 23.5% 23.0% 21.8% 17.7% 16.8% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 21.9% 22.6% 22.2% 23.4% 25.4% : 28.3% 28.7% 27.2% 25.2%
30.6% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : : : : : 2.4% 2.3% 2.2% 2.0% 1.6% 3.2% 3.3% 3.3%

Prevention and public health services : : : : : 1.3% 1.4% 1.3% 1.2% 1.1% 2.6% 2.6% 2.5%

Health administration and health insurance : : : : : 1.9% 1.8% 2.1% 2.0% 2.5% 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : : : : : 43.3% 42.9% 45.8% 53.5% 47.1% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : : : : 0.8% 0.8% 0.9% 0.4% 0.5% 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care : : : : : 11.9% 12.7% 12.6% 10.9% 10.8% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables : : : : : 32.4% 32.4% 29.4% 24.6% 30.9% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : : : : 2.4% 2.4% 2.4% 2.0% 1.6% 1.6% 1.6% 1.6%

Prevention and public health services : : : : : 2.0% 1.6% 1.7% 3.2% 2.7% 2.5%

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Health administration and health insurance : : : : : 2.1% 2.0% 2.3% 2.2% 3.1% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants : : 1.32 1.63 1.79 1.96 2.17 2.26 : : 2.42 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : 0.9 0.9 0.9 0.9 1.0 1.0 : : 1.1 0.9 0.9 0.8

CTS per 100 000 inhabitants : : 2.5 2.6 2.9 3.1 3.4 3.4 : : 3.5 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : 0.0 0.0 0.0 0.0 0.0 0.0 : : 0.0 0.1 0.1 0.1

Proportion of the population that is obese : : : 16.4 : 17.6 : 19.6 : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : 38.6 : 40.0 : 31.8 : 38.9 : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 8.7 8.9 9.2 8.8 9.0 8.8 8.3 7.9 7.4 : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 474 488 501 536 557 606 617 621 625 627 629 329 335 344

Practising nurses per 100 000 inhabitants 429 428 423 429 429 432 438 : 330 360 390 840 812 837

General practitioners per 100 000 inhabitants : : 26 25 31 27 28 30 30 31 32 : 78 78.3

Acute hospital beds per 100 000 inhabitants 382 379 386 394 395 395 405 402 399 : : 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 4.2 4.2 3.9 4.0 4.0 : : : : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : : : : : : : 19.9 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : : : : : : : 6368 6530 7031

Acute care bed occupancy rates 74.0 75.0 73.0 75.0 73.0 73.4 72.5 70.6 : : : 72.0 73.1 70.2

Hospital curative average length of stay 6.0 5.7 5.6 5.8 5.4 5.4 5.3 5.3 : : : 6.5 6.3 6.3

Day cases as % of all hospital discharges : : : : : : : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario #N/A #N/A #N/A #N/A #N/A #N/A

AWG risk scenario #N/A #N/A #N/A #N/A #N/A #N/A

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) #N/A #N/A #N/A #N/A #N/A #N/A

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

#N/A 3.1

#N/A 0.9

#N/A 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, Hungary had a GDP per capita of 16.3

PPS (in thousands), below the EU average of 27.9.

Population was estimated at 9.9 million in 2013

and is expected to fall gradually to 9.2% by 2060,

a decrease of 7.5% in contrast with the average EU

increase of 3.1%.

Total and public expenditure on health as % of

GDP

Total expenditure (127) on health as a percentage of

GDP (8.1% in 2013) has decreased slightly over

the last decade (from 8.6% in 2003, although it has

been relatively flat since 2010), below the EU

average (128) of 10.2%. Public expenditure is lower

than in 2003, 6.1% of GDP, though it has been

relatively flat since 2007. It is also below the EU

average of 7.7% in 2013.

When expressed in per capita terms, total spending

on health at 1486 PPS is far below the EU average

of 2988 in 2013. So is public spending on health

care: 944 PPS vs. an average of 2208 PPS in 2013.

Expenditure projections

As a consequence of demographic changes, health

care expenditure is projected to increase by 0.8 pps

of GDP, below the average growth expected for

the EU (0.9 pps of GDP).(129), according to the

"AWG reference scenario". When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health **care** expenditure is expected to increase by 1.5 pps of GDP from now until 2060 (EU1.6).

(127) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

(128) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

(129) I.e. considering the "reference scenario" of the projections (see The 2015Ageing Report at

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

Overall, for Hungary no significant short-term risks of fiscal stress appear at the horizon, though some variables point to possible short-term challenges. Medium risks appear, on the contrary,

in the medium term from a debt sustainability analysis perspective due to the still moderately high stock of debt at the end of projections (2026), and the sensitivity to possible shocks to nominal growth, interest rates and the government primary balance. Low medium-term risks are, on the contrary, highlighted by the analysis of the sustainability gap indicator S1, largely due to positive projected developments on ageing.

Overall, Hungary appears to face medium fiscal sustainability risks in the medium term. No sustainability risks appear over the long run.

Health status

Life expectancy at birth (79.1 years for women and 72.2 years for men in 2013) is far below the respective EU averages (83.3 and 77.8 years of life expectancy in 2013). However, healthy life years, at birth 60.1 years for women and 59.1 years for men, are closer to the EU averages of 61.5 and 61.4 in 2013. The infant mortality rate of 5 deaths per 1000 live births (5‰) is higher than the EU average of 3.9‰ in 2013, having gradually fallen over the last decade (from 7.3‰ in 2003).

As for the lifestyle of the population, the rate of daily smokers was 26.5% in 2009, according to Eurostat, although other sources provide estimates of 31% in 2009 and 25.8% in 2014. According to the Hungarian European Health Interview Survey, the rate of current smokers was 31.4% in 2009 and 27.5% in 2014, (130). Since 2009 the total number of smoked cigarettes decreased by 8%, however in 2012 the number of smoked roll cigarettes was double compare to the previous result. The obesity rate of the population was at 23.6%, in 2012, the second highest proportion in the EU (after Malta) and far above the EU average of 15.5% in 2013. Alcohol consumption was 11.2 litres per capita in 2012, above the EU average of 9.8, and it has decreased from 13.1 in 2003. According to the World Health Organisation's global status report on alcohol and health 2014 the pure alcohol (130) European Health Interview Survey, 2014. (ELEF 2014); Nemzeti Egészségfejlesztési Intézet: Egészségjelentés 2015 (46.o.)

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consumption/year in Hungary (recorded and unrecorded) is in case of men 20,4 litre and in case of women 7,1 litre (131). Among the European Union member states, Hungary is on the 5th place with an alcohol consumption of 14,15 litre/person/year (total consumption) (132).

System characteristics

Coverage

The health care system operates within the scheme of a social security system based on societal solidarity. A Bismarckian model of insurance has been established: the main feature is the right to benefits in exchange for contributions. Health insurance contributions and direct government transfers provide the funding for cash benefits and benefits in kind. Health insurance contributions are proportional to income: In case of employees it amounts to 7% of the gross salary (3 % cash benefits, 4 % benefits in kind). The health care system covers virtually entire population (less than

1% is not covered). Membership is compulsory for

all residents.

Gainfully employed and assimilated persons are

insured against all risks: employees (including the

public sector), the self-employed (including

members of co-operatives), several assimilated

groups, and beneficiaries of income subsidy, jobseeker

benefit and job-seeker aid paid prior to

retirement.

Various groups of the not gainfully employed

population are entitled to health care benefits:

Minors permanently resident in Hungary, persons

who have fulfilled the minimum retirement age

and whose monthly income does not exceed 30%

of the minimum wage, homeless people, prisoners,

full-time students, pensioners, beneficiaries of

various benefits, allowances, or income supports,

persons placed in residential institutions providing

personal care, restrained persons, persons whose

need has been recognised by the local government

(131)

obal_alcohol_report/msb_gsr_2014_3.pdf?ua=1

(132)

http://www.euro.who.int/_data/assets/pdf_file/0003

/160680/e96457.pdf - Annex 1 ADULT PER CAPITA

ALCOHOL CONSUMPTION IN THE EU, CANDIDATE

COUNTRIES, NORWAY AND SWITZERLAND (2009)

(including income supports of the unemployed),

social supports, persons whose ability to work is

reduced at least by 50%. For those who fall under

this category, the central budget transfers a

monthly amount of 5,790 HUF/person as health

service contribution into the Health Insurance

Fund (HIF).

Self-employed persons who perform activities in a

complementary way or their joint ventures, and

otherwise not insured or entitled persons are

obliged to pay a health care contribution (in case

of continuous residence in Hungary for a year -

HUF 7,050 per month). Financing for groups

covered without contributing is provided by the

central budget in terms of a fixed per capita fee.

Dependant close family members or their spouses

are also obliged to pay health care contribution

unless they are socially entitled, which must be

justified by the local government (and their

obligation can also be undertaken).

Persons not insured or not entitled to health care

can enter into contractual arrangements with the

National Health Insurance Fund Administration

(NHIFA - Országos Egészségbiztosítási Pénztár)

for entitlement to health care services. In case of

adults, the contribution amounts to half of the

minimum wage, in case of minors and students

30% of the minimum wage (only for benefits in

kind –not necessary Hungarian Certificate of

domicile).

The government elected in 2010 opted for a

systematic move on the way to a national health

service by further centralising the allocation of

capacities; establishing a new hierarchical system

of actively managed patient routes; organising

more effective competition of generics in public

purchases of pharmaceuticals; and making steps

towards replacing contributions by taxes.

Administrative organisation and revenue

collection mechanism

The health care budget is made up of three

components: (1) the budget of the HIF derived

from health insurance contributions and earmarked

health care tax (72% in 2016); (2) direct

government transfers from the central budget (21%

in 2016) and other incomes (7% -social tax,

incomes from pharmaceutical companies, accident

tax, public health product tax).

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In addition, local government budgets are derived

from local taxes and from the central government

grants for investment. The budget-setting

processes at different levels are practically

independent, apart from central government

subsidies for regional and local levels.

A key principle is the institutional separation of

capital and recurrent costs, which applies to all

sub-sectors. While investment is decided upon and financed by either local or central government, the HIF covers recurrent costs only.

Since 2012, the hospitals owned by the capital, cities and counties are state-owned. Dual financing still prevails, so recurrent costs are financed by the Health Insurance Fund, while capital costs by the maintainer. However, as the National Healthcare Service Center (earlier: National Institute for Quality- and Organizational Development in Healthcare and Medicines) fulfils maintenance and supervisory duties over state owned health institutions.

Restructuring was launched in 2011, and the operation of the new structure started as of 1 July 2012. The basic principle of the new structure is to centralise specialised care with high costs and relatively low patient numbers. Forms of care with higher case numbers, being less specialised and less costly should be provided close to the population. A change of function or profile refining was introduced for 58 service providers.

4.3% of inpatient care capacities was closed. In line with changes in structure, function and integration, a number of economic interventions aiming at improving effectiveness were introduced - essentially contributing to sustained institutional functioning. Consequently, a part of resources made available could be reallocated to financing outpatient care.

In 2011, the "Simmelweis Plan" reorganised the health care system. The new structure basically centralised the administrative functions and system management under the responsibility of the State Secretariat for Health Care of the Ministry of Human Resources (MHR) and related institutions such as the National Institute for Quality- and Organizational Development in Healthcare and Medicines (at present: National Healthcare Service Center), the National Centre for Patient Rights and Documentation and the Office of Health Authorisation and Administrative Procedures. Epidemiological and other public health issues belong to the National Public Health and Medical

Officer Service and its affiliates.

The management of the provision of service and patient pathways is split between the level of NUTS3 administrative units and the higher level of health-regions and nationally. Service providers, including outpatient and care centres manage patient pathways at lower levels.

All agents within this system are linked to the HIF, which is in charge of managing the finances of the health care system. The emergence of new institutions in the management of patient pathways means that the importance of the HIF as a central institution in the health sector has been reduced. Its role has been further eroded by the partial devolution of responsibilities to a new network of government offices at NUTS3-level (known as “government windows”).

The level of expenditure on the administration of such a system, where entitlements are not linked to contribution payments and virtually the entire decision-making power rests with the Ministry of Health, is not high. Public and total expenditure on

health administration and insurance as a percentage of GDP (0.11% and 0.11% respectively) is well below the EU average (0.27% and 0.47% respectively in 2013).

Role of private insurance and out of pocket

co-payments

In 2013, private expenditure accounted for 36.4% of total health spending, considerably more than in the EU on average (22.6%). Also very large in comparison to the EU average is the share of out-of-pocket payments (27.5% vs. 14.1% in the EU).

Types of providers, referral systems and patient choice

Health care provision is the state's responsibility.

The delivery system is organised on the basis of "territorial supply obligation", which assigns the responsibility to different levels of government according to the principle of subsidiarity (the service should be provided at the lowest effective level of organisation). This way, municipalities are responsible for providing primary care, while

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responsibility for secondary and tertiary health

care services is the central government's

responsibility. Nevertheless, even if obliged by law

to provide a given level of care, the local

authorities are not obliged to deliver it. Each level

is allowed to outsource service delivery to private

providers. Moreover, the owner of health care

facilities (whether private or public) is obliged to

keep it in working order, i.e. to cover capital costs,

which is particularly relevant in case of stateowned

equipment and facilities being used by

private providers to deliver subcontracted services.

Control, coordination, supervision and delivery of

public health services are the responsibility of the

central government which provides the services

through the National Public Health and Medical

Officer Service, in some cases in cooperation with

the other institutions.

Provision of primary care is within the area of

responsibility of the municipalities. They may

provide it through salaried doctors or contract the delivery to independent physicians, who need to have relevant qualifications and a "practice right" to be eligible. The "practice right" is the right to perform the professional activities, which can be sold and bought by another qualified physician. By establishing the territorial reach of the primary care districts and the number of practices in each of them, local governments can control the amount and type of care provided to the population.

Patients can freely choose a family doctor and change him/her once a year. Doctors cannot refuse the patients who live in their primary care district, but are allowed to refuse patients from other districts.

A number of reforms have been enacted over the last decade to provide incentives to take up the posts of physicians and nurses. The reforms have not produced visible results so far. Although slightly higher than a decade ago, the number of practicing physicians (321 per 100 000 inhabitants in 2013), practising nurses (643 in 2013) and in

particular general practitioners (34 in 2010) is still well below the EU respective averages in the respective years (344, 837 and 78 per 100 000 inhabitants).

Although there is an official referral system and family doctors formally act as gatekeepers, the payment system includes no incentives to provide definitive care and avoid unnecessary referrals.

Consequently, the number of referrals to specialists and hospitals is high. Only the 2007 reform (reducing inpatient capacity of hospitals by setting up a few regional universal hospitals and medical clinics, strengthening of the referral system and introducing a formal transparent system of waiting lists) has allowed the authorities to limit hospital overutilisation. Indeed, the number of acute hospital beds per 100000 inhabitants is, at 399, above the EU average of 356. It has fallen since 2011 (414). Inpatient discharges per 100 inhabitants fell from 24.4 in 2004 to 19.9 in 2011 (EU average: 16.5).

Responsibility for secondary and tertiary care is

shared among different levels of local and regional government. Formally, the state (through the National Healthcare Service Center) owns large multi-speciality county hospitals providing secondary and tertiary inpatient and outpatient care to the acutely and chronically ill. However, municipalities and central government also play a role, the former being responsible for polyclinics (outpatient specialist care), dispensaries (outpatient care for the chronically ill) and state-owned hospitals (secondary inpatient and outpatient care), while the latter own – through specific ministries – a number of acute and chronic hospitals. Dialysis and home care have in comparison a significant share of private ownership.

Treatment options, covered health services

Local authorities are required by law to provide services at a given level of care.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Family doctors can be employed according to four

different schemes: (1) municipality employee paid on the basis of a monthly salary; (2) family doctor under a contract using public equipment and paid a capitation fee from the HIF; (3) family doctor being an independent provider with no municipal contract and no territorial supply obligation (large majority of the GPs); he/she is entitled to a capitation fee from the HIF only if he/she has minimum threshold of registered patients; (4) "freelance medical doctor", not being subject to public employee regulations, but not having a status of self-employed private entrepreneur either;

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he/she receives an out-of-pocket payment directly from the patient.

Capitation fees paid under schemes (2) and (3) are adjusted to the age structure of the patients covered: children and elderly weigh most, working age population least. Moreover, in order to avoid negative impact of the excessive practice size on

the quality of care, a threshold of the number of patients is set above which the capitation payment is only partial.

The payment system in secondary and tertiary care depends on the type of institution and services provided. Outpatient specialist services are financed by fee-for-service points, whereby each procedure is assigned a number of points according to its complexity and requirement of services and providers report total monthly number of points to the HIF for reimbursement. The monetary value of a point is defined in advance, and part of the sub-budget is put aside at the beginning of each year to compensate for possible 'excessive' provision of services. The sustainability of outpatient budget is achieved by a so-called performance volume limit. In the beginning of each year, based on previous years' data, the performance volume limit is defined for every single outpatient health service provider. Performance volume limit for the year of 2014 was defined, in agreement with professional bodies. In 2016, 1 financing point equals to 1.50 HUF.

Consequently, even if control mechanisms have been set in place, the fee-for-service payment scheme in hospitals could discourage treatment as an outpatient and encourage hospitals to treat as an inpatient for financial gain, rather than for the ideal treatment of the patient.

Inpatient services are reimbursed according to the DRG-based prospective payment system, except for a few high-cost interventions reimbursed on a case basis. State owned hospitals are paid by DRGs. In addition, there are income flows to hospitals for outpatient care, chronic care,

laboratory care and wages. Hospitals report the total amount of completed procedures to the HIF which calculates their total value by multiplying the DRG points by the national base fee (value of one point) - set in advance for each year. The

sustainability of financing inpatient care is also ensured by the performance volume limit.

Currently one single weight-point equals 150 000

HUF. Chronic care is financed by a daily fee.

Wages transfers are calculated by a monthly request of providers and it's financed by the National Health Insurance Fund Administration. Finally, in order to improve the income situation of health workers, there was a wage increase started in 2012 year and was continued in 2013-2015.

The market for pharmaceutical products

Pharmaceutical spending accounts for 30.7% of total (public and private) current health expenditure and 20.2% of current public health care expenditure in 2013. Reimbursement is regulated while prices are (to some extent) freely determined by the market (even if decisions on reimbursement have impact on market operators' price policies). Prices of original drugs are established on the basis of external price referencing (comparison with the prices in the other EEA countries), while the maximum generics' prices are additionally linked to the original drug price. Reimbursement applies to two positive lists: one includes drugs which can be prescribed by any physician and are reimbursed at either 0%, 25%, 55% or 80%; the other includes

drugs with special indications, to be prescribed by specialists and reimbursed at either 50%, 70%, 90% or 100%. Moreover, physicians are obliged to prescribe reference medicines.

The 2010-2012 reform of the pharmaceutical market launched in the context of the state debt reduction aimed at rationalising medication use and strengthening competition for generic drugs. The decision was made to improve the efficiency of the pharmaceutical reimbursement system in order to meet the needs of patients. In practice, this also meant cuts in the pharmaceutical budget. A number of austerity measures were introduced in order to meet the budgetary constraints. In particular these measures are:

- modified legal provisions regulating payment obligations for the pharmaceutical companies,
- enhanced generic competition,
- requirements for enforcing patient compliance,
- revision of pharmaceutical treatment protocols,

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- re-contracting of volume agreements, and the
- introduction of prescribing by active substance.

As a result of these measures, a substantial decrease in prices of pharmaceuticals in outpatient

care could be realised during recent years, and public expenses could be decreased without increasing the (even sometimes with decreasing) financial burden on patients. At the same time, a number of new innovative drugs could be included in the reimbursement scheme.

eHealth, Electronic Health Record

There is a relatively limited use of IT in the provision and organisation of healthcare.

Health and health-system information and reporting mechanisms/ Use of Health

Technology Assessments and cost-benefit analysis

Further measures to improve quality will include implementing a monitoring and evaluation system based on defined indicators. Major IT development plans include establishing a database for the insurance system, developing a personal

identification system, improving remote

diagnostics and telemedicine.

Healthy lifestyle and disease prevention activities

have received a lot of attention mainly through

programmes aiming at improving the health status

and quality of life of the population. Total

expenditure on prevention and public health

services as 0.2% of GDP is about the EU average

(0.24% in 2011) while public. However, public

expenditure on prevention and public health

services as % total public current expenditure on

health is in line with the EU average (2.4% vs.

2.5% in 2013).

Recently legislated and/or planned policy

reform

To reduce shortages of medical staff, a

comprehensive residency support programme was

introduced in 2011 and was announced again for

2016. Beyond emigration, attrition puts further

pressure on skills shortages. To address this

challenge, wages of health professionals were

increased substantially since 2012. However, they

remain low in a European perspective.

Challenges

The analysis above shows that a range of reforms have been implemented in recent years like for example to improve hospital efficiency and inpatient care supply or to promote the healthy life of the population in particular. Therefore, Hungary should continue to pursue them together with new challenging reforms. The main challenges for the

Hungarian health care system are as follows:

- To improve the long-term sustainability of health insurance system, to avoid negative consequences for access and equity. This may mean improving the basis for more sustainable and larger financing of health care (e.g. considering additional sources of general budget funds), with a better balance between resources and demand, between the number of contributors and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources

are brought into the sector, it is important that

they are pooled together through the strong

pooling mechanisms in place today.

- To foster effective coordination mechanism

between public entities responsible for

investment decisions and providers actually

using health care facilities.

- To continue efforts to strengthen care

coordination, by promoting the role of GPs and

avoiding unnecessary use of secondary and

tertiary care. On one hand, supply of human

resources to the primary care sector should be

fostered by providing an adequate set of

financial (performance-related component

added to the current capitation-based

remuneration) incentives. On the other hand,

control and organisational measures

strengthening the referral system should limit

the use of specialist and hospital care.

- To develop the mechanism of updating the

hospital payment system (relationship between

the actual costs of treatments and tariffs

become outdated). A sector-wide survey has

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been conducted recently in order to tackle this problem.

- To strengthen monitoring and control by modernising and developing information technologies as well as by supporting human resources involvement in the decision making process. To introduce effective mechanisms for assuring quality of care: clear definition of tasks and competences of the health care providers (especially in the area of emergency care), more stringent conditions for licensing and accreditation, consistent development and application of medical guidelines.

- To strengthen efforts to promote healthy lifestyles, in particular by preventing smoking, excessive alcohol consumption, unhealthy diet and physical activity. Public health has been

underlined as a priority in the development of
recent health strategy for the health system. In
this framework, the public health programme
should continue, the importance of medical
screening should be stressed.

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Table 1.13.1: Statistical Annex – Hungary

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 75 83 91 91 102 108 94 98 101 99 101 9289 9800 9934

GDP per capita PPS (thousands) 17.3 17.3 17.6 17.8 17.5 17.3 16.0 16.5 16.7 16.2 16.3 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 4.1 5.0 4.2 4.1 0.3 1.1 -6.6 1.3 1.9 -1.2 1.4 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 17.4 0.7 7.1 1.8 -6.9 -1.7 -3.1 5.5 1.5 -1.9 2.4 3.2
-0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 8.6 8.2 8.5 8.3 7.7 7.5 7.7 8.1 8.0 8.0 8.1 10.4 10.1 10.1

Total current as % of GDP 8.3 7.9 8.2 8.0 7.4 7.3 7.6 7.8 7.8 7.5 7.4 9.8 9.6 9.7

Total capital investment as % of GDP 0.3 0.3 0.3 0.3 0.3 0.2 0.2 0.2 0.2 0.4 0.7 0.6 0.5 0.5

Total per capita PPS 982 1038 1143 1204 1184 1221 1232 1324 1376 1397 1486 2828 2911 2995

Public as % of GDP 6.1 5.7 5.9 5.8 5.2 5.0 5.1 5.2 5.1 5.0 5.1 8.1 7.8 7.8

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Public current as % of GDP 5.9 5.5 5.7 5.5 5.0 4.9 5.0 5.0 4.9 4.7 4.8 7.9 7.7 7.7

Public per capita PPS 659 679 755 790 749 780 770 811 877 873 944 2079 2218 2208

Public capital investment as % of GDP 0.2 0.3 0.2 0.2 0.2 0.2 0.1 0.2 0.2 0.2 0.4 0.2 0.2 0.1

Public as % total expenditure on health 71.1 69.6 69.9 69.7 67.3 67.0 65.6 64.8 63.8 62.5 63.6 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 11.5 11.2 11.2 10.7 9.9 10.0 9.9 10.2 10.4 10.9 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0 97.0 97.0 97.0 96.0 96.0 96.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 26.4 25.8 25.8 25.0 26.3 26.4 25.9 27.0 28.0 29.1 27.5 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 10.1 10.1 10.1 10.1 10.1 10.0 10.0 10.0 10.0 9.9 9.9 502.1 504.5 506.6

Life expectancy at birth for females 76.7 77.2 77.2 77.8 77.8 78.3 78.4 78.6 78.7 78.7 79.1 82.6 83.1 83.3

Life expectancy at birth for males 68.4 68.7 68.7 69.2 69.4 70.0 70.3 70.7 71.2 71.6 72.2 76.6 77.3 77.8

Healthy life years at birth females 57.8 : 54.3 57.2 57.8 58.2 58.2 58.6 59.1 60.5 60.1 : 62.1 61.5

Healthy life years at birth males 53.5 : 52.2 54.4 55.1 54.8 55.9 56.3 57.6 59.2 59.1 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 158 147 130 121 119 114 113 111 223 219 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 7.3 6.6 6.2 5.7 5.9 5.6 5.1 5.3 4.9 4.9 5.0 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.25 2.10 2.16 2.08 1.95 1.89 1.88 1.91 1.88 1.94 1.94 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.10 0.09 0.08 0.08 0.08 0.09 0.09 0.09 0.09 0.14 0.15 0.18 0.18 0.19

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Out-patient curative and rehabilitative care 1.96 1.87 1.83 1.81 1.63 1.55 1.60 1.76 1.75 1.73 1.74 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 2.29 2.31 2.56 2.56 2.35 2.32 2.51 2.65 2.75 2.49 2.26 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.33 0.35 0.33 0.35 0.29 0.28 0.29 0.18 0.19 0.19 0.19 0.31 0.31 0.32

Prevention and public health services 0.41 0.36 0.37 0.34 0.31 0.30 0.34 0.35 0.31 0.26 0.20 0.25 0.25 0.24

Health administration and health insurance 0.10 0.09 0.09 0.09 0.09 0.09 0.09 0.11 0.11 0.13 0.13 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 1.96 1.84 1.89 1.82 1.74 1.69 1.66 1.68 1.65 1.73 1.74 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.08 0.07 0.07 0.07 0.07 0.08 0.08 0.08 0.07 0.13 0.14 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.06 1.00 0.96 0.92 0.86 0.87 0.89 0.92 0.91 0.91 0.93 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 1.45 1.37 1.58 1.60 1.22 1.14 1.22 1.29 1.28 1.04 0.96 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.18 0.21 0.20 0.20 0.14 0.16 0.18 0.09 0.10 0.10 0.10 0.13 0.12 0.13

Prevention and public health services 0.27 0.24 0.24 0.22 0.20 0.19 0.19 0.20 0.16 0.13 0.12 0.25 0.20 0.19

Health administration and health insurance 0.09 0.08 0.08 0.08 0.08 0.07 0.07 0.11 0.11 0.11 0.11 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.13.2: Statistical Annex - continued – Hungary

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative **care** 27.1% 26.5% 26.4% 26.0% 26.3% 26.0% 24.8% 24.4% 24.1% 25.7%
26.3% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative **care** 1.1% 1.1% 1.0% 1.0% 1.1% 1.2% 1.2% 1.2% 1.1% 1.9% 2.1% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative **care** 23.6% 23.6% 22.3% 22.6% 22.0% 21.3% 21.1% 22.5% 22.4% 22.9%
23.6% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 27.6% 29.1% 31.3% 32.0% 31.7% 31.9% 33.2% 33.8% 35.3%
33.0% 30.7% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 4.0% 4.4% 4.1% 4.3% 3.9% 3.9% 3.8% 2.3% 2.4% 2.6% 2.5%
3.2% 3.3% 3.3%

Prevention and public health services 4.9% 4.5% 4.5% 4.3% 4.2% 4.1% 4.5% 4.5% 4.0% 3.4% 2.7% 2.6% 2.6%
2.5%

Health administration and health insurance 1.2% 1.1% 1.1% 1.1% 1.2% 1.2% 1.2% 1.4% 1.4% 1.7% 1.8% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative **care** 33.5% 33.6% 33.2% 32.9% 35.1% 34.8% 33.5% 33.4% 33.5% 36.5%
36.6% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative **care** 1.3% 1.3% 1.2% 1.2% 1.5% 1.6% 1.6% 1.6% 1.5% 2.6% 2.9% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative **care** 18.1% 18.3% 16.8% 16.6% 17.3% 17.9% 18.0% 18.3% 18.5% 19.2%
19.5% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 24.8% 25.0% 27.7% 28.9% 24.6% 23.5% 24.6% 25.6% 26.0%
21.9% 20.2% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 3.1% 3.8% 3.5% 3.7% 2.9% 3.2% 3.6% 1.7% 2.1% 2.1% 2.0%
1.6% 1.6% 1.6%

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Prevention and public health services 4.6% 4.4% 4.2% 4.0% 4.0% 3.9% 3.8% 4.0% 3.2% 2.7% 2.4% 3.2% 2.7% 2.5%

Health administration and health insurance 1.6% 1.5% 1.4% 1.4% 1.6% 1.5% 1.4% 2.3% 2.2% 2.4% 2.4% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 0.26 0.26 0.26 0.26 0.28 0.28 0.28 0.30 0.30 0.28 0.30 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.3 0.3 0.3 0.3 0.3 0.3 0.4 0.4 0.4 0.4 0.4 0.9 0.9 0.8

CTS per 100 000 inhabitants 0.7 0.7 0.7 0.7 0.7 0.7 0.7 0.7 0.8 0.8 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.0 0.0 0.0 0.1 0.1 0.1 0.0 0.0 0.0 0.0 0.1 0.1 0.1

Proportion of the population that is obese 18.8 : : : : : 23.6 : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 30.4 : : : : 26.1 26.5 : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 13.1 13.1 12.9 13.2 12.6 11.6 11.5 10.8 11.4 11.2 : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 325 334 278 304 280 309 302 287 296 309 321 329 335 344

Practising nurses per 100 000 inhabitants 577 578 595 620 595 615 621 622 621 632 643 840 812 837

General practitioners per 100 000 inhabitants : : : : : 35 34 : : : : 78 78.3

Acute hospital beds per 100 000 inhabitants 555 553 554 555 416 413 413 414 415 398 399 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 12.2 12.5 12.9 12.8 10.8 11.3 11.9 11.6 11.8 11.8 11.7 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : 24.4 24.6 23.8 20.6 20.4 20.5 19.9 19.9 : : 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : 481 527 594 833 1,110 1,223 1,247 1,475 : : 6368 6530 7031

Acute care bed occupancy rates 77.0 77.0 76.0 70.0 69.0 75.3 74.3 71.6 71.1 69.2 : 72.0 73.1 70.2

Hospital curative average length of stay 6.7 6.5 6.3 6.1 5.6 5.6 5.4 5.4 5.3 5.2 : 6.5 6.3 6.3

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Day cases as % of all hospital discharges : 2.0 2.2 2.5 4.0 5.4 5.6 5.9 6.9 : : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 4.7 4.8 5.1 5.3 5.4 5.4

AWG risk scenario 4.7 5.0 5.6 5.9 6.1 6.2

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 9.9 9.8 9.7 9.5 9.3 9.2

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-7.5 3.1

0.8 0.9

1.5 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

Ireland has a GDP per capita of 33.9 PPS (in

thousands), far above the EU average of 27. 9.

Population was estimated at 4.6 million in 2013.

Total and public expenditure on health as % of

GDP

Total expenditure (133) on health as a percentage of

GDP (8.9% in 2013) has increased over the last

decade (from 7.3% in 2003, although it has

decreased since the 2009 peak of 10%) but is still

below the EU average (134) of 10.1% in 2013.

Public expenditure has increased, though to a

smaller extent: from 5.6% in 2003 to 6.0% of GDP

in 2013. Again, it is below the peak of 7.2% in

2009. It is also below the EU average of 7.7% in

2013.

When expressed in per capita terms, total current

spending on health at 3156 PPS in Ireland is above

the EU average of 2988 in 2013. However, public

current spending on health care is, at 2136 PPS,

lower than the EU average of 2208 PPS in 2013.

Expenditure projections and fiscal sustainability

According to Eurostat 2013 projections, total

population in Ireland is projected to increase from

around 4.5 million in 2011 to 5.3 million in 2060.

As a consequence of demographic changes, health

care expenditure is projected to increase by 1.2 pps

of GDP, above the average growth expected for

the EU (0.9) (135), according to the Reference

Scenario. When taking into account the impact of

(133) Data on health expenditure is taken from OECD health data

and Eurostat database. The variables total and public

expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(134) The EU averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units and units of staff where relevant. The EU

average for each year is based on all the available

information in each year.

(135) I.e. considering the "reference scenario" of the projections

(see The 2015 Ageing Report at

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

non-demographic drivers on future spending

growth (AWG risk scenario), health care

expenditure is expected to increase by 1.9 pps of

GDP from now until 2060 (EU 1.6).

Overall, for Ireland no significant short-term risks of fiscal stress appear at the horizon, though some macro-financial variables point to possible shortterm challenges.

Risks appear to be high in the medium term from a debt sustainability analysis perspective due to the still high debt at the end of projections (2026) and the high sensitivity to possible shocks to nominal growth and interest rates. High medium-term risks emerge also from the analysis of the sustainability gap indicator S1, again due to the high initial debtto-GDP ratio and the projected costs of ageing, thus leading to overall high risks for the country in the medium term.

No significant sustainability risks appear over the long run, despite increasing costs of ageing, due a relatively favourable initial budgetary position.

Health status

Life expectancy at birth (83.1 years for women and 79.0 years for men in 2013) is close to the respective EU averages (83.1 and 77.6 years of life expectancy in 2013).(136) However, healthy life

years, at 68 years for women and 65.8 years for men, were far above the EU averages of 61.8 and 61.6 in 2013. The infant mortality rate of 3.5 deaths per 1,000 live births (0.35%) 3.5 lower than the EU average of 3.9 deaths per 1,000 live births (0.39%) in 2013, having gradually fallen over most of the last decade (from 0.51% % in 2003), although it has been relatively flat since 2006.

As for the lifestyle of the Irish population, data from the 2015 Healthy Ireland survey has shown that 23% of the Irish population aged 15 and over are regular smokers This 2015 Healthy Ireland survey also shows that 23% of the Irish population aged 15 and over are obese while the survey also shows a reduction in alcohol consumption from

(136) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and Eurostat database.

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12.7 litres per capita in 2003 to 11 litres in 2015,

but still above the EU average of 10.0 in 2012.

System characteristics

Coverage

All persons ordinarily resident in the country are

entitled, subject to certain charges, to all in-patient

public hospital services in public wards including

consultant services and out-patient public hospital

services including consultant services. Some

groups are exempted from the charges (e.g.

pregnant women, those suffering from certain

medical conditions) and there is an annual cap of

EUR 750 for these charges. A medical card

ensures free access to all general practitioner

services, prescribed drugs (137), emergency,

inpatient, outpatient, certain dental aural

ophthalmic and maternity care. Those with an

income up to 50% above the income threshold for

a medical card are eligible to free general

practitioner services (GP visit card holders). Since

Summer 2015 all children under 6 years of age (1st

July 2015) and all persons of 70 years and older

(4th August 2015) are eligible for free general

practitioner services. The remainder of the

population are not entitled to free GP services.(138)

Non-medical card holders are not covered for

aural, ophthalmic and dental care and must also

pay the first EUR 144 each month towards

prescribed pharmaceuticals; thereafter the public

health system covers 100% of the cost.

Administrative organisation and revenue

collection mechanism

In 2013, 67.7% of total health expenditure funding

came from government sources (taxes at central

level) and from the Health Contribution Levy

(substituted by a new Universal Social Charge in

2011).

There has been an effort in recent years to reduce

administrative costs and improve the general

management of the sector. The Health Service

(137) A prescription charge of EUR 2.50 per item in respect of

items dispensed to medical card holders subject to a

monthly cap of EUR 25.00 per person or family.

(138) As a result, Ireland scores a bit above 5 on the scope of

basic coverage (the third lowest OECD value) and a bit below 5 out of 6 on the depth of coverage according to the OECD scoreboard.

Executive (HSE) was established under the Health Act 2004 as the single body with statutory responsibility for the management and delivery of health and personal social services in the Republic of Ireland. As outlined in the Health Act, 2004 the objective of the Executive is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.

As regards the funding of the HSE and the Department of Health, the budget is determined by the Parliament. Each year the Parliament (Oireachtas) votes public monies to fund the Department of Health and services provided by or on behalf of the HSE. Since the start of 2015 the HSE no longer has a separate Vote and its spending and funding are accounted for as part of the Health Vote. The HSE submits for the Minister for Health's approval, its National Service Plan

setting out the type and volume of Health and

Social **Care** services to be provided by the HSE

that year. The HSE is required to operate within

the limits of its allocation, as approved by

Parliament, in delivering at a minimum, the levels

of service which are provided for in the Plan.

During the course of the year, detailed information

related to service activity level and expenditure

levels are provided to the Minister by way of

monthly Performance Monitoring Reports against

the Plan.

Role of private insurance and out of pocket

co-payments

In recent years, private expenditure as a percentage

of total health expenditure has increased (from a

trough of 23.3% in 2003 to 32.3% in 2013) and is

above the EU average (22.6% in 2013).

Note also that more than 40% of the private

expenditure is voluntary community-rated health

insurance (139) (which 45.8% of the population

takes up) to help cover for a) cost-sharing

(complementary insurance) when not eligible for a

medical card, b) the services and goods excluded

from the benefit basket (supplementary) and c) the

same goods and services as the primary coverage

(139) See for instance McDaid D, Wiley M, Maresso A and

Mossialos E. Ireland: Health system review, Health

Systems in Transition, 2009; 11(4): 1 – 268.

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(duplicative). (140) It would be important that this

type of insurance does not discourage the recourse

to the most cost-effective services (e.g. more

primary care than specialist care or hospital care

when the latter are unnecessary).

Out-of-pocket payments are about 16.8% of all

health-expenditure and have increased since their

lowest value of 14.8 in 2007.

Types of providers, referral systems and patient

choice

The public health service is a mix of public and

private provision. Primary care is delivered in

public health centres and private premises of

general practitioners (GPs). In recent years,

Primary Care Centres have been developed within

which both GPs and a range of primary care

professionals employed by the HSE are housed.

Outpatient specialist care is delivered in hospital

outpatient departments. Approximately 85% of

acute care beds are within the public hospital

system. Persons may also decide to access services

in the private hospital sector and in most such

cases patients use private health insurance to meet

the costs involved.

The number of licensed physicians per 100 000

inhabitants in Ireland is, at 269, below the EU

average of 344 in 2013, below the 2010 peak of

308 (before which it had been steadily increasing).

The number of general practitioners (GPs) per 100

000 inhabitants was 73 in 2013, below the EU

average of 78.3. The number of nurses per 100 000

inhabitants (1240 in 2013) is far above the EU

average of 837.

Medical card and GP Visit card holders are free to

select any GP participating in the General Medical

Services (GMS) Scheme but must continue to use this GP subject to applying to and getting approval from the Health Service Executive (HSE) for a change of GP under the GMS Scheme. The remainder of the population make their own arrangements to access primary care physicians but must pay the full private fee for this service.

Access to specialist medical services in acute (140) In addition, in 2002 the Government established the National Treatment Purchase Fund to pay for the treatment in the private hospital sector of patients deemed to have been waiting for too long for surgery in the public hospital system.

hospitals is available only on foot of a referral by a primary care physician. The delivery of specialist medical care and care utilisation is strongly centred on hospitals where most specialists work.

(141) Authorities have planned the greater use of ICT and a standard approach to the use of electronic health information, which can help in implementing more effective referral systems and care coordination and as a consequence improve

effectiveness and efficiency of care (see below for more details).

In 2013 the number of acute care beds per 100 000 inhabitants was 211, compared to an EU average of 356. The number has been decreased since 2003.

Inpatient hospital discharges per 100 inhabitants in 2013 were, at 13.5, below the EU average of 16.5.

There were 20,270 day case discharges per 100,000 inhabitants in 2013, far above the EU average of 7,031. As a result, the ratio of day cases to longer stays is amongst the highest in Europe.

Acute care bed occupancy rates in 2010 were 93.8%, above the EU average of 70.2%. The rates have been increasing since a value of 85% in 2003.

Average length of stay has fallen from 6.5 in 2003 to 5.7 days in 2013, slightly below the EU average of 6.3.

It should be noted that hospital bed data for Ireland excludes private hospitals, and is therefore underreported compared with other countries. This also applies to hospital discharge data.

There is a Common Basket of services of the public health system that has to be delivered to the whole population covered.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

GPs are paid on a capitation (per number of registered patients) basis plus a fee-per-item basis for specified services (e.g. immunisations) for medical card and GP visit card patients (i.e. 40%

(141) Indeed, according to the OECD, the level of choice has a score of a bit more than 4 out of 6, while gatekeeping scores 2 out of 6.

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of the population as of June, 2013). (142),(143)

Heretofore, there has been limited room to use performance-related payments to encourage health promotion, chronic disease prevention or disease management actions. However, in 2015, a package of measures was introduced, including terms for the delivery of GP care without fees for

all children under 6 years and the provision of GP

care without fees to all persons aged 70 years and

over. These represent the first phase in the delivery

of a universal GP service. The new enhanced

under-6 service involves age-based preventive

checks focused on health and wellbeing and the

prevention of disease and also covers an agreed

cycle of care for children under 6 diagnosed with

asthma.

A Diabetes Cycle of Care for adult Medical Card

and GP Visit Card patients who have Type 2

Diabetes was also introduced in 2015.

Historically, specialists have been permitted to

engage in private fee-for-service practise in

conjunction with the receipt of salary as public

hospital employees. This dual practice in

conjunction with the presence of duplicative

private insurance (private insurance that covers the

same goods and services as the primary coverage)

riskled inducing specialists to devote an excessive

proportion of their time to private practice, with

consequent negative effects of the service for

public patients. In an attempt to mitigate the problem, in 2008 authorities negotiated a new employment contract for specialists, granting that a proportion of consultants will not have any fees from private practice while those who engage in private practice are obliged to have a minimum of 80% public patients workload. (144)

Public remuneration of doctors is determined by the central government and following the severe economic crisis national authorities have been strongly controlling the wages in the health sector.

Hospitals are paid or funded using a combination of prospective global budgets and activity-

(142) The remaining 60% of the population must pay GPs on a private fee per visit basis.

(143) The OECD score for remuneration incentives to raise the volume of care is 3 out of 6 for Ireland as a result of this mix of fee-for-service, salary and capitation systems.

(144) Monitoring arrangements based upon measurement of activity and case-mix have been introduced.

related/DRG payment. Efforts continue to improve cost transparency and efficiency in the sector.

The introduction of an activity-based funding

mechanism is a key health reform initiative. In May 2015, the authorities published an action plan for 2015-2017 to implement activity-based funding in public hospitals. The actual transition from block-funding of hospital activities is a gradual process that commenced in January 2016 and will extend over several years, starting with inpatient and day-cases before widening to outpatient care. In the longer term, the programme will consider implementation of activity-based funding in other areas such as emergency, community and home care. Activity-based funding is meant to improve quality, transparency, data collection and the allocation of resources across hospitals. It is important to note that while the new funding model will encourage hospitals to use resources at their disposal more efficiently within their overall budgetary ceilings, activity-based funding does not seek to reduce current expenditure on acute hospital services. Implementation of the forthcoming stages could prove challenging in the absence of a complete system of patient identifiers

and fully reformed financial management systems.

A new Healthcare Pricing Office (HPO) was established on an administrative basis in January 2014 to set the national DRG (145) prices on which the activity-based funding system is based and to manage the HIPE (146) dataset.

The market for pharmaceutical products

The initial price of all reimbursable medicines is based on clinical performance, economic evaluation, the cost of existing medicines and international prices (currently based on the average manufacturing price in BE, DK, FR, DE, NL, ES, UK, FI and AT in line with current agreement with industry). Discounts and rebates plus price freezes and cuts are measures to control expenditure directly. The authorities, through the Health Service Executive have established a Medicines Management Programme. A key focus of the programme is on cost-effective prescribing and the (145) Diagnosis-Related Groups (or DRGs) are a classification which groups hospital case types that are clinically similar and are expected to have a similar hospital resource usage.

(146) HIPE (Hospital Inpatient Enquiry) is the principal source

of national data on discharges from acute hospitals in

Ireland.

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reduction in drug expenditure through more

rational prescribing.

Pharmaceutical spending as a proportion of current

health spending increased from 15.4% in 2001 to

18.6% in 2010 and then fell to 17.8% by 2012

(OECD figures). .

The ESRI report "Pharmaceutical Prices,

Prescribing Practices and Usage of Generics in a

Comparative Context" was published in 2013 and

showed that prices for originator in-patent

medicines and generic medicines were higher in

Ireland compared to other EU Member States.

Several policies have been implemented to reduce

the price of pharmaceuticals and details of the

main policy initiatives are as follows:

- Price Reductions

Price reductions of the order of 30% per item

reimbursed have been achieved between 2009 and 2013; the average cost per item reimbursed is now running at 2001/2002 levels

- Agreement with Industry

The authorities have entered into a series of price reduction agreements with both the Irish Pharmaceutical Healthcare Association (IPHA) and the Association of Pharmaceutical Manufacturers in Ireland (APMI). Taking these Agreements together, it is estimated that cumulative savings in excess of EUR 1.5 billion have been generated between 2006 and 2014.

Successor agreements are expected to be introduced in 2016.

- Generic Substitution and Reference Pricing

The Health (Pricing and Supply of Medical Goods) Act 2013 is expected to promote price competition, a greater use of generics and deliver lower medicine prices for the taxpayer and for patients.

The act brought about significant structural change to the system of pricing and reimbursement of medicines in Ireland.

The impact of this legislation has been positive in terms of increasing the level of generic penetration in the Irish market. A target for generic penetration of the off-patent market by volume of 70% by end 2016 has been exceeded. Generics now account for over 70% of the total off-patent market by volume and over 50% by value.

Reference pricing, which involves setting a common reimbursement amount for designated interchangeable groups of medicines, has delivered savings in the region of EUR 50 million in 2014 and a further EUR 25 million in 2015.

Health and health-system information and reporting mechanisms/ Use of Health

Technology Assessments and cost-benefit analysis

The Health Information and Quality Authority (Incorporating the Office of the Chief Inspector of Social Services) was established in mid-2007. It has a broad range of functions which include the setting and monitoring of service standards and health technology assessment. The Chief Inspector of Social Services currently registers

regulates residential services for older people,
regulates residential and residential respite services
for children and adults with disabilities and
inspects children's residential centres, special care
units and foster care settings.

Future plans to develop HIQA's role include
extending the Authority's remit for standard setting
to private hospitals, overseeing a licensing system
for public and private healthcare providers and to
continue undertaking Health Technology
Assessments in priority areas to support
investment and disinvestment decisions.

The National Clinical Effectiveness Committee
(NCEC) is a Ministerial committee established in
2010. It provides oversight for the National
Framework for Clinical Effectiveness. Its terms of
reference are to prioritise and quality assure to the
level of international methodological standards a
suite of National Clinical Guidelines and National
Clinical Audit, prioritised, as significant for the
Irish healthcare system. Each guideline has a full
budget impact assessment and Health Technology

Assessment if required.

A policy mandate for guideline implementation is provided through Ministerial endorsement.

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Relevant Key Performance Indicators and audit are identified for each guideline to track and monitor implementation through the HSE Performance Assurance Reports, compliance with HIQAs National Standards for Safer Better Healthcare. It is intended that increased alignment with the clinical indemnity scheme and plans for licensing of hospitals will further strengthen the mandate for guideline implementation.

eHealth, Electronic Health Record

An eHealth – Strategy for Ireland was published in December 2013. This Strategy provided for the establishment of a new entity to be known as eHealth Ireland to be headed by a Chief Information Officer Though progress has been slower than initially set out, individual health

identifiers (IHIs) – the cornerstone of eHealth development – are now finally reaching an operational stage. eHealth Ireland has now been established and a Chief Information Officer was recruited in 2014 and is working on various strands of work. IHIs have been created, as a proof of concept, for 95% of the population, and will when operational be piloted in key strategic systems in the acute and primary care sectors. By 2017, a maternity newborn system is to be rolled out, issuing an IHI to all newborns automatically. A business case for the development of an EHR for Ireland is being finalised and will be published later in 2016 for initial deployment following approval in the new National Children's Hospital.

Recently legislated and/or planned policy reforms

Legislation has been introduced to provide for charging of all private in-patients in public hospitals.

The Nursing Homes Support Scheme (NHSS), often referred to as the “Fair Deal” is a scheme of financial support for people who require long-term

nursing home care. The statutory based scheme commenced on the 27th October 2009 with the enactment of the Nursing Homes Support Scheme Act 2009 and replaced the former Nursing Home Subvention scheme which had been in existence since 1993. The NHSS is operated by the HSE. This Scheme was reviewed and a report of the Review was published in 2015. Work is underway in implementing the recommendations contained in the Review.

The Government has embarked upon a major programme of health reform, the aim of which is to deliver universal healthcare, where access to healthcare is based on need and not on ability to pay.

In April 2014, the White Paper on Universal Health Insurance was published which set out in some detail a proposed UHI model. Following its publication, the Department of Health initiated a major costing project, involving the ESRI, the Health Insurance Authority and others, to examine the cost implications of a change to the particular

UHI model proposed in the White Paper.

The reports detailing the estimated cost of this UHI model were published on the 18 November 2015.

Having considered the findings, it was concluded that the high costs associated with the White Paper model of UHI were not acceptable and that there was a need for further research and cost modelling in relation to the best means to achieve universal healthcare. This work will be carried out under the auspices of the joint Department of Health/ESRI Three-Year Research Programme on Health Reform. Both the research undertaken to date and that planned in the next phase of the costing exercise will assist in deciding on the best longterm approach to achieving the goal of universal healthcare.

In the meantime, work is progressing on key health reforms that are major milestones on the road to universal healthcare and have the potential to drive performance improvement and deliver significant benefits in terms of timely access to high quality

care. They include: Healthy Ireland and the public health agenda; building sufficient capacity to

satisfy unmet demand; the expansion and development of primary and social care and reforming structures, ICT and financial systems with key initiatives such as the phased extension of GP care without fees, the establishment of Hospital Groups and Community Healthcare Organisations, the implementation of activity-based funding and the improved management of chronic diseases.

The Irish National Dementia Strategy was launched in December 2014. This delivers on a commitment in the Programme for Government to Health care systems

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develop a national Alzheimer's and other dementias strategy to increase awareness, ensure early diagnosis and intervention and develop enhanced community based services.

The Department of Health and the HSE have agreed a joint initiative with the Atlantic Philanthropies to implement significant elements of the Strategy over the period 2014-2017. This

National Dementia Strategy Implementation

Programme represents a combined investment of EUR 27.5m, with Atlantic Philanthropies contributing EUR 12million, and the HSE contributing EUR 15.5million. This programme will promote a greater focus on timely diagnosis of dementia and on the value of early intervention, along with the long-term objective of making people in Ireland generally more aware and understanding of the needs of people with dementia, and of the contribution that those with dementia continue to make to our society.

A National Office for Dementia has been established within the HSE to coordinate the implementation of the Strategy.

A Monitoring Group, chaired by the Department of Health, has been established to assist with and advise on implementation of the National Dementia Strategy, including the National Dementia Strategy Implementation Programme.

The introduction of activity-based funding and a Healthcare Pricing Office described under “Price

of healthcare services, purchasing, contracting and remuneration mechanisms" above will help to deliver greater efficiency and transparency in the delivery of services and therefore will enhance the sustainability of the health system.

Finally, the Department of Health has launched a pilot data collection of the private hospital sector.

This is an important step in order close the current data gap, and allow statistics for Ireland to be viewed in a more comparable way with other Member States.

Challenges

- To consider changes in payment procedures to physicians (e.g. through the use of mixed payment schemes) to encourage health promotion, disease prevention and disease management activities in primary **care** and make primary **care** more attractive; To implement measures to prevent chronic diseases and their complications.
- To continue to enhance primary **care** provision by increasing the numbers and spatial

distribution of primary care professionals and

ensuring an effective referral system from

primary to specialist care and from specialist to

primary care. This could improve access to

care by different population groups and reduce

unnecessary use of hospital care and therefore

overall costs. A related challenge in

streamlining patient care is the introduction of

individual patient identifiers which is being

addressed. These improvements could be

complemented with incentives for patients,

both financial and non-financial, to encourage

the use of primary care versus specialist care.

- To reduce unnecessary use of specialist and

hospital care and within hospitals, ensuring that

care is provided in the most clinically

appropriate and cost-effective way, for

example by maximising the proportion of

elective care provided on a day case basis, dayof-

surgery admission and reducing

inappropriate lengths of stay.

- To explore the means to improve the way private and public provision are better integrated in an overall provision framework and reconsider the current system of payment incentives which may be detrimental to public patients and the public sector.

- To consider additional measures regarding direct pharmaceutical expenditure control, product reimbursement on the basis of costeffectiveness information and greater use of generics vs. branded medicines.

- To continue to enhance managerial accountability and decrease administrative costs while aligning incentives (payments, cost-sharing) with national public health goals and effectiveness and efficiency. The efforts in setting up activity-based costing should help improve quality, transparency, data collection and a reallocation of resources across hospitals

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- To improve data collection in some crucial

areas such as resources and care utilisation.

Better monitoring of activity in the sector,

combined with greater use of health technology

assessment could be used for planning

purposes and for defining the extent of costsharing.

The work to develop IHIs should be a

key plank of future developments.

- To further enhance health promotion and

disease prevention activities i.e. promoting

healthy life styles and disease screening given

the recent pattern of risk factors (diet, smoking,

alcohol, obesity).

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Table 1.14.1: Statistical Annex – Ireland

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 146 156 170 185 197 188 169 166 174 175 179 9289 9800 9934

GDP per capita PPS (thousands) 30.0 30.9 31.8 32.9 34.5 32.0 30.7 33.0 33.8 34.0 33.9 26.8 28.0 27.9

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Real GDP growth (% year-on-year) per capita 2.0 2.4 3.7 2.8 1.9 -4.2 -7.3 -1.5 1.8 -0.1 -0.6 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 5.0 7.0 2.9 2.0 6.6 9.4 2.6 -8.8 -3.7 1.7 0.0 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 7.3 7.6 7.6 7.5 7.9 9.0 10.0 9.2 8.7 8.9 8.9 10.4 10.1 10.1

Total current as % of GDP 6.6 6.8 6.9 7.0 7.2 8.3 9.2 8.5 8.0 8.1 : 9.8 9.6 9.7

Total capital investment as % of GDP 0.7 0.8 0.6 0.5 0.7 0.7 0.7 0.7 0.7 0.8 : 0.6 0.5 0.5

Total per capita PPS 2394 2681 2837 2991 3234 3424 3375 3045 3000 3063 3156 2828 2911 2995

Public as % of GDP 5.6 5.8 5.8 5.7 6.0 6.8 7.2 6.4 5.9 6.0 6.0 8.1 7.8 7.8

Public current as % of GDP 5.0 5.2 5.2 5.2 5.4 6.2 6.7 5.9 5.5 5.5 : 7.9 7.7 7.7

Public per capita PPS 1770 1964 2074 2176 2319 2443 2294 1983 2035 2070 2136 2079 2218 2208

Public capital investment as % of GDP 0.6 0.6 0.5 0.4 0.5 0.5 0.5 0.5 0.4 0.4 : 0.2 0.2 0.1

Public as % total expenditure on health 76.7 76.3 76.0 75.4 75.7 75.4 72.6 69.6 67.8 67.6 67.7 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 19.3 19.6 19.2 18.8 18.5 17.8 17.3 12.1 15.5 16.7 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 15.3 15.0 16.0 16.1 14.8 15.3 16.1 18.2 17.7 16.9 16.8 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 4.0 4.0 4.1 4.2 4.3 4.5 4.5 4.5 4.6 4.6 4.6 502.1 504.5 506.6

Life expectancy at birth for females 80.7 81.1 81.3 81.7 82.1 82.4 82.7 83.1 83.0 83.2 83.1 82.6 83.1 83.3

Life expectancy at birth for males 75.7 76.1 76.7 76.9 77.3 77.9 77.8 78.5 78.6 78.7 79.0 76.6 77.3 77.8

Healthy life years at birth females 65.4 64.2 64.0 64.9 65.6 65.1 65.2 66.9 68.3 68.5 68.0 : 62.1 61.5

Healthy life years at birth males 63.4 62.5 62.9 63.2 62.9 63.5 63.9 65.9 66.1 65.9 65.8 : 61.7 61.4

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Amenable mortality rates per 100 000 inhabitants* 66 60 59 57 53 55 50 48 117 110 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 5.1 4.6 3.8 3.9 3.2 3.8 3.3 3.6 3.5 3.5 3.5 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 3.13 2.99 3.01

Day cases curative and rehabilitative care : : : : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care : : : : : 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.10 1.10 1.20 1.20 1.30 1.50 1.60 1.60 1.40 1.40 : 1.60 1.55
1.44

Therapeutic appliances and other medical durables : : : : : 0.31 0.31 0.32

Prevention and public health services : : : : : 0.25 0.25 0.24

Health administration and health insurance : : : : : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : : : : 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care : : : : : 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.72 0.79 0.84 0.90 0.94 1.10 1.23 1.22 1.13 1.13 : 0.79 1.07
0.96

Therapeutic appliances and other medical durables : : : : : 0.13 0.12 0.13

Prevention and public health services 0.20 0.20 0.20 0.20 0.20 0.20 0.20 : : : 0.25 0.20 0.19

Health administration and health insurance 0.14 : : : : : 0.11 0.27 0.27

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EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.14.2: Statistical Annex - continued – Ireland

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : : : : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : : : : : 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 16.7% 16.2% 17.3% 17.1% 18.1% 18.1% 17.3% 18.8% 17.6%
17.3% : 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : : : : : 3.2% 3.3% 3.3%

Prevention and public health services : : : : : 2.6% 2.6% 2.5%

Health administration and health insurance : : : : : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : : : : : 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : : : : 2.0% 2.1% 2.3%

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Out-patient curative and rehabilitative care : : : : : 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 14.3% 15.3% 16.0% 17.2% 17.3% 17.6% 18.2% 20.8% 20.7%
20.3% : 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : : : : 1.6% 1.6% 1.6%

Prevention and public health services 4.0% 3.8% 3.8% 3.8% 3.7% 3.2% 3.0% : : : 3.2% 2.7% 2.5%

Health administration and health insurance 2.8% : : : : : 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants : : : 0.80 0.85 0.90 1.19 1.24 1.31 1.24 1.33 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants : : 1.1 1.3 1.4 1.4 1.5 1.5 1.6 1.7 1.8 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : 0.1 0.2 0.2 0.2 0.2 0.2 0.2 0.1 0.1 0.1

Proportion of the population that is obese : : : 23.0 : 28.5 : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : : : 29.0 27.0 : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 12.7 14.3 13.4 13.4 13.4 12.4 11.3 12.8 12.0 11.8 : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants : : : 272 280 290 301 308 267 271 269 329 335 344

Practising nurses per 100 000 inhabitants : 1246 1236 1274 1296 1288 1274 1294 1261 1260 1240 840 812 837

General practitioners per 100 000 inhabitants 51 52 51 51 53 52 54 56 72 72 73 : 78 78.3

Acute hospital beds per 100 000 inhabitants 280 278 276 270 265 256 234 221 217 209 211 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita : : : 3.3 : : 3.8 : : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 13.7 13.8 13.6 13.7 13.7 13.5 13.2 13.0 12.9 13.7 13.5 16.6 16.4
16.5

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Day cases discharges per 100 000 inhabitants 9,749 10,466 10,667 15,542 16,500 17,425 18,404 18,998 19,311 20,016 20,270 6368 6530 7031

Acute care bed occupancy rates 85.0 85.0 86.0 87.0 87.0 88.8 89.2 91.4 91.9 92.6 93.8 72.0 73.1 70.2

Hospital curative average length of stay 6.5 6.4 6.5 6.3 6.1 6.2 6.1 6.0 5.9 5.9 5.7 6.5 6.3 6.3

Day cases as % of all hospital discharges 41.5 43.1 44.0 53.2 54.6 56.3 58.1 59.3 60.0 59.4 60.0 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 6.0 6.3 6.9 7.3 7.3 7.2

AWG risk scenario 6.0 6.5 7.4 8.0 8.1 7.9

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 4.6 4.6 4.6 4.7 5.0 5.3

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

14.3 3.1

1.2 0.9

1.9 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population;

GDP per capita (25,158 PPS in 2013) is slightly

under the EU average (27,900 PPS in 2013)

slightly down from 26,067 in 2012. After a

moderate growth in 2015 (0.8%), Italy's economic

growth is expected to pick-up in 2016, with a

projected rate of 1.4%, and in 2017, roughly stable

at 1.3%. (147)

Population, estimated as 59.7 million in 2013, is

projected to increase to 66.3 million in 2060,

which at 10.1% (148) represents a higher growth

rate with respect to the average for the EU (3.1%

over the same period).

Total and public expenditure on health as % of

GDP, per capita PPP, public expenditure as %

of total government expenditure. Recent

trends and vs. EU average;

Total (public plus private) expenditure (149) on

health as a percentage of GDP (9.1% in 2013) is

below the EU average (150) (10.1% in 2013). It has

increased from 8.2% in 2003. Public expenditure

on health as a percentage of GDP is also slightly

below the EU average (7.1% vs. 7.8% in 2013), up

from 6.2% in 2003. Total (2394 PPS) and public

(1868 PPS in 2013) per capita expenditure were

below the EU average (2988 PPS and 2208 PPS in

2013), having consistently increased since 2003

(1934 PPS and 1412 PPS).

The significant slowdown of the increase in the

public health care expenditure has been achieved

due to the governance regulations and procedures

implemented in the last years, namely the Health

Pact between State and Regions, the monitoring of

the fulfilment of the budget objectives and the

activation of the Deficit Reduction Plan procedure

(147) European Commission (2016), European Economic

Forecast - Winter 2016.

(148) The increase rate is calculated using value of 60.2 as a

starting level for 2013.

(149) Data on expenditure is taken from WHO HFA DB 2015.

(150) The EU averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units or units of staff where relevant. The EU

average for each year is based on all the available

information in each year.

for those regions not complying with the agreed

budget rules. As a result, public health care

expenditure has grown by an annual average of 1.0

% in nominal terms over the period 2006-2014,

against the 7.1% of the period 2000-2006 (151).

Expenditure projections and fiscal sustainability

As a result of ageing, health care expenditure is

projected to increase by 0.7 pps of GDP until 2060

(below the average change in the EU of 0.9 pps).

(152) When taking into account the impact of nondemographic

drivers on future spending growth

(AWG risk scenario), health care expenditure is

expected to increase by 1.2 pps of GDP from now

until 2060 (EU: 1.6).

Medium term sustainability risks for Italy mainly

derive from the high debt-to-GDP ratio and do not

stem from health care expenditure and the

projected cost of ageing. (153)

Health status and disability (life expectancy,

healthy life years, mortality, infant mortality)

Life expectancy at birth (85.2 years for women and

80.3 years for men in 2013) is above the EU average (83.3 and 77.6 years in 2013). Healthy life years at birth are for men (61.8 in 2013) and for women (60.9 in 2013) similar, though the first higher and the second lower, to the EU average (respectively 61.4. and 61.5).

System characteristics

System financing: taxed-based or insurancebased

A regionally based National Health Service

(NHS), with a division of responsibilities between

the central government and the regional

governments (set by the 2001 Constitutional

(151) Ministero dell'economia e delle finanze – RGS (2015),

Il_monitoraggio_del_sistema_sanitario, Report no.2.

[http://www.rgs.mef.gov.it/Documenti/VERSIONE-I/Attivit--](http://www.rgs.mef.gov.it/Documenti/VERSIONE-I/Attivit--i/Spesa-soci/Attivit-monitoraggio-RGS/2015/IMDSSRS02_15_09_2015.pdf)

[i/Spesa-soci/Attivit-monitoraggio-RGS/2015/IMDSSRS02_](http://www.rgs.mef.gov.it/Documenti/VERSIONE-I/Attivit--i/Spesa-soci/Attivit-monitoraggio-RGS/2015/IMDSSRS02_15_09_2015.pdf)

[15_09_2015.pdf](http://www.rgs.mef.gov.it/Documenti/VERSIONE-I/Attivit--i/Spesa-soci/Attivit-monitoraggio-RGS/2015/IMDSSRS02_15_09_2015.pdf).

(152) I.e. considering the "reference scenario" of the projections

(see the 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

(153) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

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Amendment), and funded mainly by taxation,

provides full coverage of resident population. (154)

Starting from 2013, a new mechanism has been set

for the distribution of financial resources among

regions, according to the procedure envisaged in

legislative decree 68/2011, which may be

summarised as follows:

1. each year, the total amount of resources

addressed to the financing of health system

(according to the evolution of macroeconomic

variables and budget constraint) is defined (so

called "fabbisogno nazionale standard");

2. 5 benchmark regions are identified, among

regions which:

- have guaranteed the delivery of health services

efficiently and appropriately ensuring, at the

same time, a budget balance position;

- have fulfilled the achievements

("Adempimenti") foreseen by law, according to

the assessment of the relevant Committee (socalled

"Tavolo degli Adempimenti");

- have reached a high score in health quality

ranking, according to the set of indicators

envisaged in the Health Pact;

3. three regions out of the 5 benchmark ones are

selected by the Conference of regions, being

fixed the top ranked region;

4. the average regional standard costs are

computed on the basis of the actual costs of

the three reference regions;

5. standard costs are applied to the regional

population, weighted with regional age

structure;

6. the resulting distribution is applied to the

fabbisogno nazionale standard, obtaining the

fabbisogno sanitario of each region

("fabbisogno regionale standard").

(154) Including foreign citizens, and their dependent relatives,

who are in one of the following positions: a) employed; b)

enrolled in the employment lists; c) had applied for a

renewal of the permit of stay. As for dispositions

concerning non- EU citizens, see law 40/1998, articles 32-

34.

The financial coverage of the regional fabbisogno

sanitario is guaranteed through a mix of financial

resources:

1. the regional tax on production activities

(IRAP);

2. the surcharge on personal income tax;

3. revenues of the ASL/AO (Local Health

Bodies/Hospital Bodies - Aziende Sanitarie

Locali/Aziende Ospedaliere) from either sale

of services or fees paid by citizens (so-called

“tickets”);

4. as for Regions with ordinary institutional

status (regioni a statuto ordinario), a share of

VAT revenue is granted to cover the

difference between their fabbisogno sanitario

and the resources obtained through the

financial channels under points a)-c);

5. as for Regions with special institutional status

(regioni a statuto speciale), the quota of their

fabbisogno sanitario not covered by the

financial channels under points a)-c) is to be

financed through their own resources

(additional contribution) (155).

Regions are required to ensure a budget balance

position. If they fail to comply with this

requirement, a set of automatic measures is

foreseen in order to restore the budget balance

position (mainly the increase of regional taxes). In

case of a deficit exceeding the 5% threshold

(computed as a ratio between the value of regional

deficit in nominal terms and the financial resources

assigned to regions to finance health expenditure),

regions are obliged to present a 'Deficit Reduction

Plan' (Piano di Rientro). The latter has a time

horizon of three years and lays down all the

necessary measures to be taken by the region

concerned to achieve the budgetary balance.

(155) For region Sicily only, this additional contribution accounts

for at maximum 49.11% of its fabbisogno sanitario. The

remaining part is financed by the National Health Fund

(Fondo Sanitario Nazionale).

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Revenue collection mechanism (tax/social security contributions/premium)

In 2013, 78% of total health expenditure funding came from earmarked public sources, including regional tax on production activities (corporation tax on the value added of companies and on the salaries of public sector workers - IRAP), regional surcharge on income tax and a share of VAT revenue (see §. 1).

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions

According to the organisational setting of the

Italian Health Care System, the Ministry of Health, in agreement with the Ministry of Economy and Finance, defines general objectives and national policy priorities, as well as the basic levels of health care treatments which are provided for free over the national territory (so called Livelli

Essenziali di Assistenza-LEA); regions are in charge with planning, coordinating and providing health services (including primary, specialist outpatient and hospital care, health promotion, disease prevention and rehabilitation, long-term nursing and psychiatric care) for their residents.

They have large autonomy in the way they organise care delivery, within the general framework designed at national level. The funds to be allocated to each type of care are somewhat determined by both the central government and regions.

A committee (so-called Comitato LEA) is in charge of monitoring the provision of LEAs in each region; the committee is composed of representatives of the ministries concerned (Health and Economy and Finance), the Department of Regional Affairs (within the Presidency of the Council of Ministers) and Regions (156).

Regions may choose to provide extra LEA benefits, and some do, but the relative costs should be covered through their own financial resources.

(156) Such a committee was first established in 2005, according

to article 9 of the Health Pact of 23rd March 2005.

Recently, the budget law for 2016, has foreseen the

establishment of the National Committee for the

updating of LEA.

Coverage (population)

Health services are provided for free to all citizens;

however, a fee (co-payment) may be requested for

the provision of some health services (e.g.

specialist health services) depending on income

and age requirements.

Treatment options, covered health services

Primary care and hospital inpatient care are free at

the point of use. Outpatient specialist consultations

that follow a referral from a general practitioner

(GP - family doctor), diagnostic procedures

involve a small fee as do pharmaceuticals

prescribed by a physician in those regions who

have chosen to use a fee. Unwarranted visits to

emergency departments also involve a fee. Dental

care is guaranteed for specific groups of the

populations (children, vulnerable groups such as

disabled, people with HIV and those with rare

diseases) and in emergency cases, while others

purchase dental care are out-of-pocket. Eyeglasses

and contact lenses and dental prostheses are not

funded or provided by regions. Patients visiting a

physician without a referral or buying over-the-counter

medicines have to pay for the full cost of

care out of their pockets. Children below 6, and

elderly (65+) individuals with an income below a

certain threshold, pregnant women and people with

certain medical conditions are exempted from costsharing.

According to the OECD (2010) 15.6% of

the population buys duplicative private insurance

(to cover for the same services covered by public

provision/ funding).

Waiting times and lists for specialist consultation

and hospital surgery are considered long by the

population and there are important regional

variations in the waiting time, which are seen as a

problem in Italy. To reduce waiting times, the 28th

of October 2010 the Agreement between the

Government, the Regions and Autonomous

Provinces on the Government National Plan of

waiting lists (PNGLA) for 2010-2012 was signed.

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(157). In addition, patients are allowed to obtain

hospital **care** in other regions and there is a system

of interregional compensation whereby regions

paid for the patients they send away and receive

the payments of those who come into the region to

receive treatment. The interregional mobility is

directly related to the right of citizens to choose

health **care** treatments, for example by accessing

high specialised health structures located out of

their own region.

Role of private insurance and out of pocket

co-payments

In 2013, 18% of total (public and private) health

care expenditure came from out-of-pocket

payments and 4 % from private insurance. The

remaining 78% was publicly funded. Out-of-pocket

payments in Italy are currently above EU

average (14.1 in 2013).

Types of providers, referral systems and patient choice

As the responsibility for care delivery has been delegated to the regions there may be differences in the way the various types of care are organised/delivered.

In general, health care services are provided for free through public providers (ASLs, public hospitals, university public hospitals) as well as private accredited providers. Health services can be delivered also by private non-accredited providers but the relative costs are fully charged on the users.

Primary care is provided by independent general practitioners (GPs) and paediatricians acting on the basis of a contract with the NHS, and running their activities in single practices or in joint practices (for which a financial incentive is provided).

Outpatient specialist care is provided by specialist doctors in outpatient departments in hospitals as well as in private ambulatories (both accredited

and not accredited). A decree of Ministry of health

(issued according to Decree law 78/2015,

converted into Law 125/2015) has recently laid

(157) For further information, see:

http://www.salute.gov.it/portale/temi/p2_5.jsp?area=qualita

&menu=liste.

down supplying conditions and appropriateness

indications, which doctors must report in their

prescriptions. In case doctors do not comply with

this obligation, the additional part of their

compensation is reduced and any specialist care

provided in contrast with the decree is charged to

patients.

Day case and inpatient care also take part in

hospitals. Provision has traditionally been public

but currently health services are provided also by

private providers. According to the OECD (2012),

about 68% of all acute hospital beds are public, 4%

are private not-for profit and 28% is private for

profit. Some public hospitals (Aziende

Ospedaliere) have also been given financial and

technical autonomy (contracting with the ASLs), while others remain under the direct management of the ASLs.

The ASLs oversee also health promotion, disease prevention and occupational diseases activities.

The number of practising physicians per 100 000 inhabitants (390 in 2013) is above the EU average (344 in 2013). The number of GPs per 100 000 inhabitants (75 in 2013) is in line with the EU average (78.3 in 2013). The number of nurses per 100 000 inhabitants (614 in 2013) is below the EU average of 837.

Authorities' efforts to encourage the use of primary

care vis-à-vis specialist and hospital care include compulsory registration with a GP and a compulsory referral system from primary to secondary care (i.e. GPs act like gatekeepers to specialist and hospital care), while allowing patient choice of GP, specialist and hospital. (158) The coverage of primary care services in health centres is guaranteed over 24 hours, through the primary care out of hours (so called guardia medica). Over

time there has been a strong emphasis on primary

care as the first point of access to care, emphasis

that is to continue to ensure quality and efficiency

of care. Patient satisfaction with primary care GPs

and paediatricians is high. Moreover, authorities

have been introducing a number of ICT and

eHealth solutions to allow for nationwide

electronic exchange of medical data (including

patient electronic medical records and patient e-

(158) Indeed, according to the OECD, the level of choice of

provider and gatekeeping in Italy both score of 6 out of 6.

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card) to support care coordination, reduce medical

errors and increase cost-efficiency as well as

monitoring activity and consumption.

The number of acute care beds per 100 000

inhabitants (275 in 2012) is below the EU average

(360 in 2012; 356 in 2013). In line with the EU

trend, the number of acute beds in Italy has been

decreasing over the last decade (351 in 2003), as a result of the policies run over the last years aimed at reducing the rate of acute beds towards the standard levels set by the current legislation. (159)

In some areas there may be a shortage of followup/

long-term care beds/ facilities which might

create bed-blockages in acute care. It is regional

government to plan for the number of hospitals,

the provision of specific specialised services.

Pricing, purchasing and contracting of

healthcare services and remuneration

mechanisms;

Primary care physicians are paid on a capitation

basis, while outpatient and inpatient specialists

acting in public structures are paid by a salary. The

pay scale is determined at national level. Primary

care physicians appear to be eligible to receive

bonuses regarding preventive care or disease

management activities. (160) Private sector doctors

are paid a fee-for-service.

Hospitals remuneration is on a payment per case

basis using DRGs. (161) Hospital remuneration

methods are defined at central level with the DRG

weights and other service rates negotiated at

regional level.

(159) According to law decree 65/2012, the standard rate for

acute care beds is set at 300 per 100 000 inhabitants.

(160) It is foreseen by article 8 of the National General

Agreement (Accordo nazionale collettivo) concerning the

discipline of GP.

(161) The OECD score for remuneration incentives to raise the

volume of care in Italy is a bit more than 3 out of 6 as a

result of the use of activity related payment in hospital

remuneration though not in other areas..The OECD overall

efficiency score for Italy is slightly higher than its group

average (about 1.8 years potential gain to be made through

greater efficiency in the sector compared to the group

average of 2.6 years) and above the OECD average (2.3

years). There are nevertheless areas for improvement

including: continue to improve efficiency in the hospital

sector notably through the publication of comparable

information on activity and quality and/or through an

element of activity related payment of physicians;

increasing consistency in the allocation of resources across

levels of government.

When looking at hospital activity, inpatient discharges per 100 inhabitants are below the EU average (11.8 vs. 16.5 in 2013). As day case discharges have, similar to inpatient discharges, been decreasing (contrary to the EU (162) trend), also day cases discharges per 100.000 inhabitants is now below the EU average (4070 in Italy and 7031 as EU average in 2013). Overall acute hospital average length of stay (6.8 days in 2013) (163) is slightly above the EU average (6.3 days in 2013).

The market for pharmaceutical products Total (1.6%) and public (0.8%) expenditure on pharmaceuticals as a percentage of GDP was about and below the EU average (respectively 1.4% and 1%) in 2013. Total (18.2 %) and public (11.9%) pharmaceutical expenditure as a percentage of total current health expenditure is respectively above and slightly below the EU average (14.9% and 12.5% in 2013). The policy priority is to keep under control the dynamics of public

pharmaceutical expenditure by fixing appropriate

ceilings as a share of the financing level of the

National Health Service (Servizio Sanitario

Nazionale - SSN) contributed by the State. (164)

The authorities have implemented a number of

policies to control expenditure on pharmaceuticals,

based on (i) limits to expenditure dynamics and (ii)

control of pharmaceuticals prices. Expenditure

rules on pharmaceutical products exist since 2001;

however, since 2008, a new rule was introduced,

foreseeing thresholds for pharmaceutical products

supplied by pharmacies or, directly, by the ASLs.

The rule establishes two expenditures ceilings for

pharmaceutical products (including patient copayments)

expressed as a percentage of the

financing level for the National Health Service

contributed by the State. Starting from 2013, the

thresholds are set as follows:

- 11.35% for pharmaceutical products supplied

by pharmacies;

- 3.5% for pharmaceutical products supplied by

hospitals.

(162) This refers to the aggregate EU-28.

(163) Eurostat, Last update 10.07.15, In-patient average length of

stay (in days), Services of curative care.

(164) For the details, see section 6.

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- The expenditure ceilings must be respected

both at regional and national levels.

As for the latter expenditure item, since 2008 an

automatic procedure (so-called pay-back) is in

place to compensate for possible overruns.

Concerning price control policies, the initial price

of a new pharmaceutical product is based on

clinical performance, economic evaluation, on the

cost of existing treatments. There are controlled

price updates. Price setting involves important

negotiations between the Italian Pharmaceutical

Agency (Agenzia Italiana del Farmaco - AIFA)

and the pharmaceutical companies and

negotiations take into consideration the social

relevance of the disease, the effect of the

medicines, the expected utilisation and financial

impact, prices in other countries, prices of similar products in Italy. Discounts, payback and price freezes and cuts are some of the mechanisms used to directly control expenditure. There is a positive list of reimbursed products which is based on health technology assessment information/ economic evaluation. Reference pricing for reimbursement purposes is also applied. For medicines for which generics are available the reimbursement level is set at the lowest price of the drugs in a group (defined as drugs with same active ingredient, bioequivalent form and therapeutic indications), and the cheapest price must be at least 20% lower than the originator product. For those without generics, the reimbursement level of a new drug is based on a sort of average cost of a defined group of medicines that are related but slightly different chemically.

Authorities promote rational prescribing of physicians through treatment and prescription guidelines complemented with education and

information campaigns on the prescription and use of medicines and the monitoring of prescribing behaviour (by regions and ASLs). GPs receive some kind of feedback on their prescription patterns. Authorities also pursue information and education campaigns directed at patients and some regions have introduced a small fee for either pack or receipt to make patients more sensitive to the cost of medicines and encourage a rational use of medicines on the patients' side. There is an explicit generics policy. Generic sales' targets are set by the Italian Pharmaceutical Agency. Generic substitution takes place i.e. pharmacies are obliged to offer the generic medicine when available. If patients refuse a generic, they will have to pay the difference between the reimbursement price of the branded drug and the pharmacy retail price of the cheapest available generic. Generics are exempted from the mandatory discount of pharmacies to the NHS so as to encourage pharmacies to hold and sell generics.

In order to monitor and keep under control the dynamics of pharmaceutical expenditure and GP's

prescriptions, an comprehensive information

system called “Sistema Tessera sanitaria” has

been implemented

Use of Health Technology Assessments and

cost-benefit analysis

Health Technology Assessment is undertaken at

various levels although there is no national

structure responsible for conducting, promoting,

coordinating or financing HTA. There are clinical

guidelines for medical interventions and medicines

established through the National Programme on

Clinical Guidelines.

eHealth (e-prescription, e-medical records)

Starting from 2003, the “Tessera Sanitaria”

information system (herehence “TS”) has been

gradually implemented under the supervision and

management of the Ministry of Economy and

Finance - Department of General Accounts. In

2009, such a system was fully implemented in all

regions and since then it has been regularly utilised

for the monitoring of the full procedure for

pharmaceutical and specialist care provisions, from

the prescription to the delivery. Besides, through a set of performance indicators, the Tessera Sanitaria system allows to make cross-regional comparative analysis on the efficiency and appropriateness of prescriptions.

Since 2013, the TS has also been utilised for the gradual implementation of the electronic medical prescription (ricetta elettronica) over the entire national territory, in line with the programme of the Italian Digital Agenda (Agenda Digitale Italiana) which foresees the full dematerialisation of medical prescriptions . In this regards, the TS has implemented a technological infrastructure for electronic interconnection with doctors,

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pharmacies, hospitals and other public health body, or private health body accredited by the National Health System. (165)

Since 2015, TS also allows patients to check online their own health care expenses, made available

to the Fiscal Agency (Agenzia delle entrate) for

the pre-filled income tax statement (730-precompilato).

Finally, according to law decree 179/2012, article

12, a project concerning the implementation of the

patient's electronic health record (Fascicolo

Sanitario Elettronico) has been started.

Health and health-system information and

reporting mechanisms

Following a pilot period, a comprehensive

information and monitoring system (National

Healthcare Information System) - using 130

indicators and covering population health status,

budgetary and economic efficiency, organisation

climate and staff satisfaction, patient satisfaction,

performance indicators (appropriateness, quality)

and effectiveness in reaching regional targets - is

now fully operational. A comprehensive set of

indicators has been introduced by the Health Pact

2010-2012, for evaluating the performance of

regional health services.

Several regions have adopted the system which

uses standard codes. As a result, Italy will be able

to gather extensive information at regional and sub-regional levels, which is publicly available on a website allowing for public comparisons. Such a system, allows regions to identify good practices as well as areas for improvement. Physicians are being monitored in terms of their activity and compliance with guidelines as well as their prescription behaviour. They receive feedback on their prescription patterns.

(165) All this further strengthens the accuracy and timeliness in checking prescription appropriateness and requirements for co-payment exemptions. In 2015, about 350 million of dematerialised prescriptions were issued. Thanks to the eprescription system, since 1st March 2016 the validity of prescriptions has been extended also to regions other than that of residence.

Health promotion and disease prevention policies

The central Government through the Ministry of Health sets and monitors public health priorities in terms of process, outcomes and the reduction of health inequalities. There are some risk factors that

can translate into an important burden of disease and financial costs. The latest National Health plan lists a number of priority areas for health promotion and disease prevention which is proposed as good practice across the regions.

Health promotion and disease prevention activities has not historically received the same emphasis as in other countries in the EU, as seen by its pattern of expenditure and some indicators. However, in 2013, public and total expenditure on prevention and public health services as a % of GDP are in line with the EU average (0.25% and 0.25% vs. 0.24% and 0.19% in 2013), after a decade of consistently being markedly lower than average.

Public and total expenditure on prevention and public health services as a % of current health expenditure (public and total, respectively) are currently both above the EU average (3.7% vs. 2.5% and 2.9% vs. 2.5% in 2013).

Transparency and corruption

In order to guarantee the full accountability and monitoring of health sector, Italy has implemented an integrated governance framework.

Health expenditure trends are analysed on a quarterly and yearly basis, relating on a set of standardised economic accounts, mainly based on a profit and losses account and a balance sheet account. These accounts are filled at the regional level and single public provider of health services, on the basis of harmonised recording criteria.

A dedicated committee (named “Tavolo degli Adempimenti”) is in charge with the analysis of expenditure trend, the verification of the budget balance position and the fulfilment of the other requirements envisaged in the legislation.

A bonus (equal to the 3% of the regional share of national health fund) is granted to regions conditionally to a positive evaluation by the Tavolo degli Adempimenti about the fulfilment of all the requirements (and, firstly, the budget balance position) envisaged in the legislation.

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Recently legislated and/or planned policy

reform

In July 2014, a new Health Pact was signed

between central government and regions. The main

issues regulated by the Pact are as follows:

the financial framework, i. e. the level of

fabbisogno nazionale standard for each of the

years 2014-2016;

a procedure for the revision of the current basic

healthcare levels (LEA);

a procedure for the revision of co-payment

schemes, in order to make them more fair without

affecting current revenues;

a strengthening of monitoring activity, through an

increased role of the National Agency for regional

Health Services (Agenzia Nazionale per i Servizi

Sanitari Regionali, AGENAS) in evaluating the

quality of regional health services.

Recently, the latest budget law for 2016,

introduced a Deficit Reduction Plan (Piano di

Rientro) procedure also for hospital bodies as an

additional tool to restore budget balance positions

and improve an efficient use of public resources.

Results from QUESTIONNAIRE

(budgeting practices, international benchmarking, health policy levers)

To be filled in after questionnaires have been sent back to the European Commission.

Challenges

The analysis above shows that a range of reforms have been implemented in recent years for example to strengthen primary care provision and its use, to improve efficiency, to improve data collection, information and monitoring systems and the use of ICT solutions, to control overall expenditure and pharmaceutical expenditure while delivering quality healthcare. They were to a very large extent successful and, therefore, Italy should continue to pursue them. The main challenges for the Italian health care system are as follows:

- To continue increasing the efficiency of health

care spending, promoting quality and

integrated care as well as a focusing on costs,

to tackle the impact on spending due to

population ageing and non-demographic

factors.

- To extend the possibilities of hospitals to provide ambulatory and day care as well as to transfer more health care services into the ambulatory sector in order to reduce the number of inpatient care treatments, as well as to strategically direct more resources towards providers of lower levels of care, to increase efficiency.

- To tackle unwarranted regional variation in waiting times and resource distribution. In particular, monitor and correct potential uneven distribution of hospital beds (follow-up and long-term care), to free-up capacity in acute settings as a driver of lower waiting times. To the same end, further develop ICT solutions to increase service efficiency of operations

- To re-think the current mix between doctors and nurses, to favour solutions that relying less heavily on doctors, in the cases where nurses can represent a substitute, consistently with a

more primary-care oriented system.

- To further the efforts in the field of

pharmaceuticals by considering additional

measures, both on the side of patients and of

health care professionals, to improve the

rational prescribing and usage of medicines.

The policies could help reducing the high level

of out-of-pocket payments and improving

access to cost-effective new medicines by

generating savings to the public payer.

- To ensure a greater and nationally coordinated

use of health technology assessment to

determine new high-cost equipment capacity,

the benefit basket and the cost-sharing design

across medical interventions.

- To implement the National Health Information

System across all regions and sub-regional

levels which has a strong potential to monitor

and relate expenditure with activity and with

outcomes and in identifying good practices and

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areas for improvement. To encourage debate, information exchange, and peer reviews between regions once the system is fully implemented. In this context, the patient e-card (Tessera Sanitaria) should be fully exploited

- To continue to monitor regional expenditure policies making regions showing deficit in the health sector budget restore the balance and ensure efficiency and appropriateness in the provision of LEAs. To continue to improve accountability and governance of the system and identify possible cost-savings in the health sector administration, as it currently involves national and regional institutions.

- To further the efforts to support public health priorities and enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening.

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Table 1.15.1: Statistical Annex – Italy

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Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 1391 1449 1490 1549 1610 1633 1574 1606 1639 1615 1607 9289 9800 9934

GDP per capita PPS (thousands) 27.4 26.9 27.1 27.8 28.5 27.9 25.6 26.2 26.4 26.1 25.2 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita -0.8 0.7 0.2 1.6 0.9 -1.9 -6.1 1.2 0.1 -2.7 -2.1 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita -2.4 4.8 3.0 2.8 -3.0 2.6 -0.7 1.3 -1.6 -3.3 -3.2 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 8.2 8.5 8.7 8.8 8.5 8.9 9.4 9.4 9.3 9.2 9.1 10.4 10.1 10.1

Total current as % of GDP 7.9 8.2 8.4 8.5 8.2 8.6 9.0 8.9 8.8 8.8 8.8 9.8 9.6 9.7

Total capital investment as % of GDP 0.3 0.3 0.4 0.4 0.3 0.3 0.4 0.5 0.4 0.4 0.3 0.6 0.5 0.5

Total per capita PPS 1934 2095 2201 2307 2299 2421 2452 2497 2498 2444 2394 2828 2911 2995

Public as % of GDP 6.2 6.6 6.8 6.9 6.7 7.0 7.4 7.4 7.1 7.1 7.1 8.1 7.8 7.8

Public current as % of GDP 5.9 6.2 6.5 6.6 6.3 6.6 7.0 7.0 6.8 6.8 6.8 7.9 7.7 7.7

Public per capita PPS 1412 1556 1646 1728 1726 1844 1868 1898 1878 1877 1868 2079 2218 2208

Public capital investment as % of GDP 0.3 0.3 0.3 0.3 0.3 0.4 0.4 0.4 0.3 0.3 0.3 0.2 0.2 0.1

Public as % total expenditure on health 76.2 77.4 77.9 78.2 78.3 78.9 78.9 78.9 77.1 77.3 78.0 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 13.3 14.1 14.4 14.6 14.3 14.8 14.6 14.9 14.7 14.4 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 : : : : 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 20.8 20.1 19.0 18.7 18.8 18.5 17.7 17.5 18.8 18.8 18.0 14.1 14.4 14.1

Population and health status 2009 2011 2013

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Population, current (millions) 57.5 57.5 57.9 58.1 58.2 58.7 59.0 59.2 59.4 59.4 59.7 502.1 504.5 506.6

Life expectancy at birth for females 82.8 83.7 83.6 84.1 84.2 84.2 84.3 84.7 84.8 84.8 85.2 82.6 83.1 83.3

Life expectancy at birth for males 77.3 78.0 78.1 78.6 78.8 78.9 79.1 79.5 79.7 79.8 80.3 76.6 77.3 77.8

Healthy life years at birth females 74.4 71.0 67.8 64.7 62.6 61.8 62.6 : 62.7 61.5 60.9 : 62.1 61.5

Healthy life years at birth males 70.9 68.7 66.6 65.2 63.4 62.9 63.4 : 63.5 62.1 61.8 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 74 : : 62 61 61 59 55 123 121 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 3.9 3.9 3.8 3.6 3.5 3.3 3.4 3.2 2.9 2.9 2.9 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 3.60 3.80 3.89 3.99 3.86 4.10 4.29 4.31 4.21 4.23 4.21 3.13 2.99 3.01

Day cases curative and rehabilitative care : : : : : : : : : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.76 2.87 2.99 3.01 2.93 3.09 3.30 3.33 3.32 3.40 3.39 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.70 1.70 1.70 1.70 1.60 1.60 1.70 1.70 1.60 1.60 1.60 1.60 1.55
1.44

Therapeutic appliances and other medical durables : : : : : : : : : : 0.31 0.31 0.32

Prevention and public health services 0.03 0.04 0.03 0.04 0.04 0.04 0.04 0.04 0.04 0.04 0.25 0.25 0.25 0.24

Health administration and health insurance 0.05 0.04 0.05 0.05 0.05 0.06 0.06 0.06 0.06 0.06 : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : : : : : : : : : 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : : : : : : 0.16 0.16 0.18

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Out-patient curative and rehabilitative care 1.89 1.98 2.15 2.16 2.09 2.21 2.42 2.46 2.40 2.47 2.52 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.87 0.91 0.91 0.91 0.86 0.85 0.90 0.90 0.84 0.81 0.81 0.79 1.07 0.96

Therapeutic appliances and other medical durables : : : : : : : : : : 0.13 0.12 0.13

Prevention and public health services 0.03 0.04 0.03 0.04 0.04 0.04 0.04 0.04 0.04 0.04 0.25 0.25 0.20 0.19

Health administration and health insurance 0.07 0.07 0.07 0.08 0.08 0.08 0.09 0.09 0.09 0.12 0.11 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.15.2: Statistical Annex - continued – Italy

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 45.8% 46.4% 46.5% 47.1% 47.3% 47.9% 47.8% 48.1% 47.7% 47.9% 48.0% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : : : : : : : : : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 35.1% 35.1% 35.8% 35.6% 35.9% 36.1% 36.8% 37.3% 37.7% 38.5% 38.6% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 21.7% 20.8% 20.3% 20.1% 19.6% 18.7% 18.9% 19.0% 18.1% 18.1% 18.2% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : : : : : : : : : : 3.2% 3.3% 3.3%

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Prevention and public health services 0.4% 0.4% 0.4% 0.4% 0.4% 0.5% 0.5% 0.5% 0.5% 0.5% 2.9% 2.6% 2.6% 2.5%

Health administration and health insurance 0.6% 0.5% 0.6% 0.6% 0.6% 0.7% 0.6% 0.6% 0.7% 0.7% : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : : : : : 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : : : : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care 32.0% 31.7% 33.1% 32.8% 33.1% 33.3% 34.4% 35.1% 35.4% 36.3% 37.1% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 14.6% 14.7% 14.0% 13.9% 13.6% 12.8% 12.9% 12.8% 12.3% 11.9% 11.9% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : : : : 1.6% 1.6% 1.6%

Prevention and public health services 0.6% 0.6% 0.5% 0.5% 0.6% 0.6% 0.6% 0.6% 0.6% 0.6% 3.7% 3.2% 2.7% 2.5%

Health administration and health insurance 1.2% 1.1% 1.1% 1.1% 1.2% 1.2% 1.2% 1.3% 1.4% 1.7% 1.6% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 1.18 1.40 1.48 1.67 1.85 1.97 2.12 2.20 2.36 2.46 : 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : 1.0 1.1 1.2 1.2 1.2 1.3 : 0.9 0.9 0.8

CTS per 100 000 inhabitants 2.4 2.6 2.8 2.9 3.0 3.0 3.1 3.2 3.2 3.3 : 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : 0.2 0.2 0.2 0.2 0.2 0.3 : 0.1 0.1 0.1

Proportion of the population that is obese 9.0 : 9.9 10.2 9.9 9.9 10.3 10.3 10.0 : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 24.2 : 22.3 23.0 22.4 22.4 23.3 23.1 22.5 22.1 21.1 23.2 22.4 22.0

Alcohol consumption litres per capita 8.6 8.3 7.4 7.3 7.2 6.8 6.4 6.1 : : : 10.3 10.0 9.8

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Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants : : : : : 374 : : 387 390 329 335 344

Practising nurses per 100 000 inhabitants : : : : : : 634 641 614 840 812 837

General practitioners per 100 000 inhabitants 82 82 81 80 80 79 78 76 76 76 75 : 78 78.3

Acute hospital beds per 100 000 inhabitants 351 333 331 323 313 302 292 287 276 275 : 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita : : 6.1 : : : : : 6.8 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 15.2 14.9 14.6 14.4 13.9 13.5 13.2 12.8 12.2 12.1 11.8 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 6,309 6,677 6,803 6,649 6,156 5,958 5,414 5,097 4,757 4 ,350 4,070 6368 6530 7031

Acute care bed occupancy rates 76.0 76.0 77.0 78.0 78.0 78.8 79.4 78.7 78.5 77.5 : 72.0 73.1 70.2

Hospital curative average length of stay 6.7 6.7 6.7 6.7 6.7 6.8 6.7 6.7 6.8 6.8 6.8 6.5 6.3 6.3

Day cases as % of all hospital discharges 29.3 30.9 31.8 31.5 30.7 : 29.0 28.5 28.0 26.4 25.6 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 6.1 6.2 6.4 6.6 6.8 6.7

AWG risk scenario 6.1 6.2 6.6 7.0 7.2 7.2

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 60.2 62.1 64.2 66.3 67.0 66.3

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

10.1 3.1

0.7 0.9

1.2 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, Latvia had a GDP per capita of 14.9 PPS

(in thousands), below the EU average of 27.9.

Population was close to 2 million in 2014.

Total and public expenditure on health as % of

GDP

Total expenditure (166) on health as a percentage of

GDP (5.7% in 2013) is below the EU average (167)

of 10.1%. Public expenditure is at 3.5% of GDP,

far below the average of 7.8% in 2013.

When expressed in per capita terms, total spending

on health at 1000 PPS in Latvia is below the EU

average of 2988 in 2013. So is public spending on

health care: 619 PPS vs. an average of 2208 PPS in

2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care

expenditure is projected to increase by 0.6 pps of

GDP, below the average growth expected for the

EU of 0.9 pps of GDP according to the AWG

reference scenario. When taking into account the

impact of non-demographic drivers on future

spending growth (AWG risk scenario), health care

expenditure is expected to increase by 1.5 pps of

GDP from now until 2060 (EU: 1.6). (168)

Overall, for Latvia no significant short-term risks

of fiscal stress appear at the horizon, though some

macro-financial indicators point to possible shortterm

challenges.

(166) Data on health expenditure is taken from OECD health data

and Eurostat database. The variables total and public

expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(167) The EU averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units and units of staff where relevant. The EU

average for each year is based on all the available

information in each year.

(168) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

Risks appear to be low in the medium term from a

debt sustainability analysis perspective due to the

low stock of debt at the end of projections (2026).

No sustainability risks appear over the long run

thanks to the pension reforms implemented in the

past.

Health status

Life expectancy at birth continues to increase

gradually in Latvia (78.9 years for women and

69.3 years for men in 2013) but it is far below the

respective EU averages (83.3 and 77.8 years of life

expectancy). (169) Healthy life years, at 54.2 years

for women and 51.7 for men are below the EU

averages of 61.5 and 61.4 in 2013, but has

increased gradually in last decade, although it

should be noted 2013 has seen a sharp drop. The

infant mortality rate of 4.4‰ (after a sharp drop from 6.3‰ in 2012) is higher than the EU average of 3.9‰ in 2011, having fallen over the last decade (from 11‰ in 2001). Future data should clarify whether this is a one-off occurrence or represents a change of trend.

As for the lifestyle of the Latvian population, there is a proportion of regular smokers of 27.9% above the EU average of 23.2% in 2009. Alcohol consumption is, at 10.2 litres per capita, higher than the EU average of 9.8.

System characteristics (170)

Coverage

The Latvian health system is a tax-funded social insurance system. The services included in the statutory provision are determined annually in the

Basic **Care** Programme.

Public health **care** benefits provided in kind include a wide range of services provided by GPs, specialists,, hospitals and emergency **care** units, as well as pharmaceutical **care**. Cash health **care** benefits (including maternity and sickness) are

provided through social insurance, financed

(169) Data on health status including life expectancy, healthy life

years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and

Eurostat database.

(170) This section draws on ASISP (2014)

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through mandatory insurance contributions from

employers and employees (171).

Despite full population coverage, the services

available 100% free of charge are limited. The

system suffers from low accessibility due to

financial reasons. In 2013 12% of the population

reported unmet needs for health care (according to

EUROSTAT) because they could not afford it

financially (in contrast with the EU average of

2.4%), while in the lowest income quintile the rate

reported is close to 24%. This is the highest level

of unmet need for health care in the EU and has

been so for for a decade, being significantly

different from its Baltic neighbours (Lithuania and Estonia). Self-reported unmet need for dental examination due to affordability concerns are also the highest in the EU (More than 35% for the 1st income quintile, i.e. the **poorest**, and 18.4% for the total population in 2013).

Patients pay directly for those services that are not financed by the state, for example, dental **care** for adults, psychotherapy, most available rehabilitation and physiotherapy services as well as a significant proportion of medicines. Patients also pay the full cost if they do not follow the standard procedure for accessing publicly financed **care** (for example, directly visiting a specialist without first obtaining a primary **care** referral when required) This is most often the case when patients wish to avoid waiting lists for publicly funded **care**.

Additionally, patients also pay in full the cost of all services provided by health **care** providers who are not under contract to the Latvian health system .

2013 data shows that Latvia has the fourth highest

incidence of "under-the-table payments" to doctors

on the part of patients (Health Powerhouse (2015)).

During the economic crisis until 2012 some new

measures were introduced as an additional social

safety net. An exemption from patient charges was

introduced for those households with a monthly

income below EUR 171 per family member. Those

with an income below EUR 213 euro were

exempted from 50% of fees. From 2012 this was

scaled back, with only those with an income below

EUR 128 being exempted. This threshold appears

to be too low to ensure good health care access for

those from vulnerable groups. As obtaining this

status requires several administrative procedures

(171) ASISP (2014).

such as means-testing, and the latter may act as

barriers to access for the elderly and infirm.

Nevertheless from 2015 payment of daily

treatment in hospital was reduced from EUR 13.52

to 10 euro, as well as the patient's co-payment (for

a surgical procedure in hospital) was reduced from

EUR 42.69 to EUR 31.

The share of private expenditure on health in total

health expenditure (38.1% in 2013) is far higher than the EU average of 22.6%. Out-of-pocket expenditure constitutes about 36.5% of total health expenditure, far above the EU average (14.1% in 2013). The authorities' effort to improve access to care is reflected in the observed reduction from 2003 (45.7%).

Statistical analysis of the expenditure of Latvian households has shown that the share devoted to health expenditure has increased by 3.3% in 2012 up to 6.1% of the income of households. Whereas in 2008 it represented the 9th highest expenditure group, by 2011 and 2012 it had gone up to the 5th highest, above items such as clothing and footwear (172).

Beyond affordability, low accessibility is also influenced by long waiting lists for diagnostics and treatments. As of 2014, cancer patients with cancer had to wait on average 25 working days after diagnosis for treatment. the waiting time for an appointment with a rheumatologist was 86 working days (173).

Administrative organisation and revenue

collection mechanism

Public funding, including transfers from general

taxes (state or municipal budgets), together

constitute 61.9% of total health expenditure

funding (2013), compared with the EU average of

77.4%.

Financial resources for the public health system

come from central government general taxation.

As explained above, out-of-pocket payments are

also a very important financial source for the

system.

(172) ASISP, (2014).

(173) ASISP (2014).

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There are plans to levy compulsory health

insurance contributions to supplement the funding

of health care. The Ministry of Health is working

on the new health care funding model.

Types of providers, referral systems and patient

choice

The total number of practising physicians per 100

000 inhabitants (319 in 2013) is below the EU

average (344) and has increased since 2003 (279) .

Data on the physician skill-mix indicates that the

number of GPs per 100 000 inhabitants (59 in

2009) is below the EU average (78) although it

registered a steady increase since 2003 (45) as part

of the authorities' effort to improve primary care

provision. The number of nurses (488 in 2013) per

100 000 inhabitants is far below the EU average

(837 in 2013).

Latvia has 350 acute care hospital beds per 100

000 inhabitants (down from 543 in 2003), close to

the EU (EU average of 356 in 2013).

The General Practitioner (GP) acts as a main point

of entry into the health care system and as a

gatekeeper to secondary ambulatory and hospital

care. In order to receive the state financed

secondary ambulatory or hospital care the referral

from GP or other doctor is required. The referral to

receive state financed health care services can be

issued by doctors who are contracted with NHS.

However there are numerous direct access

specialists to whom no referral is required

(gynaecologists, narcologists, ophthalmologists,

paediatricians, child surgeons, dentists and sports

doctors). Also patients with certain disease may go

directly to the relevant specialists. No referral is

needed to attend the endocrinologist in case of

diabetes, psychiatrist in case of psychiatric disease,

oncologist in case of oncological disease,

pneumologist in case of tuberculosis,

dermatologist in case of sexually transmitted

disease, infectologist in case of HIV. No referral is

required also in case of emergency medical

assistance.

The patient has the right to choose a physician and

health care institution. The patient has a right to

freely register with a chosen GP and may freely

change and register with a new GP.

Treatment options, covered health services

Services included in the statutory provision are

defined by law. The statutory health care system covers only services provided by physicians and institutions that have contractual agreements with the Latvian health system.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

The Latvian public health system acts as the main purchaser of health care for the population, directly commissioning both public and private providers (including GPs, dentists and hospitals). In 2012, it held contracts with 2,139 health care providers (174).

Large tertiary and specialised hospitals are owned by the stated, whereas smaller and regional hospitals tend to be owned by municipalities. GPs and those medical specialists not working for hospitals or health centres tend to work as selfemployed private providers.

The market for pharmaceutical products

Total pharmaceutical expenditure, at 1.56% of GDP, above the EU average of 1.44%. However, public pharmaceutical expenditure at 0.6% of GDP

is far below the 0.96% EU average. This difference

reflects partly the level of co-payments in the

pharmaceutical sector.

Legislation and policies in the field of

pharmaceuticals are the responsibility of the

Department of Pharmacy of the Ministry of Health.

In addition, there are two main institutions

concerned with regulation of pharmaceuticals: the

SAM (State agency of Medicines), reorganised in

2009 and the NHS (National Health Service),

which is responsible for reimbursement and

pricing decisions.

There is a positive list in accordance with the

Regulations of the Cabinet of Ministers Nr.899

“Procedures for the Reimbursement of

Expenditures for the Acquisition of Medicinal

Products and Medicinal Devices Intended for Outpatient

Medical Treatment” (31.10.2006),

designating a range of conditions (for example,

(174) ASISP (2014)

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diabetes, cancer, mental disorders) for which drugs are reimbursed according to the degree of severity. The objective is to keep expanding the positive list as well as to reduce the level of co-insurance required from patients. Patients pay the full price for a significant share of prescribed pharmaceuticals and the full price of all nonprescription drugs in the outpatient sector. In fact, about more than 60% of out of pocket (OOP) payments in Latvia are spent on pharmaceuticals and about 50% of these are related to payments for non-reimbursable prescription drugs or OTC drugs. Inpatient pharmaceutical care is provided free of charge as the costs are included in the cost of inpatient services. There is a co-payment of EUR 0.71 per prescription for outpatient pharmaceuticals on the positive list (if the pharmaceutical has 100% reimbursement level) and co-insurance of 25% (if the pharmaceutical has 75% reimbursement level) or 50% (if the pharmaceutical has 50% reimbursement level). However, households with

an income below EUR 128 per family member per month are exempted from user charges.

In 2012, the existing reference price system for pharmaceuticals from List A was modified. Since the reform, only one pharmaceutical product per reference group has the status of reference medicine and is reimbursed by the NHS.

Pharmaceutical products are supplied to the public by a regulated distribution system consisting of licensed enterprises that manufacture and/or distribute them. In 2013, there were 64 licensed wholesalers and 7 licensed manufacturers of active pharmaceutical substances in Latvia (State Agency of Medicines of Latvia, 2013).

Wholesalers are private enterprises. The total wholesale turnover of pharmaceuticals (excluding sales among wholesalers) is EUR 295 million.

Domestic production accounts for about 5% of the pharmaceutical market. However, Latvian manufacturers export most of their pharmaceutical products. Foreign manufacturers operate through representative offices, subsidiaries or limited liability companies. Some of them perform only

promotion and marketing activities, while others

have established companies and are licensed as

wholesalers.

Hospitals purchase medicines from wholesalers or

pharmacies. Large purchases of pharmaceuticals

are put out to tender.

Most pharmacies are privately owned, pharmacies

can be run by a pharmacist as a pharmaceutical

practice, by a company or a local community

government. If it is registered as a company, at

least 50% of the shares have to be owned by a

pharmacist or at least half the board must consist

of certified pharmacists. In fact, the pharmacy

market is dominated by five chains, with the most

important chain being "AS Sentor Farm Aptiekas",

which owned most of the top 10 general

pharmacies with the largest turnover in last five

years. A small number of pharmacies exist at

health care institutions and, in rural areas, under

certain conditions determined by Pharmacy law,

pharmacies can also be owned by pharmacy

assistants.

eHealth, Electronic Health Record

The NHS is responsible for the implementation of the eHealth policy and the establishment of the necessary infrastructure. Financial resources for these tasks are provided by the Ministry of Health, but certain specific projects are financed by the EU.

In the framework of the first and second round eHealth projects which were finalised accordingly in the end of 2014 and the following eHealth information systems are developed – eHealth integration platform information system (IS), ebooking IS, e-referral IS, electronic health record IS, e-prescription IS, as well an eHealth portal.

The publicly available part of the eHealth portal will provide the actual information about health

care in Latvia, as well information about health prevention and other related topics. The authorised part of the eHealth portal will provide the easy access for inhabitants to their health data but for health care professionals - a virtual workplace. The publicly available part of the eHealth portal is open

since June 2016. Currently NHS is working to provide the access to the authorised part of the eHealth portal in the nearest future.

On 11 March 2014 Cabinet of Ministers accepted the Regulations No. 134 "Regulations Regarding Unified Electronic Information System of the Health Sector", which determine the manager of Health care systems

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the electronic health information system, the data stored in the health information system and the data processing procedures as well as the procedures for the issuing of data. As it is stated in the Regulations No. 134 all health care institutions and pharmacies are obliged to start using eprescription and e- sick lists by December 31, 2016 and rest of IS functionalities by 2017 July 1.. In accordance with the regulations No.134 the eHealth IS will provide the centralised processing of person's health-related data necessary for medical treatment, the preparation of eprescriptions,

the preparation of sick lists, ebooking

and e-referrals.

Since 2010 patients can access to certain health

care records collected in some state information

systems, ie. the patients have a right to access the

information about the health **care** services received

and paid by the state budget (information sent by

health **care** institutions to NHS for payment

purposes), about the GP to whom the patient is

registered, the patient's newborn health data and

the patient's data within the diabetes mellitus

patients' register. The information can be accessed

by using state's e-services' portal www.latvija.lv

(authenticated with internet bank, electronic

signature).

Health and health-system information and

reporting mechanisms/ Use of Health

Technology Assessments and cost-benefit

analysis

The main performer and coordinator of the official

statistical work in Latvia is the Central Statistical

Bureau (CSB). The CSB is a direct administration

body subordinated to the Ministry of Economics and is responsible for organisation of the statistical work and authenticity of the data it has produced by summarising the information obtained from respondents.

There are two main institutions responsible for the collection of health-related information in Latvia: the Centre for Disease Prevention and Control (CDPC) and the NHS.

CDPC is the central institution responsible for collecting and summarising health related data in Latvia. CDPC is responsible for numerous information systems and databases where health data are collected (for example, HIV/AIDS Case Register, The Newborn Register, The Register of Patients Suffering from Diabetes, Malignant Neoplasms, Occupational Diseases, Congenital Anomalies, Injuries, Psychiatric Disorders, Tuberculosis, Multiple Sclerosis and Addiction, Death Cause Database of Latvian Inhabitants, National Infectious Disease Surveillance and Monitoring System etc.). The data which is

collected in the named information systems is

defined by law and is submitted to CDPC by

health care institutions. All health care institutions

in Latvia have a legal obligation to submit the

relevant patient health data to CDPC. In

accordance with the Regulations of the Cabinet of

Ministers No.10 (01.06.2009) „Regulations on the

state statistical overviews of health care” all health

care institutions in Latvia are also obliged to

prepare and submit to CDPC the annual statistical

overviews about delivered health care services.

The NHS collects the data related to the use of

NHS paid health services. All contracted providers

irrespective of their ownership status have to

electronically submit patient information about

NHS paid services for payment purposes.

Data on occupational accidents is collected by the

State Labour Inspectorate. In accordance with the

Regulation of the Cabinet of Ministers No. 468

“The Approval of Medical Technologies and the

Implementation of New Technologies”

(28.06.2005) the NHS is responsible for assessing

and approving medical technologies. NHS is also responsible for registering the approved medical technologies and maintaining the database of approved medical technologies.

In order to utilise a new medical technology, a health care institution, medical practitioner or medical personnel professional organisation is required to provide a package of documents including: a technical description of the new technology; a summary of published studies documenting the effectiveness of the technology; the justification of the need for the new medical technology (aims and the provisional results), the necessary qualifications of the medical practitioners who will use the technology; a description of the space within the treatment institution in which the technology will be used; the costs of the new technology; and a justification of the use of resources to purchase it.

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Every new technology is then assessed by the NHS with regard to safety aspects (risks and potential side-effects), potential impact and efficiency, an assessment of the influence of the technology on the patient's health and quality of life, professional ethics, as well as the economic justification of its use. About 50 to 60 evaluations of new technologies are conducted each year according to a methodology that is specified in the abovementioned regulations. A positive assessment is a prerequisite for the introduction of a new technology in Latvia.

Since 2002, every new medicine is evaluated according to the Guidelines on Economic Evaluation of Pharmaceuticals (approved by regulations of the Cabinet of Ministers No.899) prior to being entered into the positive list of NHS paid medicines.

Health promotion and disease prevention policies

Total (0.04%) and public (0.04%) expenditure on prevention and public health as a % of GDP is far lower than the EU average (respectively 0.24%

and 0.19% in 2013). The sharp drop with respect to earlier figures means that it will be necessary to monitor closely the future evolution of these variables to ascertain whether this really represents a change of trend rather or just a one-off impact.

Public health is coordinated by the Ministry of Health. Activities are planned and monitored mostly by the Centre for Disease Prevention and Control (CDPC), which is the main institution for infectious and non-infectious disease control and which coordinates collection of all health-related information. The CDPC engages in health promotion and organises the State Immunisation Programme, which is carried out by GPs and paediatricians and financed through the NHS.

Recently legislated and/or planned policy reform

Recent policy response

The implementation of The Maternal and Child Health Improvement Plan for 2012 – 2014, was approved in 2012. The main objective of the plan is to improve the health of mother and child

through measures such as: statutory provision of fertility treatment and in vitro fertilisation procedures, reimbursement of pharmaceuticals for infertility treatment; introduction of the principle “money follows the pregnant woman” in order to involve gynaecologists and other specialists from private sector into the state-funded maternity care; to reduce the risk of hereditary pathology an additional preventive procedures for pregnant women included in the statutory provision; 50% reimbursement of the flu vaccine for pregnant women and 25% prescription drug cost reimbursement for pregnant women and women in the period following childbirth up to 42 days (except, when the diagnosis is eligible for other reimbursement categories (100%, 75% or 50%); 50% prescription drug cost reimbursement for children under the age of 24 months (except, when the diagnosis is eligible for other reimbursement categories (100% or 75%); establishment of The Committee of Experts on Confidential Analysis of Maternal Mortality to investigate the death causes

of pregnant women or women in postnatal period
(until the 42nd day) and to develop
recommendations for the medical treatment
institutions, medical staff associations and policy
makers in order to avoid the identified mistakes
and nonconformities in the future. It is planned to
introduce a perinatal deaths audit system in Latvia,
as well.

The implementation of mental health care policy
action plan for 2013- 2014, adopted in 2013,,
which includes the measures to improve the
quality and availability of mental health care
services, the skills and knowledge of professionals
who are involved in the care of persons with
mental disorders, to reduce the stigma in the
society, to improve the legal framework to protect
the rights of persons receiving mental health care
services, as well to improve the monitoring of
mental disorders in the population.

Cardiovascular Health Improvement Action Plan
for 2013- 2015, adopted in 2013, which aims to
improve the cardiovascular health of the

population. The Plan includes measures to promote

healthy lifestyle habits in the population and early

diagnosis and quality of cardiovascular health **care**

services in the out-patient and in-patient health

care settings, as well the monitoring of

cardiovascular diseases. Implementation is

pending additional financial resources.

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In 2014 was adopted The Public Health Strategy

for 2014-2020 to improve the healthy life years of

the population, reduce risk factors for noninfectious

diseases improve the health of both

pregnant women and children, decrease the impact

of traumatism and environmental risks upon public

health, prevent infectious diseases, and to increase

the accessibility of health **care** services.

The implementation of Primary Health **Care**

Action Plan for 2014.-2016, adopted in 2014. The

aim is to improve the access, quality and safety of

the primary health care. The Plan includes the measures to improve the territorial and organisational accessibility of primary health care providers, the requirements for primary health care providers and services, the provision of primary health care services, the further development of primary health care quality assurance system, to promote the primary health care specialists' cooperation with other health care specialists and specialists from other sectors (e.g. social workers, school nurses), to improve financing mechanisms of primary health care, and to strengthen the collaboration between the pharmaceutical and primary health care sectors.

Addressing problems with medical personnel accessibility for citizens living in the regions outside the capital, in April 2015, the Ministry of Health required medical universities to give priority residency positions to those applicants who have concluded an agreement with a regional municipality and/or state medical institution

outside the capital for work relations in rural area

after the completion of the residency program.

Accordingly, the residential program 2015-2016

accommodates 34 residents with a "regional

arrangement".

A number of measures have been taken within the

scope of the eHealth project in order to provide

patients with access to the eHealth portal and thus

gradually ensuring that patients have access to all

the data that is stored in the system.

To change public attitude towards health and

improve public health indicators, number of

changes in laws and regulations have been made in

order to limit unhealthy products and habits, such

as the regulations on restriction of trans-fatty acid

amounts in food products, as well as the

regulations ensuring availability of healthy food in

educational institutions, hospitals and nursing

homes. As a result of the Ministry's initiative,

Parliament has adopted the law on restriction of

availability of energy drinks to children, as well as

amendments to the Law "On Excise Tax" to

increase rates of excise tax on alcoholic beverages

from 1 August 2015. Currently, the Parliament is evaluating a new law on stronger restrictions on smoking.

The development of the National Network of Healthy Cities. The aim of the Network is to improve the municipal employees' knowledge on public health and health promotion, to promote the local governments' involvement in the health promotion, to promote the exchange of the knowledge and good practice among local municipalities and to provide the methodological support for local governments on public health and health prevention issues. Currently there are 43 municipalities participating in the Network (36% of municipalities in Latvia) (data from 17.03.2016).

Since 2015 in order to improve the availability of pharmaceuticals and medical devices for children under the age of 18, the reimbursable pharmaceuticals and medical devices are reimbursed at 100 % for several group of diagnosis, for example pharmaceuticals in the case

of conjunctivitis, atopic dermatitis, acute

bronchitis, etc. As well in 2015 measures were also

taken to reduce the amount of the patient's copayment

from 50% to 25% to patients diagnosed

with diseases such as Crohn's disease, ulcerative

colitis and psoriasis.

Taking into account the epidemiological risks and

in order to improve the availability of medicines

for hepatitis C and HIV/AIDS patients, the health

sector in 2016 budget provided additional 4.2

million euro. This gave the opportunity to increase

compensation for the expenses of the treatment of

hepatitis C from 75% to 100% starting from 1

January 2016. In the first month, state-covered

therapy of hepatitis C was provided to 172

patients, from which in 32 cases the newest

therapies (interferon free therapy) were used.

Starting from January 2017, the state will cover the

expenses related to liver transplantation for adults.

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Policy changes under preparation/adoption

The NHS is working on the introduction of the Nord-DRG activity-based accounting system in hospitals. The use of DRGs is expected to increase transparency in the inpatient sector, both concerning performance (as it will allow evaluating the complexity of patients treated in different institutions) and resource allocation (as resources will be allocated according to the number and type of patients treated). This is seen to be a considerable advantage when compared to the current payment system, where resource allocation does not always follow rational criteria.

The Ministry of Health with the technical assistance of the WHO Regional Office for Europe elaborated and in 2016 was adopted Diagnosis related groups (DRG) Implementation Plan for the next 3 years. DRG Implementation Plan is the roadmap for Latvia and will guide all stakeholders through the DRG implementation process during this period. It provides and defines the main goals, actions, responsible stakeholders, involved parties and timelines.

In the new programming period of the EU funds

the Ministry of Health has succeeded to attract

funding for health promotion from the European

Social Fund of a total amount of 55,4 million

euros.

In order to achieve significant improvements in

health care quality, efficiency and availability the

collaboration initiated at the end of 2014 with the

World Bank for the priority health areas

(cardiovascular, oncology, perinatal and neonatal

period care and mental health) for the development

and implementation of the health network

guidelines especially for the health improvement

of people at risk of social exclusion and poverty

will be continued. Based on the research conducted

by the World Bank the national health sector

reform plan will be elaborated. It is also planned to

launch a uniform health care quality assurance

concept elaboration and implementation using EU

funds in 2014-2020th the programming period

investments.

To continue modernisation of the united health

information system it is planned to develop and launch the implementation of eHealth projects, with the aim to centralise management of health data (including finances), as well as to develop an electronic patient identification system.

Possible future policy changes

In February 2015, the government approved the Action Plan aimed to develop a sustainable health system by providing a stable and predictable funding for health care, including the assessment of possible development of new health care financing (health insurance) model. Taking into account the fact that health sector is still underfunded and many needs are still uncovered, this task of new health care financing model and increasing the proportion of health sector funding to the GDP, is highlighted as a priority of the declaration of the Intended Activities of the Cabinet of Ministers Headed by M ris Kučinskis as well.

Ministry of Health has prepared the estimates on the necessary extra funds for the health sector:

6. to gradually increase of the average wage of

medical professionals;

7. to decrease the patient contributions and

copayments for the health care services;

8. to decrease the patient payments for

pharmaceuticals by decreasing the copayments

for reimbursable pharmaceuticals, expanding

the list of pharmaceuticals eligible for

reimbursement, expanding the list of

conditions for which drugs are reimbursed;

9. to decrease the waiting times to out-patient

and in-patient health care services by

allocation additional funds for diagnostic and

treatment procedures;

10. to increase the availability of rehabilitation

services;

The above policy changes are still being

considered taking into account whether additional

funds are allocated.

Challenges

The analysis above shows that a wide range of

reforms have been implemented over the years, to

a large extent successfully (e.g. the development of

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a strong primary care system), and which Latvia should continue to pursue. However, some policies have met with a number of obstacles and there may be room for improvements in a number of areas. The main challenges for the Latvian health

care system are as follows:

- To improve, as acknowledged by the authorities, the basis for more sustainable and larger financing of health care in the future (e.g. considering additional sources of general budget funds), with a better balance between resources and demand, between the number of contributors (including general, unmarked taxes etc. contributions) and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources are brought into the sector it is

important that they do not remain fragmented

but are pooled together maintaining the strong

pooling mechanisms in place today.

- To define a comprehensive human resources strategy – including higher education prospects – to ensure a balanced skill-mix, avoid staff shortages and motivate and retain staff to the sector.

- To continue to enhance and better distribute primary health care services and basic specialist services to improve equity of access and the effectiveness and efficiency of health care delivery as well as ensuring effective referral systems from primary to specialist care and improving care coordination between types of care. This can be helped through developing electronic patient records in the future.

- Continue the efforts to make hospital budgets more prospective and costs more transparent.

- To continue to improve data collection and monitoring of inputs, processes, outputs and

outcomes so that regular performance

assessment can be conducted and used to

improve access, quality and sustainability of

care.

- To gradually increase the use of costeffectiveness

information in determining the

basket of goods and the extent of cost-sharing.

- To enhance health promotion and disease

prevention activities i.e. promoting healthy life

styles and disease screening given the recent

pattern of risk factors (diet, smoking, alcohol,

lack of exercise, obesity). The introduction of a

smoking ban accompanied by taxes on tobacco,

alcohol and soft drinks, stricter regulation of

tobacco advertisement and labelling as well as

stricter road safety measures can contribute to

improving population health status in the long

run. Health education and healthy

environments in various settings (school and

workplaces) can also be a cheap

complementary policy.

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Table 1.16.1: Statistical Annex – Latvia

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 10 12 14 17 23 24 19 18 20 22 23 9289 9800 9934

GDP per capita PPS (thousands) 15.3 15.8 15.9 16.2 15.4 13.9 12.7 13.3 13.8 14.5 14.9 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 8.7 10.0 11.3 12.0 10.9 -1.7 -16.3 0.8 7.3 6.5 5.1 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 7.8 17.0 8.7 19.2 14.3 -7.0 -13.6 -4.8 1.3 3.0 1.9 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 6.2 6.5 6.4 6.8 7.0 6.6 6.8 6.5 6.1 5.9 5.7 10.4 10.1 10.1

Total current as % of GDP : 6.5 6.2 6.2 6.2 6.0 6.2 6.0 : : : 9.8 9.6 9.7

Total capital investment as % of GDP : 0.0 0.2 0.6 0.8 0.6 0.6 0.5 : : : 0.6 0.5 0.5

Total per capita PPS 401 493 599 810 1112 1143 924 848 925 978 1000 2828 2911 2995

Public as % of GDP 3.2 3.7 3.6 4.4 4.3 4.1 4.1 3.9 3.9 3.6 3.5 8.1 7.8 7.8

Public current as % of GDP : 3.7 3.5 3.8 3.6 3.6 3.7 3.6 3.5 3.2 3.2 7.9 7.7 7.7

Public per capita PPS 212 264 307 421 536 586 497 : 587 593 619 2079 2218 2208

Public capital investment as % of GDP : 0.0 0.2 0.6 0.6 0.5 0.4 0.3 0.3 0.3 0.4 0.2 0.2 0.1

Public as % total expenditure on health 52.8 56.3 57.0 64.1 60.8 62.1 59.5 59.6 63.5 60.6 61.9 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 9.7 9.7 12.0 12.8 11.9 11.8 10.8 9.7 10.7 10.7 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance : : : : : : : 100.0 100.0 : 99.7 99.7 98.7

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Out-of-pocket expenditure on health as % of total expenditure on health 45.7 40.6 41.7 35.6 39.3 37.3 38.8 37.8
32.1 35.1 36.5 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 2.3 2.3 2.2 2.2 2.2 2.2 2.2 2.1 2.1 2.0 2.0 502.1 504.5 506.6

Life expectancy at birth for females 75.7 76.0 76.3 76.1 76.2 77.5 77.7 78.0 78.8 78.9 78.9 82.6 83.1 83.3

Life expectancy at birth for males 65.3 65.6 64.9 65.0 65.3 66.5 67.5 67.9 68.6 68.9 69.3 76.6 77.3 77.8

Healthy life years at birth females : : 53.2 52.5 54.8 54.3 56.0 56.4 56.6 59.0 54.2 : 62.1 61.5

Healthy life years at birth males : : 50.8 50.8 51.4 51.6 52.6 53.1 53.6 54.6 51.7 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 219 201 199 185 168 154 144 145 290 318 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 9.4 9.3 7.7 7.4 8.5 6.6 7.6 5.6 6.6 6.3 4.4 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : 2.07 1.85 1.81 1.96 1.74 1.96 1.71 : : 3.13 2.99 3.01

Day cases curative and rehabilitative care : 0.06 0.04 0.07 0.08 0.09 0.10 0.23 : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care : 1.36 1.46 1.32 0.89 1.49 1.26 1.17 : : 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables : 1.54 1.40 1.44 1.65 1.29 1.52 1.56 : : 1.60 1.55 1.44

Therapeutic appliances and other medical durables : 0.39 0.41 0.17 0.41 0.17 0.27 0.21 : : 0.31 0.31 0.32

Prevention and public health services : 0.06 0.02 0.19 0.10 0.09 0.19 0.14 : : 0.04 0.25 0.25 0.24

Health administration and health insurance : 0.19 0.17 0.20 0.25 0.17 0.21 0.19 0.17 0.14 0.13 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : 1.55 1.34 1.33 1.62 1.42 1.60 1.29 : : 2.73 2.61 2.62

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Day cases curative and rehabilitative care : 0.06 0.04 0.06 0.06 0.06 0.08 0.19 : : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care : 0.61 0.64 0.65 0.36 0.52 0.52 0.60 : : : 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables : 0.40 0.44 0.47 0.44 0.49 0.55 0.60 : : : 0.79 1.07 0.96

Therapeutic appliances and other medical durables : 0.05 0.01 0.00 0.01 0.00 0.05 0.00 : : : 0.13 0.12 0.13

Prevention and public health services : 0.06 0.01 0.17 0.10 0.09 0.19 0.14 0.18 0.15 0.04 0.25 0.20 0.19

Health administration and health insurance : 0.17 0.50 0.48 0.31 0.42 0.18 0.21 0.18 0.14 0.14 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.16.2: Statistical Annex - continued – Latvia

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : 31.7% 29.7% 29.2% 31.5% 29.0% 31.5% 28.6% : : : 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : 0.9% 0.6% 1.1% 1.3% 1.5% 1.6% 3.9% : : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : 20.9% 23.5% 21.3% 14.3% 24.9% 20.2% 19.6% : : : 23.3% 23.5% 23.2%

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Pharmaceuticals and other medical non-durables : 23.6% 22.5% 23.2% 26.5% 21.5% 24.4% 26.1% : : : 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : 6.0% 6.6% 2.7% 6.6% 2.8% 4.3% 3.5% : : : 3.2% 3.3% 3.3%

Prevention and public health services : 0.9% 0.3% 3.1% 1.6% 1.5% 3.0% 2.3% : : : 2.6% 2.6% 2.5%

Health administration and health insurance : 2.9% 2.7% 3.2% 4.0% 2.8% 3.4% 3.2% : : : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : 42.3% 38.6% 34.9% 44.5% 39.3% 43.0% 36.2% : : : 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : 1.6% 1.2% 1.6% 1.6% 1.7% 2.2% 5.3% : : : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care : 16.7% 18.4% 17.1% 9.9% 14.4% 14.0% 16.9% : : : 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables : 10.9% 12.7% 12.3% 12.1% 13.6% 14.8% 16.9% : : : 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : 1.4% 0.3% 0.0% 0.3% 0.0% 1.3% 0.0% : : : 1.6% 1.6% 1.6%

Prevention and public health services : 1.6% 0.3% 4.5% 2.7% 2.5% 5.1% 3.9% 5.0% 4.7% 1.2% 3.2% 2.7% 2.5%

Health administration and health insurance : 4.6% 14.3% 12.7% 8.6% 11.8% 4.8% 5.8% 5.2% 4.4% 4.3% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 0.13 0.09 0.26 0.26 0.48 0.66 0.71 0.79 0.92 0.98 1.04 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.1 0.1 0.1 0.2 0.3 0.3 0.4 0.6 0.5 0.6 0.7 0.9 0.9 0.8

CTS per 100 000 inhabitants 1.3 1.5 1.8 1.8 2.1 2.3 2.4 2.8 3.1 3.2 3.5 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : : : : : : : 0.0 0.1 0.1 0.1

Proportion of the population that is obese 15.5 : : : : 16.9 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : 30.1 : 30.4 : 27.9 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 8.2 8.8 9.9 10.4 12.1 11.8 9.9 9.8 10.2 10.2 : 10.3 10.0 9.8

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Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 279 285 288 294 304 311 299 302 314 314 319 329 335 344

Practising nurses per 100 000 inhabitants 464 477 487 544 535 534 465 486 496 486 488 840 812 837

General practitioners per 100 000 inhabitants 45 53 57 57 58 59 59 : : : : 78 78.3

Acute hospital beds per 100 000 inhabitants 543 534 525 517 513 507 428 344 358 356 350 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 4.8 5.1 5.3 5.6 6.0 6.2 5.9 5.9 6.3 7.0 6.2 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : 19.7 21.3 20.6 21.1 20.3 17.9 14.9 17.6 17.4 17.2 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : : : : 528 : : 6,791 7,198 7,341 6368 6530 7031

Acute care bed occupancy rates 74.0 75.0 74.0 76.0 76.0 75.5 64.0 71.1 70.4 68.1 68.0 72.0 73.1 70.2

Hospital curative average length of stay 7.9 7.8 7.4 7.2 7.1 7.1 6.1 6.2 6.0 5.8 5.8 6.5 6.3 6.3

Day cases as % of all hospital discharges : : 10.6 : : 2.5 : : 27.9 29.3 29.9 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 3.8 4.0 4.2 4.4 4.5 4.4

AWG risk scenario 3.8 4.3 4.8 5.2 5.4 5.3

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 2.0 1.9 1.6 1.5 1.5 1.4

EU- latest national data

EU- latest national data

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Change 2013 - 2060 EU Change 2013 - 2060

-30.7 3.1

0.6 0.9

1.5 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, Lithuania had a GDP per capita of 17.9

PPS (in thousands), below the EU average of 27.9.

Population was estimated at 3 million in 2013,

which is expected to decrease down to 1.8 million

by 2060.

Total and public expenditure on health as % of

GDP

Total expenditure (175) on health as a percentage of

GDP (6.2% in 2013) is below the EU average (176)

of 10.1%. Public expenditure is, at 4.2% of GDP,

equal to the EU average, far below the average of

7.8% in 2013.

When expressed in per capita terms, total spending on health at 1243 PPS in Lithuania is below the EU average of 2988 in 2013. So is public spending on health care: 827 PPS vs. an average of 2208 PPS in 2013.

Expenditure projections

As a consequence of demographic changes, health care expenditure is projected to increase by 0.1 pp of GDP, below the average growth expected for the EU (0.9) (177), according to the Reference Scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 0.9 pp of GDP from now until 2060 (EU1.7).

Overall, Lithuania presents no significant risks of fiscal stress over the short run. Likewise, low risks

(175) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

(176) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

(177) I.e. considering the "reference scenario" of the projections (see The 2015 Ageing Report at

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

appear in the medium term from a debt sustainability analysis perspective, given the relatively moderate level of public debt, and they are due to the unfavourable projected cost of ageing. Medium sustainability risks also appear for Lithuania over the long run. These risks are primarily related to the strong projected impact of age-related public spending (notably pensions and, to a lesser extent, healthcare and long-term care).

Health status

Life expectancy at birth (79.6 years for women and 68.5 years for men in 2013) is far below the respective EU averages (83.3 and 77.8 years of life expectancy). (178) Healthy life years, at 61.6 years

for women and 56.8 for men, are below the EU averages of 61.5 and 61.4 in 2013. The infant mortality rate of 3.7‰; is equal to the EU average of 3.97‰; in 2013, having gradually fallen over the last decade (from 8,1‰; in 2004).

As for the lifestyle of the Lithuanian population, there is a proportion of regular smokers of 24.2% in 2008 higher than the EU average of 23.2% in 2009. Alcohol consumption is, at 14.3, higher than the EU average of 9.8.

System characteristics

Coverage

Compulsory statutory health insurance, based on compulsory insurance contributions, plus transfers from the State budget, provide health care coverage to approximately 98-99% of the resident population. The National Health Insurance Fund (NHIF) and its regional branches, the Territorial Health Insurance Funds (THIFs), contract with care providers for the provision of services and reimburse the insured for medicines. The set of (mostly public) services organised at municipal,

county and national level constitute the Lithuanian

National Health Systems (LNHS). The services

included in the statutory provision are defined by

law. This is broad definition which is further

detailed by decrees of the Minister of Health and

by contracts among THIFs and providers. The

(178) Data on health status including life expectancy, healthy life

years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and

Eurostat database.

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definition of benefit package is not revised

annually.

Free emergency care is provided to the all

permanent residents. Most of the other services are

also free for insured people, but if patients want to

have higher service standard or additional services

not covered by compulsory health insurance they

have to pay to different extents. Cost-sharing

applies to some services: for instance, the majority

of pharmaceuticals and dental services.

The share of private expenditure on health in total health expenditure (33.4% in 2013) is far higher than the EU average (22.6). Out-of-pocket expenditure constitutes about 32.6% of total health expenditure, well above the EU average (14.1% in 2013).

There are several cost-sharing exemptions: 19 categories of population are exempted from payment of compulsory health insurance contributions as they are insured by the government. In 2015, the number of such persons was 1.64 million (almost 56% of the total population). There are also two groups of people to whom a ceiling is applied:

11. various groups of self-employed people on the income calculated on the sum which does not exceed the sum of 48 amounts of the taxable income approved by the government of the Republic of Lithuania for the current year;

12. people on the income from individual agricultural activities of the natural persons,

who engage in that type of individual activities, for whom contributions are being calculated on a sum which does not exceed the sum of 12 amounts of the taxable income.

In addition to formal payments, informal (nonofficial) payments are still reported. These do not encourage a more effective use of services and constitute an additional barrier to access as there are no exemptions for low income or high risk groups.

Administrative organisation and revenue collection mechanism

The NHIF allocates the budget to the THIFs according to a formula based on the number of residents in each county, their age and gender. As it stands, it may be worth exploring if additional gains can be achieved through resource reallocation across the country to improve the geographic distribution of care (there appears to be an overconcentration of services in richer and urban areas and underfunding in other parts of the country). The THIFs then establish contractual

arrangements with service providers.

Expenditure under the Compulsory health

insurance fund is constrained by the sums

approved by the Law on the Approval of Financial

Indicators of the budget of CHIF. The budget of

the CHIF is balanced out within a year. Once a

month, the accounts for the provided health care

services and dispensed medicines and minor

medical aid equipment subject to compensation are

being submitted by the health care institutions and

pharmacies to the THIF wherewith it has

concluded a contract. Under the conditions of the

contracts, without exceeding the approved

appropriations of the budget of the NHIF and not

later than within 30 days from the receipt of a bill,

the THIFs must settle the accounts submitted by

the individual health care institutions and

pharmacies wherewith the said funds have

concluded contracts.

Types of providers, referral systems and patient

choice

Primary care is provided by general practitioners

(GPs) or GP teams, consisting of a district internist
or district paediatrician together with a surgeon
and an obstetrician-gynaecologist, nurses and other
staff. Services are provided in primary care health
centres or GPs private offices, community posts,
ambulatories and polyclinics around the country.

Specialist ambulatory care is provided in
polyclinics and hospital outpatient departments,
mostly state or municipally-owned facilities,
although private provision of specialist outpatient

care is growing. Inpatient care is provided in
general and specialised hospitals. Providers
establish contracts with the THIFs. Virtually all
pharmacies (except for a few) and the majority of
dental practices are private. Pharmacies establish
contracts with THIFs and receive reimbursement
for the pharmaceuticals (included into positive list)
delivered to the patients. Dental practices operate
on a totally private basis. The only exception is
represented by those dental practices which are

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within the structure of Primary health care centres.

The payment for primary dental services is

included into Primary Health Care capitation rate.

The total number of practising physicians per 100

000 inhabitants (428 in 2013) is above the EU

average (344) and has increased gradually since

2003. Data on the physician skill-mix indicates

that the number of GPs per 100 000 inhabitants (86

in 2013), excluding district internists and district

paediatrician which are working very much like

GPs, is above the EU average (78.3). This is due to

a high increase throughout the last two decades as

part of the authorities' efforts to improve primary

care provision (8.3 in 1998). The number of nurses

(755 in 2013) per 100 000 inhabitants is below the

EU average (837 in 2013), having registered an

important reduction since 2003 (759). This may be

associated with staff, particularly nurses, migrating

to other EU countries that need to provide nursing

care and offer better wages. This skill mix, coupled

with non homogenous physician distribution is still

posing some difficulties to a well-functioning

primary health care sector, which is acknowledged

by the authorities.

Since the early 1990s, national authorities have

made a significant and, to a large extent, successful

effort to enhance primary care provision, to

strengthen the referral system from primary care to

specialist doctors and to strengthen the gatekeeping

role of GPs to reduce the unnecessary use

of specialist and hospital care. This is amongst

other things done through a financial incentive to

visit, one's own GP as the first step; i.e. imposing

an extra cost for non-referred consultations. All

inhabitants have to register with a GP who acts

like a family doctor and refers patients to other

types of care. Patients are able to choose their

health centre and their GP and choose a hospital

after referral. To implement a well-functioning

referral system and choice, it is necessary to

continue the efforts so far to change the skill mix

and improve the distribution of primary care across

the country and possibly to improve access to

primary care / GPs after normal office hours

(although office hours are already long compared

to other countries). Shortages of GPs can lead to

high waiting times to visit GPs and therefore

individuals skipping the referral system and going

straight to hospital, making unnecessary use of

(free) emergency care.

Lithuania has one of the largest numbers of acute

care hospital beds per 100 000 inhabitants (530 in

2013) in the EU (EU average of 356 in 2013),

although it has seen a large reduction in the last

two decades (700 in 1998).

These values were perhaps a result of the efforts to

modernise care facilities and improve quality of

care. However, for a country spending a relative

small percentage of their overall GDP on health, it

may be too high a value to allocate to

infrastructure. It may be worth investigating if

investment in infrastructure is still necessary and

to carefully consider what type of infrastructure

can be cost-effective given the size of the country,

the budget for health and the economic situation.

Treatment options, covered health services

Health services in the statutory provision basket

are broadly defined by law. This definition is made more detailed by decrees of the Minister of Health and by contracts among THIFs and their providers.

The definition of the benefit package is not revised annually.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Payment systems have evolved over the years. GPs

(or GP teams) receive a mix of capitation, approximately 74.5 % of total payments in 2015,

according to the number and age of their listed

patients (age-adjusted capitation), fees for defined

activities (health promotion and disease

prevention), as well as bonuses for some

performance indicators (the remaining 25.5 %).

This mixed system intends to render primary care

more attractive and provide incentives for primary

care provision including some health promotion

and disease prevention activities. Authorities are considering a further enlargement of the noncapitation share of GPs' payment, and there is a set of additional performance indicators related to reduction of avoidable hospitalisations elaborated for that. Specialists are paid per consultation, consisting of up to three visits for the same reason; if the patient needs to see specialist further on – the new episode of consultation is reimbursed to the provider. Remuneration is determined by the central government (Ministry of Health).

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Hospitalisation rates are still high although progress towards primary care and reducing hospital capacity has been significant. The number of hospital surgery done as day cases was 2568 day cases per 100 000 inhabitants in 2013 vs. the EU average of 7031). On the contrary, the number of inpatient cases per 100 inhabitants was 23.2 in 2013, above the EU average of 16.5.

Hospitals are paid mostly on the basis of cost per case (450 groups of diagnosis – nationally elaborated DRGs) according to annual contracts.

The decision was made to switch to Australian Refined DRG system from 2012. Implementation was delayed until 2014 due to coding problems.

The hospital budgets are very stringent in terms of budget caps. However, there is flexibility to provide more short-term, day and outpatient services (so-called priority services) instead of ordinary hospitalisations.

The market for pharmaceutical products Imported medicines now come mainly from Western Europe but not from the former Soviet Union, which resulted in a large increase in prices.

The reimbursable price is set on the basis of international prices, which may make pharmaceuticals rather expensive depending on the countries used. As a result, to control overall expenditure, the authorities have implemented some policies: a) the reimbursable price is determined on the basis of 95% of the average of manufacturer prices in CZ, EE, HU, LV, PL,SK,

RO, BG and b) there is a reference price mechanism, whereby the maximum reimbursement price of a new drug is based on other drugs that have both the same active ingredient and form and according to the disease, and c) there are the positive lists (the list of pharmaceuticals that can be reimbursed) as much as possible based on economic evaluation information. Compared to the range of policies used by neighbouring countries, there is perhaps room to explore other additional measures regarding product price regulation and direct expenditure control. On 1st of April 2010, new provisions of the Amendment of Law on Pharmacy concerning the regulation of prices of non-reimbursed pharmaceuticals entered into force. The government sets the maximum wholesaler and pharmacy mark-ups for prescriptions and OTC. The representatives of manufacturers shall provide manufacturer prices for the Lithuanian market, as well as the prices at which the pharmaceuticals are distributed in the reference countries in order to compare them.

Since 2010, there are some novelties in the reimbursement system in Lithuania. The new rule about the price of generic is set by the Governmental Decree. The first generic in the group shall be 50 % cheaper than original, the second 15 % cheaper than the first and the third 15 % cheaper than the second generic. According to the new provisions, every year the price list is renewed in the case when the group of reimbursed medicinal products consists of more than 3 medicinal products of different manufacturers. In this case, the most expensive medicinal product can be only 40% more expensive than the second cheapest in that group. Therapeutically interchangeable pharmaceuticals with different INN are going to be put in one cluster. The pharmaceuticals will be clustered regarding the therapeutic effect, indication of reimbursement, presentation form and age groups of patients. Since 1st of May 2010 pharmacies are obliged to show prices of pharmaceuticals to patients in a special computer monitor. Since 1st of June, 2010 prescribing medicinal product by INN is obligatory

with some exceptions set by the Minister of Health.

eHealth, Electronic Health Record

Health aims to improve the accessibility and quality of healthcare services and to ensure the necessary information exchange using the information and communication technologies.

The Ministry of Health of the Republic of Lithuania has coordinated the is National Electronic Health System Development Program for the period of 2009 – 2015, including the development of e-prescription, data exchange between healthcare institutions, as well as an electronic health record (HER) for patients.

Establishment, deployment and development of the infrastructure and Electronic Health Record services of national eHealth system (ESPBI IS) was one of the most important directions of headway foreseen in the National Electronic Health System Development Programme for the period of 2009–2015 and it remains such in the period of 2015–2025. A key feature of the

Lithuanian eHealth system is that it enables faster,

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safer and more efficient exchange of the data about the patients' treatment services, procedures and lab tests results among healthcare institutions and enables secondary usage of patient health records.

Patient-needs-oriented EHR aims to assure lifelong and effective provision of healthcare services in Lithuania. EHR is being developed gradually, i.e. during the first years it will carry only the most important information of patient health and certain certificates. Later it will be expanded and supplemented with more detailed medical data.

Lithuania strives to involve all healthcare institutions in participation and secure data exchange, to enable successful functioning of the ESPBI IS and to create, store and transfer data about patient health even between European countries according to the principle "one resident – one EHR".

In order to ensure a coherent policy of

development of the eHealth system in Lithuania,

smooth operation of health care institutions, to

save the time of doctors and patients, to receive

health care services of a better quality, the eHealth

System Development Program for period of 2015-

2025 was approved by Order No V-1006 of the

Minister of Health of the Republic of Lithuania of

27 August 2015, i.e. it is aimed that all health care

institutions should participate in the eHealth

system in order to create conditions for all health

care institutions in Lithuania to provide patient's

electronic health records from the health care

institutions information systems or through the

portal www.esveikata.lt.

Health and health-system information and

reporting mechanisms/ Use of Health

Technology Assessments and cost-benefit

analysis

Data has much improved in recent years although

it is still lacking in a number of areas. Information

and monitoring of physician and hospital activity

can be used for example for establishing contracts

and prospective budgets.

Currently there is no structure to conduct health

technology assessment in great part due to the fact

that it requires additional administrative capacity

and scientific know-how, currently not available.

Therefore, cost-effectiveness knowledge is used in

a limited way to determine the benefit package, the

extent of cost-sharing or develop treatment

guidelines to harmonise and rationalise medical

practices.

There is an HTA model developed and

successfully deployed in Lithuania, which is based

on the assessment of applications submitted to

competent HTA bodies, responsible for assessing

medical devices, medical procedures, public health

technologies and medicines according to the

priorities set by the Ministry of Health. The

greatest priority is attributed to the technologies

which have the greatest impact on morbidity,

mortality and disablement.

As introduced earlier, there are indeed a number of

risk factors to health that deserve attention and action. Consequently, the central government has set a number of public health objectives, some of which are very detailed and have been implemented with the help of the WHO. Currently there are six prevention programs carried out in Lithuania: Heart and vascular diseases prevention programme, Sealant program for children, Cervical cancer, Mammography, Colorectal cancer and Prostate cancer screening programmes.

However, total (0.08%) and public (0.08%) expenditure on prevention and public health as a share of GDP is much lower than the EU average (respectively 0.24% and 0.19% in 2013).

Recently legislated and/or planned policy reforms

In 2013 the creation of the Integrated Health **Care** and Functional Cluster System was started, thus seeking to start quality treatment of patients suffering from serious illnesses as soon as possible, to manage patient flows more efficiently and optimise the activities of hospitals.

In order to achieve a more effective operation of

system of the national health care institutions, the next health care system development and hospital network consolidation strategic plan was approved by the Minister of Health in July 2014. The strategic plan foresees the directions and priorities of the Lithuanian national health system development and optimisation.

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Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. the development of a strong primary care system), and which Lithuania should continue to pursue. However, some policies have met with a number of obstacles and there may be room for improvements in a number of areas. The main challenges for the Lithuanian health care system are as follows:

- To improve, as acknowledge by the authorities,

the basis for more sustainable and larger financing of health care in the future (e.g. considering additional sources of general budget funds), with a better balance between resources and demand, between the number of contributors and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources are brought into the sector it is important that they do not remain fragmented but are pooled together maintaining the strong pooling mechanisms in place today.

- To continue to enhance and better distribute primary health care services and basic specialist services to improve equity of access and the effectiveness and efficiency of health care delivery as well as ensuring effective referral systems from primary to specialist care and improving care coordination between types of care. This can be helped through developing

electronic patient records in the future.

- To continue the efforts to decrease hospital

beds while increasing day-case surgery and

concentrating high-tech hospital services.

- To implement a comprehensive human

resources strategy to ensure a balanced skillmix,

avoid staff shortages and motivate and

retain staff to the sector, especially in view of

migration and ageing.

- To consider additional measures regarding

price regulation and direct expenditure control,

including incentives for good prescribing

practices and a more explicit policy on generics

and the monitoring of prescription of drugs.

- To continue to improve data collection and

monitoring of inputs, processes, outputs and

outcomes so that regular performance

assessment can be conducted and use to

continuously improve access, quality and

sustainability of care.

- To gradually increase the use of costeffectiveness

information in determining the

basket of goods and the extent of cost-sharing.

- On the basis of the defined public health

priorities, continue to enhance health

promotion and disease prevention activities, i.e.

promoting healthy life styles and disease

screening given the recent pattern of risk

factors (diet, smoking, alcohol, lack of

exercise, obesity) as detailed in the national

plan, including the smoking ban and health

education in schools and health centres. Taxes

on tobacco, alcohol and soft drinks, stricter

regulation of tobacco advertisement and

labelling as well as stricter road safety

measures and bicycle lanes and greener areas

are some of the measures that can encourage

healthier life-styles.

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Table 1.17.1: Statistical Annex – Lithuania

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

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GDP, in billion Euro, current prices 17 18 21 24 29 33 27 28 31 33 35 9289 9800 9934

GDP per capita PPS (thousands) 14.3 15.0 15.5 16.1 17.0 16.1 14.1 15.3 16.2 17.1 17.9 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 11.2 8.6 9.6 9.5 11.1 4.0 -13.9 3.7 8.5 5.1 4.4 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 12.8 -5.1 12.7 16.4 11.5 10.5 -1.9 -2.4 5.0 2.2 -2.3 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 6.5 5.7 5.8 6.2 6.2 6.6 7.5 7.1 6.9 6.7 6.2 10.4 10.1 10.1

Total current as % of GDP : 5.5 5.7 5.8 5.8 6.3 7.4 6.9 6.6 6.4 6.1 9.8 9.6 9.7

Total capital investment as % of GDP : 0.2 0.2 0.4 0.4 0.3 0.1 0.2 0.3 0.3 0.1 0.6 0.5 0.5

Total per capita PPS 539 515 618 768 941 1139 1078 1071 1189 1253 1243 2828 2911 2995

Public as % of GDP 4.9 3.8 4.0 4.3 4.5 4.8 5.5 5.0 4.7 4.4 4.2 8.1 7.8 7.8

Public current as % of GDP : 3.7 3.8 3.9 4.1 4.5 5.4 4.9 4.7 4.3 4.1 7.9 7.7 7.7

Public per capita PPS 409 333 399 489 619 772 769 736 822 817 827 2079 2218 2208

Public capital investment as % of GDP : 0.2 0.2 0.4 0.4 0.3 0.1 0.1 0.1 0.1 0.1 0.2 0.2 0.1

Public as % total expenditure on health 76.0 67.5 67.8 69.5 73.0 72.3 72.9 70.8 69.1 65.2 66.6 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 14.8 14.4 16.8 15.5 15.0 14.8 14.9 16.5 17.3 16.3 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance : : : : : : : 100.0 100.0 : 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 23.2 32.9 32.8 31.9 28.4 28.2 26.8 27.6 28.2 31.8 32.6 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 3.4 3.4 3.4 3.3 3.2 3.2 3.2 3.1 3.1 3.0 3.0 502.1 504.5 506.6

Life expectancy at birth for females 77.7 77.7 77.4 77.1 77.2 77.6 78.7 78.9 79.3 79.6 79.6 82.6 83.1 83.3

Life expectancy at birth for males 66.4 66.2 65.2 65.0 64.5 65.9 67.1 67.6 68.1 68.4 68.5 76.6 77.3 77.8

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Healthy life years at birth females : : 54.6 56.5 58.1 59.6 61.2 62.3 62.0 61.6 61.6 : 62.1 61.5

Healthy life years at birth males : : 51.4 52.6 53.3 54.5 57.2 57.4 57.0 56.6 56.8 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 128 129 135 140 132 134 131 125 262 255 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 6.7 8.1 7.1 7.2 6.3 5.5 5.6 5.0 4.8 3.9 3.7 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : 1.72 1.77 1.83 1.77 1.84 2.11 1.96 1.90 1.89 1.73 3.13 2.99 3.01

Day cases curative and rehabilitative care : 0.07 0.08 0.11 0.14 0.18 0.22 0.22 0.20 0.11 0.10 0.18 0.18 0.19

Out-patient curative and rehabilitative care : 0.99 0.97 1.15 1.13 1.31 1.53 1.41 1.42 1.33 1.41 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables : 1.87 1.94 1.81 1.66 1.66 1.98 1.84 1.71 1.84 1.73 1.60 1.55
1.44

Therapeutic appliances and other medical durables : 0.19 0.19 0.23 0.20 0.22 0.22 0.24 0.20 0.18 0.18 0.31 0.31
0.32

Prevention and public health services : 0.11 0.11 0.09 0.12 0.08 0.09 0.06 0.08 0.07 0.08 0.25 0.25 0.24

Health administration and health insurance : 0.12 0.12 0.10 0.12 0.20 0.15 0.14 0.13 0.13 0.11 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : 1.57 1.60 1.65 1.60 1.68 1.93 1.82 1.78 1.77 1.59 2.73 2.61 2.62

Day cases curative and rehabilitative care : 0.07 0.08 0.10 0.14 0.17 0.21 0.21 0.20 0.09 0.10 0.16 0.16 0.18

Out-patient curative and rehabilitative care : 0.69 0.70 0.79 0.82 0.91 1.09 0.99 0.96 0.83 0.81 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables : 0.65 0.67 0.65 0.64 0.62 0.77 0.69 0.59 0.58 0.58 0.79 1.07
0.96

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Therapeutic appliances and other medical durables : 0.05 0.04 0.05 0.05 0.05 0.06 0.05 0.05 0.04 0.04 0.13 0.12 0.13

Prevention and public health services : 0.11 0.11 0.09 0.12 0.08 0.09 0.06 0.08 0.07 0.08 0.25 0.20 0.19

Health administration and health insurance : 0.12 0.10 0.09 0.11 0.19 0.15 0.13 0.12 0.11 0.03 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.17.2: Statistical Annex - continued – Lithuania

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : 31.3% 31.3% 31.4% 30.4% 29.0% 28.4% 28.4% 29.0% 29.7% 28.2% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : 1.3% 1.4% 1.9% 2.4% 2.8% 3.0% 3.2% 3.0% 1.7% 1.6% 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : 18.0% 17.2% 19.7% 19.4% 20.7% 20.6% 20.5% 21.6% 20.9% 23.0% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables : 34.0% 34.3% 31.0% 28.5% 26.2% 26.6% 26.7% 26.1% 28.9% 28.2% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : 3.5% 3.4% 3.9% 3.4% 3.5% 3.0% 3.5% 3.0% 2.8% 2.9% 3.2% 3.3% 3.3%

Prevention and public health services : 2.0% 1.9% 1.5% 2.1% 1.3% 1.2% 0.9% 1.2% 1.1% 1.4% 2.6% 2.6% 2.5%

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Health administration and health insurance : 2.2% 2.1% 1.7% 2.1% 3.2% 2.0% 2.0% 2.0% 2.0% 1.8% 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : 42.9% 42.4% 41.9% 38.6% 37.2% 35.8% 36.9% 38.3% 41.5% 39.1% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : 1.9% 2.1% 2.5% 3.4% 3.8% 3.9% 4.3% 4.3% 2.1% 2.5% 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care : 18.9% 18.6% 20.1% 19.8% 20.1% 20.2% 20.1% 20.6% 19.4% 19.9% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables : 17.8% 17.8% 16.5% 15.5% 13.7% 14.3% 14.0% 12.7% 13.6% 14.3% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : 1.4% 1.1% 1.3% 1.2% 1.1% 1.1% 1.0% 1.1% 0.9% 1.0% 1.6% 1.6% 1.6%

Prevention and public health services : 3.0% 2.9% 2.3% 2.9% 1.8% 1.7% 1.2% 1.7% 1.6% 2.0% 3.2% 2.7% 2.5%

Health administration and health insurance : 3.2% 2.6% 2.3% 2.7% 4.3% 2.8% 2.6% 2.5% 2.6% 0.8% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 0.09 0.12 0.15 0.29 0.33 0.42 0.51 0.47 0.59 1.00 1.05 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : 0.5 0.6 0.7 0.7 0.7 0.6 0.7 0.9 0.9 0.8

CTS per 100 000 inhabitants 0.9 1.1 1.2 1.2 1.0 1.3 1.5 1.8 2.0 2.4 2.4 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.1 0.1 0.1

Proportion of the population that is obese : : : : : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : 27.0 24.5 26.5 : 24.2 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 11.3 12.1 12.3 12.7 13.4 13.3 12.4 12.9 12.7 14.4 14.3 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

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Practising physicians per 100 000 inhabitants 363 356 362 365 372 370 365 383 409 422 428 329 335 344

Practising nurses per 100 000 inhabitants 724 713 710 711 705 711 697 716 753 759 755 840 812 837

General practitioners per 100 000 inhabitants 65 65 66 67 69 68 69 72 85 85 86 : 78 78.3

Acute hospital beds per 100 000 inhabitants 581 555 528 510 509 505 502 513 538 538 530 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 6.5 6.7 7.0 6.8 7.2 7.3 7.2 7.3 7.7 8.0 8.1 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 22.0 22.2 22.1 21.3 21.6 21.7 21.9 22.6 23.8 : 23.2 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 523 610 822 982 1,374 1,605 1,729 1,927 2,349 : 2,568 6368 6530 7031

Acute care bed occupancy rates 73.0 77.0 79.0 76.0 76.0 72.7 72.4 72.0 73.1 72.5 71.6 72.0 73.1 70.2

Hospital curative average length of stay 7.5 7.4 7.3 7.1 6.9 6.7 6.4 6.3 6.4 6.3 6.3 6.5 6.3 6.3

Day cases as % of all hospital discharges 2.3 2.7 3.6 4.4 6.0 6.9 7.3 7.9 9.0 : 10.0 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 4.2 4.4 4.6 4.7 4.5 4.3

AWG risk scenario 4.2 4.7 5.3 5.5 5.4 5.1

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 3.0 2.6 2.2 2.0 1.9 1.8

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-38.1 3.1

0.1 0.9

0.9 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population

GDP per capita (63,577 PPS in 2013) of

Luxembourg is the highest in the EU. Despite

decreasing significantly since its peak in 2007

(72,780 PPS), it remains more than double of the

EU average of 24,600 PPS. Economic output is

expected to continue growing significantly faster

than the euro-area average. During 2015,

Luxembourg's economy was expected to register

positive growth of 4.7%, which is expected to

continue by 3.8% in 2016 and by 4.4% in 2017

(179). Currently, the population is 0.5 million and

projected to more than double by 2060, reaching

1.1 million.

Total and public expenditure on health as % of

GDP

Total expenditure on health as a percentage of

GDP (7.1% in 2013) is below the EU average

(10.1% in 2013) and has decreased over the last

decade, though with fluctuations, from a level of

8.2% in 2004. Public expenditure on health as a

percentage of GDP has followed the same path,

and is with 5.9% both below the EU average and

its value in 2004 (7.8% and 7% respectively).

However, when expressed in per capita terms, both

total and public expenditure (5,091 PPS and 4,260

PPS in 2013) are well above the EU average

(2,988 PPS and 2,208 PPS in 2013).

Expenditure projections and fiscal sustainability

As a result of population ageing (180), health care

expenditure is projected to increase by 0.5 pps of

GDP (below the average change in the EU of 0.9

pps in the "AWG reference scenario"). When

taking into account the impact of non-demographic

drivers on future spending growth ("AWG risk

scenario"), health care expenditure is expected to

(179) European Commission (2016), European Economic

Forecast Winter 2016.

(180) I.e. considering the "pure ageing scenario" of the

projections (see The 2009 Ageing Report at:

[http://ec.europa.eu/economy](http://ec.europa.eu/economy_finance/publications/publication14992_en.pdf)

finance/publications/publication14992_en.pdf).

increase by 0.8 pps of GDP from now until 2060

(EU: 1.6) (181).

Sustainability risks appear to be low in the

medium-term from a debt sustainability analysis

perspective due to the low level of debt at the end

of projections (2026). However, in the long run,

Luxembourg faces medium risks to fiscal

sustainability. These risks are entirely driven by

the necessity to meet future increases in ageing

costs (notably pension and long-term **care**

expenditure) (182).

Health status

Life expectancy (83.9 for women and 79.8 for men

in 2013) and healthy life years at birth (62.9 for

women and 63.8 for men in 2013) are all above the

EU average and have overall increased over the

last decade, although the trend seems to be inverted in recent years for healthy life years, both for women and men (183). Mortality is mainly due to cardiovascular diseases, cancers, ischaemic heart, cerebrovascular and respiratory diseases.

(184) Transport accidents are slightly above the EU average, but broadly in line with it and death due to intentional self-harm is lower compared to EU average. In addition, infant mortality is amongst the lowest of the EU thanks to comprehensive and free antenatal and postnatal services. Amenable mortality, mortality rates which are thought avoidable if appropriate and timely care is delivered, is below EU average (in 2011, 116 vs 128.4 at EU level). As for the lifestyle of population, an increasing trend in the share of overweight population seems to have characterised Luxembourg in the past years. On the contrary, alcohol consumption has been decreasing over the past decade and so has the share of regular smokers. Programmes to prevent obesity through healthy eating and sports have already been launched, especially among young and children,

and, paired with other existing initiatives to

promote healthy behaviours, such as regulations on

(181) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(182) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

(183) Data on life expectancy and healthy life years is from the

Eurostat database.

(184) Health Systems in Transition, HiT in Brief Luxembourg,

WHO (2015).

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alcohol advertising, they should be further

expanded (185).

System characteristics

Overall description of the system

In 2013, about 83.7% of total health expenditure

was public expenditure (statutory insurance

contributions and taxation), about 10.8% was outof-

pocket spending and the remaining 5.6% mainly

came from voluntary private health insurance.

Compulsory health insurance (186) is provided and

managed by the National Health Insurance (Caisse

Nationale de Santé, CNS), which was created by

merging multiple sickness funds into one single

payer in 2009. The CNS is obliged to maintain a

reserve between 10% and 20% of the total planned

expenditure (187).

The health insurance is mainly financed by

contributions. Contributions are equally split

between employers and employees, which are

calculated as percentage of gross-income (188).

Different rules apply to the self-employed and

specific professions. The central government

participates by paying 40% of the contributions. If

gross-income does not exceed a certain level, no

contributions have to be paid as a means to support

low income or disadvantaged groups.

Coverage

Luxembourg's health care is based on a very

comprehensive compulsory health insurance

package. In 2012, 97.2% (189) of all citizens and

registered residents were covered by the statutory

health insurance system. Further, the system

(185) <http://www.clep.lu/code-de-deontologie/>.

(186) The social health insurance comprises health **care**, longterm

care and accident insurance

(187) According to the OECD, Luxembourg scores 1 out of 6 in

the OECD scoreboard due to the not very stringent budget

controls. See Joumard, I., C. André and C. Nicq (2010),

“Health **Care** Systems: Efficiency and Institutions”, OECD

Economics Department Working Papers, No. 769, OECD

Publishing, p. 39. doi: 10.1787/5kmfp51f5f9t-en

<http://www.oecd.org/officialdocuments/publicdisplaydocu>

mentpdf/?doclanguage=en&cote=eco/wkp(2010)25.

(188) With a maximum limit of five times the minimum

guaranteed income.

(189) Health Systems in Transition, HiT in Brief Luxembourg,

WHO (2015).

covers a high number of cross-border workers and

their family members.

Administrative organisation

Health system regulation is a shared responsibility

of the Ministry of Health and the Ministry of Social Security, which cooperate regarding the organisation, legislation and financing of the system. The Ministry of Health focusses on the planning and organisation of health care service delivery, enacting laws and regulations applying to health providers and directly co-finances public health programmes. It is further responsible for the determination of the national hospital plan and the scope of work of health care professionals. The Ministry of Social Security defines social policy and oversees the public institutions funded by the health, accident and long-term care insurance schemes. Public expenditure on health administration and health insurance as a percentage of GDP (0.1%) is below the EU average (0.47%). Public expenditure on health administration and health insurance as a share of total current health expenditure is also below average with 1.5% recorded for 2012 (vs. EU average 4.9% in 2013).

Role of private insurance and out of pocket

co-payments

A low level of cost-sharing applies to many services. A higher level of cost-sharing applies to glasses and contact lenses, dental care and dental prostheses. Cost-sharing exemptions apply for people where the amount of cost-sharing exceeds 2.5% of the gross-income. In fact, out-of-pocket spending accounts for only a small part of private expenditure and decreased over the last decade (10.8% of total health spending which is less than the EU-average of 14.1%, after a decrease during the last decade from a level of 13.3%). Additional voluntary private insurance is taken up by around 56% of the population to cover out-of-pocket payments and cost sharing (complementary insurance). Note, however, that voluntary private health insurance schemes only account for about 4.2% of total expenditure in 2011. As a proportion of total benefits reimbursed, the part of voluntary insurance remains then very low since the compulsory system reimburses a comprehensive set of services.

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Types of providers, referral systems and patient

choice

Primary care is provided by general practitioners

(GPs) who are self-employed and mostly work in

individual private practices. Specialist outpatient

care is provided by self-employed individuals

working in their own private practices and/or

hospital.

In Luxembourg, the number of practising

physicians per 100 000 inhabitants (281 in 2013) is

below the EU average (344 in 2013). The number

of GPs has increased, from 78 in 2005 to 86 per

100.000 inhabitants in 2013, which is higher than

the average in the EU. To practise, physicians need

an approval of their qualifications by the Ministry

of Health but there are no legal barriers to limit the

medical personnel as such, especially since the EU

legislation on mutual recognition of medical

qualifications has been introduced. Considering

that the system remains quite attractive, the number of physicians practising in Luxembourg is expected to continue to increase even if the high proportion of physicians aged 45+ (68% in 2007), likely to retire in the short to medium term, will lessen this inflow. In comparison, the number of nurses per 100 000 inhabitants (1193) is one of the highest of the EU and there are 4.1 practising nurses per physician. The remuneration of nurses is indeed very attractive in Luxembourg, with a ratio of 1.4 to the average wage of the working population in Luxembourg.

Patients are free to register with a GP but GPs have no gate-keeping role: patients can directly consult specialists even in the case of common primary

care. Patients have the right to choose their GP, specialist and hospital and there are no legal means to limit the volume of activity even if there are some limitations on the number of visits to more than one physician of the same speciality within a certain period of time. In this context of free choice, improving the availability and transparency

of information about health care providers' activity

and availability is essential to optimise the patients'

choice. Finally, pharmaceuticals are exclusively

distributed through pharmacies whose number is

strictly controlled by the authorities.

Pricing, purchasing and contracting of

healthcare services and remuneration

mechanisms

Physicians are paid on a fee-for-service basis.

There are no performance-related payment

bonuses for example to provide incentives for costeffective

health promotion, disease prevention, or

disease management. The fees for medical services

are negotiated every 2 years between the National

Health Insurance and representatives of health care

professionals. Every health care provider has to be

contracted with the CNS; and it is determined by

law that they must adhere to the fees agreed upon.

Health care services in Luxembourg are organised

based on a reimbursement system. Generally, the

patient has to pay the costs in advance and submits

the receipts to the CNS for partial or total

reimbursement. Exceptions apply to hospital

treatments as well as third party payment for

disadvantaged groups.

Hospitals are financed by the National Health

Insurance. Every two years, the government

decides upon a global budget which is then divided

annually by the health insurance between the

hospitals. Hospitals (190) have autonomy to recruit

their staff. The hospitals are encouraged to review

their quality management regularly. These efforts

have been undertaken by the CNS in order to

improve quality and cost-containment; the activity

is combined with a financial reward.

Hospital discharge rates per 100 inhabitants are

below the EU average (13.2 vs 16.5 in 2013) for

inpatients and decreased over the last ten

years (191). Conversely, after increasing all through

the last decade, day-case discharges per 100 000

inhabitants are above EU average (7,395 vs 7,031).

The average length of stay (7.3 days in 2013) is

above the EU average (6.3 days) but has been quite

stable over the last ten years. This may partly be a

consequence of a financing system based on global

hospital budgets, which does not directly incentivise its reduction. To tackle this issue, in light of the relatively low bed occupancy rate, the current system based on the global budget could benefit from including some elements of activity- (190)

<http://www.legilux.public.lu/leg/textescoordonnes/codes/co>

de_securite_sociale/code_securite_sociale.pdf#page=57.

(191) Eurostat.

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based reimbursement, to promote a more efficient use of resources.

Since 1995, for pharmaceuticals, patients must pay only the part of the costs to the pharmacy not being reimbursed by the health insurance. (192)

The market for pharmaceutical products

Total expenditure on pharmaceuticals as a percentage of GDP (193) is well below the EU average (0.62% (194) vs. 1.44% in 2013) while consumption is around average.

Luxembourg imports all pharmaceuticals products at prices based on those used in the country of origin which normally is Belgium, Germany or France (195). Drugs are sold in pharmacies only.

The counsellor's role of the pharmacist has been increased by encouraging the substitution of a drug by a cheaper one if they have the same qualitative and quantitative fundamentals. For this purpose, doctors and pharmacists have a list of exchangeable products. The CNS maintains a comprehensive list of drugs approved for reimbursement (positive list). There are three categories of reimbursement for pharmaceuticals for outpatient care, with reimbursement rates of 40%, 80% or 100%. Drugs administered at the hospital fall under hospital's budget and are thus free of charge for the patient.

Use of Health Technology Assessments and cost-benefit analysis;

The use of Health Technology Assessment appears to be limited in terms of the definition of the benefit basket.

(192) Positive list of pharmaceuticals, reimbursement is possible

only if on list Cf Art 22 CSS

<http://www.legilux.public.lu/leg/textescoordonnes/codes/co>

de_securite_sociale/code_securite_sociale.pdf#page=57.

(193) Expenditure on pharmaceuticals used here corresponds to

category HC.5.1 in the OECD System of Health Accounts.

Note that this SHA-based estimate only records

pharmaceuticals in ambulatory **care** (pharmacies), not in

hospitals and that over the counter drugs are not included

either.

(194) Latest available figure is 2012.

(195) When determining the price for products imported from

outside Europe, the price of the product in Belgium, France

and Germany is taken into account.

Health and health-system information and

reporting mechanisms;

Luxembourg has been quite active in this field in

recent years and a number of projects have been

established to monitor and collect health **care** data.

The Luxembourgish government has adopted a

national eHealth plan which envisages the

establishment of a national eHealth agency and the

introduction of an electronic health record,
enabling the exchange and sharing of health data
between health care professionals. The aim is to
improve quality and performance of the system
and to control the development of expenditure,
especially by avoiding redundant tests and
examinations. In the medium term, each patient
will have a personal file containing administrative
data and diagnostic data such as laboratories
results, radiological data and medications register.

Health promotion and disease prevention
policies;

Several programmes are in place in order to
promote health, including breast cancer screening,
smoking cessation, free contraception, prenatal and
postnatal programmes, and flu vaccination.

Further, the Ministry of Health supports school
health programmes, vaccination programmes,
healthy living programmes and the distribution of
health education material.

Public expenditure on prevention and public health
services as a percentage of GDP (0.13%) and as a

percentage of total current health expenditure

(1.9%) are well below the EU average in 2013

(0.24%).

Recently legislated and/or planned policy

reforms

Facing the general economic crisis in Europe, the

reform of the health system from 2010 (196) not

only tried to tackle the negative effects of the crisis

but provided also some structural changes in order

to improve the quality of care and to rationalise

expenditure.

Measures include the creation of the Cellule

d'expertise médicale to review services and

(196)

<http://www.legilux.public.lu/leg/a/archives/2010/0242/a24>

2.pdf#page=2.

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medical devices proposed for introduction into the

health benefit basket or the modification thereof.

In addition, the possibility was introduced for

patients, especially chronically ill persons, to choose a doctor as a reference point for their medical treatments and follow-ups. The GP organises the care path and manages the patients' medical records, for which the eHealth agency is responsible.

The standardisation of medical procedures and the organisation of hospital networks as well as a better coordination between primary and hospital

care were actively supported to improve quality and efficiency. Further, policies promoting greater generic drug substitution (patients refusing the substitution proposed by the pharmacist have greater proportion of cost-sharing) have been introduced. Measures also included the introductions/strengthening of tools to monitor the quality of care and to increase transparency (at patient, hospital and physician level, as well as at the health insurance level). In particular, the law of 2010 scheduled the creation of an electronic patient file to be used in all health care sectors and

containing all the information related to the health

status of a patient.

For the legislative period 2013-2018 the

government intends to strengthen health care

promotion and prevention of diseases by

integrating health questions in all policies ("health

in all policies"). The ongoing growth of health care

expenditure shall be aligned to the economic

growth of the country.

The major new policy plans include:

- creation of a Health Observatory: preparing anonymous epidemiological data necessary for working out national action plans in order to fight diseases such as cancer, chronic or cardiovascular diseases and the evaluation of measures taken in the context of national health policy;

- creation of a health care fund: revenues come from taxes on products and substances whose consumption badly influences health;

- introduction of a DRG System (197) (tarification à l'activité) instead of the hospital

budgeting system.

Challenges

The analysis above has shown that a range of reforms have been implemented in recent years – e.g. improvements regarding hospital efficiency, improved data collection and monitoring and the control of pharmaceutical expenditure – and which Luxembourg should continue to pursue. The main challenges for the Luxembourgish health care system are as follows:

- To improve the basis for more sustainable and efficient financing of health care in the future (e.g. considering additional sources of general budget funds), aiming at a better balance between resources and spending.
- To continue to enhance and better distribute primary health care services to improve effectiveness and efficiency of health care delivery. To continue to shift excessive capacity and activity of acute inpatient care towards ambulatory and outpatient care

services, and strategically directing more resources towards providers of lower levels of

care.

- To implement a monitoring of human resources

in the health **care** sector that ensures a balanced skill-mix, that avoids staff shortages and that motivates and retains staff to the sector in the future. In addition, to consider enhancing financial and institutional incentives for health

care professionals to provide adequate levels of services to patients based on quality indicators, performance-based reporting and payment bonuses.

- To increase the use of cost-effectiveness information, such as HTAs, in determining the basket of goods.

(197) Diagnosis related group (DRG) is a patient classification system adopted on the basis of diagnosis consisting of distinct groupings. It is a scheme that provides a means for relating the type of patients a hospital treats with the costs incurred by the hospital. DRG are based upon the patient's principal diagnosis, ICD diagnoses, gender, **age**, sex,

treatment procedure, discharge status, and the presence of

complications or comorbidities.

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- To improve the systems for data collection and

monitoring of inputs, processes, outputs and

outcomes so that regular performance

assessment can be conducted.

- Promote the use of the recently deployed

eHealth tools including electronic patient

records can help ensuring effective referral

systems from primary to specialist **care** and

improving **care** coordination between types of

care.

- To foster public action in the area of health

promotion and disease prevention on the basis

of the defined public health priorities (diet,

smoking, alcohol, lack of exercise), given the

pattern of risk factors.

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Table 1.18.1: Statistical Annex – Luxembourg

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 26 28 30 33 37 38 36 40 42 44 47 9289 9800 9934

GDP per capita PPS (thousands) 64.3 67.5 66.0 69.2 72.8 69.6 62.3 64.4 65.8 63.3 63.6 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 0.4 3.0 3.6 3.3 4.9 -2.5 -7.3 1.2 -0.4 -2.4 -0.4 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 13.2 10.1 0.4 0.7 -8.0 5.2 2.4 -4.2 -4.2 -5.2 -1.5
3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 7.7 8.2 8.0 7.8 6.8 7.3 8.1 7.7 7.4 7.2 7.1 10.4 10.1 10.1

Total current as % of GDP 7.1 7.5 7.1 6.7 6.2 6.7 7.6 7.2 6.9 6.8 : 9.8 9.6 9.7

Total capital investment as % of GDP 0.6 0.7 0.8 1.1 0.6 0.7 0.5 0.5 0.4 0.4 : 0.6 0.5 0.5

Total per capita PPS 3610 4125 4240 4567 4344 4726 4931 5002 5044 4932 5091 2828 2911 2995

Public as % of GDP 6.5 7.0 6.8 6.6 5.8 6.5 7.0 6.6 6.3 6.0 5.9 8.1 7.8 7.8

Public current as % of GDP 5.9 6.2 5.9 5.5 5.2 5.8 6.5 6.1 5.9 5.6 : 7.9 7.7 7.7

Public per capita PPS 2165 2387 2443 2489 2508 2703 2823 2837 2558 2730 : 2079 2218 2208

Public capital investment as % of GDP 0.6 0.7 0.8 1.1 0.6 0.7 0.5 0.5 0.4 0.4 : 0.2 0.2 0.1

Public as % total expenditure on health 84.2 84.9 84.9 85.2 85.6 88.4 86.7 85.8 85.4 83.4 83.7 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 11.5 12.0 12.5 11.9 12.1 12.0 11.9 11.5 11.5
11.5 : 14.8 14.9 :Proportion of the population covered by public or primary private health insurance 98.7 98.8 98.7 98.2 97.9 : : :
97.2 96.9 96.4 99.7 99.7 98.7

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Out-of-pocket expenditure on health as % of total expenditure on health 13.3 12.8 12.9 13.4 10.3 10.1 9.9 10.2
11.2 11.6 10.8 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 502.1 504.5 506.6

Life expectancy at birth for females 80.8 82.4 82.3 81.9 82.2 83.1 83.3 83.5 83.6 83.8 83.9 82.6 83.1 83.3

Life expectancy at birth for males 74.8 76.0 76.7 76.8 76.7 78.1 78.1 77.9 78.5 79.1 79.8 76.6 77.3 77.8

Healthy life years at birth females : 60.2 62.4 62.1 64.6 64.2 65.9 66.4 67.1 66.4 62.9 : 62.1 61.5

Healthy life years at birth males : 59.5 62.3 61.2 62.3 64.8 65.1 64.4 65.8 65.8 63.8 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 81 69 65 66 63 59 61 57 116 103 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.9 3.9 2.6 2.5 1.8 1.8 2.5 3.4 4.3 2.5 3.9 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 1.96 2.02 1.90 1.74 1.62 1.65 1.91 1.75 1.67 1.68 : 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.00 : : 0.00 0.15 0.17 0.15 0.15 0.19 : 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.08 2.26 2.14 2.05 1.98 2.15 2.42 2.35 2.20 1.92 : 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 0.78 0.78 0.73 0.68 0.66 0.68 0.75 0.69 0.66 0.62 : 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.17 0.17 0.16 0.16 0.16 0.15 0.17 0.17 0.16 0.16 : 0.31 0.31
0.32

Prevention and public health services 0.14 0.12 0.16 0.13 0.14 0.12 0.18 0.14 0.14 0.13 : 0.25 0.25 0.24

Health administration and health insurance 0.10 0.10 0.12 0.09 0.09 0.09 0.12 0.21 0.09 0.10 : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

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Inpatient curative and rehabilitative care 1.76 1.83 1.70 1.58 1.42 1.55 1.74 1.59 1.55 1.51 : 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.00 : : : 0.00 0.15 0.17 0.15 0.14 0.17 : 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.76 1.92 1.80 1.68 1.63 1.81 2.01 1.92 1.73 1.43 : 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.65 0.66 0.61 0.58 0.55 0.59 0.64 0.59 0.55 0.51 : 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.08 0.09 0.08 0.08 0.08 0.08 0.09 0.09 0.08 0.08 : 0.13 0.12 0.13

Prevention and public health services 0.13 0.12 0.16 0.13 0.13 0.12 0.18 0.14 0.13 0.13 : 0.25 0.20 0.19

Health administration and health insurance 0.08 0.08 0.08 0.08 0.07 0.08 0.09 0.08 0.08 0.08 : 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.18.2: Statistical Annex - continued – Luxembourg

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 27.7% 27.0% 26.6% 26.0% 26.2% 24.7% 25.0% 24.3% 24.1% 24.8% : 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 0.0% : : : 0.0% 2.2% 2.2% 2.1% 2.2% 2.8% : 1.8% 1.9% 1.9%

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Out-patient curative and rehabilitative care 29.4% 30.2% 30.0% 30.6% 32.0% 32.2% 31.7% 32.7% 31.7% 28.4% : 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 11.0% 10.4% 10.2% 10.2% 10.7% 10.2% 9.8% 9.6% 9.5% 9.2% : 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 2.3% 2.3% 2.3% 2.4% 2.6% 2.3% 2.2% 2.4% 2.3% 2.4% : 3.2% 3.3% 3.3%

Prevention and public health services 2.0% 1.6% 2.2% 1.9% 2.3% 1.8% 2.4% 1.9% 2.0% 1.9% : 2.6% 2.6% 2.5%

Health administration and health insurance 1.4% 1.3% 1.7% 1.3% 1.5% 1.3% 1.6% 2.9% 1.3% 1.5% : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 30.0% 29.4% 28.7% 28.5% 27.3% 26.6% 26.6% 26.1% 26.5% 27.0% : 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 0.0% : : : 0.0% 2.5% 2.5% 2.4% 2.4% 3.1% : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care 30.0% 30.8% 30.4% 30.3% 31.3% 31.0% 30.7% 31.5% 29.5% 25.6% : 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 11.1% 10.6% 10.3% 10.5% 10.6% 10.1% 9.8% 9.7% 9.4% 9.1% : 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 1.4% 1.4% 1.4% 1.5% 1.5% 1.4% 1.4% 1.5% 1.4% 1.5% : 1.6% 1.6% 1.6%

Prevention and public health services 2.2% 1.9% 2.7% 2.3% 2.5% 2.1% 2.8% 2.3% 2.2% 2.3% : 3.2% 2.7% 2.5%

Health administration and health insurance 1.4% 1.3% 1.3% 1.4% 1.4% 1.4% 1.3% 1.3% 1.4% 1.5% : 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 1.11 1.09 1.07 1.06 1.04 1.23 1.41 1.38 1.35 1.32 1.29 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 1.1 1.1 1.1 1.7 1.7 1.6 1.6 1.6 1.5 1.5 1.5 0.9 0.9 0.8

CTS per 100 000 inhabitants 2.7 2.8 2.8 2.8 2.7 2.7 2.6 2.6 2.5 2.4 2.2 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.2 0.1 0.1 0.1

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Proportion of the population that is obese 18.2 18.6 20.4 20.0 20.3 22.1 22.1 22.5 23.5 23.0 22.7 14.9 15.4 15.5

Proportion of the population that is a regular smoker 28.0 27.0 23.0 21.0 21.0 20.0 19.0 18.3 16.9 16.8 15.7 23.2 22.4 22.0

Alcohol consumption litres per capita 12.6 12.4 11.8 12.0 11.8 11.5 11.4 11.4 11.4 11.3 11.0 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 238 242 255 261 268 272 270 277 276 278 281 329 335 344

Practising nurses per 100 000 inhabitants 894 909 1097 1094 : : 1112 1105 1127 1192 1193 840 812 837

General practitioners per 100 000 inhabitants 67 69 78 77 82 81 79 82 82 83 86 : 78 78.3

Acute hospital beds per 100 000 inhabitants : 502 454 447 440 432 421 414 406 396 387 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 6.3 6.5 6.5 6.4 6.5 6.6 6.7 6.4 6.6 6.6 6.5 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 17.1 16.8 16.2 15.8 15.7 15.7 15.2 14.5 14.7 14.3 13.2 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 4,188 4,361 4,475 5,065 5,685 6,364 6,493 6,204 6,983 7 ,403 7,395 6368 6530 7031

Acute care bed occupancy rates : 64.0 69.0 70.0 70.0 70.7 71.8 71.1 71.1 72.0 70.4 72.0 73.1 70.2

Hospital curative average length of stay 7.3 7.1 7.2 7.4 7.4 7.3 7.4 7.5 7.3 7.4 7.3 6.5 6.3 6.2

Day cases as % of all hospital discharges 19.9 20.8 21.7 24.5 26.9 : 29.9 30.0 32.2 34.2 35.9 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 4.6 4.6 4.7 4.8 5.0 5.1

AWG risk scenario 4.6 4.6 4.8 5.0 5.3 5.4

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 0.5 0.6 0.8 0.9 1.1 1.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

110.5 3.1

0.5 0.9

0.8 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

GDP per capita is currently below EU average

with 21,620 PPS in 2013 (EU: 27,900). The

population was estimated at 0.4 million in 2013. It

is expected to stay within half a million in the

coming decades, with the fastest expansion

occurring in the next years. The total population is

projected to grow from 421,364 in 2013 to around

476,000 by 2060.

Total and public expenditure on health as % of

GDP

Total expenditure on health as a percentage of

GDP (8.7% in 2013) has increased over the last

decade (from 8.2% in 2003) and is below the EU

average of 10.1% in 2013. Throughout the last

decade, public expenditure has first increased then

decreased as share of GDP: from 5.7% in 2003 up

to 6.3% in 2006, and then down to 5.8% of GDP in

2013 (EU: 7.8% in 2013). When expressed in per

capita terms, also total spending on health at 2,171

PPS in 2013 was below the EU average of 2,988 in

2013. So was public spending on health care:

1,435 PPS vs. an average of 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care

expenditure is projected to increase by a

considerable 2.1 pps of GDP between 2013- 2060,

high above the average growth expected for the

EU of 0.9 pps of GDP, according to the "AWG

reference scenario". When taking into account the

impact of non-demographic drivers on future

spending growth ("AWG risk scenario"), health

care expenditure is expected to increase by 3.0 pps

of GDP from now until 2060 (EU: 1.6) (198).

Medium sustainability risks appear for Malta over

the long run. These risks are entirely related to the

strong projected impact of **age**-related public

(198) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

spending (notably pensions, healthcare and longterm

care) (199).

Health status

Life expectancy at birth, 84.0 years for women and

79.6 years for men, is above the respective EU

averages of 83.1 and 77.6 years in 2013. Healthy

life year expectancy is very high with 72.7 years

for women and 71.6 for men in Malta versus 61.8

and 61.6 in 2013 in the EU (200). The infant

mortality rate of 6.7‰; is above the EU average of

3.9‰; in 2013, having remained relatively

consistent throughout the last decade, however

caution needs to be exercised when interpreting

such figures in view of the fact that termination of

pregnancy is illegal in Malta.

As for the lifestyle of the Maltese population, the data indicates a proportion of regular smokers of 19.2% in 2008, being below the EU average of 22%. The proportion of the obese population is far above EU level at 23% in 2009 (EU: 15.5%), while the alcohol consumption is below the EU level.

System characteristics

Overall description of the system

A National Health Service (NHS), managed by the Ministry of Health and funded through taxation, provides coverage for a comprehensive range of services (preventive, curative and rehabilitative **care**).

Coverage

The Maltese health **care** system is based on the principle of equity and solidarity with universal coverage, where a comprehensive basket of services is offered free at the point of use to all entitled persons. The system also provides coverage for vulnerable population groups such as

illegal migrants.

(199) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

(200) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and Eurostat database.

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Administrative organisation and revenue

collection mechanism

The budget for the public health sector is defined annually in Parliament when the general budget is approved. A specific unit for financial management and control has been set up to monitor and control the financial management of the public health system.

Role of private insurance and out of pocket co-payments

Private expenditure constituted a relatively high

share, with 33.9%, of total health expenditure in 2013, which is above the EU average of 22.6%. A large part of private expenditure is out-of-pocket expenditure (31.5% of total health expenditure in 2013 and much higher than the respective EU average of 14.1%), showing an increase since 2003 (29%). Authorities ensure means-tested entitlement (for people with low incomes) to pharmaceuticals, dental and optical care, i.e. benefits mostly excluded from the free public healthcare basket. The remainder is left to private health insurance whose share of private expenditure has remained steady over the last few years. The chronically ill are provided with free medicines according to their condition in a system which is separate from the one mentioned above. Types of providers, referral systems and patient choice

The public health-care system is the key provider of health services. The private sector complements the provision of health services, in particular in the area of primary health care. In addition some

services, especially for long-term and chronic care,
are also provided by the private sector, the Church
and other voluntary organisations.

The public health-care system provides a
comprehensive basket of services to all persons
residing in Malta who are covered by the Maltese
social security legislation and also provides for all
necessary care to groups such as irregular
immigrants and foreign workers who have valid
work permits. There are no user charges or copayments
for health services. The private sector
acts as a complementary mechanism for healthcare
coverage and service delivery.

The state health service and private general
practitioners (GPs) provide primary health-care
services. Increasing the effectiveness and
consolidation of the position of the primary health
care system is the cornerstone of the National
health care system. To this effect a number of
actions have been implemented to strengthen
quality and efficiency of services such as new

referral systems in liaison with the private family

doctor. Private family doctors are empowered to

directly refer patients with musculoskeletal

problems for physiotherapy services in Primary

Health Care setting. Both Public and Private

Doctors also refer their patients for Bone

Densitometry and X-Rays.

Secondary and tertiary care is mainly provided by

specialised public hospitals of varying sizes. The

main acute general services are provided by one

teaching hospital incorporating all specialised,

ambulatory, inpatient care and intensive-care

services. There has been a significant amount of

investment in public-private partnerships, in order

to improve the capacity in terms of surgical

operations as well as diagnostic and emergency

services.

Under the NHS, primary care is delivered through

a network of public health centres, provided by

general practitioners (GPs), nurses and some

specialists. NHS outpatient specialist care is

centred in the hospitals outpatient departments, in which most of the specialists work, with a number of ambulatory specialist clinics being held in primary health centres. Hospital care is mostly delivered in NHS hospitals. In addition to NHS provision, there is also private outpatient primary care and basic specialist care practice, given mostly from the private doctor's office, for private patients, though often conducted by the same doctors that work for the NHS.

To emphasise primary care use there is a compulsory referral system from primary care to specialist doctors and GPs act like gatekeepers to specialist and hospital care. However, this system is very often bypassed by patients attending specialist health care directly in the private sector.

One reason is the degree of choice of GP, or specialist, in the private sector and the other is that in certain specialist areas there are relatively long waiting times.

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Some of the health centres are equipped to deal with minor emergencies for 24 hours and 7 days a week. Nevertheless, the mainstay amongst the Maltese public for treatment for emergencies, minor or major tends to be directly at the accident and emergency department at Mater Dei Hospital.

As a rule, patients consult more frequently GPs in the private sector than GPs in the public sector, mostly due to the continuity of care that the same GP in the private sector can provide, as opposed to the GP on call in the public sector. However, not all GPs in the private sector are well equipped to deal with any sort of emergency, especially those requiring urgent investigations such as specific blood tests and radiography. Furthermore, shortages of GPs in the NHS still result in waiting times for primary care, which, combined with high patient expectations, has led to some excess and unnecessary use of NHS specialist and hospital emergency care or patients searching for private

care. This peaks in weekends when private

practitioners tend to have their days off.

A number of initiatives are being adopted in Malta

to help alleviate this problem. There has been

active engagement of the ministry responsible for

health with financial authorities as the setting up of

group medical practices was being hindered by

some regulatory barriers in the legislation on the

setting up of partnerships or companies. In

addition, European investment is being sought to

create a major primary care hub which should

alleviate the congestion at the hospital. Indeed,

according to this plan, a number of services,

particularly those that are ambulatory, elective in

nature, and not dependent on other hospital

infrastructure, would be moved towards the

primary care hub, in addition to other primary care

functions. It would be desirable that this would be

accompanied by a cultural shift within the

population, increasing their likelihood to visit the

primary care facilities for emergency care. Further

investment is being sought for setting up of an

integrated IT infrastructure which would bridge

between primary and secondary care, together with

public and private care. This should also

significantly increase continuity of care and,

consequently, one hopes, the increased

engagement of the public with primary care

services.

The density of physicians in Malta is at the

average density in the EU. In 2013, there were 346

practising physicians per 100 000 inhabitants,

compared to 344 in EU. The number of general

practitioners is slightly above the EU average (80

per 100 000 inhabitants vs. 78 in the EU). The

number of nurses per 100 000 inhabitants (702 in

2011) is below the EU average of 837.

In 2013, the number of acute care beds was low

256 compared to 356 per 100 000 inhabitants in

the EU. With this capacity Malta achieves

discharge rates of 14.0 per 100 inhabitants (EU:

16.5).

Treatment options, covered health services

The public healthcare system offers primary,

secondary and tertiary health care services. The private sector acts as a complementary mechanism for health care coverage.

The state health service and private general practitioners comprise primary health care in Malta. However, the two systems of primary care practice function independently of one another as the latter account for two-thirds of the workload.

Secondary and tertiary care is mainly provided by specialised public hospitals of varying size and function. The main acute general services are provided by one new main teaching hospital incorporating all specialised, ambulatory, inpatient care and intensive care services. Malta has become almost self-sufficient in terms of providing most tertiary care. When it comes to the provision of highly specialised care for the treatment of rare diseases or specialised interventions patients are sent overseas because it would neither be costeffective nor feasible to conduct such treatments

locally.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

GPs and specialists are paid on a salary basis when working for the NHS, while they receive a fee-for-service in the private sector. The collective agreement with the Medical Association of Malta concluded by Government in 2007 includes job plans for doctors in senior posts resulting in better pay per performance. The possibility of exclusivity contracts with the NHS has been introduced, remunerated at a higher rate. Such job plans and exclusivity contracts have also been extended to various levels within the general practice

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profession with the revision of the said collective agreement in 2013.

Hospital remuneration is defined by the government on a prospective global budget basis but managers' decision making autonomy assists in increasing hospital efficiency.

The market for pharmaceutical products

While there is no direct product price regulation, there is a tendering system to control the prices of NHS covered medicines and a cost/benefit analysis is conducted prior to include a medicine in the Government Formulary List. Authorities promote the rational prescribing of physicians through treatment guidelines. Education and information campaigns on the prescription and use of medicines are also organised from time to time.

Within the NHS prescribing is done by active ingredient and pharmacists dispense the products procured by the public system which may include generics. For private patients generic substitution is voluntary.

Use of Health Technology Assessments and cost-benefit analysis

The use of health technology assessment (HTA) for decision-making purposes is increasing (including the development of treatment guidelines or for defining the benefit package or medicines).

Since HTA requires scientific know how and

administrative capacity which for a small country

may represent a significant cost, local authorities

are engaging with initiatives such as EUnetHTA.

Authorities are encouraging providers to set up

patient **care** protocols to enhance safety and

clinical outcomes.

eHealth, Electronic Health Record

eHealth and electronic hospital records empower

patients by introducing access to their medical

data. While hospital activity data is available in

certain detail, even from parts of the private sector,

there are still information gaps in a number of

areas (e.g. providers' clinical outcomes,

appropriateness of processes, outputs, patient

experiences and satisfaction). The existing national

eHealth platform lacks certain essential

components needed to provide cost-effective, cost-efficient

and sustainable health services on a

national scale. A gap analysis and a needs analysis

were carried out, and a number of work packages

have been designed to address the situation, with

the help of ERDF funds. To this effect, the eHealth

Project aims to develop a comprehensive national

eHealth infrastructure and integrated portfolio of eHealth systems, in support of improvement of Malta's health and increased efficiency and sustainability of Malta's healthcare system. The deliverables of the Project are important for the cost-effective and sustainable use of available resources and to meet strategic objectives such as the strengthening of primary care, as envisaged in the NHSS.

Health promotion and disease prevention policies

The central government has set a number of relevant public health objectives strongly associated with the risk factors and pattern of mortality and disease. Priorities include curbing smoking and alcohol consumption and the reduction of obesity through a national platform that promotes healthy diet and exercise.

Authorities also see the education sector as an important partner through the inclusion of health promotion and disease prevention in school curricula and the training of health staff. Such

public health objectives are clearly defined in strategy and policy documents published over the past five years, including obesity, noncommunicable disease and sexual health, among others.

Recently legislated and/or planned policy reforms

Recent policy response

A landmark Health Act was approved by the Maltese Parliament in 2013, repealing the old Department of Health Constitution Ordinance and creating a modern framework separating policy from regulation and operations.

This Act also enshrined patient rights into a legal instrument for the first time.

The implementation of the new Mental Health Act (MHA), which fully entered into force in October 2014, brought patients' rights to the forefront of service delivery. Patient consent to treatment, the

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use of the least restrictive types of treatment,

respect for patient autonomy, patient

empowerment and the offering of treatment in the

community where possible, have all contributed to

a gradual reorientation in service provision.

The Act also established a Commissioner for the

Promotion of Rights of Persons with Mental

Disorders. Government Mental Health Services

and the Office of the Commissioner have worked

closely to ensure that the rights of persons

suffering from mental disorders are safeguarded.

Another major milestone in shaping health services

provision is the Human Organs, Tissues and Cells

Donation Bill which is being discussed in

Parliament and underwent the second reading on

the 8th March, 2016.

With respect to major policy reforms noteworthy is

the finalisation and launch of the National Health

Systems Strategy (NHSS) in 2014. Sustainable

high quality healthcare is the focal point of the

NHSS. In order to put this into action a detailed

Action Plan (AP) and a Cost-Benefit Analysis

(CBA) were completed by January 2015.

The Health Systems Performance Assessment

(HSPA) was also completed during 2015. The HSPA collates the indicators that were selected following an extensive and rigorous process to monitor the implementation of the NHSS. The HSPA 2015 demonstrates the baseline results and interpretation of these indicators and will be repeated every two years.

The Steering Committee tasked with overseeing the implementation of the NHSS was enacted. It includes the most senior members of the Department of Health.

A number of concrete measures to increase the effectiveness and consolidation of the position of the primary health care system is the cornerstone of the NHSS. A number of actions implemented to strengthen quality and efficiency of services include:

- strengthening of prevention and screening strategies - breast, colorectal and cervical;

Preventive strategies – introduction of ‘Lifestyle Clinics’, strengthening of immunisation services;

- introduction of innovative services –

anticoagulant clinics, chronic disease

management clinics, backslap plaster services,

conduct of minor surgery, setting up of

outreach clinics, provision of services by social

worker;

- strengthening of existing services – extending

opening hours, orthopaedic outreach clinics

have increased in frequency, increased

involvement of private family doctor, provision

of scoliosis screening programmes in schools;

- provision of latest technology equipment in

health centres;

- upgrading of the present infrastructure.

There have also been efforts to develop more

community-based services for long-term and

mental health care. Other health reforms that have

taken place in recent years include use of health

technology assessment to define the public benefits

package and the introduction of the Pharmacy of

Your Choice scheme to provide more equitable

access to medicines.

The focus on prevention and community services has led to progress in areas such as cancer prevention with the development of cancer screening programmes. Since 2009, a number of national plans and strategies have been launched to address major public health issues, mainly cancer, obesity, sexual health and non-communicable diseases. The National Breastfeeding Policy and Action Plan 2015-2020, launched in July 2015, seeks to increase the initiation of breastfeeding rates and support the family of the breastfed child.

Policy changes under preparation/adoption

Demographic projections are showing that the drive for the attainment of better efficiency within the sector needs to be strengthened. Pursuing healthcare reforms to increase cost-effectiveness of the public health sector is therefore a priority for the government. The following are the key thrusts of the reform Malta is undertaking.

- Improving governance: the government continues investing in the overall governance of the public health services. The focus is on

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ensuring better leadership, oversight, management and co-ordination of policy, services, supplies and resources. Measures include:

- the launch in 2014 of the National Health Systems Strategy (NHSS) for the period 2014 to 2020; the first Health System Performance Assessment Report has been completed;
- curtailment and containment of costs through the introduction of various internal control mechanisms and monitoring of operational costs: measures include the implementation of financial governance models which have led to restructuring, increased efficiency of service delivery, containment of indirect administrative costs and deterrence of abuse and misuse of resources. Improved financial control through the recruitment of financial and audit expertise has also reaped benefits, particularly through the enforcement and monitoring of financial

and procurement protocols;

- centralisation of procurement services to

increase gains from economies of scale, whilst

instilling accountability by making each entity

responsible for its own purchasing;

- emphasis on health promotion and disease

prevention: the growing burden of chronic

disease represents a major challenge for health

systems and economic and social development

across Europe. The government continues

working on ensuring that people adopt healthy

lifestyles that are conducive to healthy ageing

with the aim of increasing the long term

sustainability of the health system. Work on the

implementation of policy and strategy

document issued in the past years such as the

National Cancer Plan 2011-2015; A Strategy

for the Prevention and Control of Non-

Communicable Disease in Malta (2010); A

Healthy Weight for Life: A National Strategy

for Malta 2012-2020 will continue.

- New measures in the area of health promotion

and disease prevention are mainly focused on

tackling obesity and diabetes which are both identified as national health challenges. Other measures include: the Food and Nutrition Policy and Action Plan was published in 2014. The Health Behaviour in School Children study was completed and international report published in March 2016. Fieldwork for the European Health Interview Survey has been completed and the National Food Consumption Survey is ongoing. The National Breastfeeding Policy and Action Plan 2015-2020 was published in 2015. (201) The Diabetes Strategy was published in December 2015. The Communicable Disease Strategy was published in 2013. It is Government's aim to publish a specific strategy on HIV in 2016;

- strengthening primary health care to reduce acute hospital costs: Initiatives under this measure are aimed at alleviating the pressure from more costly acute care provision and increasing the interaction between public and private primary care provision with the aim of

enhancing access. Particular focus is on those services related to chronic disease management and this will be made possible through better resource utilisation, simplification of processes and empowering the private sector;

- increasing the range of services offered at primary level – new services planned include the introduction of chronic disease management clinics and devolution of anticoagulant clinics from the acute to the primary sector;

- upgrading of current primary healthcare facilities – a programme of upgrading and refurbishment of the Gozo General Hospital and Health Centres/peripheral clinics is currently underway;

- opening of new regional centres co-financed by the EU including the building of a Primary

Care Regional Hub that will provide a whole myriad of services closer to the community;

- training of healthcare professionals for integrating acute and community **care**.

(201) [http://health.gov.mt/en/Pages/National-](http://health.gov.mt/en/Pages/National-Strategies/NHS.aspx)

Strategies/NHS.aspx

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Challenges

The analysis shows that a number of reforms have been implemented in recent years notably to reduce waiting times for elective surgery and to establish public health priorities. The main challenges for the Maltese health **care** system are as follows:

- To continue increasing the efficiency of health

care spending in order to adequately respond to

the increasing health **care** expenditure over the

coming decades. To evaluate whether the

ongoing strategy of health system reform is

sufficient to cope with the challenge of future

spending growth.

- To monitor health systems performance and

enhance its functioning as needed, in particular

with regard to monitoring the quality of care.

- To continue to include more elements of

activity related payment in primary care and

specialist outpatient care to induce a higher

number of consultations.

- To continue to enhance primary care provision

by increasing the numbers and spatial

distribution of GPs and nurses possibly by

using private provision for the benefit of all

NHS patients. To make the referral system

more effective and improve care coordination.

- To investigate if additional measures regarding

price regulation, expenditure control, and good

prescribing practices are needed to ensure a

more cost-effective use of medicines.

- To improve data collection in some crucial

areas such as expenditure, resources and care

utilisation and improve the monitoring of

activity in the sector. This should also include

efforts to assess and publish evaluations of the

quality of care provided and to increase the use

of health technology assessment in decisionmaking.

- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity) in various settings (at work, in school).

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Table 1.19.1: Statistical Annex – Malta

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 5 5 5 5 6 6 6 7 7 7 8 9289 9800 9934

GDP per capita PPS (thousands) 21.2 21.3 21.8 21.7 22.2 22.3 21.2 21.8 21.4 21.5 21.6 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 0.1 -0.9 2.9 2.2 3.7 3.2 -3.5 3.8 1.0 0.3 1.9 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 5.5 2.2 9.9 3.1 -3.8 -0.5 -1.7 3.6 15.9 -8.3 2.0 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 8.2 8.5 9.1 9.1 8.5 8.2 8.3 8.3 9.5 8.7 8.7 10.4 10.1 10.1

Total current as % of GDP 6.5 7.1 7.3 7.5 7.2 7.7 7.9 8.0 9.0 8.3 8.2 9.8 9.6 9.7

Total capital investment as % of GDP 1.7 1.4 1.8 1.6 1.3 0.5 0.5 0.4 0.5 0.5 0.5 0.6 0.5 0.5

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Total per capita PPS 1339 1409 1586 1664 1648 1683 1703 1813 2167 2067 2171 2828 2911 2995

Public as % of GDP 5.7 5.9 6.3 6.3 5.7 5.3 5.4 5.3 6.6 5.7 5.8 8.1 7.8 7.8

Public current as % of GDP 4.6 5.0 5.0 5.2 4.8 5.0 5.1 5.1 6.3 5.4 5.4 7.9 7.7 7.7

Public per capita PPS 933 979 1094 1139 1100 1090 1106 1163 1510 1352 1435 2079 2218 2208

Public capital investment as % of GDP 1.2 0.9 1.2 1.1 0.9 0.3 0.3 0.2 0.3 0.3 0.4 0.2 0.2 0.1

Public as % total expenditure on health 69.7 69.5 69.0 68.5 66.7 64.8 64.9 64.2 69.7 65.4 66.1 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 12.5 13.5 14.4 14.6 13.6 12.5 12.5 13.1 13.3 13.5 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 : 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 28.7 28.2 28.9 29.6 31.2 33.0 32.5 33.3 30.3 32.2 31.5 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 502.1 504.5 506.6

Life expectancy at birth for females 80.8 81.2 81.4 82.0 82.2 82.3 82.7 83.6 83.0 83.0 84.0 82.6 83.1 83.3

Life expectancy at birth for males 76.4 77.4 77.3 77.0 77.5 77.1 77.9 79.3 78.6 78.6 79.6 76.6 77.3 77.8

Healthy life years at birth females : : 70.4 69.5 71.1 72.1 71.0 71.3 70.7 72.2 72.7 : 62.1 61.5

Healthy life years at birth males : : 68.6 68.3 69.2 68.8 69.4 70.1 69.9 71.5 71.6 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 84 80 78 80 76 70 72 56 147 129 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 5.7 5.7 5.4 3.7 6.6 8.5 5.5 5.6 6.5 5.3 6.7 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

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Inpatient curative and rehabilitative care : : : : : 3.13 2.99 3.01

Day cases curative and rehabilitative care : : : : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care : : : : : 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.86 1.19 1.32 1.43 1.39 1.44 1.47 1.50 1.85 1.57 1.60 1.60 1.55
1.44

Therapeutic appliances and other medical durables : : : : : 0.31 0.31 0.32

Prevention and public health services : : : : : 0.25 0.25 0.24

Health administration and health insurance : : : : : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : : : : 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care : : : : : 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.74 0.33 0.36 0.41 0.37 0.40 0.42 0.39 0.47 0.32 0.34 0.79 1.07
0.96

Therapeutic appliances and other medical durables : : : : : 0.13 0.12 0.13

Prevention and public health services : : : : : 0.25 0.20 0.19

Health administration and health insurance : : : : : 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.19.2: Statistical Annex - continued – Malta

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : : : : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : : : : : 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 28.4% 16.7% 18.1% 19.0% 19.3% 18.7% 18.7% 18.9% 20.5%
19.0% 19.5% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : : : : : 3.2% 3.3% 3.3%

Prevention and public health services : : : : : 2.6% 2.6% 2.5%

Health administration and health insurance : : : : : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : : : : : 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : : : : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care : : : : : 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 16.2% 6.6% 7.2% 7.9% 7.6% 8.1% 8.2% 7.7% 7.5% 6.0% 6.3%
10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : : : : 1.6% 1.6% 1.6%

Prevention and public health services : : : : : 3.2% 2.7% 2.5%

Health administration and health insurance : : : : : 1.4% 3.5% 3.5%

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Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants : : : 0.74 0.73 0.73 0.72 0.72 0.48 0.72 0.94 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : 0.5 0.7 1.0 1.0 1.0 1.0 1.0 0.9 0.9 0.9 0.8

CTS per 100 000 inhabitants : : : 2.5 2.7 3.2 3.1 3.1 2.9 2.9 1.9 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : 0.0 0.0 0.0 0.2 0.2 0.2 0.2 0.5 0.1 0.1 0.1

Proportion of the population that is obese : : : : 22.9 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : : : : 19.2 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 6.3 6.3 6.3 6.7 7.6 7.8 7.2 7.6 7.8 : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants : : : : : 304 308 317 329 346 329 335 344

Practising nurses per 100 000 inhabitants 519 532 550 561 584 643 618 647 669 669 702 840 812 837

General practitioners per 100 000 inhabitants : : : : 72 69 67 76 80 80 : 78 78.3

Acute hospital beds per 100 000 inhabitants 340 299 280 284 269 277 271 270 241 250 255 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 2.3 2.4 2.6 3.6 2.6 2.4 2.5 : : : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : 6.9 7.9 7.8 7.3 9.5 10.9 12.3 13.6 14.1 14.0 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : 3,509 3,461 3,458 3,427 3,578 3,957 6,759 7,145 7 ,639 7,763 6368 6530 7031

Acute care bed occupancy rates 83.4 85.4 87.5 89.6 80.4 78.0 82.3 81.5 83.2 83.2 : 72.0 73.1 70.2

Hospital curative average length of stay 4.6 4.6 4.7 5.3 4.8 4.9 5.0 5.0 5.3 5.3 5.3 6.5 6.3 6.3

Day cases as % of all hospital discharges : 33.8 30.5 : 31.8 27.4 26.6 35.4 34.4 35.2 35.7 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 5.7 6.3 7.0 7.5 7.6 7.8

AWG risk scenario 5.7 6.4 7.4 8.2 8.4 8.7

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 0.4 0.4 0.5 0.5 0.5 0.5

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

12.7 3.1

2.1 0.9

3.0 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population

GDP per capita (34,380 PPS in 2013) is in The

Netherlands well above the EU average (27,881

PPS in 2013), and has increased significantly since

2003, when it was 31,930 PPS. The economy of

the Netherlands grew by 2% in 2015. Forward looking indicators suggest that the recovery will continue, with growth forecast at 1.7% in 2016 and 2% in 2017. (202).

Current population stands at 16.8 million people and has been increasing throughout the last decade.

According to projections, the increase will continue, reaching 17.1 million in 2060.

Total and public expenditure on health

Total expenditure on health as a percentage of GDP (12.9% in 2013) has significantly increased since 2003, when the share was roughly 10% (203).

This level is also relatively high with respect to the EU-average (10.1% GDP in 2013). The same applies to public expenditure on health as a percentage of GDP, recorded as 10.3%, which is higher than the EU average for the same period (7.8% in 2013). Total (4,492 PPS in 2013) and public (3,336 PPS in 2011) per capita expenditure are also above the EU average (2,988 PPS and 2,218 PPS for the same years, respectively 2013 and 2011).

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to increase by 1.0 pps of GDP (AWG reference scenario), (204) above the average increase of 0.9 pps for the EU. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), the increase reaches 1.6 pps of GDP from now till 2060, in line with the EU average of 1.6 pps. The country faces both medium and long term risks (202) European Commission (2016), European Economic Forecast Spring 2016 (203) This is of course partly a denominator effect because of unfavourable economic conditions. (204) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

from a debt sustainability point of view, the latter, driven by the projected dynamics of population ageing and by the unfavourable initial budgetary position. (205)

Health status

Whereas life expectancy for women is in line with the average with 83.2 years (83.3 for the EU), men

live longer in The Netherlands than in the EU as a whole: 79.5 vs 77.8 in 2013. Notably, healthy life years have decreased for Dutch women, from 64.3 years in 2007, to 57.5 in 2013, which brings the Netherlands under the EU average. However this has methodological reasons (206). For men the picture is slightly better. Years spent in good health are still less than in 2007 (66.1), but are with 61.4 broadly in line with the EU average of 61.6 in 2013. (207)

Data show an increase in the proportion of the population which is obese (from 8.4% in 1998 to 11.4% in 2011) although the last few years a stabilisation can be recognised. There has been a steady reduction of the proportion of the population that is a regular smoker, going from 26.7% in 2003 to 18.5% in 2013, under the EU Average (22.0). Alcohol consumption is decreasing too and was in 2012 with 9.1 litres under the EU average (9.8 litre).

System characteristics

System financing

The healthcare system in the Netherlands is insurance based. In 2013, 79.9% of total health expenditure funding was generated from public sources.

(205) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

(206) The definition of Healthy Life Years used in the European Survey on Income and Living Conditions is different than that of Statistics Netherlands (CBS). CBS and the OECD instead show that the percentage of women older than 65 who feel healthy or very healthy is very stable in the Netherlands.

(207) Data on life expectancy and healthy life years is from the Eurostat database.

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Revenue collection mechanism

Health insurance organisations operating under the health insurance act, have the obligation to accept every citizen requesting a basic health insurance.

In addition the insurer is not allowed to request different premiums from different clients. As the cost profiles of the individual insured differ, a system has been set up to compensate insurers for those cost differences (risk equalisation scheme).

The funding of health insurers comes from roughly three different sources. In the first place health insurance organisations collect a nominal premium from each person insured. The level of this premium differs between health insurance organisations depending on the policy of the organisation, their internal organisation, their reserves etc. In addition citizens pay through their employer an insurance premium, based on their income. This contribution is distributed to the different health insurers on the basis of the above described risk equalisation and counts again for roughly 50% of the total revenue of the health insurers). The distribution is based on the risk profile of the population in each health insurance organisation. Indicators such as age, sex, medication use, healthcare use and socio-economic status of the insured play a role in the risk

equalisation scheme. A good functioning risk equalisation scheme is vital, to prevent insurers to select citizens with a specific risk profile. The Dutch risk equalisation scheme has both ex ante and ex post risk equalisation mechanism, although ex-post measures are being cancelled. That means that insurers will run a bigger risk, but a lack of ex post measures forms an incentive for insurers to purchase healthcare more effectively. The third source of funding that insurers receive is a state contribution for the insured under the age of 18 (10% of total revenue). Altogether, nominal premium, deductible and 18- contribution account for the remaining 50%.

Insurers collect insurance premiums and the risk equalisation scheme between insurers applies to all funds for the basic benefit package. Private and public authorities publish comparative standardised information on premiums, benefits, performance in claim processing and patient satisfaction. The annual switching rate of the insured between funds (the insured can decide

before the beginning of each calendar year whether

they want to switch health care insurer) is between

6% and 7%. (208) As a general issue characterising

patients choosing between alternative providers,

information asymmetries, technical complexity

and uncertainty as to future needs make switching

between funds more difficult. In addition, four

insurers account for about 90% of the market.

Whether this concentration in the insurance market

reduces the expected benefits of competition

between insurers is unclear. It may also increase

the bargaining power of insurers over care

providers and pharmaceutical companies which

may lead to cost-savings.

Public (0.35%) and total (0.54%) expenditure on

health administration and health insurance as a

percentage of GDP are similar to the EU average,

though both slightly higher (0.27% and 0.47%

respectively in 2013), which is in line with

expectations considering the system is based on

multiple insurers. The higher than average can be

explained by the efforts to supervise costs, prices,

quality, contractual terms and market

developments in the health market as well as

ensuring risk-equalisation and prevent riskselection,

which are necessary in the context of

competition in health insurance. (209)

The current healthcare system is open-ended,

although the Cabinet uses annual budget

projections for public spending. The most

influential decisions are taken at the start of the

cabinet; in the (max. 4) years the cabinet is in

power, adjustments are made to the path set out at

the start. Note, though, that for some treatments

the government still defines budgets and for other

health care provision the government decides on

the remuneration methods for providers or sets

prices for treatments. Individual insurers have to

determine resource allocation / financing between

sectors of care (primary care services, specialists

outpatient care, hospitals current spending) and for

private hospitals to decide on infrastructure and

equipment. Since the healthcare system is openended,

total health expenditure may exceed the

(208)

<http://www.vektis.nl/downloads/Publicaties/2016/Zorgther>

mometer%20nr17/#5/z.

(209) A system based on "regulated" competition inherently needs more regulatory capacity.

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budget-projections. (210) However, in the recent years expected growth of health expenditure turned out to be lower instead, but according to the Netherlands Bureau for Economic Policy Analysis (CPB) latest projections, health **care** expenditure is expected to increase over the period 2018-2021. (211) Possible ways to finance the expected increase of health expenditure are increasing employer taxes and health insurance premiums, or increasing cost- sharing mechanisms or removing increased interventions from the basic benefit package.

Administrative organisation: levels of government, levels and types of social security

settings involved, Ministries involved, other

institutions

All health insurers are obliged to accept all

applicants and to charge each individual applicant

the same nominal premium for the same

policy. (212) For groups, premium may differ.

Applicants are free to choose an insurer. A Health

Insurance Income Support scheme provides

means-tested subsidies to help those below a

certain income threshold (about 70% of the

households receive such a subsidy) to pay for their

insurance premiums. (213)

Coverage (population)

Since 2006, a mandatory universal health

insurance scheme operated by private health

insurance funds (for profit and not-for-profit)

provides 100% population coverage, through

contracts with providers.

(210) According to the OECD, The Netherlands scores 2 out of 6

in the OECD scoreboard due to the not very stringent

budget controls.

(211) In these projections, health care expenditure is rising as a

percentage of GDP as the projection is based on the longterm

trend excluding policy measures and on demographic

developments.

(212) The voluntary deductible can then influence the price paid

for a specific policy, even though the benefits package is

the same.

(213) The law on the health insurance income support scheme

states that no household should pay more on their health

care premiums paid to insurers than a fixed percentage of

their income. Any costs for health insurance premiums

above this percentage are compensated through the health

care allowance. In 2011 approximately 70% will receive an

allowance.

Treatment options, covered health services

The basic (but comprehensive) insurance package

is fixed by law. Health insurers set a nominal

community-rated insurance premium

corresponding to that package.

Role of private insurance and out of pocket

co-payments

In 2013, private health expenditure was about

20.1% of total health expenditure (excluding

capital formation), in line with EU average. Out-of-pocket expenditure (214) was 5.2% of total current health expenditure in 20014. Out-of-pocket payments apply to certain services but are limited. Eyeglasses, contact lenses and certain dental prostheses, for example, are not covered by mandatory insurance. In 2008, the government introduced an annual mandatory deductible of EUR 150 for insured people 18 and over (which has since been increased to EUR 360 in 2014). GP services are exempted from the mandatory deductible, as a means to encourage primary care services vis-à-vis specialist consultations and hospital care (indeed, to be able to go to a specialist, one needs a referral from the GP). In addition, this exemption is intended not create a financial barrier for individuals to access this type of primary care, thereby supporting the role of the GP as gatekeeper in the Dutch healthcare system. Some services have recently been excluded from the basic package of care, while others have been added. (215) About 84% of the population buy

supplementary private insurance, thought this

figure seems to be declining over time. (216) It is

possible to reinsure the mandatory deductible.

(214) Note that the EUR 150 mandatory deductible is not

included in the 5.7% out-of-pocket-payments. In 2010 the

total amount of OOP caused by the mandatory deductible is

nearly EUR 1.5 billion. The actual amount of OOP is

therefore higher than the 5.7% reported here.

(215) Some of those removed include examples such as special

chairs, allergen-free mattress covers, medication for

erectile malfunction, whereas methadone treatment and

treatment of dyslexia for children have been added to those

included.

(216)

https://www.nza.nl/1048076/1048181/Marktscan_Z

orgverzekeringsmarkt_2015.pdf, page 51.

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Types of providers, referral systems and patient

choice

Provision is mostly private but publicly regulated.

Primary care is provided by independent general practitioners (GPs), often working in private group practices. (217) Outpatient specialist care is provided in outpatient hospital departments.

Almost all hospitals are non-profits while university hospitals are public. Providers have to establish contracts with health insurers.

The number of practising physicians per 100 000 inhabitants (329 in 2013) is below the EU average (3448), showing a consistent increase since 2003 (262). The number of GPs per 100 000 inhabitants (78 in 2013) is in line with the EU average (78.3 in 2013), although it shows a consistent increase (64 in 2003). The number of nurses per 100 000 inhabitants (1,210 in 2013) is above the EU average (837 in 2013) and has increased throughout the decade. This fits with authorities' objective, in recent years, to increase the supply of staff. The numbers above suggest that the skill mix is improving in the direction of a more primary care oriented provision (which the authorities wish to continue to pursue). Staff supply is regulated:

there are quotas for medical students and by publicly financed training for medical specialties, although there is no regulation in terms of physician location. Perhaps as a result there is some concentration of medical staff in some regions/areas and staff shortages in others. Authorities have made strong efforts to use primary care vis-à-vis specialist and hospital care. Residents have to register with a GP and there is a compulsory referral system from primary care to specialist doctors i.e. GPs act like gatekeepers to specialist and hospital care. In addition, GP services are free. Free choice of GP is allowed but given the number of GPs and their capacity constraints, choice may be limited in some areas. Free choice of a specialist or hospital is also allowed. (218) Moreover, authorities have planned to introduce preconditions for and stimulate the usage of ICT and e- health solutions to allow for electronic exchange of medical data (e.g. eprescribing or e-appointments and eHealth (217) There are also a not insignificant number of salaried GPs.

(218) Indeed, according to the OECD, the level of choice of

provider in The Netherlands has a score of about 3 out of 6,

while gatekeeping scores 6 out of 6.

records), to support and render the referral system

and care coordination more effective, reduce

medical errors and increase cost-efficiency.

The number of acute care beds per 100.000

inhabitants (334 in 2011) has actually increased

over time (from 292 in 2003) remaining below the

EU average (360 in 2011). Hospitals have

autonomy to recruit medical staff and other health

professionals and their remuneration level,

although a pay scale is set at national level in a

collective labour agreement by employers and

trade unions.

Pricing, purchasing and contracting of

healthcare services and remuneration

mechanisms

GPs are paid a mix of a capitation (EUR 58 per

patient minimum, with increments for age and

deprivation index) and a consultation fee (EUR 9).

(219) Specialists are paid either a salary or a fee for

service or a mix of the two. GPs are eligible to receive bonuses regarding their activity or performance; these bonuses may relate to all kinds of agreements between the insurer and the GP, e.g. the prescription of generics.

Hospitals are paid by a combination of fixed fees and budgets, set by the Dutch Healthcare Authority (NZa), and by fees negotiated by the hospital and the insurer. A 66%-part of prices was fixed and set by NZa, 34% was set through negotiations between insurers and hospitals. After 2012 however, 70% is set through negotiations between insurers and hospitals. Hospital and mental healthcare fees are based on Diagnosis Treatment Combinations. (220)

When looking at hospital activity, inpatient discharges are lower than the EU average (11.6 vs. 16.3 in 2012) but are more than compensated by a very high number of day case discharges, which are significantly higher than the EU average (13936 vs. 6965 in 2012). The proportion of surgical procedures conducted as day cases (54.6%) is considerably higher than the EU

(219) Note that there are also salaried GPs, most of them working

for another GP.

(220) The OECD score for remuneration incentives to raise the

volume of care in The Netherlands is therefore about 3.5

out of 6 as a result of the mix remuneration systems for

physicians and hospitals.

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average (30.1% in 2012). Hospital average length

of stay is in line with the EU average (6.3 days).

All these figures point to a high hospital

throughput and high hospital efficiency. (221)

The market for pharmaceutical products

Since the 1980s, the authorities have implemented

a number of policies to control expenditure on

pharmaceuticals. Although pricing is free there is a

maximum price (222) set for each product with a

given active substance, strength and formulation

which is based on the prices of medicines in four

reference countries (BE, DE, UK and FR) the so

called external reference pricing, and (since 2004)

price negotiations between healthcare insurers, pharmacists and producers. (223) Externally dispensed pharmaceutical: the authorities also apply internal reference pricing, (224) whereby the maximum reimbursement level of a medicine is a weighted average price of the products in each cluster of products that a medicine belongs to, using 1998 prices. New products introduced after 1998 can get a premium price if the manufacturer demonstrates cost-effective added value, and the price of this new product becomes the maximum reimbursement level for all the products that followed and are added to the initial drug to form a cluster. Clusters of pharmaceuticals define "therapeutic equivalents", where pharmaceuticals are equivalent if they have comparable clinical characteristics, a more or less similar indication, route of administration, targeted age group and for which no clinically relevant differences in income apply. For externally dispensed pharmaceutical: only pharmaceuticals included in GVS are covered by basic health insurance - even though

reimbursement may sometimes be obtained

through complementary voluntary health

insurance. (225)

(221) Though this may be partly due to the broad coverage for

long-term care.

(222) The system was laid down in the Pricing Act of 1996.

(223) A maximum price is only set for pharmaceuticals within

the GVS. For pharmaceuticals which are used by medical

specialists (usually for inpatient care), there is no

maximum price.

(224) The reference pricing system, introduced in 1993, is called

the Medicine Reimbursement System (GVS).

(225) Note that free choice is not excluded; if patients opt for a

more expensive pharmaceutical in the same group, they

have to pay the excess themselves, except if the physician

decides that the more expensive one is clinically relevant

for that particular individual case.

The authorities promote rational prescribing of

physicians by stimulating the development of

treatment guidelines, set up by medical experts,

and the monitoring of prescribing behaviour. They

also promote education and information campaigns

on the prescription and use of medicines and regional platforms of physicians and pharmacists exist to discuss the use of medicines and improve its effective use. Some insurers have started to offer financial incentives to GPs based on efficient prescription of some drugs. Prescribing is done by active ingredient as part of medical training. A number of insurers initiated a policy of selective contracting of generic medicines; as of the 1st of July 2008, these insurers reimburse only the cheapest generic product (more precisely, those that are at the same price level as the cheapest pharmaceutical plus 5%) within a number of bigselling therapeutic classes. Producers of generics responded by substantially lowering their generic list prices. Insurers and their enrolees benefit from the system, but pharmacists may lose some revenues as a result of diminishing discounts and rebates provided by generic producers. As a result of these policies, the average prices of prescription medication have dropped considerably in the past.

Use of Health Technology Assessments and cost-benefit analysis

The National Institute for Health Research and the Health Care Insurance Board (ZiNL) conduct and gather information on health technology assessment (HTA). Based on this HTA, the ZiNL advises the central government on what should be covered under the basic benefit package of care and the extent of reimbursement /cost-sharing in the system. It is used to determine the reimbursement of medicines and applied to new high-tech equipment, while prices are mainly set by the healthcare authority (NZa). The HTA helps defining clinical guidelines which are compulsory and to meet with effective monitoring of compliance. The ultimate decision on what should, and what should not be covered in the basic package is made by the central government. The central role of specialists in the absorption of treatment into the basic package should not be left unmentioned. New treatments or methods of diagnosis-setting adopted by medical specialists are more or less automatically covered in the basic package, since the basic package covers health

care "according to the latest developments in

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science and technology". Only after ZiNL research shows that some methods or treatments are (cost-) ineffective the ZiNL may advise that type of treatment to be removed from the basic package.

eHealth (e-prescription, e-medical records)

In the Netherlands, there is no national system for the exchange of data on e-prescription or emedical records. The exchange of medical data is facilitated mainly on a regional level. Most of the medical records are updated electronically and are no longer available in paper. A survey shows that 93% of general practitioners and 66% of medical specialists update their records mainly or exclusively electronically. Furthermore, many doctors exchange patient data electronically. Nearly all (90%) of the general practitioners exchange patient data electronically with public pharmacies, emergency general practitioner

services and hospitals. Almost half (46%) of medical specialists exchange patient data electronically with general practitioners. There are also systems which connect medical specialists or other healthcare providers who are active in the same chain of care (for example cancer or diabetes). Recently national policy has been introduced which states that the majority of chronically ill patients must have access to their own medical data (for example prescribed pharmacy), within the period 2014-2019. With this policy the Dutch government aims for more patient empowerment, higher quality and more effective care.

Health and health-system information and reporting mechanisms;

In order to improve access and reduce the waiting time for hospital surgery, authorities have obliged hospitals and mental healthcare providers to give information to an integrated central and nationwide information system on patients on a waiting list.

This information can be used by insurers and their

insured to choose between hospitals. The publishing of this information is designed to encourage providers to increase activity and reduce waiting times. Data on patients' experience of care is published by the government, the insurers and NGOs. This improved information transparency has certainly contributed to reduce waiting times and lists, even though the major factor was most probably the implementation of pay-per-volume systems for most health care providers.

Comprehensive data exists, which enables information on physician and hospital activity and quality and patient care utilisation to be published. This information is used by insurers and patients to choose providers and by providers to improve their own activity. Surveys are conducted on patient's experience and satisfaction with the care provided.

A general health care sector performance report is published on a regular basis using a comprehensive set of indicators.

Health promotion and disease prevention

policies

The central government has set a number of relevant public health objectives, set in terms of processes and the reduction of health inequalities.

The ambition is to decrease or at least stabilise the difference in life expectancy by 2030 compared to now, which, given the expected developments on social determinants of health and the international position of the Netherlands, is an ambitious goal.

With regards to healthy life expectancy, the ambition is that of a significant decrease in differences by 2030. Consistently, although the current level is in line with the average (2.6 vs 2.5% for EU in 2013), public expenditure on prevention and public health services as percentage of GDP has been higher than the EU level in the past years (2009 onwards) and, in terms of total expenditure, it still is (3.2% vs 2.5% for EU in 2013).

Recently legislated and/or planned policy reforms

Measures to control health care costs have been implemented by the government since 2008 for

acute care. The breach of the Stability and Growth

Pact criteria in 2010 reinforced the government's

recognition that an effective control of public costs

(including health care costs) was needed. The

political drive of the current government (in office

since 2012) to reduce the national debt to no more

than 3% of the national budget has led to

significant reductions in the health care budget.

The measures that have been implemented can be

grouped into four categories:

(1) Shifting costs from public to private sources;

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(2) Shifting costs between various statutory

sources (e.g. transfer of care from the exceptional

medical expenses act (AWBZ) to the

municipalities), mostly in combination with major

cuts in the budgets;

(3) Substitution of institutional care with home

care and secondary care with primary care; and

(4) Increased focus on improving efficiency and eliminating fraud.

Initially, from 2009, the measures were mainly targeted at reducing overspending, shifting costs from public to private sources by limiting the basic package and efforts to prevent improper health care consumption. From 2011 onwards, the measures focused more on structural changes in the area of acute care, with the government seeking to reach a consensus with stakeholders to agree on further cost containment.

The future policy agenda for the Dutch health system commits itself to the promotion of high quality and sustainable care. In 2011, the first outline agreements between the Minister of Health, health care providers and insurers were concluded, which form a base for less growth of healthcare consumption and more high quality healthcare. These agreements work, because the use of agreements between parties is part of Dutch political culture, and because for providers there is

always the latent threat of the government imposing measures, such as tariff cuts, when the agreed terms are not met. Also, the healthcare purchasing market provides sufficient incentives for both insurers and providers to produce healthcare of good quality at acceptable prices. These objectives, moderate growth and improved quality of care, need to be anchored into the Dutch healthcare system. The following policy objectives will be aimed for in doing so: Primary healthcare (PHC). The Dutch healthcare system is widely known for its well-functioning PHC system. The aim is to further improve coordination between general practitioners, pharmacies, district nurses, and paramedics. Especially the district nurse will become more important; as from 2015 it will be reimbursed by the insurer (without usage will be subject to own risk), with a central role for care in districts. A central role of PHC will also make it possible for healthcare to become more patientoriented, as more care can be provided at or near a patients home.

Regarding innovation, to safeguard high quality

care, it is important that innovative new health services will stay available for patients. New and innovative healthcare services will therefore be adopted into the basic package, under strict conditions of proven therapeutic effect and costefficiency.

Also, innovation raises the voice of patients, by means of increased self-reliance, as well as unburden healthcare providers. Both aspects, again, make it possible for healthcare to become more patient-oriented.

On transparency, insurers need to know what the outcome of healthcare provision is, as a means of purchasing care based on quality. This also means that they are not obliged to remunerate inefficient healthcare. For the system to work efficiently, it is therefore important that everyone takes up responsibility to solely provide sensible and costconscious

healthcare. Care provision receipts therefore need to become more understandable for patients and quality of healthcare provision will become more widely available by ZiNL. (226) This

will empower patients, and it also provides a base

for insurers to select care providers, mainly

through selective contracting of healthcare by the

insurer. The effect aimed for is that non-sensible

use of care will be cut back, while it can also

improve safety and, again, patient-oriented

healthcare.

Challenges

The analysis above shows that a wide range of

reforms have been implemented over the years, to

a large extent successfully (e.g. the policies to

control pharmaceutical expenditure; to strengthen

primary care; to reduce hospital use; to improve

data collection and monitoring; and, to improve

life-styles), and which The Netherlands should

continue to pursue. The challenges for the Dutch

health care system are as follows:

(226) Regarding patient information, ZiNL has set up a website

support informed patient choice: kiesbeter.nl; furthermore

it is also among the responsibilities of the insurer to make

quality of care available to their enrollees, in a transparent

and comparable manner.

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- To continue increasing the efficiency of health

care spending in order to adequately respond to

the increasing health care expenditure over the

coming decades, which is a risk to the mediumterm

sustainability of public finances.

- To continue to enhance and better distribute

primary health care services and basic

specialist services to improve equity of access

and the effectiveness and efficiency of health

care delivery; To ensure an effective referral

systems from primary to specialist and hospital

care and improving care coordination between

types of care, notably by ensuring that users

register with their GP and through the

development of electronic patient records in the

future.

- To find a balance between possible economies

of scale and consumer choice between

providers and insurers. Possible economies of scale exist in health care provision and insurance; and the challenge is to balance these economies of scale with the need for sufficient user choice between providers/insurers, so that providers/insurers will also in the long-run optimise the mix between quality and costs.

- To ensure that the gains expected to be achieved through competition between insurers as well as providers outweigh the administrative costs associated with the need to monitor and regulate many different dimensions of the health care market.

- To continue to improve accountability and governance of the system and identify possible cost-savings in the health sector administration.

To further the existing efforts, such as financial incentives for GPs in smaller areas, to ensure that resource allocation, including that of medical staff, between regions is not detrimental to poorer regions.

- To continue to improve data collection and

monitoring of inputs, processes, outputs and

outcomes so that regular performance

assessment can be conducted and use to

continuously improve access, quality and

sustainability of care and serve as a tool of

patient empowerment.

- To further the efforts to support public health

priorities and enhance health promotion and

disease prevention activities, i.e. promoting

healthy life styles and disease screening given

the recent pattern of risk factors (smoking,

alcohol) and the pattern of both infectious and

non-infectious diseases.

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Table 1.20.1: Statistical Annex – The Netherlands

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 507 524 546 579 613 639 618 632 643 645 651 9289 9800 9934

GDP per capita PPS (thousands) 31.9 33.0 33.9 35.2 36.8 36.5 33.7 34.2 34.9 34.6 34.4 26.8 28.0 27.9

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Real GDP growth (% year-on-year) per capita -0.1 1.9 1.8 3.2 3.7 1.4 -4.2 1.0 0.5 -1.6 -1.1 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 9.7 4.0 11.1 2.0 3.8 3.6 3.6 3.3 0.1 3.1 0.5 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 9.8 10.0 10.9 10.8 10.8 11.0 11.9 12.2 12.1 12.7 12.9 10.4 10.1 10.1

Total current as % of GDP 9.0 9.1 9.4 9.3 9.3 9.5 10.3 10.4 10.5 11.0 11.0 9.8 9.6 9.7

Total capital investment as % of GDP 0.8 0.9 1.5 1.5 1.5 1.5 1.6 1.7 1.6 1.7 1.9 0.6 0.5 0.5

Total per capita PPS 2735 2886 3271 3425 3624 3847 3998 4159 4196 4393 4492 2828 2911 2995

Public as % of GDP 6.0 6.0 7.0 8.4 8.4 8.7 9.5 9.6 9.6 10.1 10.3 8.1 7.8 7.8

Public current as % of GDP 6.0 6.0 6.7 8.0 8.0 8.2 8.9 9.1 9.1 9.5 9.6 7.9 7.7 7.7

Public per capita PPS 1673 1727 2115 2680 2835 3035 3181 3301 3336 : : 2079 2218 2208

Public capital investment as % of GDP 0.0 0.0 0.4 0.4 0.4 0.5 0.6 0.6 0.5 0.6 0.7 0.2 0.2 0.1

Public as % total expenditure on health 61.2 59.8 64.7 78.3 78.2 78.9 79.6 79.4 79.5 79.6 79.9 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 12.1 12.4 12.7 15.8 16.1 15.8 16.1 16.4 16.8 17.7 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 97.9 97.9 97.9 98.5 98.6 98.8 98.8 98.8 99.9 99.8 99.8 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 8.0 7.9 8.1 6.7 6.5 6.6 5.8 5.8 5.9 6.0 5.4 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 16.3 16.3 16.3 16.3 16.4 16.4 16.5 16.6 16.7 16.7 16.8 502.1 504.5 506.6

Life expectancy at birth for females 81.0 81.5 81.7 82.0 82.5 82.5 82.9 83.0 83.1 83.0 83.2 82.6 83.1 83.3

Life expectancy at birth for males 76.3 76.9 77.2 77.7 78.1 78.4 78.7 78.9 79.4 79.3 79.5 76.6 77.3 77.8

Healthy life years at birth females 58.8 : 63.5 63.5 64.3 59.9 60.1 60.2 59.0 58.9 57.5 : 62.1 61.5

Healthy life years at birth males 61.7 : 65.4 65.2 66.1 62.5 61.7 61.3 64.0 63.5 61.4 : 61.7 61.4

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Amenable mortality rates per 100 000 inhabitants* 67 64 60 57 55 52 50 49 103 103 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.8 4.4 4.9 4.4 4.1 3.8 3.8 3.8 3.6 3.7 3.8 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : : 2.68 2.64 2.64 2.72 3.00 3.16 3.13 3.37 3.50 3.13 2.99 3.01

Day cases curative and rehabilitative care : : : : : : : : : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care : : 1.80 1.80 1.82 1.90 2.07 2.03 2.06 2.14 2.13 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables : : 1.03 1.00 1.02 0.98 1.02 1.02 1.00 0.90 0.85 1.60 1.55 1.44

Therapeutic appliances and other medical durables : : 0.46 0.45 0.43 0.46 0.43 0.45 0.47 0.50 0.47 0.31 0.31 0.32

Prevention and public health services 0.48 0.45 0.44 0.42 0.42 0.42 0.46 0.46 0.43 0.42 0.35 0.25 0.25 0.24

Health administration and health insurance 0.50 0.51 0.47 0.48 0.49 0.47 0.49 0.50 0.53 0.54 0.54 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : 2.10 2.60 2.60 2.68 2.95 3.12 3.09 3.33 3.45 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : : : : : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care : : 0.84 1.20 1.20 1.31 1.44 1.40 1.40 1.46 1.48 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables : : 0.59 0.82 0.84 0.82 0.84 0.84 0.82 0.73 0.68 0.79 1.07 0.96

Therapeutic appliances and other medical durables : : 0.17 0.21 0.20 0.20 0.22 0.22 0.22 0.23 0.22 0.13 0.12 0.13

Prevention and public health services 0.24 0.22 0.24 0.27 0.28 0.29 0.32 0.33 0.31 0.31 0.25 0.25 0.20 0.19

Health administration and health insurance 0.27 0.28 0.21 0.34 0.34 0.31 0.31 0.31 0.33 0.32 0.35 0.11 0.27 0.27

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EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.20.2: Statistical Annex - continued – The Netherlands

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : : 28.5% 28.4% 28.4% 28.5% 29.3% 30.3% 29.9% 30.7% 31.9% 31.8%
31.3% 31.1%

Day cases curative and rehabilitative care : : : : : : : : : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : : 19.1% 19.4% 19.5% 19.9% 20.2% 19.5% 19.7% 19.5% 19.4%
23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables : : 10.9% 10.8% 11.0% 10.3% 10.0% 9.8% 9.5% 8.2% 7.7%
16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables : : 4.9% 4.8% 4.7% 4.8% 4.2% 4.3% 4.5% 4.5% 4.3% 3.2%
3.3% 3.3%

Prevention and public health services 5.3% 5.0% 4.7% 4.5% 4.5% 4.4% 4.5% 4.4% 4.1% 3.8% 3.2% 2.6% 2.6%
2.5%

Health administration and health insurance 5.6% 5.6% 5.0% 5.2% 5.3% 4.9% 4.8% 4.8% 5.1% 4.9% 4.9% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative **care** : 31.5% 32.6% 32.6% 32.6% 33.1% 34.4% 34.0% 34.9% 35.9% 34.6%
34.1% 34.0%

Day cases curative and rehabilitative **care** ::::::::::: 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative **care** : : 12.6% 15.1% 15.0% 16.0% 16.2% 15.4% 15.4% 15.3% 15.4%
22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables : : 8.8% 10.3% 10.5% 10.0% 9.4% 9.3% 9.0% 7.7% 7.1% 10.0%
13.9% 12.5%

Therapeutic appliances and other medical durables : 2.5% 2.6% 2.6% 2.5% 2.5% 2.5% 2.5% 2.4% 2.3% 1.6%
1.6% 1.6%

Prevention and public health services 4.0% 3.7% 3.6% 3.4% 3.5% 3.5% 3.6% 3.6% 3.4% 3.3% 2.6% 3.2% 2.7% 2.5%

Health administration and health insurance 4.6% 4.7% 3.1% 4.3% 4.2% 3.8% 3.5% 3.4% 3.6% 3.4% 3.6% 1.4%
3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants : 0.62 0.66 0.78 0.76 1.04 1.10 1.22 1.29 1.18 1.15 1.0 1.1 1.0

Angiography units per 100 000 inhabitants :::: 0.7 1.0 0.9 :::: 0.9 0.9 0.8

CTS per 100 000 inhabitants : 0.7 0.8 0.8 0.8 1.0 1.1 1.2 1.3 1.1 1.2 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : 0.1 : 0.2 0.2 0.4 0.5 0.5 0.5 0.3 0.1 0.1 0.1

Proportion of the population that is obese 10.7 10.9 10.7 11.3 11.2 11.1 11.8 11.4 11.4 : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 26.7 25.4 25.2 25.2 23.1 23.3 22.6 20.9 20.8 18.4 18.5 23.2
22.4 22.0

Alcohol consumption litres per capita 9.6 9.6 9.7 9.8 9.5 9.6 9.2 9.3 8.9 9.1 : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 262 265 271 280 279 287 292 296 313 325 329 329 335 344

Practising nurses per 100 000 inhabitants 812 826 833 834 844 855 : : 1190 1210 840 812 837

General practitioners per 100 000 inhabitants 64 65 66 68 68 70 72 73 73 77 78 : 78 78.3

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Acute hospital beds per 100 000 inhabitants 292 291 286 318 317 310 306 326 334 332 : 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 5.5 5.3 5.4 5.6 5.7 5.9 5.7 6.6 6.6 6.2 6.2 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 9.4 9.9 10.1 10.4 10.6 11.0 11.3 11.6 11.9 11.6 : 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 7,493 8,269 8,817 9,602 10,324 10,987 11,766 12,509 12,618
13,936 : 6368 6530 7031

Acute care bed occupancy rates 68.0 67.0 67.0 67.0 56.0 54.5 52.7 52.8 47.5 45.6 : 72.0 73.1 70.2

Hospital curative average length of stay 7.9 7.5 7.2 6.6 6.2 6.0 5.6 5.6 5.8 6.4 : 6.5 6.3 6.3

Day cases as % of all hospital discharges 44.3 45.6 46.5 48.0 49.3 50.1 51.1 51.8 51.4 54.6 : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 7.2 7.5 7.9 8.2 8.2 8.1

AWG risk scenario 7.2 7.7 8.2 8.6 8.8 8.8

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 16.8 17.2 17.6 17.6 17.4 17.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

1.6 3.1

1.0 0.9

1.6 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability, demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, GDP per capita (16,800 PPS) in Poland

was below the EU level of 27,900 PPS. Poland

remained with positive growth rates of real GDP

during the crisis. In 2013, population is estimated

at 38.1 million. (227) Poland's population is

characterised by declining growth with an ageing

population and a rising share of older age cohorts.

The population is projected to decrease to 33.2

million until 2060.

Total and public expenditure on health as % of

GDP

Total expenditure on health was at 6.7% of GDP in

2013 (EU: 10.1% in 2013). Public spending on

health was at 4.6% of GDP (EU: 7.8%). Spending

relative to GDP was increasing steadily between

2003 and 2009 and has slightly decreased since. In

2012, 10.9% of total government expenditure was

channelled towards health spending (EU: 14.9%).

In per capita terms, total (1,215 PPS) and public

spending (845 PPS) were well below the

respective EU averages (2,988 PPS and 2,208

PPS).

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to

increase by 1.2 pps of GDP (AWG reference

scenario), above the average increase of 0.9 pps for

the EU. When taking into account the impact of

non-demographic drivers on future spending

growth (AWG risk scenario), health care

expenditure is expected to increase by 2.2 pps of

GDP from now till 2060 compared to the EU

average of 1.6 pps (228) Overall, projected health

care expenditure poses a risk to the medium and

long-term sustainability of public finances. The

medium-term risks are related to the unfavourable

initial budgetary position and the projected impact

of age-related spending. Over the long run, Poland

faces medium risks to fiscal sustainability. These

(227) According to the Central Statistical Office of Poland, the

population on 31st June 2015 was 38.45 mln.

(228) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

risks are largely due to an unfavourable initial

budgetary position, but also to the necessity to

meet future increases in ageing costs (notably

healthcare and long-term care). (229)

Health status

In 2014 life expectancy at birth was 81.7 years for

women and 73.7 years for men, below the EU

averages (EU: 83.6 for women and 78.1 for men).

However, in 2013 healthy life years were slightly

above the EU average for women (62.7 vs. 61.5

years), but below the EU average for men (59.2 vs.

61.4 years). Amenable mortality rates, i.e. deaths

that should not occur with timely and effective

care, are well above the EU average (165 deaths in

Poland versus 128 deaths in the EU per 100 000

inhabitants). Infant mortality was at the level of

4.6‰ in 2013 (EU: 3.9‰).

System characteristics

Administrative organisation, system financing,

revenue collection mechanism

The health care system in Poland is described by two basic acts. Details of the operation of general health insurance system are defined by the Act of 27 August 2004 on healthcare services financed from public funds. The insurer is the National Health Fund (NHF). Rules pertaining to therapeutic activity in Poland are regulated by the Act of 15 April 2011 on therapeutic activity, having a systemic nature of the health care system.

The act defines the rules for the therapeutic activity, in particular the conditions to be met by entities carrying out therapeutic activity, as well as the categories of entities and kinds of therapeutic activity.

Since 2003, a centralised National Health Fund (NHF) manages the financial resources and allocates them between providers based on individual contract. Moreover, in 1990 the Agricultural Social Insurance Fund was

established in order to realise tasks connected with

full servicing of farmers' social insurance. (230)

(229) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(230) The main regulation defining farmers' social insurance

obligations and entitlements to benefits is the act of 20

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Funds are coming mostly from universal health

insurance contributions collected by the NHF.

Moreover, government budgets (state, regional or

local authorities) contribute for specified purposes,

such as health insurance contributions for specific

groups of the population (e.g. unemployed

receiving social security benefits, persons

receiving social pensions, farmers, war veterans,

etc.), capital expenditure in public health care

institutions, highly specialised tertiary care

procedures (such as organ transplants, heart

surgery, treatments abroad) and very expensive

drugs (in total around 10%).

The NHF contributions are calculated on the gross income base, which makes it a sort of earmarked type of personal income tax (PIT). The base differs slightly for some defined social groups: farmers (depending on the size of the farm), self-employed (depending on income, but with a lower limit) and beneficiaries of social security (depending on the gross amount of benefits). The contribution rate amounts currently to 9% of the base, 7.75% of which are subtracted from PIT and 1.25% are paid directly by the insured person.

In 2011, a major reform was introduced allowing for the possibility of direct transformation of public health care units, including public hospitals into corporate units (corporatisation). The law regulates that both public and private hospitals contracted by NHF will function according to the same rules. Also public hospitals that were transformed into corporate units will be allowed to offer for fees services outside the contracts with NHF. (231)

December 1990 on social insurance for farmers. The current regulation of farmer's health insurance is included in the act of 5 December 2014 to amend the act on health insurance contributions made by farmers for years 2012-2014 (pol. ustawa z 5 grudnia 2014 r. o zmianie ustawy o sk,adkach na ubezpieczenie zdrowotne rolników za lata 2012-2014) which prolonged previous regulations by the end of 2016).

(231) Please, notice that the Act of 15 April 2011 on medical activity regulates the transformations of public independent health care provider (pol. samodzielny publiczny zak,ad opieki zdrowotnej (SPZOZ) – specific name for health care provider). In accordance with this act, if the health care provider is not able to finance its own deficit, then its founder can defray the negative balance or is obliged to transform this provider into corporate unit (or budgetary unit) or decide on liquidation of the unprofitable provider.

The laws' purpose is to increase the efficiency of health care providers and thus improve the functioning of health care system. If the financial report on public hospital activity indicates a net

loss, then hospital or his owner has 3 months to

cover it. Otherwise, the owner makes a decision:

transformation into corporate unit or liquidation.

Since July 2011, 62 public hospitals were

corporatised (1 of them was privatised). (232) It will

be interesting to observe the law's further impact in

the coming years.

Coverage and role of private insurance and

out of pocket co-payments

Public health insurance covers 91.6% of the

population. (233) Practically all social groups are

covered by mandatory health insurance. There is

no legal possibility to opt-out from the system on

the grounds of income, social group or source of

means of living. The law identifies the package of

health services provided under the insurance

scheme, as well as a limited list of excluded

services. A number of services, defined by law, are

provided for co-payments, whose level is legally

limited and depends on the income of an insured

person. (234) For dental care, a precise system of

point pricing with respect to a standard basket of

dental procedures and materials is established. (235)

Shares of public and private expenditure in total

health care spending have been stable over the last

decade: 70% of expenditure being publicly and

30% privately financed (EU: 77% public and 23%

private). As such, health financing is based to a

higher degree on private sources than in the other

EU countries. Out-of-pocket spending accounts for

a large majority of private expenditure (22.8% of

total expenditure on health in 2013; EU: 14.3%).

As there are no patient charges for medical

treatment by general practitioners, specialists or in

hospitals, private co-payments are foremost for

(232) By today, 191 hospitals have changed their organisational

form (into corporate unit). Majority of them , (ca. 70%,)

are owned or controlled by public body (mainly local

government).

(233) The guaranteed benefit baskets are stored in the regulations

of the Minister of Health, not in the act.

(234) Only charges for accommodation and catering in the care

and treatment facility, nursing and care facility or in

medical rehabilitation facility that provides twenty-four

hour services are dependent on the income.

(235) As a result, Poland scores about 5.9 out of 6 on the breadth, 6 in the scope and around 5.3 on the depth of basic coverage according to the OECD scoreboard.

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outpatient pharmaceuticals. This suggests a relative underdevelopment of other, more institutionalised patterns of financing (such as supplementary insurance schemes).

Private expenditure also includes the pre-payment schemes, of which main components are "medical subscriptions" and different insurance policies protecting against the risk of high expenditures on

health care. The former ones are mainly the expanded packages of health services offered by employers to their employees. They usually include services that the employers are obliged to provide in accordance with law and cover mostly outpatients services. The latter ones are still in the early stage of development and concern a minor number of patients.

Types of providers, referral systems and patient

choice

Health care services are provided by public and non-public therapeutic entities and private medical practitioners (individual or group medical practice). All providers are independent in terms of organisation, personnel, assets and finances.

Primary health care is provided in outpatient clinics and at home (with doctors obliged to provide home services when required for medical reasons). Family physicians (or general practitioners – GPs) act as gatekeepers for specialist and hospital care. Patients have a free choice of the GP, with a limited number of changes available per year. Also, there is free choice of and direct access to certain specialists (e.g. gynaecologists, psychiatrists, oncologists, dentist and venereologist). Specialist outpatient care is based mostly on private medical practices or specialised health centres (mainly in the big cities), which developed on the basis of the former

public specialised health care centres. Inpatient

hospital care is provided predominantly in public

hospitals. The number of non-public hospitals

increased over the last decade (428 private

hospitals of 1013 in 2016). (236)

While the insurance coverage is practically

universal, the supply of health care is seemingly

not sufficient to provide the whole population with

(236) In terms of the number of hospital beds the public sector

dominates. Private hospitals are relatively small.

timely and adequate care. The number of

practising physicians per 100 000 inhabitants (224

in 2013) is one of the lowest in the EU (EU: 344).

The same is true for GPs (22 per 100 000

inhabitants in Poland vs. 78 in the EU in 2013),

although their number has steadily increased in the

last decade. The number of nurses is also low (527

per 100 000 inhabitants in 2013), and below the

EU average of 837. Staff shortages are particularly

perceptible in some regions and for some

specialisations as the regional and sub-sectorial

discrepancies in care availability are significant.

A characteristic feature of the Polish health care system is the widespread phenomenon of double (or multiple) employment: physicians keep parttime salaried job in (mostly public) health care units and simultaneously act as individual medical practitioners. Indeed, only for a small minority of individual practitioners (with the exception of dentists) this occupation is reported as their main or only job. Such practice may have a strong negative effect on the quality of services provided by the health care units and their economic situation, as their equipment and facilities are often used by the physicians for their secondary activities.

Total expenditure on inpatient care as a % of GDP was below the EU average (2.1% vs. 3.0% in 2013), as was public expenditure (2.0% vs. 2.6% in 2013). Inpatient care accounts for roughly 45% of public expenditure on health in Poland compared to 34% in the EU. High expenditure may be a sign of a health system which is oriented away from ambulatory and towards hospital care,

providing potential to increase the relatively costeffective

of care, by shifting away from hospital

centric health care provision.

The capacity of Polish hospitals (430 beds per 100

000 inhabitants in 2013) is higher than the EU

average of 356 in spite of the reduction over the

last decades (486 in 2003), which occurred in line

with the decline in average length of stay (7.9 days

in 2005; 6.7 in 2013 which located Poland above

the EU average of 6.3 days). Also, the number of

hospital inpatient discharges decreased from 16.8

in 2004 to 16.2 in 2011 per 100 inhabitants (EU:

16.5 in 2013).

Total and public expenditure on outpatient care as

a % of GDP were below the EU average (1.5% and

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0.9% vs. 2.2% and 1.8% in 2012). Total and public

expenditure on outpatient care as a % of current

health expenditure were roughly around the EU

average (23% and 20% vs. 23% and 23% in 2012).

Physicians employed by the health care units can be remunerated according to a number of contractual arrangements, although salary is the most widespread pattern. Individually practising physicians are generally paid according to the capitation principle, on the basis of patient lists.

Hospitals are financed on the basis of the contracts concluded between individual entities and the National Health Fund. A uniform classification of hospital services, mainly based on defining individual groups of procedures and prices for basic units serves as a basis for those contracts.

The market for pharmaceutical products

The pharmaceutical market in Poland is divided into two segments: open (through pharmacies) and closed (through hospitals) markets. Over the last decade, the value of drugs sold has increased in both markets, while the quantity has decreased in hospitals and remained stable in pharmacies. These developments suggest a sharp increase in the average price of hospital drugs, driven mainly by a growing use of original drugs. In the open market,

the shares of reimbursed and over-the counter drugs were broadly equal until 2004. Since then a significant increase in the quantity of prescribed and reimbursed drugs has exceeded significantly that of the OTC drugs. However, in terms of value the gap between the growth rates of the two groups has been much narrower, which suggests a much higher price dynamics of the OTC pharmaceuticals, resulting from high effectiveness of advertising campaigns and insufficient competition between the OTC drugs producers.

More detailed analysis of the structure of pharmaceutical market allows observing the increase in the share of imported drugs, linked to the fall in their relative price, as well as the growth in the total value of sold generics, driven mainly by the relative increase in their prices, rather than quantities sold.

New drug reimbursement regulations and changes to the official list of subsidised drugs have been introduced in 2012. Now the Ministry of Health can negotiate the fixed refundable price of a drug

directly with manufacturers. Thus, prices of reimbursed drugs are identical in all pharmacies.

Under the reimbursement law, the list is updated every two months.

Use of Health Technology Assessments and cost-benefit analysis

The Centre for Health Care Quality Monitoring provides independent accreditation on the basis of a published set of standards. Quality requirements, national guidelines and standards are developed based on independent expertise. Further schemes include developing a better system to evaluate services. The use of technology assessment is increasing, leading to evidence-based contracting of services.

The Agency for Health Technology Assessment and Tariff System was established in 2005 as an advisory body to the Ministry of Health. It is responsible for preparing health technology assessment reports, collecting information on health technology assessment results and methodologies. The main task of the agency is to prepare for the Minister of Health

recommendations on financing all health care services from public funds (especially in relation to drug reimbursement list, national and local government health care programs, therapeutic drugs programs (high-cost, innovative drugs) and hospital's chemotherapy drugs list).

eHealth (e-prescription, e-medical records)

In 2013, an electronic verification of beneficiaries' rights was introduced (so-called eWUŚ system).

This allows for verification whether the person is entitled to benefits financed from public means.

Also an individual health e-account (so-called ZIP) was introduced in July 2013, on which the insures' data will be collected.

The following legal regulations were adopted aiming at the modernisation of the current system of gathering, processing and usage of information in healthcare. Those regulations are deriving from the act of 28 April 2011 on information system in healthcare. The act and its implementing legislation provide the legal framework for the functioning of information system in healthcare. It

is also a foundation for implementation of solutions supporting the exchange of medical data,

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which need to be used in treatment process in Poland. Under this act there are IT solutions being developed currently, through which it will be possible to prepare tools for implementation of healthcare information as well as to conduct electronic medical records (documentation) in medical entities.

Currently, the following projects are done:

1. Electronic Platform for Collection, Analysis and Dissemination of Digital Resources on Medical Events (P1). Information systems which will be launched within this project will become electronic platform of medical data. The aim of this project is to build an electronic platform for public services in healthcare, enabling different stakeholders to collect, analyse and share their digital resources on medical events. The

project includes the necessity to ensure appropriate level of security as regards data and services. Due to high sensitivity of data being processed (medical data), feeding the data, as well as their processing will be done with the full knowledge of patient, in compliance with the required security and confidentiality measures. Projects allow to implement ePrescription, referral, Online Patient Account as well as to exchange electronic medical documentation. The platform will be connected with local information systems of healthcare providers and with the data being processed, which makes the functioning of the system to be liable to high requirements of security level.

2. Domain-specific information and

communication systems in healthcare (P4) – the project will enable building and implementation of information and communication systems supporting specific business areas, as follows:

- Healthcare Statistics System,
- Risks Monitoring System,
- Integrated System of Monitoring Trade in Medicinal Products,

- System Monitoring Education Medical

Professionals,

- System of Registration of Healthcare

Resources.

3. Platform P2, i.e. Platform for sharing

services and resources of digital medical records

with on-line businesses was established and

launched at the beginning of 2013. P2 platform is a

universal IT tool used to keep registers and provide

electronic services. P2 platform enables electronic

registration and updating of register data (e.g. it is

possible to apply for permission to run a

pharmacy), gives healthcare providers the

opportunity to submit their applications to the

register electronically, to keep documents in

electronic form, provides wider usage of digital

signature and assists public administration in

downloading registry data. During integration with

the P2 platform the registers are rebuilt so that they

are consistent with the reference architecture of a

medical register. The following registers were

integrated with the P2 platform:

- Register of permits for running commonly available pharmacies, pharmacy points and Register of permits for running hospital pharmacies, company pharmacies as well as hospital pharmacy departments,
- Register of permits for running pharmaceutical warehouses,
- Coding Systems Register,
- Register of Medicinal Products Authorized for the Market on the territory of the Republic of Poland,
- Register of Medically Assisted Procreation,
- Residency IT System (SIR).

Full operation of the system will be possible when the above mentioned projects are finalised.

Feeding the system with medical data and electronic medical documentation is the vital requirement for full operation of the system. For this purpose healthcare providers were obliged to keep medical documentation in electronic form starting from 1 January 2018. Until that time healthcare providers can develop and process medical documentation in traditional (paper) form

as well as in electronic one. Due to the solution implemented in Poland as regards exchange of medical documentation, medical documentation

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will be held by healthcare providers in the information and communication system and its dissemination will be possible through Medical Information System (MIS), i.e. P1 platform, mentioned above. Healthcare provider will feed into MIS the data or medical electronic documents possible to be downloaded by other healthcare provider when necessary for the continuity of treatment and providing patients with medical products and devices. Sharing the data is possible only with the consent of patient. EPrescription and referral will be specific documents available during data sharing. It will be possible to provide those documents within P1 platform directly, through special application.

As mentioned above, the computerisation of

healthcare system in Poland is developing dynamically. In accordance with current regulations, healthcare information system will eventually include databases functioning within: Medical Information System (MIS), which is information and communication system used for processing data on provided, being provided and planned healthcare services shared by healthcare providers' information and communication systems, domain-specific information and communication systems (Register of Medical Services System of the National Health Fund, Healthcare Statistics System, System of Registration of Health Resources, Risks Monitoring System, Accessibility to health care services Monitoring System, Register of Medicinal Products Authorized for the Market on the territory of the Republic of Poland, Integrated System of Monitoring Trade in Medicinal Products, System Monitoring Education Medical Professionals, Reimbursement List Operation System) and Medical registers.

Health and health-system information and

reporting mechanisms

The collection and processing of statistical data on

health care is governed by the Council of Ministers

on the program of statistical surveys. In 2016, as

well as planned for 2017, the program foresees the

following tests, which consist of dozens of

statistical forms, as e.g. health's status of the

population, health's monitoring, hospitalisation,

prevention, vaccination, economic aspects of

health care, the National Health Account and

others. A separate branch of IT-systems is used by

the National Health Fund as the primary payer.

These systems include eHealth (e-prescription, emedical

records, e-referrals), a system for billing

services, in which data are collected both on the

number of benefits, types of benefits and costs of

benefits. Together with the characteristics of

patients (age, sex, region) this creates a

comprehensive source of information for an

effective allocation of resources.

Health promotion and disease prevention

policies

Public health has gained a large momentum in 2015. The Parliament adopted the law on public health (from September 11th), which entered into force in December 2015. According to this legislation new governance, inter-ministerial coordination and financing mechanisms are in place. Overall spending on public health programmes will increase in 2016, compared to 2015. Before 2016 total and public expenditure on prevention and public health services as a % of GDP were below the EU average (0.16% and 0.12% vs. 0.24% and 0.19% in the EU). Public and total expenditure on prevention and public health services as a % of current health expenditure were at the EU average (2.6% and 2.7% in Poland vs. 2.5% and 2.5% in the EU in 2012).

Transparency and corruption

Regarding anti-corruption regulations in the functioning of the Ministry of Health, this area is particularly vulnerable to issues of lobbying, informal pressures and corruption proposals in meetings with external stakeholders, in particular

with representatives of the pharmaceutical industry

involved in creating the list of reimbursed drugs.

In view of the need to normalise the above

mentioned contacts, a special procedure was

adopted on how to receive visitors in the Ministry

of Health. The procedure provides transparency

rules for meetings with external stakeholders,

especially in the context of possible lobbying

activities. The Ministry of Health collaborates with

the European Healthcare and Corruption Network

(EHFCN) since 2006. This cooperation relies

mainly on exchange of experiences, information,

data and best practices. The Network is the only

international organisation in the Europe, which is

dedicated to combating corruption, fraud and

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losses in health care systems. The Ministry of

Health also took part in the awareness-raising

campaign organised by the EHFCN, the aim of

which was to show the scale of corruption in the

healthcare sector in Europe, by pointing to what the lost funds could be allocated due to fraud and corruption in health. The Ministry of Health takes part in the implementation of the “Government Anti-Corruption Programme for years 2014-2019”, aiming at reducing the level of corruption in Poland

Recently legislated and/or planned policy reforms

Since 2012, many amendments have been made to basic governance laws of the health care insurance system. These related to the provision of health care services include: 1) Changes in the contracting of health care services by the National Health Fund – with emphasis on the complexity of the services and experience of service provider; 2) Changes in primary health care - by changing eligibility requirements for doctors which could serve as a family physician; 3) Changes in the financing of cross- border treatment in a State other than the Member State of affiliation - implementation of Community legislation.

Related to pharmaceuticals, the reimbursement system was changed. Medicinal products are reimbursed on the basis of administrative decision issued by Minister of Health. Furthermore the system of fixed prices and margins was introduced.

In 2015 the Act of 11 September 2015 on public health was introduced. It defines specific tasks of public health and indicates institutions involved in providing these tasks and rules of financing these activities. The act promotes health and enhances the disease prevention activities. The baseline for implementation of these tasks will be the National Health Program.

An amendment to the act on health care services financed from the public funds is being prepared.

According to the project, people aged 75 or more will receive certain drugs (from the reimbursement list) for free.

Pharmacovigilance - a key element of the adopted amendments has remodelled the definition of "adverse reaction of medicinal product". It has basically expanded the group of people entitled to

report adverse reaction of pharmaceuticals (for instant: patients, nurses, midwives, paramedics, laboratory diagnosticians), introduced possible requirements for post-authorisation studies and obligation to report adverse reaction to Eudravigilance by stakeholders.

Moreover, the obligation to pay health insurance premiums by farmers operating in farms over 6 acres conversion was introduced. Until the adoption of the Act, for all farmers, premiums were paid from the state budget.

The Ministry of Health prepared a Regional Healthcare Needs Maps of Poland in order to analyse current and projected demographic trends and the health status of the society. The analysis is conducted at a regional level with respect to available healthcare resources and infrastructure, identifying needs for policy reform. Regional Healthcare Needs Maps of Poland is created for each voivodeship and includes projections of healthcare needs of the society at a county and voivodeship level. These documents provide the basis for the Healthcare Needs Map of Poland,

which additionally contains analysis of healthcare

provided at national level (ex.: transplantology).

This approach identifies fields of healthcare

system, which require coordinated intervention of

more than one voivode or appropriate State

authorities. Identified priorities for healthcare

policy at a regional level and Regional Healthcare

Needs Maps of Poland should be taken into

account by the National Health Fund at the process

of contracting of healthcare providers. This should

lead to more rational financing of healthcare

investments and healthcare system, decrease the

risk of strictly arbitral decisions and increase the

transparency of the system. Until the end of 2015

Healthcare Needs Maps in the fields of oncology

and cardiology were prepared.

In addition, in 2015 the Ministry of Health

introduced fast-track waiting lists for cancer

patients. They are now guaranteed diagnostics and

treatment within specified times, and there are no

financing limits for treatment. Health **care**

providers, who ensure timeliness and

comprehensiveness of health care services, face no

financing ceilings.

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Challenges

The Polish government has continued in recent years to tackle the pervasive inefficiencies of the health system. The main challenges for the Polish health system currently are as follows:

- To continue increasing the efficiency of health

care spending in order to adequately respond to

the increasing health care expenditure over the coming decades, as this is a risk to the longterm sustainability of public finances.

- To improve the basis for more sustainable and

larger financing of health care in the future.

This can improve access and quality of care

and its distribution between population groups

and regional areas.

- To develop a comprehensive human resources

strategy that tackles spatial/regional disparities,

ensures sufficient numbers of staff in general,
aims at increasing the number of general
practitioners relative to specialist clinicians,
and in the future in view of staff and population
ageing and motivates and retains staff to the
sector and to the country.

- To foster the reallocation of resources aiming
at reducing the high share of spending on
inpatient care and increasing the relatively low
share of spending on typically more on
outpatient care services.

- To strengthen the role of primary health care
within the system and that of general
practitioners in their role as gatekeepers.

- To carry out the mapping of health care needs
aiming at identifying priorities for resources reallocation
and serving as a basis for
investments in the health system.

- To tackle the multiple employment
phenomenon, affecting accessibility and quality
of public health services, and the widespread

illegal use of public equipment and facilities by

the individual practitioners.

- To pursue the restructuring and reorganisation

of the hospital sector, aiming at rationalising

existing hospital bed capacity and improving

the cost-efficiency within hospitals, ensuring

that care is provided in the most clinically

appropriate and cost-effective way, for

example by maximising the proportion of

elective care provided on a day case basis, dayof-

surgery admission; To closely monitor the

effects on access to and quality of care related

to possibility of voluntary transformation of

public hospitals into corporate units

(corporatisation).

- To foster a wide use of Health Technology

Assessment and information and

communication technologies in health care.

- To enhance health promotion and disease

prevention activities, promoting disease

screening given the most recent pattern of risk

factors (circulatory system diseases, cancers).

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Table 1.21.1: Statistical Annex – Poland

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 192 205 245 273 314 364 315 362 380 389 395 9289 9800 9934

GDP per capita PPS (thousands) 12.7 13.1 13.5 14.1 15.1 15.0 14.7 15.7 16.3 16.7 16.8 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 3.9 5.4 3.7 6.3 6.8 5.1 1.5 2.9 4.5 2.0 1.6 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 2.9 4.7 3.9 6.1 9.0 14.4 6.2 0.2 2.3 0.2 0.2 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 6.2 6.2 6.2 6.2 6.3 6.9 7.2 7.0 6.9 6.8 6.7 10.4 10.1 10.1

Total current as % of GDP 6.0 5.9 5.9 5.9 5.9 6.4 6.7 6.6 6.4 6.3 6.4 9.8 9.6 9.7

Total capital investment as % of GDP 0.3 0.3 0.4 0.4 0.4 0.5 0.5 0.5 0.5 0.4 0.3 0.6 0.5 0.5

Total per capita PPS 579 631 672 726 826 968 1079 1119 1185 1211 1215 2828 2911 2995

Public as % of GDP 4.4 4.3 4.3 4.3 4.5 4.9 5.2 5.0 4.8 4.7 4.6 8.1 7.8 7.8

Public current as % of GDP 4.1 4.0 4.0 4.1 4.2 4.6 4.8 4.7 4.5 4.4 4.5 7.9 7.7 7.7

Public per capita PPS 383 407 434 472 537 646 712 733 833 838 845 2079 2218 2208

Public capital investment as % of GDP 0.2 0.2 0.3 0.3 0.3 0.3 0.3 0.3 0.3 0.3 0.2 0.1 0.2 0.2 0.1

Public as % total expenditure on health 69.9 68.5 69.4 69.8 70.5 71.7 71.6 71.2 70.3 69.2 69.6 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 9.6 9.9 10.1 10.5 10.7 11.6 11.4 11.0 10.8 10.9 : 14.8 14.9 :

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Proportion of the population covered by public or primary private health insurance : : 97.3 99.3 98.1 97.8 97.8 97.8 96.6 91.0 91.6 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 27.6 29.4 27.8 27.1 26.3 24.4 24.4 23.7 24.0 24.3 22.8 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 38.2 38.2 38.2 38.2 38.1 38.1 38.1 38.0 38.1 38.1 38.1 502.1 504.5 506.6

Life expectancy at birth for females 78.8 79.2 79.3 79.7 79.8 80.0 80.1 80.7 81.1 81.1 81.2 82.6 83.1 83.3

Life expectancy at birth for males 70.5 70.6 70.8 70.9 71.0 71.3 71.6 72.2 72.5 72.6 73.0 76.6 77.3 77.8

Healthy life years at birth females : : 66.9 62.9 61.5 63.0 62.5 62.3 63.3 62.8 62.7 : 62.1 61.5

Healthy life years at birth males : : 61.2 58.4 57.6 58.6 58.3 58.5 59.1 59.1 59.2 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 109 106 102 97 94 91 87 83 171 165 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 7.0 6.8 6.4 6.0 6.0 5.6 5.6 5.0 4.7 4.6 4.6 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 1.73 1.70 1.76 1.79 1.91 2.17 2.23 2.20 2.11 2.11 2.13 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.06 0.11 0.11 0.10 0.10 0.13 0.14 0.14 0.14 0.14 0.14 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.37 1.27 1.13 1.16 1.21 1.37 1.49 1.42 1.40 1.44 1.48 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.89 1.84 1.74 1.69 1.57 1.58 1.65 1.59 1.54 1.41 1.38 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.14 0.14 0.16 0.16 0.16 0.18 0.16 0.14 0.14 0.14 0.14 0.31 0.31 0.32

Prevention and public health services 0.21 0.10 0.14 0.14 0.14 0.15 0.16 0.14 0.14 0.13 0.16 0.25 0.25 0.24

Health administration and health insurance 0.09 0.15 0.09 0.09 0.12 0.11 0.10 0.09 0.11 0.08 0.21 0.42 0.41 0.47

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Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 1.67 1.64 1.70 1.73 1.84 2.10 2.15 2.11 2.01 2.02 2.04 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.06 0.11 0.11 0.10 0.10 0.13 0.14 0.14 0.14 0.13 0.13 0.16 0.16 0.18

Out-patient curative and rehabilitative care : 0.74 0.64 0.66 0.70 0.81 0.91 0.84 0.79 0.81 0.88 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.76 0.67 0.66 0.65 0.59 0.61 0.64 0.63 0.61 0.47 0.44 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.04 0.04 0.07 0.08 0.08 0.08 0.06 0.05 0.05 0.06 0.05 0.13 0.12 0.13

Prevention and public health services 0.19 0.09 0.10 0.10 0.10 0.10 0.10 0.09 0.09 0.12 0.25 0.20 0.19

Health administration and health insurance 0.08 0.15 0.09 0.09 0.12 0.11 0.09 0.09 0.10 0.08 0.13 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.21.2: Statistical Annex - continued – Poland

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 28.9% 28.7% 30.1% 30.6% 32.2% 33.7% 33.2% 33.6% 33.0% 33.3% 33.4% 31.8% 31.3% 31.1%

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Day cases curative and rehabilitative care 1.0% 1.9% 1.9% 1.7% 1.8% 2.0% 2.1% 2.2% 2.2% 2.1% 2.1% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative care 22.9% 21.5% 19.3% 19.8% 20.4% 21.3% 22.2% 21.7% 21.9% 22.7%
23.2% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 31.6% 31.1% 29.7% 28.9% 26.5% 24.6% 24.6% 24.3% 24.1%
22.3% 21.6% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 2.3% 2.4% 2.7% 2.7% 2.8% 2.7% 2.4% 2.2% 2.2% 2.3% 2.2%
3.2% 3.3% 3.3%

Prevention and public health services 3.5% 1.7% 2.4% 2.4% 2.4% 2.3% 2.4% 2.1% 2.2% 2.1% 2.6% 2.6% 2.6%
2.5%

Health administration and health insurance 1.5% 2.5% 1.5% 1.5% 2.0% 1.7% 1.5% 1.4% 1.7% 1.3% 3.3% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 40.3% 40.9% 42.3% 42.7% 44.3% 45.6% 44.6% 45.0% 44.4% 45.6%
45.3% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 1.4% 2.8% 2.8% 2.4% 2.5% 2.8% 2.9% 3.0% 3.1% 3.0% 3.0% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative care : 18.5% 15.9% 16.3% 16.9% 17.6% 18.9% 17.9% 17.4% 18.3% 19.6%
22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 18.4% 16.7% 16.4% 16.0% 14.2% 13.2% 13.3% 13.4% 13.5%
10.6% 9.8% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 1.0% 1.0% 1.8% 1.9% 1.8% 1.7% 1.3% 1.1% 1.1% 1.3% 1.2%
1.6% 1.6% 1.6%

Prevention and public health services 4.6% 2.2% 2.5% 2.5% 2.4% 2.2% 2.1% 2.1% 2.0% 2.0% 2.7% 3.2% 2.7%
2.5%

Health administration and health insurance 2.0% 3.7% 2.2% 2.1% 3.0% 2.3% 2.0% 1.9% 2.3% 1.7% 2.8% 1.4%
3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants 0.10 0.19 0.20 0.19 0.27 0.29 0.37 0.47 0.48 : 0.64 1.0 1.1 1.0

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Angiography units per 100 000 inhabitants : : : : : 0.6 0.8 0.9 1.0 : 1.1 0.9 0.9 0.8

CTS per 100 000 inhabitants 0.6 0.7 0.8 0.9 1.0 1.1 1.2 1.4 1.3 : 1.7 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : : 0.0 0.0 0.0 0.0 : : 0.1 0.1 0.1

Proportion of the population that is obese : 12.5 : : : 16.4 15.8 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : 26.3 : : : 23.8 23.8 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 9.1 9.2 9.5 10.4 10.9 11.4 10.7 10.0 10.1 10.1 10.7 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 243 229 214 218 219 216 217 217 219 223 224 329 335 344

Practising nurses per 100 000 inhabitants 475 493 509 509 518 519 525 524 521 556 527 840 812 837

General practitioners per 100 000 inhabitants 12 13 14 14 16 22 21 21 20 22 22 : 78 78.3

Acute hospital beds per 100 000 inhabitants 486 479 469 465 462 441 439 435 429 432 431 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 6.1 6.2 6.3 6.6 6.8 6.8 6.8 6.6 6.8 7.0 7.1 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 16.8 17.2 13.8 14.3 14.0 14.2 15.7 15.5 15.6 : 16.2 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 1,630 1,878 2,105 2,685 2,818 2,894 3,770 4,050 4,362 : 4,328 6368 6530 7031

Acute care bed occupancy rates : : : : : : : : : : 72.0 73.1 70.2

Hospital curative average length of stay : : 7.9 7.6 7.4 7.5 7.4 7.3 7.1 6.8 6.7 6.5 6.3 6.3

Day cases as % of all hospital discharges 8.8 9.9 13.7 16.2 17.2 : 19.4 20.7 21.8 : 21.1 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 4.2 4.4 4.8 5.1 5.2 5.5

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AWG risk scenario 4.2 4.7 5.4 5.9 6.1 6.4

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 38.5 38.4 37.5 36.2 34.8 33.2

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-13.8 3.1

1.2 0.9

2.2 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

GDP per capita (20.3 thousand PPS in 2013) is

lower than the EU average (27.9 thousand PPS).

Portugal's current population is estimated at 10.5

million people in 2013 and is expected to fall to

8.2 by 2060.

Total and public expenditure on health as % of

GDP

Total expenditure (237) on health as a percentage of

GDP (9.7% in 2013, latest available data) has

remained relatively stable over the last decade

(from 9.7% in 2003) and is slightly below the EU

average (238) of 10.1% in 2013. Throughout the

last decade, public expenditure has decreased as %

of GDP: from 6.7% in 2003 to 6.3% of GDP in

2011 (EU: 7.8% in 2013).

When expressed in per capita terms, also total

spending on health at 1,903 PPS in Portugal in

2013 was far below the EU average of 2,988. So

was public spending on health care: 1,338 PPS vs.

an average of 2,218 PPS in 2011.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care

expenditure is projected to increase by 2.5 pps of

GDP, above the average growth expected for the

EU of 0.9 pps of GDP, according to the "AWG

reference scenario". When taking into account the

impact of non-demographic drivers on future

spending growth (AWG risk scenario), health care

expenditure is expected to increase by 3.5 pps of

GDP from now until 2060 (EU: 1.6). (239)

(237) Data on health expenditure is taken from OECD health data

and Eurostat database. The variables total and public

expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(238) The EU averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units and units of staff where relevant. The EU

average for each year is based on all the available

information in each year.

(239) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

Overall, for Portugal no significant short-term

risks of fiscal stress appear at the horizon, though

some variables point to possible short-term

challenges.

Risks appear, on the contrary, to be high in the

medium term from a debt sustainability analysis

perspective due to the still high stock of debt at the

end of projections (2026) and the high sensitivity

to possible shocks to nominal growth and interest rates.

No sustainability risks appear over the long run thanks to the pension reforms implemented in the past and conditional on maintaining the government structural primary balance at a level as high as forecasted by the Commission services for 2017 (close to 2% of GDP) well beyond that year.(240)

Health status

In the last decades, the health status of the Portuguese population has improved considerably.

This evolution seems to be correlated with increases in financial resources devoted to health

care and to improvements in socio-economic conditions. Life expectancy (84 years for women and 77.6 for men in 2013) is about the EU average (83.3 for women and 77.8 for men). However, healthy life years (62.2 years for women and 63.9 for men in 2011) are above the EU average (61.95 and 61.4 respectively). Mortality by prostate cancer, stroke and road accidents is quite high

according to OECD standards though mortality by road accidents has decreased in recent years. Infant mortality is below the EU average (2.9‰ vs. 3.9‰). The incidence of HIV/AIDS and tuberculosis has been defined as a public health priority.

System characteristics

Coverage

A National Health Service (NHS) provides 100% population coverage (to all the resident population and Portuguese citizens). The NHS is mainly funded by general taxation. There are also a

(240) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf

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number of complementary public and private health insurance schemes (called "health subsystems") covering certain professions. These include the banking sector private schemes and the

three public subsystems for civil servants, police and military (ADSE, SAD and ADM). ADSE and SAD are funded on a voluntary basis by employees' contributions collected centrally, while ADM is also funded by state budget. These schemes cover about 14% of the population.

Administrative organisation and revenue collection mechanism

The budget for the health sector is defined annually in parliament when the general budget is approved. In recent years, authorities have tightened the monitoring over the budget execution. The information system has been strengthened and financial flows are regularly followed up on both an accrual and cash basis.

In 2013, 64.7% of total health expenditure funding came from government sources (direct and indirect taxes collected centrally). The remaining part is private expenditure on health including private voluntary health insurance and out-of-pocket payments. A large part of private expenditure is out-of-pockets which represent 26.6% of total expenditure on health (EU average of 14.1% in

2013), showing a slight increase since 2003 (24.8)

but a decrease since 2010 (28.9). The rest comes

from private insurance.

The Ministry of Health sets the national health

policy strategy, defining public health and policy

priorities, specifying the regulatory framework,

defining the system organogram and providing the

overall management of the health care system.

The "Administração Central do Sistema de Saúde"

(ACSS) implements the decisions of the Ministry

of Health under its supervision. It coordinates,

monitors and controls NHS resource allocation and

use, human resources policies and health facilities

management. The ACSS is responsible for

defining the budget allocation across regions and

areas of provision (e.g. contractos-programa for

hospitals), for defining hospital capacity and the

service network (e.g. definition of health centres

and hospital catchment areas and services provided

by different hospitals) and for developing the

contracting procedures within the sector. ACSS is

also responsible for defining financial and activity

targets and for monitoring the financial and activity flows in the system. Together with "Servicos Partilhados do Ministerio da Saúde" (SPMS), it is responsible for developing information systems that support monitoring, assessment and policy implementation in the system.

The "Servicos Partilhados do Ministerio da Saúde" is the centralised purchasing agency for the Ministry of Health and tenders for and purchases centrally a variety of medical goods and services from medicines and medical devices to ICT services. The "National Agency for Pharmaceuticals" (Infarmed) is in charge of developing and implementing pricing and reimbursement policies, clinical and economic evaluation and monitoring prescription and dispensing practices together with SPMS.

There are also five regional health authorities which are responsible for implementing public health objectives and for purchasing primary, specialist and hospital care for their respective catchment population under the framework defined

by the ACSS. Nevertheless, decision-making remains highly centralised (which may actually have helped with the implementation of costcontainment policies in recent times).

Role of private insurance and out of pocket co-payments

Co-payments (fixed fees) apply to primary care

and specialist consultations, hospital care, home

care and emergency care. Fees are lower for

primary care than for specialist consultations and

these are lower than emergency care to encourage

a more cost-effective path of care. Cost-sharing

also applies to pharmaceuticals (a share of the

price) and public coverage of eye care and dental

care is limited. There are exemptions based on

income, for certain population groups (e.g.

fireman) and certain medical conditions. As a

result, more than 55% of the population is

exempted from any cost-sharing in publicly

provided/ publicly funded services and goods.

The take up of private voluntary health insurance has been growing over the years, mainly through employers as benefits package. 20.2% of the population takes up private voluntary health

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insurance, but it only accounts for 8.7% of health expenditure in 2013.

Coverage of services, types of providers, referral systems and patient choice

The NHS provides coverage for a wide range of health **care** services and goods. NHS supplies primary health **care** (including family medicine, pre-natal and post-natal follow up, prevention and promotion), outpatient specialist consultations and hospital **care** (day-case and inpatient) directly through a network of publicly owned facilities.

The NHS also provides a wide range of related services including diagnostic services, physiotherapy and dialysis **care** either directly or through contracts with private providers.

Primary care functions as the central pillar of the system. NHS primary health care is provided through a network of group practices which include health centres, the more recent Family Health Units (Unidades de Saude Familiares - USFs) and mobile units to outreach the more rural/isolated parts of the country. There is a 24-hour primary care and paediatric counselling phone helpline. Primary care provision is mostly performed by the public sector.

Residents have to register with a family doctor (a general practitioner – GP). As about 11% of the population does not currently have a family doctor, a national patient registry has been put in place to eliminate duplicate registration, identify vacancies in family doctors lists and allocate patients to family doctors. In addition, the number of patients per family doctor has been increased to about 1,900 patients per doctor in traditional health centres and will be potentially increased in USFs. NHS family doctors refer patients for specialist

care, operating as gatekeepers. In other words, a compulsory referral system is in place from primary care and the family doctor to the outpatient specialist. NHS outpatient consultations typically take place in hospital outpatient departments. There is an integrated nationwide electronic system to manage primary care referrals to specialty consultations across the country. This aims to ensure timely access to specialist consultations.

The NHS, through a network of general and specialised hospitals (including 3 oncological centres), provides most of the outpatient specialist care and hospital day-case and inpatient care. In order to improve access and reduce the waiting time for hospital surgery, authorities have in place an integrated central and nationwide electronic system to manage patients on waiting list. In addition, they have introduced clinically defined maximum waiting times for visits to GPs, outpatient specialist consultations and hospital surgery. The NHS also contracts hospital services

from several private and social entities. When 75%

of the maximum waiting time for surgery has

elapsed, the patient can choose a private provider

to have access to care. This mechanism has

allowed reducing waiting times for surgery by

more than 50% since 2006. The vast majority of

hospitals are public (85.7% of total acute care

beds, with 6.6% owned by private not-for-profit

hospitals and 7.7% owned by private for-profit

hospitals).

Ambulatory diagnostic services, physiotherapy and

dialysis care are often provided by the private

sector (private for-profit and not-for-profit entities)

contracted by the NHS to provide care for NHS

users. The contracting rules have been harmonised

with NHS conditions (e.g. fees have been aligned

with NHS costs) in recent years. Since 2013, NHS

developed the legal framework to implement

tender processes to select providers through the

lowest bid increasing providers' competition.

In addition, those who have enrolled in one of the

public sub-systems have directly access to

specialist or hospital care allowed by their scheme

(which contracts only private specialists or

hospitals) or provided by their own facilities. For

these patients service coverage overlaps to a

certain extent with that of the NHS, notably in

terms of mainstream ambulatory specialties. The

government also has a system of vouchers for

dental care for certain population groups (pregnant

women, elderly beneficiaries of the solidarity

supplement and young people under 16 years)

based on an indication of a family doctor and

based on clinical criteria. The goal is to improve

access to these services as NHS coverage is

limited. For low income populations, there are also

additional benefits, e.g. increased medicines

reimbursement, prescription glasses.

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Finally, specialist outpatient care can also take

place in specialists' private individual or group

practices and hospital care in private clinics and

hospitals for private users at the cost of patient.

Often, private provision, especially outpatient

consultations, is conducted by the same specialists

that work for the NHS although the public wage

and working time is adjusted accordingly.

In mainland Portugal (public sector, 2013) there

are 28,886 practicing physicians (2.91 per 1,000

inhabitants) and they are disaggregated by

specialists (20,067) and internships (8,819). The

specialty of family medicine started in the early

eighties and is recognised worldwide as it can be

verified by The "World Health Report 2008" -

primary health care ("Now More Than Ever") and

"World Organization of Family Doctors" reports.

Within the total number for public sector, there are

7,651 family physicians (0.77 per 1,000

inhabitants, year 2013) working in family practices

and they are disaggregated by specialists (6,106)

and internships (1,545).

Portugal suffered from staff shortages and an

unequal distribution of resources with a high

concentration of physicians including GPs in big

urban areas and a higher concentration in the

region Centro. To address these, two medical degrees were created – with a focus on improving the skill mix towards primary care and needed specific specialties – and mobility rules have been changed slightly. Also, a small monetary bonus is given to doctors who moved to disadvantaged areas and further measures have been taken to encourage the mobility of doctors and other health workers. Acute hospital beds stand at 284 per 100,000 inhabitants in 2013 and significantly below the EU average of 356 per 100,000 inhabitants, showing a reduction over the decade with the increase of one day surgery and long term care network.

Staff supply is regulated: there are quotas for medical students and by specialty and there is now some regulation regarding the opening of vacancies to improve staff distribution. In addition, the definition and adoption of the recently developed 3-year hospital strategic plans has implications for staff distribution and vacancies. Authorities are also developing a human resources

planning instrument to help identify in which geographic areas or medical specialties there may be staff shortages developing and adjust training accordingly.

Purchasing and contracting of healthcare services and remuneration mechanisms;

Remuneration is defined by the government. USFs

primary care doctors receive capitation wages

which are based on the characteristics of the

population served and pay for performance. In

addition, as USFs are part of an ongoing reform to

create more autonomous and multidisciplinary

teams in primary care and incentives for better

performance (e.g. better follow up of patients,

notably chronic patients, better pre and post-natal

care, more cost-effective use of medicines). In this

context a small performance-related team bonus is

paid to the practice on the basis of achieving prenegotiated

targets. Health centres' doctors receive

a salary.

NHS specialists working in hospitals are paid a

salary. Hospitals are paid on prospective global

budgets based on DRGs, with the possibility to reallocate resources across cost-categories. In addition to the transfers from the government, hospitals generate their own revenue, through flatrate user charges for outpatient and diagnostic services, special services (e.g. individual private rooms) and from privately insured patients.

Doctors in outpatient private practices are paid a fee for service and are paid a wage when providing hospital services.

Doctors' consultations per capita are below the EU average (4.1 in 2012 vs. 6.2 in 2013). When looking at hospital activity, inpatient discharges per 100 inhabitants are lower than the EU average (respectively 7.9 vs. 16.5) while day-cases per 100,000 inhabitants are slightly higher at 7,533 vs. 7,031 in 2011. The proportion of surgical procedures conducted as day cases (48.7%) is therefore much higher than the EU average of 30.4% in 2013. Hospital average length of stay for curative care is above the EU average (7.2 days vs. 6.3 days in 2013), though this may be a result of

having only complex cases as inpatient.

Measures of input, process, output and outcome are used on a regular basis to compare the relative performance of hospitals (available at a website).

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This process has been extended to primary care providers since 2014.

The market for pharmaceutical products, the use of Health Technology Assessment and cost-benefit analysis

The authorities have in place a large number of policies to control expenditure on pharmaceuticals.

The initial price of all reimbursable medicines is based on clinical performance, economic evaluation, the cost of existing medicines and international prices (based on the minimum manufacturing price in ES, FR and SI). Overall payback agreements and specific payback and price-volume agreements control expenditure directly. The authorities apply internal reference

pricing, whereby the maximum reimbursement level of a product is based on the average of the 5 cheapest products of same active ingredient, form and dosage. There is a positive list of reimbursed products which is based on health technology assessment information.

In addition to compulsory e-prescription and INN prescription, authorities promote rational prescribing of physicians through compulsory treatment guidelines or practice protocols and prescription targets in primary care. Pharmacies have to dispense one of the five cheapest products of the same active ingredient. This is complemented with monitoring of prescribing and dispensing behaviour and education and information campaigns on the prescription and use of medicines. Direct advertisement of reimbursed pharmaceuticals is not allowed.

Portugal has made a very strong effort to promote the use of generics and there is an explicit policy target on generics equal to 60% for the NHS market. The price of generics must be 50% less than the branded product when it enters the market

and subsequent price reductions apply. Generics application for pricing and reimbursement is evaluated faster than other medicines and legal and administrative rules have been simplified. These new regulations, in the medicines department, have led to an increase in the use of generics. The Infarmed (that regulates and controls pharmaceuticals) publishes an annual statistical report on sales growth of pharmaceuticals and the impact on the NHS and on patients direct cost. eHealth (e-prescription, e-medical records) and information and reporting mechanisms; The authorities have introduced a number of eHealth actions including the individual electronic NHS card, e-prescribing, e-appointments and electronic patient records. These e-actions help improving monitoring and control of prescription and consumption of services and goods and render the referral system and care coordination more effective, reducing the use of unnecessary pharmaceutical, specialist and hospital emergency

care.

Health promotion and disease prevention

policies

Despite the large health improvement since the 1970s, the authorities point to the need to improve health status further through promotion and prevention activities. Moreover, the authorities propose to continue the ongoing primary care reform to reinforce promotion and prevention for all including to those who are more vulnerable or at greater risk. The National Health Plan 2012-2016 defined strategies, priorities and targets to the development of health prevention policies.

Transparency and corruption.

Since 2011, different measures have been implemented to address corruption and increase transparency. In terms of addressing corruption, the Ministry of Health developed a structured partnership with the judicial and police authorities, and created an anti-corruption intra-ministerial coordination group. With the aim of preventing corruption, several legal frameworks have been improved, reinforcing competition and

transparency (e.g. medical prescription, public contracting). The automation of invoice verification (e.g. medicines, ancillary exams, long term care) increased the ability to detect fraud and increased dramatically the number of criminal prosecutions. In parallel, since September 2011, financial, economic (P&L), activity, efficiency and quality data is publicised monthly for each NHS institution, contributing to the transparency of the all health system.

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Recently legislated and/or planned policy reforms

Recent policy response

Fiscal consolidation to bring government revenues and spending into line had implications for the health sector through the adoption of a wide range of reforms in this area. Reforms aimed at further improving its efficiency and controlling spending in this area. Recent policies included:

- Review and increase overall NHS moderating

mainly emergency services;

- Enacted legislation which automatically

reduces the prices of medicines when their

patent expires to 50 per cent of their previous

price;

- Annual revision of prices of medicines and of

countries of reference in order to achieve cost

savings;

- Improvement of the monitoring system of

prescription of medicines and diagnostic;

- Enacted compulsory prescriptions by INN for

physicians at all levels of the system, both

public and private, to increase the use of

generics medicines and the less costly available

products;

- Enacted legislation aimed at removing all

effective entry barriers for generic medicines,

in particular by reducing administrative/legal

hurdles in order to speed up the use and

reimbursement of generics;

- Enacted prescription guidelines with reference

to medicines and the realisation of

complementary diagnostic exams on the basis
of international prescription guidelines and
integrated them in the electronic prescription
system;

- Reinforcement of the centralised acquisition of
vehicles, utilities, external services and other
cross functional goods and services;

- Enacted measures to increase competition
among private providers and reduction of fees;

- As part of the reorganisation of health services
provision and notably the concentration and
specialisation of hospital services and the
further development of a cost-effective primary

care service, reinforcement measures aimed at
further reduce unnecessary visits to specialists

and emergencies and to improve care
coordination;

- On the basis of a comprehensive set of
indicators, publication of regular trimestral
reports comparing hospital performance
(benchmarking);

- Ensured full interoperability of IT systems in

hospital, in order to gather real time

information on hospital activities and to

produce monthly reports;

- Set-up of a system of patient electronic medical

records and ensure access to all relevant health

care facilities;

- Reorganisation and rationalisation of the

hospital network through specialisation,

concentration and downsizing of hospital

services, joint management and joint operation

of hospitals;

- Updated the legal framework applying to the

organisation of working time of healthcare

staff;

- Reduction of patient transportation costs.

Policy changes under preparation/adoption

There are several policies under

preparation/adoption:

- Strengthening the model of integrated care, in

permanent coordination between the Ministry

of Health and the Ministry of Labour,

Solidarity and Social Security, to consolidate

the co-responsibility between both sectors,

which guaranteeing access to care that meet the

health and social needs of patients' chronic

conditions and of people in situation of

dependence;

- Implementation of the figure of the family

nurse (in line with family doctor);

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- Implementation of an integrated management

program for chronic disease;

- Develop a forecast mapping for human

resources;

- Implementation of measures for territorial

distribution of services to ensure equity in

access and rationality in care provision;

- Development of services according to the

European Network of Reference Centres;

- Increased freedom of choice of providers in the

NHS to ensure competition and more access to

care provision;

- Implementation of health education, literacy

and self-care program;

Possible future policy changes

Some possible future policy changes include:

- Integrating primary care, hospital services and

continuous care;

- Increasing access at the primary care level by

enabling the possibility to contract services

with private primary care units;

- Taking measures to organise and prepare the

health sector to face an ageing population.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. the policies to control pharmaceutical expenditure or to strengthen primary care or to reduce hospital use or to improve data collection and monitoring), and which Portugal should continue to pursue and consolidate. The main challenges for the

Portuguese health care system are as follows:

- To continue to enhance primary care provision

by increasing the numbers and spatial

distribution of GPs and nurses and increasing

opening hours in health centres. This could

improve access to care while reducing

unnecessary use of hospital care and therefore

overall costs. This can be helped through

implementing the comprehensive e-agenda

planned by the authorities.

- To investigate if there is room to include an

element of activity related payment in

outpatient care (e.g. through the use of mixed

payment schemes) to induce a higher number

of outpatient consultations.

- To increase hospital output per bed while

reducing the use of unnecessary hospital care.

In addition to consolidate/ finalise the measures

pursued in recent years to reduce duplication

and improve efficiency and quality in the

hospital sector (e.g. concentration and

specialisation of hospitals within regions),

authorities could perhaps also consider including an element performance related payment in hospital budgeting procedures notably using information on output and outcomes. They could also consider increasing the supply of follow-up care for long-term care patients so as to reduce the unnecessary use of acute care settings for long-term care patients.

- To continue to improve decision-making coherence across levels of government and between the NHS central authority and its regional branches.

- To improve data collection in some crucial areas such as resources and care utilisation.

Better monitoring of activity in the sector could be used for planning and budgeting purposes.

This should include efforts to assess and publish evaluations of the quantity and quality of care provided by the various providers for example. To increase the use of health technology assessment in decision-making,

including for assessing new equipment or

pharmaceuticals and before buying new

equipment.

- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity) in various settings (at work, in school). The authorities could also consider what other complimentary measures such as higher excise taxes on tobacco, alcohol, softHealth

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drinks or tighter road safety measures could

complement existing measures including the

smoking ban recently introduced.

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Table 1.22.1: Statistical Annex – Portugal

Sources: EUROSTAT, OECD and WHO

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General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 146 152 159 166 175 179 175 180 176 168 170 9289 9800 9934

GDP per capita PPS (thousands) 19.4 19.4 20.3 20.7 21.2 20.7 19.8 20.5 20.4 20.7 20.3 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita -1.6 1.0 0.3 1.1 2.1 -0.1 -3.0 1.9 -1.1 -2.8 -0.5 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 6.4 4.3 3.3 -2.0 1.7 2.2 2.6 1.8 -6.3 -5.6 -2.8 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 9.7 10.1 10.4 10.0 10.0 10.2 10.8 10.8 10.2 9.9 9.7 10.4 10.1 10.1

Total current as % of GDP 9.2 9.5 9.8 9.4 9.4 9.7 10.2 10.2 9.7 9.3 9.1 9.8 9.6 9.7

Total capital investment as % of GDP 0.6 0.6 0.6 0.6 0.6 0.6 0.6 0.7 0.6 0.6 0.6 0.6 0.5 0.5

Total per capita PPS 1639 1765 1889 1915 2009 2091 2168 2219 2058 1917 1903 2828 2911 2995

Public as % of GDP 6.7 6.8 7.0 6.7 6.7 6.7 7.2 7.1 6.7 6.4 6.3 8.1 7.8 7.8

Public current as % of GDP 6.4 6.6 6.8 6.4 6.3 6.4 6.9 6.8 6.3 6.1 6.1 7.9 7.7 7.7

Public per capita PPS 1060 1138 1214 1177 1228 1255 1332 1351 1338 : : 2079 2218 2208

Public capital investment as % of GDP 0.3 0.2 0.2 0.4 0.3 0.3 0.3 0.3 0.3 0.2 0.2 0.2 0.2 0.1

Public as % total expenditure on health 68.8 68.1 68.0 67.0 66.7 65.3 66.5 65.9 65.0 64.0 64.7 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 15.0 15.2 15.5 14.8 14.9 14.7 14.5 13.0 13.2 12.9 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 24.8 24.8 25.2 26.8 27.2 28.5 27.3 27.4 28.9 27.4 26.6 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 10.5 10.5 10.5 10.5 10.5 10.6 10.6 10.6 10.6 10.5 10.5 502.1 504.5 506.6

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Life expectancy at birth for females 80.8 81.8 81.5 82.5 82.5 82.7 82.8 83.2 83.8 83.6 84.0 82.6 83.1 83.3

Life expectancy at birth for males 74.2 75.0 74.9 75.5 75.9 76.2 76.5 76.8 77.3 77.3 77.6 76.6 77.3 77.8

Healthy life years at birth females 61.8 52.4 57.1 57.9 57.9 57.6 56.4 56.7 58.6 62.6 62.2 : 62.1 61.5

Healthy life years at birth males 59.8 55.4 58.6 60.0 58.5 59.2 58.3 59.3 60.7 64.5 63.9 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 133 117 111 97 98 94 90 85 171 171 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.1 3.8 3.5 3.3 3.4 3.3 3.6 2.5 3.1 3.4 2.9 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.18 2.17 2.19 2.00 1.98 1.94 2.01 1.98 1.91 1.71 1.68 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.31 0.33 0.39 0.36 0.40 0.48 0.59 0.58 0.58 0.69 0.71 0.18 0.18 0.19

Out-patient curative and rehabilitative care 3.01 3.18 3.28 3.22 3.20 3.40 3.78 3.94 3.84 3.66 3.63 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 2.02 2.12 2.15 2.13 2.10 2.08 2.09 1.99 1.83 1.56 1.43 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.34 0.33 0.33 0.33 0.33 0.35 0.36 0.37 0.36 0.38 0.39 0.31
0.31 0.32

Prevention and public health services 0.19 0.19 0.20 0.17 0.17 0.18 0.21 0.22 0.20 : 0.16 0.25 0.25 0.24

Health administration and health insurance 0.12 0.13 0.13 0.14 0.14 0.15 0.16 0.17 0.17 0.20 0.20 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : : : : : : 1.46 1.45 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : : : 0.66 0.67 0.16 0.16 0.18

Out-patient curative and rehabilitative care : : : : : : : 2.24 2.28 1.74 1.71 1.80

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Pharmaceuticals and other medical non-durables 1.16 1.22 1.22 1.18 1.17 1.17 1.24 1.25 1.01 0.83 0.78 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.10 0.10 0.10 0.10 0.10 0.10 0.12 0.11 0.12 0.11 0.11 0.13 0.12 0.13

Prevention and public health services 0.13 0.13 0.14 0.11 0.11 0.12 0.15 0.15 0.14 0.07 0.06 0.25 0.20 0.19

Health administration and health insurance 0.08 0.09 0.08 0.09 0.09 0.08 0.10 0.10 0.11 : 0.11 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.22.2: Statistical Annex - continued – Portugal

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 23.8% 22.9% 22.4% 21.3% 21.2% 20.1% 19.6% 19.5% 19.8% 18.3% 18.4% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 3.3% 3.5% 4.0% 3.8% 4.2% 4.9% 5.8% 5.7% 6.0% 7.4% 7.7% 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 32.9% 33.5% 33.5% 34.3% 34.2% 35.2% 36.9% 38.8% 39.8% 39.2% 39.7% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 22.0% 22.3% 22.0% 22.7% 22.5% 21.6% 20.4% 19.6% 18.9% 16.7% 15.6% 16.3% 16.2% 14.9%

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Therapeutic appliances and other medical durables 3.7% 3.4% 3.3% 3.5% 3.5% 3.6% 3.6% 3.6% 3.8% 4.0% 4.2%
3.2% 3.3% 3.3%

Prevention and public health services 2.1% 2.0% 2.0% 1.8% 1.8% 1.9% 2.1% 2.2% 2.1% : 1.7% 2.6% 2.6% 2.5%

Health administration and health insurance 1.3% 1.4% 1.3% 1.5% 1.5% 1.6% 1.6% 1.7% 1.8% 2.1% 2.1% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : : : : : 23.8% 23.8% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : : : : 10.7% 11.1% 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care : : : : : 36.4% 37.5% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 18.1% 18.5% 17.8% 18.5% 18.5% 18.3% 17.9% 18.3% 16.0%
13.5% 12.8% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 1.5% 1.6% 1.5% 1.6% 1.6% 1.6% 1.7% 1.6% 1.8% 1.7% 1.8%
1.6% 1.6% 1.6%

Prevention and public health services 2.0% 2.0% 2.0% 1.7% 1.7% 1.9% 2.2% 2.2% 2.2% 1.1% 1.0% 3.2% 2.7%
2.5%

Health administration and health insurance 1.3% 1.3% 1.2% 1.4% 1.4% 1.3% 1.5% 1.5% 1.7% : 1.8% 1.4% 3.5%
3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants : : : 0.58 0.89 0.92 : : : : 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : 0.5 : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants : : 2.6 2.6 2.6 2.7 : : : : 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : 0.1 : : : : 0.1 0.1 0.1

Proportion of the population that is obese : : : 15.4 : : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : : : 18.6 : : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 12.7 12.2 12.1 11.7 11.3 11.2 10.9 10.8 10.3 : : 10.3 10.0 9.8

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Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 267 273 273 279 279 285 291 295 304 321 337 329 335 344

Practising nurses per 100 000 inhabitants 419 435 456 481 509 534 560 587 634 580 610 840 812 837

General practitioners per 100 000 inhabitants 45 46 46 47 47 48 49 50 51 54 57 : 78 78.3

Acute hospital beds per 100 000 inhabitants 293 292 289 283 279 277 276 278 280 288 284 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 3.7 3.8 3.9 3.9 4.1 4.5 4.0 4.1 4.2 4.1 : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : : 9.1 9.5 14.4 16.8 17.5 15.1 : : 7.9 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : : 954 1,343 6,426 8,671 9,497 8,615 : : 7,533 6368 6530 7031

Acute care bed occupancy rates 74.0 73.0 74.0 75.0 75.0 75.3 75.7 76.0 75.0 76.9 74.9 72.0 73.1 70.2

Hospital curative average length of stay 7.1 7.1 7.0 7.1 6.9 6.8 7.0 7.1 7.0 7.5 7.2 6.5 6.3 6.3

Day cases as % of all hospital discharges : : 9.5 : : : 35.2 36.4 : : 48.7 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 6.0 6.4 7.1 7.8 8.3 8.5

AWG risk scenario 6.0 6.6 7.6 8.6 9.2 9.6

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 10.5 10.1 9.8 9.4 8.8 8.2

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-21.6 3.1

2.5 0.9

3.5 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, GDP per capita (12,700 PPS) in Romania

was one of the lowest in the EU. Romania's

economy has grown significantly since accession

to the European Union, but the country is still

facing important development challenges. In light

of a continuously difficult economic and fiscal

situation, Romania was under three precautionary

Balance-of-Payments assistance programmes

provided by the European Union and the

International Monetary Fund. Health care reforms

were part of the conditionality agreed under the

programmes. Current population is estimated at

20.0 million. Romania's population is characterised

by a declining growth with an ageing population

and a rising share of older age cohorts. The

population is projected to decrease to 17.4 million

until 2060.

Total and public expenditure on health as % of

GDP

Romania has historically committed a relatively

low share of its GDP to health care. Total

expenditure on health was at 5.3% of GDP in

2013, i.e. nearly half the EU expenditure level

(EU: 10.1% in 2013). Public spending on health

was at 4.3% of GDP (EU: 7.8%). Spending

relative to GDP has been relatively constant since

2003. In 2013, only 8.4% of total government

expenditure was channelled towards health

spending (241) (EU: 14.9%). In per capita terms,

total (767 PPS) and public spending (607 PPS) are

well below the respective EU averages (2,988 PPS

and 2,208 PPS). However, per capita expenditure

has tripled in the past ten years.

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to

increase by 1.0 pp of GDP (AWG reference

scenario), above the average increase of 0.9 pp for

the EU. When taking into account the impact of

non-demographic drivers on future spending

(241) This is according to the Classification of the functions of

government (Cofog) data. According to national data, the

figure is 11.6% in 2013.

growth (AWG risk scenario), health care

expenditure is expected to increase by 1.7 pp of

GDP from now until 2060 compared to the EU

average of 1.6 pps Overall, projected health care

expenditure poses a risk to the medium and longterm

sustainability of public finances. (242)

Sustainability risks appear for Romania over the

long run. These risks derive primarily from the

unfavourable initial budgetary position,

compounded by age-related public spending,

notably for healthcare and long-term care. (243)

Health status

Health outcomes in Romania are lagging behind

EU standards. Life expectancy at birth is 71.6

years for men and 78.7 years for women, far below the EU averages (EU: 77.6 for men and 83.1 for women). Also healthy life years are below the EU averages for women (57.9 vs. 61.8 years), and for men (58.6 vs. 61.6 years). Amenable mortality rates, i.e. deaths that should not occur with timely and effective care, are well above EU average (353 deaths in Romania versus 128 deaths in the EU per 100 000 inhabitants). Infant mortality is at a high level of 9.2‰; in 2013 (EU: 3.9‰; in 2013).

System characteristics

Administrative organisation, system financing, revenue collection mechanism,

Law 95/2006 on Health Care Reform is the basic health care law in Romania, defining the role of social health insurance, private health insurance, hospitals organisation, community care, primary health care, pharmaceuticals, emergency services, public health, and national health programmes.

The system is organised on two main levels: national/central and district. The national level is responsible for defining general objectives and

ensuring the fundamental principles of government

health policy; the main central institutions in

charge are the Ministry of Public Health (MPH)

and the National Health Insurance House (NHIH).

The ministry defines the health policies, while

NHIF autonomously administrates the social

health insurance system. The NHIF is the main

(242) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(243) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

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financial source of the system receiving

contributions collected by National Agency for

Fiscal Administration (NAFA). Through an annual

framework contract, the health **care** services are

contracted between the NHIH and providers as

well as the MPH.

Financing is based on income related health insurance contributions. The rate is 10.7% of payroll, of which the employer pays 5.2% and the employee 5.5%. The self-employed categories pay 5.5% of their earnings. Theoretical coverage is 100% of the population. Many groups including children, dependants, disabled, unemployed, military personnel and war veterans, and those on sickness or maternity leave have free access to health insurance. Due to these exceptions there are around 5 million contributors and 20 million beneficiaries. Overall, the revenue base is very narrow.

A total of 42 District Health Insurance Funds (DHIFs) purchase and reimburse care for their respective population by establishing contracts with care providers, while the NHIH, which regulates and administers the mandatory health insurance, establishes contracts with the College of Physicians, defining remuneration systems. The State budget (through taxation revenues) covers public health services funding (health promotion

and disease prevention activities) and capital

investment. The basic benefits package is defined

yearly in agreement between the NHIF and the

Ministry of Health, and approved by the

Government.

Since 2009, with the support of the European

Commission (EC), the World Bank, and the

International Monetary Fund (IMF), the

Government of Romania has been working on a

structural reform of its health care system. The

reform program seeks to put emphasis on primary

and secondary prevention, reduce unnecessary

inpatient admission services, and develop

sustainable access to higher-quality secondary

ambulatory services. Recently, a new basic

benefits package was approved for this purpose. A

hospital rationalisation plan was developed and

some small hospitals were closed. A simple Health

Technology Assessment (HTA) tool has been

implemented for evidence-based access to

essential technologies, and some medicines

without proof of health benefits were excluded

from the list of compensated drugs, resulting in budgetary savings. The basic package should be fully functional in three to five years, and during this period it is necessary to perform continuous monitoring, timely evaluation, and economic/budget impact analysis in order to adjust the package to the population health needs, in accordance to health system performance targets.

The pace of health sector reform implementation has been slow due to the lack of resources to finance some critical steps necessary to support the new policies, as well as lack of administrative capacity. It is a challenge to consolidate the current hospital structure if an alternative modern ambulatory service is not fully functional before closing down and eliminating unnecessary beds.

Merging fragmented services from multi-building hospitals cannot be easily completed without the rehabilitation of an appropriate building to host the new comprehensive and articulated hospital.

Coverage and role of private insurance and out of pocket co-payments

Social health insurance is compulsory for all citizens and for foreigners residing in the country.

The share of private total health expenditure (20% in 2013) is below the EU average of 23%, as a result of a large reduction in out-of-pocket expenditure (19.4% of total health expenditure in 2011 vs. 34% in 2001) and the efforts by national authorities to improve access to care for certain groups of the population. However, there remains about 5% of the population that is not correctly insured and cannot access services because they do not pay contributions, lack the appropriate official papers and residency requirements or have not registered with a family doctor/GP. There are plans to give the uninsured access to certain preventive health programmes on top of emergency care.

Access to healthcare remains a major concern.

Despite a mandatory health insurance system, only 86 % of the population was insured in 2014.

Compared with a EU average of 3.7 %, 10.4 % of the Romanians report having had unmet healthcare needs due to cost, distance or waiting times.

Widespread informal payments add to the costs

and are among the main reasons for poor access to

healthcare, especially for patients with low

income. Access to healthcare is further hindered by

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the unavailability of health professionals. The

number of physicians and nurses per inhabitant is

very low compared with the EU average, mainly

due to the emigration of qualified physicians to

other EU countries, poor working conditions and

low salaries. Despite this situation, there is no

formal strategy on healthcare human resources in

place.

Current cost-sharing rules do not necessarily

encourage a greater use of primary care services

vis-à-vis specialist and inpatient care, or a greater

use of more cost-effective services, although they

encourage the use of generics. In April 2013, copayments

for certain medical services were

introduced. Contributions are between RON 5 and

10 per patient. Emergency care, family doctors and medical laboratories do not charge the co-payment.

Children up to 18 years, youth aged 18-26 without income, pregnant women, war veterans, persons with chronic diseases, and pensioners receiving a pension benefits inferior to RON 740 per month are exempted from these co-payments.

There are reports of significant informal (nonofficial) payments. While they may increase the income of physicians, informal payments do not bring additional revenues to the insurance funds, do not encourage a more effective use of services and constitute an additional barrier to access as there are no exemptions for low income or high risk groups. Some studies estimate that they increase out-of-pocket expenditure to more than 30%. Hence, it would be worth investigating if the current cost-sharing could be adjusted to encourage greater use of more effective and costeffective services: e.g. more use of primary care than specialist care, more health promotion and

disease prevention activities (e.g. vaccination),

more cost-effective pharmaceuticals, while

tackling informal payments.

Private insurance companies can offer

supplementary and/or complementary health

insurance. Packages cover the services not

included in the basic benefit package, higher comfort

hospital accommodation and co-payments

charged by providers for the services included in

the basic benefit package. Eligibility for private

co-insurance is conditioned on paying the

mandatory contribution for the basic package of

services.

Types of providers, referral systems and patient

choice

Public and private provision coexist. Primary care

is provided by independent general practitioners

and nurses operating in private practices.

Ambulatory specialist care is provided in

specialised centres and hospital outpatient

departments. Inpatient hospital care is provided in

hospitals, mostly publicly owned, and is

increasingly under the responsibility of local authorities. All these providers establish contracts with the NHIF.

The total number of practising physicians per 100 000 inhabitants (264 in 2013) is well below the EU average (344 in 2013), but has been rising continuously throughout the last decade. This may explain the difficulties in availability and distribution of physicians across the country. Data on the physician skill-mix indicates that the number of GPs per 100 000 inhabitants (64 in 2013) is below the EU average (EU: 78).

Moreover, GPs seem to have a limited medical role in health care delivery. The number of nurses (601 in 2013) per 100 000 inhabitants is below the EU average of 837. Romania has suffered heavily from staff migration to other EU countries, where qualified health staff is needed and wage levels are higher.

National authorities have made limited efforts to enhance primary care financing and provision and strengthen the referral system from primary care to

specialist doctors as well as the gatekeeping role of

GPs (to reduce the unnecessary use of specialist

and hospital care). All inhabitants have to register

with a GP, who acts like a family doctor and as a

gatekeeper referring patients to specialist and

hospital care. However, despite it being

mandatory, many have not yet registered with a

GP and the referral system is often bypassed by

some groups of the population. In addition, urgent

/after-hours access to primary care services is very

limited resulting in an unnecessary use of hospital

emergency wards. Patients can choose their GP

and choose the specialist and hospital after referral.

This referral and coordination role is to be further

enhanced through the use of ICT systems and the

implementation of electronic patient records, as

started in 2015, and electronic monitoring of

prescriptions, which can help control expenditure.

In 2014, the budget for primary care physicians

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was increased to roughly 8% of expenditure by the

NHIH. However, compared to the EU, the budget

for primary care lags significantly behind.

Romania has seen only a modest reduction in the

number of acute care beds per 100 000 inhabitants

in the last decade (456 in 2003 vs. 450 in 2013)

and its number is still higher than the EU average

(EU: 356). Many hospital beds in Romania are

however not necessarily used for acute care but for

other purposes such as long-term hospitalisation of

patients with chronic diseases. Further reductions

in hospital capacity is an area where further

improvements can still be made, but the total

number of beds and its use will, in the medium and

long-run strongly depend on the changes in the

provision of long-term care services implemented

in Romania (which can reduce bed blocking in

acute care settings) as well as changes in surgical

practices.

Public expenditure on inpatient care as a share of

GDP is below the EU average (1.9% vs. 2.6% in

the EU). However, inpatient care accounts for roughly 46% of public expenditure on health in Romania, compared to 34% in the EU. The number of hospital inpatient discharges was at a very high level, with 22 discharges per 100 inhabitants, in 2013 (EU: 16.5 in 2013).

Total and public expenditure on outpatient care as a share of GDP were below the EU average (0.6% and 0.4% vs. 2.2% and 1.8% in the EU). Total and public expenditure on outpatient care as a share of current health expenditure were also below the EU average (11% and 8% vs. 23% and 23% in the EU). Low expenditure may be a sign of a health system which is oriented away from ambulatory and towards hospital care, providing potential to increase the relatively cost-effective of care, by shifting away from hospital centric health care provision.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Payments systems have evolved over the years

involving a mixture of remuneration schemes. GPs receive a mix of capitation and fees for defined activities (health promotion, disease prevention and disease management activities). This mixed system intends to render primary care more attractive and provide incentives for primary care provision, including some health promotion, disease prevention activities and disease management. Ambulatory specialists are remunerated on a fee-for-service basis while hospital staff is paid on a salary basis. Acute care hospitals remuneration is based on prospective activity-based payment using DRGs and fee-forservices or flat rate per case. Although significantly improved and based on complex criteria, the basis for establishing contracts between the NHIH and the various providers could be further improved to favour cost-effective interventions in the long-run.

The introduction of a new benefits package would require a revision in health provider payment mechanisms. The hospital payment system is

based on production of services (a Diagnosis Related Group [DRG] system, which was piloted in 2003 and implemented in 2005), but the system needs to be transformed to better estimate the costs and eliminate perverse incentives. For example, some mild cases that could be treated in ambulatory services are being admitted because the DRG system overestimates the cost of treating those cases. On the other hand, some more complex cases are being referred because the DRG value is below the real cost. In parallel, in primary care, NHIF allocates (6%) of the total insurance found introducing a cap in the annual contract that eliminate the incentives to increase the PHC services.

The market for pharmaceutical products

Total spending on outpatient pharmaceuticals has reached a respectable level 1.8% of GDP in 2013, rising by from 1.1% of GDP in 2003. Overall, spending in the pharmaceutical sector grew faster than spending in the health sector. As a consequence, the share of pharmaceutical within

total health expenditure has reached a high 35%

(from 20% in 2003). This is one of the highest

shares in the EU. Much of the growth in

expenditure has been borne by the private sector

financing of outpatient pharmaceuticals.

In order to control the spending bill for the public

payer, pharmaceutical spending is limited by a

defined threshold, and overspending is recuperated

from the manufacturers (payback, claw-back

system). The system has been criticised, because

of the high overspending that has to be financed by

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manufacturers, but has proved to provide an

effective budget ceiling. The pharmaceutical

budget is still structurally overspent increasing

future fiscal risks. While overspending is

recovered via the claw-back tax and is thus budget

neutral, it has led to withdrawals of cheap generic

medicines from the market. The planned revisions

of the claw-back tax and of the public

reimbursement for distributors of pharmaceutical

products to incentivise the provision of low cost

medicines to patients are yet to be implemented.

Recommendations regarding the listing of

medicines on the national formulary are the

responsibility of the National Transparency

Committee (NTC). However the NTC Processes

appear to be opaque and ad hoc. Recently, an

interim HTA process was elaborated for the

approval of new drugs, and since 2015, the

Ministry of Health applies a rapid systematic HTA

process to delist and enlist molecules from the list

of reimbursable medicines.

With respect to pricing, there is extensive reliance

on the use of external reference pricing for

medicines manufactured outside Romania (with

cost-plus pricing for those manufactured

domestically). External reference pricing is based

on the lowest price from within a basket of 12 EU

countries according to an algorithm published by

the Ministry of Public Health. However, prices

have not been updated in the past years.

Prescription medicines are subsidised in

accordance with four reimbursement lists:

- List A: includes most commonly used

medicines (largely generics), reimbursed at

90% (10% co-insurance)

- List B: includes mostly originator medicines;

reimbursed at 50% (50% co-insurance)

- List C: comprises medicines for chronic

diseases included in the National Health

Programs and/or for specific population groups

(pregnant women, children, teenagers, etc.).

List C medicines are fully reimbursed for

eligible beneficiaries.

- List D: medicines without proven

effectiveness, reimbursed at 20%.

Use of Health Technology Assessments and

cost-benefit analysis

An interim Health Technology Assessment (HTA)

tool to implement evidence-based access to

essential technologies has been implemented, and

reimbursement rates of some medicines without

proof of health benefits were reduced to 20% from

the list of compensated drugs, resulting in

significant savings. Based on the tool, the list of

subsidised medicines based on was undertaken in 2015.

Corruption

Corruption is present in many economic sectors and involves appointed and elected officials at all levels of government as well as civil servants and employees of public institutions. This is borne out by the record of criminal investigations and convictions for corruption (244). Preventing corruption in public administration was one of the key priorities of the 2012-2015 national anticorruption strategy. The evaluation of the strategy shows some progress in putting in place corruption prevention measures at the level of national administration. It concludes, however, that local administration structures are severely lagging behind in terms of building up the necessary capacity to prevent corruption effectively. The government plans an extension of the strategy that will include additional measures to remedy the weaknesses identified in the evaluation.

Corruption remains a challenge in the health

sector, despite some recent action to combat the problem. Oversight of public procurement contracts in the health sector is insufficient (see section 3.1). The centralised procurement unit in the Ministry of Health is heavily understaffed and its mandate covers only 25 % of hospitals. The lack of transparency in medical reimbursements constitutes a severe challenge in putting in place measures to prevent fraud and corruption over reimbursement claims. This has a direct impact on the health budget. Although services provided in private health units are partially covered by public funds under the single national health insurance scheme, they are not included in the monitoring exercise for the use of public funds. While healthcare was one of the key sectors addressed by (244) COM (2016) 41 final; SWD (2016) 16 final.

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the 2012-2015 national anti-corruption strategy, the sectorial strategy did not produce tangible results. The challenge facing the renewed sectorial

strategy is to integrate the findings of existing policy assessments into a comprehensive approach that extends to all relevant players and processes.

Recently legislated and/or planned policy reforms

Romania has embarked on a set of reforms in recent years. A National Health Strategy 2014-2020 was approved by the end of 2014. The strategy covers the following areas: public health and health care (with a focus on improving the health of women and children, reduce morbidity and mortality of non-communicable diseases ensuring equitable access – especially for vulnerable groups – to healthcare quality and efficient in terms of cost), health research, eHealth technologies and health infrastructure (the national, regional and local).

Several pilot projects were implemented, such as to improve access to health care for vulnerable persons, programs for prevention and curative health of women and children, to increase the access of persons belonging to remote and isolated

communities to health care.

In addition, in 2014 a new package of basic health services was approved, introducing chronic disease management provided by family doctors. At the primary health care level, preventive consultations were introduced for people over the age of 18 to check for certain major diseases and conditions. Also day hospitalisations were regulated and their financing improved to reduce excessive use and duration of hospitalisations. The basic package aimed to decrease admissions to hospitals, increase the number of cases resolved in day- care facilities and to establish the conditions for the development of primary health care and ambulatory services.

Under the package, certain diagnoses (104 medical conditions), surgical procedures (96) and medical services (36) will be dealt with in day-care facilities. Admission to hospital is allowed, however, in cases of medical need.

In order to generate savings, a centralised procurement system was developed and the

capacity of centralised procurement unit enhanced,
focusing on the procurement of medicines,
vaccines and of other medical supplies. In 2014,
there were 15 centralised procurements for drugs,
vaccines and other medical supplies, with savings
of more than RON 47 million.

In order to modernise the IT infrastructure,
following the introduction of electronic
prescriptions in 2012 a system of eHealth cards
was implemented in 2015. Cards serve as a
mandatory tool for reimbursement for most
medical services delivered by registered providers.

NHIH distributed more than 15 million health
insurance cards, and health insurance card usage
commenced in February 2014 and became
mandatory on 1 May 2015. In 2014, NHIH also
implemented the electronic patient file system,
replacing the prior hard-copy patient file system.

The electronic file system is currently functional
and accessible.

In order to reduce the excessive use of
hospitalisation, the funds allocated for outpatient

care and primary health care were increased to

encourage treating patients in ambulatory

specialist and the family physician. Additional

funds have been allocated for primary care from

RON 1424.9 mln in 2014 (6.7%) to RON 1513.7

mln in 2015 (6.97% from total health expenditure

of NHIH). In the period 2016-2018 the aim is that

of an annual increase of 5% (compared to the

allocation for 2015) of funds for primary health

care. In 2016 the budget for primary care is in the

amount of 1515.5 million (including permanent

centres), approximately at the level of 2015, and it

represents 6.97% of total health care expenditure

of NHIH, excluding amounts for cost-volume

contracts and cost for salary increases related to

personnel paid from public funds provided by

GEO 35/2015.

To reduce informal payments, the project Good

Governance in the health system aims to develop a

coherent policy to prevent and combat corruption

in health.

To increase the quality of care and reduce

vulnerabilities, the order regarding ethics council
in public hospitals, regulating the organisation of a
system for monitoring and control of notifications
and complaints regarding patients' rights and their
abuse to healthcare professionals, was approved.

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In line with strategic directions of the health
strategy, an analysis on the resources needed to
modernise the healthcare infrastructure was
developed and set out in the World Bank project
which was negotiated with representatives of the
World Bank. A loan was also approved by the
World Bank Board in March 2014 in this regard,
and the project has become effective in 2015. The
main objectives of the project on health sector
reform - improving the quality and efficiency of
the health system are:

- rationalising the hospital network by providing
goods, services other than consulting, advisory
services and training in emergency regional
hospitals, district hospitals and regional

hospitals selected;

- strengthening secondary care outpatient

specialist by providing goods, works, services

other than consulting, consultancy and training;

- improving the capacity of the Ministry of

Health and other relevant government

institutions for governance and management

sector, to reduce the gap between policy and

practice and to reinforce the capacity and

improve quality of care by providing goods,

works, services other than advisory,

consultancy and training; and

- supporting the Ministry of Health and the

Project Management Unit (PMU) in the

management and implementation of the

project, including fiduciary duties, monitoring,

evaluation and reporting by providing goods,

works, services other than consulting,

consulting services, training, audit and

operational costs.

Challenges

The analysis above shows that a number of

reforms have been implemented over the years

aiming to improve the efficiency of care delivery

and which Romania should continue to pursue.

Reforms have met with a number of obstacles and

there is still room for improvement in core areas of

care. The main challenges for the Romanian health

system are as follows:

- To continue increasing the efficiency of health

care spending in order to adequately respond to

the increasing health care expenditure over the

coming decades, which is a risk to the longterm

sustainability of public finances.

- To improve the basis for more sustainable and

larger financing of health care in the future to

improve access as well as quality of care and

its distribution between population groups and

regional areas.

- To increase equity in financing of care and

tackle informal payments.

- To define a comprehensive human resources

strategy to ensure a balanced skill-mix, avoid

staff shortages and motivate and retain staff to the sector.

- To continue to enhance and better distribute primary health care services and basic specialist services to improve equity of access and the effectiveness and efficiency of health care delivery; to ensure an effective referral systems from primary to specialist and hospital care and improving care coordination between types of care, notably by ensuring that users register with their GP and through the development of electronic patient records in the future.

- To continue the efforts to decrease over and unnecessary use of hospital inpatients care by decreasing the number of hospital beds, through hospital restructuring and rationalisation: to increase day case surgery, to improve the provision of after-hours primary care services, and to reduce the number of uninsured who tend to use emergency services

rather than primary care services (which are not covered to large extent).

- To make more use of cost-effectiveness information, as planned, in determining the basket of goods and the extent of cost-sharing and define the latter to induce cost-effective behaviour. To explore if current cost-sharing could be adjusted to encourage greater use of more effective and cost-effective services: e.g. more use of primary care than specialist care, more health promotion and disease prevention

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activities (e.g. vaccination), more cost-effective pharmaceuticals.

- To reduce the causes of structural overspending of the pharmaceutical budget, increasing the cost-effectiveness of prescribed and used medicines, which could make more room for financing of new cost-effective innovations.
- To tackle corruption in the health system.

- To continue to improve accountability and governance of the system and identify possible cost-savings in the health sector administration, as it currently involves many national and district institutions. To ensure that resource allocation between regions is not detrimental to

poorer regions.

- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and use to continuously improve access, quality and sustainability of care.

- To clearly establish public health priorities and enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (smoking, alcohol) and the pattern of both infectious and noninfectious diseases.

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Table 1.23.1: Statistical Annex – Romania

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 53 61 80 98 125 142 120 127 133 134 144 9289 9800 9934

GDP per capita PPS (thousands) 13.5 13.4 12.8 13.4 13.7 13.8 12.5 12.6 12.7 13.0 12.7 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 5.7 9.1 4.8 8.5 7.9 9.2 -5.8 -0.6 2.8 1.0 3.9 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita -1.2 11.8 5.6 0.4 11.1 13.4 -2.0 4.5 -3.2 0.3 -0.2 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 5.3 5.5 5.5 5.1 5.2 5.4 5.7 6.0 5.6 5.6 5.3 10.4 10.1 10.1

Total current as % of GDP 5.2 5.4 5.5 5.0 5.1 5.3 5.6 5.8 5.5 5.5 5.2 9.8 9.6 9.7

Total capital investment as % of GDP 0.1 0.0 0.0 0.0 0.1 0.2 0.1 0.1 0.1 0.1 0.2 0.6 0.5 0.5

Total per capita PPS 236 303 358 398 497 663 678 751 751 790 815 2828 2911 2995

Public as % of GDP 4.5 4.1 4.4 4.1 4.3 4.5 4.5 4.8 4.4 4.5 4.3 8.1 7.8 7.8

Public current as % of GDP 4.4 4.0 4.4 4.0 4.2 4.3 4.4 4.7 4.3 4.4 4.1 7.9 7.7 7.7

Public per capita PPS 194 222 286 312 397 513 518 575 596 634 650 2079 2218 2208

Public capital investment as % of GDP 0.1 0.0 0.0 0.0 0.1 0.2 0.1 0.1 0.1 0.1 0.2 0.2 0.2 0.1

Public as % total expenditure on health 84.8 74.5 80.4 79.8 82.1 82.0 79.0 80.3 79.3 80.2 79.7 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 10.4 7.4 8.0 7.6 9.7 9.7 10.2 10.2 10.4 10.4 11.4 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance : : : : : : 100.0 100.0 : 99.7 99.7 98.7

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Out-of-pocket expenditure on health as % of total expenditure on health 15.1 24.3 18.5 20.0 17.6 18.2 20.8 19.6 20.7 19.5 19.7 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 21.5 21.5 21.4 21.3 21.1 20.6 20.4 20.3 20.2 20.1 20.0 502.1 504.5 506.6

Life expectancy at birth for females 75.1 75.1 75.4 76.1 76.8 77.5 77.7 77.7 78.2 78.1 78.7 82.6 83.1 83.3

Life expectancy at birth for males 67.9 67.8 68.4 69.0 69.5 69.7 69.8 70.0 70.8 70.9 71.6 76.6 77.3 77.8

Healthy life years at birth females : : : 62.5 62.9 61.7 57.5 57.0 57.7 57.9 : 62.1 61.5

Healthy life years at birth males : : : 60.5 60.0 59.8 57.3 57.4 57.6 58.6 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 233 223 225 216 198 185 182 179 357 353 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 16.7 16.8 15.0 13.9 12.0 11.0 10.1 9.8 9.4 9.0 9.2 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.28 1.97 2.02 1.87 1.84 1.93 2.09 2.35 1.89 1.98 1.92 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.00 0.09 0.00 0.00 0.00 0.00 0.00 0.00 0.00 : 0.13 0.18 0.18 0.19

Out-patient curative and rehabilitative care 0.51 0.52 0.50 0.42 0.47 0.58 0.52 0.53 0.51 0.55 0.55 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.07 1.46 1.55 1.41 1.36 1.36 1.39 1.44 1.68 1.61 1.81 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.03 0.04 0.03 0.03 0.04 0.04 0.04 0.03 0.02 0.02 0.02 0.31 0.31 0.32

Prevention and public health services 0.33 0.36 0.37 0.27 0.34 0.31 0.46 0.36 0.38 0.37 : 0.25 0.25 0.24

Health administration and health insurance 0.31 0.26 0.22 0.32 0.29 0.09 0.08 0.11 0.11 0.09 : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

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Inpatient curative and rehabilitative care 2.23 1.87 1.98 1.82 1.80 1.89 2.04 2.31 1.87 1.95 1.89 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.00 0.09 0.00 0.00 0.00 0.00 0.00 0.00 0.00 : 0.13 0.16 0.16 0.18

Out-patient curative and rehabilitative care 0.41 0.34 0.36 0.31 0.36 0.44 0.37 0.34 0.32 0.35 : 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.45 0.46 0.74 0.58 0.63 0.61 0.47 0.58 0.79 0.79 1.01 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.01 0.01 0.02 0.02 0.02 0.01 0.01 0.01 0.01 0.01 0.01 0.13 0.12 0.13

Prevention and public health services 0.33 0.31 0.34 0.26 0.33 0.31 0.45 0.36 0.38 0.37 : 0.25 0.20 0.19

Health administration and health insurance 0.28 0.24 0.19 0.32 0.33 0.14 0.10 0.11 0.11 0.09 : 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.23.2: Statistical Annex - continued – Romania

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 43.7% 36.3% 36.8% 37.1% 35.8% 36.6% 37.4% 40.4% 34.3% 36.3% 37.3% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 0.0% 1.7% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% : 2.5% 1.8% 1.9% 1.9%

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Out-patient curative and rehabilitative care 9.8% 9.6% 9.1% 8.3% 9.1% 11.0% 9.3% 9.1% 9.3% 10.1% 10.7%
23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 20.5% 26.9% 28.2% 28.0% 26.5% 25.8% 24.9% 24.7% 30.5%
29.5% 35.1% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 0.6% 0.7% 0.5% 0.6% 0.8% 0.8% 0.7% 0.5% 0.4% 0.4% 0.4%
3.2% 3.3% 3.3%

Prevention and public health services 6.3% 6.6% 6.7% 5.4% 6.6% 5.9% 8.2% 6.2% 6.9% 6.8% : 2.6% 2.6% 2.5%

Health administration and health insurance 5.9% 4.8% 4.0% 6.3% 5.6% 1.7% 1.4% 1.9% 2.0% 1.6% : 4.2% 4.3%
4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 50.6% 46.4% 44.9% 45.4% 42.9% 44.1% 46.4% 49.7% 43.1% 44.7%
46.3% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 0.0% 2.2% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% : 3.2% 2.0% 2.1%
2.3%

Out-patient curative and rehabilitative care 9.3% 8.4% 8.2% 7.7% 8.6% 10.3% 8.4% 7.3% 7.4% 8.0% : 22.0%
22.3% 23.4%

Pharmaceuticals and other medical non-durables 10.2% 11.4% 16.8% 14.5% 15.0% 14.2% 10.7% 12.5% 18.2%
18.1% 24.8% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 0.2% 0.2% 0.5% 0.5% 0.5% 0.2% 0.2% 0.2% 0.2% 0.2% 0.2%
1.6% 1.6% 1.6%

Prevention and public health services 7.5% 7.7% 7.7% 6.5% 7.9% 7.2% 10.2% 7.7% 8.8% 8.5% : 3.2% 2.7% 2.5%

Health administration and health insurance 6.3% 5.9% 4.2% 8.0% 7.8% 3.4% 2.2% 2.4% 2.4% 2.1% : 1.4% 3.5%
3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants : : : 0.11 0.13 0.19 0.24 0.31 : 0.44 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : 0.1 0.2 0.2 0.2 0.2 : 0.3 0.9 0.9 0.8

CTS per 100 000 inhabitants : : : 0.3 0.4 0.5 0.6 0.7 : 1.0 1.8 1.7 1.6

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PET scanners per 100 000 inhabitants : : : : 0.0 0.0 0.0 0.0 0.0 : 0.0 0.1 0.1 0.1

Proportion of the population that is obese : : : : 7.9 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 21.4 : : : : 20.5 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 8.8 9.8 7.7 8.5 10.6 11.9 10.4 9.0 9.1 : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 199 208 217 216 212 221 226 237 239 261 264 329 335 344

Practising nurses per 100 000 inhabitants 528 535 548 563 566 555 569 526 534 580 601 840 812 837

General practitioners per 100 000 inhabitants : 56 67 82 123 128 83 68 68 69 64 : 78 78.3

Acute hospital beds per 100 000 inhabitants 452 443 456 456 448 450 462 433 413 442 450 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 5.6 4.5 4.8 5.0 4.9 5.1 5.2 5.0 4.8 4.9 4.8 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : : : : 21.3 22.5 24.5 23.3 21.4 21.8 22.0 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : : : : : 4,333 5,205 5,569 6 ,819 8,399 6368 6530 7031

Acute care bed occupancy rates : : : : : 73.1 : : : : 72.0 73.1 70.2

Hospital curative average length of stay : : : : : 6.6 6.5 6.5 6.5 6.3 6.5 6.3 6.3

Day cases as % of all hospital discharges : : : : : 15.0 18.3 20.6 23.8 27.6 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 3.8 4.1 4.3 4.6 4.7 4.8

AWG risk scenario 3.8 4.3 4.8 5.2 5.4 5.5

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Population projections until 2060 (millions) 20.0 19.7 19.0 18.4 17.9 17.4

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-12.9 3.1

1.0 0.9

1.7 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population

GDP per capita (19,556 PPS in 2013) is lower than

the EU average (27,881 PPS). Slovakia recorded

high real GDP growth, above the EU average,

throughout the decade. As a result of the global

economic crisis, real GDP growth was -5.1% in

2009 followed by positive growth thereafter.

Slovakia's current population stands at 5.4 million

people in 2013 and has been fairly stable

throughout the decade. The projections reveal a

decrease from 5.4 million people in 2013 to 4.6

million in 2060.

Total and public expenditure on health as % of

GDP

Total expenditure on health as a percentage of

GDP (8.2% in 2013) is below the EU average

(10.1%). It has increased from 5.4% in 2003, but is

lower than that registered in 2009 and 2010. Public

expenditure on health as a percentage of GDP is

below the EU average (in 2013 it was 5.6%

compared to 7.8% in the EU). Total (1,676 PPS in

2013) and public (1,174 PPS in 2013) per capita

expenditure are lower than the EU average (2,988

PPS and 2,208 PPS).

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to

increase by 2.0 pps of GDP (AWG reference

scenario), much above the average increase of 0.9

pps for the EU. When taking into account the

impact of non-demographic drivers on future

spending growth (AWG risk scenario), health care

expenditure is expected to increase by 3.3 pps of

GDP from now till 2060 compared to the EU

average of 1.6 pps (245)

Over the long run, however, medium sustainability

risks appear for the Slovak Republic. These risks

derive primarily from the projected impact of age-related

public spending (notably healthcare and

(245) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

pensions), compounded by the unfavourable initial

budgetary position. (246)

Health status

Despite showing an improvement, the health status

of the Slovak population lags slightly behind the

EU average. While showing a consistent increase,

life expectancy (80.1 years for women and 72.9

years for men in 2013) is still below the EU

average (83.3 for women and 77.8 for men). So are

healthy life years (54.3 years for women and 54.5

years for men in 2013 vs. EU average of 61.5 and

61.4 respectively), which have been interestingly

showing a decreasing trend after 2007, only to start

picking up again over the recent years. Amenable

mortality rates show a consistent decrease over the decade but are still fairly high notably compared to other countries of similar GDP per capita (e.g. 217 per 100,000 inhabitants in Slovakia for 2012).

Infant mortality is also above the EU average (5.5‰ vs. 3.9‰ in 2013).

System characteristics

System financing, revenue collection, population coverage and role of private insurance and out-of-pocket payments

The Slovak health care system is a compulsory social health insurance scheme covering all residents. In practice, a small share of the population (about 4% in 2011) (247) does not pay the required contributions (248) and is not covered if they are not entitled to automatic membership (249). Insured persons are allowed to choose health insurance fund among three health insurance companies. The State pays the contributions of some population groups (dependent children, pensioners, persons taking care of children aged up

(246) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(247) [http://www.udzssk.](http://www.udzssk.sk/documents/14214/21128/Sprava_o+stave+vykonavan)

sk/documents/14214/21128/Sprava_o+stave+vykonavan

ia+VZP_2014_final.pdf/d1948cc6-023c-4529-be7d-

15022d29f5ea

(248) For all the economically inactive people health contributions are paid by the state. The aforementioned 4% comprises off the self-payers, self-employed persons and employers who do not pay the required insurance even though they should.

(249) Old-age pensioners, persons on early retirement or those receiving a disability pension whose degree of incapacity is 70% or more.

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to 3 years, all students up to the age of 26, fulltime

postgraduate students up to the age of 30,

PhD students and other groups) to ensure their

coverage.

Public health insurance is assured by three health insurance companies (HICs), one of which is state-owned and two of which, had the form of private joint stock companies. The market is dominated by the state-owned company, whose share amounts to 63% of the total insurers in 2012. (250)

Mandatory insurance contributions vary according to groups: 14% of the gross monthly earning for employees (employees and employers pay 7 and 7%, respectively), 7 % for disabled persons (the self-employed pay 7%, and for the employed the employer pays 5% and employee pays 2%) and self-employed. The minimum and maximum assessment bases for the groups equal the average wage divided by two and average wage multiplied by five respectively. The contributions paid by the State on behalf of some population groups (dependent children, pensioners, persons taking care of children aged up to 3 years) amounted to 4.3% of the average wage in 2016.

Moreover, a risk equalisation scheme has been introduced by the State which can redistribute

companies' revenues in order to compensate

between insurance companies for the existing

demographic and socio-economic differences of

the insured. Redistribution criteria include sex,

age, costly chronic diseases (so called Pharmacy

Cost Groups) and the number of policyholders

whose contribution is paid by the State. (251)

In 2013, 68% of total health expenditure funding

came from mandatory health contributions plus

6.7% government sources (direct and indirect taxes

collected centrally). The remaining part is private

expenditure on health including private health

insurance and out-of-pocket payments. A large

part of private expenditure is out-of-pockets

(though not necessarily cost-sharing for publicly

goods and services as explained below) which

represent 23.3% of total expenditure on health (EU

(250) [http://www.udzssk.](http://www.udzssk.sk/documents/14214/33878/TS_zmena+ZP_19.11.2015.pdf/62f67e6a-6829-40c9-9d6d-fa04589f3906)

[sk/documents/14214/33878/TS_zmena+ZP_19.11.2015.](http://www.udzssk.sk/documents/14214/33878/TS_zmena+ZP_19.11.2015.pdf/62f67e6a-6829-40c9-9d6d-fa04589f3906)

[pdf/62f67e6a-6829-40c9-9d6d-fa04589f3906](http://www.udzssk.sk/documents/14214/33878/TS_zmena+ZP_19.11.2015.pdf/62f67e6a-6829-40c9-9d6d-fa04589f3906)

(251) <http://www.zakonypreludi.sk/zz/2004-580>)

average of 14.1% in 2013). This is nevertheless

lower than in previous years.

Small lump-sum fees (co-payments) for many medical services and goods were introduced in 2003 with the aim of controlling consumption but in 2006 most of them were abolished (primary and specialist outpatient care, hospital stays) or considerably lowered (prescriptions for medicines). Following the changes in 2006, various payments were introduced by individual healthcare providers. In 2015, the government passed legislation to regulate payments by banning e.g. payments for appointments at a scheduled time. However, the media have since reported that new payments have been introduced to bypass the legislation. (252) In addition to cost-sharing for medicines, fees apply to emergency services, ambulance transportation and spa treatment. A small number of services (e.g. in dental care (253) and cosmetic surgery) are not covered. The aim of introducing fees was to limit excess demand and ensure a coherent path of care. However, there were concerns for the already high private

expenditure and they were abolished. Note that in addition to formal out-of-pockets there are persistent, considerable and unmeasured informal payments. These are not adjusted to individual socio-economic characteristics, so they can have a negative impact on access and discourage a more effective use of services. The design of costsharing is an area that may require further policy analysis.

Private health insurance mostly corresponds to supplementary private health insurances that cover non-essential services not provided under social health insurance.

The State defines annually health care expenditure targets for different health services but overshooting is possible. The State can influence the volume of funds available to the HIC.

Furthermore it can influence spending through regulation in particular areas (e.g. price-setting for medical rescue services). However, on the whole,

(252) <http://www.health.gov.sk/?poplatky-v-zdravotnictve>

(253) Standard dental case is covered, the use of non-standard

materials is not: <https://www.vszp.sk/poistenci/zdravotnastarostlivost/>

kedy-platit-za-zdravotnu-starostlivost.html or

<http://www.dovera.sk/najcastejsie-otazky/a295/co-mipreplatite->

u-zubara)

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it is up to the HIC to decide on healthcare

spending.

Administrative organisation: levels of

government, levels and types of social security

settings involved, Ministries involved, other

institutions

The Ministry of Health develops the national

health policy strategy, defines public health and

policy priorities and provides the overall

management of the health **care** system as a whole.

The Ministry of Health and the Office for the

Supervision of Health **Care** regulate and supervise

the activity of the health insurance companies.

The contracts between HIC and inpatient and

outpatient providers regulate only the mandatory list of services covered by public health insurance, whereas prices and detailed conditions are negotiable without regulation. The network of strategic public healthcare providers and general practitioners are privileged (254) as HIC are obliged to sign contracts with all the hospitals and their departments. Other providers or certain types of their services may be omitted from contracting. Reimbursement of pharmaceuticals is regulated via a specified list of medicines with fixed prices and reimbursement levels.

There are constraints on the health insurance companies' use of profits made from public insurance and payments for health care provision.

In 2007, the government banned the use of profits to pay dividends. In 2011 the Constitutional court found this was not in line with the Constitution. As of 2011, HICs may again use profits to pay dividends. However, conditions apply, that is before paying out dividends, HIC must create 1. reserves for the provision of planned healthcare (i.e. healthcare to be provided to patients on

waiting lists) and 2. a separate reserve fund at least

to the value of 20 % of common capital stock.

(254) These healthcare providers were selected by the

government as “strategic providers”. The majority is

public, however a growing proportion is privately owned.

HICs are obligated to conclude contracts with these HCPs,

no matter what the quality of their service provision is.

This makes strategic providers privileged compared to nonstrategic

HCPs. Only hospitals have been designated

strategic, not GPs.

In terms of centralisation, the state-owned HIC

procures a group of expensive pharmaceuticals

centrally for all the hospitals.

Coverage of services, types of providers,

referral systems and patient choice

A wide range of health care services and goods is

provided through a network of private and publicly

owned facilities contracted by insurance

companies: primary health care, outpatient

specialist consultations and hospital care (day-case

and inpatient), emergency and transporting

medical services, and a range of related services

including imaging diagnostic services,

laboratories, (255) physiotherapy, dialysis care,

home nursing agencies and hospices. Health

insurance companies have to contract all general

practitioners and pharmacies and a specified

minimum number of specialists and hospitals.

The provision of health care is decentralised and

based on a public-private mix. Public and private

health care providers sign contracts with the health

insurance companies in order to be eligible for

reimbursement. General practitioners (GPs) and

outpatient specialists can be independent private

providers or public providers. Most private

primary care providers have contracts with health

insurance companies. Only some private primary

care providers such as dentists are working on the

basis of direct payments from patients and without

a contract with health insurance companies. There

is some current policy discussion on encouraging

group practices rather than individual practices.

Patients have to register with a GP whom they can

choose freely. A so-called "exchange card", introduced in 2008, works as a referral tool from a GP to a specialist or hospital. The aim is to have GPs referring patients for specialist care, operating as gate-keepers. Since 1 April 2013, the GP

(255) A comparison of spending data among EU and OECD countries (based on available OECD data) shows that per capita spending on laboratories and diagnostic imaging in Slovakia is slightly higher than the average level of the OECD and the EU, 98, 90 and 86 USD respectively in 2013 (in PPPs, current prices). The average spending of Hungary, Poland and the Czech Republic is significantly lower at 41 USD. A similar difference in spending is seen with regard to transportation and medical rescue services. While Slovakia spent 86 USD per capita (in PPPs, current prices), the OECD average was at 53 USD and the EU average as well as the average of Poland, Hungary and the Czech Republic was at 46 USD.

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referral system is in operation again, after it was

abolished in 2010. However, the system does not work for all specialties (e.g. accident and emergency, chronic care, outpatient psychiatric care, dentists and gynaecologists) and it does not appear to be very effective due to shortages of GPs especially in certain areas. (256) This is something the authorities see as a policy priority.

Secondary and tertiary care are provided in a number of general and specialised hospitals, polyclinics, hospices and nursing homes. The ownership and management of most public institutions has been decentralised from central to regional level. The 2007 reform introduced healthcare districts, whereby all GPs, gynaecologists and dentists are obliged to provide care to each patient resident in their respective territorial districts, who in turn has the right to choose freely his/her physician. Moreover, a minimum network of public health care providers was established (including 37 hospitals, a part of which is now privately owned) (257), which have to

be contracted by the health care companies. While choosing the providers beyond the list of minimum public network each fund could establish its own evaluation criteria. The government adopted an official list of indicators to assess the quality of providers.

In case of out-patient medical treatment, there is direct access to the primary care physician contracted by the health insurance company (information about the contracted physicians shall be provided by each of the health insurance companies). If the specialist outpatient care is needed, the referral of primary care physician is requested. Patients do not pay for the specialist outpatient care provided. (258) When hospitalisation is needed, the referral of GPs is requested except in case of immediate hospitalisation. In this case the patient does not have to pay a fee for the health care provided.

(256) In 2014, the government introduced a residential program to facilitate the training of GPs and paediatricians for rural

areas (<http://www.health.gov.sk/?rezidenti>) The aim is to

train 100-150 doctors a year.

(<http://www.health.gov.sk/?faq-rezidenti>)

(257) <https://www.vszp.sk/poistenci/zdravotnastarostlivost/>

pevna-siet-poskytovatelov-k-1-1-2016.html

(258) In practice, fees may apply (as mentioned above). Fees are

mostly related to accompanying services and

administrative steps.

There is direct access to the contracted dentist

(information on the contracted dentists shall be

provided by each health insurance company).

There is a "standard" dental treatment which is

reimbursed by the public health insurance. The

price difference for additional treatment or abovestandard

is paid by the patient. The price of nonstandard

treatment is determined by each dental

practice and varies between clinics. The dentist is

obliged to inform the patient in advance about the

expenses for services with private co-payment and

about the expenses of direct payment and in what

amount.

In the case of emergency care (Medical First Aid

or Hospital Emergency Service) in the hospital
there is a fee of EUR 1.99. If it is found necessary to
keep the patient in the in-patient care in the
hospital after examination, the charge EUR 1.99
does not apply.

Some primary and specialist outpatient care also
take place in specialists' private individual or
group practices and some hospital care takes in
private clinics and hospitals at the cost of patient.
The number of practicing physicians per 100,000
inhabitants (300 in 2007, latest available data) is
below the EU average (344 in 2013). The number
of GPs per 100,000 inhabitants (42 in 2007, latest
available data) is also below EU average (78.3 in
2013). The numbers suggest that the skill mix may
need to improve to ensure a good distribution of
GPs, currently deemed unequal by the authorities,
and the effectiveness of the referral system and the
GPs' gatekeeping role which the authorities want
to reinforce. Indeed, this is one of the policy
priorities of the Slovak authorities with the
introduction of the residential programme for GPs.

Acute hospital beds stand at 424 per 100 000 inhabitants and higher than the EU average of 356 per 100 000 inhabitants in 2013, though showing a reduction over the decade.

A next consideration to be made is the existence of staff supply regulations. As it turns out, there are no quotas for medical students as the pool of graduated medical students through the entire hierarchy is sufficient. The location of physicians is partially managed by HICs since each HIC manages its own minimal network of physicians depending on the geographical density of their

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clients. Specialists in locations with fewer patients have more convenient contracts.

Purchasing and contracting of healthcare services and remuneration mechanisms

Primary care physicians are paid mainly on a capitation basis. Specialists are paid on a fee-for-service basis. The current system of financing

health care is based on a combination of a point and fixed price system. For outpatient care, each medical service has a point value listed by the Slovak Ministry of Health. As the list of medical services with assigned point values is not being updated regularly and new services/ procedures are being introduced, HIC now set fixed prices for these, rather than setting a point value. For inpatient care, hospitals get typically fixed-rate payments for long-terms stays of chronic patients. For most hospital stays hospitals get payments per discharge. These depend on the department and are negotiated by HICs and HCPs. (259)

Health insurance companies are responsible for contracting hospitals. They sign contracts with health care providers for different quantity of health care services on the basis of selected regional needs. They have the possibility to differentiate the quantity of health care services purchased according to the quality of providers.

The number of physicians' consultations per capita

is high above the EU average (11 vs. 6.2 in 2013).

When looking at hospital activity, inpatient

discharges are higher than the EU average

(respectively 1,767 vs. 1,649) in 2011. Hospital

average length of stay for curative care is at the EU

average (6.2 days vs. 6.3 days in 2013). Assessing

and adjusting hospital remuneration is something

the authorities have indicated as a policy priority.

(260)

(259)

http://hpi.sk/cdata/Publications/hpi_zakladne_ramce

_2014.pdf

(260) By 2016: data collection in a new DRG system has started

without impacting yet actual financial flows. Date of first

payments through the DRG system is yet to be determined.

The market for pharmaceutical products, the

use of Health Technology Assessment and

cost-benefit analysis

Medicines are divided into three categories by law

according to their clinical performance and

economic evaluation: medicines fully paid by the

health insurance; medicines partially paid by the

health insurance company and with co-payment by patients; and medicines fully paid by patients. The physician who prescribes the medicines is obliged to inform patients on reimbursement category, in which a medicine is placed. The pharmacy is obliged to issue the receipt of the amount of overall payment and the private co-payment.

A number of measures have been adopted to control pharmaceutical expenditure. In addition to price reductions, and external reference pricing and a regressive mark-up were introduced in recent years. The initial model was based on the referencing of prices against the average of six lowest prices in the EU. In 2011, referencing was tightened, so that drug prices could not exceed the level of the second lowest price in the EU. As of 2013, prices are referenced at the level of the average of three lowest prices for a given drug in the EU. Slovakia has established a greater use of generics as a policy priority. In 2012, a Pharmaceutical Cost Group (PCG) model was introduced, that is supposed to bring a more

equitable redistribution of finances from public

health insurance. (261)

eHealth, Electronic Health Record

Implementation of eHealth and its inevitable

functions has been postponed until after January

2017.

(261) A comparison of data on spending on pharmaceuticals

among OECD and EU countries shows that per capita

spending in Slovakia is still significantly higher than

spending in the average of EU as well as of the OECD

(based on available OECD data). While in 2013 Slovakia

spent 533 USD (in PPPs, current prices), the OECD and

EU averages were at 395 and 332 USD respectively.

Slovakia also spends more on medical goods. In 2013, per

capita spending on medical goods in Slovakia was 719

USD (in PPPs, current prices), the OECD and EU averages

were at 636 and 585 USD respectively.

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Health promotion and disease prevention

policies

The need to improve health status further through

promotion and prevention activities is a policy priority. Slovakia spends less on prevention and public health services than the EU average (1.5% of public current health expenditure relative to 2.5% in the EU).

Transparency and corruption

The contracts between HICs and healthcare providers are published online mandatorily. All contracts of state-owned healthcare providers are also mandatorily published online (including public procurement contracts). Online publishing is also used as a tool to put into transparency any interactions among physicians and pharmaceutical companies. The companies have to publish a list of doctors who took part on the medical congresses and conferences organised by them. Starting in July 2016, companies will be publishing all transfers of value to HCP (e.g. doctors and nurses), including the name of the HCP, the value and purpose of the transfer of value (both financial and non-financial). (262)

Recently legislated and/or planned policy

reforms

Health insurance

The system of risk compensation in public health insurance was extended by adding the morbidity parameter through classification of policy holders in pharmaceutical cost groups (PCG). Since the second half of 2012, the revenues of insurance companies have thus been following real costs of treatment of their policy holders.

Reform of primary care

The average number of patient visits per year in Slovakia is almost twice as much compared with the EU average. One reason for this is a poor integration of health care providers which is demonstrated by a high degree of fragmentation of primary health care providers; where in 2,933

(262) <http://www.health.gov.sk/Clanok?mz-zavadzatrparentnejsie->

pravidla-pri-zverejnovani-vydavkovfarmaceutickych-firiem-na-propagaciu-a-marketing

territorial units (263) (municipalities) exist with a

total of 2,863 primary care physicians. (264) The

other problem is the high rate of referrals; a high number of patient visits indicates inadequate patient management by primary physicians, where more than 80% of patients with chronic disease are transferred from the first contact with a GP physician directly to a hospital specialist. The MoH has taken actions to proportionally change the redistribution of patients visits from nowadays 80% managed by specialists and only 20% fully managed by GPs to around 60% and 40% in the next few years. Efforts to make the profession of a general practitioner more attractive are continuing, in order to attract young doctors. The Ministry of Health has legislatively defined a new form of preparation of general practitioners already during their university studies, and as from July 2014, GP's have the possibility to perform pre-operation examinations of patients with common diseases. In 2015 legislation was passed allowing GPs broader rights in treating chronic patients, previously treated by specialists (e.g. patients with diabetes). Improving the financial management and economy of providers

The Slovak Government undertakes to ensure that,

on average, health care facilities established by the

Ministry of Health of the Slovak Republic will

operate on a balanced budget without needing

additional financial assistance from the state

budget and that their indebtedness will be

considerably reduced. The indebtedness of state

hospitals has not slowed down since 2012. (265)

Thus, further a balanced financial performance of

hospitals has not yet been achieved. The financial

management of hospitals needs to be set in a

manner that rewards performance and efficiency.

However, prior to introducing performance-based

remuneration of executive managers, it is

necessary to ensure systematic collection,

monitoring and evaluation of the relevant

(263) <http://www.vlada.gov.sk/slovensko/>

(264)

<http://www.nczisk.sk/Documents/publikacie/analyti>

cke/zdravotnictvo_slovenskej_republiky_v_cislach_2014.p

df

(265) According to data provided to the Ministry of Finance by

the MoH, in 2012 the indebtedness of hospitals affiliated

with the MoH grew by EUR 93 million, in 2013 by EUR

95 million. In 2014 the rate slowed down to EUR 71 mln,

but in 2015 it again rose to EUR 108 milion. At the end of

2015 total indebtedness reached EUR 533 million.

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indicators. Correctly set financial management of

hospitals may considerably help prevent the

accumulation of their debts and thus increase the

efficiency of spending. The savings in the

procurement of energy, materials, services and

other inputs used by hospitals can be achieved by

centralising purchases at the level of hospitals'

managements. With the introduction of central

procurement, it will be possible for the hospitals to

spend their funds more effectively without

compromising the treatment of patients. Hospital

managements will also focus on operational

savings by curtailing duplication of processes and

personnel.

Better integration of healthcare provision

One of the planned steps conducive to stabilise expenditure is the introduction of an integrated model of health care provision. The position of general practitioners will be further reinforced in order to reduce more expensive treatment in hospitals and by specialist physicians. The residency programme will bring a new generation of general practitioners and help improve the treatment management process. Medical students will be required to undergo a period of training in outpatient facilities already during their university studies. Following the completion of their study programmes, graduates will be required to work for a certain number of years in outpatient facilities in Slovakia. One of the key components of the integrated model of health care provision will include the application of eHealth in practice.

An insufficient coordination of the current types of establishments in the treatment process often causes that e.g. a more specialised or knowledgeable and costly healthcare provider

(HC) than necessary is dealing with a simple medicinal case. A clear definition of the types of hospitals and the extent of care provided by them and a better coordination of involvement of outpatient and inpatient facilities in individual stages of treatment could help increase the efficiency in the use of capacities. Hospitals types should be defined according to the extent of healthcare provision. The portfolio of healthcare provision should reflect the variability of cases and the levels of difficulty so that adequate capacity is achieved for the needs of the catchment area. At the same time, the coordination between outpatient and inpatient establishments should improve. The aim will be to set the system so that providers at such level are used in individual cases that staff and physical resources would not be wasted. Particular setting and detailed definitions will be gradually profiled in the Strategic Healthcare Framework for 2014 – 2030 which is an ex ante conditionality for using EU financial resources. As of 2016, no significant progress has been achieved

yet.

Introduction of diagnosis-related group (DRG)

payments

With the introduction of diagnosis-related group

payments, it will be possible to identify internal

reserves of resources in the public health insurance

system, increase transparency in the relations

between insurance companies and hospitals and

manage them in a meaningful and effective

manner. For every hospital case, the DRG system

will assign a portion of funds set in advance –

based on diagnosis, procedure, age, gender,

presence of other diseases or complications and

other measurable criteria. If an identical procedure

is performed during the treatment of an identical

diagnosis, every hospital will receive the same

amount from an insurance company. DRG

payments will provide a transparent healthcare

funding system for in-patient healthcare facilities,

thus bringing more fairness to the funding of

healthcare providers. The creation of a uniform

platform for the funding of the provided hospital

services in the form of the DRG system will

contribute to the possibility to compare healthcare provided in the individual healthcare facilities, and a broader scope of information will be collected for decision-making and control.

In 2016, hospitals are still to be reimbursed according to current rules (pre-DRG). At the same time, they are to receive information on how they would be reimbursed within the DRG system.

However, this information will not yet be based on a uniform base rate per diagnosis. Rather, hospitals will be assigned into 5 base rate categories, calculated based on their current income level (and thus reflecting the current differences in reimbursement). The information is also not based on actual costs per diagnosis of Slovak hospitals. It is based on information costs collected within the German system (Slovakia is adopting the German DRG system) with some adjustments made based on data collected in Slovakia. The date of first

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reimbursements based on the DRG system is not yet known.

Construction of a modern hospital in Bratislava

Along with the adoption of measures aimed at

stopping the growing indebtedness of hospitals,

investments will be made in acute hospitals which

will replace some of the most obsolete and least

efficient facilities. The intention to build a new

hospital in Bratislava is included in the 2016

government manifesto. It is now expected that it

will be financed from public funds.

Challenges

The analysis above shows, that a range of reforms

have been started/implemented in recent years.

However, when it comes to the efficiency of health

care provision, Slovakia's performance is

relatively low. (266) The main challenges for the

Slovak health care system are as follows:

- To continue increasing the efficiency of health

care spending in order to adequately respond to

perceived current inefficiencies, such as high

spending on ancillary services (diagnostic

imaging, laboratories, transportation and medical rescue services), pharmaceuticals and medical goods, as well as the increasing health

care expenditure over the coming decades. This is a risk to the long-term sustainability of public finances.

- To introduce an integrated care model, e.g. by establishing health centres and devising and implementing the master plan for an effective geographic distribution of health care resources, by safeguarding accessibility and delivering efficiency gains.

- To further promote the supply of general practitioners by removing the restrictions on the volume and range of primary health services, introducing the performance element to payment schemes, and improving the attractiveness of being a general practitioner.

- To ensure balanced hospital budgets by improving the efficient utilisation of resources, hardening budgetary constraints, improving

guidance and supervision in procurement processes and enhancing payment systems, by introducing a diagnosis-related groups payment system as planned currently. To continue recent efforts to optimise the utilisation of acute care beds (low bed occupancy rates imply an excess of hospital beds which may lead to inefficiency in the operating costs of hospitals), by introducing effective referral system and control of admissions.

- To implement measures for a comprehensive streamlining of public hospital care, including transforming acute care beds into long-term care beds.

- To promote the rational use of medicines by combining different policies, such as electronic prescription, monitoring and guidelines linked with electronic systems and providing feedback to physicians appears an effective way of improving prescription behaviour. This may reduce the risk of over-prescription and wrong

co-medication. To introduce a national procurement system for pharmaceuticals in order to enhance the bargaining power of hospitals against pharmaceuticals companies.

- To fully implement and extend the pilot project on 'eHealth' information tools, including electronic health records, e-prescriptions and ereferrals and aiming to improve coordination between inpatient and outpatient care and to limit overuse of services and pharmaceuticals.

- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and used to continuously improve access, quality and sustainability of care.

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Table 1.24.1: Statistical Annex – Slovakia

Sources: EUROSTAT, OECD and WHO

General context

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GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 30 35 39 45 56 66 64 67 70 72 74 9289 9800 9934

GDP per capita PPS (thousands) 13.5 13.7 14.7 15.8 17.7 18.4 17.4 18.6 18.7 19.2 19.6 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 4.8 5.0 6.6 8.3 10.4 5.6 -5.1 4.2 3.6 1.6 0.8 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita : : : 13.1 16.6 9.1 8.3 2.4 -8.3 4.0 1.5 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP : : 7.0 7.4 7.8 8.0 9.2 9.0 8.0 8.2 8.2 10.4 10.1 10.1

Total current as % of GDP 5.4 6.5 6.8 7.0 7.4 7.6 8.6 8.5 7.6 7.7 7.6 9.8 9.6 9.7

Total capital investment as % of GDP : : 0.3 0.3 0.4 0.4 0.5 0.5 0.4 0.5 0.6 0.6 0.5 0.5

Total per capita PPS : : 985 1148 1358 1525 1623 1681 1555 1634 1676 2828 2911 2995

Public as % of GDP : : 5.2 5.0 5.2 5.4 6.0 5.8 5.6 : 5.8 8.1 7.8 7.8

Public current as % of GDP 4.8 5.0 5.1 4.9 5.1 5.4 6.0 5.8 5.6 5.5 5.6 7.9 7.7 7.7

Public per capita PPS : : 697 752 875 1000 1040 1052 1102 : 1174 2079 2218 2208

Public capital investment as % of GDP : : 0.2 0.1 0.1 0.1 0.0 0.0 0.0 : 0.1 0.2 0.2 0.1

Public as % total expenditure on health : : 74.4 68.3 66.8 67.8 65.7 64.5 70.9 : 70.0 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 16.2 12.5 12.6 15.9 18.7 20.1 18.8 16.0 15.6
16.4 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 96.9 95.6 97.6 96.3 95.5 95.4
95.4 95.4 95.2 95.0 94.6 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health : : 23.6 26.6 27.4 26.1 26.9 27.2 23.6 22.4
22.1 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 502.1 504.5 506.6

Life expectancy at birth for females 77.7 78.0 78.1 78.4 78.4 79.0 79.1 79.3 79.8 79.9 80.1 82.6 83.1 83.3

Life expectancy at birth for males 69.8 70.3 70.2 70.4 70.6 70.9 71.4 71.8 72.3 72.5 72.9 76.6 77.3 77.8

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Healthy life years at birth females : : 56.6 54.6 56.1 52.5 52.6 52.0 52.3 53.1 54.3 : 62.1 61.5

Healthy life years at birth males : : 55.2 54.5 55.6 52.1 52.4 52.4 52.1 53.4 54.5 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 104 101 92 86 102 116 110 105 223 217 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 7.9 6.8 7.2 6.6 6.1 5.9 5.7 5.7 4.9 5.8 5.5 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : : 1.89 1.50 1.66 1.66 1.81 1.81 1.67 : 1.80 3.13 2.99 3.01

Day cases curative and rehabilitative care : : 0.00 : 0.00 0.00 0.00 0.00 0.00 : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care : : 1.20 1.62 1.72 1.85 2.15 2.00 1.82 : 1.89 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables : : 2.24 2.19 2.17 2.22 2.43 2.38 2.18 : : 1.60 1.55 1.44

Therapeutic appliances and other medical durables : : 0.54 0.56 0.61 0.60 0.75 0.75 0.70 : : 0.31 0.31 0.32

Prevention and public health services : : 0.16 0.32 0.37 0.37 0.42 0.45 0.21 : : 0.25 0.25 0.24

Health administration and health insurance : : 0.28 0.29 0.27 0.31 0.29 0.29 0.26 0.25 0.25 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : 1.87 1.24 1.36 1.40 1.54 1.53 1.59 : 1.71 2.73 2.61 2.62

Day cases curative and rehabilitative care : : 0.00 0.00 0.00 0.00 0.00 0.00 0.00 : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care : : 0.77 1.12 1.24 1.32 1.53 1.34 1.36 : 1.42 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables : : 1.65 1.59 1.50 1.58 1.70 1.65 1.52 0.83 0.78 0.79 1.07 0.96

Therapeutic appliances and other medical durables : : 0.14 0.16 0.16 0.17 0.20 0.19 0.20 : : 0.13 0.12 0.13

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Prevention and public health services : : 0.09 0.13 0.15 0.15 0.18 0.17 0.09 0.09 0.08 0.25 0.20 0.19

Health administration and health insurance : : 0.27 0.28 0.28 0.30 0.29 0.29 0.26 : 0.25 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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1.24. Slovakia

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Table 1.24.2: Statistical Annex - continued – Slovakia

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : : 28.0% 21.4% 22.5% 21.8% 21.0% 21.3% 22.0% : 23.8% 31.8% 31.3%
31.1%

Day cases curative and rehabilitative care : : 0.0% : 0.0% 0.0% 0.0% 0.0% 0.0% : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care : : 17.8% 23.1% 23.3% 24.2% 25.0% 23.6% 23.9% : 24.9% 23.3%
23.5% 23.2%

Pharmaceuticals and other medical non-durables : : 33.2% 31.2% 29.4% 29.1% 28.2% 28.1% 28.7% : : 16.3%
16.2% 14.9%

Therapeutic appliances and other medical durables : : 8.0% 8.0% 8.3% 7.9% 8.7% 8.8% 9.2% : : 3.2% 3.3% 3.3%

Prevention and public health services : : 2.4% 4.6% 5.0% 4.8% 4.9% 5.3% 2.8% : : 2.6% 2.6% 2.5%

Health administration and health insurance : : 4.1% 4.1% 3.7% 4.1% 3.4% 3.4% 3.4% 3.3% 3.3% 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

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Inpatient curative and rehabilitative **care** : : 36.8% 25.3% 26.6% 26.0% 25.8% 26.6% 28.4% : 30.4% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative **care** : : 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% : : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative **care** : : 15.2% 22.8% 24.3% 24.5% 25.7% 23.3% 24.3% : 25.3% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables : : 32.5% 32.4% 29.4% 29.4% 28.5% 28.7% 27.1% 14.9% 13.8% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : 2.8% 3.3% 3.1% 3.2% 3.4% 3.3% 3.6% : : 1.6% 1.6% 1.6%

Prevention and public health services : : 1.8% 2.6% 2.9% 2.8% 3.0% 3.0% 1.6% 1.5% 1.5% 3.2% 2.7% 2.5%

Health administration and health insurance : : 5.4% 5.7% 5.4% 5.6% 4.9% 5.0% 4.7% : 4.5% 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants 0.20 0.37 0.43 0.45 0.57 0.61 0.61 0.68 0.70 0.63 0.67 1.0 1.1 1.0

Angiography units per 100 000 inhabitants 0.7 0.8 0.8 0.7 0.8 0.8 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.8

CTS per 100 000 inhabitants 0.9 1.0 1.1 1.2 1.4 1.4 1.3 1.4 1.5 1.6 1.5 1.8 1.7 1.6

PET scanners per 100 000 inhabitants 0.0 0.0 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1

Proportion of the population that is obese 15.4 16.5 17.6 : 16.7 16.9 15.1 : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 22.1 : : : : 19.3 19.5 : : : : 23.2 22.4 22.0

Alcohol consumption litres per capita 9.9 10.0 11.1 10.9 11.1 11.9 11.2 11.0 10.7 10.8 10.6 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 315 315 : : 300 : : : : : 329 335 344

Practising nurses per 100 000 inhabitants 680 664 632 633 662 658 637 640 628 580 580 840 812 837

General practitioners per 100 000 inhabitants : : : : 42 : : : : : 78 78.3

Acute hospital beds per 100 000 inhabitants 509 484 501 488 492 487 480 475 449 437 424 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

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Doctors consultations per capita 12.4 11.9 11.3 10.4 11.2 12.1 11.6 11.6 11.0 11.2 11.0 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 19.0 17.9 17.8 18.0 16.9 18.2 18.0 18.0 17.7 : : 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : : : : : : : : 6368 6530 7031

Acute care bed occupancy rates 65.0 68.0 67.0 68.0 68.0 67.5 67.3 66.5 65.5 67.3 67.4 72.0 73.1 70.2

Hospital curative average length of stay 7.4 7.3 7.3 7.2 7.0 6.9 6.7 6.6 6.3 6.2 6.2 6.5 6.3 6.3

Day cases as % of all hospital discharges : : : : : : : : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 5.7 6.1 6.7 7.1 7.5 7.7

AWG risk scenario 5.7 6.4 7.5 8.2 8.8 9.0

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 5.4 5.4 5.3 5.1 4.9 4.6

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-15.8 3.1

2.0 0.9

3.3 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

1.25. SLOVENIA

General context: Expenditure, fiscal

sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population;

The gap between Slovenian (21,000 PPS in 2013)

and average EU GDP per capita (27,900 PPS) has

remained somewhat stable since 2009 (21100 vs

26800 PPS in 2009), although slightly increasing.

Indeed, the negative impact of the economic and

financial crisis on the Slovenian economy has been

very strong (GDP growth (267) slowdown from

6.9% in 2007 to 3.3% in 2008 and -7.8% in 2009).

After years of low or negative growth 2012 and

2013 recorded, respectively, -2.7 and -1.1, the

economy picked-up during 2014 with 3.0%. The

positive trend continued through 2015(268) (2.9%)

and is projected positive until 2017 (2.3%

projected, with a slightly lower level in 2016). (269)

The Slovenian population is projected to decrease

from 2.1 million in 2013 to 2 million in 2060. Life

expectancy is projected to increase by 7.1 years for

men and 5.9 for women, i.e. somewhat faster than

in the EU on average. Slovenia is expected to be strongly affected by the ageing process. From already high starting levels, the share of the old population (65+) is expected to almost double (from 17.3% to 29.4%) and the share of the very old (80+) to increase almost threefold (from 4.6% to 12.4%).

Total and public expenditure on health(270) as % of GDP

In 2013 total expenditure on health care amounted to 9.2% of GDP, having slightly increased, though not steadily, during the last decade (8.7% in 2003).

This is below the EU average of 10.1%, when looking at weighted average. Looking at the unweighted average and at median EU values however, respectively 8.7% and 8.9%, the level of total health expenditure in Slovenia is slightly higher than both EU values. The same applies to public expenditure on health care, broadly constant over the last decade (+0.4%) and accounting for

(267) Source: <http://pxweb.stat.si/pxweb/Dialog/Saveshow.asp>.

(268) Source: <http://www.stat.si/StatWeb/en/shownews?>

id=5796&idp=1&headerbar=10.

(269) European Commission (2016), European Economic Forecast Winter 2016.

(270) This aggregate includes capital investments.

6.6% (271) of 2013 GDP, which is below the EU

(272) average of 7.8% when looking at the weighted

figure, but is higher both than the unweighted and

(6.4%) and than the median (6.1%) values. Also

when measured in per capita terms, both total and

public health care expenditure are lower than the

EU weighted average: 1901 PPS vs. 2988 PPS and

1361 PPS vs. 2208 PPS respectively (figures for

2013 in PPS EUR). Comparing these values to

unweighted average (2,399 PPS) and median

(2,085) does not bring Slovenia above average, but

it considerably reduces the gap, placing Slovenia

very close to the median level for total health

expenditure PPS. With an unweighted average

value of 1,696 and a median of 1,398, an entirely

similar reasoning applies to public health

expenditure PPS, in which Slovenia almost

matches the median level.

As a result of declining revenues of compulsory health insurance contributions (and in view of the target that compulsory health insurance should be financed without any further borrowing or increase in the contribution rate), public health expenditure, declined for four consecutive years in real terms, having declined by as much as -3.6% over the entire 2010–2013 period. (273) In 2013 public health expenditure as a share of GDP was thus 6.6%. At the same time, there was a change in the ratio of public to private expenditure on health. The share of public expenditure declined; it stood at 71.8% in 2013, which is lower than EU average. Slovenia had already recorded relatively low health expenditure growth before the crisis, but also during the crisis called for strict austerity measures. In the period 2000-2009 health expenditure per capita averaging 4.7% growth per year in real terms in EU28 countries and in Slovenia 4.0%; during the crisis in 2009-2012 it declined to 0.6% in EU28 countries and in (271) Including public long-term health expenditure (HC.3) and capital investments.

(272) This figure refers to the weighted average.

(273) SURS, 2015: [http://www.stat.si/StatWeb/en/shownews?](http://www.stat.si/StatWeb/en/shownews?id=5306&idp=10&headerbar=15)

id=5306&idp=10&headerbar=15 and IMAD

calculation. According to international recommendations,

the GDP implicit price deflator was used to calculate real

growth (SURS, 2015: [http://www.stat.si/StatWeb/en/shownews?](http://www.stat.si/StatWeb/en/shownews?id=5404&idp=1&headerbar=10)

id=5404&idp=1&headerbar=10.

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Slovenia it fell annually by 0.5% in real terms.

(274)

Expenditure projections and fiscal sustainability

Driven by the change in demographic structure,

public spending on health care is projected to

increase by 21% or 1.2 pps of GDP, more than

13% average increase in the EU (0.9 pps)

according to the "AWG reference scenario". (275)

When taking into account the impact of nondemographic

drivers on future spending growth

(AWG risk scenario), health care expenditure is

expected to increase by 1.9 pps of GDP from now

until 2060 (EU: 1.6). Such a large projected

growth in public health care spending, together

with considerable expected increase in the other

age-related items of public expenditure (e.g.

pensions, long-term care, education) (276) and the

unfavourable current budgetary stance, results in

high risk for both the medium and the long-term

sustainability of the Slovenian public finances.

Slovenia faces high sustainability risks over the

medium and the long term due to the high initial

debt-to-GDP ratio, the unfavourable initial

budgetary position and the strong projected impact

of age-related public spending (notably pensions,

healthcare and long-term care). (277)

Health status

The indicators of health status of the Slovenian

population appear similar to those of the EU

average. Life expectancy, both of women (83.6

years) and of men (77.2 years) is about the same

than in the other EU countries (respective averages

of 83.3 and 77.8 years) and is consistent with

Slovenia's economic development level, while

healthy life expectancy stands below the EU

average for women (59.5 vs 61.5 years) and is

(274) OECD Health at a glance: Europe 2014 and Institute of

Macroeconomic Analysis and Development (2015)

Development report 2015. Indicators of Slovenia's

Development. Health expenditure.

(275) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(276) SI has the second highest projected growth of pensions

expenditures in EU (3.5 pp of GDP until 2060), the second

highest growth of education expenditure (0.8 pp of GDP

until 2060) and LTC expenditure are also expected to grow

faster than on average in EU (1.5 p.p. of GDP).

(277) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

slightly lower for men (57.6 vs. 61.4 years) (278).

Infant mortality of 2.9‰ (2013) is well below the

EU average of 3.9‰.

Over the last decade the main non-communicable

diseases accounted for about 80% of all deaths in Slovenia; external causes for 9%; and communicable diseases for less than 1%. In total, 38.5% of all deaths were caused by diseases of the circulatory system, followed by neoplasms (29.1%), ischaemic heart disease (10%), injuries and poisoning (9.8%) and cerebrovascular diseases (7.9%). (279) Mortality by age and sex shows a pattern similar to the European averages.

The lifestyle-related risk factors are in general less prevalent than in the other EU countries.

Percentage of regular smokers (20.5% in 2012) is below the EU average in the recorded closest years (22.4% in 2011 and 22% in 2013 and alcohol consumption (9.5% litres per capita in 2013) is close to the EU average number (9.8 litres per capita).

System characteristics

System financing, revenue collection

mechanism, coverage and role of private

insurance and out of pocket co-payments

The Slovenian health system is a Bismarckian

system based on statutory health insurance, which

is fully regulated by national legislation and administered by the single insurer, Health Insurance Institute of Slovenia (HIIS), an independent public institution. HIIS operates in accordance with the "Stability Pact", whereby HIIS is not allowed to record a loss at the end of the year or go into debt and it cannot itself increase insurance contribution rates (280). The health insurance system is mandatory, providing universal coverage. The extent of rights deriving (278) Data on life expectancy and healthy life years is taken from the Eurostat database. Data on life-styles is taken from the Eurostat database and the OECD health data. (279) WHO Country Cooperation Strategy at a glance

http://www.who.int/countryfocus/cooperation_strategy/ccs

briefs_svn_en.pdf.

(280) European Observatory on Health System and Policies, World Health Organization and Ministry for Health (2016). Analysis of Health System in Slovenia. Health System Expenditure Review. Final report.

<http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/An>

aliza/Report_Expenditure_review_Slovenia_FINAL_FOR

MATTED_without_cover.pdf

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from compulsory health insurance is specified by

the law on health care and health insurance and the

regulations on compulsory health insurance, i.e.

the act adopted by the assembly of the Health

Insurance Institute of Slovenia.

Compulsory health insurance comprises insurance

in the case of illness or injury outside work, and

insurance in the case of injury at work and

occupational diseases. The extent of rights to

health care services is defined in percent share of

the total service costs. This means that the

compulsory health insurance "covers" the majority

of health related risks, however, not necessarily all

of them and neither in full. The balance is either to

be paid by the insured person, or, alternatively and

most common, the insured person takes out a

complementary insurance policy with a private

health insurance company. More than 95 % of the population liable for co-payments is insured by voluntary complementary health insurance. (281)

In the 2009–2013 period a series of measures were introduced to balance Health Insurance Institute operations. To generate additional revenues measures included increasing contributions for self-employed and requiring contributions from student employers. (282) However, the majority of measures focused on reducing expenditure by reducing the prices of health services, transferring a portion of expenditure on health to complementary health insurance schemes, lowering expenditure on medicines, medical devices, sickness allowances and obligations under international agreements. These measures significantly reduced health care providers' revenue from compulsory health insurance, which had an impact on increasing the losses of these providers, particularly hospitals. (283)

Voluntary health insurance (VHI) has two main forms: complementary VHI provides insurance to cover co-payments only, and supplementary VHI

provides insurance for a higher standard and a

wider scope of benefits than the mandatory

(281) Health Insurance Institute of Slovenia. Web page:

<http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74>

130DE0AC1256E89004A4C0C.

(282) Health Insurance Institute of Slovenia. Web page:

<http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74>

130DE0AC1256E89004A4C0C.

(283) Institute of Macroeconomic Analysis and Development

(2014) Development report 2014. Indicators of Slovenia's

Development. Health expenditure.

insurance. Since public entities have gradually

reduced health financing over the nineties, the

share of the population holding voluntary

complementary health insurances has increased a

lot and 72% of the whole population in 2012 were

covered, however, when excluding children and

students by the age of 26 who are fully covered by

compulsory health insurance, 95 % of population

liable for co-payments is holding complementary

VHI. (284)

Overall levels of enrolment in complementary health insurance have not changed dramatically during the crisis. (285) Total enrolment in 2014 (1,485,697) was at its highest level since 2008 (1,492,330). Since 2009, the government has started to cover co-payments for economically disadvantaged people who meet predetermined criteria. (286) To avoid cream-skimming by insurers and to equalise the variations in risk structure, a risk-equalisation scheme was introduced in 2005. Risk equalisation is retrospective, calculated on the basis of expenditures for health care services and for health care providers. (287) Premiums have been community rated since 2006, are similar across the insurers (i.e. premiums currently do not differ across insurers by more than EUR 1 per month) and do not generally increase drastically over time. The large premium increase (by more than 16 %) in 2014 was in response to the 2012 "Fiscal Balance Act", which shifted some costs from HIIS to VHI in an effort to keep public expenditure sustainable.

Out-of-pocket payments exist as two main mechanisms: cost sharing and direct payments. Cost sharing takes the form of flat rate copayments and applies to most types of health **care** services and to all patients with the exception of some vulnerable social groups (children, unemployed, those with income below a given threshold, chronically ill). However, since a large

(284) OECD Health Statistics 2015.

(285) Overall, the largest decrease in total enrolment was in 2010, when the number of VHI enrolees fell by around 12,000 people (-0.8%); there were smaller decreases in VHI enrolees of around 8,200 and 3,800 in 2009 and 2011, respectively.

(286) Health Insurance Institute of Slovenia. Web page:

<http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>.

(287) Health Insurance Institute of Slovenia. Web page:

<http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>.

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majority of patients is covered by voluntary insurance covering complementary co-payments, this form hardly exists in the form of direct payments. The latter are used, however, in case of visits to the providers who do not have a contract with the HIIS, to the specialists without a GP's referral and to private dentists. The out-of-pocket payments are also used to avoid waiting times and pay for extra services, not included in the general benefit package of the social insurance system.

Compulsory health insurance contributions constitute the major source of health care financing with 65.2% of total expenditure (2013). (288)

General national and municipal-level taxation represents 6.6% of total expenditure (only 3.2% of current expenditure), and is mostly devoted to the financing of capital investments in hospitals, specialised health institutions at national and regional levels, national health programmes, medical education and research (Ministry of

Health) and public health centres and public pharmacies (municipalities). The share of government budget funding is one of the lowest in the EU and transitioning towards a system that is less reliant on contributions could improve the future stability of health care financing.

Contributions to fund the HIIS are mostly related to earnings from employment. The contribution rate amounts to 13.45% of gross income, out of which 6.36% is paid by the employee and 7.09% by the employer. They represent the major source of public funding. The other public source of finance is general taxation. This non-earmarked revenue allocated for health is estimated annually and accounted for about 14% of the total general government health expenditure in 2012. (289)

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions

The coverage by compulsory health insurance (CHI) is universal. It covers the contributors (employees, pensioners, farmers, self-employed),

their dependants (subsidised by the compulsory

(288) Statistical Office of the Republic of Slovenia 2015. Health

Expenditure and Sources of Funding.

(289) OECD Fiscal Sustainability of Health Systems, 2015, page

35.

health insurance), but also unemployed and

individuals without income (whose contributions

are paid by the National Institute for Employment,

central government and municipalities). The

benefits package comprises a wide coverage of

primary, secondary and tertiary services,

pharmaceuticals, medical devices, long sick leave

and travel's costs. Some services are 100% covered

by CHI, while others are only covered up to a

certain % of the service's full value. However, the

difference to the full value is usually covered by

complementary health insurance.

More than 95 % of insured CHI that are liable for

co-payments is included also in voluntary

complementary health insurance to cover costsharing

in the social security system.

Complementary health insurance guarantees full

co-payment coverage for all services covered by compulsory health insurance. This could lead to unnecessary care. (290) Introducing a fee for some health services, which could not be covered and reimbursed by complementary insurance, would represent a supplementary tool for cost control for the public health purse. There is also room to continue to rationalise the public benefit basket by reducing the reimbursement rate or delisting certain less medically necessary services, such as spa treatments, non-emergency ambulance transportation or less clinically-effective medicines. (291)

Private sources account for 28.2% of total health expenditure in 2013 and exceed the EU level (22.6% weighted average, 26.5% unweighted average). Private sources consist of two main sources of financing: out-of-pocket payments, representing around 12.1% in 2013 and voluntary health insurance accounting for 14.6% in 2013. Total private expenditure has been increasing considerably over the recent years: its average real yearly growth over the period 2000-2013 has

amounted to 3.2% (OECD average: 3.5 %). (292)

However, out-of-pocket payments are still

relatively low as most health services and

medicines are covered by compulsory and

complementary health insurance schemes. Out-of-pocket

expenditure accounted for only 12.1% of

total health expenditure in 2013, compared with

(290) OECD (2013). 2013 Economic Survey - Slovenia

(291) OECD (2013). 2013 Economic Survey - Slovenia

(292) OECD Stat 2015.

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20.6% in the EU-28 (unweighted average); per

capita, this is EUR 216 in PPS terms in Slovenia

and EUR 385 in PPS terms in the EU. (293) During

the crisis, a significant share of the shortfall in

public funding was compensated for by

complementary health insurance schemes, so that

out-of-pocket expenditure increased only

marginally. Had this not been the case, they would

have been significantly affected by lower

availability and higher out-of-pocket payments as

public funding declined. (294)

Slovenian households allocate the largest shares of

out-of-pocket expenditure to medical goods (2013:

40%; of which 36% for over-the-counter

medicines), therapeutic appliances (20%; of which

16% for glasses), various other health services

(physiotherapy) and alternative medicine (11%),

dental care (8%) and specialist outpatient care

(8%). In 2009–2013, increases in out-of-pocket

expenditure were recorded by medical goods,

long-term institutional care and patient transport),

while significant decreases in out-of-pocket

expenditure were recorded by dental care,

specialist outpatient care, and various other health

services (physiotherapy, alternative medicine).

(295)

There is scope to increase out-of-pocket health

expenditure in Slovenia as its burden amounts to

slightly above 2% of final household consumption,

and is one percentage point lower than the OECD

average (OECD, 2011e). Concerns over rising

inequalities in access to care could be addressed by

differentiating co-payments according to income

levels while ensuring full co-payment coverage for

chronically ill people. (296)

Types of providers, referral systems and patient

choice;

Public primary health care is provided by a mix of

public and private providers with concessions.

Public providers include health care centres and

health stations, institutions established and owned

by local communities. Private providers are

(293) Source Eurostat Database.

(294) Institute of Macroeconomic Analysis and Development

(2014) Development report 2014. Indicators of Slovenia's

Development. Health expenditure.

(295) OECD Stat 2015.

(296) OECD (2013). 2013 Economic Survey - Slovenia

individual health care professionals working

individually or in group practices offering various

combinations of services and specialties.

The patients can choose the primary care provider

among those who have a contract with the HIIS

and have the right to change them after a year. The personal physician plays the role of the gatekeeper since his referral is necessary to proceed to specialist and hospital care. The referral is not required only in case of chronic diseases or longterm treatment when many consecutive contacts with a specialist are necessary. Moreover, patients can select a private physician of their choice, but must cover all costs out-of-pocket.

Specialist outpatient care is provided in hospitals or private health facilities, while ambulatory services are provided in the polyclinics affiliated with hospitals, in community health centres or in private specialists' offices.

Specialists can also work part time in private and public health centres, based on civil law contracts.

There exist also some private polyclinics, which may or may not have contracts with HIIS and, based on whether or not they hold a contract, paid either in the form of social insurance reimbursement, or as out-of-pocket payments.

Although the number of physicians has been

growing more strongly in recent years, Slovenia's gap with the EU remains significant. In the last decade, the number of practising physicians per 100,000 population has been slowly growing from 225 in 2003 to 263 in 2013 (EU average in 2013 was 344). In the 2000–2012 period, the number of physicians in Slovenia grew on average annually by 1.7%, which is the same as the EU average.

(297)

Slovenia lags the most regarding the number of general practitioners. After Slovenia took certain

measures (298) to strengthen primary health care, in

(297) Institute of Macroeconomic Analysis and Development

(2014) Development report 2014. Indicators of Slovenia's

Development. Health Care Resources.

(298) In 2010 and 2011 Slovenia took certain measures to

strengthen primary health care: (i) the introduction of new teaching outpatient clinics where physicians specialising in general practice can register their patients; (ii) the introduction of so-called reference outpatient clinics where registered nurses assume greater responsibilities; and (iii)

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recent years the number of general practitioners has increased reaching 50 per 100000 inhabitants in 2013, still significantly lower than the EU average (2013: 78.3). (299) This suggests under provision and problems with access to the primary health care, especially in light of the gatekeeper function exercised by the latter. One of the indicators showing the capacity of the primary level to assume a greater workload is the ratio of general practitioners to specialists. On this indicator too Slovenia lags behind the EU average: the proportion of general practitioners in the total number of physicians stands at 19%, compared with 22.5% in the EU. In Slovenia, at the primary level, besides general practitioners, there are also paediatricians and gynaecologists who have their own patients.

The number of nurses, however, is in line with the EU averages (827 per 100000 in Slovenia vs. 837 in the EU). Therefore, Slovenia has adequate opportunities to introduce changes in the

responsibilities of nurses in view of the fact that the number of qualified nurses has been growing in recent years (300) as well as in view of the high ratio of practicing physicians to nurses. The large inflow of nurses to the labour market will have to be regulated by additional systemic measures in both health care (a further transfer of certain duties from doctors to registered nurses) and long-term care (faster development of community nursing care). Given the restrictions on hiring in the public sector, qualified nurses may otherwise have difficulty finding a job. (301)

Due to a lack of providers or long waiting times for some specialised services and surgeries, access to some health care services remains limited.

Specific incentives could be developed to promote and encourage staff to work in some specialities currently in shortage. An increase in the supply of primary-care doctors would allow more extensive gatekeeping and cost-effective prevention in the medium term, though this strategy could boost

additional funding for the primary level of health care

(Ministry of Health, 2012).

(299) Eurostat.

(300) In 2008–2012, on average 445 nurses graduated every year,

12% more than on average in the period 2003–2008.

(301) Institute of Macroeconomic Analysis and Development

(2014) Development report 2014. Indicators of Slovenia's

Development. Health Care Resources.

spending in the short term. Nevertheless, and more

generally, the human resources strategy needs to

tackle staff and population ageing in the future.

To tackle the shortage of doctors at primary level,

particularly in demographic areas with an ageing

population, an analytical document (302) was

prepared in 2013. The medium-term objective of

this document in the next 5 years is to reach a

proportion of 1.500 patients to one doctor at

primary care level.

To achieve this objective, it is estimated that 1,364

GPs would be required at national level, which

requires additional 318 GPs in the next five years.

Since 2013 the Ministry has increased the number

of places available for general practitioners specialisations, in a way, that 66% of available specialisations were intended for general practitioners. The number of available specialisation for general practitioners also increased in 2014 and 2015.

By reducing the proportion of patients to GPs, this is expected to improve not only the quality and safety of patient care, but also to reduce the cost of patient care, due to the gatekeeping function of primary care.

The Ministry of Health is aware also that the existing primary healthcare system, though well organised, urgently needs to be upgraded in order to be able to cope with future challenges. In this context, one of the most important projects is the establishment of “model practices” that will, by upgrading the work of family medicine teams, show the path of development in this area in terms of their organisational structures, services and, not least of all, financial resources. (303)

Reference outpatient clinics are family medicine

outpatient clinics that are, in addition to a junior nurse, reinforced by a graduate nurse (registered nurse) with additional knowledge, which ensures the transfer of competencies from a doctor to a graduate nurse who treats and manages chronic patients. This is a reinforcement of family

(302) "Public network of primary health care in the Republic of Slovenia in the field of general practitioners and paediatricians at the primary level", (2013).

(303) Ministry of Health (2014).

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medicine teams and thus represents basic public health services, which is a priority of health policy. It should result in the improved management of patients with chronic diseases, since part of their care should be taken over by a graduate nurse. A graduate nurse should also cope with some other tasks to be carried out in family practice outpatient clinics, in particular in the area of preventive care and health care in outpatient clinics of the

registered population.

The aim is to convert the majority of family practice outpatient clinics into reference outpatient clinics in a period of 5 to 7 years. From 2011 until 2015, 587 reference outpatient clinics have been set up. The Ministry of health is planning that all general practices would become model practices by 2017.

The organisation of the healthcare network at the primary level and simulations taking into consideration the structure of the population and the number of required healthcare staff (for the purposes of planning human resources) is underway. (304)

There were 27 hospitals in Slovenia in 2013 and a large majority of them were state owned. Although legal provisions allow for establishment of new private hospitals, privatisation remained limited and there have not been significant private investments in health infrastructure.

The capacity of acute care hospitals beds (359 beds per 100 000 inhabitants in 2013) (305), average

length of stay (6.3 days) and the number of inpatient discharges (16.6 per 100 000 inhabitants) are similar to the average figures for the EU (respectively 356 beds, 6.3 days and 16.5 discharges per 10000 inhabitants) and suggest an efficient utilisation of hospital care. However, the number of hospital beds in acute care could be further lowered, as low occupancy and turnover rates point to excess capacity. In a number of countries the decline in the number of acute care hospital beds accelerated in 2010–2011 because of the economic crisis and austerity measures in public health care; at first there was no such response to the crisis in Slovenia. Nevertheless, the number of acute care beds declined in 2012, which

(304) Ministry of Health (2014)

(305) National Institute for Public Health, 2015.

is probably related to the rationalisation of operations in hospitals. The data about the proportion of surgical procedures conducted as day cases is low compared to EU average (10.5% vs. 28.7% in 2011) and, despite recent progress in

increasing the share of surgeries carried out as day cases, more could be done to further develop ambulatory care. (306) This suggests that a strategy to increase day case interventions should be then encouraged also to reduce waiting times for surgery.

In the scope of health care services, the transfer of programmes from acute hospital care to day hospital care or specialist outpatient care is in progress. For this purpose, standards and a diagnosis-related group system are gradually being introduced for treatment in day hospital care.

With regard to the transfer of health care services from hospital inpatient care to ambulatory outpatient care or day care, data have been improving from year to year in Slovenia.

According to data for 2013, the proportion of cataract surgeries carried out as day cases was 89%. For example, 86.1% of carpal canal treatments were carried out as day cases during the

same year. (307) Considered is also the introduction of more systematic monitoring and making necessary changes to the model of payment of providers of specialist services at the secondary and tertiary levels.

Pricing, purchasing and contracting of healthcare services and remuneration mechanisms;

Within each annual financial plan the HIIS defines a maximum overall amount to be spent on health services in the upcoming year. This annual budget is defined in cooperation with the Ministry of Health and the Ministry of Finance, taking into consideration the macroeconomic situation which affects the expected revenues of the system. The national health budget is determined at the national level, with no further geographical disaggregation (local tax revenue is managed separately by local authorities according to their own criteria).

(306) OECD (2013). 2013 Economic Survey - Slovenia

(307) Health Insurance Institute of Slovenia. Annual Report for the Year 2015. (2016).

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The first stage consists of partnership negotiations

with different groups of health care providers and

other stakeholders over the volume of services to

be provided and reimbursed by the HIIS. The

second stage involves the individual providers in

the negotiations with the HIIS on the type and

volume of services that will be provided, the tariffs

for these programmes and services, methods of

payment, quality requirements, the supervision of

the implementation of the contract and the

individual rights and responsibilities of the

contracting parties. The reimbursements are

capped, thus the services provided in excess of the

contracted amounts – however, with some

exceptions - are not paid for. The same applies to

the services which have been contracted but

actually not provided.

Voluntary complementary health insurance is

provided by one mutual insurance company
obliged by law to provide VHI for co-payments
and two profit-oriented private insurance
companies.

Public expenditure on health administration and
health insurance as a percentage of GDP (0.16%)
and as a percentage of current health expenditure
(2.6%) is slightly below the EU average in 2013
(respectively 0.27% and 3.5%). Over the last
decade, major efforts have been done to reduce
administrative costs and improve the general
management of the sector and, given the system's
organisation and regulation, it is important that
they be paired with measures to improve quality
monitoring.

Payment mechanisms and levels are regulated
based on annual contractual arrangements between
the HIIS and health care providers as explained
before. Each programme has an annual budget at
the national level, which is then translated into
caps in budgets for individual providers.

Primary care providers are paid through a

combined system of capitation and fee-for service payments. The reimbursable volume of services is outlined in prospectively determined annual contracts. Half of the value of these services is paid per capita for the patients registered with the physician, while the other half is paid on the basis of fee-for-service, according to the number of services provided.

Outpatient specialist care is remunerated on the basis of fee-for-service, according to an HIIS classification of services, whereas the volume of services provided is outlined in the contracts. In order to promote preventive services and reduce specialists' referrals, one of the eligibility criteria for HIIS payments is the implementation by the providers of prospectively determined volumes of preventive services.

Different payment mechanisms are valid for certain types of services: for non-acute inpatient

care reimbursement is based on prospectively determined number of bed days, for psychiatric

care and rehabilitation programme on

prospectively determined number of cases, dental services on the fee-for service model.

Hospital care is reimbursed according to a Diagnosis-Related Group (DRG) model, which replaced in 2003 the per-case payment system, which consisted in payments for complete inpatient episodes, and as such did not accounted for the differences in severity of cases. It provided a perverse incentive to increase the number of single inpatient admissions. The DRG model is based on a classification of 653 diagnosis-related groups, which are defined by the clinical diagnosis, procedures undertaken and length of treatment. Payment is based on the volume and value of programmes determined prospectively in the contract. The annual volume of a health care programme reimbursable by the HIIS is limited by the budget, and defined on the basis of the respective programme executed during the previous year, adjusted by the additional annual programmes aiming at improving access to health services and the efficiency of providers. The cost

weight used to calculate the value of case-mix is calculated as the relative price of each DRG in comparison to the average DRG price at national level. Since 2005, two procedures, dialysis services and transplantation programme, have been excluded from the prospective DRG model and reimbursed retrospectively on the fee-for-service and per-case basis respectively.

The diagnosis-related group system was updated on 1 January 2013 by introducing the Australian modification to the International Classification of

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Diseases ICD-10-AM and the Classification of Diagnostic and Therapeutic Procedures. (308)

The hospitals' employees are salaried under general rules, with some specialists having a special health care contract.

The market for pharmaceutical products

In 2013 pharmaceutical spending accounted for

1.34% of GDP and 21.7% of public health care

expenditure, slightly above the average figures for the EU (1.5% and 17.1% respectively).

An international pricing system determines exfactory prices with respect to the level in comparable EU Member States, while internal reference pricing uses the national system of reference prices for mutually interchangeable pharmaceuticals. The system is based on generic substitution of products officially recognised as mutually interchangeable (based on their essential similarity) and listed in a national list of substitutable pharmaceuticals. The lowest drug price in the same group will be used as reference price.

Members of a special committee, formed of experts from various health care fields, decide the levels of reimbursement based on cost-benefit analyses and available financial resources. A positive list details pharmaceuticals that are reimbursable (75% reimbursed by the compulsory insurance and the rest either by complementary insurance either by out-of-pocket payments).

Each physician has a prescribing number in order to control the volume and the type of pharmaceuticals prescribed. Appropriate penalties can be issued by the HIIS to contracted physicians in case of irregularities.

The impact of systemic measures on the cost control of medicinal products since 2006 is as follows: the proportion of costs for medicinal products with respect to overall health care expenditure in 2006 was 21.7% (the proportion accounted for by compulsory health insurance was 15.9%); in 2011, this figure fell to 20.1% (of which compulsory health insurance accounted for 13.2%) with respect to overall health care

(308) The Ministry of Health (2014). expenditure. Lowering costs through the aforementioned measures – particularly for generics and innovative medical products (with expired patent protection) – facilitated the financing of new innovative medicinal products for which there is no alternative on the market. In order to ensure the entry of new innovative

medicinal products on the market, additional systemic measures are being introduced, such as: joint public contracts for the purchase of specific medicinal products in hospitals, therapeutic equivalents for non-hospital treatment with medicinal products and the introduction of compulsory discounts for certain groups of medicinal products financed from public funds.(309)

Use of Health Technology Assessments and cost-benefit analysis

Health technology assessment (HTA) is performed at a very basic level. An important step forward has been the launch of a programme for the standardisation of equipment and the introduction of technical guidelines. In 2005, a standard procedure for assessing and implementing new or adapted health care programmes and other new methods of work among the programs of health care was introduced. It was revised then in 2009.

In 2010 the Ministry of Health started with activities to set up an HTA network for the

organised and systematic assessment of health care

technologies (old and new) for all submitted health

technologies proposals.

eHealth and health-system information and

reporting mechanisms;

The national eHealth project includes different

electronic solutions with a strategic goal to

increase the quality and efficiency of the health

system, including better planning and management

of health care organisations and the health system

as a whole.

A significant progress in the field of eHealth was

made in 2015 and national implementation is

continuing in 2016. An important amendment to

the legislation that deals with the databases

containing medical data was adopted in 2015,

(309) The Ministry of Health (2014).

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which was key for implementation of deliverables

of the national eHealth project.

All hospitals, healthcare centres and pharmacies are connected to the healthcare network that enables secure and reliable communication between them.

The central register of patient data (a solution that enables exchange and shared use of medical documents) currently enables access to over 1.3 million documents for over 400.000 patients and thus enables health professionals to save time and make medical decisions based on accurate data (mainly discharge letters and ambulatory results).

Legal and technical basis for patient summary that was defined according to the (EU) eHealth network guidelines was established in 2015. The collection of patient summaries will start in the second half of 2016.

ePrescription was launched nationally in November 2015. More than 70% of prescriptions are already prescribed electronically. The main advantage of the system is a possibility for doctors and pharmacists to check interactions and contraindications of the prescribed medicines.

The national implementation of a central

information system for collecting data from all waiting lists was launched at the end of 2015, more than 75% of healthcare providers already sent data about all patients waiting for the medical service.

Enabling eBooking of medical services is already mandatory for all healthcare providers on a secondary and tertiary level. eReferral and mandatory eBooking of medical service made by the family doctor (or nurse) will start in the first half of 2016.

A "telestroke solution" (i.e. a system that enables a remote consultation and examination of the patient with a suspected brain stroke through a video conference system) is in full use.

Some other, minor solutions that provide valuable data are also in full use (collecting quality

indicators of medical care from all family medicine 'model' practices is in place from the beginning of 2015, a portal for safe exchange of radiology picture material is enabled and in use, an application for doctors for terminologies is in place) and a patient portal that will enable a patient

to see his/her own medical data will be published

in 2016.

Health promotion and disease prevention

policies

Health promotion and disease prevention is mainly

done through State's and HIIS's large scale

programmes, GPs and nurses thanks to a strong

emphasis given on health promotion and disease

prevention during education and employers for

occupational diseases. In 2013, public expenditure

on prevention and public health services as a % of

GDP (0.23%) and as a percentage of total current

health expenditure (3.7%) is above the EU average

(0.19% and 2.5% respectively). The most recent

health promotion campaigns included (310);

tackling regional health inequalities, HIV/AIDS

prevention, anti-smoking and alcohol policy, food

and nutrition, enhancing physical activity,

improving mental health and reducing all forms of

addiction or dependency. Vaccination rates for

diphtheria, tetanus pertussis are high (95%). (311)

The proportion of screening rates for cervical

cancer is also quite high (72.1% of the target

population in 2015. (312)

Recently legislated and/or planned policy

reforms

Improving health care and maintaining its financial

sustainability is high on political agenda. Work is

ongoing towards the implementation of a reform of

the healthcare sector. The economic crisis, rising

unemployment, insufficient financial resources and

ageing population were main triggers for

reforming the health care system. In June 2013 the

Ministry of Health opened a public debate on the

new legislation proposal on health care. At the

same time the proposal of the new public health

services development strategy was launched for

the public debate.

The combination of compulsory and

complementary health insurance, which are the

main financial sources for financing health care, is

insufficient and not in line with guidelines of

social welfare policy. Importantly, the current

system is based on sources of financing

(310) National Institute of Public Health and Ministry of Health.

(311) OECD. health at glance 2015.

(312) Oi Ljubljana, 2015.

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(contributions) that are subject to cyclical fluctuations, and do not guarantee sustainable financing in the future. Work was put into providing financial projections and scenarios of abolishing complementary health insurance and introducing other/alternative ways of solidaritybased financing schemes..

Changes are envisaged also in the field of health

care provider network (mainly hospitals), their management, organisational structure and accountability.

One envisaged reform is the broadening of contribution rates to certain new types of revenues with the aim of equalising the financial burden and diminishing large differences in contribution rates among specific groups of insured persons or better

balancing the burden on the insured based on the widest possible social consensus. Some steps in this direction were done in 2013 with the adoption of the amendments to the "Health Care and Health Insurance Law". Contribution rates of some groups of the population (self-employed, farmers etc.) were raised, so that partial broadening of contribution bases was introduced.

The findings from the analysis of the health care system undertaken in cooperation with the World Health Organisation and the European Observatory on Health Systems and Policies will shape the reform. On the basis of the analysis, the "National Health Care Resolution Plan 2016-2025" was approved by the government in December 2015 and was adopted by Parliament in March 2016. In the "Resolution on National Health Care Plan 2016-2025": Together for a society of health" it is anticipated that the Ministry of Health will ensure an appropriate way of planning human resources in health care, that would in addition to the needs of the population also take into account the changing

demographic structure. Special attention will be dedicated to the balance of health care professionals, by transferring certain competences and responsibilities between occupational groups and introducing new content in line with developments in medicine and other health professions. Therefore the following measures are currently planned:

- Action 1: To establish a system for monitoring human resources in the health care system and national register of health professionals.
- Action 2: To adopt a national plan for the development and management of human resources in the health sector and the relevant legislation.
- Action 3: In cooperation with local communities to introduce incentives for work in the areas of employment less attractive.

Based on the resolution, it is expected that the "Health Care and Health Insurance Act" will be in public discussion in autumn 2016 and adopted in 2017. This will focus on the issues of financing and

sustainability of the healthcare system, on
improving payment and purchasing practices with
focus on efficiency and quality and on reorganising
the system of long-term care.

In 2015, the Ministry of Health started a pilot
project in the area of waiting times. The project is
ongoing and it is anticipated that it will last until
June 2016. Emerging results from the pilot will be
translated into system changes and incorporated
into legislation. Further planned changes concern
the "Patient Rights Act and Rules" on the
management of waiting lists and on maximum
allowed waiting times by health service. The
implementation of the eBooking of medical
services a uniform base will be established to
manage waiting lists.

In addition, the Ministry of Health has launched
and/ or designed a number of proposed measures,
also in line with the "National Health Care Plan"
with a focus on health promotion and disease
prevention. The national programme on nutrition
and physical activity was adopted in July 2015 and

implementation is in progress. In the same direction is the recent adoption of the "Dementia Strategy". The aim of the strategy is to ensure preventive measures, early diagnosis and appropriate standard of health and social protection and medical care for people with dementia.

A system of "family medicine model practices" was launched at the primary healthcare level in 2011, and expected to cover all practices by end 2018, is currently being implemented to strengthen preventive approaches in primary care and lower the pressure at a secondary healthcare level.

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With the objective to reduce lifestyle-related noncommunicable diseases, the project "Towards better health and reducing inequalities in health" was launched to strengthen the public health role of primary healthcare centres. All age groups are included with the special focus on vulnerable

groups and pilot testing has already started. To the same end, to tackle the above average economic burden of tobacco use, the Ministry of Health put a proposal of the new "Restriction of the Use of Tobacco and related Products Act" under public discussion.

Further proposals concern pharmacies and their regulation. The proposed legislation aims at ensuring better regulation of pharmacies and the cost-effectiveness of the system. On the hospital level, seamless care and clinical pharmacy are envisaged to optimise the prescription of medicines and to achieve better compliance and safety for patients.

Challenges

The analysis above shows that a wide range of promising reforms has been implemented in recent years to strengthen the efficiency of care provision and cost control. In addition, the Slovenian health care system has recently undergone a comprehensive review highlighting critical areas of improvement that should shape planned reforms

in the sector. Based, amongst others, on emerging

results, the main challenges for the health system

emerge as follows:

- To continue increasing the efficiency of health

care spending, promoting quality and

integrated care as well as focussing on costs in

view of the increasing health care expenditure,

which is a challenge to the fiscal sustainability

over the coming decades (for instance

furthering the efforts in the area of prevention).

To this end, to promote public procurement as

a means to rationalise expenditure.

- To improve the basis for more sustainable and

efficient financing of health care in the future

(e.g. considering additional sources of general

budget funds), aiming at a better balance

between resources and spending, as well as the

number of contributors and the number of

beneficiaries. This implies tackling the lack of

sufficient in-built automatic stabilisers,

especially in view of the need to re-consider

the role of complementary health insurance as a

driver of excess demand and avoidable costs.

- To tackle the excessive use of specialist and

hospital care by strengthening the role of the

primary care sector and family doctors as

gatekeepers and the coordination and

integration of care among different health care

levels, while ensuring adequate coverage both

in urban and in rural areas. To this end to

enhance processes and procedures along

patients' care pathways. To promote the use of

quality indicators and patient oriented measures

for health care procedures.

- To further the efforts to contain long waiting

lists for some health care services by a more

efficient allocation of human and capital

resources between sectors and specialisations

through active purchasing of services by public

health insurance institute and by promoting day

cases for surgical procedures. To this end,

promote the use of ICT in the gathering,

storage, use and exchange of health

information.

- To foster the process of modernisation, specialisation and competition among hospitals, for example by allowing for selective contracting of hospitals by health insurance funds, and extending legal possibilities for quality-based financing of hospital care services. To improve reimbursement mechanisms that create incentives to increase efficiency, including improving the current DRG system to better reflect actual costs. To this end, consider whether remuneration mechanisms of hospital staff and management could be better linked to performance, for instance with the implementation of pay-for-performance (P4P) schemes.

- To gradually increase the use of costeffectiveness information in determining the basket of goods (by using HTA) and the extent of cost-sharing.

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Table 1.25.1: Statistical Annex – Slovenia

(1) All the figures under EU-latest national data are computed as weighted averages. Source: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 26 28 29 32 35 38 36 36 37 36 36 9289 9800 9934

GDP per capita PPS (thousands) 21.1 22.1 22.8 23.4 24.0 23.7 20.5 21.1 21.3 21.3 21.0 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 2.9 4.4 3.8 5.5 6.4 3.2 -8.8 0.9 0.5 -2.7 -1.2 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 3.5 0.8 3.9 4.5 1.0 9.6 0.8 -2.7 0.0 2.9 -3.4 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 8.7 8.4 8.4 8.3 7.9 8.4 9.2 8.9 8.9 9.4 9.2 10.4 10.1 10.1

Total current as % of GDP 8.1 8.0 8.0 7.8 7.5 7.9 8.6 8.6 8.6 8.7 8.7 9.8 9.6 9.7

Total capital investment as % of GDP 0.5 0.4 0.4 0.5 0.4 0.5 0.6 0.3 0.3 0.6 0.5 0.6 0.5 0.5

Total per capita PPS 1323 1377 1455 1552 1635 1875 1954 1875 1897 1952 1901 2828 2911 2995

Public as % of GDP 6.2 6.1 6.1 6.0 5.7 6.2 6.8 6.6 6.5 : 6.6 8.1 7.8 7.8

Public current as % of GDP 5.9 5.8 5.8 5.7 5.3 5.8 6.3 6.3 6.3 6.3 6.2 7.9 7.7 7.7

Public per capita PPS 882 941 995 1044 1089 1271 1300 1293 1398 : 1361 2079 2218 2208

Public capital investment as % of GDP 0.3 0.3 0.3 0.3 0.3 0.4 0.5 0.3 0.3 : 0.4 0.2 0.2 0.1

Public as % total expenditure on health 71.6 73.1 72.6 72.3 71.9 73.9 73.7 74.0 73.7 : 71.6 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 14.1 14.0 14.0 14.2 13.9 14.1 14.6 14.0 13.8 14.6 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 99.0 99.0 99.0 99.0 99.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

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Out-of-pocket expenditure on health as % of total expenditure on health 12.7 12.3 13.2 12.5 13.8 12.8 12.7 12.7
12.2 11.9 12.1 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 2.0 2.0 2.0 2.0 2.0 2.0 2.0 2.0 2.1 2.1 2.1 502.1 504.5 506.6

Life expectancy at birth for females 80.3 80.8 80.9 82.0 82.0 82.6 82.7 83.1 83.3 83.3 83.6 82.6 83.1 83.3

Life expectancy at birth for males 72.5 73.5 73.9 74.5 74.6 75.5 75.9 76.4 76.8 77.1 77.2 76.6 77.3 77.8

Healthy life years at birth females : : 60.1 61.0 62.3 60.9 61.5 54.6 53.8 55.6 59.5 : 62.1 61.5

Healthy life years at birth males : : 56.4 57.7 58.7 59.4 60.6 53.4 54.0 56.5 57.6 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 93 85 76 68 73 77 82 73 160 158 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 4.0 3.7 4.1 3.4 2.8 2.4 2.4 2.5 2.9 1.6 2.9 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.34 2.31 2.27 2.15 2.06 2.31 2.56 2.58 2.61 : 2.47 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.18 0.18 0.19 0.17 0.17 0.20 0.21 0.21 0.21 0.20 0.18 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.04 2.00 2.04 2.04 1.97 2.01 2.07 2.06 2.06 : 2.13 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.76 1.73 1.74 1.69 1.54 1.54 1.73 1.75 1.72 : : 1.60 1.55 1.44

Therapeutic appliances and other medical durables 0.24 0.22 0.22 0.20 0.22 0.25 0.30 0.31 0.30 0.29 0.29 0.31
0.31 0.32

Prevention and public health services 0.29 0.30 0.30 0.30 0.29 0.30 0.32 0.33 0.34 : 0.33 0.25 0.25 0.24

Health administration and health insurance 0.42 0.35 0.29 0.35 0.38 0.34 0.38 0.30 0.30 0.17 0.34 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.12 2.10 2.03 1.92 1.82 2.05 2.28 2.29 2.32 : 2.14 2.73 2.61 2.62

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Day cases curative and rehabilitative care 0.17 0.16 0.18 0.17 0.16 0.19 0.20 0.20 0.19 0.19 0.17 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.26 1.23 1.26 1.32 1.22 1.32 1.39 1.39 1.42 : 1.49 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 1.07 1.06 1.06 1.04 0.92 0.92 1.00 0.98 0.96 1.37 1.34 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.05 0.04 0.04 0.04 0.04 0.04 0.04 0.04 0.05 0.05 0.06 0.06 0.13 0.12 0.13

Prevention and public health services 0.23 0.23 0.22 0.22 0.21 0.22 0.25 0.25 0.25 0.24 0.23 0.25 0.20 0.19

Health administration and health insurance 0.23 0.20 0.18 0.17 0.16 0.16 0.18 0.17 0.16 : 0.16 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.25.2: Statistical Annex - continued – Slovenia

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(1) All the figures under EU-latest national data are computed as weighted averages. Source: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 28.9% 29.0% 28.5% 27.6% 27.5% 29.3% 29.8% 30.1% 30.5% : 28.3% 31.8% 31.3% 31.1%

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Day cases curative and rehabilitative care 2.2% 2.2% 2.4% 2.2% 2.3% 2.6% 2.5% 2.4% 2.4% 2.3% 2.1% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative care 25.2% 25.1% 25.6% 26.2% 26.3% 25.5% 24.1% 24.0% 24.1% : 24.5%
23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 21.7% 21.7% 21.9% 21.7% 20.6% 19.5% 20.1% 20.4% 20.1% : :
16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 3.0% 2.7% 2.7% 2.6% 2.9% 3.2% 3.5% 3.6% 3.6% 3.4% 3.4%
3.2% 3.3% 3.3%

Prevention and public health services 3.6% 3.8% 3.8% 3.9% 3.9% 3.8% 3.7% 3.8% 4.0% : 3.8% 2.6% 2.6% 2.5%

Health administration and health insurance 5.2% 4.4% 3.6% 4.5% 5.1% 4.3% 4.4% 3.5% 3.5% 1.9% 3.9% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 36.1% 36.1% 34.9% 33.9% 34.2% 35.5% 36.4% 36.5% 37.1% : 34.7%
34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 2.8% 2.8% 3.2% 2.9% 3.1% 3.3% 3.2% 3.1% 3.1% 3.0% 2.8% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative care 21.4% 21.2% 21.6% 23.3% 22.9% 22.9% 22.2% 22.2% 22.7% : 24.0%
22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 18.2% 18.2% 18.2% 18.4% 17.3% 15.9% 15.9% 15.6% 15.4%
21.9% 21.7% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 0.8% 0.7% 0.7% 0.7% 0.7% 0.7% 0.7% 0.8% 0.8% 1.0% 0.9%
1.6% 1.6% 1.6%

Prevention and public health services 3.9% 4.0% 3.8% 3.9% 3.9% 3.8% 4.0% 4.0% 4.0% 3.9% 3.7% 3.2% 2.7%
2.5%

Health administration and health insurance 3.9% 3.4% 3.1% 3.0% 3.1% 2.8% 2.8% 2.8% 2.6% : 2.6% 1.4% 3.5%
3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants : : : 0.55 0.60 0.69 0.69 0.73 0.83 0.88 0.87 1.0 1.1 1.0

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Angiography units per 100 000 inhabitants : 0.4 0.5 0.5 0.5 0.5 0.6 0.9 0.9 0.8 0.8 0.9 0.9 0.8

CTS per 100 000 inhabitants : 0.9 1.0 1.0 1.1 1.2 1.2 1.3 1.3 1.3 1.2 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : 0.1 0.1 0.0 0.0 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1

Proportion of the population that is obese : : : : 16.4 16.8 : : : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker : : 23.0 18.5 18.9 18.7 : : : 20.5 : 23.2 22.4 22.0

Alcohol consumption litres per capita 11.5 12.3 13.5 12.3 11.0 10.9 10.5 10.3 10.6 11.0 9.5 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 225 230 235 236 239 240 241 243 249 254 263 329 335 344

Practising nurses per 100 000 inhabitants 735 740 748 760 775 788 803 819 833 816 827 840 812 837

General practitioners per 100 000 inhabitants : : 38 38 41 41 42 44 45 47 50 : 78 78.3

Acute hospital beds per 100 000 inhabitants 401 385 388 384 378 383 371 368 369 362 359 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 6.9 : : 6.6 6.7 6.7 6.6 6.4 6.5 6.3 6.5 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants : 15.5 15.4 16.0 16.2 16.2 16.6 16.3 16.6 : : 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : 1,665 2,026 2,142 2,243 2,484 2,566 2,229 1,950 : : 6368 6530 7031

Acute care bed occupancy rates 68.0 73.0 70.0 72.0 70.0 71.5 71.2 69.7 68.9 68.8 67.9 72.0 73.1 70.2

Hospital curative average length of stay 6.1 6.2 5.8 5.8 5.5 5.7 5.6 5.5 6.8 7.0 6.3 6.5 6.3 6.3

Day cases as % of all hospital discharges : 9.7 11.7 11.8 12.1 13.3 13.4 12.0 10.5 : : 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 5.7 5.9 6.4 6.8 6.9 6.8

AWG risk scenario 5.7 6.1 6.8 7.3 7.5 7.5

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Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 2.1 2.1 2.1 2.1 2.1 2.0

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-1.0 3.1

1.2 0.9

1.9 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, Spain had a GDP per capita of 24.1 PPS

(in thousands), below the EU average of 27.9.

Population was estimated at 46.4 million in July of

2015 (313). After increasing steadily for past years,

it has started decreasing in 2012 due to ageing.

Total and public expenditure on health as % of

GDP

Total expenditure (314) on health as a percentage of

GDP (8.9% in 2013) has increased over the last decade (from 8.2% in 2003), but is still below the EU average (315) of 10.1% in 2011. Public expenditure has increased though to a smaller extent: from 5.7% in 2001 to 6.3% of GDP in 2011. It is also below the EU average of 7.8% in 2013.

When expressed in per capita terms, total spending on health at EUR 2,085 PPS in Spain is below the EU average of 2,988 in 2013. So is public spending on health care: EUR 1,468 PPS vs. an average of EUR 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, from 2013 to 2060 health care expenditure is projected to increase by 1.1 pps of GDP above the average growth expected for the EU of 0.9 pps of GDP, according to the AWG reference scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.9 pps of GDP from now until 2060

(EU: 1.6).

(313) Data source:

http://www.ine.es/inebaseDYN/cp30321/cp_inicio.htm

(314) Data on health expenditure is taken from OECD health data

and Eurostat database. The variables total and public

expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(315) The EU averages are weighted averages using GDP,

population, expenditure or current expenditure on health in

millions of units and units of staff where relevant. The EU

average for each year is based on all the available

information in each year.

Overall, for Spain no significant short-term risks of

fiscal stress arise, though some variables point to

possible short-term challenges. Risks appear, on

the contrary, to be high in the medium term from a

debt sustainability analysis perspective (2026). No

sustainability risks appear for Spain over the long

run notably thanks to reforms containing long-term

expenditure pressures, in particular pension

expenditures.

Health status

Life expectancy at birth (86.1 years for women and 80.2 years for men in 2013) and healthy life years (63.9 years for women and 64.7 years for men) are among the highest in the EU and well above the respective EU averages (83.3 and 77.8 years of life expectancy in 2013, 61.5 and 61.4 in 2013 for the healthy life years). (316) An infant mortality rate of 2.7 per thousand is lower than the EU average of 3.9% in 2013, having gradually fallen over most of the last decade (from 3.9% in 2003).

As for the lifestyle of the Spanish population, the data indicates a considerable fall in the proportion of the regular smokers (from 28.1% in 2003 to 23.9% in 2011), although the share is still above the EU average of 22.4%. Over the same period the proportion of the obese in the population has increased (from 13.1% in 2003 to 15.7% in 2008 and 16.6% in 2011), while the alcohol consumption shows a very small reduction from 10.2 litres per capita in 2003 to 9.8 litres in 2010.

System characteristics

Overall description of the system

The Spanish health **care** system is fully devolved to the regions. Despite the decentralised character of the system, eligibility depends on the general regulations of the Central government.

Autonomous communities (ACs, i.e.: regional governments) are in charge of the process of accreditation of coverage which is decided in each case by the Social Security authorities dependent on Central government. All of them respect the principle of universality of health **care** in the

(316) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and Eurostat database.

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framework of the Spanish Constitution and State

General Health **Care** and Social Security Laws, extending it not only to the Spanish citizens contributing financially to the system, but also to

EU temporary residents and non-residents (non-EU residents, including illegal immigrants are not fully covered) . There is also a Common Basket of services of the National Health System that has to be delivered to the whole population covered.

Coverage

Through the Royal Decree 16/2012, the Spanish health system was reformed to cover those who are insured as part of the system (including both Spanish and overseas citizens). This covers workers affiliated with the Seguridad Social, pensioners as well as recipients of social benefits.

Coverage can also be provided, if requested, to non-insured Spanish, EU and EEA citizens who are legal residents in Spain whose annual income is below 100,000 euros and who are not covered by any other health insurance. Illegal non-EEA immigrants are only covered free of charge for emergency care, with the exception of children and pregnant women, who are fully covered.

Administrative organisation and revenue collection mechanism

The system is a unique combination of central,

regional and local management and financing of

health care. It is mostly tax-funded. Public

expenditure accounts for 70.4% of total

expenditure on health, out-of-pocket expenditure

22.8% and the rest is private health insurance

(2013 figures).

The reform in 2001 marked the finalisation of the

devolution process, which meant that all of the 17

regions were granted complete freedom to manage

their own health services. Health funding was

integrated within the general financing system

through tax cession; and ear-marking of funds was

phased out. The new system since the 2009 reform

(317) follows the same structure of regions

financing implemented in 2001 aimed at

reinforcing the basic principles: elements of

taxation ceded to regional administrations and

(317) Law 22/2009 that regulates the financing system of

Autonomous Communities of common regime and Cities

with Autonomic Statute.

assignments from the state's general budget. As a

result of this reform, 90% of regional revenues

stem from taxes.

Under the 2009 reform the financing of health

services is as follows:

Specified shares of taxes are ceded to the ACs:

50% of personal income tax and VAT and 58% of the main excise taxes (hydrocarbons, alcohol, and tobacco). The system since 2001 includes regional direct control over taxes on gifts and inheritances, properties and property transfers and gambling taxes. ACs can also raise their own taxes.

The Fundamental Public Services Guarantee Fund

guarantees that health care, education and social services are equally provided regardless the place of residence. It is made up of 75% of the taxes ceded to ACs plus state transfer. This is distributed to ACs on the basis of population, extension, dispersion, insularity (as before) plus the equivalent protected population (split into subgroups by age).

The Global Sufficiency Fund guarantees that ACs have enough resources to finance all their competences. It is fully financed by the central

government. Consequently, ACs can use the remaining 25% of ceded taxes plus this State fund to meet their competences.

Finally, in order to promote economic convergence and development of those ACs with lower income per capita, the system relies on two new Convergence Funds fully financed by the Spanish state's budget transfers (the Competitiveness Funds and the Cooperation Funds), over which the central administration holds more discretion.

At the central level the Ministry of Health is responsible for: general coordination and basic health legislation; definition of benefits package guaranteed by the NHS; pharmaceutical policy and medical education, while the Inter-territorial Council of the NHS has a coordination role. At regional level, the ACs hold health planning powers and the capacity to organise their own health services in their regions.

The level of expenditure on administration is relatively low. Public and total expenditure on health administration and insurance as a

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percentage of GDP (0.14% and 0.27%) are below the respective EU averages (0.27% and 0.47% respectively in 2013); so is public expenditure (2.3%) on health administration and health insurance as a percentage of total public current health expenditure (EU average of 3.5% in 2013).

Budget control is performed the same as in any other public institution. However, in the public health sector the usual tool for management is that of contract-programmes or management contracts.

In the health system these contracts have the following general characteristics: they define the quantitative and qualitative objectives, the budget and the evaluation system. The time period referred to in the contracts tends to be one year.

The contracts are made between the Regional Ministries and the Health Services, and between the Health Services governing bodies and the health care areas or facilities.

Role of private insurance and out of pocket

co-payments

Private expenditure and out-of-pocket expenditure

constitute respectively 29.6% and 22.8% of total

expenditure on health in 2011. The share of out-of-pocket

payments shows a slightly declining path

(23.8% in 2003) up to a low of 19.2% in 2009 but

has steadily increased since then up to 22.8% in

2013 and remains above the EU average of 14.1%.

This is partly due to the 2012 reform to

pharmaceutical co-payments explained in more

detail below. Since primary and specialist care

services are provided without cost sharing, out-of-pocket

spending accounts mainly for cost-sharing

in the area of pharmaceuticals, medical aids and

prostheses, optical and dentist services, as well as

private use of private medical and hospital

services.

Cost-sharing from patients is limited to medicines.

The structure of pharmaceutical co-payments has

been reformed in 2012 and has different features

for pensioners and non-pensioners, although in

both cases there are three bands according to

income (below EUR 18,000 annual income,

between EUR 18,000 and EUR 100,000 and above

EUR 100,000). Non-pensioners need to pay 40%,

60% and 80% of the price of medicines, with no

upward limit. Pensioners pay 10% for the first two

bands and 60% for the upper band, with an upward

monthly limit of 8, 18 and 60 EUR. There are

exemptions for those people on some social

benefits, in receipt of non-contributory pensions,

disabled, unemployed not on receipt of

unemployment benefits and persons who have

suffered occupational accidents. There is no

reimbursement system; patients pay their share at

the pharmacy which bills the rest to regional health

services.

Civil servants' mutual funds require co-payments

of 30% of the price of pharmaceuticals from all

their beneficiaries (including the retired ones).

Particular groups are always exempt from the full

co-payments: AIDS patients and chronic diseases

(both 10%, with EUR 2.64 ceiling).

In addition, the concerns voiced regarding the

length of the waiting lists have resulted in the

implementation of indicators and minimum basic

and (countrywide) common requirements for

waiting lists for specialists, diagnostic and

therapeutic trials and surgery.

Types of providers, referral systems and patient

choice

The Spanish health care system is focused on

primary and ambulatory care. Primary health care

(PHC) is an integrated system composed of PHC

centres and multidisciplinary teams providing

personal and public health services in well-equipped

centres. PHC is provided by general

practitioners (GPs) and primary health care

paediatricians, who play an important role as

gatekeepers and referral points to specialists.

These in turn refer patients to hospital care. Single-handed

practices are restricted to small villages

and to the private sector. PHC is to a great extent

publicly funded and run. (318) Inpatient care is

provided in hospitals which are mostly publicly

owned. The NHS also contracts services from

private non-profit providers.

The number of practicing physicians per 100 000

inhabitants (381 in 2013) is above the average in

the EU (344 in 2013). In Spain, GPs are a type of

specialist (Family and Community Medicine).

There are about 75 GPs per 100 000 inhabitants,

below the EU average (78.3 in 2013). The average

(318) The only public-private mix is the formula of health

associations used in Catalonia by delegating powers to

private companies within certain geographic areas.

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number of consultations per inhabitant per year

(frequentation) (319) is, at 7.4, above the EU

average of 6.2 (2011).

The number of practising nurses at 514 per

100,000 inhabitants in 2013 shows a significant

increase (431 in 2003) but is far lower than the EU

average (average of 837 in 2013). It should also be

noted that the ratio of nurses to physicians is 1.34

in the latest available year, one of the lowest in the

EU (average 2.4), indicating a likely imbalance in

the health care workforce.

Given two-stage referral procedure (GP-specialist-hospital)

access to inpatient care is closely

controlled. This has allowed authorities to reduce

capacity and activity of hospitals over the last

decade. In 2013, overall capacity of hospitals was

considerably lower than in most other EU

countries, with 228 acute hospital beds per

100,000 inhabitants, compared to the EU average

of 356 beds.

Inpatient hospital discharges per 100 inhabitants in

2013 were, at 9.9, below the EU average of 16.5.

There were 6,465 day case discharges per 100,000

inhabitants in 2013, below the EU average of

7,031. As a result, the ratio of day cases to longer

stays is amongst the highest in Europe, evidence of

a relatively efficient use of hospital resources.

Acute care bed occupancy rates in 2011 were

75.8%, slightly above the EU average of 70.2%.

Average length of stay has fallen from 6.9 in 2003

to 6.1 in 2013, slightly below the EU average of

6.3.

This is a reflection of the progressive shift towards

ambulatory specialised care, which is resulting in procedures being performed without overnight stay that previously required admission to the hospital.

Such an increase in day-hospital places is found in both absolute numbers and in rates per 100,000 inhabitants. Note that in terms of hospital activity 39.4% of all discharges are day case discharges, far above the EU average of 30.4% in 2013.

(319) National Health System of Spain Annual Report 2011, page 36;

https://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/informeAnualSNS2011/Informe_anual_SNS_2011.pdf

f/equidad/informeAnualSNS2011/Informe_anual_SNS_2011.pdf

This however puts pressure on the GP to act as effective gatekeeper and also to co-ordinate the care received by patients effectively.

Treatment options, covered health services

There is a Common Basket of services of the National Health System that has to be delivered to the whole population covered. Beyond that, specific additional services may be provided by

different regions to their citizens.

Price of healthcare services, purchasing,

contracting and remuneration mechanisms

Primary health care staff are paid a salary plus a capitation component (amounting to 15% of the total), which takes into account the demographic structure and the geographical dispersion of the population covered by their services.

Hospital doctors and specialists in ambulatory care units have a status similar to that of civil servants and are almost exclusively paid a salary. Both GP and hospital doctors have an additional component for professional development (professional career), and in some cases, a small additional productivity component related to performance. Other health

care professions (nurses, midwives, social workers and public health professionals) are paid by salary as well.

The basic salary is regulated by the national government, although each AC has the right to vary some additional components.

Public hospital funding is generally carried out

prospectively through negotiation of a contract programme between the hospital and the regional authority third-party payer, setting out the objectives (in quantity and quality) to be achieved by the hospital and assigning financial resources to these objectives. The purchasing institution then monitors the contracts according to the agreed timetable. Until the 1990s a traditional retrospective reimbursement with no prior negotiation was a routine mechanism. Then, from 1991 first aggregate measures of activity (e.g. weighted health care unit) were defined which enabled comparison among hospitals. Over recent years some attempts have been made to develop a more sophisticated prospective payment system based on diagnosis-related groups or Patient

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Management Categories. Some elements have been adopted in a few autonomous communities so far, but no general trend can be specified. Public

hospitals are also allowed to have another, albeit minor, source of financing, by providing services to people or schemes not covered by the NHS. On the other hand, hospitals functioning outside the NHS may provide services to the public system, which are specifically regulated by individual agreements or contracts.

The market for pharmaceutical products

The Spanish pharmaceutical market is the fourth largest in the EU-28 and eighth in the world by value.

The pharmaceutical market is dominated by the state who is the main actor, responsible for regulating and authorising clinical trials, controlling the advertising of drugs, regulating the quality and manufacturing of pharmaceutical products, fixing the price of drugs, setting copayments and establishing the list of publicly financed medicines. Once authorities decide on which products are to be reimbursed, they regulate the price of reimbursed products. The initial price decision is based on clinical performance, the cost

of existing treatments, cost-plus calculations and international prices. International price referencing is based on ex-factory prices of all EU countries. Spain also uses reference pricing for reimbursement: the reimbursement level is the lowest price, calculated by cost of treatment/day for all the drugs of the same group. (320) The reference pricing mechanism in Spain tries to give a signal to the market by the regulator, aiming at manufacturers adapting their prices. Some other regulations (profit and commercial margins, limited operating hours) have been adopted to contain costs increase. Discounts and price freezes and cuts are some mechanisms used to directly control expenditure. (321) The use of generic medicaments has increased in recent years since the regulation regarding the reference pricing system was adopted in 2003 which meant important public savings.

(320) Royal Decree Law 4/2010, March 26th

(321) See "Analysis of differences and commonalities in pricing and reimbursement systems in Europe", Jaime Espin and Joan Rovira, 2007 for DG Enterprise and Industry.

Pharmaceutical regulation is an exclusive responsibility of the national administration, though the role of autonomous communities in modulating consumption is paramount, given their full responsibility for pharmaceutical management (through programs to improve prescription's quality and the relationship with pharmacists).

Total and public expenditure on pharmaceuticals (1.6% and 0.86% of GDP in 2013) have fallen from their 2010 peaks of (1.77% and 1.28%). Both are close to the EU average, with public expenditure being slightly lower and total expenditure slightly higher. Pharmaceutical spending as a proportion of public health spending fell from 22.3% in 2003 to 13.7% in 2013, still above the EU average of 12.5%. Surprisingly, although there was a marked fall in outpatient pharmaceutical expenditure after the economic crisis, hospital pharmaceutical expenditure, which was less closely monitored by the authorities, continued to increase over this period. The Spanish authorities have now required disclosure on

hospital expenditure data from the regions, a

welcome step that will increase transparency in

this sector.

The regions have implemented several measures to

promote generics prescription among physicians.

However, despite these efforts in 2012 the generic

market remains less developed than in other EU

countries, with a generic penetration by value of

18.4 % and by volume of 39.7 % in 2012

(compared with 21% and 54% respectively for the

EU as a whole).

Use of Health Technology Assessments and

cost-benefit analysis

Health Technologies Assessment (HTA) is present

both at national and regional level. The recent

creation of the platform of HTA agencies (

AUnETS) has marked a turning point in the

direction of fostering coordination and synergies.

The regulation of the inclusion of new items in the

NHS common benefits basket explicitly requires as

a previous step the appraisal by the National HTA

agency in cooperation with AUnETS.

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eHealth, Electronic Health Record

The "Electronic Health Record of the National Healthcare System" (Historia Clínica Digital del Sistema Nacional de Salud, HCDSNS) was initiated in 2006 with the following objectives in mind:

To guarantee citizens' electronic access to their own health data and to the health data of those they represent that are available in digital format at any of the health services that make up the NHS, as long as they comply with the minimum security requirements laid down to protect their own data against illegal intrusion by those who have not been duly authorised to access such data.

To ensure the healthcare professionals duly authorised by each health service for such a function can access specific personal health data sets generated by a regional authority other than the one requiring the information, as long as the user or patient seeks the professional's healthcare

services at a public NHS health centre.

To provide the NHS with a secure access system that guarantees citizens the confidentiality of their personal health data.

The HCDSNS system should be dynamic and simple as regards access and be at the service of citizens and professionals.

In June 2014, 20 million citizens from 15 of the 17 Autonomous Regions have shared, at least partially, their medical history, which could be consulted by healthcare professionals.

Health and health-system information and reporting mechanisms

The "Dirección General de Salud Pública, Calidad e Innovación" includes under its umbrella the "Subdirección General de Información Sanitaria e Innovación", la "Subdirección General de Calidad y Cohesión" and the Observatory of the NHS.

These units concentrate the functions of assessment and monitoring at national level and also manage the discretionary funding linked to the development of the "National Quality Plan".

Health information systems have been developed

and are trying to improve coordination among regions. The "Institute of Health Information" is the repository of administrative databases and basic health-related statistics for the ACs, manages regional health data, the National Health Survey, the "Health **Care** Barometer" and the "National Mortality Register". All these sources of information have allowed for the building of the "Set of Key Indicators for the SNS" (INCLASNS); the chosen indicators cover demographics, health status and its determinants, health **care** resources supply, activity, quality, expenditure and citizens' satisfaction (322).

At consultation level, ICTs are improving coordination with the implementation of electronic medical records (currently implemented within the regions; there are pilot projects across the regions(323) and improving cost savings with the electronic prescription of medicaments (better follow- up of patients and avoiding misuse).

Health promotion and disease prevention policies

Health planning is a competence of the regional health departments and as such, each one develops their regional health 4-5 yearly plans (HPs). They are the principal instrument for identifying intended courses of action and planning resources towards the achievement of previously defined health goals. All share the purpose of responding to identified health needs and offering strategies for health systems action, inspired by “WHO’s Health for All” and HEALTH21 strategies. These plans in turn materialise in regional strategic plans, infrastructure plans, regional health strategies and health programmes.

In terms of public intervention on lifestyle patterns, Spain has been quite successful in introducing anti-tobacco law (strict regulation of advertising and places to smoke) and enacting stricter rules on occupational health and accident prevention and in results regarding diminishing traffic accidents (through campaigns and legislation). In the area of pharmaceuticals’

(322) The statistic portal of National Health System is publicly

available in

<http://www.msps.es/estadEstudios/estadisticas/sisInfSanSN>

S/home.htm

(323) ICT in the National Health System Ed. 2010

<http://www.ontsi.red.es/articles/detail.action?id=4559&req>

uest_locale=en

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consumption, education is being improved by antiself-

medication campaigns and the new adaption

of packages to dose prescription. The

pharmaceutical co-payments described above are

also likely to reduce self-medication.

Recently legislated and/or planned policy

reforms

A new voluntary budget rule on healthcare

spending for application at regional level was

approved in mid-June 2015. The new budget rule

limits growth in healthcare and pharmaceutical

spending in 2015 and 2016 to the reference rate of

medium-term economic growth of the Spanish economy. If eligible spending exceeds that rate, then the region concerned would be prevented from offering health care services other than those included in the national basket of health services and would be asked to apply efficiency-enhancing measures. Regional governments can comply with the rule on a voluntary basis, and financial incentives to their participation have been devised by the Ministry of Finance and the Ministry of Health in consultation with the health industry. It is however unclear at this stage how many regions will comply with this new rule and therefore what

Challenges

Over the years, with a lower share of GDP allocated to health compared to other European countries, the Spanish NHS has shown the ability to yield sustained good results measured in different dimensions of performance:

- Population health status parameters and health

care amenable outcomes.

- Coverage, access and financial equity

parameters.

- Health care quality and safety.
- Users' satisfaction and system legitimated by the population.

Despite this positive achievement, the NHS is still

striving to overcome certain challenges:

- Alignment of providers' incentives with the system's quality and efficiency objectives throughout the system (different levels of management, health professionals, non-health professionals, external providers ...). For example, staff incentives could be improved and adaptation to chronic diseases and changes in demand
- Transition from an acute care-driven model to the management of chronic diseases, including mental disorders.
- Improve the integration of the different levels of care, increasing the resolution capacity of GP by boosting their case manager's role.
- Shifting to a user-centred model in a predominantly public provision structure,

staffed mainly by civil servants and statutory personnel. It is necessary a cultural change aimed to increase the productivity of the health sector, and so on, in order to reduce waiting lists and to cope with patient's expectations.

- Improve the efficiency of pharmaceutical expenditure by increasing generic penetration and improving the transparency of hospital pharmaceutical expenditure.

- The issue of ageing workforce should be tackled, as in the rest of the EU, through the promotion of the medical education and more flexible salary regulation rewarding quality and efficient work. The imbalances in the health

care workforce structure should also be tackled and the possibility of expanding the role of nurses in the provision of care considered.

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Table 1.26.1: Statistical Annex – Spain

Sources: EUROSTAT, OECD and WHO

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General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 803 861 931 1008 1081 1116 1079 1081 1070 1043 1031 9289 9800 9934

GDP per capita PPS (thousands) 25.5 25.6 25.7 26.6 27.3 26.4 24.7 24.7 24.5 24.4 24.1 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 1.4 1.6 1.9 2.5 1.6 -0.7 -4.5 -0.5 -0.1 -1.7 -0.7 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 13.2 2.5 2.8 3.7 2.8 4.4 2.7 0.0 -2.3 -3.2 -5.2 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 8.2 8.2 8.3 8.4 8.5 8.9 9.6 9.7 9.4 9.3 8.9 10.4 10.1 10.1

Total current as % of GDP 7.9 8.0 8.0 8.1 8.2 8.6 9.3 9.4 9.3 9.2 8.8 9.8 9.6 9.7

Total capital investment as % of GDP 0.3 0.2 0.3 0.3 0.3 0.3 0.3 0.2 0.2 0.1 0.1 0.6 0.5 0.5

Total per capita PPS 1637 1770 1895 2044 2180 2322 2383 2387 2303 2204 2085 2828 2911 2995

Public as % of GDP 5.7 5.8 5.9 6.0 6.1 6.5 7.2 7.2 6.9 6.7 6.3 8.1 7.8 7.8

Public current as % of GDP 5.5 5.6 5.7 5.8 5.9 6.3 7.0 7.0 6.8 6.6 6.3 7.9 7.7 7.7

Public per capita PPS 1079 1175 1262 1370 1464 1587 1677 1667 1691 1581 1468 2079 2218 2208

Public capital investment as % of GDP 0.2 0.2 0.2 0.3 0.3 0.3 0.2 0.2 0.1 0.1 0.0 0.2 0.2 0.1

Public as % total expenditure on health 70.3 70.6 70.9 71.6 71.8 72.9 75.0 74.3 73.4 71.7 70.4 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 13.5 14.1 14.8 14.6 14.5 14.7 14.7 14.3 14.2 13.0 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 99.5 : : 98.3 : : : 99.9 99.9 : 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 23.8 23.4 22.9 21.9 21.2 21.0 19.2 20.4 20.6 22.1 22.8 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 42.5 42.5 43.3 44.0 44.8 45.7 46.2 46.5 46.7 46.8 46.7 502.1 504.5 506.6

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Life expectancy at birth for females 83.0 83.7 83.6 84.4 84.4 84.6 85.0 85.5 85.6 85.5 86.1 82.6 83.1 83.3

Life expectancy at birth for males 76.4 77.0 77.0 77.8 77.9 78.3 78.8 79.2 79.5 79.5 80.2 76.6 77.3 77.8

Healthy life years at birth females 70.2 62.7 63.4 63.5 63.2 63.7 62.1 63.8 65.6 65.8 63.9 : 62.1 61.5

Healthy life years at birth males 66.8 62.6 63.3 63.9 63.5 64.0 63.1 64.5 65.4 64.8 64.7 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 67 62 61 57 56 53 51 49 103 102 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 3.9 3.9 3.7 3.5 3.4 3.3 3.2 3.2 3.1 3.1 2.7 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 1.70 1.73 1.77 1.80 1.83 2.00 2.18 2.17 2.23 2.21 2.02 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.13 0.15 0.15 0.15 0.15 0.17 0.18 0.18 0.18 0.18 0.18 0.18 0.18 0.19

Out-patient curative and rehabilitative care 2.56 2.58 2.58 2.59 2.61 2.75 2.91 2.92 2.91 2.92 2.76 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.72 1.70 1.67 1.60 1.58 1.63 1.75 1.77 1.66 1.53 1.60 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.22 0.23 0.25 0.27 0.30 0.33 0.35 0.37 0.37 0.36 0.37 0.31
0.31 0.32

Prevention and public health services 0.19 0.19 0.19 0.20 0.21 0.21 0.26 0.22 0.20 0.19 0.18 0.25 0.25 0.24

Health administration and health insurance 0.27 0.26 0.26 0.27 0.29 0.28 0.31 0.28 0.29 0.29 0.27 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 1.54 1.57 1.61 1.65 1.68 1.84 2.04 2.02 2.07 2.04 1.93 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.13 0.14 0.15 0.15 0.15 0.16 0.18 0.18 0.18 0.18 0.17 0.16 0.16 0.18

Out-patient curative and rehabilitative care 1.45 1.46 1.47 1.51 1.55 1.68 1.83 1.82 1.81 1.77 1.68 1.74 1.71 1.80

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Pharmaceuticals and other medical non-durables 1.23 1.21 1.18 1.15 1.13 1.17 1.28 1.28 1.18 1.04 0.86 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.02 0.02 0.02 0.02 0.02 0.02 0.02 0.02 0.02 0.02 0.02 0.01 0.13 0.12 0.13

Prevention and public health services 0.18 0.18 0.18 0.19 0.20 0.20 0.25 0.21 0.20 0.19 0.18 0.25 0.20 0.19

Health administration and health insurance 0.14 0.12 0.12 0.12 0.13 0.13 0.15 0.14 0.14 0.14 0.14 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

Health care systems

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Table 1.26.2: Statistical Annex - continued – Spain

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care 21.5% 21.7% 22.0% 22.2% 22.4% 23.2% 23.4% 23.1% 24.1% 24.1% 23.1% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 1.7% 1.9% 1.9% 1.9% 1.9% 1.9% 1.9% 1.9% 2.0% 2.0% 2.0% 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 32.4% 32.3% 32.1% 32.0% 31.9% 31.9% 31.2% 31.0% 31.4% 31.9% 31.5% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 21.8% 21.3% 20.8% 19.8% 19.3% 18.9% 18.8% 18.8% 17.9% 16.7% 18.3% 16.3% 16.2% 14.9%

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Therapeutic appliances and other medical durables 2.8% 2.9% 3.2% 3.3% 3.7% 3.8% 3.8% 3.9% 3.9% 3.9% 4.2%
3.2% 3.3% 3.3%

Prevention and public health services 2.4% 2.4% 2.4% 2.5% 2.6% 2.4% 2.8% 2.3% 2.2% 2.1% 2.1% 2.6% 2.6%
2.5%

Health administration and health insurance 3.4% 3.3% 3.2% 3.3% 3.5% 3.2% 3.3% 3.0% 3.1% 3.2% 3.1% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 27.9% 28.1% 28.5% 28.7% 28.7% 29.4% 29.3% 29.0% 30.5% 31.1%
30.8% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 2.3% 2.6% 2.6% 2.6% 2.6% 2.6% 2.6% 2.5% 2.7% 2.7% 2.8% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative care 26.3% 26.2% 26.0% 26.3% 26.5% 26.8% 26.3% 26.1% 26.7% 26.9%
26.8% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 22.3% 21.7% 20.9% 20.0% 19.3% 18.7% 18.4% 18.4% 17.4%
15.8% 13.7% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 0.4% 0.3% 0.4% 0.3% 0.3% 0.3% 0.3% 0.3% 0.3% 0.3% 0.2% 0.2%
1.6% 1.6% 1.6%

Prevention and public health services 3.3% 3.2% 3.2% 3.3% 3.4% 3.2% 3.6% 3.0% 2.9% 2.9% 2.8% 3.2% 2.7%
2.5%

Health administration and health insurance 2.5% 2.2% 2.2% 2.2% 2.2% 2.1% 2.1% 2.0% 2.0% 2.1% 2.3% 1.4%
3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants 0.73 0.77 0.81 0.88 0.93 : : 1.25 1.34 1.48 1.53 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : : 0.5 0.5 0.6 0.6 0.9 0.9 0.8

CTS per 100 000 inhabitants : : : : : 1.6 1.7 1.7 1.8 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : : 0.1 0.1 0.1 0.2 0.1 0.1 0.1

Proportion of the population that is obese 13.1 : : 14.9 : 15.7 16.0 : 16.6 : : 14.9 15.4 15.5

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Proportion of the population that is a regular smoker 28.1 : : 26.4 : 25.2 26.2 : 23.9 : : 23.2 22.4 22.0

Alcohol consumption litres per capita 10.2 10.4 11.9 11.9 11.1 10.2 10.0 9.8 : : : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 324 346 357 365 359 358 363 380 388 382 381 329 335 344

Practising nurses per 100 000 inhabitants 431 432 439 449 464 486 500 521 528 524 514 840 812 837

General practitioners per 100 000 inhabitants : : 71 72 70 73 73 75 75 75 75 : 78 78.3

Acute hospital beds per 100 000 inhabitants 263 261 258 253 253 249 247 243 238 230 228 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 9.5 : : 8.1 : : 7.5 : 7.4 : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 4.2 10.8 10.8 10.7 10.7 10.6 10.4 10.2 10.1 9.9 9.9 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants : : : 3,026 4,382 : 5,784 6,206 4,069 7,216 6,465 6368 6530 7031

Acute care bed occupancy rates 79.0 79.0 79.0 78.0 78.0 77.7 77.6 76.4 75.4 75.8 75.8 72.0 73.1 70.2

Hospital curative average length of stay 6.9 6.7 6.7 6.6 6.6 6.5 6.4 6.3 6.1 6.1 6.1 6.5 6.3 6.3

Day cases as % of all hospital discharges : : : 22.0 29.1 : 35.7 37.7 28.7 42.1 39.4 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 5.9 6.2 6.6 7.0 7.1 6.9

AWG risk scenario 5.9 6.4 7.2 7.8 8.0 7.8

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 46.6 45.7 44.5 44.7 45.6 46.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

-1.0 3.1

1.1 0.9

1.9 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General country statistics: GDP, GDP per

capita; population

GDP per capita (32.2 thousand PPS in 2013) is

well above the EU average (27,9 thousand PPS in

2013).

The Swedish population was estimated in 2013 to

be 9.6 million and is projected to increase

significantly to 13.1 million by 2060, a 36% rise

compared to the more modest 3.1% change of the

EU average for that period.

Total and public expenditure on health as % of

GDP

Total expenditure (324) on health as a percentage of

GDP (9.7% in 2013) is slightly below the EU average (325) (10.1%). It has been fluctuating between 9% and 10% roughly for the last decade (2003-2013). Public expenditure on health as a percentage of GDP is, however, comparable with the EU average (7.9% for both in 2013), having increased from 7.2% in 2001. Total (3,250 PPS in 2013) and public (2,648 PPS in 2013) per capita expenditure is above the EU average (2,988 PPS and 2208 PPS in 2013), having consistently increased since 2001 (2,181 PPS and 1,742 PPS).

Expenditure projections and fiscal sustainability

As a result of ageing (326), health care expenditure is projected to increase by 0.4 pps of GDP (much below the average change in the EU of 0.9 pps).

Good health (translated by a constant health scenario) could reduce the projected expenditure increase to zero, highlighting the importance of improving health behaviour.

(324) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under

the System of Health Accounts and include HC.1-HC.9 +

HC.R.1.

(325) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units or units of staff where relevant. The EU average for each year is based on all the available information in each year.

(326) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

Risks also appear to be low in the medium-term from a debt sustainability analysis perspective due to the relatively low stock of debt at the end of projections (2026), even when considering possible shocks to nominal growth and interest rates. Medium sustainability risks appear over the long run due to both the relatively unfavourable initial budgetary position and the projected impact of age-related public spending (in particular, longterm care spending).

Health status

Life expectancy (83.8 years for women and 80.2 years for men in 2013) is above the EU average

(83.3 and 77.8) and among the highest in the world. Healthy life years (66.0 years for women and 66.9 for men in 2013) are above the EU average (61.5 and 61.4 respectively).

There are two major causes of death in Sweden.

Mortality and morbidity due to diseases of the circulatory system has been significantly reduced during the last 30 years and this is one of the major causes contributing to the rise in life expectancy but they are still the most common cause of death for both women and men, being the underlying cause in 38% of all deaths among women and 37% of all deaths among men in 2012.

The second most common cause of death is neoplasm (cancer), corresponding to 23% of all deaths among women and 27% among men in 2009. Out of all deaths due to cancer, breast cancer used to be the most common form among women.

For women that is now lung cancer. Prostate cancer is the most common cause of deaths due to cancer among men.

The number of traffic-related deaths decreased

from 16.2 to 3.5 deaths per 100 000 inhabitants

between 1970 and 2012. Sweden has the world's

lowest rate of mortality due to road traffic

accidents among children aged 0–17 years.

Health care systems

1.27. Sweden

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System characteristics

System financing, revenue collection

mechanism, coverage and role of private

insurance and out of pocket co-payments

The level of taxes to be earmarked to the health

sector is defined by the central government

(general taxation), the counties or regions (county taxation) and the municipalities (for local taxes).

The Parliament, the central government, the county

government and the municipal government set the

public budget for health, in each respective

responsibility. The central government determines

resource allocation across regions (based on

demographic and mortality/morbidity data and

historic costs). The funds to be allocated to each

sector/ type of **care** are determined by the counties

or regions and the municipalities given their

respective responsibilities. Hospitals then exercise

their autonomy to recruit medical staff and other

health professionals and negotiate salaries. The

Ministry of Social Affairs and Health defines

general policy guidelines and regulation.

This suggests a rather complex and decentralised

decision making and resource allocation process,

within a nationally agreed regulatory framework

but in the presence of a not explicitly defined basic

benefit package. Nevertheless, the level of

expenditure in administering such a system is not

high. Public (0.13%) and total (0.14%) expenditure

on health administration and health insurance as a

percentage of GDP is below the EU average

(0.27% and 0.47% respectively in 2013), as is

public and total expenditure on health

administration and health insurance as a

percentage of current health expenditure (1.4% and

1.3% vs. 3.5% and 4.9% in 2013), falling behind

by a substantial margin as well.

This decentralised tradition has however also led

to regional differences in terms of cost-sharing, type of treatment, access to new medicines and inequalities in avoidable care and mortality. These regional differences as well as care coordination difficulties between counties and municipalities have been the focus of debate in the 2000s. (327)

(327) WHO/Europe (2012b),

Interestingly, while in the 1990s mostly counties were using a purchaser-provider split, they now appear to have gone back to the more traditional way of public provision and administration. In some counties there has been a move towards integrating each hospital with primary care and municipal services.

There is a strict health budget defined annually by regions and for different health services. Budget deficits in the sector have occurred in the past and have resulted in a number of cost-containment policies and stricter budget rules. (328)

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other

institutions

On the basis of legal provisions (harmonised legislation and guidelines) and under the supervisor role of the Government through the Ministry of Health and Social Affairs, the counties or regions (18 counties, 2 regions and one independent island community) and the municipalities are responsible for providing or funding a wide range of health related services.

Regionally organised services include primary, specialist outpatient and hospital care, health promotion, disease prevention and rehabilitation.

Coverage (population)

A regionally based National Health Service (NHS), funded on the basis of taxes (central, county and municipal taxes), provides full population coverage.

To improve access and reduce the waiting times for primary care, legislation was introduced to allow for the choice of primary care physician and the contracting with private primary care

providers. To reduce waiting times for hospital surgery and reduce important regional variations in the waiting time, which are seen as a problem in Sweden (e.g. for hip replacement and cataracts), a law from July 2010 regulates the waiting time guarantee which provides a national time guarantee for care (i.e. care must be provided (328) According to the OECD, Sweden scores 6 out of 6 in the OECD scoreboard due to the very stringent budget controls.

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within 3 months) and an optional agreement between the councils allows patients a free choice of hospital (329). In addition, the Swedish Association of Local Authorities and Regions together with the National Board of Health and Welfare publish comparisons of the quality and efficiency of health care in different counties or regions and hospitals. Waiting times - reported by the county/regional level to the national

administration according to agreed guidelines -

have seen a reduction since these systems have been implemented.

Hence, some efforts to improve access may help explain the increase in public and total expenditure observed in the last decade though it does not appear to be the main explanation.

Role of private insurance and out of pocket co-payments

Most services (primary, outpatient specialist care, hospital day care and inpatient care, dental care, physiotherapy) involve a co-payment at the point of use. This fee may vary across services and across counties or regions. In addition, eyeglasses and contact lenses and physiotherapist services are not funded or provided by counties or regions and high cost-sharing applies to dental care, dental prostheses and pharmaceuticals. It is not clear whether the current cost-sharing design induces a greater use of more cost-effective services (e.g. primary care vs. specialist care when this is not necessary). Children, those with certain medical

conditions and those who have reached an upper limit for out-of-pocket payments are exempted from cost-sharing. 2.3% of the population buys supplementary private insurance (to cover the services not covered by public provision/ funding).

In 2013, private expenditure and out-of-pocket expenditure were 18.5% and 16.3% of total health expenditure and therefore respectively below and above the EU average (22.6% and 14.1%). The share of private expenditure was lower in 2013 than in 2001. Out-of-pocket expenditure was nevertheless slightly higher (16.3% in 2013 and 15.9% in 2001).

(329) The formula is 0-7-90-90. Contact with primary care immediately, visit with doctor in primary care within 7 days, visit with doctor in specialised care within 90 days and access to care (for example an operation) within 90 days from the doctors decision.

Types of providers, referral systems and patient choice

As care provision is defined at the county level, there are some differences in the way the various

types of care are organised. In general, primary

care is provided by general practitioners (GPs) in

public health centres while outpatient specialist

care is provided in outpatient departments in

public hospitals. There are 79 hospitals in Sweden,

many of which are local hospitals with limited

specialisation, some of which are regional

hospitals offering a wider range of specialties and

7 are regional highly specialised university

hospitals. About 98% of all hospital beds are

public. Provision has traditionally been public but

private provision notably in terms of private

primary care providers, with whom the councils or

regions establish contracts, has been encouraged.

Some hospitals are run by private companies but

are financed by public funds. There are also some

private practices of physiotherapists or psychiatric

care. Private provision is more common in densely

populated urban areas. Still, dual practice of

private physicians should be of minor significance,

since private practitioners who are reimbursed

according to a national tariff are prevented by law

to also occupy public-sector employment.

The number of practising physicians per 100 000

inhabitants (401 in 2012) is above the EU average

(341 in 2012) and showing a consistent increase

since 2003 (338.2). The number of GPs per 100

000 inhabitants (64 in 2012) is below the EU

average (78 the same year), but showing an

increase from 2001. The number of nurses per 100

000 inhabitants (1,115 in 2012) is well above the

EU average (829 in the same year) having

consistently increased throughout the decade, by a

bit more than 10% since the beginning of the

millennium. The authorities acknowledge

shortages of physicians in some specialties and in

some counties. In particular, they acknowledge a

general shortage of GPs, especially significant in

certain municipalities, which results in longer

waiting times to see a GP. As a consequence,

patients tend to see specialists or go to emergency

care directly but unnecessarily. This has forced

some counties to recruit GPs from abroad or pay

higher wages, increasing the costs of health care

delivery. These elements suggest that a

comprehensive human resources strategy may be

necessary in order to ensure that the skill mix goes

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in the direction of a primary care oriented

provision, which the authorities wish to pursue,

that training, recruitment and bringing licensed but

non-practising physicians back into the sector can

compensate for staff shortages and losses due to

retirement. Staff supply is regulated in terms of

quotas for medical students and by speciality but

not in terms of the location of physicians, which

explains the disparities in staff availability across

counties or regions.

Authorities' efforts to encourage the use of primary

care vis-à-vis specialist and hospital care have

included contracting with private primary care

providers and allowing patient choice of GP. These

may not have yet proven very successful because a

stronger emphasis on primary care requires sufficient numbers of staff and the right skill mix, which are currently lacking. This means that residents are free to choose and register with a GP but there is no compulsory referral system from primary care to specialist doctors i.e. GPs acting as gatekeepers to specialist and hospital care. Choice of GP, specialist and hospital is allowed and a priority for the authorities, (330) and even seen as possibly strengthening the role of primary care.

Indeed, experience from recent primary care reform in Stockholm County Council "Vårdval Stockholm" shows that increased elements of patient choice and competition has led to, with respect to the impact on other subsectors and ancillary services, the observation of no "spillover" effects. On the contrary, primary care has increased its share of total ambulatory care and utilisation of medical services declined slightly. There has also been a relatively large proportion of new entrants into the primary care sector. The

implementation of the customer choice reform

within primary care across the country, as one part

of a new national legislation, may thus strengthen

the role of primary care. (331) Moreover, authorities

have been introducing a number of ICT and

eHealth solutions to allow for nationwide

electronic exchange of medical data (including

patient electronic medical records) to support care

coordination, reduce medical errors and increase

cost-efficiency.

(330) According to the OECD, the level of choice of provider in

Sweden has indeed a score of 6 out of 6, while gatekeeping

scores 0 out of 6.

(331) There is indeed a national regulation that all counties

should have a "patient/care choice system" for the selection

of primary care provider ("Vårdvalssystem").

The number of acute care beds per 100 000

inhabitants (194 in 2013) is far below the EU

average of 356 in 2013 and displaying a decreasing

trend over the last decade and is one of the lowest

in the EU. However, structural differences have to

be taken into account when analysing these figures. For instance, the "Ädel-reform" of 1992 transferred the responsibility for those considered medically treated to the social care sector (especially the elderly, who instead receive social care in the elderly care sector), which had a significant impact on demand for health care beds. In addition, the average length of stay has been effectively shortened in Sweden by utilising open specialised care to a larger extent than previously. Still, in some areas there may be a shortage of follow-up/long-term care beds/ facilities which creates bed-blockages in acute care (unnecessary and long use of acute care beds) and may contribute to longer waiting times for surgery. While counties or regions plan for the number of hospitals and the provision of specific specialised services, there appears to be no regulation in terms of the number of beds or the supply of high cost equipment capacity, which may explain county/ regional and even hospital differences in the

numbers of units of high-cost equipment. Hospitals

have autonomy to recruit medical staff and other

health professionals and to determine their

remuneration level.

Pricing, purchasing and contracting of

healthcare services and remuneration

mechanisms

Public sector physicians (GPs and specialists) are

paid a salary. Salaries are determined at hospital

level. Physicians appear not to be eligible to

receive bonuses regarding their activity or

performance. (332) It would perhaps be interesting

to investigate if an element of performance-based

payment related to health promotion, disease

prevention or disease management actions or

treatment of vulnerable patients by GPs could be

used more widely, to render primary care more

(332) As for the private practitioners, they are reimbursed

according to a national tariff, and thus compensated on a

fee- for-service basis. A small portion of the private health

care production is in fact conducted by private

practitioners. Other private health care production is

instead based on local contractual arrangements where decisions on doctors' payment in large are decentralised to the private healthcare provider.

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attractive in general and in the regions where the more severe shortages are felt in particular.

When looking at hospital activity, inpatient discharges - per 100 inhabitants - are below the EU average (1,499 vs. 1,649) and the number of day case discharges is well below the EU average (2,038 vs. 7,031 in 2013). The proportion of surgical procedures conducted as day cases (12%) is far below the EU average (30.4% in 2013).

Overall hospital average length of stay (5.6 days in 2012) is also below the EU average (6.3 days in 2012). These figures suggest that there may be some room to increase hospital throughput/efficiency by improving the way surgical treatments are conducted (i.e. more use of day case surgery) and by providing alternative care

services for long-term care patients in particular psychiatric patients. These figures may explain why waiting times for elective surgery may be deemed long.

The market for pharmaceutical products

Total (1.11%) and public (0.58%) expenditure on pharmaceuticals as a percentage of GDP (333) was below the EU average (respectively 1.44% and 0.96%) in 2013. This is similar for total (10.1% vs. the average of 14.9% in 2013) and public (6.3% vs. EU average 12.5% in 2013) pharmaceutical expenditure as a percentage of total and public current health expenditure respectively. The low shares probably relate to the large number of policies in place in this area.

The authorities have implemented a number of policies to control expenditure on pharmaceuticals, although some policies have been discontinued in recent years (e.g. reference pricing which was discontinued in 2002, making Sweden one of the few countries in Europe (with Denmark and the United Kingdom). Initial price is based on economic evaluation. The authorities use price

volume agreements with pharmaceutical companies. There is a positive list of reimbursed products which is based on health technology assessment information/ economic evaluation. Authorities promote rational prescribing of

(333) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 in the OECD System of Health Accounts.

Note that this SHA-based estimate only records pharmaceuticals in ambulatory care (pharmacies), not in hospitals.

physicians through treatment and prescription guidelines complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines. There are monthly, quarterly and annual evaluations at county level on prescriptions and co-payments and physicians receive feedback. These are coupled with pharmaceutical budgets at county level. There are also information and education campaigns directed at patients and costsharing to encourage a rational use of medicines on the patients' side. Patients pay the full price up to a

certain cost level (1100SEK), after which there are some stepwise reductions in the additional costs. In a year the maximum amount a patient can pay in reimbursable medicines is 2200 SEK. There is an explicit generics policy. Generic substitution takes place i.e. pharmacies are obliged to dispense the cheaper product and to replace the prescription by a generic medicine when available. If patients refuse a generic they will have to pay the difference between the reimbursement price of the branded drug and the pharmacy retail price of the cheapest available generic. Moreover, this cost is deemed extra and will not be considered in the computation of the maximum costs a patient can incur in a year on medicines. Although prescription by active element is not compulsory, doctors are encouraged to prescribe generic alternatives. Generics face a fast track registration and speedy decision.

Use of Health Technology Assessments and cost-benefit analysis

The Swedish Council on Health Technology Assessment conducts and gathers information on

health technology assessment and conducts economic evaluation and cost-effectiveness analysis which is used to define whether new medicines are covered by the health system and to what extent (level of reimbursement) as well as to define clinical guidelines for medicines.

Health and health-system information and reporting mechanisms

Sweden has extensive information management and statistics systems and comprehensive data is gathered on physician and hospital activity and quality and health status. Data is provided at county/ region and municipal level and compiled by the Swedish Association of Local Authorities

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and Regions together with the National Board of Health and Welfare. Some of this information is published, and allows for public comparisons of counties/ regions and hospitals in terms of both activity and quality. Physicians are monitored and

are given feedback on their prescription behaviour.

Public health promotion and disease

prevention policies

The central Government, through the Ministry of

Health and Social Affairs, sets and monitors public

health priorities in terms of process, outcomes and

the reduction of health inequalities. As section 1

suggests there are some risk factors that can

translate into an important burden of disease and

financial costs. Authorities have emphasised health

promotion and disease prevention measures in

recent years. Promotion and prevention are seen by

the authorities as a means to ensure long-term

sustainability of the health budget: they reduce the

development of disease and therefore the need for

care and therefore the need for funding. Public and

total expenditure on prevention and public health

services as a % of GDP are both above the EU

average (0.29% and 0.34% in 2013). Similarly, as

a % of total current health expenditure, both public

and total expenditure on prevention and public

health services are higher than the EU average

(3.1% for both vs. 2.1% in 2013).

Recently legislated and/or planned policy

reforms

Recent policy response

A top priority has been related to a number of initiatives aimed at strengthening the position of patients and to stimulate patient engagement.

Freedom of choice of providers has been a priority and this requires increased information and knowledge for patients. It is important that the information is available and easy for everyone to understand and to use, so that nobody is disadvantaged in a system that rewards freedom of choice and increases the demand for self-care.

There have been several important policy initiatives in this direction.

A new Patients Act that is as accessible, transparent and pedagogical as possible for both patients and health care personnel was implemented in 2014. The new Act is an important piece of legislation in helping the on-going shift in Sweden, from a health care perspective to a patient perspective. The proposal includes a number of

ideas to further strengthen the patients' choice of providers all over the country, as well as increased information for patients.

Patients and citizens should receive electronic access to their health care information and a tool that helps them to actively engage in their own health and health development. The Government has taken the initiative to develop an online personal health account. It will give individuals comprehensive access to information and other services related to their health. The account holder can store medical records, drug prescription and vaccination lists, or results from health and fitness applications that the user may connect to the account. The role of the government has been to create a secure technical platform in which public health care providers, private health care providers and companies can provide new interactive services.

Patients' experiences and opinions of the health care services are important inputs in health care development and improvement. The National

Patient Survey is a recurring measurement of patient-perceived quality, which is conducted each year. In the Agreement on the development of the quality registries, development of Patient Reported Outcome Measures linked to the registries is rewarded, as a means of gaining knowledge of how patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.

A second top priority has been the care of vulnerable populations, and patient groups with complex needs. These include patients with psychiatric illnesses, elderly with multi-morbidity, chronic diseases, women's health and cancer.

One of the initiatives is directed towards elderly with multiple diseases. The government is investing SEK 4.3 billion during this electoral period to improve the health and social care of older adults with complex health conditions. The aim is to have home care, elderly care, primary

care and hospital care collaborate more effectively

in the care of older adults.

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So far the strategy has led to a number of results, for example a significant decrease in use of inappropriate medications, within all of the county councils as well as an increased number of preventive interventions in the municipalities.

Policy changes under preparation/adoption

A primary objective of the Swedish health care system is the provision of high-quality care on equal terms, irrespective of the person receiving it.

Reception, care, and treatment shall be offered on equal terms to everybody – irrespective of age, gender, sexual orientation, disability, place of residence, education, social status, country of birth or religious beliefs. Equality and equity of care are at the very heart of the Swedish Health and Medical Services Act.

The Government's support to public performance

reports has laid the foundation for systematically

following up and highlighting developments of

disparities in health and medical care. This

information helped form the basis for the

Government's decision to develop a strategy for

equality in health care.

One question which has attracted a great deal of

interest in recent years is how men and women are

treated within the health service. Several studies

have shown that there are systematic and

significant differences in the way men and women

are treated. The latest follow ups by the National

Board of Health and Welfare show that there have

been some improvements in this area. On the other

hand, there are differences in access to care and

treatment between different socioeconomic groups,

counties and between those born in Sweden and

those born abroad.

Furthermore, the government's focus on analysis

and open comparisons revealed increasing regional

disparities across the country. The different county

councils make a number of decisions that might

lead to the situation that patients do not receive the same treatment in different part of the countries.

There are currently discussions on how care could be more effectively organised in order to guarantee good care all over Sweden. A government committee has for example been given the task to study how highly specialised care can be concentrated to ensure quality and equality.

Six regional cancer centers have been established, which work across counties in order to optimise care. This model might serve as an example of how to improve care also for other patient groups.

There is also a comprehensive initiative to shorten the waiting times in cancer care. This builds on the Danish example with specially designed tracks for different kind of cancers.

Challenges

The analysis above has shown that a range of reforms has been implemented in recent years. For example, the reduction of waiting times, improvements to hospital efficiency, improved

data collection and monitoring and the control of pharmaceutical expenditure, some to a large extent successful, and which Sweden should continue to pursue. The main challenges for the Swedish health care system are as follows:

- To ensure the coherence of resource allocation to different types of care in different regions controlling for demographic and mortality/morbidity characteristics of the population.
- To ensure consistency in access to health care in different regions, ensuring that different fees and remuneration mechanisms do not impact on the health outcomes of the population.
- More generally, to develop a comprehensive human resources strategy that tackles current shortages in primary care staff and ensures sufficient numbers of staff in general and in the future in view of staff and population ageing.
- To enhance primary care provision by increasing the numbers and spatial distribution

of GPs and primary care nurses. To couple these measures with a referral system to specialist care either through financial incentives (reimbursement levels higher if a referral takes place) or by making it compulsory. At the same time exploring if current cost-sharing arrangements can be adjusted to render primary care more attractive.

This could improve access to care while reducing unnecessary use of hospital care and therefore overall costs.

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- To increase hospital efficiency by increasing the use of day case surgery and increasing the supply of follow-up care for long-term care patients so as to reduce the unnecessary use of acute care settings for long-term care patients, notably psychiatric patients. To consolidate the measures pursued in recent years to reduce

duplication and improve efficiency and quality

in the hospital sector (e.g. concentration and

specialisation of hospitals within regions),

notably through the finalisation of the current

administrative reform.

- To ensure a greater use of health technology

assessment to determine new high-cost

equipment capacity as well as the benefit

basket and the cost-sharing design across

medical interventions as is currently done with

medicines.

- To consider whether it is worth introducing

some element of performance related payment

in physicians' remuneration (e.g. through the

use of mixed payment schemes) to encourage

health promotion, disease prevention and

disease management activities or the treatment

of vulnerable populations and increase

outpatient output.

- To take into account the potential drivers of

fiscal sustainability particularly with ageing

potentially increasing public healthcare

spending in the long-run.

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Table 1.27.1: Statistical Annex – Sweden

Sources: EUROSTAT, OECD and WHO

General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 293 307 313 335 356 352 310 369 405 423 436 9289 9800 9934

GDP per capita PPS (thousands) 30.6 32.5 32.2 33.6 35.2 33.8 30.1 31.8 32.6 32.9 32.2 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 2.0 3.8 2.7 3.7 2.6 -1.4 -5.8 5.7 2.2 0.2 0.8 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 2.1 1.3 2.4 2.4 2.3 2.0 1.4 0.7 2.4 1.2 2.2 3.2 -0.2
-0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 9.3 9.1 9.1 9.0 8.9 9.2 9.9 9.5 9.5 9.6 9.7 10.4 10.1 10.1

Total current as % of GDP 8.9 8.3 8.3 8.2 8.1 8.3 8.9 8.5 10.6 10.8 11.0 9.8 9.6 9.7

Total capital investment as % of GDP 0.4 0.8 0.8 0.8 0.9 0.9 1.0 1.0 -1.1 -1.2 -1.3 0.6 0.5 0.5

Total per capita PPS 2356 2410 2480 2601 2738 2889 2996 3028 3127 3158 3250 2828 2911 2995

Public as % of GDP 7.6 7.4 7.4 7.3 7.3 7.5 8.1 7.7 7.8 7.8 7.9 8.1 7.8 7.8

Public current as % of GDP 7.3 6.8 6.8 6.7 6.6 6.8 7.3 6.9 9.0 9.1 9.3 7.9 7.7 7.7

Public per capita PPS 1764 1794 1848 1935 2028 2126 2202 2216 2553 2565 2648 2079 2218 2208

Public capital investment as % of GDP 0.3 0.6 0.6 0.6 0.7 0.7 0.8 0.8 -1.2 -1.4 -1.3 0.2 0.2 0.1

Public as % total expenditure on health 82.0 81.4 81.1 81.1 81.3 81.5 81.5 81.5 81.7 81.2 81.5 77.6 77.2 77.4

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Public expenditure on health in % of total government expenditure 12.6 12.4 12.4 12.5 12.9 13.3 13.5 13.4 13.8
13.7 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0
100.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 16.6 17.0 17.4 17.3 17.2 17.2 17.2 17.3
17.1 17.5 16.3 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 9.0 9.0 9.0 9.0 9.1 9.2 9.3 9.3 9.4 9.5 9.6 502.1 504.5 506.6

Life expectancy at birth for females 82.5 82.8 82.9 83.1 83.1 83.3 83.5 83.6 83.8 83.6 83.8 82.6 83.1 83.3

Life expectancy at birth for males 78.0 78.4 78.5 78.8 79.0 79.2 79.4 79.6 79.9 79.9 80.2 76.6 77.3 77.8

Healthy life years at birth females 62.2 60.8 63.2 67.5 66.8 69.0 69.6 66.4 65.5 : 66.0 : 62.1 61.5

Healthy life years at birth males 62.5 62.0 64.5 67.3 67.7 69.4 70.7 67.0 67.0 : 66.9 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 65 62 57 56 53 55 52 49 112 108 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 3.1 3.1 2.4 2.8 2.5 2.5 2.5 2.5 2.1 2.6 2.7 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care 2.54 2.36 2.30 2.28 2.21 2.24 2.40 2.27 2.28 2.31 2.35 3.13 2.99 3.01

Day cases curative and rehabilitative care 0.13 0.13 0.15 0.16 0.17 0.18 0.21 0.19 0.20 0.21 0.22 0.18 0.18 0.19

Out-patient curative and rehabilitative care 3.14 2.87 2.89 2.86 2.87 2.98 3.21 3.10 3.11 3.20 3.21 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.27 1.23 1.15 1.14 1.11 1.13 1.21 1.13 1.09 1.11 1.11 1.60 1.55
1.44

Therapeutic appliances and other medical durables 0.25 0.26 0.27 0.26 0.25 0.25 0.27 0.26 0.25 0.26 0.26 0.31
0.31 0.32

Prevention and public health services 0.29 0.28 0.30 0.27 0.30 0.32 0.36 0.33 0.35 0.36 0.34 0.25 0.25 0.24

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Health administration and health insurance 0.12 0.12 0.12 0.12 0.13 0.14 0.16 0.16 0.17 0.17 0.14 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care 2.50 2.32 2.25 2.24 2.17 2.21 2.37 2.24 2.24 2.27 2.32 2.73 2.61 2.62

Day cases curative and rehabilitative care 0.13 0.12 0.15 0.16 0.16 0.18 0.20 0.19 0.20 0.20 0.22 0.16 0.16 0.18

Out-patient curative and rehabilitative care 2.39 2.17 2.16 2.17 2.18 2.26 2.44 2.37 2.37 2.44 2.43 1.74 1.71 1.80

Pharmaceuticals and other medical non-durables 0.80 0.73 0.71 0.69 0.67 0.67 0.70 0.66 0.64 0.61 0.58 0.79 1.07 0.96

Therapeutic appliances and other medical durables 0.09 0.10 0.11 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.11 0.13 0.12 0.13

Prevention and public health services 0.22 0.20 0.22 0.20 0.22 0.24 0.28 0.25 0.27 0.27 0.29 0.25 0.20 0.19

Health administration and health insurance 0.10 0.10 0.10 0.10 0.11 0.11 0.13 0.13 0.14 0.13 0.13 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

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Table 1.27.2: Statistical Annex - continued – Sweden

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

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Inpatient curative and rehabilitative care 28.5% 28.6% 27.8% 27.9% 27.4% 27.0% 26.8% 26.8% 21.6% 21.4%
21.4% 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care 1.5% 1.6% 1.8% 2.0% 2.0% 2.2% 2.3% 2.3% 1.9% 1.9% 2.0% 1.8%
1.9% 1.9%

Out-patient curative and rehabilitative care 35.2% 34.7% 34.9% 35.0% 35.6% 35.9% 35.9% 36.6% 29.5% 29.6%
29.2% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 14.3% 14.9% 13.9% 14.0% 13.8% 13.6% 13.5% 13.3% 10.3%
10.3% 10.1% 16.3% 16.2% 14.9%

Therapeutic appliances and other medical durables 2.8% 3.1% 3.3% 3.2% 3.1% 3.0% 3.0% 3.0% 2.4% 2.4% 2.4%
3.2% 3.3% 3.3%

Prevention and public health services 3.3% 3.4% 3.6% 3.3% 3.7% 3.9% 4.0% 3.9% 3.3% 3.3% 3.1% 2.6% 2.6%
2.5%

Health administration and health insurance 1.3% 1.5% 1.5% 1.5% 1.6% 1.7% 1.8% 1.9% 1.6% 1.6% 1.3% 4.2%
4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care 34.1% 34.2% 33.3% 33.6% 32.9% 32.5% 32.4% 32.3% 25.0% 24.8%
25.1% 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care 1.7% 1.8% 2.2% 2.4% 2.4% 2.7% 2.8% 2.7% 2.2% 2.2% 2.3% 2.0%
2.1% 2.3%

Out-patient curative and rehabilitative care 32.6% 32.0% 32.0% 32.5% 33.0% 33.2% 33.3% 34.1% 26.5% 26.7%
26.3% 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 10.9% 10.8% 10.5% 10.3% 10.2% 9.9% 9.6% 9.5% 7.1% 6.7%
6.3% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables 1.3% 1.5% 1.6% 1.5% 1.4% 1.4% 1.4% 1.5% 1.1% 1.1% 1.1%
1.6% 1.6% 1.6%

Prevention and public health services 3.0% 2.9% 3.3% 3.0% 3.3% 3.5% 3.8% 3.6% 3.0% 3.0% 3.1% 3.2% 2.7%
2.5%

Health administration and health insurance 1.4% 1.5% 1.5% 1.5% 1.7% 1.7% 1.8% 1.9% 1.5% 1.5% 1.4% 1.4%
3.5% 3.5%

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Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

MRI units per 100 000 inhabitants : : : : : : : : 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants : : : : : : : : 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : : : : : 0.1 0.1 0.1

Proportion of the population that is obese 9.7 9.8 10.7 9.6 10.2 10.3 10.9 11.3 11.0 : : 14.9 15.4 15.5

Proportion of the population that is a regular smoker 17.2 15.9 15.7 15.2 13.8 14.6 14.0 13.6 13.1 12.8 10.7 23.2 22.4 22.0

Alcohol consumption litres per capita 6.9 6.6 6.5 6.5 6.9 6.9 7.3 7.3 7.4 7.3 7.4 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 338 345 352 361 369 375 382 389 396 401 : 329 335 344

Practising nurses per 100 000 inhabitants 1041 1054 1074 1089 1100 1104 1103 1110 1113 1115 : 840 812 837

General practitioners per 100 000 inhabitants 57 58 59 61 62 62 63 63 63 64 : : 78 78.3

Acute hospital beds per 100 000 inhabitants 223 223 218 212 211 207 204 202 201 195 194 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 2.8 2.8 2.8 2.8 2.8 2.9 2.9 2.9 3.0 : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 14.7 14.8 14.9 15.0 15.1 15.1 15.2 15.2 : : 15.0 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 1,213 1,247 1,296 1,291 1,334 1,335 1,391 1,398 : : 2 ,038 6368 6530 7031

Acute care bed occupancy rates : : : : : : : : 72.0 73.1 70.2

Hospital curative average length of stay 6.5 6.4 6.3 6.3 6.2 6.2 6.1 5.9 5.7 5.6 : 6.5 6.3 6.3

Day cases as % of all hospital discharges 7.6 8.0 8.2 8.1 : : 8.4 8.4 : : 12.0 27.8 28.7 30.4

Population and Expenditure projections

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Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 6.9 7.0 7.2 7.2 7.3 7.3

AWG risk scenario 6.9 7.2 7.6 7.8 8.0 8.0

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 9.6 10.2 11.0 11.8 12.5 13.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

36.3 3.1

0.4 0.9

1.2 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

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General context: Expenditure, fiscal

sustainability and demographic trends

General statistics: GDP, GDP per capita;

population

In 2013, the UK had a GDP per capita of 27.3 PPS

(in thousands), below the EU average of 27.9 PPS.

Growth finally took hold in the UK in 2013. UK

GDP grew by 2.9% in 2014. 2015 recorded a

lower, but positive 2.3% and growth is projected to

continue through 2016 and 2017 at 2.1%. (334)

Population was estimated at 63.9 million in 2013.

According to Eurostat 2013 projections, total

population in the United Kingdom is projected to

increase from around 64.1 million in 2013 to 80.1

million in 2060, with an increase of 25%, well

above EU average level of 3.1%.

Total and public expenditure on health as % of

GDP

Total expenditure on health as a percentage of

GDP (9.1% in 2013) has fallen since the 2009 peak

of 9.7%, due to tight post-crisis budget constraints,

and is currently slightly below the EU average of

10.1%. Public expenditure is at 7.6% of GDP, in

line with the EU average (7.78%) and similarly has

fallen since its peak of 8.1% in 2009.

When expressed in per capita terms, total spending

on health at 2,734 PPS in the UK is below the EU

average of 2,988 PPS in 2013. So is public

spending on health care: 1,927 PPS vs. an average

of 2,208 PPS in 2013 in the EU.

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health

care expenditure is projected to increase by 1.3 pps

of GDP, above the average growth expected for

the EU (0.9 pps) (335), according to the "AWG

Reference Scenario". When taking into account the

impact of non-demographic drivers on future

spending growth (AWG risk scenario), health care

expenditure is expected to increase by 2.0 pps of

GDP from now until 2060 (EU: 1.6 pps).

(334) European Commission (2016), European Economic

Forecast Winter 2016.

(335) I.e. considering the "reference scenario" of the projections

(see The 2015 Ageing Report at

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

Sustainability risks emerge in the medium term

due to the high initial debt-to-GDP ratio, the

projected cost of ageing and the unfavourable

initial budgetary position. Over the long run, the

projected increase of age-related public spending

(notably pensions, healthcare and to a lesser extent

long-term care), compounded by the unfavourable

initial budgetary position, determine medium fiscal risks (336).

Health status

Life expectancy at birth (82.9 years for women and 79.2 years for men in 2013) is, respectively, below and above EU averages (83.3 for women and 77.8 for men in 2013) (337). In the same year, healthy life years, at 64.8 years for women and 64.4 years for men, are both above to the EU average of 61.5 and 61.4. The infant mortality rate of 4.2‰ is higher than the EU average of 3.9‰; in 2011, having gradually fallen over the last decade (from 5.3‰; in 2003).

As for the lifestyle of the UK population, the proportion of regular smokers of 20.0% is below the EU average (22.4% in 2011 and 22% in 2013).

Obesity rates in the population are, at 24.9%, also well above the EU average of 15.5% in 2013.

Alcohol consumption is, at 10.3 litres per capita, slightly higher than the EU average of 2011 (10 litres per capita) (338).

System characteristics

Coverage

Services are free at the point of need to all residents. Cost-sharing is limited and applies to some prescription drugs (90% of prescriptions are dispensed with no charge), optical and dental services. Cost-sharing schemes vary across the four countries (e.g. there are no prescription fees in Wales and reduced prescription fees in Scotland).

(336) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

(337) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database.

Data on life-styles is taken from OECD health data and Eurostat database.

(338) However the OECD reports the UK as characterised by levels of alcohol consumption to have increased during the

last 30 years. [http://www.oecd.org/unitedkingdom/Health-at-](http://www.oecd.org/unitedkingdom/Health-at-a-Glance-2015-Key-Findings-UK.pdf)

a-Glance-2015-Key-Findings-UK.pdf

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Eyeglasses and contact lenses are mostly not funded or provided by the NHS. Children, elderly, pregnant women, those with certain medical conditions, those with an income below a certain threshold, beneficiaries of social benefits and those who have reached an upper limit for out-of-pocket payments are exempted from cost-sharing. In addition, dental charges are regulated to limit the overall cost of a course of treatment. As for prescriptions, these cost GBP 8.20 per item. It is however possible to purchase covering all such costs incurred over a 3-month or 12-month period. In 2013, private and out-of-pocket expenditure were 16.5% and 9.3% of total health expenditure and therefore below the EU average (22.6% and 14.1%).

Current government policy is to increase access by increasing the choice of primary care physicians by extending service opening hours to evenings and weekends. This is seen as a means to improve access and reduce the waiting times for primary

care visits. There are also targets to receive

treatment following a GP referral (such as an 18-

week target in England). Patients waiting longer

than the target were sometimes referred for

treatment to private hospitals or hospital abroad.

Both inpatient and outpatient waiting time

statistics are published across the four countries in

the UK. In addition, public comparisons of

different health services in terms of several

performance indicators are available to help

patients exercise choice and to encourage

providers to improve their activities.

Surveys show that patients are generally satisfied

with the NHS, especially those who have received

NHS care.

Administrative organisation and revenue

collection mechanism

The total budget of public funds to be allocated to

the health sector is defined by the UK Parliament,

the UK government and the Scottish, Welsh and

Northern Ireland governments. Scotland, Wales

and Northern Ireland receive a funding block from

HM Treasury and are responsible for the resource

allocation in their respective countries. The central government determines resource allocation across countries and regions based on demographic and mortality/morbidity data and historic costs. The funds to be allocated to each sector/ type of care are determined by the UK government and the Scottish, Welsh and Northern Ireland governments given their respective responsibilities. The Department of Health (DH) defines general policy guidelines and priorities for the NHS in England, to which it allocates the budget. DH uses part of the budget received by the Treasury to cover running costs, finance arms' length bodies and other issues of national relevance such as public health. The rest flows to NHS England, responsible for the national-level commissioning of a restricted set of services (specialised services, primary care, offender healthcare and some services for the armed forces) that allocates resources to Clinical Commissioning Groups (CCGs, formerly PCTs), responsible for the local commissioning of healthcare services.

The head of the DH, the Secretary of State for health responds to the UK Prime Minister. The basic benefit package is not explicitly defined but, through periodic assessments, the National

Institute for Health and Care Excellence evaluates some interventions, medical devices and pharmaceuticals on the grounds of their clinical and cost-effectiveness.

Although data is available on public/governmental spending on healthcare (both through the Estimates process, public expenditure transparency systems like OSCAR and through NHS England's Board papers), there is no Government information on total expenditure on health administration (incorporating both health insurance and public spending).

There is a strict health budget defined annually by country and for different health services. Overall health spending for England and the overall block grants to the Scotland, Wales and Northern Ireland are fixed in advance in spending reviews. The results of the most recent spending review, which

covers the years 2016-17 to 2019-20, were announced on 25 November 2015 and define a real terms increase of GBP 10 billion in NHS funding in England.

Role of private insurance and out of pocket co-payments

9.9% of the population buys duplicative private insurance (to cover the same services that are

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publicly provided/ funded). In 2013, private and out-of-pocket expenditure were 16.5% and 9.3% of total health expenditure and therefore below the EU average (22.6% and 14.1%) in 2013.

Types of providers, referral systems and patient choice

As care provision is defined at country level, there are some differences between England, Wales, Scotland and Northern Ireland in the way care is purchased and delivered.

In England, NHS Trusts (Acute Trusts, Foundation

Trusts, Ambulance Trusts, Mental Health Trusts,

and Care Trusts) are responsible for providing care

to all residents. 209 Clinical Commissioning

Groups are the local organisations in charge of

ensuring residents are provided much of secondary

care. Indeed CCGs control the large majority of

the NHS budget by commissioning secondary care

for their local population through contracts with

Trusts and other providers. Primary care,

commissioned by NHS England (339), is provided

by independent general practitioners (GPs),

dentists, or opticians working mostly in private

group practices. NHS walk-in centres provide

primary care during out-of-office hours as they

have longer opening hours than most independent

GPs, while the NHS Choices website and NHS

111 phone line provide information on health,

allowing people to conduct an initial disease

assessment and find information on health

providers. 152 NHS Foundation Trusts in England

(a type of hospital with large autonomy and run by

local managers, staff and the public) and 88 NHS

Trusts provide outpatient specialist care and day case and inpatient hospital care. Trusts oversee NHS hospitals and specialist care centres. Some of these are regional or national centres for more specialised care. The large majority of all acute care hospital beds are public. Private provision mostly relates to common, non-elective surgical treatments as well as dental and optical care. Salaried public hospital physicians are allowed to conduct private practice on a part-time basis but only under certain circumstances so as to reduce possible perverse incentives to reduce public sector activity and increase demand for their private practice.

(339) CCGs are increasingly being delegated responsibility for this area.

Scotland, Wales and Northern Ireland have different models. In Scotland, 14 NHS Boards are responsible for the provision of health services by creating community health partnerships.

Community health partnerships work with local

authorities, clinical teams and the voluntary sector

to support health improvement of local

communities. In 2009, the Welsh Assembly

launched a consultation to end the internal market

in Wales and create a unified health system

through the Public health Wales National Health

Service Trust. This resulted in the redesign of

healthcare delivery in Wales. The 22 Local health

Boards who were responsible for commissioning

health services for their residents were reduced to

7. The 13 NHS Trusts that provided hospital care

were reduced to 3. In Northern Ireland, 4 Health

and Social Services Boards are responsible for

commissioning health services from a range of

providers. 5 (formerly 19) Health and Social

Services Trusts are the main service providers.

The number of practising physicians per 100,000

inhabitants (277 in 2013) is below the EU average

(344 in 2013) though showing a consistent

increase since 2003 (218). The number of GPs per

100,000 inhabitants (80 in 2013) is above the EU

average (78.3 in 2013). The number of nurses per

100,000 inhabitants (818 in 2013) is below the EU average (837 in 2013), showing a consistent year-on-year reduction since the peak value of 1024 in 2005.

Changes in remuneration and wage increases have been used to attract licensed but not-practicing physicians back into the sector. In addition, authorities have hired foreign staff. They have used national procurement to have more GPs in areas where shortages were perceived. These suggests the need to continue a comprehensive human resources strategy to ensure that the skill mix goes in the direction of a primary care oriented provision, which authorities wish to pursue, that training, recruitment and attracting licensed staff back into the sector can compensate for staff shortages and losses due to retirement. Staff supply is regulated in terms of quotas for medical students but not by speciality or in terms of the location of physicians, which may explain some of the disparities in staff availability across geographic areas. Current government policy

focuses on increasing access to primary care by

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extending service opening hours to evenings and weekends.

Authorities have always strongly encouraged the

use of primary care vis-à-vis specialist and hospital

care. Patients are encouraged to register with a GP

and there is a compulsory referral system to

specialist and hospital care i.e. GPs are

gatekeepers to most (340) specialist and hospital

care. While choice of GP has been limited in the

past, authorities (old and new) have made patient

choice over primary care providers a priority and

as a result patient choice of GP has been increasing

though limited to a geographic area. Choice of

specialist and hospital is allowed, and there is a

large amount of information explaining to patients

how to exercise their choice. From October 2014,

GPs in England are able to register patients from

outside of their practice area. Where they do so, they are not obliged to provide home visits, out of hours care. In these circumstances, responsibility for ensuring the patient has access to urgent care when away from the practice area, rests with NHS England.

The number of acute care beds per 100 000 inhabitants (228 in 2013) is below the EU average of 356 and has consistently decreased in recent times (312 in 2003). Authorities indicate that while there are no shortages of non-acute care beds, patients may at times create bed-blockages in acute care while awaiting appropriate follow-up care contributing to lengthen waiting times for elective surgery. It is for the central government to plan the opening of new public hospitals, but there appears to be no regulation in terms of the number of beds, the provision of specific specialised services or the supply of high cost equipment capacity. This has, however, not contributed to excessive capacity in terms of beds or high-cost equipment. Hospitals have autonomy to recruit medical and other health

staff, while their pay scale is determined at

national level.

Treatment options, covered health services

The basic benefit package is not explicitly defined

but through clinical and cost-effectiveness

assessments, the National Institute for Health and

Care Excellence assesses some interventions,

(340) There are some self-referring secondary services.

medical devices and pharmaceuticals on the

grounds of their clinical- and cost-effectiveness.

Price of healthcare services, purchasing,

contracting and remuneration mechanisms

Primary care practitioners, grouped in primary care

practices, are mostly independent contractors.

Primary care practices are paid for a mix of

capitation, additional funding for the provision of

enhanced services, services related to preventive

care, chronic disease management and patient

satisfaction. For the provision of preventative care

and patient satisfaction primary care practices are

paid through the Quality and Outcomes

Framework. This is a voluntary scheme in England, but the vast majority of practices in England take it up. It ensures that practices are rewarded for providing systematic quality of care for patients, not just for the number of patients on their list.

Outpatient and inpatient specialists working in the public sector are paid a salary but are also eligible to receive bonuses related to preventive care and chronic disease activities and targets.

Hospital doctor salaries are determined at hospital level. Private sector doctors are paid on a fee-for-service basis. Hospital doctors can carry out private professional services or fee-paying services, in line with the provisions governing the relationship between NHS work, private practice and fee-paying services in their terms and conditions of service. This means doctors are required to inform their clinical managers of any regular commitments in respect of private professional services or fee-paying activity. Where there is a conflict in scheduling work, NHS

commitments must take precedence over private work.

An NHS GP is free to operate a private practice with private patients if they wish to do so. There are heavy restrictions on a GP's ability to charge fees to their NHS registered patients, but there are exceptions for procedures outside the General Medical Services Contracts Regulations such as signing passport applications and holiday insurance claims which GPs can issue a charge for.

When looking at hospital activity, inpatient discharges per 100 inhabitants are below the EU

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average (12.4 vs. 16.5 in 2013) but are more than compensated by the very high number of day case discharges which is well above the EU average (15,607, more than double EU average of 7,031 in 2013). The proportion of surgical procedures conducted as day cases (55.8%) is considerably above the EU average (almost twice the EU level

of 30.4% in 2013) and indeed one of the EU

highest. Overall hospital curative average length of

stay (6.6 days in 2011) is slightly above the EU

average (6.2 days). These figures suggest that

hospital throughput/efficiency is overall very high.

The market for pharmaceutical products

The Drug Tariff sets out what NHS dispensing

contractors will be paid for the drugs supplied.

There are controlled price amendments

(increases/decreases). There is a list of products

that cannot be supplied by prescribers as well as a

list of products which will only be reimbursed if

the listed conditions are fulfilled. Authorities

promote rational prescribing by physicians through

treatment and prescription guidelines (NICE

guidance on clinical and cost-effectiveness effects

of interventions, making prescribing measures

available for primary care. Information is also

available via NICE in the British National

Formulary [BNF] and the BNF for Children)

complemented with monitoring of prescribing

behaviour and education and information

campaigns on the prescription and use of

medicines.

These are coupled with pharmaceutical budgets.

For example, CCGs commonly define local lists of

recommended drugs which are considered

sufficient to meet the needs of patients as costeffectively

as possible and prescribers (in the UK,

nurses, pharmacists and other allied health

professionals can, and have, trained to become

prescribers) may be asked to justify prescribing

outside the recommendations. There are also

prescribing advisers employed at various levels of

healthcare organisations to encourage rational and

cost-effective prescribing and reviewing

prescribing behaviour. Some CCGs also run

prescribing incentives schemes with GPs so that

they receive a (modest) bonus if they use costeffective

clinically appropriate prescribing.

In England, patients pay a flat rate prescription

charge for each item dispensed via an NHS

prescription, unless one qualifies for exemption.

There is an explicit generics policy although

generic substitution cannot take place i.e.

pharmacies are obliged to dispense the product prescribed by the doctor. However, prescribers are strongly encouraged to prescribe by their generic name for good professional practice (so pharmacists can provide the patient the cheapest product available) and for value for money reasons.

eHealth, Electronic Health Record

The Department of Health published an Information Strategy (May 2012) which set out a ten-year framework for transforming information for health and care. Working with stakeholders DH are in the process of implementing this vision and making progress. A key commitment was to give patients online record access to their GP record by March 2015.

In England resources have been made available to help the service accelerate progress towards a fully integrated health and care service- over GBP 500 m available to NHS trusts to accelerate progress to towards use of integrated digital care records by 2018, and over GBP 100 m to support nurses,

midwives and health visitors to make better use of

digital technology in all care settings. In addition,

in 2013, the government allocated GBP 5.3 bn to

support the transformation in integrated health and

social care through the Better Care Fund.

NHS England's Business Plan 2014/15 - 2016/17

outlined that by March 2015 patients would be

able to order repeat prescriptions online, book

appointments online and have online access to GP

records available in 95% of GP practices.

Health and health-system information and

reporting mechanisms/ Use of Health

Technology Assessments and cost-benefit

analysis

A large amount of prescribing data is available,

practice by practice, to prescribers and advisers to

allow benchmarking and encourage improvement.

There are also information and education

campaigns directed at patients and cost-sharing to

encourage a rational use of medicines on the

patients' side. For many years, the DH published

the share of generic prescribing as an indicator but

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the focus has now developed in one of making the best use of medicines. This is called Medicines Optimisation and it works to make sure that the right patient gets the right choice of medicine at the right time. The Medicines and Prescribing Centre (part of NICE) provides a wide range of material and training to promote good quality prescribing. Prescribing advisers also encourage generic prescription.

Within the Quality Outcomes Framework, an annual reward scheme, detailed information is provided in the form of indicators to assess the performance of each GP at the national level.

Capturing GPs' performance is also GPOS (general practice outcome standards).

The HS Outcomes Framework includes a set of system performance indicators that contribute to the evaluation of the performance of NHS England in managing the health care sector so that it generates improvements in health outcomes.

Further measures to improve quality will include implementing a monitoring and evaluation system based on defined indicators. Major IT development plans include establishing a database for the insurance system, developing a personal identification system, improving remote diagnostics and telemedicine.

Healthy lifestyle and disease prevention activities have received a lot of attention mainly through programmes aiming at improving the health status and quality of life of the population.

Recently legislated and/or planned policy reforms

The NHS in England has undergone major changes in its core organisational and governance structure; most changes took effect on April 1 2013 (for an overview of the most important changes see

<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>; accessed November 1, 2013).

The Department of Health (DH) is still responsible for strategic leadership of both the health and social **care** systems, but is no longer the

headquarters of the NHS, nor will it directly manage any NHS organisations. This responsibility has shifted to the new organisation NHS England.

NHS England is responsible for:

- Using its national remit to secure improvements in population health (variously improvements in NHS outcomes, and national priorities identified in the NHS Mandate),
- National commissioning of primary care (general practice, dentistry, community pharmacy, and ophthalmology) and specialised services,
- Allocation of funds between services and to local Clinical Commissioning Groups,
- Oversight of the activities of Clinical Commissioning Groups.

Primary care trusts (PCTs) and strategic health authorities (SHAs) have been abolished and new organisations, clinical commissioning groups (CCGs), were established. Primary care trusts (PCTs) used to commission most NHS services

and controlled 80% of the NHS budget. On April 1 2013, PCTs were abolished and CCGs were established. All GP practices must now be a member of a CCG and the groups also include other health professionals, such as nurses. CCGs commission most services and can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities, or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers. A new regulator (Monitor) oversees and regulates these new arrangements (for more information on this new regulator see <http://www.monitornhsft.gov.uk/about-monitor-0>; accessed November 1, 2013). As of January 2016 the vast majority of hospitals and other NHS trusts have become foundation trusts (341); foundation trust will have more 'freedom' and a different structure than NHS

trusts (for more details see [http://www.monitornhsft.](http://www.monitornhsft.gov.uk/about-nhs-foundation-trusts/what-are-)

gov.uk/about-nhs-foundation-trusts/what-are-

(341) 101 foundation trusts out of 154 acute trusts

43 foundation trusts out of 56 mental health trusts

3 foundation trusts out of 37 community providers

5 foundation trusts out of 10 ambulance trusts

<http://www.nhsconfed.org/resources/key-statistics-on-the-nhs>,

accessed March 2 2016.

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nhs-foundation-trusts; accessed November 1,

2013).

In addition, local authorities are tasked to take on a

bigger role, which is in line with the political aim

of greater overall responsibility at the local level.

Local authorities are intended to assume

responsibility for budgets for public health. Health

and wellbeing boards have duties to encourage

integrated working between commissioners of

services across health, social **care**, public health

and children's services. With the aim to support the joint effort of NHS and local government in working around people, placing their well-being as the focus of health and care services, the Better Care fund created a local single pooled budget. A new organisation, Public Health England (PHE), provides national leadership and expert services to support public health.

The authorities have implemented a number of policies to control expenditure on pharmaceuticals.

There are no separate pricing and reimbursement decisions for reimbursed medicines. The

Pharmaceutical Price Regulation Scheme controls the price of branded medicines and the profits pharmaceutical companies can make on selling drugs to the NHS. If companies make too high a profit on NHS reimbursed drugs, they must either reduce the price or repay the NHS.

The 2014 Pharmaceutical Price Regulation Scheme (PPRS) was introduced on 1 January 2014. The scheme will provide assurance on almost all the branded medicines bill for the NHS.

The bill will stay flat over the first 2 years of the scheme and will grow slowly after that. The industry will make payments to the Department of Health if NHS spending on branded medicines exceeds the allowed growth rate.

The document "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21" sets out a clearly defined list of priorities for 2016/2017 for each health system and longer term challenges, summarised by nine must dos, supporting the planned delivery of the Forward View. The priorities focus on improvements that all components of the system should try to achieve, ranging from the aggregate financial balance, to quality improvements at all levels of care (primary, emergency and secondary care) and realising efficiency gains.

The Forward View itself focusses on three main key areas:

- prevention and public health in light of projected risk factors in the population;
- removing the barriers between different

healthcare providers;

- efficiency in spending to ensure there is no

mismatch between resources and need (342).

Challenges

The analysis above shows that a range of reforms

have been implemented in recent years, for

example, to ensure access to a wide range of care,

to improve the quality of care, to increase patient

choice, to reduce waiting times, to increase activity

and efficiency and to control pharmaceutical

expenditure. They were to a large extent successful

and the UK should continue to pursue them. The

main challenges for the UK health care system are

as follows:

- To continue increasing the efficiency of health

care spending, promoting quality and

integrated patient packages as well as a

focusing on productivity and costs in order to

avoid the mismatch between health care needs

and resources and ensure consistency with a

challenging overall budgetary framework, in

view of the future projected increase in health

care expenditure over the coming decades, due

to population ageing and non-demographic

factors.

- To continue to enhance primary care provision

by increasing the numbers and spatial

distribution of GPs and primary care nurses,

investing more in training and developing

options to increase retention as envisaged in the

Forward View. Additional numbers of needed

primary care staff can render the referral

system to specialist care more effective and

increase actual patient choice.

- To enact the commitment to remove the

barriers between different healthcare

(342) [https://www.england.nhs.uk/wpcontent/](https://www.england.nhs.uk/wpcontent/uploads/2014/10/5yfv-web.pdf)

uploads/2014/10/5yfv-web.pdf, accessed March 3,

2016.

Health care systems

1.28. United Kingdom

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providers so that care is shifted towards

community settings, care is delivered in an

integrated way and patients, especially those

with chronic conditions, are increasingly

empowered. Consistently, to shift resources

from acute to primary and community services

to strengthen and further develop communitybased

care.

- To reinforce the existing human resources

strategy to tackle current shortages in staff,

including in primary care staff, and ensure

sufficient numbers of staff in the future in view

of staff and population ageing.

- To continue to monitor the coherence of

resource allocation to different types of care

across geographic areas following devolution

and decentralised commissioning of care to

CCGs, to avoid possible variations in care

availability and quality.

- To further the efforts to improve information in

a number of areas and further introducing ICT

and eHealth solutions to allow for nationwide electronic exchange of medical data (including patient electronic medical records) to support choice, reduce medical errors and increase cost-efficiency such that general practitioners, municipalities and hospitals work closely together to give citizens a coordinated package of treatment.

- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity) in various settings (at work, in school).
- To ensure equal access to health promotion and disease prevention activities to help reducing health inequalities between UK countries and regions.

Health care systems

1.28. United Kingdom

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Table 1.28.1: Statistical Annex – United Kingdom

Sources: EUROSTAT, OECD and WHO

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General context

GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

GDP, in billion Euro, current prices 1720 1849 1946 2063 2169 1908 1668 1813 1866 2054 2043 9289 9800 9934

GDP per capita PPS (thousands) 31.9 32.9 33.2 33.4 32.9 31.0 28.2 27.4 27.0 27.4 27.3 26.8 28.0 27.9

Real GDP growth (% year-on-year) per capita 3.5 2.7 2.6 2.2 2.7 -1.4 -5.8 0.9 0.4 -1.2 1.1 -4.8 1.4 -0.1

Real total health expenditure growth (% year-on-year) per capita 5.8 4.6 5.5 4.2 3.7 3.4 4.4 -2.8 -1.1 -0.8 -0.5 3.2 -0.2 -0.4

Expenditure on health* 2009 2011 2013

Total as % of GDP 7.8 7.9 8.1 8.3 8.4 8.8 9.7 9.4 9.2 9.3 9.1 10.4 10.1 10.1

Total current as % of GDP 7.1 7.3 7.4 7.6 7.6 7.9 8.8 8.6 8.5 8.5 8.5 9.8 9.6 9.7

Total capital investment as % of GDP 0.7 0.6 0.7 0.7 0.7 0.9 1.0 0.8 0.8 0.8 0.7 0.6 0.5 0.5

Total per capita PPS 1707 1833 1984 2124 2246 2392 2573 2574 2619 2684 2734 2828 2911 2995

Public as % of GDP 6.2 6.4 6.6 6.8 6.7 7.2 8.1 7.9 7.7 7.8 7.6 8.1 7.8 7.8

Public current as % of GDP 6.0 6.3 6.4 6.6 6.6 7.0 7.8 7.6 7.4 7.3 7.3 7.9 7.7 7.7

Public per capita PPS 1306 1442 1550 1664 1750 1858 2028 2070 1997 1852 1927 2079 2218 2208

Public capital investment as % of GDP 0.2 0.2 0.2 0.2 0.2 0.2 0.3 0.3 0.3 0.4 0.3 0.2 0.2 0.1

Public as % total expenditure on health 79.3 81.4 81.3 81.7 80.5 81.5 83.2 84.0 83.4 84.0 83.5 77.6 77.2 77.4

Public expenditure on health in % of total government expenditure 15.1 15.7 15.7 16.1 16.2 15.7 16.3 16.2 16.5 16.6 : 14.8 14.9 :

Proportion of the population covered by public or primary private health insurance 100.0 100.0 100.0 100.0 100.0 100.0 100.0 99.7 99.7 98.7

Out-of-pocket expenditure on health as % of total expenditure on health 11.1 10.0 9.6 9.9 10.1 8.9 8.7 8.8 9.3 9.0 9.3 14.1 14.4 14.1

Population and health status 2009 2011 2013

Population, current (millions) 59.8 59.8 60.2 60.6 61.1 61.6 62.0 62.5 63.0 63.5 63.9 502.1 504.5 506.6

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Life expectancy at birth for females 80.5 81.1 81.3 81.6 81.8 81.8 82.4 82.6 83.0 82.8 82.9 82.6 83.1 83.3

Life expectancy at birth for males 76.2 76.8 77.0 77.3 77.6 77.7 78.3 78.6 79.0 79.1 79.2 76.6 77.3 77.8

Healthy life years at birth females 60.9 : 65.5 64.9 66.0 66.3 66.1 65.6 65.2 64.5 64.8 : 62.1 61.5

Healthy life years at birth males 61.5 : 64.2 64.8 64.6 65.0 65.0 64.9 65.2 64.6 64.4 : 61.7 61.4

Amenable mortality rates per 100 000 inhabitants* 77 72 68 63 60 58 54 52 105 104 : 64.4 128.4 :

Infant mortality rate per 1 000 live births 5.3 5.0 5.1 4.9 4.7 4.6 4.5 4.2 4.2 4.1 3.8 4.2 3.9 3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : : : 3.13 2.99 3.01

Day cases curative and rehabilitative care : : : : : : : 0.18 0.18 0.19

Out-patient curative and rehabilitative care 1.30 1.29 1.37 1.22 0.83 1.40 1.24 1.14 1.00 1.06 0.98 2.29 2.25 2.24

Pharmaceuticals and other medical non-durables 1.00 1.00 1.00 1.00 1.00 1.00 : : : : : 1.60 1.55 1.44

Therapeutic appliances and other medical durables : : : : : : : 0.31 0.31 0.32

Prevention and public health services : : : : : : : 0.25 0.25 0.24

Health administration and health insurance : : : : : : : 0.42 0.41 0.47

Composition of public current expenditure as % of GDP

Inpatient curative and rehabilitative care : : : : : : : 2.73 2.61 2.62

Day cases curative and rehabilitative care : : : : : : : 0.16 0.16 0.18

Out-patient curative and rehabilitative care : : : : : : : 1.74 1.71 1.80

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Pharmaceuticals and other medical non-durables 0.73 0.74 0.74 0.70 0.67 0.68 0.72 0.79 0.79 0.81 0.80 0.79 1.07
0.96

Therapeutic appliances and other medical durables : : : : : 0.13 0.12 0.13

Prevention and public health services : : : : : 0.25 0.20 0.19

Health administration and health insurance : : : : : 0.11 0.27 0.27

EU- latest national data

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

EU- latest national data

Health care systems

1.28. United Kingdom

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Table 1.28.2: Statistical Annex - continued – United Kingdom

Sources: EUROSTAT, OECD and WHO

Composition of total as % of total current health expenditure 2003 2004 2005 2006 2007 2008 2009 2010 2011
2012 2013 2009 2011 2013

Inpatient curative and rehabilitative care : : : : : 31.8% 31.3% 31.1%

Day cases curative and rehabilitative care : : : : : 1.8% 1.9% 1.9%

Out-patient curative and rehabilitative care 18.3% 17.7% 18.4% 16.2% 10.9% 17.6% 14.2% 13.3% 11.8% 12.4%
11.6% 23.3% 23.5% 23.2%

Pharmaceuticals and other medical non-durables 14.1% 13.7% 13.4% 13.2% 13.1% 12.6% : : : : 16.3% 16.2%
14.9%

Therapeutic appliances and other medical durables : : : : : 3.2% 3.3% 3.3%

Prevention and public health services : : : : : 2.6% 2.6% 2.5%

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Health administration and health insurance : : : : : : : : : : 4.2% 4.3% 4.9%

Composition of public as % of public current health expenditure

Inpatient curative and rehabilitative care : : : : : : : : : : 34.6% 34.1% 34.0%

Day cases curative and rehabilitative care : : : : : : : : : : 2.0% 2.1% 2.3%

Out-patient curative and rehabilitative care : : : : : : : : : : 22.0% 22.3% 23.4%

Pharmaceuticals and other medical non-durables 12.2% 11.8% 11.5% 10.6% 10.2% 9.8% 9.2% 10.4% 10.6%
11.0% 10.9% 10.0% 13.9% 12.5%

Therapeutic appliances and other medical durables : : : : : : : : : : 1.6% 1.6% 1.6%

Prevention and public health services : : : : : : : : : : 3.2% 2.7% 2.5%

Health administration and health insurance : : : : : : : : : : 1.4% 3.5% 3.5%

Expenditure drivers (technology, life style) 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009
2011 2013

MRI units per 100 000 inhabitants 0.46 0.50 0.54 0.56 : 0.55 : 0.63 0.66 : 0.61 1.0 1.1 1.0

Angiography units per 100 000 inhabitants : : : 0.1 0.1 : : : : : 0.9 0.9 0.8

CTS per 100 000 inhabitants 0.7 0.7 0.7 0.8 : 0.7 : 0.8 0.8 : 0.8 1.8 1.7 1.6

PET scanners per 100 000 inhabitants : : : : : : : : : : 0.1 0.1 0.1

Proportion of the population that is obese 23.0 23.0 23.0 24.0 24.0 24.5 23.0 26.1 24.8 24.7 24.9 14.9 15.4 15.5

Proportion of the population that is a regular smoker 26.0 25.0 24.0 22.0 21.0 21.0 21.0 20.0 20.0 20.0 : 23.2 22.4
22.0

Alcohol consumption litres per capita 11.6 11.7 11.5 11.3 11.5 10.7 10.8 10.5 10.3 9.7 : 10.3 10.0 9.8

Providers 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Practising physicians per 100 000 inhabitants 218 231 239 245 249 258 267 272 276 275 277 329 335 344

Practising nurses per 100 000 inhabitants 1003 1016 1024 991 963 967 983 960 841 821 818 840 812 837

General practitioners per 100 000 inhabitants : 58 60 60 60 59 58 80 81 80 80 : 78 78.3

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Acute hospital beds per 100 000 inhabitants 312 308 299 287 275 272 268 241 237 231 228 373 360 356

Outputs 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2009 2011 2013

Doctors consultations per capita 5.2 5.3 5.0 5.1 5.0 5.9 5.0 : : : 6.3 6.2 6.2

Hospital inpatient discharges per 100 inhabitants 12.8 12.8 12.7 12.5 12.5 12.6 12.7 12.7 12.5 12.4 12.4 16.6 16.4 16.5

Day cases discharges per 100 000 inhabitants 10,253 10,653 11,667 12,358 13,152 14,009 14,487 14,826 15,059 15,086 15,607 6368 6530 7031

Acute care bed occupancy rates 84.0 84.0 84.0 83.0 84.0 84.8 84.2 84.4 : : : 72.0 73.1 70.2

Hospital curative average length of stay 7.1 6.9 6.7 6.4 6.3 6.2 6.1 5.9 5.9 5.9 5.9 6.5 6.3 6.3

Day cases as % of all hospital discharges 43.9 : : 50.2 51.7 : 53.2 53.9 54.6 54.8 55.8 27.8 28.7 30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP* 2013 2020 2030 2040 2050 2060

AWG reference scenario 7.8 8.1 8.5 8.8 9.0 9.1

AWG risk scenario 7.8 8.2 8.8 9.4 9.7 9.8

Note: *Excluding expenditure on medical long-term care component.

Population projections 2013 2020 2030 2040 2050 2060

Population projections until 2060 (millions) 64.1 66.9 70.6 74.0 77.3 80.1

EU- latest national data

EU- latest national data

Change 2013 - 2060 EU Change 2013 - 2060

25.0 3.1

1.3 0.9

2.0 1.6

Change 2013 - 2060, in % EU - Change 2013 - 2060, in %

2. LONG-TERM CARE SYSTEMS

2.1. AUSTRIA

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General context: expenditure, fiscal

sustainability and demographic trends

Austria, federal republic consisting of nine states

("Bundesländer"), and member of the European

Union since 1995, has a population of about 8.5

million inhabitants, which accounts for slightly

less than 1.7% of the EU population in 2013. With

a GDP of more than EUR 300 billion (323 in

2013), or 33,200 PPS per capita it is also among

the richest EU member states. Public expenditure

on LTC was with 1.3% of GDP in 2012 low

compared to other rich member states, but above

average compared to the overall EU average of

1.0% of GDP.

Health status

Life expectancy at birth for both men and women

in 2013 was 78.6 years and 83.8 years and lies

above the EU average values (77.8 and 83.3 years

respectively in 2013). Nevertheless, the healthy

life years at birth are with 60.2 years (women) and 59.7 years (men) below the EU-average (61.5 and 61.4 respectively). At the same time the percentage of the Austrian population having a long-standing illness or health problem is slightly higher than in the Union as a whole (34.5% vs EU 32.5% respectively). The percentage of the population indicating a self-perceived severe limitation in its daily activities has been slightly decreasing in the last few years, going from 10.2 in 2004 to 9.7 in 2013, but is still higher than the EU-average of 8.7%.

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.78 million residents living with strong limitations due to health problems in 2013, an increase of 57% is envisaged until 2060 to around 1.22 million. That is a steeper increase than in the EU as a whole (57% vs. 40%). Also as a share of the population, the dependents are becoming a bigger group, from

9.2% to 12.6%, an increase of 38%, slightly higher

than the EU average (EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

AWG reference scenario, public long-term

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 1.3 pps

of GDP by 2060 (from 1.4% to 2.7%) (343). The

AWG risk scenario, which in comparison to the

AWG reference scenario captures the impact of

additional cost drivers to demography and health

status, i.e. the possible effect of a cost and

coverage convergence, projects an increase in

spending of 2.8 pps of GDP by 2060, higher, with

almost 200% than the EU average of 149%.

Overall, projected long-term care expenditure

increase is expected to add to budgetary pressure.

Sustainability risks appear over the long run due to

the projected increase in age-related public

spending, notably deriving from long-term care

and healthcare (344).

System Characteristics

Owing to the internal division of powers is the rule

that all matters falling within the independent

remit of countries which does not expressly refer

to the Federal Constitution, legislation or by the

implementation have been transferred to the

Federal Government. Therefore, the field of social

services was the responsibility of the states.

According to the Agreement between the Federal

Government and the States, in accordance with

Art. 15a B-VG on common measures of the

Federal Government and the States for dependent

persons, BGBl. No 866/1993, the Parties agree, on

the basis of Austria's federal structure, that

provision for persons reliant on care throughout

Austria should follow identical aims and

principles. In this agreement the states are obliged

for a minimum standard of long-term care services

such as mobile care services, residential care

(343) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(344) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

Long-term care systems

2.1. Austria

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facilities, part-time care services, short-term care

services in residential care facilities, a case & care

management.

Types of care

The Austrian system of LTC has a twofold design,

consisting of cash benefits on the one hand, and

publicly organised LTC services in kind on the

other hand. The system of care provision is mainly

based on three pillars. The first pillar provides the

care allowances, the second pillar consists of

measures to support carers and the third pillar

consists of the care services.

Cash benefits As from the beginning of 2012 LTC

cash benefits ("Pflegegeld"), originally introduced

in 1993, fall within the sole competency of the

federal state.

The benefit currently amounts to EUR 157.30 per

month in level 1 (the lowest level), but may be as

high as EUR 1,688.90 in level 7 (the highest level).

(345) These cash benefits are intended to be used to

buy formal care services from public or private

providers or to reimburse informal care giving.

However, it is not being controlled for what

purposes LTC benefits are actually used by the

benefit recipients.

Measures to support family carers. Currently,

there are a large number of options to support

family carers, including by improving

compatibility between care and work, such as:

- carer's leave and part-time working

arrangements, the entitlement to a carer's leave

allowance;

- financial contributions towards the cost of

substitute care in case of unavailability of the

primary caregiver;

- social insurance for family carers;
- advisory services to citizens provided by the

Ministry of Social Affairs;

- counselling for family members;
- measures under the strategy for dementia;

(345) Stand: 26 August 2014.

- young carers;
- visits within the framework of quality

assurance in home care.

24-hour care. Under the initiative of the Ministry

of Social Affairs, the legal framework for quality-assured

24-hour care was established and a

corresponding subsidy scheme was developed in

2007. According to this scheme, caring in private

homes can be regulated as self-employed or

employed work. 24-hour home-care is an essential

tool for people in need of care and their families to

ensure a legitimate, quality-assured home care. In

accordance with Section 21b of the Federal Long-

Term Care Act, the Ministry of Social Affairs has

developed a model that finances benefits for

dependents and their family members. Provided

the conditions for funding are met (346) in

accordance with the Home Care Act

(Hausbetreuungsgesetz), a maximum amount of

EUR 550 per month (when two self-employed

carers are deployed) or EUR 1.100 per month

(when two employed carers are deployed). The

responsibilities in the financing of this scheme are

split between the federal government, financing

60%, and the states, responsible for 40%.

Long-term care fund. In the field of long-term

care the Federal Government plays a major role in

securing funding to support regional governments

(346) In order to obtain financial support for 24 hour care, the

following conditions have to be fulfilled:

- A need for (up to) 24-hour care
- Receipt of long-term care benefit at Stage 3 or higher
- Existence of a care relationship (i.e. a formal or informal contract) between a carer and the person in need of care or

a family member, or a contract between either of these

persons and a non-profit organisation offering care services

•Carers need to be able to prove that they have either

completed a theoretical training course (which is

essentially the same as that for a home help), or have cared

for the person applying for the subsidy in a proper manner

for at least six months. Alternatively, the carer must

possess official authorisation for carrying out care work or

nursing work. There are also income thresholds for

entitlement set at EUR 2,500 net per month, excluding

benefits. Assets are not taken into account. Increases of

EUR 400 for every family member who is dependent or

entitled to maintenance, and by EUR 600 for family

members who are disabled and entitled to maintenance are

established.

https://www.sozialministerium.at/siteEN/Pension_Nursing/

Long_term Care Benefit/24_hour care.

Long-term care systems

2.1. Austria

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in cover expenditure for long-term services and

facilities, alongside supporting in the provision of benefits.

The Long-term care fund, established in 2011 and managed by the Ministry of Social Affairs, supports the states and local authorities in the field of long-term care in the safeguarding and improvement of adequate care for dependent people and their families with responsive and affordable care services.

The Long-term care fund, adopted in 2011, is a significant step forward in the harmonisation of long term care services. The long-term care fund, for the years 2011 to 2016, amounts to a total of EUR 1,335 billion. An increase of EUR 700 million has been proposed for 2017 and 2018, currently under negotiation between the federal government and the states.

In addition, the states are responsible for the delivery of institutional inpatient, ambulatory, semi-outpatient and outpatient (i.e. at-home) care services. These services are de facto implemented

in cooperation with municipalities and non-profit organisations of the so-called intermediary sector, i.e. social NGOs of different types.

Role of the private sector

Services are being provided by municipalities and non-profit organisations of the so-called intermediary sector, i.e. social NGOs of different types. The role of private providers in the provision of publicly guaranteed LTC provision is unknown. At the same time cash benefits can be used to buy formal care services from public or private providers or to reimburse informal care giving.

Eligibility criteria and user choices:

dependency, care needs, income

In the Austrian LTC system no definition of “need of care” exists, but eligibility requirements for cash allowances partly could be seen as a substitute for such a definition. The assessment of the need for LTC is rather based on individual requirements for personal services and assistance. The need for both personal services and assistance is required in

order to qualify for federal or provincial LTC

allowances.

Needs assessment is based on a doctors' expert opinion. Representatives of other fields (e.g. nursing) are also brought in for an extensive assessment of the situation. The expert opinion is usually drawn up after an examination at home. It is possible for a trusted third party to be present during the examination, if desired by the person applying for LTC allowance. The eligibility decision is made by means of an official notification with the possibility to appeal against this decision at the appropriate Labour and Social Court. The examination, the classification, as well as the payment of the LTC allowance, are carried out by social insurance institutions, specifically pension insurance and accident insurance.

The specific provisions regarding the assessment of need of care are laid down in an ordinance. This ordinance defines care and assistance and the time allotted to individual tasks, e.g. dressing and undressing, care of the body, preparation of food,

feeding as well as mobility assistance. In addition to that, the Federation of Austrian Social Insurance Institutions has the right to define national guidelines for assessing needs of care. Such guidelines were issued and updated several times in order to assure the uniform interpretation of the respective laws also in practice and over different decision makers.

Co-payments, out of the pocket expenses and private insurance

Access to LTC benefits in-kind and LTC services is in principle not free of charge. Here, meanstesting applies, where all kinds of personal income, including LTC cash benefits and assets (which may get capitalised), are taken into account.

LTC cash benefits are granted without meanstesting (against income or assets) and based on

care needs categorised in seven different levels of need.

Social services are provided by entities under

private law. Persons in need of care may be

requested to make contributions to the costs of

social services but the social aspects have to be taken into consideration in assessing the share to be borne by them. Thus, there is in general some kind of means testing regarding to social services, but the concrete form differs by state.

Long-term care systems

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eHealth

The Federal Ministry for Labour, Social Affairs and Consumer Protection, has commissioned the computer application 'PFIF pflegegeldinformation' used by the Main Association of Austrian social insurance institutions. With the introduction of PFIF the existing system has been strengthened and upgraded. This application provides a valuable tool to improve the situation for dependent people and their families, by monitoring the overall process of all care allowances in Austria, including application and payment, as well as by providing comprehensive statistical evaluation of available

options. In addition, this database is constantly updated to account for changes to the existing legal framework.

In order to enhance the transparency, validity and

comparability of the data in terms of care and

long-term care and to increase the quality of care

supply, a national long-term care database

"Pflegedienstleistungsdatenbank" was launched at

the beginning of July 2012 by the Austrian Federal

Statistics Office, on behalf of the Ministry of

Social Affairs established. This is based on the

2012 — legislation on care-services related

statistics (BGBl. II No 302/2012). This database

covers all long-term care services including

mobile, semi-residential and residential care

services for elderly and dependent population.

Formal/informal caregiving

Most persons in need of care prefer staying in the

private environment and receiving informal care

from relatives or family members over formal

care; consequently, roughly 80% of persons in

need of care do receive informal care. By providing the cash allowance irrespective of the chosen care setting (formal/informal, institution/home based), the philosophy of the system again is one supporting the possibility for individual choice.

Recently legislated and/or planned policy reforms

The Working Group on Long-term Care Reform, which was established by the government to deal with respective problems and to develop a strategy for the future suggested inter alia introducing a care leave or part-time care leave for care-giving close relatives. This care leave has the aim to support the usually working relatives during the first stage of care to better coordinate work and care.

The care leave and part-time care leave was implemented in 2014, the provisions in the Federal Long-term Care Allowance Act

("Bundespflegegeldgesetz") entered into force on January 1, 2014. Since then workers can take care leave or part-time care leave waiving income from employment in order to care and nurse family members in need of care. Persons can also take family hospice leave or part-time family hospice leave for the purpose of nursing a dying close family member or a seriously ill child. These family members can claim under certain conditions care leave benefits (certain level of LTC benefit of the family member in need of care, employment contract lasts since at least three months - comprehensive insurance). A close family member may draw care leave benefits for one to three months during care leave or part-time care leave, depending on the period of leave agreed with the employer. If the level of the LTC benefit is raised, employer and employee may agree on one single additional period of care leave or part-time care leave. In case of family hospice

leave for the purpose of nursing a dying close

family member (no LTC benefit necessary) the

care leave benefits can be drawn for up to six

months (basically three months with the possibility

of prolongation up to six months). In case of

family hospice leave for the purpose of nursing a

seriously ill child the (no LTC benefit necessary)

care leave benefits can be drawn for up to nine

months (basically five months with the possibility

of prolongation up to nine months).

The rate of **care** leave benefits is income-related

and basically equal to the rate of unemployment

benefits (55 % of daily net income) plus children's

allowance.

In the context of the quality assurance of home

care the situation of **care**-giving relatives has been

evaluated and the results show that relatives often

indicate emotional stress because of their **caring**

responsibilities and should therefore be supported

as much as possible. After pilot testing, the

initiative "dialogue with relatives" has been

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established. To support family carers, psychologists or professional social workers provide free counselling services, offering advice and psychological support to prevent any health consequence due to mental stress.

It is estimated that between 115,000 and 130,000 people in Austria are currently living with some form of dementia. On the basis of population ageing and the increasing life-expectancy is foreseeable that the number of –people suffering from dementia will increase. Therefore, the Federal Government, in its current work programme, is prioritising the development of a dementia strategy “demenzstrategie”.

The first step towards the strategy was the 2014 report on dementia, "Österreichische Demenzbericht 2014", based on research carried out by the

Austria's leading health care company GmbH AHC, on behalf of Ministry of Social Affairs and Health. The report constitutes the status quo as

regards the supply situation of people with dementia impairments and provides epidemiological key messages on the prevalence of dementia in Austria.

The technical work has been carried out by 6 working groups in a participative process, emphasising the importance to a common crosspolicy approach in long-term care. Representatives of the provincial, municipal and local federations, social security institutions, scientific community, key stakeholders, developed recommendations targeting those seen as key issues.

A total of 21 recommendations reflect 7 main targets:

- involvement and empowerment of affected;
- develop width and target-group specific information;
- knowledge and skills;
- uniform conditions;
- ensure offers of dementia care;
- develop coordination and cooperation;
- quality assurance and improvement through

research.

In 2015 the report of the experts “demenzstrategie

— Living well with dementia” was presented to the

public and the implementation has started.

The future of LTC has gained increased political

attention in Austria over the last few years. To deal

with respective problems and to develop a strategy

for the future, the above mentioned Working

Group on Long-term Care Reform suggested

taking into account an amendment of the Act on

Long-term Care Funds, which was adopted in

2013.

Overall, these developments do not point towards a

structural change of the main features of the

Austrian LTC system. The aim appears to be to

safeguard financial sustainability in view of rising

demand (and without reduced accessibility).

Within this context, the Reform Working Group

rejected the idea of a separate contributionfinanced

LTC insurance and clearly stated that

LTC services should remain tax-financed.

Furthermore, the currently existing model of a

combination of universal cash benefits and (means-tested) LTC services administered by the states and municipalities has not been put into question. It is, however, the declared aim to do more to harmonise the access to available services, to focus on the further development of mobile/outpatient services (also for reasons of cost containment) and to promote innovative approaches.

The financing of the current LTC system appears to be safeguarded for the next three years, partly due to the decision to prolong the Long-term Care Fund until 2016. After that, given the rising demand, additional funds will have to be made available. But the degree to which economic resources for LTC will be raised will then again be subject to negotiations between the federal government and the states. Negotiations on the budget redistribution between the federal government and the states, including in the area of long-term care, are currently taking place for the period 2017-2021.

Another possible future policy challenge are caregiving children and adolescents ('young carers').

Care-giving children are a social phenomenon,

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which was given little credit so far. In December 2012 the results of a study, which was financed by the Federal Ministry of Labour, Social Affairs and Consumer Protection, were published under the title "Children and Adolescents as informal caregivers; an inside look into the past and present situation of young carers in Austria". This study, which was carried out by the Institute for Nursing Science, shows for the first time figures about how many care-giving children exist in Austria and on the other hand also shows the way and frequency of assistance by these children. According to this study there are 42,700 care-giving children and adolescents between the age of 5 and 18 in Austria.

Building on the results of the previous study,

raising awareness on young carers, a follow-up study "Children and young people as family carers: insight on the condition and possible support measures" was carried out in 2014. (347) This study developed a basic framework focused on young carers (e.g. the need to support young carers, information and advice, expert views, resources) as well as with focus on their family (coordination of assistance within the family.). This study provides evidence on which particular programmes can be applied to support young carers and their families and it serves as guidance for those institutions intending to implement support programmes in this area.

Challenges

Austria has a relatively fragmented system of LTC, with unequal coverage across regions and a large provision of informal care that is privately financed. The main challenges of the system appear to be:

- Improving the governance framework and increase administrative efficiency: to strengthen the existing legal and governance

framework for a clearer delineation of responsibilities of states with respect to the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and

(347)

http://www.studienreihe.at/cs/Satellite?pagename=Z02/index&n=Z02_0.

policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social assistance or housing subsidy programmes.

- Improving financing arrangements: to foster pre-funding elements, which implies setting aside some funds to pay for future obligations.

- Providing adequate levels of care to those in

need of care: to adapt and improve LTC

coverage schemes, setting a homogenous needlevel

triggering entitlement to coverage and the

depth of coverage, that is, setting the extent of

user cost-sharing on LTC benefits; and the

scope of coverage, that is, setting the types of

services included into the coverage.

- Continue to encourage home care and to

support family carers to continue to monitor

and evaluate alternative services, including

incentives for use of alternative settings; to

strengthen policies for supporting informal

carers, while ensuring that incentives for

employment of carers are not diminished and

women are not encouraged to withdraw from

the labour market for caring reasons.

- Ensuring availability of formal carers: to

determine current and future needs for

qualified human resources and facilities for

long-term care; to improve recruitment efforts,

including through the migration of LTC

workers and the extension of recruitment pools

of workers; to increase the retention of

successfully recruited LTC workers, by

improving the pay and working conditions of

the LTC workforce, training opportunities,

more responsibilities on-the-job, feedback

support and supervision.

- To facilitate appropriate utilisation across

health and long-term care: to arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC.

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- Changing payment incentives for providers:

to consider a focused use of budgets negotiated

ex-ante or based on a pre-fixed share of highneed

users.

- To facilitate appropriate utilisation across

health and long-term care: to consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- Improving value for money: to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and coordination between health and care services; to invest in ICT as an important source of information, care management and coordination.

- Prevention: To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

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Table 2.1.1: Statistical Annex – Austria

Sources: EUROSTAT, OECD and WHO

GENERAL CONTEXT

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 231 242 253 266 282 292 286 295 309 317 323 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 31.0 31.9 31.7 32.8 33.4 33.1 30.9 32.0 32.6 33.4 33.2 26.8 27.6 28.0 28.1 27.9

Population, in millions 8.1 8.1 8.2 8.3 8.3 8.3 8.3 8.4 8.4 8.4 8.5 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 1.0 1.0 1.0 1.0 1.0 1.1 1.2 1.2 1.2 1.3 : 1.0 1.0 1.0 1.0 :

Per capita PPS 272.2 285.5 291.8 312.3 321.0 339.9 363.2 388.2 401.0 413.2 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 1.9 2.1 2.1 2.1 2.2 2.3 2.3 2.4 2.4 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 81.5 82.1 82.2 82.8 83.1 83.3 83.2 83.5 83.8 83.6 83.8 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 75.9 76.4 76.6 77.1 77.4 77.7 77.6 77.8 78.3 78.4 78.6 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 69.6 60.4 60.1 61.0 61.4 59.9 60.8 60.8 60.1 62.5 60.2 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 66.2 58.3 58.2 58.7 58.7 58.5 59.5 59.4 59.5 60.2 59.7 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 21.9 21.9 21.9 23.9 32.3 31.8 34.8 34.1 33.1 34.5 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 10.2 10.2 9.4 10.2 10.3 9.7 9.5 9.7 9.6 9.7 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 19 42 66 89 91 93 74 3,433 3,771 3,851 3,931 4,183

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care at home, in thousands : : : : 87 116 145 174 177 179 166 6,442 7,296 7,444
7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 1.3 1.9 2.5 3.2 3.2 3.2 2.8 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : 247 : 290 : : : : : : : :

Number of formal carers, in thousands : : : : : : : : :

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Table 2.1.2: Statistical Annex - continued – Austria

Sources: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 8.8 9.3 9.6 9.7 9.7

Dependency

Number of dependents in millions 0.86 0.97 1.09 1.20 1.22

Share of dependents, in % 9.7 10.5 11.3 12.3 12.6

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.5 1.8 2.1 2.5 2.7

AWG risk scenario 1.6 2.1 2.7 3.5 4.2

Coverage

Number of people receiving care in an institution 82,275 100,481 120,703 149,263 160,157

Number of people receiving care at home 183,653 216,191 252,896 295,172 304,786

Number of people receiving cash benefits 513,479 617,720 734,274 877,573 920,906

% of pop. receiving formal LTC in-kind and/or cash benefits 8.8 10.1 11.5 13.6 14.3

% of dependents receiving formal LTC in-kind and/or cash benefits 90.9 96.1 100.0 100.0 100.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 37.2 37.8 38.3 38.9 39.5

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 62.8 62.2 61.7 61.1 60.5

Public spending on institutional care (% of tot. publ. spending LTC) 73.4 73.7 74.0 74.5 75.1

Public spending on home care (% of tot. publ. spending LTC in-kind) 26.6 26.3 26.0 25.5 24.9

Unit costs of institutional care per recipient, as % of GDP per capita 44.3 45.3 46.3 47.0 48.7

Unit costs of home care per recipient, as % of GDP per capita 7.2 7.5 7.8 8.1 8.5

Unit costs of cash benefits per recipient, as % of GDP per capita 16.3 16.5 16.6 16.9 17.3

2013

MS Change

2013-2060

EU Change 2013-2060

8.5 15% 3%

0.78 57% 40%

9.2 38% 36%

1.4 91% 40%

1.4 199% 149%

74,043 116% 79%

165,851 84% 78%

458,254 101% 68%

8.2 74% 68%

90.0 11% 23%

37.7 5% 1%

62.3 -3% -5%

73.4 2% 1%

26.6 -7% -1%

44.9 9% -2%

7.3 16% -3%

16.3 6% -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

Belgium has a population of just over 11 million

inhabitants. According to the basic Eurostat

scenario this number will grow to 15.4 million in

2060 (348), an increase of 38%, well above EU

average (3%).

With a GDP of EUR 393 bn, or 30,300 PPS per capita in 2013, it scores well above the EU average of 27,900 PPS (2013). With public expenditure on long-term care of 2.1% of GDP (2013) (349), Belgium spends twice as big a share of GDP compared with EU average (1% in 2012).

Health status

Life expectancy at birth for both men and women is respectively 78.1 years and 83.2 years and is in line with the EU average (77.8 and 83.3 years respectively in 2013). On the other hand, the healthy life years at birth for both sexes are 63.7 years (women) and 64.0 years (men) higher than the EU-average (61.5 and 61.4 respectively). The percentage of the Belgian population having a long-standing illness or health problem is also significantly lower than in the Union as a whole (25.9% and 32.5% respectively in 2013). The percentage of the population indicating a selfperceived severe limitation in its daily activities has been fluctuating over the last few years, and is currently slightly lower than the EU-average (8.1%

against 8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living is expected to increase significantly over the coming 50 years. From 860 thousand residents living with strong limitations due to health problems in 2013, an increase of 65% is projected until 2060 to around 1.42 million. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the (348) Eurostat 2013 Population Projections – Main Scenario. The increase in the number of dependents appears driven by the general population increase, rather than a change in the proportion of dependents, as supported by a moderate change when measured as a share of the population. Note that the Eurostat population projection is considerably higher than the current (March 2016) Belgian national projection of 13.0 million in 2060.

(349) Eurostat SHA 2011, last update April 2016.

dependents are projected to become a bigger group, from 7.7% in 2013 to 9.2% in 2060.

However, the increase is markedly less steep than

EU average, at a projected 19% (EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

AWG reference scenario, public long-term care

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 1.6 pps

of GDP (75%) by 2060 (from 2.1% to 3.7% of

GDP), above the EU average of 40%. (350) The

"AWG risk scenario", which in comparison to the

"AWG reference scenario" captures the impact of

additional cost drivers to demography and health

status, i.e. the possible effect of a cost and

coverage convergence, projects an increase in

spending of 2.6 pps (121%) of GDP by 2060,

higher, but below the EU average of 149%.

Overall, projected long-term care expenditure

increase is expected to add to budgetary pressure.

Sustainability risks appear over the long run due to

the projected increase in age-related public

spending, notably deriving from long-term care

and pensions). (351)

System Characteristics

Long-term care is part of an integrated system of

health care, complemented by social service

provision. Not unique to Belgium, long-term care

is approached as a mix of different services and

measures, funded through different sources and

organised at different levels.

The organisational landscape of long-term care

provisions is fragmented because of a division of

competencies between the Federal Government

(responsible for medical care through the health

care system) and the Communities (responsible for

non-medical care). One level further down in the

organisational landscape, cities and municipalities

(350) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(351) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

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have a responsibility as far as the financing of the construction of residential facilities are concerned (with financial support from the Communities in the form of investment subsidies).

At the same time it must be mentioned that there is no specific federal legislation relating to long-term

care. The rules to be applied are the same as the ones that are dealing with the health **care** system.

Regulations on community level deal with a wide range of aspects of provision of long-term **care** services, such as the recognition of providers, the integration of services and monitoring of quality.

Policy is aimed at supporting dependent older persons in their home environment for as long as possible. Should limitations in activities of daily

living become too severe and adequate informal or professional support at home is unavailable or insufficient, dependent persons should have access to suitable and affordable residential care facilities.

Types of care

There are many different long-term care benefits in kind. Although formally not part of long-term care, it can be mentioned that medical services are organised and paid for by the federal health insurance system, while more personal care is organised and paid for on a regional level. How these services are provided depends on the specific care setting.

Home care includes medical care and non-medical services. Medical home nursing care, which consists of services such as wound dressing and drug administration, is provided as part of the social security scheme and is currently reimbursed at the Belgian Federal level through the National Institute for Health and Disability Insurance (NIHDI). Non-medical home care services are

regulated and organised by the Communities.

These services include help with personal care tasks (e.g. help with eating or moving around, hygienic help) along with instrumental help (e.g. light housework, preparing meals). The services offered under the health insurance scheme and those provided for by the Communities partially overlap.

Since 2002 service provision entities have been set up both in Flanders and in the French community to make sure that all disciplines involved in the care for patients for a specific geographical area are provided in a coordinated manner. Care support and coordination is geared towards keeping patients at home for as long as possible.

In centres for day care and “short-stay” care, nursing care and personal care are provided to elderly persons for whom home care is temporarily unavailable. This is meant for people who do not need intensive medical care but who require care or supervision and aid in the activities of daily

living. A fixed daily compensation (depending on the severity of the limitations) is paid by the compulsory health insurance.

A residential home for the elderly is a homereplacing environment where the medical responsibility rests with a general practitioner. The cost of stay is paid by the occupant, while medical costs and the cost of care are taken by the compulsory health insurance scheme based on an objectively assessed degree of care needed.

Patients with moderate to severe limitations, but who do not need hospital treatment, are admitted in nursing homes. Legislation requires each nursing home to have a coordinating and advisory physician who is responsible for the coordination of pharmaceutical care, wound care and physiotherapy.

Each nursing home must always have a functional link with a hospital. They must cooperate with the geriatric service of the hospital and a specialised service of palliative care. While residents must

finance the cost of stay themselves, nursing care is

reimbursed by the compulsory health insurance.

Role of the private sector

Many who make use of home care services pay for

this by using “service coupons”. “Service

coupons” were introduced in 2003 as a system of

consumer subsidies for domestic services. It aimed

to increase the employment of low-qualified

labour, and at moving certain activities out of the

black economy into the legal circuit. The system

works by offering individuals a chance to buy

vouchers which can be used to pay those who

deliver domestic services such as cleaning, ironing

and occasional child-care. From the supplier side,

local work agencies coordinate those who deliver

the service. A coupon can be used to pay a work

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hour at a reduced rate and offers an additional

fiscal reduction.

While “service coupons” were never meant to be

used for the provision of care, the reality is different: the system is especially popular in the provision of home care. The number of vouchers used (counted per hour) per person for this purpose seems to level at around 110 per person per year, or 220 per family per year. The impact of budget measures rendering the system less attractive is thought to be limited.

As a result of the sixth round of state reform, the system of service coupons will become the responsibility of the regions. Depending on the political choices made on that issue, there may be an impact on the usability of the system for the purchase of non-medical care.

Eligibility criteria and user choices:

dependency, care needs, income

Since nursing care is covered by the compulsory health insurance system, every elderly person with functional impairments is eligible to receive care.

The level of care is determined by the severity of disability, determined by an assessment tool based

on the Katz scale. This principle holds both in

home and in residential care.

Eligibility criteria for personal care and family

care differ slightly between regions. In principal,

everyone in need of care is eligible to receive it.

The type and amount of care as well as the copayment

to be paid depend on the severity of the

problem and the social situation of the applicant

(family composition, income, type of residence

etc.).

Co-payments, out of the pocket expenses and

private insurance

The costs for medical care are reimbursed to the

individual by the health insurance organisation,

out-of-pocket payments are never higher than what

is allowed subject to the system of the “maximum

billing system” (described above, chapter 2.3).

Moreover, co-payments for some home nursing

services were reduced from 15% to 10% as of

February 2010.

Expenses related to non-medical long-term care

are borne by the individual, but are at least partially offset by several cash benefits. On the federal level, a monthly allowance for disabled older persons (Tegemoetkoming voor hulp aan bejaarden; Allocation pour l'aide aux personnes âgées) is granted to persons aged 65 and older for whom a severe need for care is ascertained.

This allowance is means-tested. Several other topical allowances exist, aimed at specific costs (e.g. incontinence material) or circumstances (e.g. for palliative care at home).

Flanders has introduced an additional “Flemish Care Insurance” (Zorgverzekering) in 1999, covering some of the costs of non-medical help and services borne by people with reduced selfsufficiency.

The system is organised as a residence-based compulsory insurance-type scheme: every person residing in Flanders is obligatorily covered; persons residing in Brussels are allowed, but not obliged, to join. Note that the Zorgverzekering only provides financial benefits; insurance under the scheme is not a requirement for receiving longterm

care services. Patients in residential care who do not have the means to pay for board and lodging may receive help through social assistance services which are provided for by the municipalities. However, spouses, children and grandchildren have a legal maintenance obligation toward the person in residential care and as such they may be requested to bear (part of) the costs.

Prevention and rehabilitation measures

Prevention is a regional responsibility in Belgium.

In Flanders, its goals have been defined in a

'Policy Plan for the Flemish Elderly 2010-2014'.

They include initiatives to promote healthy dietary

habits and physical activity/sports, fall prevention,

increased vaccination (especially influenza), to

reduce hospital-borne infectious diseases, to

reduce medical overconsumption (especially in

nursing homes) and to improve monitoring of

mental well-being. In the French-speaking

Community, fall prevention was explicitly stated

as a target in the Communal Plan for Health

Promotion 2008-2013. Particular attention has also

been paid to malnutrition in residential care in the

'Plan Wallon nutrition Santé et bien-être des aînés'

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('Walloon Nutrition and Well-Being Plan') which

is part of a wider national nutrition plan launched

in 2004.

Formal/informal caregiving

Belgium's elderly citizens use both formal and

informal care rather frequently compared with

most other European countries. Data from the 2004

Survey of Health Ageing and Retirement

(SHARE) indicate that the share of users of

professional nursing care and professional home

care is among the highest in Europe (13.4 and 16.6

percent respectively) (see Geerts, 2009). Despite

the high reliance on formal care there is also

substantial use of informal care. For example, 45

percent of moderately or severely dependent

elderly persons living at home receive informal

care from someone outside the household (SHARE

2004 data, see Willemé et al. 2012). The

caregivers are predominantly partners and adult

children. The frequent combination of formal and

informal care is rather exceptional, since in most

other countries the two forms of care appear to be

substitutes rather than complements.

Recently legislated and/or planned policy

reforms

In recent years, the Belgian long-term care system

did not undergo major reforms. Some

developments in the health care system

nevertheless have had an impact on the provision

of long-term care.

The co-payments that an individual using care

would need to pay, were limited through the so

called "Maximum Billing System"

(Maximumfactuur, introduced in 2001). In addition

various allowances help people (in particular with

lower incomes) cope with the financial burden of

non-medical expenses. Also some yearly

allowances were introduced, especially for longterm

care patients, for example for the use of

incontinence material.

The extension of compulsory coverage for selfemployed

persons from January 2008, can be

recognised as an important development. Before

2008, the compulsory health insurance for selfemployed

persons consisted only of a minimal

basic package, covering only "major risks". Since

2008, the self-employed have a compulsory health

insurance with the same coverage as civil servants

or employees, which means for example that

former self-employed in need for nursing care in

homes for the elderly are now covered for such

services. However, the extension of insurance

coverage for the self-employed mainly affects

acute health care expenditures.

In order to cope with a future increase in demand

for long-term care, which is certain but the exact

magnitude of which is difficult to predict, more

diverse and integrated long-term care services are

being developed in Belgium. More and better

cooperation should allow dependent persons to stay at home longer and to only move to residential care when absolutely necessary. Organising the move of patients between care facilities remains a difficult challenge.

The main change in health care policy legislated in the recent years concerns the devolution of responsibilities (and shifts in associated budgets) for a number of health care tasks from the federal to the regional level (Flanders, Wallonia and Brussels) as a consequence of the 6th Reform of the State. The reform was signed into law on January 31 2014 and became effective on July 1 2014. While the transferred responsibilities mainly concern care for the elderly, some may be classified as acute care expenditures (see country fiche on health care). A few notable examples are geriatric hospital services, revalidation, mobility aides, prevention and the maximum billing (MAB) payments. The total budget shift from the federal to the regional level is estimated to be

approximately 3.4 billion euros in 2015, almost 88% (3 billion euros) of which will be long-term care expenditures. At the time of writing there is no information available as to how the regional authorities will manage their new responsibilities, including if and how they may change the rules that govern the use of services and the associated public expenditures. Consequently, the current Belgian projections at the national level assume that the regionalised health care expenditures will evolve according to the same mechanisms that pertained at the federal level.

Challenges

Belgium has a relatively fragmented system of LTC. The main challenges towards the goal of a sustainable long-term care system appear to be:

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- Improving the governance framework: to establish a coherent and integrated legal and

governance framework for a clear delineation

of responsibilities of state and regional

authorities with respect to the provision of

long-term care services; to use care planning

processes, based on individualised need

assessments, involving health and care

providers and linking need assessment to

resource allocation; to strategically integrate

medical and social services via such a legal

framework; to define a comprehensive

approach covering both policies for informal

(family and friends) carers, and policies on the

formal provision of LTC services and its

financing.

- Encouraging independent living: to provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design.

- Ensuring availability of formal carers: to

determine current and future needs for

qualified human resources and facilities for

long-term care; to increase the retention of

successfully recruited LTC workers, by
improving the pay and working conditions of
the LTC workforce, training opportunities,
more responsibilities on-the-job, feedback
support and supervision; to seek options to
increase the productivity of LTC workers.

- Supporting family carers: to establish
policies for supporting informal carers, such as
through flexible working conditions, respite
care, carer's allowances replacing lost wages or
covering expenses incurred due to caring, cash
benefits paid to the care recipients, while
ensuring that incentives for employment of
carers are not diminished and women are not
encouraged to withdraw from the labour
market for caring reasons.

- Ensuring coordination and continuity of
care: to continue to promote coordination of
care pathways and along the care continuum,
such as through a single point of access to
information, the allocation of care coordination

responsibilities to providers or to care

managers, via dedicated governance structures

for care co-ordination and the integration of

health and care to facilitate care coordination.

- To facilitate appropriate utilisation across

health and long-term care: to create better

rules, improving (and securing) safe care

pathways and information delivered to

chronically-ill people or circulated through the

system; to steer LTC users towards appropriate

settings.

- Improving value for money: to invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and

coordination between health and care services.

- To further the efforts in the area of

prevention and to improve administrative

efficiency.

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Table 2.2.1: Statistical Annex – Belgium

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 283 299 311 327 345 354 349 365 379 387 393 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 29.8 30.1 30.3 30.5 31.1 30.4 28.9 30.2 30.5 30.7 30.3 26.8 27.6 28.0 28.1 27.9

Population, in millions 10.4 10.4 10.4 10.5 10.6 10.7 10.8 10.8 11.0 11.1 11.2 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 1.5 1.5 1.4 1.7 1.7 1.8 1.9 2.0 2.0 2.1 2.1 1.0 1.0 1.0 1.0 :

Per capita PPS 362.8 376.4 380.6 469.2 491.3 506.6 523.6 563.2 585.5 618.2 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 2.9 2.8 3.5 3.6 3.6 3.6 3.7 3.7 3.7 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 81.1 81.9 81.9 82.3 82.6 82.6 82.8 83.0 83.3 83.1 83.2 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 75.3 76.0 76.2 76.6 77.1 76.9 77.3 77.5 78.0 77.8 78.1 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 69.2 58.4 62.3 63.2 63.9 64.1 63.7 62.6 63.6 65.0 63.7 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 67.4 58.9 62.4 63.0 63.5 63.4 63.9 64.0 63.4 64.2 64.0 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 26.3 24.9 24.7 24.8 24.7 25.1 25.6 26.2 24.7 25.9 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 12.2 8.7 7.8 7.4 6.9 7.6 7.9 8.4 7.6 8.1 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

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2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 118 125 132 139 144 149 143 3,433 3,771
3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 130 248 365 483 491 500 728 6,442 7,296 7,444
7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 2.3 3.5 4.6 5.7 5.8 5.8 7.8 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : 430 : 420 : : : : : : :

Number of formal carers, in thousands : : : : : : : : :

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Table 2.2.2: Statistical Annex - continued – Belgium

(1) Cash benefits numbers not available as these benefits are recorded as benefits in-kind in the Belgian SHA.

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060).

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 11.9 12.9 14.0 14.8 15.4

Dependency

Number of dependents in millions 0.93 1.05 1.21 1.33 1.42

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Share of dependents, in % 7.9 8.1 8.6 9.0 9.2

Projected public expenditure on LTC as % of GDP

AWG reference scenario 2.3 2.6 3.0 3.5 3.7

AWG risk scenario 2.4 2.8 3.5 4.2 4.7

Coverage

Number of people receiving care in an institution 158,626 181,486 236,093 285,148 307,575

Number of people receiving care at home 784,738 889,888 1,042,053 1,159,292 1,225,738

Number of people receiving cash benefits 0 0 0 0 0

% of pop. receiving formal LTC in-kind and/or cash benefits 7.9 8.3 9.2 9.8 9.9

% of dependents receiving formal LTC in-kind and/or cash benefits 100.0 100.0 100.0 100.0 100.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 100.0 100.0 100.0 100.0 100.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 0.0 0.0 0.0 0.0 0.0

Public spending on institutional care (% of tot. publ. spending LTC) 61.7 61.6 63.2 64.8 65.5

Public spending on home care (% of tot. publ. spending LTC in-kind) 38.3 38.4 36.8 35.2 34.5

Unit costs of institutional care per recipient, as % of GDP per capita 107.5 112.5 113.8 116.7 121.6

Unit costs of home care per recipient, as % of GDP per capita 13.5 14.3 15.0 15.6 16.1

Unit costs of cash benefits per recipient, as % of GDP per capita : : : :

2013

MS Change

2013-2060

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EU Change 2013-2060

11.2 38% 3%

0.86 65% 40%

7.7 19% 36%

2.1 75% 40%

2.1 121% 149%

142,618 116% 79%

727,933 68% 78%

0 : 68%

7.8 28% 68%

100.0 : 23%

100.0 : 1%

0.0 : -5%

60.9 7% 1%

39.1 -12% -1%

101.3 20% -2%

12.7 26% -3%

: : -2%

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General context: expenditure, fiscal

sustainability and demographic trends

GDP per capita in PPS is at 12,800 and around half

of the EU average of 27,500 in 2014. Bulgaria has a population of 7.3 million inhabitants. During the coming decennia the population will steadily decrease, from 7.3 million inhabitants in 2015 to 5.5 million inhabitants in 2060. Thus, in Bulgaria the population is expected to decrease by 25%, while it is expected to increase at the EU level by 3%.

Health status

Life expectancy at birth (78.0 years for women and 71.1 years for men in 2014) are one of the lowest in the EU, while healthy life years (66.6 years for women and 62.4 years for men in 2013) are above the respective EU-averages (83.6 and 78.1 years of life expectancy in 2014, 61.5 and 61.4 in 2013 for the healthy life years). The percentage of the Bulgarian population having a long-standing illness or health problem is considerably lower than in the Union (21.2% in Bulgaria versus 36.4% in the EU in 2014). In 2014 the percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 4.0%,

which is lower than the EU-average of 8.6%.

Dependency trends

The number of people depending on others to carry out activities of daily living increases over the coming 50 years. From 280 thousand residents living with strong limitations due to health problems in 2013, an increase of 16% is envisaged until 2060 to 320 thousand. That is a less steep increase than in the EU as a whole (40%).

However, due to the population decline, as a share of the population, in the period 2013-2060, the dependents are becoming a bigger group, from 3.9% to 5.9%, an increase of 54%. This is more than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors

is a projected increase in spending of about 0.2 pps

of GDP in Bulgaria by 2060.(352) The "AWG risk

scenario", which in comparison to the "AWG

reference scenario" captures the impact of

additional cost drivers to demography and health

status, i.e. the possible effect of a cost and

coverage convergence, projects an increase in

spending of 2.5 pps of GDP in Bulgaria by 2060.

This reflects, that coverage and unit costs of care

are comparatively low in Bulgaria, and may

experience an upward trend in future, driven by

demand side factors.

In the long-term, Bulgaria has some fiscal

sustainability risks because of the unfavourable

initial budgetary position slightly compounded by

the age-related expenditures on health care and

long term care. (353)

System Characteristics

Currently, medical and social services are

regulated by different bodies and legislation.

Depending on the specific case, LTC is provided

by the state, the municipal authorities and private

providers via social insurance and social welfare.

In order to address the challenge for more integrated health-social services (354), in September 2015 the National Assembly adopted amendments to the Health Law, which regulate the integrated approach there. The regulatory framework to settle their provision is currently under preparation. The types of services and the conditions and procedure for their provision, as well as the criteria and standards concerning their quality and the procedure of controlling their observance, shall be regulated by an Ordinance adopted by the Council of Ministers upon a

(352) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(353) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(354) Integrated health and social services are activities through which medical and social service specialists provide healthcare and medical supervision and perform social

work, including in home environments, to support children,

pregnant women, people with disabilities and chronic

conditions and aged people who need assistance in the

performance of their daily activities. The services may be

provided by municipalities, medical treatment facilities and

the persons under Article 18(2) of the Law on Social

Assistance.

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proposal by the Minister of Health and the

Minister of Labour and Social Policy.

As mentioned above LTC is provided under

different legislative acts. Cash benefits are

provided to children with disabilities under the

Law on Family Allowance - monthly benefit for

raising a child with permanent disabilities (paid

until the child reaches the age of 2 years), monthly

benefit for a child with a permanent disability until

graduation from high school, but not after the age

of 20, and monthly supplement for children up to

18 years of age with permanent disability. In

addition, all family allowances are provided to children with disabilities regardless of the family income. People with disabilities are supported financially under the law on the integration of persons with disabilities and the law on social assistance. They are entitled to a monthly social integration supplements and monthly social benefits.

Organisationally, many LTC services are also provided in acute hospitals, which may be costinefficient.

Because of lacking data, the

involvement of the health care sector proper in providing LTC services is difficult to delineate.

The financial resources for LTC services are provided from the state budget, the local budgets, by registered private providers, as well as under various projects on national and international programmes. In recent years, the system for LTC has considerably expanded as a result of actions aimed at deinstitutionalisation and providing more community-based and family-friendly services.

However, there are challenges in this area, and a

more extensive network of community services

and suppliers across the country is needed to meet

the demand for care.

In 2010, legislation for organising care in homes

for medical and social care has been adopted. The

aim is to implement continuous medical

monitoring and specific care for individuals with

chronic diseases, disabilities and social problems.

However, so far there is no budget for financing

these homes, such that for now these homes have

not yet been established.

Once placed in residential institutions, the

recipients of care must pay a fee for their stay. In

most cases, the amount of this fee is 70% of the

monthly income received, but not higher than the

actual monthly expenditure for the service

provided. The amount of the fees for communitybased

social services, including services of

residential type is significantly lower. Persons with

no income and bank savings do not pay fee.

Public spending on LTC was at the level of 0.4%

of GDP in 2013 in Bulgaria, much below EU

average of 1.6% of GDP. According to the 2015

Ageing Report, in 2013 100% of this expenditure

was spent on in-kind benefits (EU: 80%), while

0% was provided via cash-benefits (EU: 20%).

Private co-payments for formal in-kind LTC

services can be significant. For example a person

that is enrolled in a public facility for elderly care

needs to transfer it 70% of his/her retirement

income, but not higher than the actual monthly

expenditure for the service provided.

In the EU, 30% of dependents are receiving formal

in-kind LTC services or cash-benefits for LTC.

This share is with 43% higher in Bulgaria. Overall,

in 2013 1.7% of Bulgarian population receives

formal LTC in-kind and/or cash benefits (EU:

4.2%). On the one hand, low shares of coverage

may indicate a situation of under-provision of LTC

services. On the other hand, higher coverage rates

may imply an increased fiscal pressure on

government budgets, possibly calling for greater

needs of policy reform.

In 2013 the expenditure for institutional (in-kind)

services makes up 31.3% of public in-kind expenditure (EU: 60%). Thus, relative to other Member States Bulgaria has a very strong focus on institutional care, which may be cost-inefficient. Taking this into account, developing of community-based social services to prevent institutionalisation and to meet the growing needs for long-term care services is among the key policy priorities. As part of the efforts to prevent institutionalisation of elderly people and people with disabilities, social services in specialised institutions are provided only if all other options prove inadequate for providing social services in the community. The following data clearly shows that: as of the end of 2014 the number of community-based social services for elderly people and people with disabilities was 440 while at the end of 2015 it reaches 482 with total capacity of 9,205 places. The number of Long-term care systems

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specialised institutions remains the same, but the trend is related to significant reduction of their capacity.

Regarding the financial support for provision of social services, the funds provided by the State for community-based social services for children and adults, as activities delegated by the State (approximately BGN 113.6 million), are significantly higher than those provided by the specialised institutions (BGN 86.9 million). In addition, since 1 of January 2016 the sustainability of 9 centres for family-type accommodation for children/youth with disabilities with constant medical care has been financially ensured by the state budget.

As institutional care is relatively costly, Member States with shares well above the EU levels may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care.

In 2016, besides the clinical pathway “palliative care”, three clinical pathways (CPs) for long term

care will be included in the scope of the activities

for hospital care paid by the NHIF, namely: CP

"Continuous treatment and early rehabilitation

after acute stage of ischemic and haemorrhagic

stroke with residual health problems", CP

"Continuous treatment and early rehabilitation

after myocardial infarction and after cardiac

interventions" and CP "Continuous treatment and

early rehabilitation after surgery with large and

very large volume and complexity of residual

health problems".

These CPs cover the traditionally existing need to

carry out this activity in the relevant conditions

and its payment with public funds. Health care

activities are included as a specific activity across

all clinical pathways and clinical procedures and

provided by health care professionals during the

hospital treatment. They are included as part of the

overall complex of medical activities, including

those related to diagnostics, treatment and

rehabilitation.

Types of care

Bulgaria is in the process of deinstitutionalising the LTC system, aiming at a higher provision of home and community care services. The main target groups of LTC are people with impairments (disability) and elderly people (65+). Services are provided in specialised institutions, communitybased social services of residential type close to family environment, and also as daily and consultative community-based social services, as well as home-based social services.

As part of the implementation of the "Concept of Deinstitutionalisation and Prevention of Social Exclusion of People Living in Institutions", the Agency for Social Assistance has developed a plan for reforming the specialised institutions for elderly people and people with disabilities 2010-2011, which outlines concrete measures and activities for the reform of 14 specialised institutions for adults with disabilities. In 2011, 12 specialised institutions were abandoned and 28 new community based services of residential type were established. 150 people were deinstitutionalised and accommodated in

community based social services of residential type. As of July 2012, the number of specialised institutions is 163 with a capacity of 11,326 places.

As of December 2015 the number of the specialised institutions is 160, with total capacity of 10 990 places. To ensure that the government is continuing its efforts toward implementation of deinstitutionalisation process an action plan for the implementation of the national strategy for longterm

care is to be developed.

The transition from traditional institutional care to community and family based services is mainly realised through an expansion of the range of services (Day Care Centres, Social Rehabilitation and Integration Centres, Protected Housing), as well as the further development of the model for services provided at home (personal assistants, social assistants, domestic assistants, domestic social patronage, public canteens). In July 2012, the number of community based social services for elderly people was 370 with a capacity of 8,043 places. As of December 2015 the number of

community-based social services for elderly and

people with disabilities reaches 482 with total

capacity of 9 205 places.

Eligibility criteria and user choices:

dependency, care needs, income

Eligibility is based on a needs' assessment which is

performed by the local authority together with the

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"Agency for Social Assistance". According to the

latest amendments to the law on social assistance

(adopted by the National Assembly in January

2015) social services are provided on the basis of

an individual support needs assessment and an

individual support plan developed by a multidisciplinary

team. The purpose of the introduction

of the multi-disciplinary assessment teams is to

allow involvement of various professionals with

specific knowledge and experience. Assessment of

LTC needs is individual and normally based on an

application to the respective welfare service.

Generally, the minimum eligibility criteria are defined in the legislation and they are nation-wide and binding. These may include the applicant's income, property status, family status, potential

care providers (friends or relatives), type and severity of disability, etc.

The family physician is responsible for the initial examination and monitoring of the health status of the elderly. In case of impaired health and the need for LTC, the elderly patient is referred to the relevant health institutions and medical nursing

care is arranged if needed. The arrangements for any medical services, medical nursing care included, are made by the family doctor. Where necessary, the doctor alerts the social services.

Upon receiving an application from the elderly patient or his/her family physician, friends or relatives, the social assistance directorate makes an initial assessment of the situation and decides on the LTC measures and programme to be applied in each specific case.

Prevention and rehabilitation measures

There are a couple of mechanisms to be mentioned. The responsible partners for the prevention of the long-term conditions and diseases are general practitioners. The National Health Insurance Fund pays the medical rehabilitation of all persons no matter whether are of working age or above, as long as there are medical indications. Determining the need for rehabilitation is not only the competence of general practitioners, but also of all other medical specialists in the outpatient and inpatient care.

There are departments of physical medicine and rehabilitation in all major hospitals and in over 20 specialised rehabilitation hospitals, funded by the NHIF, and some of them have contracts with the National Social Security Institute (NSSI). A significant part of the funds for rehabilitation are provided by the healthcare system.

Another source for prevention and rehabilitation is the National Social Security Institute (NSSI). The funds that are provided for this initiative are defined in the law on social security budget and for

2015 amount to BGN 14.2 million (EUR 7.3 million). It is envisaged that 40 000 persons can use grants for prevention and rehabilitation. The program has a maximum duration of 10 days as NSSI assumes the cost of accommodation and partially supports for food expenses up to BGN 5 (EUR 2.56) per day-stay. Any person that is socially insured has the right to obtain up to four basic diagnostic and therapeutic procedures daily. The NSSI signed contracts with 14 entities for a total of 43 institutions implementing this program. Entitled to this benefits are the socially insured for sickness, maternity and / or accident and occupational disease persons. They must have paid contributions for a period of six consecutive calendar months preceding the month before the start of rehabilitation. The persons should have a specified diagnosis by a certified physician, indicating the need for rehabilitation. Another eligible group is recipients of personal disability pension. The only condition for them is that their age is below the age of entitlement to old-age

pension.

Formal/informal caregiving

There is no established information system

collecting data on formal carers providing longterm

care. There is even less information about the

number of people providing informal care. But

there is little doubt that the overwhelming bulk of

LTC is provided by informal carers in families.

The cultural traditions in Bulgaria encourage care

for elderly people to be provided by family

members, who are not trained professionally, but

accept that responsibility out of a sense of family

duty. The provision of LTC is considered to be a

family matter. It should be noted that since 2012

up to now trainings for professionalisation of care

have been conducted under various schemes under

OP "Human Resources Development" (OP HRD).

Though informal care thus is of outmost

importance it has so far neither been legally

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recognised or financially encouraged within the system of LTC services. The informal carers can be supported financially under the National Programme “Assistants to people with disabilities” which provides home-based care (the service “Personal assistant”) to people with disabilities and seriously diseased lonely people by ensuring employment for unemployed people as personal and social assistants (the responsible body is the Agency for Social Assistance).

Home-based services are provided also by private providers, as well as under the OP HRD projects.

In this regard, it should be noted that the service “personal assistant” was provided under the “New

Opportunities for Care” project under the “New Alternatives” operation. The project was implemented by the Agency for Social Assistance in partnership with 264 municipalities and its implementation ended in February 2016. Project services were provided to: people with disabilities in difficulty or inability to self-service; people over

65 years in difficulty or inability to self-service;

families of children with disabilities; lonely

seriously ill persons. The project covered more

than 15 600 service users supported by

approximately 14 700 personal assistants.

The project “New Opportunities for Care” will be

upgraded through the “Independent Living”

scheme which has already been launched under OP

HRD 2014-2020. Under the scheme, all

municipalities on the territory of the Republic of

Bulgaria can apply with projects aimed at

facilitating access to healthcare services and

development of community-based social services

for social inclusion of people with disabilities, as

well as facilitating their access to employment. A

total of 16 000 persons with disabilities and

persons over 65 years in inability to self-service

are expected to be supported under the scheme.

Recently legislated and/or planned policy

reforms

A comprehensive reform in the area of social

services sector is underway as part of the efforts to

provide entirely new models of integrated healthsocial

services to meet more adequately the needs of vulnerable persons. In the context of the current reform a law on social services is being developed. The main objective is to improve the regulatory framework in the field of social services with a view to improve the planning, management, financing, quality and effectiveness of the social services.

Beginning 2014, the Council of Ministers has adopted a National Strategy on long-term care. The strategy has the following objectives: 1)

Developing a network for social services in the communities, tailored to the needs of the elderly and disabled people. Provision of both stationary and non-stationary social services close to and in home environment; 2) Adoption of a regulatory framework for a wide range of social services targeting vulnerable groups; 3) Ensuring sustainable financing of LTC services; 4) Improving coordination between the line institutions for LTC; 5) Phased restructuring of the system for inpatient treatment and active

deinstitutionalisation.

Key measures for the realisation of the objectives

in the field of long-term care policy are:

1. Expanding access to social services,

improvement of their quality and interaction

between health, social and educational services:

This includes the construction of an adequate

network of social services in the communities and

in home environment (new services in the

community and at home, including provision

hourly services to support social inclusion) and

uniform distribution throughout the country; the

development of innovative cross-cutting services

for the elderly and people with disabilities,

including rehabilitation, occupational therapy and

lifelong learning; the development and

maintenance of a map of long term care services in

Bulgaria; the development and improvement of

standards for the provision of long term care

services; the construction of structures for

integrated home care for the elderly.

2. Regarding the deinstitutionalisation of the

elderly and people with disabilities placed in institutions: An assessment of the needs of each person and determination of the need for support, by applying an individual approach; Preventing the risk of institutionalisation by providing alternative services in the community and to ensure the active participation of the person in this process; Restructuring and phased closure of institutions.

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3. Regarding the promotion process of long-term

care: The continued implementation of best practices for long-term **care** for mentally ill patients after their active psychiatric treatment and provision of adequate living conditions in the community through appropriate services and integrated cross-sectorial reintegration programs; The development and validation of a model for provision of long-term treatment and palliative

care: The provision of home **care** for people with chronic diseases resulting in damage to critical

functions (respiratory, neuromuscular, renal

failure, etc.).

4. Regarding support for individuals and

professionals who care for the elderly and people

with disabilities several measures are in

consideration: The provision of adequate training

and supervision of personnel providing long term

care services depending on the specific needs of

the target groups, creating a system of independent

monitoring; The development of forms of social

support services for dependent family members -

Increase in the number of professionals providing

long-term care for sick elderly and disabled people

in the home and community.

5. Regarding the increase in efficiency and

improvement in funding mechanisms for LTC

services: Encouraging providers to create services

with their own funds; Application of the principle

"money follows the client"; Analysis and

assessment of the role of the social security system

for funding and ensuring sustainability of long

term care system for the elderly and people with

disabilities; Increasing the capacity of local organisations to provide services for long term

care and promote public-private partnerships;

Promotion of entrepreneurship in the social sector

and the involvement of all stakeholders, including

businesses and service providers from the private

sector in the development and delivery of

innovative and alternative services.

Financing from the state and municipal budgets

shall to achieve the goals objectives of the

strategy, as well as funds from the European Social

Fund and European Regional Development Fund.

Additionally, some new arrangements, will be

approved in the parameters of the medium-term

forecast of the state budget and the budgets of

municipalities.

For the implementation of the National Strategy on

long-term care an action plan is about to be

developed, containing all measures and concrete

projects in order to reform and modernise the

system of long-term care.

Furthermore, in the context of the ongoing social

services reform the efforts are directed toward providing entirely new models of integrated health-social services to meet more adequately the needs of vulnerable persons. In this context the latest amendments to the Health Law, adopted by the National Assembly in September 2015, regulates the integrated health-social services. The regulatory framework to settle their provision is currently under preparation. In addition, as mentioned above, amendments to the Law on Social Assistance were adopted by the National Assembly in January 2016 in order to provide better access, individual approach and efficiency of the social services. A special Law on Social Services is currently being developed with the participation of all stakeholders in order to address adequately all challenges in this sector. The main objective is to improve the regulatory framework in the field of social services with a view to improve the planning, management, financing, quality and effectiveness of the social services.

Challenges

Bulgaria has adopted a strategy for strengthening

its long-term care system, and the implementation

of the project has to be duly monitored. The main

challenges of the system appear to be:

- Improving the governance framework: To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term

care services to face the growing demand for

LTC services; To strategically integrate

medical and social services via such a legal

framework; To define a comprehensive

approach covering both policies for informal

(family and friends) carers, and policies on the

formal provision of LTC services and its

financing; To establish good information

platforms for LTC users and providers; to use

care planning processes, based on

individualised need assessments, involving

health and care providers and linking need

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assessment to resource allocation; To deal with

cost-shifting incentives across health and care.

- Improving financing arrangements: To face

the increased LTC costs in the future e.g. to

foster pre-funding elements, which implies

setting aside some funds to pay for future

obligations; to explore the potential of private

LTC insurance as a supplementary financing

tool;

- Providing adequate levels of care to those in

need of care: To adapt and improve LTC

coverage schemes, and the scope of coverage,

that is, setting the types of services included

into the coverage. To provide targeted benefits

to those with highest LTC needs; To reduce the

risk of impoverishment of recipients and

informal carers;

- Encouraging independent living: To provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design;

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care; To improve recruitment efforts,

including through the migration of LTC

workers and the extension of recruitment pools

of workers;

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; To steer LTC users towards

appropriate settings.

- Improving value for money: To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; To

invest in ICT as an important source of

information, care management and

coordination.

- Prevention: To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

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Table 2.3.1: Statistical Annex – Bulgaria

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 19 21 24 27 33 37 37 38 41 42 42 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 10.7 11.1 11.4 11.8 12.1 12.1 11.1 11.3 11.0 11.2 11.3 26.8 27.6 28.0 28.1 27.9

Population, in millions 7.8 7.7 7.7 7.6 7.6 7.5 7.5 7.4 7.4 7.3 7.3 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.0 0.1 0.2 0.0 0.0 : : : : : 1.0 1.0 1.0 1.0 :

Per capita PPS 1.0 8.3 12.4 1.3 1.5 0.0 : : : : : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 0.3 0.4 0.1 0.1 : : : : : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Life expectancy at birth for females 75.9 76.2 76.2 76.3 76.6 77.0 77.4 77.4 77.8 77.9 78.6 82.6 82.8 83.1 83.1 83.3

Healthy life years at birth for females : : : 71.9 73.9 65.7 65.9 67.1 65.9 65.7 66.6 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : 66.2 67.1 62.1 62.1 63.0 62.1 62.1 62.4 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 32.1 29.0 24.4 21.4 19.2 18.2 18.6 19.1 :
31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 2.5 2.5 4.7 4.5 3.8 4.1 3.9 3.8 : 8.1
8.3 8.6 8.7

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving **care** in an institution, in thousands : : : 15 24 33 42 43 43 15 3,433 3,771 3,851 3,931 4,183

Number of people receiving **care** at home, in thousands : : : 33 22 11 : : : 106 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : 0.6 0.6 0.6 0.6 0.6 0.6 1.7 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of **care** recipients

Providers

Number of informal carers, in thousands : : : : :

[illegible]

Long-term *care* systems

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Table 2.3.2: Statistical Annex - continued – Bulgaria

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 7.0 6.5 6.1 5.8 5.5

Dependency

Number of dependents in millions 0.29 0.30 0.31 0.32 0.32

Share of dependents, in % 4.2 4.7 5.2 5.6 5.9

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.4 0.4 0.5 0.5 0.6

AWG risk scenario 0.5 0.7 1.0 1.7 2.9

Coverage

Number of people receiving care in an institution 16,264 16,470 17,426 18,206 19,009

Number of people receiving care at home 108,536 111,471 112,115 112,470 113,813

Number of people receiving cash benefits 0 0 0 0 0

% of pop. receiving formal LTC in-kind and/or cash benefits 1.8 2.0 2.1 2.3 2.4

% of dependents receiving formal LTC in-kind and/or cash benefits 43.0 42.5 41.3 40.8 41.1

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 100.0 100.0 100.0 100.0 100.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 0.0 0.0 0.0 0.0 0.0

Public spending on institutional care (% of tot. publ. spending LTC) 31.1 29.4 28.7 28.0 26.1

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Public spending on home care (% of tot. publ. spending LTC in-kind) 68.9 70.6 71.3 72.0 73.9

Unit costs of institutional care per recipient, as % of GDP per capita 54.5 51.0 48.5 47.9 43.1

Unit costs of home care per recipient, as % of GDP per capita 18.1 18.1 18.7 20.0 20.4

Unit costs of cash benefits per recipient, as % of GDP per capita : : : :

2013

MS Change

2013-2060

EU Change 2013-2060

7.3 -25% 3%

0.28 16% 40%

3.9 54% 36%

0.4 42% 40%

0.4 622% 149%

15,224 25% 79%

106,284 7% 78%

0 : 68%

1.7 45% 68%

43.4 -5% 23%

100.0 0% 1%

0.0 : -5%

31.3 -16% 1%

68.8 7% -1%

60.3 -28% -2%

19.0 7% -3%

:: -2%

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General context: expenditure, fiscal

sustainability and demographic trends

Croatia, member of the European Union since the summer of 2013, has a population of almost 4.3 million inhabitants, which is roughly 0.8% of the EU population. In the absence of any sizeable immigration and a decline in fertility, the population of Croatia is steadily decreasing. In the period from 2013 to 2060 a decrease of 13 percent can be expected, based on the population forecast of Eurostat, leading to a population in 2060 of 3.7 million.

In current prices the GDP of Croatia has been increasing fast from 2003 to 2008, from EUR 31 to EUR 48 bn. Since 2008 it decreased to EUR 43 bn. GDP per capita decreased from 2008 to 2009, and has remained roughly stable at a lower level since

then, currently reaching 15,200 PPS, well below

the EU average of 27,900 PPS.

Public expenditure on LTC was with 0.1% of GDP

in 2012 low compared to the overall EU average of

1.0% of GDP.

Health status

Life expectancy at birth was, in 2013, 81 years for

women and 74.5 years for men and is, although

having increased during the past decade, below the

EU average (83.3 and 77.8 years for women and

men respectively in 2013). Similarly, the healthy

life years at birth for both sexes are with 60.4 years

(women) and 57.6 years (men) lower than the EU average

(61.5 and 61.4 respectively). On the other

hand, the percentage of the Croatian population

having a long-standing illness or health problem is

slightly lower than in the Union as a whole (31%

and 32.5% respectively). The percentage of the

population indicating a self-perceived severe

limitation in its daily activities decreased from,

2010 to 2013, from 11.4% to 8%, which is slightly

lower than the EU-average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase over the coming 50 years. From 270 thousand residents living with strong limitations due to health problems in 2013, an increase of 19% is envisaged until 2060 to around 330 thousand. That is less steep an increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 6.4% to 8.8%. However, this is roughly in line with EU average, at a projected 37% (EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is likely increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a small projected increase in spending of about 0.1 pps of GDP (15%) by 2060, well below the EU

average of 40%. (355) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.2 pps (268%) of GDP by 2060, markedly higher than the EU average of 149%. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. However, no sustainability risks appear over the long run due to the projected decrease in age-related spending driven by pensions.(356)

System Characteristics

Long-term care is organised on the principle of social assistance and financed mainly from the state budget (96%), while the remainder comes from beneficiaries' participation in payment of costs of care outside one's own family. Local and regional self-governing units participate in the financing of the system and organisation of social welfare services within the scope of their

competences.

The acting Social Welfare Act (Official Gazette of the Republic of Croatia, 157/13, 152/14, 99/15) is the result of a comprehensive social welfare reform, which includes the reform of cash benefits,

(355) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(356) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

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the system of social services, the mode of their financing and the system of public social welfare centres. The primary objective was to simplify the system and provide better and more efficient access to services and benefits, establish clearer division between cash benefits and social services and rationalise the network of social services centres. Previous 15 cash benefits with different criteria and conditions for obtaining were reduced

to 10 better targeted and defined ones(357).

There is no specific data available on long-term

care expenses in Croatia. In 2009 expenses for financing of the social welfare system amounted to 0.89% of GDP (Bodiroga-Vukobrat, 2012). The share of beneficiaries of permanent social assistance in total population in 2010 stood at 2.3%, which is an increase of 0.2% as opposed to 2009 (2.1%).

The Ministry of Social Policy and Youth is in the lead as far as social welfare (including long-term care) is concerned. Social services are carried out by public institutions: Social Welfare Centres established by the State, institutions for elderly and disabled and people who suffer from severe illnesses, institutions for those with a physical, mental or sensory impairment, care homes for people suffer from mental illness and homes for children and youth with disabilities and behavioural disorders. Social Welfare Centres also decide upon monetary social assistance (European Commission 2013).

Types of care

Social welfare beneficiaries are entitled to (choose freely between) cash benefits, benefits in kind and social services, as established by law.

(357) Among ten cash benefits with different criteria and conditions for obtaining, which are better targeted and defined than previous ones, the most innovative is the guaranteed minimum benefit (GMB). GMB consolidates 4 previous supplementary cash benefits, ensuring that persons have enough funds to satisfy their basic monthly personal needs, while also stimulates the activation of those capable of working. Introduction of the GMB through a new web application in Social Welfare Centres represents the beginning of the unification of cash benefits at the state level (as it is stipulated that establishing a unique cash center - "One stop shop"). Deinstitutionalisation and the role of private providers of social services are emphasised.

There are currently ten cash benefits according to the Social Welfare Act (Article 25): the guaranteed minimum benefit, the compensation for the cost of housing, the right on firewood costs, the allowance for the personal needs of users of accommodation,

the one-off cash allowances, the fees related to education, the personal disability allowance, the allowance for assistance and care, the parent caregiver or caregiver allowance and the unemployment allowance. The personal disability allowance is granted to persons with grave disability or other severe and permanent changes in health status, for the purpose of satisfying necessities of life for involvement in the daily life of the community.

Large cities and cities which are the seats of counties are obliged to provide other types of material support and assistance, including the stimulation of volunteering and work of civil society organisation. Elderly people mostly rely on the guaranteed minimum benefit, the compensation for the cost of housing, the right on firewood costs, the allowance for the personal needs of users of accommodation, the one-off cash allowances, the personal disability allowance, the allowance for assistance and care and the in-home assistance.

The in-home assistance is awarded to persons with

secured housing and other living conditions, but

who are, due to old age, disability or other grave

health conditions unable to take care of their

personal needs alone or with help from their

families. The condition for receiving this meanstested

social service is that the assistance cannot be

obtained from parents, spouse or children, nor

based on life maintenance and support agreements

or other regulations.

There are nine categories of social services, which

are basically social benefits in kind. In-home

assistance is an example of a social service. It

implies the provision of different practical forms

of help, prescribed in bylaws (typically includes

delivery of meals, housework, assistance with

personal hygiene and satisfying other everyday

needs).

The LTC users are most often elderly and people

with disabilities. Long-term care is carried out both

through institutional and non-institutional forms of

care. Long-term accommodation is granted to

users who need over a long period of time

necessity intensive care and other life needs. There

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also exists a range of institutionalised forms of

care, e.g. permanent or temporary accommodation

or even daily or shorter stays in care centres.

In 2014, there were 258 institutional LTC

providers, governmental and non-governmental

LTC homes and other legal providers (persons) for

stay in and accommodation of adults and the

elderly (159 for the elderly and infirm/ seriously

sick people, 68 for disabled children and adults

with physical, intellectual or sensory impairments,

31 homes for mentally ill adults). (358)

Eligibility criteria and user choices:

dependency, care needs, income

Reliance on long-term care is certified by the

social welfare centres, established through special

regulations. Degree of physical and mental

impairment, duration of reliance on care, degree of

(full or partial) incapacity for independent living,

urgency and scope of assistance and care,

screening of income and assets are among the

indicators being assessed.

As a rule, the Social Welfare Centre has to verify

occasionally or at least once a year, if the

conditions for social assistance are still met. It is

also a duty of the recipient to report all relevant

changes within eight days. (359)

There is an exception when means test does not

apply, such as serious mental or physical

impairment, blindness and/or deafness (if

(358) Governmental and non-governmental LTC homes, county

LTC homes and other legal providers (persons) of LTC -

total (1.+ 2.+ 3.) includes 258 provides and serves 31.392

users, of which 21.782 are LTC users. These can be broken

down into the following categories

1. Governmental LTC homes: 46 providers and serves 8310

users, of which 3884 are LTC users.

2. Non- governmental LTC homes: 151 providers and serves

21.038 users, of which 17.154 are LTC users.

3. Other legal providers (persons) of LTC: 61 providers and

serves 2.044 users, of which 744 are LTC users.

Source: Data from governmental and non-governmental LTC

homes, county LTC homes and other legal providers

(persons) of LTC; Ministry of Social Politics and Youth.

(359) Previous supplementary cash benefits, ensuring that

persons have enough funds to satisfy their basic monthly

personal needs, while also stimulates the activation of those

capable of working. Introduction of the GMB through a

new web application in Social Welfare Centres represents

the beginning of the unification of cash benefits at the state

level (as it is stipulated that establishing a unique cash

center - "One stop shop"). Deinstitutionalisation and the

role of private providers of social services are emphasised.

blind/deaf persons have trained to care for

themselves, when determining if persons have the

right to receive the allowance for assistance and

care in full amount, as well as blindness and/or

deafness (if blind/deaf persons have trained to care

for themselves), or the fact that a person is totally

deprived of legal capacity, when determining if

persons have the right to receive the allowance for

assistance and care in reduced amount.

Means-testing is applied, meaning that a person is only eligible for this kind of assistance if his/her average income in the three months preceding the application does not exceed 200% of the base amount (per family member) or 250% of the base amount (single persons) (Article 57 (2) Social Welfare Act). (the base amount is defined by Social Welfare Act, Article 27, paragraph 2, and in 2015 it was 500 HRK (about EUR 66)).

In 2010, the total of HRK 58.1 million (about EUR 7.5 mln) was utilised for the implementation of social services of generational solidarity (day care services and in-home assistance), as well as the improvement of work quality. 75% was financed from the State budget of the Republic of Croatia, while the rest of the financing (25%) was born by the local and regional self-government units.

Role of private sector, private insurance and out of pocket co-payments

In Croatia, more than two thirds of institutional homes for the elderly are privately owned (see footnote 4).

Long-term care is financed from the state budget and partly from the budgets of regional communities (also the city of Zagreb) and local communities. Social services might be co-financed by the beneficiaries and their family members. (European Commission, 2013).

Prevention and rehabilitation measures National and county Centres for gerontology operate at the county institutes of public health. Apart from Centres of Gerontology, there are Gerontology Centres as multifunctional centres of immediate and integral multidisciplinary care for elderly people in the local community. A total of 79 Gerontology Centres for community care of elderly people operate in Croatia, 12 thereof in

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Zagreb, where most elderly people live (Ministry of Health)

Formal/informal caregiving

The aim of the Foster Families Act (Official

Gazette, 90/11, 78/12) is deinstitutionalisation and

increase of the number of foster families, their

professionalisation and specialisation for taking

care of certain categories of beneficiaries. Foster

care is defined as a non-institutional type of care

for children and adults out of their families. Types

of foster care are defined according to

beneficiaries (traditional, specialised, urgent and

temporary) as well as the status of foster care

(kinship, professional). Foster families for adults,

are taking care mainly for elderly and frail persons,

persons with disability and mentally ill adults.

Foster care is provided only upon referral from the

competent Social Welfare Centre.

The scale of family care in Croatia is above the

EU27 average. Around 17% of the respondents

aged 35-49 report having to care for elderly

relatives at least several times a week. The age

cohort 50-64 apparently bears the greatest load

when it comes to taking care of elderly: 24%

female respondents and 13% male respondents of

that age group are involved in those activities, which places Croatia among the top three countries in Europe (after Italy and Estonia). (Bodiroga-Vukobrat, 2012).

In addition to religious communities and nongovernmental organisations, the role of the civil

sector's associations in the long-term care arrangements is important in Croatia. There are various pensioners' associations organised at national, regional and local levels. For example, one of the oldest civil society organisations in Croatia is the National Pensioners' Convention of Croatia (Cro. Matica umirovljenika Hrvatske) with around 270,000 members, 300 associations and 800 branches and clubs at the local level. The association and its members, organise the purchase of winter foodstuffs, meat, fruits and vegetables, as well as heating fuel at preferential prices with payment by installments, while its volunteers visit the sick and infirm, and socialise in clubs, branches and associations.

Recently legislated and/or planned policy

reforms

During 2013 a new Act on Social Welfare was created and it was put into force on January 1 2014. This Act established prerequisites for enhancing efficiency, transparency, IT and expertise base in the system of social welfare and as well raises the community awareness of social rights. It contains new criteria for social benefits and services in order to promote the integration of those who suffer social exclusion. Setting standards for quality in social services lays foundations for deinstitutionalisation and developing new extra-institutional services, it offers wider choice and services improvement within the process of social integration; it enables creation of comprehensive social beneficiaries base. As for the cash benefits, they are better defined in the context of persons at great risk of poverty and social exclusion. The new Act introduced guaranteed minimum benefit which is a new type of cash benefit merged from four previous social cash benefits which were under

jurisdiction of three different Ministries. The state

decides on the height of this allowance on an

annual basis.

The new Act on Social Welfare enabled

transparent and fair system of "social services

contracting" which means that all service providers

within the network will form the service price on

basis of a single calculation methodology and

this procedure will be prescribed in a separate

bylaw. Final service price will also depend on the

service provider's harmonisation with directives

for service providing within the network, taking

into account his/her professional resources,

location and harmonisation with minimum quality

standards.

Introducing guaranteed minimum benefit into

social welfare system represents the beginning of

merging various benefits and services and is a step

forward to establishing a centre in charge of all

cash benefits, a kind of „one stop shop“. This

centre would consequently take charge of all

existing cash benefits which are currently under

jurisdiction of various state institutes and offices.

Further informatisation of the social welfare system and establishing network with other systems with the scope of data exchange will result

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with lowering administration costs as well as simplifying the whole process.

Law on Unique Expertise Body (Official Gazette, 85/14, 95/15) presumes founding of the single expertise body meaning that expertise would be done in one place which would shorten the existing administrative procedures. According to the past regulations every service claimer has to be examined every single time when he/she is claiming for benefits in various systems. Besides generating unnecessary expenses this procedure is quite tiring for the benefit claimer.

According to the new Law on Unique Expertise Body, an individual benefit claimer can obtain his/her rights in various systems based on one document and the expertise given from the single

expertise body (pension insurance, professional rehabilitation and employment of persons with disability, various types of maternity and parental allowances, allowances for civil and military war victims). This body should function as an independent working unit within the Institute for expertise, professional rehabilitation and employment of persons with disability, with branch offices all around the country (local and regional). The expertise procedure would be based on a single methodology for determining the disability level/residual functional and working capacity. Since January 1, 2015 for this is responsible respective Institute for expert evaluation, professional rehabilitation and employment of disabled people.

Besides the above mentioned laws, this is partly regulated by the Family Law (Official Gazette, 103/15) according to which parents have obligation to maintain an adult child who has severe and permanent illness and disability and is not able to live independently/work, children have obligation to maintain their disabled and without

living resources parents, and grandchildren have obligation to maintain their disabled and without living resources grandparents (if grandparents maintained grandchildren).

The social welfare system provides assistance to individuals at risk of poverty or social exclusion as well as those living in non-adequate personal or family environment. It includes prevention, promoting changes, assisting individuals, families or groups in their everyday needs as well as enhancing their social inclusion. The concept for fulfilling these conditions is defined by the Ministry of Social Policy and Youth Strategic plan 2015-2017 which sets three goals to be achieved in the upcoming period:

Goal 1. Develop comprehensive approach to various user groups by improving the legislative frame and upgrading service providers efficiency:

- provide equal access to the social services network for all users and providers alike, and effective access to cash benefits for disabled

people;

- improve and develop of strategic and

legislative framework focussed on elderly,

people with addiction problems, asylum

seekers, victims of trafficking and homeless

- increase the efficiency of the social welfare

centers;

- improve of legal regulations and implement

regulations to ensure more effective protection

of the individual rights of citizens;

- implement and monitor the process of

transformation and de-institutionalisation of

social welfare homes founded by the Republic

of Croatia;

- increase service quality by improving the

infrastructure of homes founded by the

Republic of Croatia;

- as stated above, the goal is to improve the

system through more efficient legislative frame

and developing various social programs which

will, consequently, guarantee system

improvements especially in the context of

groups at social risk.

Goal 2. Enhance the process of social inclusion

for various user groups:

- develop volunteerism and systems of measurement and evaluate of volunteer contributions;

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- increase availability and quality of social services with the regional uniformity;
- improve quality of professional work providers;
- increase level of social inclusion of people with disabilities;
- develop services that contribute to the inclusion of the elderly, people with addiction problems, asylum seekers, victims of trafficking and the homeless in the community life.

The idea of volunteering development is present in several national documents such as: Croatian Government programme for the period 2011-2015, Law on Youth, Law on Youth Advisory Boards,

Law on Agency for Mobility and EU Programmes,

National Youth Programme 2014-2017 and

Strategy of Social **Care** for Older People 2014-

2016. Volunteering is presented as an activity to be

enhanced and promoted with the goal of improving

life quality both for service users and volunteers

and enhancing social inclusion of marginalised

social groups. Promoting more active engagement

of local and regional self-government in social

care system by enhancing the work of NGO's and

humanitarian aid organisations and assuring them

financial assistance contributes to extra

institutional service development. This type of

service development is planned as well in the

Transformation and deinstitutionalisation plan of

social **care** homes and other legal entities who

practice social welfare activities in Republic of

Croatia 2011-2016 (2018).

Goal 3 Improve **care** for vulnerable groups by

setting more efficient coordination in

enforcement of national and international

strategic documents:

- ensure conditions for the implementation of EU

policies, VE and other international initiatives

in accordance with the competence;

- ensure conditions for use of EU funds;

- strengthen workforce and capacity of the

respective Croatian social welfare authorities;

- improve care of disabled people by establishing

more effective coordination, monitoring and

evaluation of the implementation of the

National Strategy for Equalisation of

Opportunities for Disabled People 2007 to

2015 and the Convention on the Rights of

Disabled People.

The Ministry of Social Policy and Youth conducts

expert activities related to EU, Council of Europe

and UN membership obligations as well as other

international and regional initiatives in the field of

social policy and social inclusion and it is obliged

to submit reports to these organisations. Ministry

also informs various user groups on the

possibilities offered in EU funds. Furthermore, it

develops bilateral and multilateral cooperation

with organisations/institutions acting in the field of

social welfare by organising and participating in

international and regional events

Challenges

Croatia has a relatively fragmented system of LTC,

a feature that often leads to inefficiencies. At

present, Croatia has not developed a

comprehensive strategy and long-term care is

spread across health and social-welfare systems.

The main challenges of the system appear to be:

- Improving the governance framework and administrative efficiency: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; Improving financing

arrangements: to determine the extent of user

cost-sharing on LTC benefits; to include assets

in the means-test used to determine individual

cost-sharing (or entitlement to public support)

for B&L costs better reflects the distribution of

economic welfare among individuals.

- Providing adequate levels of care to those in

need of care: to adapt and improve LTC

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coverage schemes, setting the need-level

triggering entitlement to coverage; the depth of

coverage, that is, setting the extent of user costsharing

on LTC benefits.

- Encouraging home care: to develop

alternatives to institutional care by e.g.

developing new legislative frameworks

encouraging home care and regulation

controlling admissions to institutional care or

the establishment of additional payments, cash

benefits or financial incentives to encourage

home care; to monitor and evaluate alternative

services, including incentives for use of

alternative settings.

- Ensuring availability of formal carers: to

determine current and future needs for

qualified human resources and facilities for

long-term care;

- Supporting family carers: to establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- To facilitate appropriate utilisation across

health and long-term care: to arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; to steer LTC users towards

appropriate settings.

- Improving value for money: to invest in ICT

as an important source of information, care

management and coordination.

- Prevention: to promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; to employ prevention

and health-promotion policies and identify risk

groups and detect morbidity patterns earlier.

Long-term care systems

2.4. Croatia

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Table 2.4.1: Statistical Annex – Croatia

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 31 33 37 40 44 48 45 45 45 44 43 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 15.1 15.6 15.9 16.3 17.3 17.0 15.1 14.9 15.3 15.4 15.2 26.8 27.6 28.0 28.1 27.9

Population, in millions 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 4.3 502 503 504 506 507

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Public expenditure on long-term care

As % of GDP : : : : : 0.0 0.1 : 1.0 1.0 1.0 1.0 :

Per capita PPS : : : : : 6.6 7.4 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : : : : : 0.1 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 78.1 78.8 78.8 79.3 79.2 79.7 79.7 79.9 80.4 80.6 81.0 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 71.0 71.8 71.7 72.4 72.2 72.3 72.8 73.4 73.8 73.9 74.5 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : : : : 60.4 61.7 64.2 60.4 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : : : : 57.4 59.8 61.9 57.6 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : : : : 36.5 36.8 29.2 31.0 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : : : : 11.4 7.7 5.3 8.0 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : : 16 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : : 17 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : : 0.8 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

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Number of informal carers, in thousands : : : : : : : : :

Number of formal carers, in thousands : : : : : : : : :

Long-term care systems

2.4. Croatia

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Table 2.4.2: Statistical Annex - continued – Croatia

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060).

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 4.2 4.1 4.0 3.8 3.7

Dependency

Number of dependents in millions 0.29 0.31 0.32 0.33 0.33

Share of dependents, in % 7.0 7.5 8.2 8.5 8.8

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.4 0.5 0.5 0.5 0.5

AWG risk scenario 0.5 0.6 0.8 1.1 1.6

Coverage

Number of people receiving care in an institution 16,210 16,658 17,075 16,872 16,533

Number of people receiving care at home 17,696 18,185 18,640 18,418 18,048

Number of people receiving cash benefits 111,912 115,005 117,883 116,483 114,140

% of pop. receiving formal LTC in-kind and/or cash benefits 3.5 3.7 3.9 4.0 4.0

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% of dependents receiving formal LTC in-kind and/or cash benefits 49.9 48.7 47.6 46.6 45.7

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 88.8 88.5 88.0 87.9 88.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 11.2 11.5 12.0 12.1 12.0

Public spending on institutional care (% of tot. publ. spending LTC) 61.3 60.8 60.3 59.9 59.6

Public spending on home care (% of tot. publ. spending LTC in-kind) 38.7 39.2 39.7 40.1 40.4

Unit costs of institutional care per recipient, as % of GDP per capita 62.5 60.7 57.5 57.2 57.5

Unit costs of home care per recipient, as % of GDP per capita 36.1 35.8 34.7 35.1 35.6

Unit costs of cash benefits per recipient, as % of GDP per capita 1.9 1.9 1.9 1.9 1.9

2013

MS Change

2013-2060

EU Change 2013-2060

4.3 -13% 3%

0.27 19% 40%

6.4 37% 36%

0.4 15% 40%

0.4 268% 149%

15,574 6% 79%

17,001 6% 78%

107,516 6% 68%

3.3 22% 68%

51.1 -11% 23%

89.0 -1% 1%

11.0 9% -5%

61.5 -3% 1%

38.5 5% -1%

63.9 -10% -2%

36.6 -3% -3%

1.9 2% -2%

2.5. CYPRUS

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General context: expenditure, fiscal

sustainability and demographic trends

GDP per capita is currently below EU average

with 21,900 PPS in 2013 (EU: 27,900). Population

was estimated at 0.9 million 2013. According to

Eurostat 2013 projections, the total population is

projected to increase from around 0.9 million in

2013 to 1.1 million in 2060.

Health status

Life expectancy at birth (85.0 years for women and

80.1 years for men) is above EU average levels of

83.3 and 77.8 years in 2013. The same is true for

healthy life years with 65.0 years for women and 64.3 years for men versus 61.5 and 61.4 in 2013 in the EU. The percentage of the population having a long-standing illness or health problem is slightly above this share in the Union (33.2% in Cyprus versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in daily activities stands at 8.0%, which is slightly lower than the EU-average of 8.7%.

Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase significantly over the coming 50 years. From 6 thousand residents living with strong limitations due to health problems in 2013, an increase of 105% is envisaged until 2060, to slightly more than 13 thousand. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 7.2% to 11.4%, an increase of 58%. This is much more than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

"AWG reference scenario", public long-term

expenditure is driven by the combination of

changes in the population structure and by a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 0.2 pps

of GDP by 2060 (360). The "AWG risk scenario",

which in comparison to the "AWG reference

scenario" captures the impact of additional cost

drivers to demography and health status, i.e. the

possible effect of a cost and coverage convergence,

projects an increase in spending of 1.7 pps of GDP

by 2060. This reflects the fact that coverage and

unit costs of care are comparatively low in Cyprus,

and may experience an upward trend in future,

driven by demand side factors. Overall, the

projected long-term care expenditure increase is

expected to add to the budgetary pressure,

contributing to the risk for long-term sustainability

of public finances.

System Characteristics

Policies and measures that fall within the spectrum

of long-term care are administered by the Ministry

of Health (long-term health care) and the Ministry

of Labour, Welfare and Social Insurance (MLWSI)

(long-term social care, sensory, cognitive) through

the Social Welfare Services (SWS) and the

Department for Social Inclusion of Persons with

Disabilities (DSID).

In July 2014, the Guaranteed Minimum Income

(GMI) and Social Benefits legislation was adopted

and the competent Ministry is MLWSI.

The Guaranteed Minimum Income and in General

the Social Benefits (Emergency Needs and Care

Needs) Decree of 2015 N.353/2015 (administered

by the Ministry of Labour, Welfare and Social

Insurance, Social Welfare Services) incorporates

the “Scheme for the Subsidisation of Care

Services” which cover social care needs of

recipients of guaranteed minimum income and members of their family unit. The Scheme mainly covers cash benefits and in justified cases it may provide for in-kind services.

Subsidisation of care services under the Decree, covers home care, day care, respite care and residential care in approved and registered care services (natural and/or legal persons) under the relevant legislative framework of the SWS. Longterm social care services are provided by the government, local authorities, non-governmental

(360) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

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organisations (NGOs), and the private sector (private for profit enterprises).

Furthermore, the SWS subsidise social care programmes at local level run by NGO's and Local Authorities [State Aid Scheme, under the

Regulation 360/2012 for the provision of services

of general economic interest (De minimis)]. These

programmes (day-care, residential care, home care

and child care) cover the social care needs of older

people, people with disabilities and children at

local level.

The State (SWS) provides full time care in

residential homes for older persons and persons

with mental and physical disabilities and it

operates Houses in the Community for persons

with mental and physical multiple disabilities.

Moreover, additional cash benefits are regulated

by the DSID for persons with disabilities,

irrespective of their income level, targeting to

cover the cost of disability. In particular, under two

special laws and two schemes, persons with severe

motor disability, paraplegia, quadriplegia or

blindness are entitled to monthly cash benefits.

These benefits cover the cost for the purchase of

care services but also rehabilitation services

(physiotherapy, occupational therapy, speech

therapy etc). For the rehabilitation of the disabled

persons immediately after their treatment, but due to the absence of a rehabilitation policy person with disabilities often use DSID cash benefits for this purpose.

In 2012, per capita spending for LTC was at the level of 37 PPS (EU: 317 PPS). LTC constitutes a minor share of total government expenditure. In 2012, it accounted for 0.2% of total government spending (EU: 2.1%).

Public spending on LTC reached 0.3% of GDP in 2013 in Cyprus, below EU average of 1.6% of GDP. 39% of this spending were spent on in-kind benefits (EU: 80%), while 61% was being provided as cash-benefits (EU: 20%). Thus, Cyprus uses cash benefits to a very large extent, which is a consequence of the lack of a formal public LTC scheme. It is not clear which role private co-payments for formal in-kind LTC play in financing of LTC services.

Types of care

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC.

This share is with 22% lower in Cyprus. Overall,

1.6% of the population (aged 15+) receives formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform. The expenditure for institutional (in-kind) services makes up 9% of public expenditure (EU: 61%), 91% are being spent for LTC services provided at home (EU: 39%). However, as discussed above, Cyprus spends most of its LTC resources via cash benefits, thus having a relative focus of LTC policies on home care.

Eligibility criteria and user choices:

dependency, care needs, income

Only individuals entitled to GMI may be entitled to subsidisation of social LTC, except of persons with severe disability (motor/paraplegia/quadruplegia/blindness) who are entitled to this irrespective of their income level. No qualifying period is defined for LTC eligibility.

Entitlement to long-term social care is based upon need i.e. based on the person's ability to carry out his/her daily home and personal care and his/her ability to meet his/her frequent activities outside of his/her home (i.e. shopping, doctor visits, social activities). In addition, the Decree (N.353/2015) does not provide for any element of duration/degree of dependency. Only in the case of home care provided by Domestic Worker, the persons should be deprived of their ability for selfcare.

GMI applications are evaluated by the Welfare Benefits Administration Service, which informs the SWS whether the applicant fits in the category of people who can be assessed for the provision of care services based on the legislation and whether the applicant receives care benefit from any other Service. Subsequently, the Social Welfare Services assess the care need of applicants and then communicate the results of their assessment to the Service for the Management of Welfare Benefits

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for their decision on the application according to the results of the assessment.

The SWS perform in situ visits to the accommodation of the applicants/beneficiaries to assess the need for care with the use of specific assessment tools. The SWS may ask for additional certificates/reports from other Services (including medical reports). Subsequently, the information collected is assessed by Specialised Assessment Teams of the SWS. In case of a positive evaluation of the care needs of the applicant/ beneficiary which corresponds to the approval of care provision, it includes the type, the extent and the duration of the care that will be provided as well as the amount of subsidisation. Between the beneficiary and the approved service provider an Agreement for the Provision of Social Care is signed, which should be notified to the SWS for the correctness of the content and for the future

quality checks of the service provision.

In case the beneficiary prefers a different type of

care than the one proposed, then she/he has the

right to make his/her own arrangements,

nevertheless the subsidisation of care will

correspond to the approved amount.

In the case of persons with disabilities, in order to

become entitled of disability cash benefits by

DSID or the GMI-Disability additional benefit

they have to follow a disability assessment and

certification through the DSID Disability

Assessment Centre.

Prevention and rehabilitation measures

In Cyprus the health care system for the elderly

people is strongly acute-care oriented. Hospital

and specialist care is a priority over other models

of care. Elderly patients have the opportunity to

visit the primary health care services either at the

out patients surgeries or at the health care centers

all over the districts. The GPs do not function as

gatekeepers for medical care, as hospitals and

private specialists are directly accessible to patients. Nursing homes as such do not exist, but elderly and very elderly people in need of complex care stay in hospitals or in special care wards in retirement homes. Health care provision is also offered in hospital physiotherapy services, according to their needs.

Long-term care includes health, personal, and support services, aiming at helping people to remain at home and live as independently as possible. Long-term care is mainly provided either in the home of the person receiving services or at a family member's home. In-home services may be short-term -for someone who is recovering from surgery, for example -or long-term, for people who need help continuously.

Long-term care Services are provided mainly to people with a high level of dependency, often elderly people, those with chronic diseases and people with physical, learning and mental disabilities. The Nursing Services of the Ministry

of Health facilitate the long-term care provided by a network of Community Nurses (General Nursing Community Nurses and Mental Health Community Nurses) through home visits to mentally ill patients, disabled people, artificially ventilated patients at home and elderly people who live alone and encounter severe health problems.

The long-term care provided by the Mental Health Services, is being ensured by monitoring chronic mental patients in the community (at their homes or at rehabilitation units, such as Day Centers and Occupational Rehabilitation Units). These services are provided by a multi-disciplinary team of mental health professionals – psychiatrists, clinical psychologists, ergo therapists, nursing officers.

Formal/informal caregiving

According to the Decree 353/2015 the following

types of care (formal care), are covered:

Home care which covers a wide range of care services and includes personal and household care.

To cover the needs of home care either by an approved natural and/or legal person, or by

Domestic Worker the maximum amount granted as a subsidy is EUR 400/month per family unit. For extraordinary and justified cases a larger amount can be covered for instance, when additional care attendants are required.

Day care is offered during the day covering personal care services, meals, social and creative activities. The State may pay a cash benefit to recipients of long-term care of up to EUR 137 per month for day care provided by approved natural and/or legal persons. In some cases the

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transportation/accompanying costs especially for persons with disabilities are also covered.

Residential care provides for a 24hour care, where the person requires continuous support and their needs cannot be covered by family members or other supportive services in their environment.

In addition to free residential care in public institutions, the state may pay monthly cash benefit for residential care provided by approved natural and/or legal persons. Cash benefits vary from EUR 625 to EUR 745 per month depending on the care needs of the beneficiary (e.g. bedridden, mobility difficulties or not). Residential homes may be public, private or non-governmental.

Respite Care is for short periods of time in order to give short spells of rest to the informal caregiver and can take the form of the above types of

care (home, residential or day care). Informal carers are supported in their valuable role and simultaneously the person concerned is supported for staying in their home environment. Respite

care is arranged depending on the needs and preferences of the people themselves and of their families as far as possible.

The level of the subsidisation for the above types of care is defined by an automated analysis of the specific assessment tools used by the SWS.

Another type of care that is covered by the Decree,

but is outside the scope of the present Fiche, is

child care and the state may pay cash benefit up to

EUR 102 per month.

Recently legislated and/or planned policy

reforms

In July 2014, the Cyprus Government has

reformed the welfare system by introducing a

Guaranteed Minimum Income (GMI). In the

relevant Law (N. 109(I)/2014), article 10 (2) refers

to the care needs of the GMI recipients and their

family members, where additional assistance can

be provided. In this direction, the Minister of

Labour, Welfare and Social Insurance, issued in

August 2014 a Decree that incorporates the

“Scheme for the Subsidisation of Care Services”

and it was revised in 2015 (N.353/2015). The new

Scheme subsidises the social care needs of GMI

recipients, including the members of their family

unit, as described in section “LTC System

Characteristics”.

Challenges

Cyprus has recently reformed and clearly defined eligibility for LTC benefits, but has a relatively low coverage and financing of the system relatively fragmented system and overall system governance seems improvable. The main challenges of the system appear to be:

- Improving the governance framework: to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and

transfers (e.g. pensions), and existing social assistance

or housing subsidy programmes.

- Improving financing arrangements: to face

the increased LTC costs in the future e.g. by

tax-broadening, which means financing beyond

revenues earned by the working-age

population; to foster pre-funding elements,

which implies setting aside some funds to pay

for future obligations; to explore the potential

of private LTC insurance as a supplementary

financing tool;

- Providing adequate levels of care to those in

need of care: to reduce the risk of

impoverishment of recipients and informal

carers.

- Ensuring availability of formal carers: to

determine current and future needs for

qualified human resources and facilities for

long-term care.

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- Supporting family carers: to establish policies for supporting informal carers, such as through flexible working conditions, , carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- Ensuring coordination and continuity of care: to establish better coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care coordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: to steer LTC users

towards appropriate settings.

- Improving value for money: to invest in ICT

as an important source of information, care

management and coordination.

- Prevention: to promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; to employ prevention

and health-promotion policies and identify

risk groups and detect morbidity patterns

earlier.

Long-term care systems

2.5. Cyprus

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Table 2.5.1: Statistical Annex – Cyprus

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 13 14 15 16 17 19 18 19 20 19 18 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 24.5 25.6 26.4 27.0 27.6 27.9 26.3 26.0 24.5 23.3 21.9 26.8 27.6 28.0 28.1 27.9

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Population, in millions 0.7 0.7 0.7 0.7 0.8 0.8 0.8 0.8 0.8 0.9 0.9 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.2 0.2 0.2 : 1.0 1.0 1.0 1.0 :

Per capita PPS 2.2 2.0 2.1 2.5 2.6 2.7 3.1 35.3 37.2 36.7 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 0.0 0.0 0.0 0.0 0.0 0.0 0.3 0.3 0.3 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 81.2 81.8 80.8 82.0 82.1 82.9 83.5 83.9 83.1 83.4 85.0 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 76.8 76.5 76.5 78.1 77.6 78.2 78.5 79.2 79.3 78.9 80.1 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 69.6 : 58.2 63.4 62.8 64.5 65.3 64.2 61.0 64.0 65.0 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 68.4 : 59.8 64.2 63.1 63.9 64.8 65.1 61.6 63.4 64.3 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 26.3 29.1 28.7 25.9 28.4 34.0 32.7 32.6 33.2 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 10.7 8.5 8.2 6.9 6.7 7.6 10.3 7.9 8.0 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 3 3 4 4 4 5 3 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : : : : 3 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : 0.4 0.4 0.5 0.5 0.5 0.5 0.7 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : : : : : : : :

Number of formal carers, in thousands : : : : : : : : : : :

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2.5. Cyprus

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Table 2.5.2: Statistical Annex - continued – Cyprus

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 0.9 0.9 1.0 1.0 1.1

Dependency

Number of dependents in millions 0.07 0.09 0.10 0.12 0.13

Share of dependents, in % 8.1 9.4 10.6 11.1 11.4

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.3 0.4 0.4 0.5 0.5

AWG risk scenario 0.3 0.5 0.7 1.1 2.0

Coverage

Number of people receiving care in an institution 3,598 4,456 5,452 6,438 7,372

Number of people receiving care at home 3,841 4,965 6,243 7,470 8,688

Number of people receiving cash benefits 8,706 10,676 12,900 15,137 17,307

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% of pop. receiving formal LTC in-kind and/or cash benefits 1.8 2.2 2.5 2.8 3.0

% of dependents receiving formal LTC in-kind and/or cash benefits 22.4 23.2 24.1 25.1 26.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 39.3 38.6 37.8 38.2 38.9

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 60.7 61.4 62.2 61.8 61.1

Public spending on institutional care (% of tot. publ. spending LTC) 8.7 8.1 7.7 7.4 7.2

Public spending on home care (% of tot. publ. spending LTC in-kind) 91.3 91.9 92.3 92.6 92.8

Unit costs of institutional care per recipient, as % of GDP per capita 2.6 2.4 2.2 2.1 2.1

Unit costs of home care per recipient, as % of GDP per capita 25.8 24.0 22.7 22.9 23.5

Unit costs of cash benefits per recipient, as % of GDP per capita 19.2 19.3 19.6 19.8 19.9

2013

MS Change

2013-2060

EU Change 2013-2060

0.9 30% 3%

0.06 105% 40%

7.2 58% 36%

0.3 97% 40%

0.3 697% 149%

3,115 137% 79%

3,252 167% 78%

7,624 127% 68%

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1.6 84% 68%

22.4 16% 23%

38.6 1% 1%

61.4 -1% -5%

9.0 -20% 1%

91.0 2% -1%

2.5 -13% -2%

23.8 -2% -3%

17.8 12% -2%

2.6. CZECH REPUBLIC

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General context: expenditure, fiscal

sustainability and demographic trends

GDP per capita in PPS is at 21,600 and below EU

average of 27,900 in 2013. The Czech Republic

has a population of 10.5 million inhabitants.

During the coming decennia the population will

remain roughly constant at 10.5 million.

Health status

Life expectancy at birth for both women and men

is respectively 81.3 years and 75.2 years in 2013

and is below the EU averages (83.3 and 77.8 years

respectively). Healthy life years at birth are with

64.2 years (women) and 62.5 years (men) above the EU-averages (61.5 and 61.4, respectively). The percentage of the Czech population having a longstanding illness or health problem is slightly lower than in the Union (31.5% in the Czech Republic versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 6.4%, which is lower than the EU-average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 840 thousand residents living with strong limitations due to health problems in 2013, an increase of 52% is envisaged until 2060 to slightly more than 1.28 million. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 8% to 11.6%, an increase of 44%.

This is more than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a projected increase in spending of about 0.7 pps of GDP by 2060. (361) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 5.3 pps of GDP by 2060. This reflects, that coverage and unit costs of care are comparatively low in the Czech Republic, and may experience an upward trend in future, driven by demand side factors.

Over the long run, medium sustainability risks appear for the Czech Republic. However, these risks derive primarily from the projected impact of

age-related public spending (notably health care

and pensions), and not primarily long-term care.

(362)

System Characteristics

Funding and also provision of long-term care is not

completely separated from health and social care.

Home care services are provided by special

providers contracted by health insurers and

reimbursed by public health insurance system only

if indicated by a general practitioner. Institutional

care is provided in specific facilities or in

residential social care establishments,

predominantly providing social care and nursing

care to a limited extent only. Reimbursement for

home and institutional care is based on fee-for-service.

Public spending on LTC reached 0.7% of GDP in

2013 in the Czech Republic, below EU average of

1.6% of GDP (Based on the 2015 Ageing Report).

The Czech Republic seems to have a high usage of

cash benefits. In fact, 63% of public LTC spending

is done via cash benefits (EU: 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC.

This share is with 91% much higher in the Czech Republic. It means that 9 out of 10 individuals

aged 15 or more and declaring themselves as severely dependent, would receive some kind of formal **care** (at home or in institution, in kind or in cash). Overall, 7% of the population (**aged** 15+)

(361) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(362) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf

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receive formal LTC in-kind and/or cash benefits

(EU: 4%).

The expenditure for institutional (in-kind) services makes up 82% of public in-kind expenditure (EU:

61%), 18% being spent for LTC services provided

at home (EU: 39%). Thus, relative to other

Member States the Czech Republic has a focus on

institutional care, which may not always be costefficient.

As institutional care is relatively costly,

Member States with shares well above the EU

levels may benefit from efficiency gains by

shifting some coverage (and thus expenditure)

from institutional to other types of care. However,

in the Czech Republic a significant part of the

costs of institutional care is covered by the care

recipients themselves. Thus, shifting from

institutional long-term care to home care may not

heavily decrease public costs, but may improve

quality of life of recipients who receive care at

home rather than in institutions.

Types of care, eligibility criteria and user

choices: dependency, care needs, income

Recipients of care are differentiated on a four level

scale according to the recipient's care needs, which

is specified in the law. Care allowance is not means-tested except for patients below age of 18 years. The highest care allowance amounts to roughly half of the average salary.

Social care services are mostly provided by informal carers, but also by professional social services. Formal carers of social services can be registered or unregistered. If registered they are bound by administrative maximum prices. If a person is unregistered, then free pricing of services applies to be fully covered by private payments.

Some services, such as social prevention or rehabilitation are provided without private copayments.

For institutional care, recipient's income (up to 85%) can be used to cover costs accommodation and food for residential care.

Reimbursement of other social services is limited by the recipient's care allowance. Any remaining costs have to be covered privately, either by the recipient or his family. However, in some cases, a top-up from the Ministry of Labour and Social

Affairs and the municipalities to cover nursing

care can be made available.

Recently legislated and/or planned policy

reforms

There have been no recent reforms of the longterm

care system. As for the future, an

interdepartmental working group was created,

which aims to find solutions to the problems of

social and health care borders. Following the

results of the survey an amendment to existing

legislation is planned.

Challenges

The main challenges of the system appear to be:

- Improving the governance framework: To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities with respect to the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver

high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To establish good information platforms for LTC users and providers; To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social assistance or housing subsidy programmes; To deal with cost-shifting incentives across health and care.

- Providing adequate levels of care to those in need of care: To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user

cost-sharing on LTC benefits; and the depth of coverage, that is, setting the types of services included into the coverage.

- Encouraging home care: To develop alternatives to institutional care by e.g.

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developing new legislative frameworks

encouraging home care and regulation

controlling admissions to institutional care or

the establishment of additional payments, cash

benefits or financial incentives to encourage

home care; to monitor and evaluate alternative

services, including incentives for use of

alternative settings.

- Ensuring availability of formal carers: To determine current and future needs for qualified human resources and facilities for long-term care.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Facilitating appropriate utilisation across

health and long-term care: To arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; To steer LTC users towards

appropriate settings.

- Improving value for money: To invest in ICT

as an important source of information, care

management and coordination.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

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people with chronic care; To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

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Table 2.6.1: Statistical Annex – Czech Republic

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 88 96 109 124 138 161 148 156 164 161 157 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 18.5 19.0 20.0 21.2 22.3 21.3 19.9 20.6 21.6 21.5 21.6 26.8 27.6 28.0 28.1 27.9

Population, in millions 10.2 10.2 10.2 10.2 10.3 10.3 10.4 10.5 10.5 10.5 10.5 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.3 0.2 0.2 0.2 0.3 0.2 0.3 0.3 0.3 0.3 : 1.0 1.0 1.0 1.0 :

Per capita PPS 42.2 40.3 44.2 48.5 55.8 47.2 54.2 57.1 61.8 62.6 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 0.5 0.5 0.6 0.6 0.5 0.6 0.6 0.7 0.7 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 78.6 79.1 79.2 79.9 80.2 80.5 80.5 80.9 81.1 81.2 81.3 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 72.0 72.5 72.9 73.5 73.8 74.1 74.3 74.5 74.8 75.1 75.2 76.6 76.9 77.3 77.4 77.8

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Healthy life years at birth for females : : 60.0 59.9 63.3 63.4 62.7 64.5 63.6 64.1 64.2 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : 58.0 57.9 61.4 61.3 61.1 62.2 62.2 62.3 62.5 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 30.3 29.8 27.7 27.8 29.7 29.0 30.7 30.0 31.5 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 7.4 6.8 5.4 5.6 6.2 6.0 6.1 6.2 6.4 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 51 71 91 111 113 115 345 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : 120 112 104 96 99 101 94 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : 1.7 1.8 1.9 2.0 2.0 2.1 4.2 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : 257 276 281 : : : : :

Number of formal carers, in thousands : : : : 38 : : : : :

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Table 2.6.2: Statistical Annex - continued – Czech Republic

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

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PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 10.7 10.8 10.9 11.1 11.1

Dependency

Number of dependents in millions 0.92 1.05 1.13 1.20 1.28

Share of dependents, in % 8.6 9.7 10.4 10.8 11.6

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.9 1.0 1.2 1.2 1.4

AWG risk scenario 1.0 1.5 2.4 3.7 6.0

Coverage

Number of people receiving care in an institution 375,221 416,670 459,044 483,889 516,950

Number of people receiving care at home 108,781 140,239 167,912 183,870 216,051

Number of people receiving cash benefits 375,036 458,512 542,079 584,165 676,382

% of pop. receiving formal LTC in-kind and/or cash benefits 8.1 9.4 10.7 11.3 12.7

% of dependents receiving formal LTC in-kind and/or cash benefits 93.4 97.1 100.0 100.0 100.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 36.4 35.8 34.4 34.6 33.1

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 63.6 64.2 65.6 65.4 66.9

Public spending on institutional care (% of tot. publ. spending LTC) 80.7 78.3 76.7 75.9 73.8

Public spending on home care (% of tot. publ. spending LTC in-kind) 19.3 21.7 23.3 24.1 26.2

Unit costs of institutional care per recipient, as % of GDP per capita 7.1 7.3 7.3 7.5 7.4

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Unit costs of home care per recipient, as % of GDP per capita 5.9 6.0 6.1 6.2 6.2

Unit costs of cash benefits per recipient, as % of GDP per capita 15.4 15.2 15.4 15.4 15.4

2013

MS Change

2013-2060

EU Change 2013-2060

10.5 5% 3%

0.84 52% 40%

8.0 44% 36%

0.7 87% 40%

0.7 698% 149%

344,785 50% 79%

94,305 129% 78%

328,989 106% 68%

7.3 74% 68%

91.2 10% 23%

36.9 -10% 1%

63.1 6% -5%

81.6 -9% 1%

18.4 42% -1%

6.9 7% -2%

5.7 10% -3%

15.1 2% -2%

2.7. DENMARK

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General context: expenditure, sustainability

and demographic trends

GDP per capita in PPS is at 32,100 and far above

EU average of 27,900 in 2013. Denmark has a

population of 5.6 million inhabitants, which is

roughly 0.8% of the EU population. During the

coming decennia the population will steadily grow,

from 5.6 million inhabitants in 2013 to 6.5 million

inhabitants in 2060. This 17% increase is much

higher than the EU average of 3%.

Health status

Life expectancy at birth for both women and men

is respectively 82.4 years and 78.3 years in 2013

and is below the EU average for women and above

the EU average for men (83.3 and 77.8 years,

respectively). Healthy life years at birth are with

59.1 years (women) and 60.4 years (men) below

the EU-averages (61.5 and 61.4, respectively). The

percentage of the Danish population having a longstanding

illness or health problem is slightly lower

than in the Union (28.9% in Denmark versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 6.8%, which is lower than the EU-average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 440 thousand residents living with strong limitations due to health problems in 2013, an increase of 36% is envisaged until 2060 to slightly more than 600 thousand. That is a slightly less steep increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 7.9% to 9.2%, an increase of 17%.

This is less than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term

expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a projected increase in spending of about 2.3 pps of GDP by 2060. (363) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.7 pps of GDP by 2060.

Overall, projected health care expenditure increase is expected to add to budgetary pressure. However, currently no sustainability risks appear for Denmark over the long run. This risk-free outlook derives primarily from a relatively limited unfavourable contribution of the initial budgetary position and from the different contributions to age-related public spending balancing each other out in the long-term. (364)

System Characteristics

Denmark has a universal and very extensive system of LTC. The overall principles of the system are determined by the central government, while local authorities are responsible for the allocation of resources, the delivery of LTC services, and the design and implementation of actual LTC policy. Therefore, 98 municipalities are responsible for a broad range of welfare services which can be provided as institutional care facilities or special housing, or home care.

Along with the Netherlands and other Nordic countries such as Sweden, Denmark has one of the highest expenditure on LTC of all EU-28 countries in 2013. Local authorities are responsible for the allocation of resources. Their LTC costs are financed through governmental grants, local taxes and equalisation amounts (received from other local authorities). The budget for LTC services is set annually and is global. As a general rule, local authorities can't set charges for LTC help, although there are exceptions.

Public spending on LTC reached 2.4% of GDP in 2013 in Denmark, above EU average of 1.6% of

GDP. 2.3% of GDP were spent on in-kind benefits,

while 0.1% of provided via cash-benefits. Most in

(363) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(364) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

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-kind expenditure is covered by the public payer,

as 91% of total LTC in-kind expenditure was

public, and 9% private. Thus, private co-payments

for formal in-kind LTC have a marginal role in

financing.

In the EU, 53% of dependents are receiving formal

in-kind LTC services or cash-benefits for LTC.

This share is with 62% much higher in Denmark,

which has one the highest coverage rates. Overall,

4.9% of the population (**aged** 15+) receive formal

LTC in-kind and/or cash benefits (EU: 4.2%). On

the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 46% of public in-kind expenditure (EU: 61%), 54% being spent for LTC services provided at home (EU: 39%). Thus, relative to other

Member States Denmark has a focus on home

care, which may be cost-efficient. As institutional

care is relatively costly, Member States with shares

well above the EU levels may benefit from

efficiency gains by shifting some coverage (and

thus expenditure) from institutional to other types

of care.

Types of care

One of the main aims of the social services for

elderly and disabled people is to ensure that they

can manage in their own homes. In cases where

elderly or disabled people cannot manage on their

own, they can move to residential care homes and

sheltered homes. Eligibility is based on a needs'

assessment performed by the local authority.

Eligible individuals may receive a cash benefit in order to employ necessary assistance. In order to qualify for this allowance, an individual must meet a given level of need.

Personal care (ADL) and practical assistance (IADL) are available to all dependent individuals without private co-payments.

Basically, all eligible individuals have free choice of care providers. Providers include senior citizen residences, gated communities, assisted living units and nursing homes and day-care centres for temporary assistance. Individuals generally pay the rent for living in a non-profit or conventional nursing home.

As to the provision of care, local authorities and private providers supply services in a competitive framework defined by quality standards, and in some cases, price requirement.

Eligibility criteria and user choices:

dependency, care needs, income

Eligibility is based on a needs' assessment which is performed by the local authority. There is no threshold / minimum dependency requested, neither for benefits in kind nor for benefits in cash.

Prevention and rehabilitation measures

Prevention and rehabilitation are a significant objective in Danish LTC policies. Local authorities are since January 2015 by law under the obligation to evaluate if the person in need of help could benefit from a rehabilitation scheme i.e. a training program focusing on regaining independence, functionality or physical functionality. The rehabilitation scheme is therefore offered to elderly citizens that are considered to be able to profit from this initiative.

Formal/informal caregiving

Even though most dependents in Denmark receive formal care, many family members provide valuable support to spouses and elder family members, especially those family members who suffer from dementia.

Recently legislated and/or planned policy

reforms

A couple of initiatives have been developed

recently, which are summarised below:

- Agreement on “Future Home care”. In 2014,

the Danish Parliament presented the

“Agreement on Future Home Care”. Among

other things the agreement strengthens the

municipalities’ rehabilitation efforts and the

services they provide to frail, elderly people.

- Transparency reform – greater focus on

quality and results. The aim is to create

Long-term care systems

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greater and more systematic knowledge about

quality and best practice, improving

accountability as well as achieving better

management of the health care and long-term

care system based on improvements in the

overall health of the population, a high level of

patient involvement and lower expenditure per

capita. The accessible health data should provide a platform for transparency and dissemination of best practice as well as management and priorities in the health care sector on the basis of key goals and results.

- Stronger health care agreements. Five health care agreements have been completed for 2015-2018 – one for each region – and they include new mandatory key action areas and specific objectives. Furthermore, across the boundaries of key action areas, the health care agreements aim to ensure focus on inequality in health and active involvement of patients and their relatives. The aim with the five health care agreements is to ensure coherence and coordination of efforts in the patient care that goes on across hospitals, general practice and municipalities so that each patient and citizen receives a treatment that is consistent and of high quality at the lowest effective cost.

- National quality goals. The Government,

Danish Regions and Local Government

Denmark will set goals for the quality of the

Danish health care in spring 2016. The national

goals will set a framework for the continuous

quality improvement. The national goals will

be supported by a number of local goals and

activities, which shall lead to local

improvements. The national goals are part of a

national programme to improve the quality in

the health care system in Denmark. Beside the

national goals, the quality programme consists

of e.g. quality improvement teams, a national

leadership programme and enhanced patient

involvement and empowerment.

- Better usage of telemedicine, health IT and

digitalisation. There is a need for sweeping

digitalisation of the health care and long-term

care system where all procedures are supported

digitally, where up-to-date patient information

is shared by all relevant parties and where IT

systems underpin better resource utilisation and

efficient care pathways, both at the hospitals

and in their cooperation with the rest of the system. In order to meet this need, the Government has presented a new overall digitalisation strategy for the health care and long-term care system.

- Coherent health care solutions. Within the health budget framework, the Government has earmarked an amount of DKK 250 million for the regions and of DKK 300 million for the municipalities in 2014 to fund coherent health care solutions and targeted treatment where the health staff work together across disciplines and authority boundaries.

- Strengthening of professionalism in municipal nursing care. The Government intends to give the municipalities and municipal nursing care better and more systematic possibilities of utilising the professional competencies in general practice and at hospitals. In this way, professionalism will be strengthened in municipal nursing care

through closer cooperation across hospitals,

general practitioners and municipalities.

- Ensuring stronger involvement of patients

and their relatives. Active involvement of

patients has a positive effect on both the results

of treatment and the satisfaction of patients.

Therefore, the Government will strengthen the

involvement of patients and their relatives in

the Danish health care and long-term care

system. The Government intends to set up

partnerships with, e.g., the Danish patient

societies on the continued work to strengthen

the involvement of patients and their relatives

in the Danish health care and long-term care

sector.

- Strengthening initiatives aimed at citizens in

need of rehabilitation. It is the Government's

goal that all patients discharged from the

hospital and with a need for rehabilitation

receive the necessary and timely rehabilitation.

This requires consistency in initiatives between

the regions and the municipalities. The

communication between hospitals and municipalities must be improved, e.g. through the rehabilitation plan, so the municipalities are able to have a better idea of the need of the

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individual citizen for rehabilitation. Therefore, the Government intends to enhance hospital competencies in terms of describing the need for rehabilitation of the group of patients with a comprehensive and complex need for rehabilitation.

- An investment of the public health care. An ambitious, long-term strategy that is targeting on areas where the public health care need to be even better. The strategy focuses on five main elements: 1) cancer 2) chronic diseases 3) strengthening of general practitioners 4) involvement of patients and relatives 5) better quality in treatments.

Challenges

Denmark provides for a comprehensive and structured LTC system, being at the forefront of many EU countries, in what concerns the efforts to continuously improve system performance; yet, cost issues are an element to be monitored closely in view of the increasing LTC expenditure. The challenges for Denmark appear to be:

- Improving the governance framework: To establish good information platforms for LTC users and providers; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation.
- Providing adequate levels of care to those in need of care: To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user costsharing on LTC benefits; and the scope of coverage, that is, setting the types of services

included into the coverage.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care; To improve recruitment efforts,

including through the migration of LTC

workers and the extension of recruitment pools

of workers.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

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Table 2.7.1: Statistical Annex – Denmark

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 193 202 213 226 233 241 230 242 246 253 255 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 31.3 32.5 32.3 33.5 33.9 33.1 30.8 31.9 32.4 32.3 32.1 26.8 27.6 28.0 28.1 27.9

Population, in millions 5.4 5.4 5.4 5.4 5.4 5.5 5.5 5.5 5.6 5.6 5.6 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 1.9 2.0 2.0 2.0 2.2 2.2 2.5 2.4 2.4 2.4 : 1.0 1.0 1.0 1.0 :

Per capita PPS 474.0 514.1 534.0 573.0 637.9 650.5 681.3 701.9 694.0 714.7 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 3.7 3.9 4.0 4.2 4.2 4.2 4.1 4.1 4.0 : 2.1 2.2 2.2 2.1 :

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Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 79.8 80.2 80.5 80.7 80.6 81.0 81.1 81.4 81.9 82.1 82.4 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 75.0 75.4 76.0 76.1 76.2 76.5 76.9 77.2 77.8 78.1 78.3 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 60.9 69.0 68.4 67.2 67.4 60.8 60.4 61.4 59.4 61.4 59.1 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 63.0 68.3 68.4 67.7 67.4 62.4 61.8 62.3 63.6 60.6 60.4 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 24.3 25.7 29.6 27.8 24.7 29.0 27.6 29.4 28.9 28.7 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : : : 7.5 7.7 7.8 7.7 6.8 6.8 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 123 106 89 72 73 74 44 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 73 96 119 142 143 145 101 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 3.6 3.7 3.8 3.9 3.9 3.9 2.6 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands 15 15 16 19 18 20 : : : : : :

Number of formal carers, in thousands 73 75 78 77 76 77 79 : : : : : :

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Table 2.7.2: Statistical Annex - continued – Denmark

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 5.8 6.1 6.3 6.4 6.5

Dependency

Number of dependents in millions 0.48 0.53 0.56 0.58 0.60

Share of dependents, in % 8.4 8.7 8.9 9.1 9.2

Projected public expenditure on LTC as % of GDP

AWG reference scenario 2.7 3.3 3.9 4.2 4.5

AWG risk scenario 2.7 3.4 4.1 4.6 5.1

Coverage

Number of people receiving care in an institution 50,628 64,937 77,611 87,103 94,585Number of people receiving care at home 116,235 141,600 160,295 175,319 184,640

Number of people receiving cash benefits 145,759 177,194 202,166 221,069 234,593

% of pop. receiving formal LTC in-kind and/or cash benefits 5.4 6.3 7.0 7.5 7.9

% of dependents receiving formal LTC in-kind and/or cash benefits 64.6 72.8 78.9 82.8 85.2

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 94.6 94.9 95.2 95.3 95.4

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Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 5.4 5.1 4.8 4.7 4.6

Public spending on institutional care (% of tot. publ. spending LTC) 46.0 46.3 47.3 47.5 48.1

Public spending on home care (% of tot. publ. spending LTC in-kind) 54.0 53.7 52.7 52.5 51.9

Unit costs of institutional care per recipient, as % of GDP per capita 133.5 134.7 140.5 140.0 142.0

Unit costs of home care per recipient, as % of GDP per capita 68.2 71.6 75.9 76.8 78.5

Unit costs of cash benefits per recipient, as % of GDP per capita 5.8 5.8 5.8 5.8 5.8

2013

MS Change

2013-2060

EU Change 2013-2060

5.6 17% 3%

0.44 36% 40%

7.9 17% 36%

2.4 83% 40%

2.4 107% 149%

44,207 114% 79%

101,331 82% 78%

128,609 82% 68%

4.9 61% 68%

61.7 38% 23%

94.6 1% 1%

5.4 -14% -5%

46.1 4% 1%

53.9 -4% -1%

135.4 5% -2%

69.0 14% -3%

5.8 0% -2%

2.8. ESTONIA

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General context: expenditure, fiscal

sustainability and demographic trends

Estonia, the most northerly of the Baltic states, is a member of the European Union since 2004, has a GDP of around EUR19 bn., or 17.8 thousand PPS per capita, below the EU average of 27.9 thousand PPS per capita. Population was estimated in 2013 at almost 1.3 million inhabitants.

During the coming decennia the population will steadily decrease, from 1.3 million inhabitants in 2013 to 1.1 million inhabitants in 2060. Thus, Estonia is facing a considerable decrease of its population by 17%, while the EU average population is estimated to increase by 3%.

Health status

Life expectancy at birth for both men and women

is respectively 72.8 years and 81.7 years and is below the EU average (77.8 and 83.3 years respectively). Similarly, the healthy life years at birth for both sexes are 57.1 years (women) and 53.9 years (men) and substantially lower than the EU-average (61.5 and 61.4 respectively). The percentage of the Estonian population having a long-standing illness or health problem is considerably higher than in the Union (44% in Estonia versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities has been decreasing from 2004 to 2010, but has increased since 2011 and is again above the EU-average (9.3% against 8.7% in 2013).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.11 million residents living with strong limitations due to health problems in 2013, an increase of 26% is envisaged until 2060 to 0.14 million. That is a less

steep increase than in the EU as a whole (40%).

Also as a share of the population, the dependents

are becoming a bigger group, from 8.6% to 13%,

an increase of 52% (EU: 36%).

Expenditure projections and fiscal

sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

AWG reference scenario, public long-term

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 0.6 pps

of GDP by 2060. (365) The "AWG risk scenario",

which in comparison to the "AWG reference

scenario" captures the impact of additional cost

drivers to demography and health status, i.e. the

possible effect of a cost and coverage convergence,

projects an increase in spending of 3.1 pps of GDP

by 2060. Overall, projected long-term care

expenditure increase is expected to add to budgetary pressure. However, no sustainability risks appear over the long run due to contained projected ageing costs and a close to neutral initial budgetary position. (366)

System Characteristics (367)

The long-term care system in Estonia consists of nursing care and welfare.

LTC services can be split into community care services (where the recipient is supported while continuing to live in her/his own home) and institutional services (care is provided in a welfare institution). Local governments determine the basket of home services and the relevant conditions and procedures to obtain them.

Municipalities also provide adequate housing for those who cannot afford it. Where necessary they also provide social housing or assist persons who need assistance with self-contained living, by adapting the dwelling or helping them find more suitable housing.

Fostering is also provided, care in a suitable family

that the recipient is not a member of. This service

is provided mainly for children and needs to be

(365) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(366) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf

(367) This section draws on OECD (2011b) and ASISP (2014).

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based on a written agreement between the

caregiver (host family) and the local municipality.

Institutional **care** is provided in welfare institutions

that provide the recipients who stay there with

appropriate **care** according to their level of

dependency and **age**. Services are provided

according to principles and in the same manner as

they would be provided to recipients living at

home.

To support informal care, a carer's allowance is

paid by local governments to guardians or

caregivers of disabled persons aged 18 years or

above.

Public spending on LTC reached 0.2% of GDP in

2012 in Estonia, below the average EU level of 1%

of GDP. 42.9% of the benefits were in-kind, while

57.1% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal

in-kind LTC services or cash-benefits for LTC.

This share is lower in Estonia with 44%. Overall,

5.8% of the population (aged 15+) receive formal

LTC in-kind and/or cash benefits (EU: 4.2%). On

the one hand, high coverage rates couple with low

overall expenditure may imply a lack of focus in

the provision of long-term care services, possibly

calling for increased prioritisation. On the other

hand low shares of coverage may indicate a

situation of under-provision of LTC services.

The expenditure for institutional (in-kind) services

makes up 91% of public in-kind expenditure (EU:

61%), 9% being spent for LTC services provided

at home (EU: 39%). Thus, relative to other

Member States Estonia might have some potential

to focus more on home care, which may be costefficient.

As institutional care is relatively costly,

Member States with shares well above the EU

levels may benefit from efficiency gains by

shifting some coverage (and thus expenditure)

from institutional to other types of care.

Types of care

As explained in the previous section, long-term

care is provided either at home or in institutional

settings. The development of home nursing care

(including home nurses and home nursing

services) is still at an early stage and faces a large

financing gap.

Care homes are not part of the health care system,

and therefore do not in principle provide medical

care to long-term care recipients. The latter

therefore are visited by family doctors, and/or use

private nursing companies.

In accordance with Tervishoiuteenuste

korraldamise seadus (Act of Organization of Health Services), nursing services include nursing healthcare services and are provided in homebased, day care and institutional settings. For more demanding cases of nursing care for the elderly, optional geriatric assessment has been available in Estonia since 2004.

The long-term care budget for the first half of 2013 was 23% higher year-on-year, a three times higher increase than for healthcare as a whole. The main drivers for this budget increase were increased investments into infrastructure supported by EU structural funds. Simultaneously, the number of long-term care cases financed by EHIF, has increased by 12% year-on-year. The availability of long-term care has significantly increased – the number of day care nursing home visits and the number of persons serviced increased by 8% and 11% respectively.

Eligibility criteria

Need for care is assessed by a local social worker,

who will take into account the dependency needs and preferences of the potential recipient and their family. The need for nursing care is assessed by a doctor (whether a general practitioner or a medical specialist). The involvement of doctors is related only to the assessment of eligibility and not to the provision of long-term care itself.

An interdisciplinary assessment team performs the assessment of the recipient's level of dependency and, based on this, sets up a personalised nursing care plan. This team includes a physician specialised in geriatrics (geriatrician or an internist trained in geriatrics) as well as a nurse, a social worker and other relevant specialists.

Co-payments, out of the pocket expenses and private insurance

LTC services are financed by the municipalities, the budget of which mainly consists of a proportion of income taxes distributed to them by

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central government. Community care services do not usually require co-payment by the individual or his or her family. In institutional care homes, however, cost-sharing can amount up to 65% of the cost of provision (in general terms between EUR 400 and EUR 500), which is equivalent to 85% of the average pension. The government is however obliged as part of social assistance to cover the full cost for recipients and their families when they are unable to pay.

Geriatric assessment and nursing care are generally covered for by the Estonian Health Insurance Fund (EHIF), which suggests a diverse funding scheme that goes beyond what is strictly healthcare.

Limited local government and EHIF budgets lead to significant financial constraints for the service.

Similarly, many welfare institutions and LTC are faced with a shortage of bed capacity and staff.

Although formally part of the healthcare sector rather than the long-term care sector, for nursing

care a co-payment of 15% (some EUR 6 per day)

for inpatient long-term care was introduced from 1

January 2010 onwards. The aim was, in part, to restrict the use of hospital resources to those in need of medical treatment. This rate is however a ceiling, and many hospitals ask for lower copayments, as the bed-day reimbursement from EHIF appears to be sufficient to cover more than 85% of the cost of provision.

Formal/informal caregiving

Informal care plays an important role in Estonia and this is recognised in legal terms. As explained above, local governments also provide a carer's allowance. The impact of the allowance in helping to reimburse care and alleviating the care burden of family members and allowing them to maintain their attachment to the labour market.

eHealth

The combination of long-term care and ICT has not been a major priority. There have been some pilot projects in the field of homecare but these are still at an early stage. Pilot projects currently are mostly concerned with either social care (Virtu) or

secondary/tertiary care (DREAMING and Eliko).

Prevention and rehabilitation

policies/measures

Neither prevention nor rehabilitation measures are

defined as (part of) LTC in Estonia; i.e. prevention

and rehabilitation are part of health care.

Recently legislated and/or planned policy

reforms

In the recent past, there have been no significant

legislative reforms in the field of long-term care.

However, there have been some policy changes in

this area. For instance, a 15% co-insurance rate

was introduced in 2010 for inpatient nursing care.

The aim of the plan was to involve patients in the

financing of the LTC system. However, the plan

met with resistance and was not implemented until

tough austerity measures were adopted as a

response to the financial crisis. As a consequence,

EHIF expenditure budgeted for inpatient nursing

care in 2011 fell by 4% lower expenditure in the

planned EHIF budget for inpatient nursing care in

2011. However, the number of patients was 1%

greater than planned. Additionally, EU structural funds aiming to strengthen infrastructure have been granted to LTC hospitals. Interdisciplinary working groups are developing strategies for better integration of health care and social care (including LTC). Successful implementation will require consensus between the HC and LTC systems, as well as a supportive legislative framework.

Challenges

Estonia has taken significant steps to ensure the fiscal sustainability of LTC expenditure and increasing its availability. The main challenges of the system appear to be:

- Improving the governance framework: To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services. To strategically integrate medical and social services via such a legal

framework. To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the Long-term care systems

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formal provision of LTC services and its financing; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; To deal with cost-shifting incentives across health and care.

- Improving financing arrangements: To face the increased LTC costs in the future. To explore the potential of private LTC insurance

as a supplementary financing tool. To

determine the extent of user cost-sharing on

LTC benefits.

- Providing adequate levels of care to those in

need of care: To adapt and improve LTC

coverage schemes,

- by setting a need-level triggering entitlement to

coverage;

- the breadth of coverage, that is, by setting the

extent of user cost-sharing on LTC benefits;

- and the depth of coverage, that is, by setting the

types of services included into the coverage.

To provide targeted benefits to those with

highest LTC needs. To reduce the risk of

impoverishment of recipients and informal

carers.

- Encouraging home care: To develop

alternatives to institutional care by e.g.

- developing new legislative frameworks

encouraging home care and regulation

controlling admissions to institutional care or

– the establishment of additional payments, cash

benefits or financial incentives to encourage

home care;

– monitoring and evaluating alternative services,

including incentives for use of alternative

settings.

- Encouraging independent living: To provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care. To increase the retention of

successfully recruited LTC workers, by

improving the pay and working conditions of

the LTC workforce, training opportunities,

more responsibilities on-the-job, feedback

support and supervision.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To steer LTC

users towards appropriate settings.

- Improving value for money: To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services. To

invest in ICT as an important source of

information, care management and

coordination.

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- Prevention: To promote healthy ageing and preventing physical and mental deterioration of

people with chronic care. To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

Long-term care systems

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Table 2.8.1: Statistical Annex – Estonia

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 9 10 11 14 16 17 14 15 17 18 19 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 16.5 17.4 18.4 19.1 19.4 17.9 15.4 16.1 17.1 18.1 17.8 26.8 27.6 28.0 28.1 27.9

Population, in millions 1.4 1.4 1.4 1.4 1.3 1.3 1.3 1.3 1.3 1.3 1.3 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.1 0.1 0.1 0.1 0.2 0.2 0.2 0.2 0.2 0.2 : 1.0 1.0 1.0 1.0 :

Per capita PPS 7.1 13.6 18.3 22.9 29.8 33.7 34.6 34.2 34.8 37.0 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 0.3 0.4 0.4 0.5 0.5 0.5 0.5 0.5 0.5 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 77.2 78.0 78.2 78.6 78.9 79.5 80.3 80.8 81.3 81.5 81.7 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 66.4 66.7 67.6 67.6 67.5 68.9 70.0 70.9 71.4 71.4 72.8 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : 53.8 52.4 53.9 54.9 57.5 59.2 58.2 57.9 57.2 57.1 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : 50.0 48.3 49.6 49.8 53.1 55.0 54.2 54.3 53.1 53.9 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 41.3 38.5 38.6 40.2 38.1 40.1 42.6 44.7 43.7 44.4 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 13.1 13.0 9.5 9.3 9.9 7.7 7.9 8.6 9.8 9.3 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 4 5 6 8 8 8 15 3,433 3,771 3,851 3,931 4,183

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care at home, in thousands : : : : 6 8 10 12 12 12 6 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 0.7 1.0 1.2 1.5 1.5 1.5 1.6 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : : : : : : : : :

Number of formal carers, in thousands : : : : : 21 18 16 15 : : : : : :

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Table 2.8.2: Statistical Annex - continued – Estonia

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)"

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 1.3 1.2 1.2 1.1 1.1

Dependency

Number of dependents in millions 0.12 0.13 0.14 0.14 0.14

Share of dependents, in % 9.5 10.7 11.9 12.4 13.0

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.7 0.8 1.0 1.1 1.2

AWG risk scenario 0.8 1.1 1.7 2.5 3.7

Coverage

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care in an institution 18,222 20,473 24,479 27,144 28,951

Number of people receiving care at home 7,493 8,555 9,599 10,767 11,169

Number of people receiving cash benefits 16,735 18,364 19,891 22,033 22,816

% of pop. receiving formal LTC in-kind and/or cash benefits 3.3 3.9 4.7 5.3 5.8

% of dependents receiving formal LTC in-kind and/or cash benefits 34.9 36.9 39.2 42.7 44.4

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 38.8 39.2 41.4 42.0 42.9

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 61.2 60.8 58.6 58.0 57.1

Public spending on institutional care (% of tot. publ. spending LTC) 90.4 90.3 90.8 90.7 91.0

Public spending on home care (% of tot. publ. spending LTC in-kind) 9.6 9.7 9.2 9.3 9.0

Unit costs of institutional care per recipient, as % of GDP per capita 17.0 17.1 17.2 17.8 18.0

Unit costs of home care per recipient, as % of GDP per capita 4.4 4.4 4.4 4.6 4.6

Unit costs of cash benefits per recipient, as % of GDP per capita 32.3 32.8 33.0 33.4 33.5

2013

MS Change

2013-2060

EU Change 2013-2060

1.3 -17% 3%

0.11 26% 40%

8.6 52% 36%

0.6 116% 40%

0.6 559% 149%

15,088 92% 79%

6,272 78% 78%

14,819 54% 68%

2.7 110% 68%

32.0 38% 23%

39.2 9% 1%

60.8 -6% -5%

90.1 1% 1%

9.9 -9% -1%

17.5 3% -2%

4.6 0% -3%

30.6 9% -2%

2.9. FINLAND

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General context of long-term care system:

expenditure, fiscal sustainability and

demographic trends

Finland, member of the European Union since

1995, has a population of around 5.4 million

inhabitants, which is roughly 1% of the EU

population in 2013. (368) It is expected to reach 6.2

million in 2060, a demographic expansion of 15%.

With a GDP of around EUR 203 billion, or 27,900

PPS per capita it roughly coincides with the EU

average GDP per capita for the most recent year of

2013.

Health status

Life expectancy at birth for both men and women

was, in 2013, respectively 78.0 years and 84.1

years and is slightly above to the EU average (77.8

and 83.3 years respectively). However, the healthy

life years at birth for both sexes are 56.2 years

(women) and 57.3 years (men) are below the EU average

(62.1 and 61.5 respectively), as measured

in 2012. At the same time, the percentage of the

Finnish population having a long-standing illness

or health problem is far higher than in the Union as

a whole (47.5% and 32.5% respectively in 2013).

The percentage of the population indicating a selfperceived

severe limitation in its daily activities

has decreased since 2004, and was lower than the

EU-average when it was last recorded in 2012

(7.1% against 8.6%).

Dependency trends

In terms of dependency, the number of patients

depending on others to perform daily activities is projected to grow from 0.43 in 2013 to 0.62 million in 2060, marking a 44% increase above the EU average of 40% for these years. The proportion of the dependents as a group in the whole population is also foreseen to increase from 7.9% to 9.9% in 2060, a change of 25% below than the EU average of 36%.

Expenditure projections and fiscal sustainability

Long-term public spending on LTC is expected to rise over the course of the next 50 years. (369) The (368) This is according to EUROPOP2013 Eurostat data.

(369) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

AWG reference scenario displays an 86% rise in expenditure from 2.4 in 2013 to 4.6 in 2060, with the EU averaging a 40% rise for those years.

However the AWG risk scenario reveals a comparably flatter increase for Finland as the corresponding growth rate is below the EU average this time (136% vs. 149%). Expenditure is still expected to grow in this scenario from 2.4 in

2013 to 5.8 in 2060.

High risks appear in the medium term from a debt

sustainability analysis perspective due to the

relatively high stock of debt at the end of

projections (2026), and the sensitivity to possible

shocks to nominal growth, interest rates and the

government primary balance. Jointly simulated

shocks to growth, interest rates and the primary

balance point to an 80% probability of a debt ratio

in 2020 greater than in 2015. Finland faces

medium sustainability risks over the long run.

These are primarily related to the unfavourable

initial budgetary position compounded by the

projected impact of age-related public spending

(notably healthcare and long-term care). (370)

System Characteristics (371)

Public spending on LTC reached 2.3% of GDP in

2012 in Finland, above the EU average of 1.0% of

GDP.

In Finland, 100% of dependents are receiving

formal in-kind LTC services or cash benefits for

LTC, far above the EU average of 53%. Overall,

9.5% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services (including sheltered housing with 24-hour assistance) makes up 34.3% of public LTC expenditure (EU: 61%), 65.7% being spent for LTC services provided at home (EU: 39%).

(370) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf

(371) This section draws on OECD (2011b) and ASISP (2014).

Long-term care systems

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LTC policy is implemented both at local and national level. The main responsibility for the

provision of LTC to elderly and disabled people, including rehabilitation, lies with the municipal authorities, their social welfare, health care service and service organisations. In contrast, at national level, the legislative framework contains the general conditions for the provision of services.

The 303 municipalities have the responsibility to provide health and LTC services for residents. They may exercise this power on their own or in cooperation with other municipalities. As well as directly providing services, municipalities can also commission them from private or public service providers, or provide LTC recipients with service vouchers that can be used to directly purchase services from private providers.

Long-term care can be provided as home care, in the recipients' own homes or in sheltered housing units, as well as, as institutional care in residential institutions for and in the inpatient wards of health centres or hospitals.

Administrative organisation

Residence is the basis for entitlement to LTC

services in Finland. Services and income security

are provided as part of health and social care. It is

the responsibility of municipalities to arrange the

delivery of these services to recipients. An

individual needs assessment is performed by the

municipality to decide whether to grant services.

As explained above, municipalities may provide

the services directly or alternatively purchase them

from other municipalities or private service

providers.

Since 2011, recipients of LTC that have received

care for more than a year have been granted the

right to change the municipality that provides them

LTC. The original municipality has to pay for the

services arranged in the new municipality.

The municipality grants services on the basis of an

individual assessment of needs. The needs must be

assessed in a flexible manner, using reliable

evaluation methods, and in cooperation with

various actors. Based on the identified needs, a

service plan is drawn up together with the person

and, if necessary, a family member or a friend.

After that, an administrative decision is made by a public servant concerning the services that the municipality is responsible for providing.

Types of care

Long-term care benefits are benefits in kind, except informal care support, which is a cash benefit. Benefits in kind include institutional care, home help, informal care support, day care, day and service centres, sheltered housing and family

care. The Social Security Institution (KELA)

provides the Care Allowance for Pensioners, a cash benefit that aims to support pension recipients with an illness or disability to continue living at home, as well as to help meet extra costs caused by illness or disability. The average allowance is around EUR 100 per month.

Home service and home nursing care support older people with their activities of daily living when they require help due to reduced functional capacity or illness. They are combined in many municipalities as home care and this is

supplemented by additional support services.

If the older person is not able to live in his/hers

own home or in sheltered accommodation

(sheltered accommodation, service homes), care

can be provided in an institutional care setting.

Institutional care can be provided both in

specialised nursing homes as well as in the

inpatient departments of health care centres (372).

LTC can only be provided in an institutional

setting if there is a medical justification or if there

are other reasons why safe care for the recipient

needs to be provided in an institution.

Informal care support is aimed at relatives with a

caring responsibility for LTC recipients. Decisions

on whether to grant informal care support are made

by local authorities.

Eligibility criteria

The sections above have shown that Finland offers

a very broad coverage to its citizens. For defining

eligibility criteria, the country does not seem to

have any means-tested criterion (for either in-kind

or cash benefit). In addition, users do have a

discretionary use of cash benefits.

(372) Usually reported as hospital beds in international statistics.

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The health care system covers all residents of the

country according to Section 19 of the Finnish

Constitution. There is no single long-term scheme.

Long-term care is provided through general social

welfare and health care legislation which is

supplemented by special legislation (for example

on services for older people and on services for

people with disabilities). Municipalities are

responsible for arranging social and health services

that their population requires and as stipulated by

legislation. Severely disabled persons have a

subjective right to certain services under the

Services and Assistance for the Disabled Act. .

As explained above, municipal authorities arrange

social services for older people on the basis of an

assessment of their individual needs by experts.

Citizens above 75 years of age and pensioners on

the highest rate of care allowance have the right to

have their needs assessed within a specified period

of time. The Social Welfare Act was amended in

2006 to include provisions on the municipalities'

responsibility and expected delays for the needs

assessment (in general within seven days or

immediately for urgent cases). Once the need has

been established, the municipal authorities in

collaboration with the recipient and, if necessary

their next of kin, draw up a personal care and

service plan that details the services and support

measures to be provided..

The Social Insurance Institution also grants care

allowances based on need to Pensioners. They are

granted to residents over the age of 16, and are in

receipt of early-retirement, old-age or disability

pension, as well as to those who receive accident

compensation allowance or special assistance for

immigrants. To qualify for the allowance, the

recipients' mobility and ability to perform daily activities independently must have been compromised (whether by illness or injury) for at least one year. This allowance is not subject to means-testing and it is payable at three different rates depending on the level of dependency, as well as costs. As of 2010, it can be paid as well to long-term institutional care recipients.

Recipients can also benefit from tax deductions for the purchase of home care. Conversion of homes to improve the ability of the recipient to perform daily tasks is also available from the public social welfare authorities in line with the Services and Assistance for the Disabled Act. Finally, repair of housing for the elderly and the disabled can also be supported due to social reasons by the housing authorities.

Co-payments, out of the pocket expenses and private insurance

Public LTC services are financed by municipal taxation as well as by central government subsidies and user fees (cost-sharing). While some services

are provided free of charge (some services for people with disabilities), other services have a flat fee (some home care services) or are means-tested and determined according to income and family composition (for example for institutional care, which tends to be the costliest). However, the current legislation also allows each municipality some degree of freedom to make their own choices in this field.

Role of the private sector

Private companies and non-profit organisations are important service providers in publicly funded LTC. With respect to housing services (service accommodation and institutional care), private organisations accounted for around 30 % of all clients in 2012, up from around 20 % in 2000.

Private organisations primarily focus on serviced accommodation with almost all institutional care provided by municipalities. Finally, the role of the private sector in home help services is relatively minor.

Most of the private sector LTC services are

commissioned by municipalities, i.e. selling of services to households directly plays a smaller role. The exception is home help services, although the purchase of these services by households is subsidised.

Formal/informal caregiving

Informal care support is targeted towards family members caring for a dependent relative (an aged spouse or parent, for example). Decisions on who receives informal care support are made by the municipalities.

Support for informal care includes caregiver's allowance, statutory leave for the caregiver (if the care is binding), necessary services to support the care-giver, and pension and accident insurance for

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the caregiver. The amount of the caregiver's allowance depends on the municipality, minimum EUR 384.67 (in 2016) per month. Support from

municipality requires an agreement between the informal caregiver and the municipality based on an individual service plan.

Prevention and rehabilitation policies and measures

Municipalities are in charge of health promotion and LTC prevention policies for the elderly. These include the provision of information on healthy lifestyles, the prevention of accidents and illness and early detection of reduced capacity to function(373). Many municipalities also provide a visiting service for elderly living at home, which includes a discussion on the challenges faced by the person and information on the public help available. Separately, each person over the age of 75 is entitled to a social-service needs assessment.

Rehabilitation of the elderly is carried out by the municipalities in co-operation with the Social Security Institution (Kela).

Recently legislated and/or planned policy reforms

There are efforts to decrease the role of

institutional care in LTC services. The aim is to decrease the share of over 75 year olds in institutional care from around 4 % currently to around 2–3 % by 2017. Simultaneously the share of elderly receiving home help services and family care is envisaged to increase. The Ministry of Social Affairs and Health has estimated that this would result in LTC costs around 300 mil. euros (14 % of current total LTC expenditure) lower than under the current care structure by 2017. However, the cost estimates are subject to considerable uncertainty and all the scenarios imply an increase in total expenditure from current levels.

The government is set to begin a comprehensive evaluation of the legislation of the social and healthcare fees during the spring of 2017.

(373) <http://www.thl.fi/fi/tutkimus-jaasiantuntijatyo/>

tyokalut/iakkaiden-neuvontapalvelut-jahyvinvointia-edistavat-kotikaynnit

Challenges

Finland has a comprehensive long-term care

system that, in the last few years has been successful in increasing the proportion of care that is administered at home rather than in more expensive institutional settings. However, the high level of expenditure, the lack of means-testing and the inequality in quality and access of services across municipal authorities mean there are still many challenges:

- Improving the governance framework: To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends)

carers, and policies on the formal provision of

LTC services and its financing; To use care

planning processes, based on individualised

need assessments, involving health and care

providers and linking need assessment to

resource allocation; To deal with cost-shifting

incentives across health and care.

- Improving financing arrangements: To

explore the potential of private LTC insurance

as a supplementary financing tool; To

determine the extent of user cost-sharing on

LTC benefits.

- Providing adequate levels of care to those in

need of care: To adapt and improve LTC

coverage schemes, setting the need-level

triggering entitlement to coverage; the breadth

of coverage, that is, setting the extent of user

cost-sharing on LTC benefits; and the depth of

coverage, that is, setting the types of services

included into the coverage; To provide targeted

benefits to those with highest LTC needs.

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

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as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; To create better rules, improving

(and securing) safe care pathways and

information delivered to chronically-ill people

or circulated through the system; To steer LTC

users towards appropriate settings.

- Changing payment incentives for providers:

To adapt provider payments for LTC away

from the basis of salary; To consider fee-for-service

to pay LTC workers in home-care

settings and capitation payments; To consider

a focused use of budgets negotiated ex-ante or

based on a pre-fixed share of high-need users.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

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Table 2.9.1: Statistical Annex – Finland

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

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GDP, in billion euro, current prices 152 158 164 173 187 194 181 187 197 200 203 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 27.0 28.9 29.3 30.4 32.1 31.7 28.3 29.2 29.6 29.0 27.9 26.8 27.6 28.0 28.1 27.9

Population, in millions 5.2 5.2 5.2 5.3 5.3 5.3 5.3 5.4 5.4 5.4 5.4 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 1.8 1.8 1.9 1.9 1.9 1.9 2.2 2.2 2.2 2.3 : 1.0 1.0 1.0 1.0 :

Per capita PPS 386.6 425.2 453.7 486.6 531.2 561.9 584.1 608.5 626.7 658.3 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 3.6 3.7 3.8 3.9 3.9 4.0 4.0 4.0 4.0 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 81.9 82.5 82.5 83.1 83.1 83.3 83.5 83.5 83.8 83.7 84.1 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 75.1 75.4 75.6 75.9 76.0 76.5 76.6 76.9 77.3 77.7 78.0 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 56.5 53.1 52.5 52.8 58.0 59.5 58.6 57.9 58.3 56.2 : : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 57.3 53.3 51.7 53.2 56.8 58.6 58.2 58.5 57.7 57.3 : : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 40.7 43.2 43.3 41.7 40.6 42.8 44.0 45.4 46.7 47.5 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 11.8 12.2 12.0 8.8 7.8 8.0 7.9 7.7 7.1 : : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 50 69 88 107 109 112 51 3,433 3,771 3,851 3,931 4,183

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Number of people receiving care at home, in thousands : : : : 56 60 63 67 68 70 159 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 2.0 2.4 2.8 3.2 3.3 3.4 3.9 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : : : : : : :

Number of formal carers, in thousands : : : : : : : : : :

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Table 2.9.2: Statistical Annex - continued – Finland

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 5.6 5.9 6.1 6.2 6.2

Dependency

Number of dependents in millions 0.47 0.53 0.58 0.60 0.62

Share of dependents, in % 8.4 9.1 9.6 9.7 9.9

Projected public expenditure on LTC as % of GDP

AWG reference scenario 2.8 3.6 4.3 4.4 4.6

AWG risk scenario 2.9 3.8 4.8 5.2 5.8

Coverage

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care in an institution 60,085 77,182 94,184 98,120 101,271

Number of people receiving care at home 181,974 227,561 269,600 278,412 284,619

Number of people receiving cash benefits 341,068 396,958 442,311 451,892 460,309

% of pop. receiving formal LTC in-kind and/or cash benefits 10.4 11.9 13.3 13.4 13.6

% of dependents receiving formal LTC in-kind and/or cash benefits 100.0 100.0 100.0 100.0 100.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 87.1 88.4 89.3 89.5 89.8

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 12.9 11.6 10.7 10.5 10.2

Public spending on institutional care (% of tot. publ. spending LTC) 34.0 33.6 33.6 33.6 33.6

Public spending on home care (% of tot. publ. spending LTC in-kind) 66.0 66.4 66.4 66.4 66.4

Unit costs of institutional care per recipient, as % of GDP per capita 79.0 80.7 82.6 83.5 85.0

Unit costs of home care per recipient, as % of GDP per capita 50.6 54.1 57.0 58.1 59.7

Unit costs of cash benefits per recipient, as % of GDP per capita 6.1 6.1 6.3 6.3 6.3

2013

MS Change

2013-2060

EU Change 2013-2060

5.4 15% 3%

0.43 44% 40%

7.9 25% 36%

2.4 86% 40%

2.4 136% 149%

51,255 98% 79%

158,919 79% 78%

308,046 49% 68%

9.5 42% 68%

100.0 : 23%

85.9 4% 1%

14.1 -27% -5%

34.3 -2% 1%

65.7 1% -1%

76.5 11% -2%

47.3 26% -3%

6.1 4% -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

France, has a population of almost 65.6 million

inhabitants, which is expected to grow by 15% up

to 75.7 million by 2060, above the EU overall

growth of 3%. With a GDP of more than EUR

2,117 bn in 2013, or 28,100 PPS per capita, it is

above the EU average GDP per capita of EUR

27,900 PPS.

Health status

Life expectancy at birth for both women and men

was, in 2013, respectively 85.6 years and 79 years

and is above the EU average (77.8 and 83.3 years

respectively). In 2013, the healthy life years at

birth for both sexes were 63 years (women) and

64.4 years (men) significantly above the EU averages

(61.4 and 61.5 respectively). At the same

time, the percentage of the French population

having a long-standing illness or health problem is

higher than in the Union as a whole (36.2% versus

32.5% in 2013). The percentage of the population

indicating a self-perceived severe limitation in its

daily activities was in 2013 9%, slightly above the

EU-average (8.7%).

Dependency trends

The share of dependents is set to increase in this

period, from 8.9% in 2013 to 11.4% of the total

population in 2060, an increase of 28%. This is

lower than the EU-average increase of 36%. From

5.8 million residents living with strong limitations

due to health problems in 2010, an increase of 48%

is envisaged until 2060 to 8.6 million. That is a

much steeper increase than in the EU as a whole

(40%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

"AWG reference scenario", public long-term

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 0.8 pps

of GDP by 2060. (374) The "AWG risk scenario",

which in comparison to the "AWG reference

scenario" captures the impact of additional cost

drivers to demography and health status, i.e. the

possible effect of a cost and coverage convergence,

projects an increase in spending of 1.1 pps of GDP

by 2060. Overall, projected long-term care

expenditure increase is expected to add to

budgetary pressure.

Overall, for France no significant short-term risks of fiscal stress appear at the horizon, although some variables point to possible short-term challenges.

Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the still high stock of debt at the end of projections (2026) and the high sensitivity to possible macro-fiscal shocks.

No significant sustainability risks appear over the long run, under the no-fiscal policy change baseline scenario, notably thanks to pension reforms implemented in the past. (375)

System Characteristics (376)

France is a unitary state subdivided in administrative areas (departments). Public provision of long-term care is organised as a twopronged system. On the one hand, the public health insurance scheme – providing universal population coverage – covers the cost of health care provided in institutions to the recipients of care (including

the dependent elderly or disabled patients). It also

funds LTC units in hospitals, as well as nursing

care provided directly in the patient's home. These

health care costs are paid for by the health

insurance scheme and patients do not need to pay

for these services themselves.

On the other hand, there are two schemes, that are

mainly financed by local authorities and that

provide social benefits to the dependents (whether

elderly or disabled) in order to help them meet part

of the cost of care not covered by health insurance,

(374) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(375) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(376) This section draws on OECD (2011b) and ASISP (2014).

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whether that care is provided in an institutional or

domiciliary setting: the "Prestation de

compensation du handicap" (PCH - Disability

compensation benefit) and the " L'Allocation

personnalisée d'autonomie " (APA - Personalised

Autonomy Benefit), briefly described below.

Public spending on LTC reached 1.3% of GDP in

2012 in France, above the EU average of 1% of

GDP. 90.3% of public LTC expenditure was spent

on in-kind benefits (EU: 80%), while 9.7% were

provided via cash-benefits (EU: 20%).

In France, 40.7% of dependents are receiving

formal in-kind LTC services or cash-benefits for

LTC, below the EU average of 53%. Overall, 3.6%

of the population (aged 15+) receive formal LTC

in-kind and/or cash benefits (EU: 4.2%). On the

one hand, low shares of coverage may indicate a

situation of under-provision of LTC services. On

the other hand, higher coverage rates may imply an

increased fiscal pressure on government budgets,

possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services

makes up 68.6% of public in-kind expenditure

(EU: 61%), 31.4% being spent for LTC services

provided at home (EU: 39%). Thus, relative to

other Member States France has a focus on

institutional care, which may be inefficient, as

institutional care is relatively costly with respect to

other types of care.

Administrative organisation

As explained above, the public provision of longterm

care relies on a two-pronged system. The cost

of health care is financed by the public health

insurance scheme, while social benefits provided

by two schemes (PCH and APA) are essentially

financed by the State and by local authorities. The

PCH and the APA are provided by departments

(local authorities).

Types of care

The range of types of care available is very large.

It comprises help with daily activities (cooking,

cleaning and laundry, etc.), help with personal

activities (bathing, getting dressed, etc.).

A dependant or disabled person can also receive a

benefit specifically aimed to adapt their home to their level of need (stair lift, walk-in bathtub, etc.) and any charge due to their situation in relation to four activities: mobility, personal care, communication and capacity to protect themselves and to control their environment.

All of these can be provided either at home or in institution.

Eligibility criteria

In general, in the basic health care insurance system cost-sharing applies to most goods and services, especially primary care and specialist consultations. Some specific categories are exempted from cost-sharing. The private voluntary complementary health insurance increases the rate of reimbursement, reducing the discrepancy between the actual amount paid by patients and the amount they are reimbursed by their social health insurance fund. In doing so, complementary health insurance reduces the ability of cost-sharing to control overconsumption, as it renders users less cost-aware. As a result, the authorities

implemented a ticket, and a “deductible” that are not covered by complementary health insurance.

According to the ticket system implemented in 2005 the patient has to pay EUR 1 for each physician visit and each biomedical analysis. The so-called medical deductible has been implemented since 2008. The patient has to pay EUR 0.50 per drug box, EUR 0.50 on each paramedical procedure and EUR 2 for each medical transport.

As most EU countries, France does allow for users to have a discretionary use of cash benefits.

Discretionary use may not necessarily lead to the most cost-effective use of cash resources, especially if the use of cash benefits is not monitored.

The PCH is available for the disabled under 60.

The dependent above 60 receive the APA, which is based on an assessment of a person's needs.

As mentioned above, the APA benefit amount varies both according to the person's level of dependency (established by a socio-medical team,

using a nation-wide unified grid – the AGGIR grid

– which identifies 6 levels of dependency, with

only the first 4 levels being taken into account for

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the granting of the APA benefit) and according to

the elderly's financial resources.

Co-payments, out of the pocket expenses and

private insurance

For the disabled under 60, a new benefit is in place

from January 2006, the PCH. It is intended to help

cover the needs of the disabled person regardless

of whether those needs have to do with labour

market attachment, home adaptation, human and

technical aids, etc. Average monthly spending per

recipient is EUR 800.

From age 60 onwards, the dependent elderly – at

home or in an institution – can receive the APA, a

universal benefit for people over 60 that was

established in 2002. This benefit is calculated on

the basis of a "help plan" designed for each

individual according to an assessment of their needs. The APA benefit is intended to cover part of the cost of the "help plan", with the rest (on average about one quarter of the total amount) being paid by the beneficiary through user fees which increase in proportion to their income.

Recipients with an income below EUR 800.53 per month do not pay these fees. The benefit amount thus depends on both the person's level of dependency as well as on the recipient's financial resources. The level of dependency is established by a socio-medical team, using the unified AGGIR grid.

The APA is administered by the relevant local departments, which cover around two third of its cost, with the rest being financed by the National Solidarity Fund for Autonomy (CNSA). The average amount of the "Help plan" granted to home care recipients care is around EUR 482 per month, of which about a fifth (EUR 94 on average) is covered by cost-sharing. The amount provided through the "Help plan" varies depending on the level of dependency from EUR 342 to EUR 991

per month.

France is one of the leading markets in terms of the proportion of its population that is covered by private LTC insurance. In 2012, 18% of the population aged over 40 years had private LTC coverage. Indemnity policies are the most frequent type of private coverage arrangement. Under this model the insured typically pay annual fees in exchange for a determined future stream of income in case they become dependent.

Role of the private sector

Care for disabled people is provided almost exclusively by the public sector, although the private sector plays an increasing role in old-age LTC: a third of health expenditure for older people (including, home care and hospitals) is for care provided in a private institution (profit making: 14% of the total; non-profit making: 19% of the total). Among all institution for older people, A quarter of all institutions providing care for older people are private profit-making institutions.

Formal/informal caregiving

In 2003, about 75% of APA recipients received

care from a family member. The majority of

informal carers were women (62%, average age of

58 years old). Only about 10% of informal

(family) carers are paid through APA.

In terms of the balance of care and work activities,

informal carers who are in employment have the

right to take 3 months of unpaid leave (up to 1 year

over their career) to care for a dependent. There

are also specific tax reductions available for carers.

Prevention and rehabilitation

policies/measures

Prevention and rehabilitation are managed by the

public health system.

Recently legislated and/or planned policy

reforms

A reform for “the adaptation of society to ageing”

was adopted by the Parliament by the end of 2015

and came into force in 2016.

This reform (645 million euros) was financed by

the Additional Solidarity Contribution for

Autonomy (CASA) introduced in 2013.

375 million euros were spent on the APA benefit in order to help the elderly remain longer in their own homes. The amount of the APA benefit was thus raised by 400 euros for the most dependent patients, and by 150 euros for the least dependent patients. Furthermore, the amount of co-payment

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(ticket modérateur) was reduced by up to 80% in some cases.

25 million euros were also be devoted to improving the wages of the low-waged domiciliary care providers.

Information is encouraged by the 2015 bill, thanks to new financing and the creation of a “trustful person” accompanying the dependent person.

Finally, the bill also supports carers:

- It creates a new status and training for people helping a dependent relative;
- It gives them a “respite assistance”, i.e. a

replacement while they take a “break” or in the case of an hospitalisation.

To promote data sharing amongst public administrations, the “loi de modernisation de notre système de santé”, promulgated in January 2016, creates a new database called « système national des données de santé » (article 193). It will contain data on the disabled and the elderly.

140 million euros were spent on subsidising technical aids to help the elderly, and especially those with most modest incomes, to remain longer at home.

80 million euros were devoted to adapt private housing to the needs of dependent people and to renovate intermediary forms of homes – named “autonomy residences” - for the elderly, who need help but not to the extent that they need to be in a nursing home.

Regulations on private dependency insurances were also introduced, as well as special help for informal carers (up to 500 euros per year in order to cover the cost of some time off).

Challenges

The main challenges of the system appear to be:

- Improving the governance framework: To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. to the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To deal with cost-shifting incentives across health and care.
- Improving financing arrangements: To face increased LTC costs, choices will be made to define the balance between public and private financing and between generations”.

- Providing adequate levels of care to those in

need of care: To adapt and improve LTC

coverage schemes, setting the need-level

triggering entitlement to coverage; the breadth

of coverage, that is, setting the extent of user

cost-sharing on LTC benefits; and the depth of

coverage, that is, setting the types of services

included into the coverage; To provide targeted

benefits to those with highest LTC needs; To

reduce the risk of impoverishment of recipients

and informal carers.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care.

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To steer LTC

users towards appropriate settings.

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- Changing payment incentives for providers:

To consider a focused use of budgets

negotiated ex-ante or based on a pre-fixed

share of high-need users.

- Improving value for money: To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; To

invest in ICT as an important source of care

management and coordination.

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Long-term care systems

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Table 2.10.1: Statistical Annex – France

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 1,637 1,711 1,772 1,853 1,946 1,996 1,939 1,998 2,059 2,087 2,117 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 26.7 27.1 27.6 27.9 28.6 27.8 26.5 27.4 27.9 27.8 28.1 26.8 27.6 28.0 28.1 27.9

Population, in millions 61.9 62.3 62.8 63.2 63.6 64.0 64.4 64.7 65.0 65.3 65.6 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 1.3 1.4 1.4 1.5 1.5 1.6 1.7 1.7 1.8 1.3 : 1.0 1.0 1.0 1.0 :

Per capita PPS 313.5 332.9 353.5 378.8 404.7 418.7 441.8 464.8 485.6 355.8 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 2.6 2.6 2.8 2.8 2.9 3.0 3.1 3.1 2.2 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 82.7 83.8 83.8 84.5 84.8 84.8 85.0 85.3 85.7 85.4 85.6 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 75.7 76.7 76.7 77.3 77.6 77.8 78.0 78.2 78.7 78.7 79.0 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 63.9 64.3 64.6 64.4 64.4 64.5 63.5 63.4 63.6 63.8 64.4 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 60.6 61.5 62.3 62.8 62.8 62.8 62.8 61.8 62.7 62.6 63.0 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 36.1 34.6 34.4 33.7 36.7 37.0 36.9 36.5 36.6 36.2 : 31.4 31.8 31.5 32.5

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People having self-perceived severe limitations in daily activities (% of pop.) : 7.3 6.6 6.3 6.1 8.6 9.0 9.6 9.3 8.8 9.0
: 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 552 532 511 491 507 523 854 3,433 3,771
3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : 521 657 792 928 947 966 1,089 6,442 7,296 7,444
7,569 6,700

% of pop. receiving formal LTC in-kind : : : 1.7 1.9 2.0 2.2 2.2 2.3 3.0 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : 1,837 : 2,102 : : : : : : : :

Number of formal carers, in thousands 160 : : : : : : : :

Long-term care systems

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Table 2.10.2: Statistical Annex - continued – France

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 67.8 70.5 72.9 74.4 75.7

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Dependency

Number of dependents in millions 6.39 7.14 7.96 8.39 8.61

Share of dependents, in % 9.4 10.1 10.9 11.3 11.4

Projected public expenditure on LTC as % of GDP

AWG reference scenario 2.1 2.2 2.6 2.7 2.8

AWG risk scenario 2.2 2.6 3.4 4.1 4.7

Coverage

Number of people receiving care in an institution 953,336 1,073,410 1,303,937 1,429,279 1,487,956

Number of people receiving care at home 1,203,116 1,345,218 1,599,657 1,731,392 1,793,138

Number of people receiving cash benefits 436,278 430,843 433,358 439,317 442,807

% of pop. receiving formal LTC in-kind and/or cash benefits 3.8 4.0 4.6 4.8 4.9

% of dependents receiving formal LTC in-kind and/or cash benefits 40.6 39.9 41.9 42.9 43.3

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 91.0 92.0 93.3 93.8 93.9

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 9.0 8.0 6.7 6.2 6.1

Public spending on institutional care (% of tot. publ. spending LTC) 68.4 67.9 66.4 65.8 65.6

Public spending on home care (% of tot. publ. spending LTC in-kind) 31.6 32.1 33.6 34.2 34.4

Unit costs of institutional care per recipient, as % of GDP per capita 93.2 91.3 89.2 88.0 87.1

Unit costs of home care per recipient, as % of GDP per capita 34.1 34.5 36.7 37.7 37.9

Unit costs of cash benefits per recipient, as % of GDP per capita 29.3 29.0 28.8 28.8 28.8

2013

MS Change

2013-2060

EU Change 2013-2060

65.6 15% 3%

5.83 48% 40%

8.9 28% 36%

2.0 41% 40%

2.0 139% 149%

854,410 74% 79%

1,088,588 65% 78%

427,786 4% 68%

3.6 36% 68%

40.7 6% 23%

90.3 4% 1%

9.7 -38% -5%

68.6 -4% 1%

31.4 10% -1%

93.9 -7% -2%

33.8 12% -3%

29.5 -2% -2%

2.11. GERMANY

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General context: Expenditure, fiscal

sustainability and demographic trends

GDP per capita in PPS is at EUR 31,700 and far above EU average of EUR 27,900 in 2013.

Germany has a population of 80.8 million inhabitants. (377) During the coming decennia the population will steadily decrease, from 80.8 million inhabitants in 2013 to 70.3 to 73.1 million inhabitants in 2060 depending on the migration rate. Thus, Germany is facing a considerable decrease of its population by 9.5 to 13%, while the EU average population is estimated to increase by 3%.

Health status

Life expectancy at birth for both women and men is respectively 83.2 years and 78.6 years in 2013 and is around the EU average for women and men (83.3 and 77.8 years respectively). Healthy life years at birth are with 57.0 years (women) and 57.8 years (men) below the EU-averages (61.5 and 61.4 respectively). The percentage of the German population having a long-standing illness or health problem is considerably higher than in the Union

(38% in Germany versus 33% in the EU). The percentage of the population indicating a selfperceived severe limitation in its daily activities stands at 10.4%, which is higher than the EUaverage (8.7%); these figures are subjective and differ between cultural backgrounds and countries (from 2.7 in Malta up to 11.3 in Slovenia). (378)

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 7.4 (379) million residents living with (self-assessed) strong (377) This is according to the German statistical office, see:

[https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/](https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Bevoelkerung/Bevoelkerung.html)

[t/Bevoelkerung/Bevoelkerung.html](https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Bevoelkerung/Bevoelkerung.html)

According to Eurostat, population stands at 80.8 million in 2014.

(378) This data (EU-SILC) is based on subjective assessment of

care needs. The comparability of cross-country data is more limited than would be the case for objective measures of **care** needs, which are however not available on a

comparable basis for all EU countries. The German

Ministry of Health perceives the numbers for Germany as a

significant overestimation of the number of dependent

people.

(379) The number of dependent population is estimated for those

insured under social health insurance only.

limitations due to health problems in 2013, an

increase of 11% is estimated until 2060 with nearly

8.2 million. (380) That is a less steep increase than

in the EU as a whole (40%). Also as a share of the

population, the dependents are becoming a bigger

group, from 10.6% to 14.1%, an increase of 33%

(EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing in most

scenarios. In the AWG reference scenario, public

long-term expenditure is driven by the

combination of changes in the population structure

and a moderately positive evolution of the health

(non-disability) status. The joint impact of those

factors is a projected increase in spending of about

1.5 pps of GDP by 2060. (381) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, which is strongly depending on subjective self-assessments, projects an increase in spending of 3.1 pps of GDP by 2060. Overall, projected long-term care expenditure increase for these two scenarios is expected to add to budgetary pressure. However, no sustainability risks appear over the long run as the favourable initial budgetary position would mitigate the projected increase in age-related expenditure. (382) In Germany, long-term care benefits are indexed to prices (whereas they are indexed to GDP per hours worked in the displayed scenarios), which is relevant for budgetary surveillance purposes. In Germany, long-term care benefits are indexed to prices (whereas they are indexed to GDP per hours worked in the AWG

reference scenario), which is relevant for

budgetary surveillance purposes. Assuming

constant unit costs in real terms, the long-term **care**

(380) According to the AWG report the robustness of

dependency rates calculated on the basis of the EU-SILC

survey has been improved, by using a 5 year average

(where available) of the dependency rates for each of the

age-gender groups.

(381) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(382) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

Long-term **care** systems

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public expenditure is projected to increase not by

more than 0.1 pps of GDP, with a spending level

of around 1.5% of GDP in 2060.

System Characteristics

Social long-term **care** insurance (LTC) insurance is

compulsory. All members of the social health insurance are covered by the public and members of the private health insurance (PHI) are covered by the private LTC insurance. Both parties are entitled to the same benefits, which is basically covering a portion of long-term nursing care costs.

If costs of care exceed benefits, the person in need of care has to bear the difference, also including support from their children or near relatives, or ultimately social assistance.

Premiums for social LTC insurance are calculated as a fixed proportion of the labour income (2.35% for insured with and 2.60% for insured without children in 2015). Employers bear one half of it and children and spouses with no substantial individual labour income are co-insured without extra costs. Private LTC insurance premiums are related to (income independent) premiums of PHI. Since 2012, employees with a family member in need of home care are entitled to reduce their weekly working time to 15 hours for up to two

years. Their employers can top up the reduced salary by half of the difference between old and new salary with an interest free credit from the Kreditanstalt für Wiederaufbau. Afterwards, the employee has to work full-time until the credit is paid back. The uptake of this policy was very low so far.

Since 2013, for informal carers getting sick or taking holidays, LTC insurance pays benefits for up to four weeks of respite care or short-term residential care, but not more than EUR 1,550 once a year. This is conditional on the informal carer having taken care of the recipient for at least six months prior to application. Also, benefits for people with dementia have been increased.

Benefits are given, even if eligibility is not established within the 3 levels of care (see below), and additional benefits within given levels of care are possible. Also, an additional optional private LTC insurance is now subsidised with a maximum of EUR 60 per year.

Public spending on LTC reached 1.4% of GDP in

2013 in Germany, below the average EU level of 1.6% of GDP. (383) 69% of the benefits were in-kind, while 31% were cash-benefits (EU: 80 vs 20%). Private co-financing of formal LTC services is important in Germany. According to OECD data 25% of LTC services are co-financed privately. In the EU, 53% of self-perceived dependents are receiving formal in-kind LTC services or cash benefits for LTC. This share is with 34% lower in Germany. Overall, 3.6% (including disabled persons) of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional services makes up 57% of public LTC expenditure (EU: 61%), 43% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States

Germany seems might have some potential to

focus more on home care, which may be costefficient.

As institutional care is relatively costly,

Member States with shares well above the EU

levels may benefit from efficiency gains by

shifting some coverage (and thus expenditure)

from institutional to other types of care.

Types of care

Recipients of LTC services can choose between

cash benefits, home care (in kind), and institutional

care. Cash benefits allow for informal care,

allowing the recipient to live at home and be taken

care of typically by his relatives. Home care (in

(383) This is according to the Ageing Report 2015. Due to

agreements taken with the Member States delegates in the

AWG-EPC, definition of LTC expenditure may deviate

from expenditure levels as reported in other publications.

Specifically, cash benefits include period economic

integration of handicapped from ESSPROS disability

function, and are projected with age specific probability.

Expenditure on this item amounts 0.4 to 0.54% of GDP for

Germany. The number of disabled persons in Germany is increasing and will continue for about the next ten years. In this projection the number of disabled persons is assumed to increase with the age specific LTC need probabilities, which is not relevant for this group, since (older) disabled persons are covered by the LTC system and not by the integration of handicapped anymore.

Long-term care systems

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kind) allows for a professional care, paid directly by the recipient to the provider. Institutional care refers to either short-term or long-term stay in a nursing home.

Eligibility criteria and user choices:

dependency, care needs, income

The LTC insurance has defined three levels of care

based on the severity of the health condition. Level

I provides for extensive care of at least 90 minutes

per day. This care duration is extended to at least 3

hours in level II (severe care) and at least 5 hours

in level III (most severe care). Even more severe

cases may receive additional care assistance.

Recipients in need of care should/must be insured

for at least six months prior to the application of

care allowance. Eligibility and the level of care are

assessed by an independent Medical Review Board

of the Statutory Health Insurance Funds (MDK)

for the social LTC insurance or an equivalent body

for the private LTC insurance.

Prevention and rehabilitation measures

Since 2016 social LTC insurance contributes to the

prevention efforts in institutions of the health

insurance with estimated 21 million Euro each

year; the amounts in the following years depend on

the reference figure and the number of recipients

of formal care in institutions. Rehabilitation

measures are not defined as (part of) LTC in

Germany; i.e. rehabilitation is part of health care.

Recently legislated and/or planned policy

reforms

The Ministry of Health has strengthened LTC with

two laws strengthening long-term care

'Pflegestärkungsgesetz' (PSG I and PSG II). PSG I

has significantly increased services for dependants

from January 2015 onwards and has increased the

number of caregivers in institutional care; besides

that a 'fund for demographic sustainable financing'

(Pflegevorsorgefonds) has been created.

PSG I and PSG II increase premiums in two steps

by 0.5% starting from 2015. Each year EUR 1.2

billion of these additional funds are invested in the

sustainable financing fund until 2034, the rest

(EUR 3.8 billion per year) in improved services for

dependents; this will increase services by 20%.

(384)

PSGII was introduced within this legislature period

(2013-2017). It redefines care levels and care

assessment methods based on individual care

demands; especially dementia is now part of the

assessment.

The German government plans to continue the

improvements for people in need of care further

with the PSG III law in 2017. PSG III strengthens

local support for people in care especially by

improving local coordination cooperation and

steering.

In order to make the job of formal carers more

attractive and to increase the quality of care, the

government plans to pass the carer education law

(Pflegeberufsgesetz). (385)

As described under section 2, new measures have

also been taken recently to strengthen prevention.

Challenges

Germany has taken significant steps to establish a

coherent financing mix, ensure the fiscal

sustainability of LTC expenditure and provide

adequate coverage to the population. The main

challenges of the system appear to be:

- Improving the governance framework: To

establish good information platforms for LTC

users and providers;

- Encouraging independent living: To provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care; To improve recruitment efforts,

including through the migration of LTC

(384)

<http://www.bmg.bund.de/pflege/pflegestaerkungsges>

etze/pflegestaerkungsgesetz-i.html

(385)

<http://www.bmg.bund.de/ministerium/meldungen/20>

16/160113-pflegeberufsgesetz.html

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workers and the extension of recruitment pools

of workers;

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To create better

rules, improving (and securing) safe care

pathways and information delivered to

chronically-ill people or circulated through the

system;

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

Long-term care systems

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Table 2.11.1: Statistical Annex – Germany:

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 2,220 2,271 2,301 2,393 2,513 2,562 2,460 2,580 2,703 2,755 2,821 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 26.9 27.8 28.8 30.1 31.3 31.3 28.6 30.8 32.1 32.1 31.7 26.8 27.6 28.0 28.1 27.9

Population, in millions 82.5 82.5 82.5 82.4 82.3 82.2 82.0 81.8 81.8 81.8 82.0 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.9 0.9 0.9 0.9 0.9 0.9 1.0 1.0 1.0 1.0 : 1.0 1.0 1.0 1.0 :

Per capita PPS 375.0 389.5 403.9 411.1 421.9 433.5 445.0 486.6 504.9 526.4 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 3.3 3.3 3.3 3.3 3.4 3.4 3.4 3.5 3.6 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 81.3 81.9 82.0 82.4 82.7 82.7 82.8 83.0 83.2 83.3 83.2 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 75.8 76.5 76.7 77.2 77.4 77.6 77.8 78.0 78.4 78.6 78.6 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : 54.8 58.3 58.6 57.7 58.1 58.7 58.7 57.9 57.0 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : 54.5 58.7 59.0 56.4 57.1 57.9 57.9 57.4 57.8 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 36.2 38.2 37.9 36.2 36.0 36.2 36.8 37.0 38.3 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 8.5 8.3 8.2 10.6 10.1 10.2 10.0 10.9 10.4 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 561 610 658 707 726 743 740 3,433 3,771
3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 1,028 1,188 1,349 1,509 1,537 1,565 348 6,442
7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 1.9 2.2 2.4 2.7 2.8 2.8 1.3 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : 3,163 : 3,256 : : : : : : : :

Number of formal carers, in thousands 511 : 556 : 595 : 642 : 683 : : : : :

Long-term care systems

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Table 2.11.2: Statistical Annex - continued – Germany

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions (Europop2013) 80.6 79.7 77.7 74.5 70.8

Dependency

Number of dependents in millions (2015 Ageing Report) 8.04 8.30 8.51 8.74 8.18

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Share of dependents (% , 2015 Ageing Report) 11.7 12.4 13.2 14.2 14.1

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.7 2.0 2.3 2.8 2.9

AWG risk scenario 1.8 2.3 3.0 3.9 4.5

Indexation of LTC spending to prices (unit costs constant in real terms) 1.4 1.4 1.5 1.5 1.5

Note: Based on projections from 2015 Ageing Report

Coverage

Number of people receiving care in an institution 835632 955660 1045394 1239627 1230541

Number of people receiving care at home 389446 423921 463042 511877 481553

Number of people receiving cash benefits 1557784 1695685 1852169 2047506 1926212

% of pop. receiving formal LTC in-kind and/or cash benefits 4.1 4.6 5.2 6.2 6.3

% of dependents receiving formal LTC in-kind and/or cash benefits 34.6 37.0 39.5 43.5 44.5

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 69.0 70.4 71.3 72.3 73.2

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 31.0 29.6 28.7 27.7 26.8

Public spending on institutional care (% of tot. publ. spending LTC) 56.9 57.9 57.6 58.6 59.9

Public spending on home care (% of tot. publ. spending LTC in-kind) 43.1 42.1 42.4 41.4 40.1

Unit costs of institutional care per recipient, as % of GDP per capita 54.7 56.6 58.5 58.2 59.4

Unit costs of home care per recipient, as % of GDP per capita 88.7 92.8 97.2 99.6 101.7

Unit costs of cash benefits per recipient, as % of GDP per capita 23.1 23.2 23.0 23.0 23.2

82.9 23% -3%

21.7 7% -2%

43.0 -7% -1%

51.8 15% -2%

31.0 -14% -5%

57.0 5% 1%

33.5 33% 23%

69.0 6% 1%

1391470 38% 68%

3.6 76% 68%

740253 66% 79%

347867 38% 78%

1.4 7% :

7.40 11% 40%

10.6 33% 36%

1.4

1.4 105% 40%

223% 149%

2013 MS Change 2013-

2060

EU Change 2013-2060

82.0 -14% 3%

2.12. GREECE

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General context: Expenditure, fiscal

sustainability and demographic trends

Greece, member of the European Union since

1981, has a population of around 11 million. With

a GDP of around EUR 180 bn or 20,173 PPS per

capita, it is below the EU average GDP per capita

of 27,881 PPS, and has contracted significantly in

the post-crisis years. Public expenditure on longterm

care is, with 0.04% of GDP (386), below the

EU average of 1.0% in 2012.

Health Status

Life expectancy at birth for men and women was,

in 2013, respectively 78.7 years and 84.0 years,

close to the EU average (77.8 and 83.3 years

respectively). In 2013, the healthy life years at

birth were 65.1 years (women) and 64.7 years

(men) well above the EU-average (61.5 and 61.4

respectively). The percentage of the Greek

population having a long-standing illness or health

problem was lower than in the Union as a whole

(23.9% and 32.5% respectively in 2013). However,

in the same year, the percentage of the population

indicating a self-perceived severe limitation in its daily activities was 10.8%, above the EU-average (8.7%).

Dependency Trends

The number of people depending on others to carry out activities of daily living is projected to rise over the next 50 years. The number of people living with strong limitations due to health problems in 2013 were 0.87 million and an increase of 24% is expected until 2060, bringing this number to slightly more than 1.07 million.

(387) The corresponding EU change for that period is 40%. Moreover, dependents are also projected to increase as a share of the population, from 7.8% to 12.5%, a rise of 60%, almost double the EU level over the same period (36%).

(386) Estimated for 2013.

(387) This figure is based on the Demographic Scenario, so the estimate is based on the effect of pure ageing.

Expenditure projections and fiscal sustainability

(388)

Based on the AWG reference scenario, the current

value of public expenditure on LTC as a percentage of GDP is projected to grow from 0.5 in 2013 to 0.9 in 2060, a difference of 88% which is more than double that of the EU for that period (40%). According to the AWG risk scenario, which also captures non-demographic cost drivers in expenditure, is foreseen to increase from 0.5 in 2013 to 1.3 in 2060. This corresponds to a bigger projected change of 166%, higher than the EU average of 149% over the same period (389).

System Characteristics

In Greece, there is no universal statutory scheme for long-term care and there is a mixed landscape of services provided by public entities private entities and families.

Traditionally, long-term care was provided by the family, and only when the family was not able to care for the dependent or to afford alternatives, the solution would be institutionalisation. In the 1980s the state began the process of recognition of the specificities of long-term care as a separate item from primary care or secondary care, with the aim

of allowing for the non –institutionalisation of the elderly who were in general good health but still required some sort of regular assistance or support.

This was implemented through KAPIs ('Open Protection Centres for the Elderly'). During the decade, local authorities worked towards the expansion of this network relying on public funding, reaching the current number of 1000 centres over the territory. However, coverage was not even and there was a substantial degree of inequality in access to services over the territory and lack of quality assessment based on the intended goals. In the 1990s, a project to deliver community and home care through the network of KAPIs was initiated under the programme Help at

(388) Greece is implementing the third adjustment programme monitored by the EU, the IMF and the ECB. The macroeconomic and budgetary prospects for Greece are assessed more frequently than for the other Member States.

The time horizon covered by the forecasts for Greece is also different than for the other Member States and assume full implementation of the adjustment programme.

Projections based on the fiscal sustainability indicators S1

and S2 are therefore not included here.

(389) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

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Home and was run by the local authorities across Greece. This programme, though very popular, never managed to achieve the necessary coverage due to funding issues.

The result is that of a currently highly fragmented system with uneven coverage across users and low coverage overall. Due to the great fragmentation of the system and limited coverage, a large share of service provision is left to informal **care**.

Administrative organisation

The state provides both direct and indirect support, the former through social services, the latter through social security funds and allowances or tax reductions. The delivery of community and home **care**, in the form of help with activities of daily

living, is left to local authorities and, informally, to the patient's network (mostly the family). Other (non-contributory) disability benefits (in cash and in kind) are provided by the social welfare system to persons who are in need of care because of a specific chronic illness or incapacity.

Available formal long-term care services (Help-at-Home, Day Care Centres, Care units for the chronic sick and limited public Residential Care Homes - MFI) are financed through the competent local authorities and are free to the user. Public nursing homes for the chronically ill are financed by the state budget and by per diem fees paid by social insurance organisations. There is also an individual contribution, ranging from 40% to 80% for pensioners in residential care.

Dependent on the level of invalidity, the state provides residential care to indigent, lonely aged people in need of care through Chronic Illness Nursing Homes. These, however, are not targeted at the elderly as only three centres have a proper

geriatric section. On top of those within public nursing homes, there is an additional capacity of approximately 3000 long-term beds within other settings, namely acute and psychiatric hospitals (1000 and 2000 beds respectively). Additional beds are available within private structures.

Several private clinics operate under a contract with EOPYY to provide long-term care (mostly to terminally ill). In addition a total of approximately 15000 long-term care beds are available in residential care homes, both non-profit, partly subsidised by the state, and partly funded by donations (and per diem fees paid by social insurance organisation for those entitled to social insurance, both for-profit, financed by the beneficiaries. Semi-residential, day-care to the elderly is provided by the 68 Day Care Centres for the Elderly (KIFI). Since their establishment they have been funded mostly by EU resources.

As with the centres of day care, the Help at Home programme (introduced in 1998) has so far been

operated by municipal enterprises and has been mostly funded by EU resources. However, the lack of criteria to contain expenditure undermines the viability of service provision, especially in the case of Help-at-Home. A fundamental weakness of this project was constituted by the poor stability of financing linked to the decentralisation to municipalities, and this resulted in very restrictive criteria to benefit from the programme (lack of both family support and financial means) and, ultimately, low coverage. (390)

Lastly, some outpatient services are provided by rehabilitation centres.

Types of care

Public services include Help at Home, KAPIs

(КАПН-Open Care Centres for Older People, i.e.

local community day centres), public residential

care homes for older people (residential care for

the poor elderly is limited with waiting list up to 3

years in many cases), Day-Care Centres for Older

People (КНФН, providing day care for dependent

older people with no family or while their family

carers are at work), Centres for chronic diseases

and rehabilitation.

Private for-profit sector's services in the LTC

system include: residential care homes (MFI), care

workers at home (often migrants), medical care

(private medical care).

Private non-profit include services and

programmes run by NGO's, charity and

philanthropic organisations, churches and their

branches and privately funded foundations These

(390) Mastrogiannakis, T., Kagialaris, G., Triantafillou, J.:

"Governance and financing of long term care", Greek

National Report (2010),

http://interlinks.euro.centre.org/sites/default/files/WP6_EL

_NRP_final.pdf.

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include: NGO's for special groups, NGO's of older

people, NGO's as service providers and NGO's

combating social exclusion. (391)

Eligibility criteria

Admissions to state operated care centres for the chronically ill (that, however, hardly cover the needs among deprived elderly people) and to contracted non-profit and for-profit clinics are subject to referral by the social services of local authorities, of “regional units” (ex-prefecture level social welfare directorates), and of the NHS hospitals. Existing legislation does not define a specific income threshold. It rather stresses that economic hardship is a crucial criterion, but other factors defining the severity of need should be taken into account too in the evaluation of each specific case.

Dependent on invalidity levels as assessed by the Centres for Certifying Incapacity (KEPA), and based on the kind of chronic illness, recipients are entitled to different levels of care provision. The invalidity levels are set at 50%, 67% or 80%.

Co-payments, out of the pocket expenses and private insurance

There are no comprehensive formal long-term care services guaranteeing universal coverage nor any specific budget allocated to long-term care services. Existing services are addressed to the neediest, indigent people. Care for the chronically ill (either in state residential units or contracted non-profit and for-profit care centres and clinics) is limited. This means that in many circumstances care must be financed privately.

Private insurance for long-term care is negligible and the cost of private residential care, by those who can afford it, is met by out-of-pocket payments. In semi-private clinics, services of rehabilitation and nursing for older people may benefit from partial coverage by the social security funds, but this is a time limited (up to 6 months) and small share of the total expenditure which mainly burdens the beneficiary. Consequently, (391) Mastrogiannakis, T., Kagialaris, G., Triantafillou, J.: "The role of informal care in long-term care", Greek National

Report (2010),

http://interlinks.euro.centre.org/sites/default/files/WP6_EL

_NRP_final.pdf.

over the last few years occupancy of private for

profit **care** homes has significantly fallen from

100% to about 80%.

In addition, due to the crisis and economic

hardship families opt to look after the elderly at

home as pension benefits are a major source of

income particularly among households with low

work intensity.

Formal/informal caregiving

Although some formal **care** is provided, informal

care giving is still an important part of the Greek

LTC system. Due to the traditional central role of

the family as a provider of elderly **care**, and to the

financial hardship and lack of supporting private

provision, families are increasingly resorting to the

use of migrant carers. These are typically hired to

look-after the elderly and often live with them,

providing 24-hour **care**, and they are entirely

financed by the patient or his network.

Prevention and rehabilitation policies/

measures

Three types of rehabilitation centres, recently

transferred under the responsibility of the Ministry

of Health and managed by ESY hospitals, provide

outpatient long-term care services (Centres for

Further Therapy and Rehabilitation of the

Disabled, Centres for Physical and Medical

Rehabilitation; and the so-called KEKYKAMEA -

Centres for Education, Training and Social

Support to Disabled Persons). Prevention is a

rather neglected policy area.

Recently legislated and/or planned policy

reforms

In 2010, the Kallikratis plan transferred social care

to local authorities, which have so far been unable

to integrate services into a comprehensive package

ensuring coverage to the citizens. In 2011, Law

4025 has redesigned the map of welfare

organisations over the territory through a

consolidation and stipulated the systematic

registration of recipients of service benefits into a unified electronic database. The following year, Law 4052 has explicitly linked AKAGE's resources to the additional purpose to support the Help at Home programme, on top of its mandate to cover future pension deficit. AKAGE will transfer

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those resources to IKA. An element of novelty within the new Help at Home is that the criteria of eligibility are clearly defined based mainly on means testing.

Another important feature was the introduction of competition among providers. Alongside municipal schemes, non-profit as well as for-profit Help at Home units would be able to submit bids for being included in the registry of certified providers in the schemes administered by IKA from which beneficiaries would be able to choose a provider. Those working in municipal schemes would be able to form “social cooperatives” and bid for becoming accredited providers under the

new, competitive system. However, due to strong stakeholder opposition, the implementation of these changes is weak and progresses with slow pace.

Challenges

Greece has a highly fragmented and unstructured system of LTCs, with low coverage and high reliance on informal care. The main challenges of the system appear to be:

- Improving the governance framework: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to share data within government

administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- Providing adequate levels of care to those in need of care: to adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost sharing on LTC benefits and the scope of coverage, that is, setting the types of services included into the coverage; to reduce the risk of impoverishment of recipients and informal carers.

- Improving financing arrangements: To determine the extent of user cost-sharing on LTC benefits; to implement centralised mean testing to determine individual cost-sharing (or entitlement to public support) so that, while

accounting for the economic context, it guarantees a uniform and equal treatment to all citizens, it captures different income components, including benefits, and it also captures wealth in the form of assets.

- Encouraging independent living: to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- Ensuring availability of formal carers: to determine current and future needs for qualified human resources and facilities for long-term care.

- Supporting family carers: to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- To facilitate appropriate utilisation across

health and long-term care: to arrange for

adequate supply of services and support outside

hospitals, while at the same time ensure that the

payment systems and financial incentives

discourage acute care use for LTC.

- Improving value for money: to encourage

competition across LTC providers to stimulate

productivity enhancements. To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; to

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invest in ICT as an important source of

information, care management and

coordination.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; to employ prevention

and health-promotion policies and identify

risk groups and detect morbidity patterns

earlier.

- Improving administrative efficiency.
- Ensuring good budgeting practices.

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Table 2.12.1: Statistical Annex – Greece

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 179 194 199 218 233 242 238 226 207 191 180 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 24.4 25.2 24.5 25.6 25.6 25.1 23.2 22.1 19.9 19.6 20.2 26.8 27.6 28.0 28.1 27.9

Population, in millions 10.9 10.9 11.0 11.0 11.0 11.1 11.1 11.1 11.1 11.1 11.0 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : : : : : 0.0 0.1 0.0 0.0 : 1.0 1.0 1.0 1.0 :

Per capita PPS : : : : : 7.8 11.0 6.8 8.0 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : : : : : 0.1 0.1 0.1 0.1 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Life expectancy at birth for females 81.8 82.0 82.3 82.6 82.5 83.0 83.3 83.3 83.6 83.4 84.0 82.6 82.8 83.1 83.1 83.3

Healthy life years at birth for females 68.4 65.5 67.4 68.1 67.6 66.2 66.8 67.7 66.9 64.9 65.1 : 62.6 62.1 62.1 61.5

People having a long-standing illness or health problem, in % of pop. : 19.2 20.1 20.3 21.7 22.2 22.1 22.8 23.4
23.8 23.9 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 5.8 6.2 6.1 6.8 8.2 8.0 8.1 8.6 10.1
10.8 : 8.1 8.3 8.6 8.7

Coverage (Based on data from Ageing Reports)

Number of people receiving **care** in an institution, in thousands : : : 66 83 100 117 121 125 4 3,433 3,771 3,851 3,931 4,183

Number of people receiving **care** at home, in thousands : : : 148 177 205 234 239 244 10 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : 1.9 2.3 2.8 3.2 3.2 3.3 0.1 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of **care** recipients

Number of informal carers, in thousands : 375 : 273 :::::::::::::::

[illegible]

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Table 2.12.2: Statistical Annex - continued – Greece

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)."

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 10.7 10.1 9.6 9.1 8.6

Dependency

Number of dependents in millions 0.92 0.97 1.05 1.10 1.07

Share of dependents, in % 8.6 9.7 11.0 12.1 12.5

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.5 0.6 0.7 0.8 0.9

AWG risk scenario 0.6 0.7 0.8 1.0 1.3

Coverage

Number of people receiving care in an institution 5,059 5,478 6,188 7,119 7,810Number of people receiving care at home 11,452 12,067 13,173 14,516 15,207

Number of people receiving cash benefits 315,731 331,154 360,689 398,348 419,119

% of pop. receiving formal LTC in-kind and/or cash benefits 3.1 3.5 4.0 4.6 5.2

% of dependents receiving formal LTC in-kind and/or cash benefits 36.3 35.9 36.2 38.2 41.2

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 8.6 7.9 7.7 8.2 8.5

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 91.4 92.1 92.3 91.8 91.5

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Public spending on institutional care (% of tot. publ. spending LTC) 26.0 26.4 26.7 27.0 27.6

Public spending on home care (% of tot. publ. spending LTC in-kind) 74.0 73.6 73.3 73.0 72.4

Unit costs of institutional care per recipient, as % of GDP per capita 25.9 23.1 22.0 23.0 23.2

Unit costs of home care per recipient, as % of GDP per capita 32.5 29.3 28.4 30.4 31.3

Unit costs of cash benefits per recipient, as % of GDP per capita 17.0 17.0 16.9 16.9 17.0

2013

MS Change

2013-2060

EU Change 2013-2060

11.0 -22% 3%

0.87 24% 40%

7.8 60% 36%

0.5 88% 40%

0.5 166% 149%

4,444 76% 79%

10,456 45% 78%

288,157 45% 68%

2.7 88% 68%

35.0 18% 23%

8.5 0% 1%

91.5 0% -5%

25.6 8% 1%

74.4 -3% -1%

26.0 -11% -2%

32.2 -3% -3%

16.9 0% -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

Hungary has a population estimated at around 9.9 million inhabitants in 2013. With a GDP of around EUR 101 bn, or 16,300 PPS per capita, it is below the EU average GDP per capita of EUR 27,900.

Health status

Life expectancy at birth for both men and women was, in 2013, respectively 72.2 years and 79.1 years and is below the EU average (77.8 and 83.3 years respectively). The healthy life years at birth for both sexes are 59.1 years (women) and 60.1 years (men) are also below the EU-average (61.5 and 61.4 respectively). At the same time, the percentage of the Hungarian population having a long-standing illness or health problem is far higher than in the Union as a whole (37% and

32.5% respectively in 2012). The percentage of the population indicating a self-perceived severe limitation in its daily activities has decreased since 2004, and is lower than the EU-average (7.8% against 8.7% in 2013).

Dependency trends

The share of dependents is expected to increase in this period, from 8% in 2013 to 11.7% of the total population in 2060, an increase of 47%, which is above the EU average increase of 36%. From around 0.79 million residents living with strong limitations due to health problems in 2013, an increase of 36% is envisaged until 2060 to 1.05 million. That is below the increase in the EU as a whole (40%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care (LTC) as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 0.4 pps

of GDP by 2060. (392) The "AWG risk scenario",

(392) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

which in comparison to the "AWG reference

scenario" captures the impact of additional cost

drivers to demography and health status, i.e. the

possible effect of a cost and coverage convergence,

projects an increase in spending of 4.2 pps of GDP

by 2060. Overall, projected long-term care

expenditure increase is expected to add to

budgetary pressure. However, no sustainability

risks appear over the long run as the favourable

initial budgetary position would mitigate the

projected increase in age-related expenditure. (393)

Overall, no significant short-term risks of fiscal

stress appear at the horizon, though some variables

point to possible short-term challenges.

Medium risks appear, on the contrary, in the

medium term from a debt sustainability analysis

perspective due to the still moderately high stock of debt at the end of projections (2026), and the sensitivity to possible shocks to nominal growth, interest rates and the government primary balance.

Low medium-term risks are, on the contrary, highlighted by the analysis of the sustainability gap indicator S1, largely due to positive projected developments on ageing. Overall, Hungary appears to face medium fiscal sustainability risks in the medium term.

No sustainability risks appear over the long run.

System Characteristics (394)

Public spending on LTC reached 0.3% of GDP in 2012 in Hungary, below the EU average of 1% of GDP. 100% of the benefits were in-kind, with no expenditure on cash benefits (EU: 80 vs 20%).

19% of dependents are receiving formal in-kind LTC services or cash benefits for LTC, below the

EU average of 53%. Overall, 1.6% of the

population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of

under-provision of LTC services. On the other

hand, higher coverage rates may imply an

(393) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf

(394) This section draws on OECD (2011b) and ASISP (2014).

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increased fiscal pressure on government budgets,

possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services

makes up 52.5% of public in-kind expenditure

(EU: 61%), 47.5% being spent for LTC services

provided at home (EU: 39%).

Long-term **care** is generally seen as a relatively

small section of the social protection system in

Hungary. However, over the last five years a rapid

shift to publicly-financed home based **care** has

taken place.

Hungary has no stand-alone LTC system. Instead,

LTC services are provided either by the health care

system or by the social care system. The two

systems have a different legislation, financing

mechanisms and services. They each have parallel

institutional networks that include institutional and

home care. There is only weak coordination

between them despite some minor recent

improvements due to the merging of the health

care and social affairs portfolios under the

supervision the Ministry of Human Resources.

Until recently the LTC system was still shaped by

the organisational logic of central planning:

centralisation (as fewer institutions are easier to

control), a preference for institutionalised care

versus home-based care and a lack of awareness

beyond its immediate operational sphere. The main

consequence was a dual structure consisting of a

centralised institutional supplemented through the

informal behaviour of individual and households.

However, this has recently changed with a shift

towards more home care.

The healthcare system provides services provided

such as nursing care in nursing departments of

hospitals and home nursing care. The social care

system provides three main types of services:

home care (including “meals-on-wheels” services),

day care and residential care.

The LTC-system does not offer cash benefits for

recipients to improve access to care. There is only

one type of social allowance, the nursing fee, for

those relatives with caring responsibility for a

disabled family member.

Beyond this, the bulk of LTC provision is left to

private households or the informal market.

Administrative organisation

Home care is organised at a local level, whether by

social work centres, homes for elderly or special

institutions. In general, the financial system of

public LTC functions as a direct subsidy to

suppliers of care. Services include help with daily

activities supervision, social assistance and

medical services. Home health care is organised by

community nurses. Additionally, there also some day-centres and transitional accommodation.

Types of care

Long-term care in Hungary includes benefits in kind (institutional or home care) as well as one cash benefit (nursing fee, as explained above). The provision of LTC is regulated by legislation on social security, such as health care and health insurance, pension and disability insurance and social assistance. As shown in the statistical annex, most services are currently provided in an institutional setting.

Eligibility criteria, co-payments, out of the pocket expenses and private insurance

As explained above, the nursing fee is a social allowance provided to carers. Applications need to be based on the expert opinion of the GP treating the dependent person. Since January 2013 they can be submitted directly to the district office. The fee is paid to carers who provide LTC for severely disabled family members (including both the

elderly as well as the severely disabled

permanently ill young (minor) family members).

In this way, the nursing fee is not only targeted to

LTC of the elderly. Additionally, the social

legislation allows local governments to give

financial help to those caring for permanently ill

family members aged over 18 but under 65.

Apart from these cash benefits services are funded

directly. Private insurance schemes are not

involved in the funding of LTC. The operational

costs of providing LTC are financed by the

"Health Insurance Fund" for health care and the

central government budget for the social care

component of LTC.

In addition, care providers are allowed to charge

user fees. The exact amount charged differs

depending on the service. The regulations stipulate

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algorithms that take into account the personal

income and real state assets of the recipient but do neither include other assets nor the availability of informal family carers. The fee can go up to 80% of monthly income for institutional care and 50 % for group homes for rehabilitation. Besides these according to the different providers the maximum fees are the following: for day care: max. 15% of monthly income; for day care + meals: max 30% of monthly income; for temporary care: max. 60%-of monthly income).

Unit costs of both residential and home care are low in comparison with the rest of the EU. In 2012 the financial support for residential care for a year was HUF 635,650, about EUR 2,200, around 22% of per capita annual GDP. In 2013 the method of calculation has changed. In contrast to the "per resident quota" in effect till 2012, since then the average wage of carers in residential homes is regulated by the government. The normative support per resident can be calculated according to further rules on residents per carer, with special

multipliers for care intensity (1.0 for regular elderly homes, 1.18 for dementia care and 0.19 for special elderly care). As a consequence, the quota for regular care has increased slightly up to HUF 651,510, (about EUR 2,255 per annum). For home care, the corresponding figure was HUF 166,080, around EUR 575 or about 6% of per capita GDP, in 2012, cut back to HUF 145,000 (around EUR 490) in 2013.

Formal/informal caregiving

There is empirical evidence showing that family relations play a relatively important role in LTC for the elderly in Hungary. The 4th wave of SHARE (Survey of Health, Ageing and Retirement in Europe), for the first time including Hungary, found that the elderly in Hungary are by far the most likely to name their offspring among the confidants they can rely on and the second most likely to name their spouses (Stoeckel and Litwin 2013). This is confirmed by existing data for the provision of informal care. OECD "Health at a glance 2013" shows a relatively high proportion of

the population aged 50 and over reporting to be informal carers. Additionally, the majority are women (the highest proportion within the OECD).

Prevention and rehabilitation

policies/measures

Prevention and rehabilitation are provided through

the health care system.

Recently legislated and/or planned policy

reforms

Modification of the responsibility of institutions

providing permanent accommodation and

care

In the "Act III. of 1993. on Social Administration and Social Benefits" (regulates the responsibility of operate of social services. Before the enactment of the act, the responsibility for ensuring services providing LTC belonged to county authorities and local authorities of cities with county rights. The state took over the social institutions of county authorities in 2012 during a process of its debt consolidation. In parallel the legislative responsibility of operating institution providing

long term care became the responsibility of the state.

The takeover process of residential social institutions took place in 2013, as the legislative responsibility of maintaining of residential institutions to people with disabilities, psychiatric patients and people with addictions became the responsibility of the state from 1 January 2013.

Simultaneously therefore all institutions which earlier were maintained by local authorities were taken over by the state. The takeover gives opportunity for reforming of these institutions and for rationalising the available capacities and for ensuring an efficient and qualitative service.

Local authorities may continue to organise residential care service for elderly at a local level.

For towns with county rights, and for the capital it is still a binding duty.

Replacement of social institutional capacities

providing nursing and care for people with disabilities and supported living

In July 2011, the Hungarian Government adopted

the Government Decree No. 1257/2011. (VII.21.)

on the strategy for the replacement of social

institutional capacities providing nursing and care

for people with disabilities 2011-2041 (hereinafter:

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DI strategy) and the implementation of

governmental tasks. The main goal of the

deinstitutionalisation is to ensure the full

enjoyment of human rights, to increase the quality

of life of persons with disabilities and at the same

time to develop and modernise the structure of the

provision of social services.

For the purpose of implementing the targeted

developments and conversions in the first threeyear

period of the 30-year-long strategy, a tender

of the Social Infrastructure Operational

Programme (TIOP 3.4.1. A-11 'Replacement of

residential institutions – social institutions

component') was launched with the overall amount

of HUF 7 billion. In the first two phases of the

tender, six projects were submitted. Four of them were related to care homes for disabled persons and two of them to psycho-social care homes. The total amount of support received by the applicants is almost HUF 6 billion (EUR 19,344,327).

The operators who applied for subsidies for deinstitutionalisation had to clearly blueprint the implementation of the transformation of their institutions and services before its beginning; demands and needs of every service user had to be measured; the process of their preparation for changes and the structures of the tailor made services had to be designed.

The "National Body for Deinstitutionalization" (hereinafter called: the Body) was established to overview and approve the feasibility studies on the basis of the principles and objectives of the deinstitutionalisation (DI) strategy. The Body outlines preliminary professional evaluation criteria by submitting professional proposals on the feasibility studies. The Body determines the order of the implementation and takes part in the

monitoring of the development. Furthermore, the

Body makes comments on the concept of

utilisation of the infrastructure remaining after the

deinstitutionalisation process indicated in the

proposals and outlines the Action Plan for

restructuring the institutions in every three years.

The Body ensures the full transparency of the

implementation of the strategy. Persons with

disabilities, civil services, advocacy groups,

representatives of social and higher education,

institutions of special education, other background

institutions, service providers and senior civil

servants take part in the activity of the Body.

The network of mentors set up by the support of

the European funds is also important for the

success of the implementation by ensuring

counselling on the questions of replacement and by

giving preparatory support for inquiring

organisations.

The DI strategy is also promoted by the Social

Renewal Operational Programme (TÁMOP

5.4.1/12 'Modernisation of social services') by

giving communicational support for a more

effective social inclusion.

In order to establish the legislative background of

the strategy, supported living was introduced from

1 January 2013 as a new form of social services in

the Act III of 1993 on Social Administration and

Social Benefits.

Supported living is a flexible combination of

various forms of housing and supportive services,

where the housing and supportive services are

separated from each other. The supported living

service provides appropriate conditions for people

with disabilities, psychiatric patients, persons with

addictions and homeless people concerning

housing and social services in accordance with the

beneficiaries' age, health condition and self-care

skills. The provided service is based on complex

needs assessments (taking into account the

necessary intensity of support, the existing abilities

and the users' will) and it is modified in parallel

with the possible changing circumstances.

The service provides: housing/living service; care

management; support for follow up the persons'

living conditions based on personal needs

assessments; meals; nursing and **care**;

development/rehabilitation, and services to help

participation in social life.

After 1 January 2013, new institutional places

providing nursing and **care** for people with

disabilities, psychiatric patients or people with

addictions can be established: a) In the case of

large institutions only by providing supported

housing; b) in the case of creating new

institutions which can only be set up in houses

described by legislative regulations on supported

housing (flat for maximum 6 people or house for

maximum 7-12 people).

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Challenges

The main challenges of the system appear to be:

- Improving the governance framework: To

establish a coherent and integrated legal and

governance framework for a clear delineation of responsibilities of state authorities wrt. to the provision of long-term care services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To set guidelines to steer decision-making at local level or by practising providers; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; To deal with cost-shifting incentives across health and care.

- Improving financing arrangements: To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private LTC insurance as a supplementary financing tool; To determine the extent of user costsharing on LTC benefits.

- Providing adequate levels of care to those in need of care: To adapt and improve LTC coverage schemes, by setting: (i) the need-level triggering entitlement to coverage; (ii) the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and (iii) the depth of coverage, that is, setting the types of services included into the coverage; To reduce the risk of impoverishment of recipients and informal carers.

- Ensuring availability of formal carers: To determine current and future needs for qualified human resources and facilities for long-term care.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer LTC users towards appropriate settings.

- Improving value for money: To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and coordination between health and care services; To invest in ICT as an important source of information, care management and coordination.

- Prevention: To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

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Table 2.13.1: Statistical Annex – Hungary

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 75 83 91 91 102 108 94 98 101 99 101 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 17.3 17.3 17.6 17.8 17.5 17.3 16.0 16.5 16.7 16.2 16.3 26.8 27.6 28.0 28.1 27.9

Population, in millions 10.1 10.1 10.1 10.1 10.1 10.0 10.0 10.0 10.0 9.9 9.9 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.3 0.3 0.3 0.2 0.3 0.3 0.3 0.3 0.2 0.3 : 1.0 1.0 1.0 1.0 :

Per capita PPS 36.7 36.1 38.7 35.3 40.7 42.5 41.1 44.5 43.0 43.6 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 0.5 0.5 0.4 0.5 0.5 0.5 0.5 0.5 0.5 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 76.7 77.2 77.2 77.8 77.8 78.3 78.4 78.6 78.7 78.7 79.1 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 68.4 68.7 68.7 69.2 69.4 70.0 70.3 70.7 71.2 71.6 72.2 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 57.8 : 54.3 57.2 57.8 58.2 58.2 58.6 59.1 60.5 60.1 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 53.5 : 52.2 54.4 55.1 54.8 55.9 56.3 57.6 59.2 59.1 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 40.1 35.8 37.0 38.2 36.2 36.0 35.7 36.0 37.0 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 14.9 13.5 12.8 10.3 8.5 8.6 8.1 7.9 7.8 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving **care** at home, in thousands : : : 41 46 52 57 58 60 61 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : 0.9 1.1 1.3 1.5 1.5 1.6 1.6 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of **care** recipients

Providers

Number of informal carers, in thousands : : : : :

Number of formal carers, in thousands 34 34 35 34 33 34 37 38 39 :::::

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Literature

Table 2.13.2: Statistical Annex - continued – Hungary

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)"

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 9.8 9.7 9.5 9.3 9.2

Dependency

Number of dependents in millions 0.83 0.92 0.98 1.02 1.07

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Share of dependents, in % 8.5 9.5 10.3 10.9 11.7

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.8 0.8 0.9 1.1 1.2

AWG risk scenario 0.9 1.3 2.1 3.1 5.0

Coverage

Number of people receiving care in an institution 103,567 117,818 136,374 152,016 164,765

Number of people receiving care at home 66,314 75,394 87,373 97,457 105,584

Number of people receiving cash benefits 0 0 0 0 0

% of pop. receiving formal LTC in-kind and/or cash benefits 1.7 2.0 2.4 2.7 3.0

% of dependents receiving formal LTC in-kind and/or cash benefits 20.4 21.1 22.9 24.4 25.2

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 100.0 100.0 100.0 100.0 100.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 0.0 0.0 0.0 0.0 0.0

Public spending on institutional care (% of tot. publ. spending LTC) 52.0 51.5 50.6 50.1 49.4

Public spending on home care (% of tot. publ. spending LTC in-kind) 48.0 48.5 49.4 49.9 50.6

Unit costs of institutional care per recipient, as % of GDP per capita 38.2 35.0 33.2 32.6 31.8

Unit costs of home care per recipient, as % of GDP per capita 55.1 51.4 50.7 50.7 50.9

Unit costs of cash benefits per recipient, as % of GDP per capita : : : :

2013

MS Change

2013-2060

EU Change 2013-2060

9.9 -8% 3%

0.79 36% 40%

8.0 47% 36%

0.8 54% 40%

0.8 564% 149%

94,950 74% 79%

60,730 74% 78%

0 : 68%

1.6 88% 68%

19.8 27% 23%

100.0 0% 1%

0.0 : -5%

52.5 -6% 1%

47.5 7% -1%

41.2 -23% -2%

58.3 -13% -3%

: : -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

GDP per capita in PPS thousand is at EUR 33.9

and far above EU average of EUR 27.9 in 2013.

Ireland has a population of 4.6 million

inhabitants.(395) During the coming decades the

population will steadily increase to 5.3 million

inhabitants in 2060. Thus, Ireland is facing a

considerable increase of its population by 14%,

while the EU average population is estimated to

increase by 3%.

Health status

Life expectancy at birth for both women and men

was, in 2013, respectively83.1 years and 83.1 79

years and is close to the EU average (83.1 and 77.6

years respectively). However, the healthy life years

at birth for both sexes are 68.0 years (women) and

66years (men) significantly above the EU-average

(61.8 and 61.6 respectively). At the same time, the

percentage of the Irish population having a longstanding

illness or health problem is lower than in

the Union as a whole (27.7% and 32.5%

respectively in 2013). The percentage of the

population indicating a self-perceived severe

limitation in its daily activities has decreased since

2004, (although it has registered a year-on-year increase in 2013) and is significantly lower than the EU-average (5.6% against 8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.22 million residents living with strong limitations due to health problems in 2013, an increase of 74% is envisaged until 2060 to slightly more than 0.38 million. That is a more steep increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 4.7% to 7.2%, an increase of 52% (EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the (395) This is according to Eurostat data.

AWG reference scenario, public long-term expenditure is driven by the combination of

changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a projected increase in spending of about 0.7 pps of GDP by 2060.(396) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.3 pps of GDP by 2060. Overall, for Ireland risks appear to be high in the medium term from a debt sustainability analysis perspective due to the still high debt at the end of projections (2026) and the high sensitivity to possible shocks to nominal growth and interest rates. No significant sustainability risks appear over the long run, despite increasing costs of ageing, due a relatively favourable initial budgetary position.(397)

System Characteristics (398)

The National Positive Ageing Strategy (NPAS)

was published in 2013. It is the first policy

document focused on the care older people since

the publication of "The Years Ahead" in 1998. It

represents the over-arching blueprint for age

related policy and service delivery across

Government and society in the years ahead

(Department of Health, 2013).

A Framework for Improved Health and Wellbeing

2013-2025 (Department of Health, 2013) is a

reform within Ireland's ongoing health reform

programme that is of key importance to the

implementation of the NPAS.

The Nursing Home Support Scheme (NHSS),

introduced in 2009, had the aim of ensuring

consistency in the funding of nursing home care by

the State and individuals. Its aim was to 'make

long term nursing home care accessible, affordable

and anxiety free' (Department of Health and

Children, 2009). It replaced the previous Nursing

Home Subvention Scheme which hugely

(396) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(397) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(398) This section draws on OECD (2011b) and ASISP (2014).

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subsidised **care** for some recipients, but meant a great number of recipients having to pay for the majority of the extremely high **care** costs.

In line with government policy, home support services are provided to assist older people to live as independently as possible in their own homes and communities. In addition to the mainstream

Home Help (HH) service, enhanced home **care** is

provided through Home **Care** Packages (HCP),

introduced in 2005 and, since 2014, Intensive

Home **Care** Packages for people with complex **care**

needs. In 2014, 10.3m hours HH were provided to

approximately 47,000 clients and 13,200 people

were in receipt of a HCP at any given time. In

2015, a total of 10.45m hours of HH were

provided to 48,000 people; approximately 15,450

HCPs were in place at any one time and almost

200 people were provided with an Intensive HCP

over the course of the year. Projected targets for

2016 are the same as the 2015 outturn figures.

The provision of short-stay residential beds is a

key component of the integrated model of care

planned for the delivery of services to older

people. Short stay beds are allocated across 'step

up/step down' care, intermediate care, rehab and

respite care depending on current demands. In

2016, over 2,000 short-stay residential care beds

will be provided, together with over 300

transitional care beds, aimed at reducing delayed

discharges from acute hospitals.

Services are provided on the basis of assessed

health-care need and there is no means-testing.

Other services include day care for about 20,000

people and meals-on wheels service.

In contrast to most other EU countries, the public

expenditure long-term care takes exclusively the

shape of in-kind benefits, with no role for cash

benefits, beyond those provided to carers.

Administrative organisation

Long-term care is funded and delivered as part of

the health services in Ireland under the auspices of

the HSE. The responsible minister is the Minister

of State with responsibility for Primary Care,

Social Care (Disabilities & Older People) and

Mental Health at the Department of for Health.

The Minister for State for Older People is also

responsible for the coordination of policy beyond

the Department of Health.

The Health Service Executive (HSE) of Ireland is

responsible for providing and/or supervising a

wide range of residential, community and home

services designed to support people to live at

home.

Types of care

In Ireland, long-term care can be taken to include

both home care and residential care. This gives a

four-fold classification of long-term care: older

people/people (under 65) with disabilities,

residential care/domiciliary care.

Several schemes/benefits provide support for

people who require long-term care.

The Nursing Homes Support Scheme provides

financial support towards the cost of long-term

nursing home care.

Home Care Packages are aimed at those requiring

medium to high support in the community. In

particular, they are aimed at older people living in

the community who are in acute hospitals and are

at risk of admission to long-term residential care.

Eligibility criteria

Applicants to the Nursing Homes Support Scheme

must undergo care need and financial assessments

to determine a) whether long-term nursing home

care is the most appropriate option (Care Needs

Assessment) and b) what they can afford to

contribute towards their cost of care. Anyone who

is assessed as requiring long-term nursing home

care can avail of the scheme, regardless of age.

However, nursing home care must be appropriate to meet the individual's care needs. The legislation underpinning the Nursing Homes Support Scheme requires each private nursing home to negotiate and agree a price for long-term residential care services with the National Treatment Purchase Fund (NTPF), should they wish to be an approved nursing home for the purposes of the Scheme. This is a necessary feature of the scheme due to the commitment by the State to meet the full balance of the cost of care over and above a person's contribution.

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To access Carer's Benefit, Carer's Allowance, Constant Attendance Allowance and Carer's Support Grant, the applicant must submit information from the care recipient's doctor as to the degree of care required. This is reviewed by a Department of Social Protection medical assessor

and the benefits are provided by the Department of

Social Protection .

Co-payments, out of the pocket expenses and

private insurance

Under the NHSS scheme people make a

contribution of up to 80% of their assessable

income and a maximum of 7.5% of the value of

any assets towards the cost of care and the State

will pay the balance. The first EUR 36,000 of

assets, or EUR 72,000 for a couple, is not counted

in the financial assessment. Where assets include

land and property in the State, the 7.5%

contribution based on such assets may be deferred

and collected from the person's estate. This is an

optional Nursing Home Loan element of the

scheme. An individual's principal residence is only

included in the financial assessment for the first

three years of their time in care. This is known as

'the three-year cap'

Government policy is to support older people to

live in dignity and independence in their own

homes and communities for as long as possible.

This is achieved through a range of community

based services such as mainstream Home Help,

Meals-on-Wheels and Respite or Day Care. In

more complex cases, enhanced Home Care

Packages (HCPs) may be provided. Home Care

Packages are an additional support over and above

existing mainstream community services. Intensive

HCPs, for those with high dependency levels were

introduced in 2014.

Role of the private sector

Public, voluntary and private for profit providers

provide long-term care in Ireland. In the past most

long-term care was either provided by public or

publicly funded care providers (often run by

Catholic and Protestant churches) or informally

typically by family members (Wren, 2009). The

last few years have seen a sharp increase in private

providers of home care. There is no official

register of private and not-for-profit home care

companies, but it is estimated that currently there

are in excess of 130 such providers (including franchises). This reflects a decline in informal care and a significant increase in the HSE budget allocation to home care services.

Formal/informal caregiving

Overall Government policy in Ireland is to maintain and support older people at home and in their communities. The Department of Social Protection operates a number of income support schemes for people who stay at home to care for elderly persons or persons with disabilities.

Carer's Allowance: Carer's Allowance is a meanstested payment for carers who look after certain people in need of full-time care and attention on a full-time basis. Those in receipt of another social welfare payment and providing someone with full time care and attention may qualify for a reduced rate of carer's allowance in addition to the original payment.

Care Sharing: From 14 March 2005, two carers who are providing care on a part-time basis in an

established pattern can be accommodated on the carer's allowance scheme.

Carer's Benefit: Carer's Benefit is a payment for people who have made social insurance contributions and who have recently left the workforce and are looking after somebody in need of full-time care and attention. Carer's benefit may be claimed for a total of 2 years for each person being cared for. Carers Leave (unpaid) may be applied for by those seeking to obtain leave to care from their place of work.

Carer's Support Grant: The Carer's Support Grant is an annual payment for full-time carers who look after certain people in need of full-time care and attention. The payment is made regardless of the carer's means but is subject to certain conditions.

Prevention and rehabilitation policies/
measures

The National Positive Ageing Strategy was published in April 2013. This Strategy provides the blueprint for a whole of Government and whole of society approach to planning for an ageing society.

The Strategy provides a vision for an age-friendly

society and includes four National Goals and

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underpinning objectives to provide direction on the issues that need to be addressed to promote positive ageing.

The Department of Health has framed a new approach to improve engagement between stakeholders and relevant Departments and Agencies.

The Cabinet Committee on Social Policy will oversee the implementation of the Strategy.

The National Carers Strategy was published in July 2012 and sets the strategic direction for future policies, services and supports provided by Government Departments and agencies for carers.

It sets out a vision to work towards an ambitious set of National Goals and Objectives to guide policy development and service delivery, to ensure that carers feel valued and supported to manage

their **caring** responsibilities with confidence and
are empowered to have a life of their own outside
of **caring**.

Recently legislated and/or planned policy
reforms

Recently legislated reforms

The Nursing Homes Support Scheme (NHSS),
often referred to as the “Fair Deal” is a scheme of
financial support for people who require long-term
nursing home **care**. The statutory based scheme
commenced on the 27th October 2009 with the
enactment of the Nursing Homes Support Scheme
Act 2009 and replaced the scheme of Nursing
Home Subvention, which had been in existence
since 1993. The NHSS is operated by the HSE.

When the Scheme commenced in 2009, a
commitment was made that it would be reviewed
after three years. The Report of the Review was
published in July 2015.

Policy reforms under preparation/adoption

It is estimated that there are currently 47,000
people with dementia in Ireland. This number is

expected to rise to approximately 132,000 by 2041. Given the increasing numbers of people with dementia, the Government gave a commitment to “Develop a national Alzheimer’s and other dementias strategy to increase awareness, ensure early diagnosis and intervention and development of enhanced community based services”. The Irish National Dementia Strategy was published in December 2014.

Possible future policy changes

The Review of the Nursing Home Support Scheme included a general examination of the Scheme, as well as the balance between residential care and care in the community, and a number of key issues have been identified for more detailed consideration across Departments and Agencies.

To this end, an Interdepartmental/Agency Working Group has been established to progress the recommendations contained in the Review. As the Scheme is statutory based, the implementation of recommendations arising from the Review may require amendments to the Nursing Homes

Support Scheme Act 2009.

Challenges

Ireland has taken significant steps to provide its

population with good quality care and to provide

care in the community. The main challenges of the

system appear to be:

- Improving the governance framework: To set the public and private financing mix and organise formal workforce supply; To face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation.
- Improving financing arrangements: To consider better pooling across generations, e.g. by levying LTC premia on those aged 40 years and over or by requiring also retirees to contribute premia to social LTC insurance,

based on their pension; To explore the potential of private LTC insurance as a supplementary financing tool; To determine the extent of user cost-sharing on LTC benefits.

- Encouraging home care: To develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation

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controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; To monitor and evaluate alternative services, including incentives for use of alternative settings.

- Ensuring availability of formal carers: To determine current and future needs for qualified human resources and facilities for long-term care; To seek options to increase the

productivity of LTC workers.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- To facilitate appropriate utilisation across

health and long-term care: To arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; To create better rules, improving

(and securing) safe care pathways and

information delivered to chronically-ill people

or circulated through the system; To steer LTC

users towards appropriate settings.

- Improving value for money: To encourage competition across LTC providers to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and coordination between health and care services; To invest in ICT as an important source of information, care management and coordination.

- Prevention: To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

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Table 2.14.1: Statistical Annex – Ireland

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

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GDP, in billion euro, current prices 146 156 170 185 197 188 169 166 174 175 179 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 30.0 30.9 31.8 32.9 34.5 32.0 30.7 33.0 33.8 34.0 33.9 26.8 27.6 28.0 28.1 27.9

Population, in millions 4.0 4.0 4.1 4.2 4.3 4.5 4.5 4.5 4.6 4.6 4.6 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : : : : : : : : : : 1.0 1.0 1.0 1.0 :

Per capita PPS : : : : : : : : : : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : : : : : : : : : : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 80.7 81.1 81.3 81.7 82.1 82.4 82.7 83.1 83.0 83.2 83.1 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 75.7 76.1 76.7 76.9 77.3 77.9 77.8 78.5 78.6 78.7 79.0 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 65.4 64.2 64.0 64.9 65.6 65.1 65.2 66.9 68.3 68.5 68.0 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 63.4 62.5 62.9 63.2 62.9 63.5 63.9 65.9 66.1 65.9 65.8 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 22.2 24.1 25.4 24.9 24.5 26.2 28.3 26.5 26.7 27.7 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 6.6 6.7 6.1 5.9 5.5 5.4 5.2 4.9 4.9 5.6 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 22 22 22 22 23 23 27 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 51 52 53 54 55 56 65 6,442 7,296 7,444 7,569 6,700

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% of pop. receiving formal LTC in-kind : : : : 1.7 1.7 1.7 1.7 1.7 1.7 2.0 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : 161 : : : : 187 : : : : :

Number of formal carers, in thousands : : : : 21 21 19 18 17 17 : : : : :

Long-term care systems

2.14. Ireland

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Table 2.14.2: Statistical Annex - continued – Ireland

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)"

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 4.6 4.6 4.7 5.0 5.3

Dependency

Number of dependents in millions 0.24 0.28 0.32 0.35 0.38

Share of dependents, in % 5.3 6.1 6.8 7.0 7.2

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.7 0.9 1.1 1.3 1.4

AWG risk scenario 0.8 1.2 1.7 2.4 3.0

Coverage

Number of people receiving care in an institution 31,738 39,813 51,499 63,866 75,023

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Number of people receiving care at home 74,533 89,658 108,890 128,331 143,888

Number of people receiving cash benefits 0 0 0 0 0

% of pop. receiving formal LTC in-kind and/or cash benefits 2.3 2.8 3.4 3.9 4.2

% of dependents receiving formal LTC in-kind and/or cash benefits 43.8 46.7 50.5 55.0 57.8

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 100.0 100.0 100.0 100.0 100.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 0.0 0.0 0.0 0.0 0.0

Public spending on institutional care (% of tot. publ. spending LTC) 35.0 35.4 36.1 36.7 37.3

Public spending on home care (% of tot. publ. spending LTC in-kind) 65.0 64.6 63.9 63.3 62.7

Unit costs of institutional care per recipient, as % of GDP per capita 37.0 35.6 35.8 38.0 36.8

Unit costs of home care per recipient, as % of GDP per capita 29.2 28.9 30.0 32.6 32.2

Unit costs of cash benefits per recipient, as % of GDP per capita : : : :

2013

MS Change

2013-2060

EU Change 2013-2060

4.6 14% 3%

0.22 74% 40%

4.7 52% 36%

0.7 111% 40%

0.7 350% 149%

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27,410 174% 79%

65,385 120% 78%

0 : 68%

2.0 106% 68%

42.6 36% 23%

100.0 0% 1%

0.0 : -5%

34.9 7% 1%

65.1 -4% -1%

39.0 -6% -2%

30.4 6% -3%

: : -2%

2.15. ITALY

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General context: Expenditure, fiscal

sustainability and demographic trends

Italy, one of the six founding fathers of the

European Union, has a population of almost 60

million inhabitants, which is almost 12% of the

total EU population. It makes it the fourth largest

country in terms of population, after Germany,

France and the United Kingdom. During the

coming decennia the population of Italy will

steadily grow, from 59.7 million inhabitants in 2013 to 66.3 million inhabitants in 2060. This 11% increase is higher than the EU average of 3%.

With a GDP of some EUR1600 bn (16% of the EU's total GDP), or 25,200 PPS per capita it is lower, though similar to the EU average of 27,900.

Total expenditure on long-term care is with 1.8% in 2013 (399) higher than the EU average of 1.0% in 2012.

Health status

Life expectancy at birth for both women and men is in 2013 respectively 85.2 years and 80.3 years and is above the EU average (83.3 and 77.8 years respectively). The healthy life years at birth for both sexes are with 60.9 years (women) and 61.8 years (men) similar to the EU-average (61.5 and 61.4 respectively). The percentage of the population having a long-standing illness has been increasing through the decade going from 21.6% (2004) to 25.4%, in 2013, and is well below the EU-average (32.5% in 2013). On the other hand, the percentage of the population indicating a selfperceived

severe limitation in its daily activities

has been steadily increasing from 5.6% (2004) to

9.7% (2013), and is above the EU-average (8.7%

in 2013).

Dependency trends

The number of people depending on others to carry

out activities of daily living increases significantly

over the coming 50 years. From 4.57 million

residents living with strong limitations due to

health problems in 2013, an increase of 51% is

envisaged until 2060 to around 6.89 million. That

is a steeper increase than in the EU as a whole

(40%). Also as a share of the population, the

(399) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

dependents are becoming a bigger group, from

7.6% to 10.4%, an increase of 37%, though in line

with the EU average (EU: 36%. (400)

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term **care** as a

percentage of GDP is steadily increasing. In the

AWG reference scenario, public long-term

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 0.9 pps

of GDP, from 1.8% to 2.7%, by 2060. (401) The

"AWG risk scenario", which in comparison to the

"AWG reference scenario" captures the impact of

additional cost drivers to demography and health

status, i.e. the possible effect of a cost and

coverage convergence, projects an increase in

spending of 1.1 pps of GDP by 2060, from 1.8% to

2.9%,. Overall, projected long-term care

expenditure increase is expected to add to

budgetary pressure. However, no sustainability

risks appear over the long run assuming full

implementation of the legislated pension reforms

and the structural primary balance. (402)

System Characteristics

Public expenditure on Long Term Care (LTC)

basically includes three components: i) LTC

services to dependent people provided by the

public health care system, ii) the social component

of LTC provisions provided by municipalities and

iii) attendance allowances (indennità di

accompagnamento). (403)

The overall expenditure accounts for 1.8

percentage points of GDP in 2013 and refers to all

LTC provisions financed by public resources,

(400) The 2015 Ageing Report.

(401) The 2015 Ageing Report.

(402) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(403) Ministero dell'economia e delle finanze - RGS (2015), Le

tendenze di medio-lungo periodo del sistema pensionistico

e socio-sanitario (Mid-long term trends for the pension,

health and long term care systems), Report no. 16.

<http://www.rgs.mef.gov.it/Documenti/VERSIONI/>

Attivit--i/Spesasoci/

Attivita_di_previsione_RGS/2015/Rapporto_n_16_10

-07-2015.pdf

Long-term care systems

2.15. Italy

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regardless of the age of recipients. Since the

incidence of dependency is strongly linked to age,

about 2/3 of the expenditure is directed at the

elderly over 65.

The health component of LTC is provided by

Regions through the local health authorities

(Aziende Sanitarie Locali, ASLs) and accounts for

about 45% of the total public expenditure on LTC.

The social component of LTC services includes a

heterogeneous group of benefits, largely in kind,

mainly provided at a local level by municipalities,

directly or in association. These provisions are

generally means-tested.

Both health and social LTC provisions include

home and residential care services. The admission

to LTC services is based on needs but also on

income levels: co-payments may play a relevant

role and together with the waiting lists tend to

shape the users' profile.

Investment in home care is average compared to other countries, although this type of service is fundamentally and informally supported by migrant care workers that are paid directly by families, also through the use of the attendance allowance. This partly explains the fact that investment in residential care is, on the contrary, relatively weak. Nevertheless, the relatively low coverage of residential care may create tensions on public home care provision insofar as severe cases, that could be treated through different forms of residential care (last stages of Alzheimer or other forms of dementia, etc.), might be left at home.

Attendance allowances are based on cash allowance programme for individuals with very severe disability. They are not means-tested. They are run by the National Institute of Social Security – INPS and financed through general taxation. The attendance allowance accounts for about 500 Euros per month (for 12 months) and is provided directly to the dependent person. Different amounts are foreseen for particular categories of disability such

as the blind or the deaf-mute. Italy spent in 2014 the equivalent of 0.90% of its GDP in LTC cash benefits, of which 0.83% of GDP for attendance allowances alone (404). The share of this type of (404) Ministero dell'economia e delle finanze - RGS (2015), Le tendenze di medio-lungo periodo del sistema pensionistico

care was in 2014 about 47% (43% of GDP spent on attendance allowances) of total LTC expenditure (405), nearly 4/5 of which covers the frail elderly over 65.

Administrative organisation

The actors directly involved in the organisation of LTC services are municipalities, local health authorities - ASLs), nursing homes (residenze sanitarie assistenziali- RSAs) and the National Institute of Social Security (INPS), but other players are involved in planning and funding these services – i.e. the central state, regions and provinces. Additionally, in Italy individual households play an important role in the organisation and provision of long-term care.

Types of care

In Italy, public long-term care for older persons

includes three main kinds of formal assistance:

community care, residential care and cash benefits.

The Italian National Health Service (Servizio

Sanitario Nazionale, SSN) plans and manages,

through local health units (aziende Sanitarie

locali), home health-care services – the so-called

‘integrated domiciliary care’ (by the Assistenza

domiciliare integrata, ADI) – and other health

services provided in residential settings. Personal

social services, both domestic and personal care

tasks provided at home (by the servizi di assistenza

domiciliare, SAD) and institutional social care are

managed at a local level by municipalities,

although this should be planned in coordination

with the ADI. In practice there may be significant

differences between different municipalities in

terms of spending on care provided. Levels of

institutionalisation of patients differs also between

regions. Long-term care is delivered by both public

and accredited private providers of health and

personal social care.

Eligibility criteria

In Italy there is not a single, national legal

definition of persons in need of care to which one

can refer.

e socio-sanitario (Mid-long term trends for the pension,

health and long term care systems), Report no. 16.

(405) Ministero dell'economia e delle finanze - RGS (2015).

Long-term care systems

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To obtain services in kind for LTC, there is not the

same unique system. Indeed, ASLs of the Italian

National Health Service are responsible for

assessing the degree of disability of citizens living

in their catchment area, but their criteria are not

homogeneous. For most health and social services,

the needs assessments are carried out by a

multidisciplinary team of the ASL – in most of

them by the geriatric evaluation units (Unità di

Valutazione Geriatrica), which include doctors,

nurses, social workers and sometimes

administrative employees. This team in some cases

classifies the claimants into categories of need, sets

out the care plan and chooses the type of provider.

However, to obtain the cash benefits provided by

the INPS, each region refers to the same

classification system: a claimant must apply to the

Local Health Authority Service (ASL) in charge of

deciding whether the health requirements (in terms

of disability and dependence) are present, through

its medical commission. If this is the case, the

claimant is referred to an INPS commission, which

makes the final decision.

Co-payments, out of the pocket expenses and

private insurance

Neither the access nor the amount of social

transfers related to the cash benefits programme

(the "Attendance Allowances") are means-tested.

The Attendance Allowance is provided only on the

base of needs. The criteria of access to residential

and home care are somewhat differentiated in the

country as well as the criteria of co-payment.

Practically in the whole country means-testing is applied to define the amount of economic resources households have to provide in order to receive the service.

Role of the private sector

Private providers of long-term care (both for-profit and not-for-profit) have a share of 65% of all institutional long-term care beds.

Private home care is increasingly important in the Italian LTC system, although there are no official data on this aspect. According to the little data available, 6.6% of those aged over 65

(NNA, 2009) received home care privately. Private home care is provided mainly by migrant workers on individual basis: in 2008 it was estimated that around 700,000 migrant workers were employed to provide home care to elderly persons (NNA, 2009).

Formal/informal caregiving

Informal care is extremely important in the Italian social protection system, but the data available are

limited.

Generally speaking, in northern Italy the culture of public (formal) service in LTC is rather widespread, partly owing to the high level of participation by women in the labour market.

These regions – and municipalities – have been making an effort to improve their LTC system, thanks also to their more developed management capabilities and their larger economic resources. In the south, by contrast, the care burden rests mostly on families (informal caregiving), with poor public (formal) support.

Prevention and rehabilitation policies/measures

Rehabilitative health care services, included in the LTC definition, are provided to disabled people at home or in residences, generally as a part of more general assistance programmes related to dependency.

Recently legislated and/or planned policy reforms

The Stability law for 2015 (Law 190/2014) and the

Stability law for 2016 (Law 208/2015) have increased the Fund for dependents in the State budget (Fondo per la non autosufficienza) up to 400 million euro per year and made it permanent as of 2015. Resources in the Fund are transferred to Regions to finance services and benefits in kind for people with severe disabilities.

Furthermore, with the Stability law for 2016 (Law 208/2015), a new Fund (90 million euro per year from 2016) has been set up in the State budget to finance interventions in favour of heavily disabled persons who have no family support. The law which regulates the measures of assistance, care and protection of the disabled is in the process of approval in Parliament.

Long-term care systems

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Challenges

Italy has a system of LTC that focusses on cash benefits as much as on residential and home care.

Based on the current features, the main challenges

of the system appear to be:

- Improving the governance framework: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to deal with cost-shifting incentives across health and care.

- Improving financing arrangements: to determine the extent of user cost-sharing on LTC benefits; to include assets in the meanstest used to determine individual cost-sharing (or entitlement to public support) for B&L costs better reflects the distribution of economic welfare among individuals.

- Providing adequate levels of care to those in

need of care: to adapt and improve LTC

coverage schemes, setting a homogenous needlevel

triggering entitlement to coverage; the

depth of coverage, that is, setting the extent of

user cost-sharing on LTC benefits; to provide

targeted benefits to those with highest LTC

needs.

- Supporting family carers: to establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: to establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: to arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; to create better rules, improving

(and securing) safe care pathways and

information delivered to chronically-ill people

or circulated through the system; to steer LTC

users towards appropriate settings.

- Improving value for money: to invest in ICT

as an important source of information, care

management and coordination; to invest in

assistive devices, which for example, facilitate

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self-care, patient centeredness, and coordination

between health and care services.

- Prevention: to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.
- Improving administrative efficiency.

Long-term care systems

2.15. Italy

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Table 2.15.1: Statistical Annex – Italy

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 1,391 1,449 1,490 1,549 1,610 1,633 1,574 1,606 1,639 1,615 1,607 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 27.4 26.9 27.1 27.8 28.5 27.9 25.6 26.2 26.4 26.1 25.2 26.8 27.6 28.0 28.1 27.9

Population, in millions 57.1 57.5 57.9 58.1 58.2 58.7 59.0 59.2 59.4 59.4 59.7 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : : : : : 1.0 1.0 1.0 1.0 :

Per capita PPS : : : : : 297.1 316.7 328.5 317.8 :

Long-term ***care*** systems

2.15. Italy

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Table 2.15.2: Statistical Annex - continued – Italy

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)."

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 62.1 64.2 66.3 67.0 66.3

Dependency

Number of dependents in millions 4.96 5.52 6.17 6.76 6.89

Share of dependents, in % 8.0 8.6 9.3 10.1 10.4

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.9 2.0 2.2 2.5 2.7

AWG risk scenario 1.9 2.0 2.3 2.7 2.9

Coverage

Number of people receiving care in an institution 319,265 353,596 404,173 471,412 503,845Number of people receiving care at home 822,153 915,927 1,042,981 1,197,286 1,258,118

Number of people receiving cash benefits 2,001,718 2,237,299 2,566,758 2,989,562 3,189,472

% of pop. receiving formal LTC in-kind and/or cash benefits 5.1 5.5 6.1 6.9 7.5

% of dependents receiving formal LTC in-kind and/or cash benefits 63.4 63.6 65.1 68.9 71.9

Composition of public expenditure and unit costs

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Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 51.3 49.7 49.8 49.5 48.6

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 48.7 50.3 50.2 50.5 51.4

Public spending on institutional care (% of tot. publ. spending LTC) 45.7 46.1 46.8 47.6 48.2

Public spending on home care (% of tot. publ. spending LTC in-kind) 54.3 53.9 53.2 52.4 51.8

Unit costs of institutional care per recipient, as % of GDP per capita 85.5 82.4 84.0 84.3 82.8

Unit costs of home care per recipient, as % of GDP per capita 39.4 37.2 37.1 36.5 35.7

Unit costs of cash benefits per recipient, as % of GDP per capita 28.3 28.5 28.6 28.4 28.8

2013

MS Change

2013-2060

EU Change 2013-2060

59.7 11% 3%

4.57 51% 40%

7.6 37% 36%

1.8 50% 40%

1.8 64% 149%

293,848 71% 79%

753,533 67% 78%

1,822,500 75% 68%

4.8 57% 68%

62.9 14% 23%

52.5 -8% 1%

47.5 8% -5%

45.1 7% 1%

54.9 -6% -1%

87.1 -5% -2%

41.4 -14% -3%

28.1 2% -2%

2.16. LATVIA

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General context: Expenditure, fiscal

sustainability and demographic trends

With a GDP of around EUR 23 bn or 14,900 PPS

per capita in 2013, Latvia is below the EU average

GDP per capita of EUR 27,900.

During the coming decennia the population of

Latvia will gradually decline, from 2.0 million

inhabitants in 2013 to 1.4 million inhabitants in

2060. This 31% fall is very different from the EU

average increase of 3%.

Health status

Life expectancy at birth for men and women was,

in 2013, respectively 69.3 years and 78.9 years,

below the EU average (77.8 and 83.3 years

respectively). In 2013 the healthy life years at birth

were 54.2 years (women) and 51.7 years (men) below the EU-average (61.4 and 61.5 respectively). At the same time, the percentage of the Latvian population having a long-standing illness or health problem is higher than in the Union as a whole (39.7% and 32.5% respectively in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2012 10.1%, below the EUaverage (8.7%).

Dependency trends

The share of dependents in Latvia is set to increase over this period from 7.2% in 2013 to 9.5% of the total population in 2060, an increase of 32%. This is slightly below the EU-average increase of 36%.

From 0.14 million residents living with strong limitations due to health problems in 2013, an increase of 8% is envisaged until 2060 to 0.16 million. This is in contrast to the increase in the EU as a whole (40%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a percentage of GDP is set to gradually increase. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a projected increase in spending of about 0.1 pps of GDP by 2060. (406) However, the "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.7 pps of GDP by 2060. Overall, for Latvia no significant short-term risks of fiscal stress appear at the horizon, though some macrofinancial indicators point to possible short-term challenges.

Risks appear to be low in the medium term from a debt sustainability analysis perspective due to the low stock of debt at the end of projections (2026).

No sustainability risks appear over the long run

thanks to the pension reforms implemented in the past. (407)

System Characteristics (408)

Administrative organisation

Latvian legislation stipulates that in a situation

when there is a need for care, municipalities need to organise the provision of services, either by the municipality itself, NGOs or private providers.

LTC is organised in a relatively fragmented way:

services provided for different target groups are organised in different ways and financed from different sources of public financing.

All types of LTC for the elderly (institutional and

residential – such as home care, day centres, etc.)

are the responsibility of municipalities while longterm

institutional social care for adults with mental

disorders and LTC (including both social and

health) of chronic psychiatric patients are the

responsibility of the Ministry of Welfare and the

Ministry of Health.

Public spending on LTC reached 0.2% of GDP in

2010 in Latvia, below the average EU level of 1%

of GDP. 84.8% of the benefits were in-kind, while

15.2% were cash-benefits (EU: 80 vs 20%).

(406) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(407) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eejp/pdf/](http://ec.europa.eu/economy_finance/publications/eejp/pdf/ip018_en.pdf)

ip018_en.pdf

(408) This section draws on OECD (2011b) and ASISP (2014).

Long-term **care** systems

2.16. Latvia

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In the EU, 53% of dependents are receiving formal

in-kind LTC services or cash-benefits for LTC.

This share is with 20.1% lower in Latvia. Overall,

1.4% of the population (**aged** 15+) receives formal

LTC in-kind and/or cash benefits (EU: 4.2%). On

the one hand, low shares of coverage may indicate

a situation of under-provision of LTC services. On

the other hand, higher coverage rates may imply an

increased fiscal pressure on government budgets,

possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 93% of public in-kind expenditure (EU: 61%), 7% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States Latvia seems might have some potential to focus more on home care, which may be cost-efficient. As institutional care is relatively costly, Member States with shares well above the EU levels may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care.

Types of care

In 2014 there were 84 municipal nursing homes for elderly (known as “social care centres” in the Latvian LTC systems) providing care for 5953 recipients. As explained above, nursing homes for elderly are run by local municipalities. There are as well several institutional care homes for the elderly run by the private sector and NGOs. These are often contracted by municipalities to provide services for their recipients, subject to meanstesting

of clients and under a price negotiated with the provider. Additionally, in 2015 there were 28 state owned/financed nursing homes for adults and children with mental disorder with 4431 recipients.

Home care is provided formally by a range of providers, including the social services of municipalities, NGOs, charities, private sector agencies and individuals. The provision of home care encompasses as well other forms of support for the elderly, such as help with daily activities (laundry, delivery of warm meals), assistant service and security buttons that can be activated by the recipient if urgent help is needed. The number of recipients receiving home care has been increasing over the last few years, with a slight fall during the economic crisis, but from 2010 it has grown again. At the end of 2014 there were 12,519 elderly and disabled recipients of home care financed by the municipalities. The majority of the services were provided by carers from the municipal social services.

Alternative forms of long-term care include day

care centres for pensioners and persons with psychosocial disabilities, halfway houses for people with mental disorders, social residential facilities as well as group houses. These services are however relatively underdeveloped.

Recipients of home care and institutional care (except institutional care for people with mental disorders) normally cover the expenses of care. For recipients who live in a household with an average income below the defined "needy" threshold (128 euro per month per person) and who are not dependent on family members or relatives, municipalities will cover all care. Municipalities can however set a higher level income threshold for access free of charge services.

In parallel to formal home care, a great proportion of home care services are provided informally without payment by family members, relatives or neighbours. Municipalities are obliged to provide home care services in situations when the elderly

or disabled person itself or persons' family

members are not able to take care of elderly or disabled person mentioned. If there are family members that are obliged to take care for the person (parents, children, spouse), but the family can't take care for the person themselves, the family members have to cover part of the expenses about the relative in the nursing home.

Finally, the municipalities can decide to provide additional long-term care cash benefits to recipients or to those relatives with caring responsibilities, although they have no legal obligation to do so. Due to this, the amount of support can vary greatly between different municipalities. Care benefit is granted by local governments mostly in cases where they cannot provide the service themselves or in cases where there are several service providers available in the municipality and the client can choose between them. In 2012 about 50% of the municipalities had reported providing some long-term care benefits.

Additionally, there is a universal state benefit for

disabled people introduced in 2008.

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Eligibility criteria

In principle there is no means-testing for access to

home care, although in practice there is some

ambiguity. Local municipalities are legally

required to fully cover long-term care expenses of

the very poor, but due to limited capacity of their

social services they usually decide to provide care

service only for those whose income is below the

officially set poverty threshold line and who are

not dependent on family members. The rest of the

demand for LTC is then taken care of by private

providers or NGOs.

The universal state benefit for disabled people is

granted on the basis of the formal disability status

of the recipient (either Category 1 or Category 2)

and the level of care needed, irrespective. The

assessment is based on the ability of the disabled person to perform daily living activities (based on the Barthel Index of Activities of Daily Living); and it is performed by the State Medical Commission for the Assessment of Health Condition and Working Ability. In December 2012 there were 11,480 recipients of this benefit, 58.3% of whom were aged 65 years and above. The amount of this benefit was set at 142 euro per month in 2013 and was increased by 50% in 2014.

Co-payments, out of the pocket expenses and private insurance

Municipalities have to provide services to everybody who needs them, if the recipient has his own resources (income) or providers, then they need to partially or fully share the costs of this service. The state has defined the amount of money that has to remain in possession of the family after the services received are paid for (the amount of monthly minimum wage for the first family member and half the minimum wage for each next family member). Municipalities can introduce provisions that are more beneficial to the

client. The threshold is set at a very low level, therefore the access to LTC for people with the income above this threshold is limited either by low affordability (especially, if the service is provided by private service providers) or nonavailability of home care services in the community.

If a person needs specialised care in a nursing home, their family members are legally obliged to cover part of the expenses. The sum of money the family member (or members) has to pay depends on their net income – once the bill for the received care services is paid, the family has to have the amount of monthly minimum wage (360 euro in 2014) for the person, and half the minimum wage (180 euro in 2014) for every other person in this family. The municipalities can set more beneficial rules for the families.

Role of the private sector

As LTC recipients in Latvia mostly cannot afford to pay the full cost of care in nursing homes, there

are some municipalities that commission services from private nursing homes. However, this area is still relatively underdeveloped.

Private home care services are available mostly in the cities; even then, costs of the services are too high to afford for the most of the families, depending on the municipality services can be cofinanced.

Depending on the municipality those can be available outside the cities as well, including in more remote areas, organised by service providers.

(409)

Formal/informal caregiving

As explained above, municipalities are also free to grant their own long-term care cash benefits. If the

municipality is unable to provide home care services, it will often grant the benefits in cash to the recipients or their relatives. As a consequence, depending on the municipality financial situation support is granted to care-takers or/and caregivers.

In 2014 only 21 municipalities out of 119 reported spending for financial support to carers; the amount of resources for this purpose has been

growing in recent years: It was 539,000 euro in 2010, 786,000 euro in 2012 and 848,543 euro in 2014. About 50% of municipalities have reported expenditures for financial support to care receivers or carers over the years. Depending on the municipality, support can be granted as a simple cash benefit to the family member providing the informal care or can be formulated as a formal

(409) For example –

<http://www.samariesi.lv/lv/pakalpojumi/aprupe-majasnovados>

<http://www.aprupemajas.lv/pakalpojumi.html>

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payment for care services on the basis of a contract, therefore formalising what was informal care. Most often these types of contracts are made between a neighbour or a relative and the municipality.

Prevention and rehabilitation

policies/measures

Government funded social rehabilitation

programme (14 or 21 days long) for persons with

different functional disorders is available. For

persons above the age 62 (old age pensioners) this

service is available only if persons are still in

employment.

Recently legislated and/or planned policy

reforms

The possible future policy changes are not going to

be targeted towards changes of the long-term care

services, but the Ministry of Welfare is planning to

support more community-based services (primarily

for children and persons with mental disabilities),

deinstitutionalisation – to create more affordable

and more diverse services for the target groups.

Challenges

The main challenges of the system appear to be:

- Improving the governance framework: To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. the provision of long-term care services. To

strategically integrate medical and social services via such a legal framework. To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing taking into account the fiscal constraints. To establish good information platforms for LTC users and providers. To set guidelines to steer decisionmaking at local level or by practising providers. To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation. To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes. To deal with cost-shifting incentives across health and care.

- Improving financing arrangements: To

explore the potential of private LTC insurance as a supplementary financing tool. To consider adjusting the extent of user cost-sharing on LTC benefits.

- Providing adequate levels of care to those in need of care: To adapt and improve LTC coverage schemes, to assess the need-level triggering entitlement to coverage; the breadth of coverage, i.e. the extent of user cost-sharing on LTC benefits; and the depth of coverage, i.e. the types of services included into the coverage; To explore the potential of providing targeted benefits to those potential recipients of LTC care with highest LTC needs. To reduce the risk of impoverishment of recipients and informal carers.

- Encouraging home care: To develop alternatives to institutional care by e.g. encouraging home care and assessing admissions to institutional care or the establishment of additional payments, cash

benefits or financial incentives to encourage

home care taking into account fiscal

constraints; to monitor and evaluate alternative

services, including incentives for use of

alternative settings.

- Encouraging independent living: To

encourage additional provision of effective

home care, tele-care and information to

recipients, as well as improving home and

general living environment design.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care.

- Supporting family carers: Assessing the

possibility to introduce policies for supporting

informal carers, such as through flexible

working conditions, respite care, carer's

allowances replacing lost wages or covering

expenses incurred due to caring, cash benefits

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paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- Ensuring coordination and continuity of

care: To establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care coordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To create better rules, improving (and securing) safe care pathways and information delivered to

chronically-ill people or circulated through the

system. To steer LTC users towards

appropriate settings.

- Changing payment incentives for providers:

To consider a focused use of budgets

negotiated ex-ante or based on a pre-fixed

share of high-need users.

- Improving value for money: To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services. To

invest in ICT as an important source of

information, care management and

coordination.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care. To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

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Table 2.16.1: Statistical Annex – Latvia

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 10 12 14 17 23 24 19 18 20 22 23 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 15.3 15.8 15.9 16.2 15.4 13.9 12.7 13.3 13.8 14.5 14.9 26.8 27.6 28.0 28.1 27.9

Population, in millions 2.3 2.3 2.2 2.2 2.2 2.2 2.1 2.1 2.0 2.0 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : 1.5 1.4 0.2 0.2 0.2 0.2 : : : 1.0 1.0 1.0 1.0 :

Per capita PPS : 151.4 159.1 28.8 28.7 31.4 28.2 32.3 : : : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 4.2 4.0 0.6 0.5 0.5 0.5 0.6 : : : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 75.7 76.0 76.3 76.1 76.2 77.5 77.7 78.0 78.8 78.9 78.9 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 65.3 65.6 64.9 65.0 65.3 66.5 67.5 67.9 68.6 68.9 69.3 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : 53.2 52.5 54.8 54.3 56.0 56.4 56.6 59.0 54.2 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : 50.8 50.8 51.4 51.6 52.6 53.1 53.6 54.6 51.7 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 36.4 36.1 33.6 34.4 34.3 35.6 36.4 36.0 39.7 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 11.1 10.3 9.1 8.2 6.9 7.5 6.7 7.1 10.1 : 8.1 8.3 8.6 8.7

Number of dependents in millions 0.14 0.14 0.14 0.14 0.13

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Share of dependents, in % 7.7 8.7 9.4 9.6 9.5

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.6 0.7 0.7 0.8 0.8

AWG risk scenario 0.8 1.1 1.5 2.3 3.4

Coverage

Number of people receiving care in an institution 10,532 9,914 9,683 9,402 8,821

Number of people receiving care at home 9,121 8,638 8,501 8,305 7,777

Number of people receiving cash benefits 8,764 8,049 7,699 7,566 7,140

% of pop. receiving formal LTC in-kind and/or cash benefits 1.5 1.6 1.7 1.7 1.7

% of dependents receiving formal LTC in-kind and/or cash benefits 19.7 18.8 18.2 18.1 17.9

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 84.6 85.3 85.6 85.9 85.8

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 15.4 14.7 14.4 14.1 14.2

Public spending on institutional care (% of tot. publ. spending LTC) 92.9 92.9 92.9 92.8 92.8

Public spending on home care (% of tot. publ. spending LTC in-kind) 7.1 7.1 7.1 7.2 7.2

Unit costs of institutional care per recipient, as % of GDP per capita 90.0 91.8 91.4 95.5 96.0

Unit costs of home care per recipient, as % of GDP per capita 7.9 8.0 8.0 8.4 8.4

Unit costs of cash benefits per recipient, as % of GDP per capita 21.1 20.9 20.8 21.0 21.1

2013

MS Change

2013-2060

EU Change 2013-2060

2.0 -31% 3%

0.14 -8% 40%

7.2 32% 36%

0.6 22% 40%

0.6 441% 149%

10,741 -18% 79%

9,218 -16% 78%

9,083 -21% 68%

1.4 18% 68%

20.1 -11% 23%

84.8 1% 1%

15.2 -7% -5%

93.0 0% 1%

7.0 2% -1%

92.2 4% -2%

8.1 4% -3%

21.1 0% -2%

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General context: Expenditure projections,

fiscal sustainability and demographic trends

GDP per capita in PPS, at 17,900 PPS per capita is

below the EU average GDP per capita of EUR

27,900 in 2013. Lithuania has a population of

around 3 million inhabitants. Over the coming

decades, the population of Lithuania will gradually

decline, from 3.0 million inhabitants in 2010 to 1.8

million inhabitants in 2060. This 38% fall is very

different from the EU average increase of 3%.

Health status

Life expectancy at birth for both men and women

was, in 2013, respectively 68.5 and 79.6 years,

which is below the EU average (77.8 and 83.3

years respectively). In 2013 the healthy life years

at birth for both sexes were 61.6 years (women)

and 56.8 years (men) below (particularly for men)

the EU-average (61.5 and 61.4 respectively). At

the same time, the percentage of the Lithuanian

population having a long-standing illness or health

problem is lower than in the Union as a whole

(31.2% and 32.5% respectively in 2013). The

percentage of the population indicating a selfperceived

severe limitation in its daily activities

was in 2013 8.2%, below the EU-average (8.7%).

Dependency trends

The share of people depending on others to carry out activities of daily living in Lithuania is almost doubling over this period, from 8.5% in 2013 to 11.3% of the total population in 2060, an increase of 34%. This is slightly below the EU-average increase of 36%. From 0.25 million residents living with strong limitations due to health problems in 2010, an decrease of 17% is envisaged until 2060 to 0.21 million. That is in contrast with the increase in the EU as a whole (40%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a projected increase in spending of about 0.9 pps of GDP by 2060 (410). The "AWG risk scenario",

which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.5 pps of GDP by 2060.

Overall, Lithuania presents no significant risks of fiscal stress over the short run. Likewise, low risks appear in the medium term from a debt sustainability analysis perspective, given the relatively moderate level of public debt, due to the unfavourable projected cost of ageing. Medium sustainability risks also appear for Lithuania over the long run. These risks are primarily related to the strong projected impact of age-related public spending (notably pensions and to a lesser extent healthcare and long-term care). (411)

System Characteristics (412)

In Lithuania there is no unified specific legislation on the provision LTC. Care is granted through different channels: social services, invalidity and sickness services. Social services are provided for

all residents who are in need. Health care is provided on the basis of social insurance and financed by the central government budget, local budgets and the Health Insurance Fund, as well as cost-sharing from the recipient (or their family).

LTC recipients are provided with benefits in kind, and there are also cash benefits for severely disabled people.

Public spending on LTC reached 0.8% of GDP in 2013 in Lithuania, below the average EU level of 1% of GDP. 64.8% of the benefits were in-kind, while 35.2% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC.

This share is with 93.1% higher in Lithuania.

Overall, 7.9% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%), one of the highest shares in the EU. On the one hand, low shares of coverage may indicate a

(410) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(411) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

(412) This section draws on OECD (2011b) and ASISP (2014).

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situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 55.8% of public in-kind expenditure (EU: 61%), 44.2% being spent for LTC services provided at home (EU: 39%).

Administrative organisation

Long-term **care** in Lithuania is organised as a central system at national level supplemented by the municipalities at regional level. The central government is responsible for making long-term national programmes and strategies as well as setting requirements and standards. At the local level, municipalities prepare and implement

municipal programmes aiming at social integration of disabled people, being responsible for the organisation of social services provision, the determination of local need for social services; for the supervision of social services as well as the organisation and provision of primary health care (including nursing hospitals). LTC is provided through day centres, home care services, residential social care institutions and nursing hospitals.

Types of care

Depending on their level of dependency and care needs, disabled people may receive permanent home care (assistance provided for recipients that continue living in their own home) or permanent nursing care in an institutional setting. LTC in the health sector is mostly provided as inpatient care in specialised nursing hospitals or in specific departments in general hospitals. During the period 2005-2010, the number of beds in separate nursing homes in the health care sector increased from

2,735 to 2,835, while the number of hospitals decreased from 59 to 49. During the same period, the total number of nursing beds (both in nursing homes and in other health care facilities) increased from 3,527 to 4,614.

Eligibility criteria

The need for LTC is assessed on the basis of principles of cooperation, participation, complexity, accessibility, social justice, relevance, efficiency, and comprehensiveness. The level of need is assessed on an individual basis of the person's dependency level and potential to develop, taking into account the individual's preferences and needs. The social services are aimed at compensating the level of dependency.

Home care and institutional care may also be provided to disabled people. The level of need of a disabled person is determined by an official list of health conditions. Provision of long-term medical treatment depends on the health condition. In the health care sector, LTC is mostly provided as inpatient services in separate nursing homes or

specialised departments in general hospitals.

Co-payments, out of the pocket expenses and

private insurance

Recipients contribute through cost-sharing to pay

for LTC services in social care homes for elderly

and disabled. No more than 80% of the recipient's

income can be taken as payment. This share can

increase in case the patients' income is above a

certain level. In most cases the difference will be

covered by the central government and local

budgets. Nursing hospital stays are financed by the

Compulsory Health Insurance budget (up to 120

days per year). Longer stays can be paid by

municipalities or by the recipients themselves.

Role of the private sector

In cases where local authorities are not able to

directly provide LTC to a recipient, they may

provide the recipient with 'money for care' that

should enable them to buy the services needed

from private providers. Cash benefits are only paid

directly to the recipient. Compensation for home

care nursing expenses was between 1.5 and 2.5

times the social insurance basic pension and depended as well on the need category of the recipient. Since 1 January 2007, this allowance has been set at 2.5 times the social insurance basic pension for all categories. The compensation for care corresponds to 0.5 times the social insurance basic pension. Cost-sharing of the provision of these services depend on the income of the recipient and/or their family.

Formal/informal caregiving

The recent extension of 'money for care' measures enables informal carers to be financially

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compensated (e.g. by care or attendance allowances) as providers of care for the care they deliver. They can also benefit from some training and social rights, as well as from the recognition that informal carers are also often clients of formal care services, with their own need for support. The

extensive use of both live-in and live-out migrant

care workers is a relatively new trend in LTC

provision. Their status is somewhere between the

two distinct categories of formal and informal

carers, and they may be initially selected by

families on the basis of factors such as

trustworthiness.

Prevention and rehabilitation

policies/measures

Rehabilitation services are paid by the NHIF and

provided by licensed providers. The first

rehabilitation stage comprises those interventions

provided at the health care facility where the

patient is treated and its cost is included in the

price of the treatment. Second stage rehabilitation

is provided in specialised units in general hospitals

as well as in specialised hospitals/sanatoriums.

Rehabilitation units are required to have a

minimum number of beds as well as service

availability of 6 days per week. The third

rehabilitation stage involves rehabilitation either in

an outpatient or tertiary level setting. In 2010 there

were 4 rehabilitation hospitals (with 705 beds in total) and 7 other medical rehabilitation facilities (3 for children and 4 for adults). The number of rehabilitation beds has increased since 2002 from 1092 in 2002 to up to 1378 in 2010. Beds in rehabilitation hospitals have an occupancy rate of at 80% with the Average Length of Stay (ALOS) being about 20 days. In sanatoriums the bed occupancy rate is lower (at 74%), while the ALOS is higher (21 days). About 50 000 inpatient rehabilitation services were provided (15.2 per 1,000 population) in 2010.

Increasing quality and availability of rehabilitation provided in an outpatient setting is one of the goals in the strategic health policy documents. This is being implemented by establishing outpatient rehabilitation units in existing municipal health care facilities and making larger investments in infrastructure, as well as through regulatory measures such as forbidding primary health care providers from referring adult patients to specialised inpatient rehabilitation and instead

directing patient flows towards outpatient rehabilitation. Since 2005 outpatient rehabilitation services have increased by 30% due to implementation of specific projects financed by Structural Funds and the establishment of specialised departments for ambulatory rehabilitation. Furthermore, the outpatient rehabilitation service volume has increased by 20% in 2010 (in comparison with 2009), although with 8.1 treatments per 1,000 population it is only around half of total inpatient services.

Recently legislated and/or planned policy reforms

New Guidelines for Deinstitutionalisation of the Social Care Homes of Disabled Children Deprived of Parental Care and Adult Disabled Persons were approved at the end of 2012. These guidelines are meant to provide the framework until 2030 for transition from institutional LTC towards home care. The aim of deinstitutionalisation is to form consistent and coordinated system care services

that create the conditions for each disabled child

deprived of parental care and each disabled person

to receive individual personalised services and

assistance while remaining involved and

participating in community life without

experiencing social exclusion.

Ambulatory nursing and care services are

relatively recent. Those services have been well

received by the population and have improved

access to long-term care services in Lithuania. As

explained above, 'money for care' measures

enable informal carers to be compensated for the

care they deliver and to benefit from some

training, social rights and recognition as recipients

of care themselves.

As explained above, there is a duration ceiling of

four months (120 days) per year on each inpatient

nursing care episode (financed, as all services

provided in public hospitals, by the National

Health Insurance Fund (NHIF). After this period

patients are transferred to the social care institution

in their municipality. A proposal to increase the duration limit in the inpatient health care nursing departments from 120 to 180 days is currently under negotiation.

From 2010 special compensation for care expenses and special compensation for attendance expenses

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were reduced to the 85% level. Since 2014 there has been a debate about whether to restore to the 100% level.

Challenges

The main challenges of the system appear to be:

- Improving the governance framework: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering

both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- Improving financing arrangements: to explore the potential of private LTC insurance as a supplementary financing tool; to determine the extent of user cost-sharing on LTC benefits.

- Providing adequate levels of care to those in need of care: To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of

coverage, that is, setting the extent of user costsharing

on LTC benefits; and the scope of

coverage, that is, setting the types of services

included into the coverage; To provide targeted

benefits to those with highest LTC needs.

- Encouraging independent living: To provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care; To improve recruitment efforts,

including through the migration of LTC

workers and the extension of recruitment pools

of workers.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- Ensuring coordination and continuity of

care: To establish better coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care coordination responsibilities to providers or to care managers, via dedicated governance structures for care coordination and the integration of health and care to facilitate care co-ordination.

- To facilitate appropriate utilisation across health and long-term care: To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; To steer LTC users towards

appropriate settings.

- Improving value for money: To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; To

invest in ICT as an important source of

information, care management and

coordination.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

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Table 2.17.1: Statistical Annex – Lithuania

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

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GDP, in billion euro, current prices 17 18 21 24 29 33 27 28 31 33 35 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 14.3 15.0 15.5 16.1 17.0 16.1 14.1 15.3 16.2 17.1 17.9 26.8 27.6 28.0 28.1 27.9

Population, in millions 3.4 3.4 3.4 3.3 3.2 3.2 3.2 3.1 3.1 3.0 3.0 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : 0.6 0.6 0.5 0.7 0.7 1.0 1.0 0.9 0.8 : 1.0 1.0 1.0 1.0 :

Per capita PPS : 74.3 76.5 77.9 108.6 111.2 136.0 155.8 155.8 156.3 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 1.9 1.8 1.6 1.9 1.8 2.2 2.4 2.3 2.3 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 77.7 77.7 77.4 77.1 77.2 77.6 78.7 78.9 79.3 79.6 79.6 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 66.4 66.2 65.2 65.0 64.5 65.9 67.1 67.6 68.1 68.4 68.5 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : 54.6 56.5 58.1 59.6 61.2 62.3 62.0 61.6 61.6 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : 51.4 52.6 53.3 54.5 57.2 57.4 57.0 56.6 56.8 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 30.3 33.5 31.7 29.1 29.7 28.1 29.0 29.6 31.2 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 11.3 10.3 9.4 7.6 7.6 7.0 8.0 8.2 8.2 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 32 40 48 56 56 57 61 3,433 3,771 3,851 3,931 4,183

% of pop. receiving formal LTC in-kind : : : 1.2 2.4 3.7 5.0 5.2 5.4 4.3 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of **care** recipients

Providers

Number of informal carers, in thousands : : : : :

Number of formal carers, in thousands : : : : :

Long-term care systems

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Table 2.17.2: Statistical Annex - continued – Lithuania

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)"

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 2.6 2.2 2.0 1.9 1.8

Dependency

Number of dependents in millions 0.26 0.24 0.24 0.24 0.21

Share of dependents, in % 9.6 11.1 12.2 12.3 11.3

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.5 1.9 2.2 2.4 2.3

AWG risk scenario 1.7 2.5 3.3 4.3 4.9

Coverage

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Number of people receiving care in an institution 62,136 58,675 58,561 58,008 51,637

Number of people receiving care at home 73,409 76,277 82,028 91,086 84,736

Number of people receiving cash benefits 110,511 110,689 117,031 122,847 111,679

% of pop. receiving formal LTC in-kind and/or cash benefits 9.3 11.3 12.9 14.3 13.5

% of dependents receiving formal LTC in-kind and/or cash benefits 96.4 100.0 100.0 100.0 100.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 62.6 63.7 62.8 61.1 60.4

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 37.4 36.3 37.2 38.9 39.6

Public spending on institutional care (% of tot. publ. spending LTC) 53.7 51.7 50.2 49.1 49.8

Public spending on home care (% of tot. publ. spending LTC in-kind) 46.3 48.3 49.8 50.9 50.2

Unit costs of institutional care per recipient, as % of GDP per capita 22.1 23.8 23.6 23.6 24.2

Unit costs of home care per recipient, as % of GDP per capita 16.1 17.1 16.7 15.6 14.9

Unit costs of cash benefits per recipient, as % of GDP per capita 13.8 13.9 14.0 14.5 14.8

2013

MS Change

2013-2060

EU Change 2013-2060

3.0 -38% 3%

0.25 -17% 40%

8.5 34% 36%

1.4 65% 40%

1.4 254% 149%

61,304 -16% 79%

66,689 27% 78%

105,541 6% 68%

7.9 71% 68%

93.1 7% 23%

64.8 -7% 1%

35.2 13% -5%

55.8 -11% 1%

44.2 14% -1%

24.0 1% -2%

17.5 -15% -3%

13.6 9% -2%

2.18. LUXEMBOURG

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General context: Expenditure, fiscal

sustainability and demographic trends

Luxembourg has roughly half a million

inhabitants, less than 1% of the EU population. It

is with 2,586 km² the smallest Member State of the

EU. Despite its limited population of 0.5 million

inhabitants, Luxembourg achieves the highest

GDP per capita with 63.6 thousand PPS in 2013, compared to a EU average of 27.9 thousand PPS.

The population is projected to double in the next decades, reaching 1.1 million in 2060. In 2012 public expenditure on LTC was with 1.7% of GDP, above average compared to the overall EU (1.0% of GDP).

Health status

In 2013 life expectancy at birth for both men and women was respectively 79.8 years and 83.9 years and was above the EU average (77.8 and 83.3 years respectively). In the same year, the healthy life years at birth for both sexes were with 62.9 years (women) and 63.8 years (men) also higher than the EU-average (61.5 and 61.4 respectively).

At the same time the percentage of the Luxembourgish population having a long-standing illness or health problem was significantly lower than in the Union as a whole (23.6% and 32.5% respectively) in 2013. The percentage of the population indicating a self-perceived severe limitation in its daily activities has been decreasing in the last few years, and was also lower than the

EU-average (7.8% against 8.7%) in 2013.

Dependency trends

The trends for dependency are increasing for

Luxembourg over the next 50 years, as indicated

by the projections. The number of people living

with health limitations is projected to rise from

0.03 million in 2013 to 0.09 in 2060, an increase of

182% compared to the EU value of 40% for that

period. Similarly the share of the dependent group

in the whole population is foreseen to increase

from 5.8% in 2013 to 7.8% in 2060; however the

corresponding change is broadly in line, slightly

smaller, than the EU average over the same period

(34% vs. the mean of 36%).

Expenditure projections and fiscal sustainability

The expenditure projections reveal a heightened

requirement for spending in the future. (413) As far

as demographic drivers are concerned, the AWG

reference scenario forecasts public expenditure on

long-term care as % of GDP to grow from 1.5 to

3.2. The projected rate for Luxembourg over the

period 2013-2060, 116%, is higher than the EU

average of 40%. The AWG risk scenario, which captures additional cost drivers to demographic and health-status related factors, projects an increase of bigger magnitude from 1.5% to 4.8% of GDP, an increase of 226%, higher than the EU average of 149%.

Over the long run, Luxembourg faces medium risks to fiscal sustainability. These risks are entirely driven by the necessity to meet future increases in ageing costs (notably pension and long-term care expenditures). (414)

System Characteristics

Long-term care insurance was introduced in 1999 as a new pillar of the social security scheme in order to cover needs of assistance and care for activities of daily living. The law was mainly inspired by the long-term care set up in Germany; however the principle of classifying the dependent persons into three levels was not upheld for Luxembourg.

There is a political commitment to the longest possible provision of home care, and the LTC law

is based on four principles: priority to home care,

priority to benefits in-kind, priority to

rehabilitation and prevention measures and

continuity of long-term caregiving.

In 2005 a change in the law defining the long-term

care system adjusted among others the benefits

package and stressed the importance of quality of

service by establishing a dedicated body.

(413) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(414) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

Long-term care systems

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Administrative organisation

Benefits are granted to all persons covered by

sickness insurance and, in addition, there is the

possibility of voluntary insurance. Compulsory

social insurance is financed by social contributions

and by a State contribution, providing benefits to
all persons recognised as being dependent,
regardless of age, income or residence.

Contributions to the long-term care insurance have
to be paid at a rate of 1.4% on all earnings
(including fringe benefits and capital) without any
upper threshold.

The long-term care insurance also covers nondependents.

If a person is not technically classified
as dependent, but needs assistance in the form of
devices (e.g. wheelchair, walking frame) or a
modification of the home (e.g. installation of a
shower on one level) devices to support activities
of daily living, these costs will be reimbursed.

The organisation of care insurance was entrusted
to two bodies, namely the Caisse Nationale de
Santé (CNS) and the Cellule d'Évaluation et
d'Orientation (CEO).

The National Health Insurance (CNS) manages the
long care insurance by managing the budget of the
long term care insurance and by taking the

decision about the care needed by LTC

beneficiaries and defined by the Cellule

d'Évaluation et d'Orientation.

The Cellule d'Évaluation et d'Orientation (CEO)

is a public body under the authority of the Ministry

for Social Security, and is in charge of assessing

the needs in activities of daily living and the other

long term care services and of designing care

plans. Indeed, based on the assessment, it draws up

a structured care plan providing the necessary

assistance to those who request it, depending on

which form of care is the most appropriate, be it

home or institutional care. CEO is also responsible

for quality monitoring and for ensuring that the

provided services match the needs of the

dependent person. Lastly, it also has the task of

providing informing and advising to protected

persons and the bodies concerned on prevention

and care of dependent persons. CEO comprises

three consultation bodies:

- the Advisory Committee, composed of

government representatives, representatives of

beneficiaries and providers, social partners and

the CNS, which consults on the evaluation of

activities run by the care insurance;

- the Commission performance, a consultative

organ composed of government

representatives, representatives of providers

and of a healthcare expert proposed by the

most representative association of patients,

which develops guidelines and standards in

particular in the quality of assistance and care,

technical aids, adaptations to dwellings;

- the concerted action, which gathers to examine

the functioning of the care, assistance and care

networks and care and assistance

establishments and propose improvements in

the system. This brings together the ministers

responsible for family affairs, health and

budget or their representatives, organisations

active in the fields of health, family and social

action, and associations representing the

beneficiaries of long-term care insurance.

Role of the private sector

Market entry to the care-giving sector is restricted

to organisations approved by the Ministry of

Family Affairs based on the fulfilment of certain

quality standards and after adhesion to a

framework contract with the National Health

Insurance, which determines the rights and

obligations for executing the nursing care services.

The following types of care providers, mostly

private, were registered by the end of 2014:

- 22 ambulatory networks offering nursing care

at home;

- 52 day-care institutions;

- 40 intermittent-care centres for alternating

short-term stays;

- 52 nursing homes and so-called integrated

homes for elderly with a mix of dependent and

less-dependent residents.

Long-term care systems

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Eligibility criteria and user choices:

dependency, care needs, income

Benefits under the dependency insurance are

granted if the dependent person is in need of

assistance and care for basic everyday activities for

at least 3.5 hours per week and if his/her

dependency condition is likely to last longer than 6

months or to be irreversible.

Co-payments, out of the pocket expenses and

private insurance

The benefit package for long-term care is offered

without any co-payment. If the beneficiary resides

in an institution, the price of accommodation

(board, lodging, basic domestic services, laundry,

etc.) has to be paid by the resident(415). The

government provides means-tested financial

support for those residents in nursing homes and

integrated homes for the elderly whose own

revenues do not allow to cover for accommodation

and services costs (accueil g rontologique).

Formal/informal caregiving

Beneficiaries **cared** for at home can receive all **care**

services that they are entitled to from professional

carers (so-called in-kind services) or subcontract

up to 10.5 hours per week to informal caregivers of

their choice (generally a family member). Both

types of service provision can be combined, which

represents the most preferred type of **care**

provision (used 69% of the home-**care**

beneficiaries in 2014). Only activities of daily

living and domestic tasks can be performed by an

informal caregiver, whereas psychological support

and counselling can only be offered by

professional caregivers. In 2014, in-kind benefits

for at-home **care** amounted to around EUR 137

million and cash benefits to around EUR 55

million.

There are no figures available on the exact number

of informal caregivers; however in 2014, a total of

6,744 beneficiaries received cash benefits or cash

and in-kind benefits (81.2% of at-home **care**

recipients). The long-term **care** insurance

furthermore takes over the costs for counselling of

the informal caregiver. However, in 2014 only 296

(415) Introducing the concept of “Accueil g rontologique” (cf.

<http://www.legilux.public.lu/leg/a/archives/2004/0070/a070.pdf#page=2>).

persons received counselling activities. Secondly,

if the informal caregiver does not benefit from a

personal pension, the long-term care insurance can

pay the pension contribution of the informal

caregiver (2,940 recipients until 2014). (416)

Prevention and rehabilitation

policies/measures

Over the last years, the networks of home care

services have implemented a new approach to

better link acute and long-term care periods for the

long-term care beneficiaries (“infirmier de liaison

ou infirmier relais”). As ambulatory care

providers, they run offices surrounding hospitals.

They organise patients’ transfers from hospital at

home and inform them about continuity in

caregiving between hospital and networks. The

services are usually privately funded.

Recently legislated and/or planned policy

reforms

The government program of 2009 announced a

review of the operation and the financial

sustainability of the long-term care insurance with

a report published in 2013. Following its

publication, highlighting the financial

sustainability risks related to the current features of

the nursing care insurance, the government has

decided to reform the system to ensure long-term

financial viability, focussing on enhancing costefficiency.

The debate, both in Parliament and

amongst stakeholders started in 2014.

As part of the 2013-2018 government programme,

several activities are planned to support the

revision of services as they are shaped, focussing

on their effectiveness and current volumes. Major

focus areas for revision are the assessments of

degrees of dependence, the evaluation of the

breadth of coverage and coordination between

involved entities, including planning of activities

and of service tariffs.

More specifically, the government set the focus on:

- simplification and standardisation of the

evaluation process by combining LTC services

and introducing flat-rates;

(416) IGSS (2015), "Rapport général sur la sécurité sociale",

Luxembourg.

Long-term care systems

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- new reimbursement possibilities of the LTC

services;

- redefining the roles of informal caregivers and

cash services strengthening the link between

services given and those covered;

- development of a transparent and effective

quality policy and control.

In the short term, the 2014 Law setting State

budget for 2015 financial year calls for a freeze of

tariffs (417) at the 2014 level. In combination with

the other health insurance measures (418), the

expected gain from the budget measures within the

Zukunftspak amounts to 3.5% of expenditures for

services in kind in 2018.

Challenges

Luxembourg has a high quality system of LTC, with high levels of satisfaction among users but important future sustainability issues to tackle. The main challenges of the system appear to be:

- Improving the governance framework: to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term

care services to face the growing demand for LTC service; to establish good information platforms for LTC users and providers;

- Improving financing arrangements: to face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; to foster pre-funding elements, which implies setting aside some funds to pay for future obligations;

- Providing adequate levels of care to those in

need of care: to adapt and improve LTC

coverage schemes, setting the need-level

triggering entitlement to coverage; the depth of

coverage, that is, setting the extent of user costsharing

on LTC benefits and the scope of

coverage, that is, setting the types of services

(417) Measure no. 256 of the New Generation Budget (BNG).

(418) Measure no. 255 of the New Generation Budget (BNG).

included into the coverage; to provide targeted

benefits to those with highest LTC needs;

- Encouraging home care to continue to

monitor and evaluate alternative services,

including incentives for use of alternative

settings;

- Ensuring availability of formal carers: to

seek options to increase the productivity of

LTC workers;

- Changing payment incentives for providers:

to adapt provider payments for LTC, including

the nomenclature of nursing care services, and

consider a focused use of budgets negotiated

ex-ante or based on a pre-fixed share of highneed

users;

- To facilitate appropriate utilisation across

health and long-term care: to arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC;

- Improving value for money: to encourage

competition across LTC providers to stimulate

productivity enhancements; to invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; to

invest in ICT as an important source of

information, care management and

coordination;

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; to employ prevention

and health-promotion policies and identify risk

groups and detect morbidity patterns earlier.

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Table 2.18.1: Statistical Annex – Luxembourg

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 26 28 30 33 37 38 36 40 42 44 47 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 64.3 67.5 66.0 69.2 72.8 69.6 62.3 64.4 65.8 63.3 63.6 26.8 27.6 28.0 28.1 27.9

Population, in millions 0.4 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 1.2 1.4 1.4 1.4 1.3 1.4 1.6 1.6 1.6 1.7 : 1.0 1.0 1.0 1.0 :

Per capita PPS 635.7 753.8 757.2 810.0 810.5 866.1 871.2 896.9 944.7 1013.2 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 3.3 3.4 3.5 3.5 3.7 3.6 3.6 3.7 3.8 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 80.8 82.4 82.3 81.9 82.2 83.1 83.3 83.5 83.6 83.8 83.9 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 74.8 76.0 76.7 76.8 76.7 78.1 78.1 77.9 78.5 79.1 79.8 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : 60.2 62.4 62.1 64.6 64.2 65.9 66.4 67.1 66.4 62.9 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : 59.5 62.3 61.2 62.3 64.8 65.1 64.4 65.8 65.8 63.8 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 23.4 22.6 23.6 26.1 24.4 22.0 21.9 20.9 20.2 23.6 : 31.4 31.8 31.5 32.5

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People having self-perceived severe limitations in daily activities (% of pop.) : 9.1 6.3 6.9 6.7 6.9 6.2 6.0 6.0 5.8 7.8
: 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 3 3 4 4 4 5 4 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 4 5 6 7 7 7 9 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 1.6 1.8 2.0 2.2 2.2 2.3 2.4 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : : 2 2 : : : : :

Number of formal carers, in thousands : : : : : : : : : : :

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Table 2.18.2: Statistical Annex - continued – Luxembourg

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU
2012 EU 2013

GDP, in billion euro, current prices 26 28 30 33 37 38 36 40 42 44 47 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 64.3 67.5 66.0 69.2 72.8 69.6 62.3 64.4 65.8 63.3 63.6 26.8 27.6 28.0 28.1 27.9

Population, in millions 0.4 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 502 503 504 506 507

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Public expenditure on long-term care

As % of GDP 1.2 1.4 1.4 1.4 1.3 1.4 1.6 1.6 1.6 1.7 : 1.0 1.0 1.0 1.0 :

Per capita PPS 635.7 753.8 757.2 810.0 810.5 866.1 871.2 896.9 944.7 1013.2 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 3.3 3.4 3.5 3.5 3.7 3.6 3.6 3.7 3.8 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 80.8 82.4 82.3 81.9 82.2 83.1 83.3 83.5 83.6 83.8 83.9 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 74.8 76.0 76.7 76.8 76.7 78.1 78.1 77.9 78.5 79.1 79.8 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : 60.2 62.4 62.1 64.6 64.2 65.9 66.4 67.1 66.4 62.9 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : 59.5 62.3 61.2 62.3 64.8 65.1 64.4 65.8 65.8 63.8 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 23.4 22.6 23.6 26.1 24.4 22.0 21.9 20.9 20.2 23.6 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 9.1 6.3 6.9 6.7 6.9 6.2 6.0 6.0 5.8 7.8 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 3 3 4 4 4 5 4 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 4 5 6 7 7 7 9 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 1.6 1.8 2.0 2.2 2.2 2.3 2.4 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : : 2 2 : : : : :

Number of formal carers, in thousands : : : : : : : : : : :

2.19. MALTA

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General context: Expenditure, fiscal

sustainability and demographic trends

In 2013, the GDP at market prices in PPS per capita stood at 21,600, which is below the EU average of 27,900. Population was estimated at 421,364 in 2013. It is expected to stay within half a million in the coming decades with the fastest expansion occurring in the next years. Total population is projected to grow from 421,364 in 2013 to around 476,000 million by 2060.

Health status

Life expectancy at birth (84.0 years for women and 79.6 years for men) are above the EU averages of 83.1 and 77.6 years in 2013. Healthy life year expectancy is very high with 72.7 years for women and 71.6 for men in Malta versus 61.8 and 61.6 in 2013 in the EU. The percentage of the population in 2012 having a long-standing illness or other health problem is slightly lower than in the Union

(29.5% in Malta against 32.5% in the EU). The percentage of the population indicating a selfperceived severe limitation in daily activities stands at 3.2%, which is considerably lower than the EU-average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 15 thousand residents living with strong limitations due to health problems in 2013, an increase of 82% is envisaged until 2060 to slightly more less 30 thousand. That is a steeper increase than in the EU as a whole (40%). Also, as a share of the population, the dependents are becoming a bigger group, from 3.5% to 5.7%, an increase of 61%.

This is much more than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the

AWG reference scenario, public long-term

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 1.2 pps

of GDP by 2060 (419). The "AWG risk scenario",

which in comparison to the "AWG reference

scenario" captures the impact of additional cost

drivers to demography and health status, i.e. the

possible effect of a cost and coverage convergence,

projects an increase in spending of 2.2 pps of GDP

by 2060.

Medium sustainability risks appear for Malta over

the long run. These risks are entirely related to the

strong projected impact of age-related public

spending (notably pensions, healthcare and longterm

care) (420).

System Characteristics

Public provision of LTC is provided at both central

and regional levels. In addition, there are also

private residential homes and several day centres

for the elderly and persons with disabilities. There has also been an expansion in the provision of community-based services and residential care places. In 2013, the number of licensed beds in LTC institutions amounted to more than 4,000. Public spending on LTC reached 1.1% of GDP in 2013 in Malta, below the EU average of 1.6% of GDP. 0.8% of GDP was spent on in-kind benefits (EU: 1.3%), while 0.3% of GDP were provided as cash-benefits (EU: 0.3%). It is not clear which role private co-payments for formal in-kind LTC play in the financing of LTC services.

Types of care

The expenditure for institutional (in-kind) services makes up 75% of public expenditure (EU: 80%), 25% being spent for LTC services provided at home (EU: 20%). institutional care is relatively costly, Member States with high shares of spending in institutional care may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care.

(419) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(420) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

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Eligibility criteria and user choices:

dependency, **care** needs, income

Eligibility for long-term **care** in state-run

institutions that cater for permanent residents is

granted to persons over 60 years and/or those with

a disability that leaves them unable to cope with

living within their own home. For all cases,

eligibility is determined by a medical evaluation.

Cash and in-kind benefits are partly means tested

and others are needs-based.

Prevention and rehabilitation measures

Acknowledging the importance of preventive

strategies that target the elderly, a vast range of

community care services exist in Malta, which are intended to enable the elderly to continue living at home and/or in his community. Amongst such services, one can cite as examples: (a) the Telecare Plus Service which allows the subscriber to call for assistance when required; (b) the Meals on Wheels, which supports elderly persons and others who are still living in their own home but who are unable to prepare a decent meal (the Maltese Cross Corps (a non-governmental organisation) in collaboration with the Department for the Elderly and Community Care provide these individuals with a cooked meal); (c) a Handyman Service that helps older adults and persons with special needs to continue living as independently as possible in their own home by offering a wide range of repair jobs; (d) a Home Care Help Service which offers non-nursing, personal help and light domestic work to older adults.

Rehabilitation services are key to reduce pressure on acute care services while delaying

institutionalisation and securing the availability of

beds allocated for long term nursing care.

Rehabilitation services for older people in Malta

are provided by the Department of Geriatrics at the

Rehabilitation Hospital Karin Grech. Older

patients admitted to Mater Dei Hospital are

referred and considered for transfer and further

management as necessary. The aim is to continue

their medical and nursing care, promote

mobilisation and help regain functional

independence. An interdisciplinary team approach

helps provide holistic care and enable reintegration

into the community.

Formal/informal care-giving

Informal care plays an important role in Maltese

society, due to the strong traditional role of the

family. Support measures offered to informal

carers in Malta include a combination of cash

benefits and care leave. Respite and support for

informal carers is provided through benefits in kind

via community services and the "Community

Care Unit". The latter consists of nurses, physiotherapists, occupational therapists, social workers and carers who provide services to clients that are house-bound.

Recently legislated and/or planned policy reforms

Malta is in the process of implementing a National Strategic Policy for Active Ageing (2014-2020), namely within three distinct pillars: active participation in the labour market; social participation; and independent living.

With regards to the first pillar, the policy supports employers to assist the ageing workforce to remain active and productive within the labour market. It also supports the ageing employees to continue to develop their skills in order to meet the changing needs of the work organisation. The second pillar focuses on financial security in old **age**, encouraging active participation in society, which includes volunteering, grandparenthood, and involvement in civic engagement. The policy promotes lifelong learning and offers support to informal carers and inter-generational solidarity.

The third pillar promotes independent living and addresses health prevention and promotion within the community sector. It links acute and geriatric rehabilitation, psychiatric mental health and wellbeing with community care services. It further promotes age-friendly communities to support good quality of life for older people within society. It finally looks at issues on abuse and end-of-life

care.

Several initiatives and programs within this National Strategic Policy have been implemented, or are in the process of being, implemented.

Amongst the initiatives which support participation in the labour market, a seminar was held in collaboration with the Occupational Health and Safety Authority to promote occupational

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health and safety principles that foster the employability of older and age workers up, and

even subsequent, to statutory retirement age. Preretirement

programs were held with different

entities to assist in the smooth transition to

retirement. Several initiatives were held to

encourage social participation by older adults.

Associations of members of day centres and

associations of residents in residential homes have

been set up to strengthen the voice of vulnerable

groups. Active ageing centres have been piloted

and set up on a permanent basis and are now being

transformed into lifelong learning hubs and

collaboration with local councils is ongoing to set

up new Active Ageing hubs which provide

informal learning opportunities to older adults.

Similar sessions are also being held in residential

homes for the elderly.

Collaboration with the Malta Communications

Authority is ongoing and several information and

communication training programs are held based

on best practice models so as to support digital

inclusion. Older adults are encouraged to lead an

independent and active life while support is

provided to those who are frailer. Information

sessions for informal carers of older persons and information sessions for informal carers of persons with dementia were held. Community services, including respite service, are being reinforced to support older adults to continue living in their own homes. Innovative financial support models for personal care at home have been introduced.

Several intergenerational programs are held including programs with Malta College of Arts, Science and Technology (MCAST) and with Eko Skola (Eco-Schools).

With regards to the second and third pillars, the government has also undertaken various measures to enhance long-term care and services for the elderly. These measures include: (a) National minimum standards for residential homes to ensure adequate environment and care of residents; (b) the upgrading of the national Telecare service to Telecare Plus, which now offers valuable add-ons and also the upgrading of the pendant to a 'smart accessory'; (c) a 'live-in carer' programme that provides older persons with full-time carers to

support them to live in the community. Besides, the government also offers a number of respite beds at various care homes to alleviate the responsibilities of informal carers towards their elder relatives. Several of these care homes have also undergone refurbishment and have been upgraded with wi-fi facilities.

In order to raise more awareness, two seminars were held, one on end-of-life care and the other to raise recognition of elder abuse and neglect. Leaflets have been distributed to the general public. Lectures on crime prevention related to older persons are being provided with the cooperation of the Malta Police Force.

In relation to dementia, the measures undertaken include: (a) the setting up of a dementia intervention team to further support persons with dementia in the community; (b) the opening of a dementia day activity centre at St Vincent de Paule Residence for the elderly and a dementia centre in Gozo, the second largest island of the Maltese archipelago; and (c) the introduction of a 24/7

dementia helpline service. Moreover, a pilot programme on dementia friendly communities has been running since January to December 2016 while booklets on dementia were published targeting both the general public as well as informal carers.

In addition to pursuing a policy of active ageing, other policy initiatives are being pursued in order to further improve the provisions of long term care and services offered in the country. Some of the new policy initiatives are hereby reported.

After the publication of the White Paper on National Minimum Standards for care homes for older people, the standards have been published. Enforcing legislation has also been drafted and is being vetted prior to presentation to Cabinet of Ministers;

The National Dementia Strategy has been published and is already being implemented (see measures above).

As part of a comprehensive strategy for elderly care, Malta is also embarking on a new service

dealing with geriatric mental health rehabilitation.

Policy guidelines have been recently adopted at the

state run St. Vincent de Paul Residence for the

elderly, which caters for long term residential and

nursing care. The intention is to have these policy

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guidelines adopted by other government residential

and nursing homes.

Challenges

The main challenges of the system appear to be:

- Improving the governance framework: to set

the public and private financing mix and

organise formal workforce supply to face the

growing number of dependents, and provide a

strategy to deliver high-performing long-term

care services to face the growing demand for

LTC services; to strategically integrate medical

and social services via such a legal framework;

to define a comprehensive approach covering

both policies for informal (family and friends)

carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers.

- Improving financing arrangements: to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to explore the potential of private LTC insurance as a supplementary financing tool.

- Encouraging home care: to develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care.

- Encouraging independent living: to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- Ensuring availability of formal carers: to

determine current and future needs for

qualified human resources and facilities for

long-term care.

- Supporting family carers: to establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: to establish better coordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- Prevention: to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

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Table 2.19.1: Statistical Annex – Malta

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 5 5 5 5 6 6 6 7 7 7 8 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 21.2 21.3 21.8 21.7 22.2 22.3 21.2 21.8 21.4 21.5 21.6 26.8 27.6 28.0 28.1 27.9

Population, in millions 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : : : : : : : : : : 1.0 1.0 1.0 1.0 :

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Per capita PPS : : : : : : : : : : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : : : : : : : : : : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 80.8 81.2 81.4 82.0 82.2 82.3 82.7 83.6 83.0 83.0 84.0 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 76.4 77.4 77.3 77.0 77.5 77.1 77.9 79.3 78.6 78.6 79.6 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : 70.4 69.5 71.1 72.1 71.0 71.3 70.7 72.2 72.7 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : 68.6 68.3 69.2 68.8 69.4 70.1 69.9 71.5 71.6 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 20.1 20.3 24.9 24.7 27.5 28.5 30.4 30.5 29.5 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 3.9 4.0 3.3 2.6 3.7 3.9 4.0 3.1 3.2 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 2 5 7 10 10 10 1 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 9 7 5 4 4 4 8 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 2.7 2.9 3.1 3.3 3.3 3.4 2.2 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : : : : : : :

Number of formal carers, in thousands : : : : : : : : : :

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Table 2.19.2: Statistical Annex - continued – Malta

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 0.4 0.5 0.5 0.5 0.5

Dependency

Number of dependents in millions 0.02 0.02 0.02 0.03 0.03

Share of dependents, in % 4.1 4.8 5.3 5.4 5.7

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.3 1.6 2.0 2.1 2.3

AWG risk scenario 1.3 1.9 2.6 3.0 3.7

Coverage

Number of people receiving **care** in an institution 1,547 2,201 2,788 2,892 3,075

Number of people receiving **care** at home 10,296 14,254 16,667 16,769 18,175

Number of people receiving cash benefits 3,342 3,184 3,136 3,058 2,926

% of pop. receiving formal LTC in-kind and/or cash benefits 3.5 4.3 4.9 4.8 5.1

% of dependents receiving formal LTC in-kind and/or cash benefits 84.9 88.7 91.8 89.8 89.3

Composition of public expenditure and unit costs

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Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 84.6 89.1 91.4 92.1 93.1

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 15.4 10.9 8.6 7.9 6.9

Public spending on institutional care (% of tot. publ. spending LTC) 75.0 75.0 76.0 76.5 76.1

Public spending on home care (% of tot. publ. spending LTC in-kind) 25.0 25.0 24.0 23.5 23.9

Unit costs of institutional care per recipient, as % of GDP per capita 228.7 228.3 234.1 241.4 249.8

Unit costs of home care per recipient, as % of GDP per capita 11.5 11.8 12.4 12.8 13.2

Unit costs of cash benefits per recipient, as % of GDP per capita 25.7 25.6 25.6 25.8 25.7

2013

MS Change

2013-2060

EU Change 2013-2060

0.4 13% 3%

0.01 82% 40%

3.5 61% 36%

1.1 104% 40%

1.1 229% 149%

1,197 157% 79%

8,103 124% 78%

3,290 -11% 68%

3.0 70% 68%

84.5 6% 23%

82.2 13% 1%

17.8 -61% -5%

75.0 2% 1%

25.0 -5% -1%

242.9 3% -2%

12.0 11% -3%

25.6 1% -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

The Netherlands is the sixth smallest country of the European Union, covering 0.8% of the total surface of the EU, where 3.3% of the total population of the EU resides. The 17 million inhabitants generated in 2013 a GDP of roughly EUR 650 billion or 6.5% of the GDP of the Union as a whole. With a GDP per capita of 34,400 PPS per capita, the Netherlands is also among the five richest Member States. Public expenditure on long-term care was in 2013 with 4.2% of GDP the highest in the EU.

Health status

Life expectancy at birth for both men and women

is respectively 79.5 years and 83.2 years, well above the EU average for men and broadly in line for women (77.8 and 83.3 years respectively in 2013). As for the healthy life years at birth however, these are lower than the EU-average for women, with 57.5 years vs EU 61.5, and in line for men, with 61.4 years. At the same time the percentage of the Dutch population having a longstanding illness or health problem is slightly higher than in the Union as a whole (36.2% and 32.5% respectively). The percentage of the population indicating a self-perceived severe limitation in its daily activities is significantly lower than the EU average (5.7% against 8.7%).

Dependency trends

The amount of people living in the Netherlands depending on others to carry out activities of daily living increases significantly over the coming 50 years. From slightly more than 1.2 million residents living with strong limitations due to health problems in 2013, an increase of 50% is envisaged until 2060 to slightly less than 1.9

million. That is a steeper increase than in the EU

as a whole (50% vs 40%). Also as a share of the

population, the dependents are becoming a bigger

group, from 7.4% to 10.9%, an increase of 47%.

This is more than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes in the Netherlands,

the projected public expenditure on long term care

as a percentage of GDP is steadily increasing with

3 percentage points of GDP, from 4.1 percent in

2013 to 7.1 percent in 2060 in the AWG reference

scenario. In this scenario, public long-term

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The "AWG risk scenario", which

in comparison to the "AWG reference scenario"

captures the impact of additional cost drivers to

demography and health status, i.e. the possible

effect of a cost and coverage convergence, projects

an increase in spending of 3.5 pps of GDP by

2060. Overall, projected long-term care

expenditure increase is expected to add to budgetary pressure. Sustainability risks appear over the long run due to the projected increase in age-related public spending, notably deriving from long-term care, and due to the unfavourable initial budgetary position.(421)

System Characteristics

In the Netherlands, a system of public long-term care insurance had been in place since 1968 until recent years. Everyone who lived in the Netherlands was insured under the AWBZ (Algemene Wet Bijzondere Ziektekosten; Exceptional Medical Expenses Act). The AWBZ covered not only care for the elderly, but in principle all chronic care, especially concerning large expenses where insurance on a private market would not be feasible. This act covered at home care and care in institutions for the elderly, institutions for the mentally and physically handicapped and institutions for chronic psychiatric patients. Some form of income-dependent

cost-sharing existed for practically all

LTC services. Moreover, in institutions a

contribution had to be paid for the comprehensive

package of care and board and lodging. However,

the LTC system has recently undergone a major

reform with the aim to promote and support

independent living. The Exceptional Medical

Expenses Act, close to becoming unmanageable

due to the breadth of covered services, was

repealed. Whereas some of those previously

covered under this act are currently covered under

the Health Insurance Act, the Social Support Act

(Wmo) or the Youth Act, the most vulnerable

(421) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

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categories, i.e. those requiring permanent

supervision or 24-hour home care, are entitled to

care services under the Long-Term Care Act

(Wlz).

Administrative organisation

The Exceptional Medical Expenses Act (AWBZ),

in place since 1968, used to cover the bulk of

expenditures, and was a truly national and largely

contribution-based scheme which covered for the

costs of personal and nursing care, guidance,

accommodation and, on certain conditions, even

medical treatment. The basket of covered benefit

had grown to such an extent over time that the

system was close to becoming unmanageable in

the previous setting. In 2007, the provision of

home help for domestic activities was delegated to

the municipalities as part of a broader

decentralising pattern. In 2015, the Exceptional

Medical Expenses Act was repealed and was

replaced in its scope by other acts like the Social

Support Act (Wmo), the Health Insurance Act

(Zvw) and Youth Act. Under the Wmo, the local

authorities are in charge of provision of care and of

the needs assessment, which they formulate based

on an interview with the citizen.

The Long-Term **Care** Act (Wlz), a compulsory

health insurance policy based on solidarity,

focusses a smaller group of high-need individuals.

The amount of the premium is (9.65%) of the

income tax, with a ceiling of 33,589 euros. In

addition, there is an income-dependent co-payment

for adults. This depends on whether the client lives

at home or in a **care** facility, is younger or older

than 65, and is single, married or has a domestic

partner.

Under the Wlz, 31 regional **care** offices

(zorgkantoren) are in charge to provide **care**

purchased with public funds. The agencies are

generally independent subsidiaries of the dominant

health insurer in each region. Although they have a

contracting budget, these agencies have no funds

of their own (except for administrative costs), as

care providers are directly paid from a general

public fund on the basis of contracts concluded

with the agencies. Hence, purchasing agencies bear

no financial risk on purchasing care. All contributions collected under Wlz are deposited into the Long-Term Care Fund, which is managed by the National Healthcare Institute. The central government tops up the fund using public funds if these funds are too low. Although the care costs are paid from the Wlz fund, the care offices are charged with keeping costs within the national and regional budget and with purchasing care as efficiently as possible. In addition, the purchasing agencies can set quality standards and check services invoiced by the healthcare providers match the required standards. All long term care tariffs are regulated by the Dutch Healthcare Authority (NZa). The NZa set maximum prices, where under bargaining between purchasing agencies and providers is allowed.

Types of care

The main recipients of LTC include persons with learning, physical or sensory disabilities, elderly persons and persons with psychiatric disorders.

The Long-Term Care Act (Wlz) covers the most vulnerable categories, i.e. those requiring permanent supervision or 24-hour care nearby, providing a broadly defined set of services including residential care. The Wmo covers a broad package of services, such as personal care, nursing and domiciliary care for individuals that need assistance but are not as severe cases. All these services (including treatment and stay in an institution) were previously delivered under AWBZ.

Most clients apply for care-in-kind, but since the mid-1990s they may also opt for a personal budget to purchase health services privately (under both Wlz and Wmo). The cost explosion of the personal budget scheme from 413 million euro in 2002 to 2.2 billion in 2010 highlights the popularity of this scheme. However, experts worry that it did not equally lower the demand for in-kind care and also tends to crowd out informal care.

In providing support under the Social Support Act,

the local authorities distinguish between general provisions and personalised provisions. General provisions are designed for the community and cover a range of services from recreational activities to transportation. Personalised provisions are designed for a single person; this might include domestic assistance and support. Currently, the assistance is aimed at being able to live independently (for example, help with organising the household or with administration).

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To facilitate the elderly living at home (as opposed to living in a rest home or care institution), the government encourages municipalities, social housing associations and care institutions to build homes adapted to the needs of older people.

Accessible local care also plays a part in helping the elderly to be independent for as long as possible. In order to achieve this, a new focus has been placed on creating local health care networks

where general practitioners, nurses and other care

givers cooperate in offering custom care to

patients.

Eligibility criteria

Patients' eligibility for Wlz care is assessed by an

independent Care Assessment Centre (CIZ). There

are no financial incentives for CIZ: its financial

position is not affected by its decisions. CIZ's task

is to carry out independent, objective and integral

assessments. The procedure is the same for care

reimbursed in cash and for in-kind care. CIZ

adopts certain standards to determine different

'profiles' (packages), in which the eligibility is

determined on the needs and characteristics of the

client.

The centre decides if patients are eligible for Wlz

care and how much care they are entitled to. Once

assessed, patients can opt either to receive in-kind

care (either in an institution or at home) or a cash

benefit ("personal budget") that is roughly

equivalent to 100% of the care related costs of in-kind

care. The cash-reimbursement option is not commonly used for treatment and stay in an institution, except for some small-scale initiatives.

For most of the budget, patients are obliged to be able to show that they did spend the money on

care. Out of the 2016 budget of 19.9 billion, 1.3 billion is the amount attributed to the personal budget. Based on these figures, cash benefits amount to roughly 6,5% of total expenditure for Wlz. (422)

Clients who prefer in-kind care have some say with regard to which care organisation delivers their care, however, the responsibility for (422)

<https://www.rijksoverheid.nl/onderwerpen/prinsjesdag/documenten/begrotingen/2015/09/15/xvivolksgezondheid-welzijn-en-sport-rijksbegroting-2016>, p

138.

organising and purchasing this care remains with the 'zorgkantoren' (regional care offices).

Under the Wmo, the local authorities are in charge of delivery and discuss the client's request for support together with the client. It is then up to the local authority to provide the appropriate type of support and determine how this support is to be organised. People can either contact the local authority or be referred by a GP. A meeting is setup to assess the request for support, in light of factors such as the possibility of the individual to draw on their personal network or on a general provision. Hence the local authority decides whether to accept or reject a request of support, which, if granted, can materialise into services of a personal budget with or without a co-payment. As for the financing, the local authorities receive funds from the central government through the Municipal Fund, which they can allocate to services discretionally. They then pay providers for services or transfer funds to the Social Insurance Bank for personal healthcare budgets. Co-payments, out of the pocket expenses and private insurance

The long-term care system is funded by social security premiums, taxes and co-payments. Since co-payments are income- and wealth-dependent, care users will not run into severe financial difficulties. But it is quite well possible that persons in institutions have to contribute so much that they just have 'a clothing allowance and pocket money' left to spend according to their own preferences. At the same time, the income-related co-payment covers only a small portion of the total costs of long-term care (10% of total for Wlz in 2015).

Role of the private sector

Institutional care providers must be non-for-profit organisations, while the home care market has been opened to for-profit companies.

Formal/informal caregiving

Since its inception in 1968, the Exceptional Medical Expenses Act has been expanded and improved. However, long-term care has also changed in its nature and extent through a whole range of supplementary regulations. This has led to

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an increased demand for care, rising costs and a sizeable bureaucracy. Moreover, it has led to a system that is aimed too much at the provision of

care (by institutions) and which is based too little on the client. In some cases, the appeal for

Exceptional Medical Expenses Act care has

increased needlessly. This neither benefits our society, nor the clients themselves. There is also

the threat of a shortage of care workers. In 2010

there were 1.3 million employees in the care and

welfare sector. According to prognoses from the

National Institute of Public Health and

Environmental Protection (Rijksinstituut voor

Volksgezondheid en Milieuhygiëne or RIVM),

over the coming 15 to 20 years at least 400,000

extra care providers will be needed in the care

sector alone, if the policy remains unchanged. At

the same time, the working population will decline

during the coming decades. To respond to this future challenge, the Netherlands has carried out projections of future needs for carers, and is implementing a reorganisation of the labour force (including financial support for institutions) in long term care. Nonetheless, given the size of the challenge, this area deserves regular monitoring. During the last few years there have been several reports published in which the conclusion is put forward that measures were needed in order to allow the Exceptional Medical Expenses Act to take future developments into account. Besides these reports, analyses have also been compiled within the care sector itself by organisations such as ActiZ (organisation for care providers in the Netherlands) as well as a collaboration of client organisations, which show that the Exceptional Medical Expenses Act does not make sufficient use of the strengths of the people involved and those around them.

Recently legislated and/or planned policy reforms

The main objective of the recent reform of LTC was to guarantee its financial sustainability in future. As such, substantial cuts were made in the system, including the delisting of day care and personal counselling under the Awbz, the closure of residential care for persons with severity package 1-3 and a substantial reduction of the state budget for municipalities to carry out the Wmo. The reform of LTC includes a radical revision of the institutional structure. The most important changes are: (a) decentralisation of non-residential (extramural) long-term care to municipalities under the new Wmo, (b) the abolishment of the Awbz and the simultaneous introduction of the Long-term Care Act (Wlz: Wet Langdurige Zorg) to cover care for the most vulnerable and (c) the transfer of personal care from the Awbz to the Health Insurance Act. In addition, municipalities are attributed the responsibility for most (423) of the youth care as established by the new Youth Law approved in 2014. The reform of LTC has not

only institutional and budgetary implications but also a normative component consisting of three main elements emphasising the importance of individual responsibility, encouraging and promoting independent whenever possible.

The first significant step was the introduction of the Wmo in 2007, a key element of which was the decentralisation of large parts of LTC from the AWBZ to municipalities, which became responsible for household services. Under the arrangement municipalities must give support to people who cannot run a household on their own and participate in social life. Each municipality has discretionary power as regards need assessment, which may lead to unequal access.

Later on, some non-residential (extramural) services in LTC were transferred to municipalities (and insurers), and, together with a 40% cut in the budget for household services, a revision of the Wmo along the following lines was adopted:

- the Wmo stresses individual and social responsibility;

- municipalities are responsible for the implementation of the Wmo;
- the municipalities deliver tailor-made services (maatwerk) based on a need assessment procedure (keuken-tafelgesprek);
- the municipalities decide on whether to assign a personal budget;
- means-testing is forbidden, but municipalities can set co-payments.

(423) Some aspects of youth care are regulated under Zvw or Wlz.

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Wlz (424) is set up as a social health insurance scheme based on income contributions and covering the entire population, who has a right to long-term care subject to need. As for the range of benefits, the Wlz covers either services in-kind or a personal budget or a total package at home (volledig pakket thuis). The system of severityadjusted packages (zorgzwaartepakketten) remains

in place. The new Wlz has many features in common with the former Awbz. For instance, the care offices have been preserved and are in charge of contracting LTC providers, the system of regional budgets is still in place and the Nza sets maximum tariffs.

Challenges

The Netherlands has undergone a major reform of the LTC system to tackle the high projected costs of its long-term care system while preserving quality. As it stands, the main challenges of the system appear to be:

- Improving the governance framework: to ensure a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social assistance

or housing subsidy programmes; to

deal with cost-shifting incentives across health

and care.

- Improving financing arrangements: to

consider reviewing the extent of user costsharing

on LTC benefits or to consider prefunding

elements, which implies setting aside

some funds to pay for future obligations.

- Support independent living: to provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design.

(424) It covers groups of people that need constant assistance due

to the nature of the condition or to the risk that the

condition would worsen with lack of support and

supervision.

- Supporting family carers: to further the

efforts in establishing policies for supporting

informal carers, such as through flexible

working conditions, respite care, carer's

allowances replacing lost wages or covering

expenses incurred due to caring, cash benefits

paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- Ensuring availability of formal carers:

further the efforts in determining current and future needs for qualified human resources and facilities for long-term care, with a focus on ensuring their future availability.

- Ensuring coordination and continuity of

care: to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care coordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- Improving value for money: to invest in

assistive devices, which for example, facilitate

self-**care**, patient centeredness, and coordination

between health and **care** services; to

invest in ICT as an important source of

information, **care** management and

coordination, to encourage competition across

LTC providers to stimulate productivity

enhancements.

- Prevention: to promote healthy ageing and preventing physical and mental deterioration of people with chronic **care**; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier

- Improving administrative efficiency

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Table 2.20.1: Statistical Annex – The Netherlands

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 507 524 546 579 613 639 618 632 643 645 651 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 31.9 33.0 33.9 35.2 36.8 36.5 33.7 34.2 34.9 34.6 34.4 26.8 27.6 28.0 28.1 27.9

Population, in millions 16.2 16.3 16.3 16.3 16.4 16.4 16.5 16.6 16.7 16.7 16.8 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : : 3.3 3.4 3.3 3.5 3.8 3.8 3.9 4.2 4.2 1.0 1.0 1.0 1.0 :

Per capita PPS 347.0 364.6 718.4 765.8 808.0 846.0 842.7 852.3 871.4 949.1 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 2.8 5.4 5.3 5.3 5.3 5.2 5.2 5.4 5.9 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 81.0 81.5 81.7 82.0 82.5 82.5 82.9 83.0 83.1 83.0 83.2 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 76.3 76.9 77.2 77.7 78.1 78.4 78.7 78.9 79.4 79.3 79.5 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 58.8 : 63.5 63.5 64.3 59.9 60.1 60.2 59.0 58.9 57.5 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 61.7 : 65.4 65.2 66.1 62.5 61.7 61.3 64.0 63.5 61.4 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 30.5 32.0 31.6 31.3 32.7 32.6 34.1 34.6 36.2 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 7.8 8.2 8.0 5.8 5.4 5.5 6.2 5.8 5.7 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 123 196 268 340 346 353 383 3,433 3,771 3,851 3,931 4,183

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care at home, in thousands : : : : 499 539 580 621 632 645 544 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 3.8 4.5 5.1 5.8 5.9 6.0 5.5 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : 3,500 : : : : : :

Number of formal carers, in thousands 293 311 301 300 300 296 303 297 289 : : : : : :

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Table 2.20.2: Statistical Annex - continued – The Netherlands

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 17.2 17.6 17.6 17.4 17.1

Dependency

Number of dependents in millions 1.38 1.56 1.73 1.85 1.86

Share of dependents, in % 8.0 8.9 9.8 10.6 10.9

Projected public expenditure on LTC as % of GDP

AWG reference scenario 3.8 4.6 5.8 6.7 7.1

AWG risk scenario 3.9 4.8 6.1 7.1 7.6

Coverage

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care in an institution 436,152 541,367 673,321 764,440 791,945

Number of people receiving care at home 622,895 765,695 900,562 977,113 967,607

Number of people receiving cash benefits 0 0 0 0 0

% of pop. receiving formal LTC in-kind and/or cash benefits 6.2 7.4 8.9 10.0 10.3

% of dependents receiving formal LTC in-kind and/or cash benefits 76.8 83.8 90.8 94.4 94.7

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 100.0 100.0 100.0 100.0 100.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 0.0 0.0 0.0 0.0 0.0

Public spending on institutional care (% of tot. publ. spending LTC) 86.4 86.1 86.4 86.6 87.1

Public spending on home care (% of tot. publ. spending LTC in-kind) 13.6 13.9 13.6 13.4 12.9

Unit costs of institutional care per recipient, as % of GDP per capita 129.5 128.7 132.3 132.0 133.9

Unit costs of home care per recipient, as % of GDP per capita 14.2 14.7 15.6 16.0 16.2

Unit costs of cash benefits per recipient, as % of GDP per capita : : : :

2013

MS Change

2013-2060

EU Change 2013-2060

16.8 2% 3%

1.24 50% 40%

7.4 47% 36%

4.1 74% 40%

4.1 86% 149%

382,744 107% 79%

543,559 78% 78%

0 : 68%

5.5 87% 68%

74.6 27% 23%

100.0 : 1%

0.0 : -5%

86.6 1% 1%

13.4 -4% -1%

156.2 -14% -2%

17.0 -4% -3%

: : -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

GDP per capita in PPS is at 16,800 and below the

EU average of 27,900 in 2013. Poland has a

population of 38.1 million inhabitants. (425) During

the coming decades the population will steadily

decrease, from 38.1 million inhabitants in 2013 to

33.2 million inhabitants in 2060. Thus, Poland is expected to face a considerable decrease of its population by 13%, while the EU average population is estimated to increase by 3%.

Health status

In 2014, life expectancy at birth for both women and men was respectively 81.7 years and 73.7 years and was below the EU average for women and men (83.6 and 78.1 years respectively). In 2013 healthy life years at birth were with 62.7 years (women) and 59.2 years (men) slightly below the EU averages (61.5 and 61.4, respectively) in 2013. The percentage of the Polish population having a long-standing illness or health problem is higher than in the Union (34.1% in Poland versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 8.1%, which is lower than the EU average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 2.6 million

residents living with strong limitations due to health problems in 2013, an increase of 45% is envisaged until 2060 to more than 3.7 million. This applies to the "demographic scenario" of the 2015 Ageing Report, which assumes that the dependent population evolves in line with the total elderly population and all gains in life expectancy are spent in bad health. That is a steeper increase than in the EU as a whole (40%). In a less pessimistic scenario, and assuming that half of the projected gains in life expectancy are spent without disability (AWG reference scenario), the increase in the number of the dependent population is 3.4 million, i.e. a 32% increase (EU: 30%). Also as a share of the population, the dependents are

(425) According to the Central Statistical Office of Poland, the population on 31st June 2015 was 38.45 mln.

becoming a bigger group and an increase of 68% is projected (from 6.7% to 11.2%). This is considerably above the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

AWG reference scenario, public long-term care

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 0.9 pps

of GDP by 2060. (426) The "AWG risk scenario",

which in comparison to the "AWG reference

scenario" captures the impact of additional cost

drivers to demography and health status, i.e. the

possible effect of a cost and coverage convergence,

projects an increase in spending of 1.9 pps of GDP

by 2060. This reflects, that coverage and unit costs

of care are comparatively low in Poland, and may

experience an upward trend in future, driven by

demand side factors.

Overall, projected long-term care expenditure

poses a risk to the medium and long-term

sustainability of public finances. The medium-term

risks are related to the unfavourable initial budgetary position and the projected impact of age-related spending. Over the long run, Poland faces medium risks to fiscal sustainability. These risks are largely due to an unfavourable initial budgetary position, but also to the necessity to meet future increases in ageing costs (notably healthcare and long-term care). (427)

System Characteristics

There is no explicit and separate LTC insurance scheme in Poland. Long-term care is very fragmented and governed by several laws relating to healthcare, social care, family benefits (nursing benefits and nursing allowance), pensions and rehabilitation. The coverage by formal LTC is low, and traditionally, LTC in Poland is provided by

(426) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(427) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

Long-term care systems

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family members at home. LTC is financed by both the public and private stakeholders. There are copayments

on formal care, and the large provision

of care is delivered informally by family members, and as such privately financed.

Polish legislation includes two kinds of separate

LTC benefits: cash benefits and in kind benefits.

Institutional care in Poland is split between the

health sector (financed by the National Health

Fund) and social assistance sector (financed

indirectly by the Ministry of Family, Labour and

Social Policy). The range of health benefits

available to a patient in need of care is contained in

the provisions of the regulation of the Ministry of

Health on the guaranteed benefits (under the

general health insurance), which determines the

list and the terms of the guaranteed benefits of the

above range.

Public spending on LTC reached 0.8% of GDP in

2013 in Poland, below the average EU level of

1.6% of GDP. Near 56% of the benefits were in-kind,

while 44% were cash-benefits (EU: 80% vs.

20%). Thus, Poland seems to have below average

usage of cash benefits.

In the EU, 53% of dependents are receiving formal

in-kind LTC services or cash-benefits for LTC.

This share is with 70% higher in Poland. However,

overall only 56% of these dependents receive

formal in-kind LTC services, while the remainder

44% receive a low amount of cash benefits.

Overall, 4.6% of the population (aged 15+) receive

formal LTC in-kind and/or cash benefits (EU:

4.2%). On the one hand, low shares of coverage

may indicate a situation of under-provision of LTC

services. On the other hand, higher coverage rates

may imply an increased fiscal pressure on

government budgets, possibly calling for greater

needs of policy reform.

The expenditure for institutional (in-kind) services

makes up 81% of public in-kind expenditure (EU:

61%), 19% being spent for LTC services provided

at home (EU: 39%). Thus, relative to other

Member States Poland has a focus on institutional

care (within formal care), which may not be

surprising regarding the fact that overall little

formal care is provided.

Types of care

Both cash benefits and in kind benefits are

available. Cash benefits include, apart from social

assistance benefits which may also be awarded to

persons in need of long-term care in difficult

situations: medical care supplement and medical

care allowance. Three types of care are provided:

home care, semi-residential care and residential

care. Home care includes in-kind nursing and

social services as well as cash benefits. Semiresidential

care is provided in day care and support

centres. Residential care is provided via the "social

assistance house", care and treatment facilities,

nursing and care facilities.

Eligibility criteria and user choices:

dependency, care needs, income

In the health sector eligibility is defined by

severity of needs measured on a Barthel scale of

disability. In the social assistance sector, and

according to the act on the social assistance, the

provided care services are granted on the basis of a

special individual needs evaluation (including age,

level of illness or disability). If the recipient of

care requires all day care, which cannot be

provided at home, then that person is entitled to a

place in the social assistance house. The income

situation of the patient, however, is taken into

account to determine the payment for care services

and charge for staying in the social assistance

house. The eligibility for other in-kind benefits

which are provided within the social assistance is

defined by an income-test. Nursing care for people

treated in residential homes is provided as a part of

general costs of stay. There is co-payment for this

kind of services, residents cover 70% of the

accommodation costs, and except for people with

the lowest income (in this case co-payment is

shared with the municipality).

Persons requiring long-term care are also entitled to long-term care in home settings and institutional long term care. The Ministry of Health regulate access to guaranteed benefits in this field. In accordance with the regulations, a patient, who in the "Barthel scale" received 40 points or less, shall be awarded general health services within the institutional or home-based long term care.

Patients cared for in institutional settings are financed by the National Health Fund. For institutional care there is also co-payment in place,

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with the patients' coverage of the accommodation costs set at 70%.

A nursing allowance is given to entitled recipients as a supplement to an old-age, disability or survivors' pension at the age of 75 or more, as well

as to recipients of any age entitled to an old-age, disability or survivors' pension being incapable to do paid work and requiring assistance in daily activities. All in-kind benefits require a copayment by the patient. A medical care allowance is given to recipients fulfilling specific health and age criteria, independent of family income. These are children up to the age of 16 requiring permanent assistance from another person and children older than 16 years with a moderate degree (level) of disability that began at the age of entitlement to the family allowance, or disabled persons with severe degree (level) of disability, without age criteria, and persons aged 75 or more. Recently legislated and/or planned policy reforms

Since 2012, there have not been any significant reforms in the field of LTC within social assistance. Minor changes referred to the standardisation of certain services which regulate rehabilitation activities and others. However, income criteria were verified in 2015 (verification

is done every three years) as well as the amount of cash benefits from social assistance. As a result, increased income criteria were established: for a single person – 634 PLN (increase by 92 PLN; 17% in comparison to the previous criteria established in 2012); for one person in a family – 514 PLN (increase by 58 PLN; 12.7%). The regulation came into force on October 1, 2015.

Income criteria form the basis of social assistance benefits, the amount of payment for care services and payment for staying in residential care homes.

Planned reforms in the field of LTC include among the others the further standardisation of services, support for the development of services and the

creation of daily care residential homes for the elderly and dependent in local environments,

reconstruction of institutional care buildings,

including modifying the method of payment for

staying in residential care homes. In 2013, 86,967

persons benefited from social assistance benefits,

whereas the number of people benefiting from

residential care homes equalled 84,112.

Moreover, several government resolutions were passed in the 2013-2015 period related to "elderly people policy". Among others, these include:

The Cabinet Resolution No 237 from December 2013 on establishing The Governmental Programme for Social Activity of Elderly People in 2014-2020: the aim of the Programme for Social Activity of Elderly People (The ASOS Programme) is to improve the quality and level of living of elderly people to allow ageing with dignity through social activity. It is planned that the State budget will spend 280 mln PLN in total on this Programme during the 2014-2020 period.

The Cabinet Resolution No 238 from December 2013 on accepting the Assumptions of the Long-Term Elderly People Policy in Poland in 2014-2020: this resolution fulfils the commitment stated in the Governmental Programme for Social Activity of Elderly People in 2012-2013 (The ASOS Programme). The ASOS Programme is the first nation-wide programme prepared on such a large scale, designed for elderly people and cross

generational cooperation.

The Cabinet Resolution No 34 of from March

2015 on establishing a multi-year programme

“Senior-WIGOR” in 2015-2020: the strategic aim

of the programme is supporting elderly people

through subsidising the activities of the local

government units intended to develop networks of

Day Care Centres “Senior-WIGOR”. Special focus

of the programme is on local government units

which have low income or high fraction of elderly

people in the total population or have no

infrastructure of social services for providing care

services for the elderly outside their home. It is

planned that the state budget will allocate 370 mln

PLN in total on this programme during the 2015-

2020 period.

Challenges

Poland has a relatively fragmented system of LTC,

with low coverage and a large provision of

informal care that is privately financed. The main

challenges of the system appear to be:

- Improving the governance framework: to

establish a coherent and integrated legal and

governance framework for a clear delineation

of responsibilities of state authorities with

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respect to the provision of long-term care

services; to set the public and private financing

mix and organise formal workforce supply to

face the growing number of dependents, and

provide a strategy to deliver high-performing

long-term care services to face the growing

demand for LTC services; to strategically

integrate medical and social services via such a

legal framework; to define a comprehensive

approach covering both policies for informal

(family and friends) carers, and policies on the

formal provision of LTC services and its

financing; to establish good information

platforms for LTC users and providers; to share

data within government administrations to

facilitate the management of potential

interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- Improving financing arrangements: to face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to explore the potential of private LTC insurance as a supplementary financing tool.

- Providing adequate levels of care to those in need of care: to adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user costsharing on LTC benefits; and the scope of coverage, that is, setting the types of services

included into the coverage; to reduce the risk of

impoverishment of recipients and informal

carers.

- Encouraging home care: to develop

alternatives to institutional care by e.g.

developing new legislative frameworks

encouraging home care and regulation

controlling admissions to institutional care.

- Ensuring availability of formal carers: to

determine current and future needs for

qualified human resources and facilities for

long-term care.

- Supporting family carers: to establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: to establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: to steer LTC users

towards appropriate settings.

- Improving value for money: to invest in ICT

as an important source of information, care

management and coordination.

- Prevention: to promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; to employ prevention

and health-promotion policies and identify

risk groups and detect morbidity patterns

earlier.

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Table 2.21.1: Statistical Annex – Poland

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 192 205 245 273 314 364 315 362 380 389 395 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 12.7 13.1 13.5 14.1 15.1 15.0 14.7 15.7 16.3 16.7 16.8 26.8 27.6 28.0 28.1 27.9

Population, in millions 38.2 38.2 38.2 38.2 38.1 38.1 38.1 38.0 38.1 38.1 38.1 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.3 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 0.4 : 1.0 1.0 1.0 1.0 :

Per capita PPS 31.0 42.7 46.2 49.6 54.0 56.8 58.9 68.1 72.5 80.0 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 1.0 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 78.8 79.2 79.3 79.7 79.8 80.0 80.1 80.7 81.1 81.1 81.2 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 70.5 70.6 70.8 70.9 71.0 71.3 71.6 72.2 72.5 72.6 73.0 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : 66.9 62.9 61.5 63.0 62.5 62.3 63.3 62.8 62.7 : 62.6 62.1 62.1 61.5

People having a long-standing illness or health problem, in % of pop. : : 32.2 32.6 32.1 30.9 32.8 33.6 34.1 34.5
34.1 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 2.3 6.3 6.9 6.6 7.4 7.9 7.3 7.5 8.1 : 8.1 8.3 8.6 8.7

Coverage (Based on data from Ageing Reports)

Number of people receiving **care** in an institution, in thousands : : : 46 73 100 127 130 133 86 3,433 3,771 3,851 3,931 4,183

% of pop. receiving formal LTC in-kind : : : 0.1 0.2 0.3 0.5 0.5 0.5 0.5 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of **care** recipients

Providers

Number of informal carers, in thousands :: 1,214 :::::::::::::::

Number of formal carers, in thousands : : : : :

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Table 2.21.2: Statistical Annex - continued – Poland

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

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2020 2030 2040 2050 2060

Population projection in millions 38.4 37.5 36.2 34.8 33.2

Dependency

Number of dependents in millions 2.79 3.14 3.49 3.58 3.72

Share of dependents, in % 7.3 8.4 9.6 10.3 11.2

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.9 1.1 1.3 1.5 1.7

AWG risk scenario 1.0 1.3 1.7 2.1 2.7

Coverage

Number of people receiving care in an institution 98,245 116,858 143,286 154,708 164,923

Number of people receiving care at home 135,206 161,532 198,372 216,039 231,057

Number of people receiving cash benefits 1,735,589 1,962,179 2,272,236 2,420,029 2,531,404

% of pop. receiving formal LTC in-kind and/or cash benefits 5.1 6.0 7.2 8.0 8.8

% of dependents receiving formal LTC in-kind and/or cash benefits 70.5 71.3 74.9 77.8 78.8

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 56.5 57.8 57.6 58.2 60.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 43.5 42.2 42.4 41.8 40.0

Public spending on institutional care (% of tot. publ. spending LTC) 81.1 80.8 80.3 80.1 79.8

Public spending on home care (% of tot. publ. spending LTC in-kind) 18.9 19.2 19.7 19.9 20.2

Unit costs of institutional care per recipient, as % of GDP per capita 161.8 162.0 152.3 156.8 164.0

Unit costs of home care per recipient, as % of GDP per capita 27.4 27.8 26.9 27.9 29.6

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Unit costs of cash benefits per recipient, as % of GDP per capita 8.7 8.7 8.8 9.0 8.9

2013

MS Change

2013-2060

EU Change 2013-2060

38.1 -13% 3%

2.56 45% 40%

6.7 68% 36%

0.8 112% 40%

0.8 235% 149%

85,891 92% 79%

118,136 96% 78%

1,583,250 60% 68%

4.6 90% 68%

69.7 13% 23%

56.0 7% 1%

44.0 -9% -5%

81.3 -2% 1%

18.8 8% -1%

164.0 0% -2%

27.5 8% -3%

8.6 4% -2%

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General context of long-term care system:

Expenditure, fiscal sustainability

In 2013, Portugal's GDP was around EUR 170 bn

or 20,300PPS per capita, below the EU average

GDP per capita of EUR 27,900. The population of

Portugal is estimated to be around 10 million

inhabitants in 2013. Over the coming decades it is

projected to fall gradually to 8.2 by 2060. This

decrease of 22% contrasts with the expected

increase of 3% for the EU as a whole.

Health status

Life expectancy at birth for men and women was,

in 2013, respectively 77.6 years and 84 years,

close to the EU average (77.65 and 83.3 years

respectively). In 2013 the healthy life years at birth

were 62.2 years (women) and 63.9 years (men)

below the EU-average (61.5 and 61.4

respectively). At the same time, the percentage of

the Portuguese population having a long-standing

illness or health problem is higher than in the

Union as a whole (39.8% and 32.5% respectively

in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2013 9.3%, far above the EU-average (8.7%).

Dependency trends

The share of dependents in Portugal is set to increase from 8.5% in 2013 to 13.4% of the total population in 2060, an increase of 57%. This is well above the EU-average increase of 36%. From 0.89 million residents living with strong limitations due to health problems in 2013, an increase of 57% is envisaged until 2060 to 1.1 million.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care (LTC) as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a projected increase in spending of about 0.4 pps

of GDP by 2060. (428) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.1 pps of GDP by 2060.

Overall, for Portugal no significant short-term risks of fiscal stress appear at the horizon, though some variables point to possible short-term challenges.

Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the still high stock of debt at the end of projections (2026) and the high sensitivity to possible shocks to nominal growth and interest rates.

No sustainability risks appear over the long run thanks to the pension reforms implemented in the past and conditional on maintaining the government structural primary balance at a level as high as forecasted by the Commission services for

2017 (close to 2% of GDP) well beyond that year.

(429)

System Characteristics (430)

Public long-term care is provided through

residential structures for elderly (ERPI - Estrutura

Residencial para Pessoas Idosas) and Long-term

Care National Network (RNCCI - “Rede Nacional de Cuidados Continuados Integrados”).

The ERPI were designed to provide temporary or

permanent accommodation for persons at

retirement age, without autonomy and without

need of continuous access to nursing and medical

care, therefore promoting a healthy ageing and

higher quality of life.

The ERPI is managed by the Ministry of Labour,

Solidarity and Social Security and is financed by

budget transfers and a monthly user co-payment

determined by a percentage of the per capita

(428) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(429) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

(430) This section draws on OECD (2011b) and ASISP (2014).

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household income, variable between 75% to 90%,

according to the user dependency degree.

The following table shows the number of

agreements and users of ERPI in December 2015:

Table 2.22.1: Number of agreements and users by degree
of dependency

Source: Portugal Ministry of Finance

The Long-term **Care** National Network (RNCCI -

“Rede Nacional de Cuidados Continuados

Integrados”) was established in 2007. Its aim is to

provide post-acute health **care** and social assistance

for persons who are dependent (whether this is due

to **age** and/or illness) who are referred to it by

hospitals as well as health primary **care** units. It is

under the coordinated jointly by the Ministries of

Health and of Social Solidarity.

Since the beginning of RNCCI, monitoring reports are published twice a year including analysis of its structure, processes and outcomes. This is based on a mandatory minimal data set for all levels of the system.

Public spending on LTC reached 0.5% of GDP in 2011 in Portugal, below the average EU level of 1.0% of GDP. 99.3% of the benefits were in-kind, while 0.7% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC.

This share is with 34.1% lower in Portugal.

Overall, 2.9% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 31.8% of public in-kind expenditure

(EU: 61%), 68.2% being spent for LTC services

provided at home (EU: 39%).

Administrative organisation

As explained above, from 2007 onwards, the

provision of both long-term health care and social assistance to dependent persons made vulnerable

by age and/or disease has been fostered by the

RNCCI and coordinated by Ministries of Health

and of Social Solidarity.

The RNCCI is responsible for monitoring both the

health care provided by units within the network as

well as the quality of their organisation. It has

defined standards and measures of quality and

audits them on a regular basis, in parallel with the

assessment and review of recipient satisfaction and

claims. Units and teams in the network are

periodically evaluated by regional coordination

teams. The RNCCI employs more than 3,000

professionals, coached through a comprehensive

training plan. The five regions, through the

Regional Coordinating Teams (ECR) in

conjunction with the Local Coordination Teams

(ECL), have the skills to ensure the criteria application relating to the referral of users to the Long Term Care National Network (RNCCI) circuit, ensuring continuous monitoring of providers to improve aspects related to its structure, process and results, to consolidate good practices, obtain autonomy gains and guarantee continuity of care beyond the permanence in the network, sharing information with other health and social services and discharge support.

In complying with the "Strategy for Quality" set by RNCCI, some actions have been progressively implemented in order to improve the system. Thus, it is important to have periodic monitoring visits conducted by the ECL provision units, in which the parameters, contained in the consensual follow-up grids, agreed between the Health Ministry and the Social Security, are checked. These grids are related with the definitions of values, goals and key factors, as well as the assessment of compliance with the agreements and the appropriate use of the resources units. It is a

battery of measurable items from which it is

possible to develop a plan of ECL feasible

recommendations. One of the main constraints

pointed out, regarding the organisation of these

teams, relates to the fact that the elements of ECL

No. Agreements for users with 2nd degree of dependency 470

No. users with 2nd degree of dependency identified on

agreements for users with 2nd degree of dependency 3717

No. Agreements exclusively for users with 2nd degree of

dependency (1 agreement for Alzheimer's patients) 46

No. users of agreements exclusively for users with 2nd

degree of dependency (the agreements for Alzheimer's

patients is for 30 users)

1845

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perform functions other than those assigned to

RNCCI, both in of Health and Social Security. The

population covered by the ECL can be different

according to the different regions. The ECL are

present in all Health Center Groupings (ACES)

and in some cases they also exist in some

extensions of these groupings.

Considering the importance that training plays in developing the skills of professionals, RNCCI has developed, since the beginning of the network, several training events regarding coordination, monitorisation, referral and care. Thus, there were several training courses organised by the Regional Health Authorities, Social Security Institute and District Centres. The training provided, with different pedagogical approaches, covered 17,147 graduates and totalled 9,748 hours of training, according to the following table.

Table 2.22.2: Number of training courses, hours and graduates per year

Source: Portugal Ministry of Finance

The decrease in training hours since 2011 relates to certain management constraints by the financing entity who delayed the implementation of training for subsequent years. On the other hand, the need to invest in some training areas, including coordination and functioning of the network, decreased, due to the network consolidation and

also due to financial restraints and limitations in

human resources influence the dynamics of the

courses.

Training carried out the following themes, among

others: Skills and strategies in the development of

RNCCI; Work Methodologies in LTC;

Organization and operation of the RNCCI units/

teams; Bioethics; Training professionals in

inpatient reference units; Implementation of the

Status of Resources Law in RNCCI; Continuous

Improvement in LTC; Quality evaluation and

auditing; Dementia in LTC; Assessment and

intervention in situations of elderly violence and

mistreatment; Palliative Care: Basic course of

Palliative Care, Intervention in Grief and Loss;

Respect for Human Dignity in RNCCI; Chronic

Pain; Geriatrics and Gerontology; Clinical

Training in geriatric syndromes, treatment of

wounds / pressure ulcers, compression therapy and

noninvasive ventilation; Clinical Risk

Management in LTC; Prevention and Control of

Infection in LTC; Individual Intervention Plan;

Nutritional intervention in LTC; Implementation

of International Classification of Functionality

(ICF); Diabetes in LTC.

Types of care

RNCCI offers a range of formal care on the basis

of diversified coordinated interventions that take

place in different types of RNCCI units. It

provides convalescence care, post-acute

rehabilitation services, medium and long-term

care, home care and palliative care.

The network operates according to a

purchaser/provider split. The portfolio of

institutional care services within RNCCI by

typology is shown in Table 2.22.3, where it can be

seen that long and medium term care are largely

the predominant types of care.

Table 2.22.3: Portfolio of institutional long-term care services

(2008-15)

Source: Portugal Ministry of Finance

Compared to 2012, the number of medical

inpatients grew 31%, up to a total of 7,759. This growth is explained by the increase in the type of the long duration and maintenance units (ULDM – Unidade de Longa Duração e Manutenção) admittance and Palliative care units (UCP), with ULDM representing 74.7% of total new beds. Currently ULDM beds represent 57% of the beds available for admission.

Institutional care services within RNCCI are provided by a range of agents: non-profit organisations (75.3% of the bed supply), by private health and residential care facilities, by SNS public hospitals and by other health care units as shown on Table 2.22.4. All must act within common

Training

courses Training hours Graduates

2007 75 345 3312

2008 246 1752 1842

2009 110 908 2756

2010 138 1208 2331

2011 141 2238 2404

2012 67 1475 1443

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2013 38 543 1075

2014 51 951 1113

2015 24 328 871

Total 890 9748 17147

Type of services No. places

31/12/2008

No. places

31/12/2010

No. places

31/12/2012

No. places

31/12/2015

Changes

2015/12

Convalescence 530 682 867 764 -12%

Medium term care 922 1,497 1,820 2,306 27%

Long-term care 1,325 2,286 3,031 4,411 46%

Palliative care 93 160 193 278 44%

Total 2,870 4,625 5,911 7,759 31%

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technical standards and their services are

subsidised by the state.

Table 2.22.4: Providers of institutional long-term care

Source: Portugal Ministry of Finance

In 2015, the development of medical inpatient responses in RNCCI, based on services hired with Private Institutions of Social Solidarity (IPSS – Instituições Privadas de Solidariedade Social), represents 78% of all agreements (75% in the previous year), representing the hiring of 5,845 beds , about 75% of supply.

Within the private institutions of social solidarity (IPSS), the Holy Houses of Mercy (SCM - Santas Casas da Misericórdia) represent 53% of all agreements, with 3,799 contracted beds, representing about 49% of the total.

In hospitals, specialised teams (EGA – Equipas de Gestão de Altas) prepare patient discharge by referral to other settings.

Home Long-Term Care Multidisciplinary Teams

(ECCI - Equipas de Cuidados Continuados

Integrados) provide local primary health care and

social support to patients not requiring a stay in institutions, and are coordinated by “community

care” units (UCC – Unidade de Cuidados

Continuados) within the local health organisations

(ACES - Agrupamentos de Centros de Saúde).

Long-term **Care** at home is provided by ECCL.

Referral routes are defined at a central level in order to enable interdisciplinary teams to operate consistently at regional and local level in referring patients in according to the capacity of the local network as well as with the personal and therapeutic profiles of recipients.

Table 2.22.5: RNCCI referring teams, by region

Source: Portugal Ministry of Finance

Most EGA (86%) were built in the pilot phase (2006-2007), being noted as one of the key factors that contributed to the success of RNCCI, existing 76 referring teams in hospitals, by the end of 2014.

Since hospitals have been aggregated in Hospital Centers (CH – Centros Hospitalares) and Local Health Units (ULS – Unidades Locais de Saúde), the number of EGA are being adjusted to this

reorganisation, but are existing in all hospitals.

The reform of primary health care initiated the implementation of Health Centers referring teams, thus constituting a benchmark circuit, and by the end of 2014, there were 521 referring teams and by the end of 2015, there were 613 (RNCCI nonpublished data).

Table 2.22.6: Number of ECCL and vacancies in 2015

Source: Portugal Ministry of Finance

The number of vacancies as shown on table 2.22.6

depends on human resource allocation to the

ECCL. The total number of vacancies in RNCCI

(Home Care and inpatient units) at the end of 2015

is 14,344, representing 740 places per 100.000

inhabitants with equal or more than 65 years,

shown in table 2.22.7.

Table 2.22.7: Number of ECCL and vacancies in 2015

Source: Portugal Ministry of Finance

No. of

agreements No. Beds No. of

agreements No. Beds

National Health Service (SNS) 26 443 15 299

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Charities (IPSS) 238 5,194 261 5,845

of wich:

SCM 169 3,596 177 3,799

other 69 1,598 84 2,046

Private sector 52 1523 60 1,615

Total 316 7,160 336 7,759

2014 2015

EGA - ACES

pilot experiment 2014 2014

North 20 23 227

Center 17 18 87

Lisbon and Tagus Valley (LVT -

Lisboa e Vale do Tejo) 21 27 117

Alentejo 5 5 55

Algarve 2 3 35

Total 65 76 521

EGA - hospitals

North 82 1,673

Center 72 1,062

Lisbon and Tagus Valley (LVT -

Lisboa e Vale do Tejo) 63 2,136

Alentejo 37 549

Algarve 32 1,165

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Total 286 6585

Number of ECCI Number of vacancies

Region Inhabitants aged ≥

65 years Nº Beds

Beds/ 100.000

Inhab. ≥ 65 Years

end 2015

Nº Vacancies

Home Care

N.º Vacancies

Home Care/

100.000 Inhab. ≥

65 Years end 2015

Total Vacancies

Total Vacancies/

100.000 Inhab. ≥

65 Years end 2015

Norte 631.439 2177 345 1673 265 3850 610

Centro 393.338 2271 577 1062 270 3333 847

LVT 696.815 2020 290 2136 307 4156 596

Alentejo 128.427 765 596 549 427 1314 1023

Algarve 87.769 526 599 1165 1327 1691 1927

TOTAL 1.937.788 7759 400 6585 340 14344 740

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"Home Long Term Care Multidisciplinary Teams"

were created in 2009, through the reform of

primary health care. These teams depend directly

from ACES.

Eligibility criteria: dependency, care needs,

income

Long-term benefits are means-tested. Although

there is an assessment of need, there is no

minimum dependency criterion above which longterm

care is provided.

Co-payments, out of the pocket expenses and

private insurance

The financial responsibilities of the public sector

are shared between the Ministry of Health and the

Ministry of Labour, Solidarity and Social Security.

The cost-sharing required by the Long-term Care

National Network is determined by the

government (Decree Law No. 101/2006, 6 June 2006, Article 12) and co-financed by both the health and social security sectors (Portaria No. 994/2006, 19 September 2006) according to the type of service. Thus, the Ministry of Health finances the costs of health care provision, while care recipients make co-payments for the social care received. The care recipient will have to contribute a co-payment according to the individual's or his/her family's income (see Despacho Normativo No. 34/2007, which specifies the conditions for which social security will pay and the amount).

From the beginning, the RNCCI is the first response with full implementation of the financing model based on family differentiation by social security. The family differentiation financing, which involves the attribution of a contribution to the user depending on the income of the household, has allowed greater equity and social fairness.

In 2013, the amount per day defined as the cost

with social support for care of medium duration and rehabilitation units (UMDR – Unidade de Média Duração e Reabilitação) was EUR 19.81 and for the long duration and maintenance units (ULDM – Unidade de Longa Duração e Manutenção) was EUR 30.34. Monitoring and follow-up made showed that on average the contribution of social security was EUR 11.31 per day of hospitalisation by patient in UMDR and EUR 17.14 in ULDM, i.e. 57.11 % and 56.50%, respectively, of the cost was paid by social security(431).

Prevention and rehabilitation policies/measures

Prevention and rehabilitation are performed by the health care system.

Recently legislated and/or planned policy reforms

Implementation of a contracting process

A working group was created (Ministerial Order No. 1981/2014 of 7 February) with the purpose of presenting a national strategy which contributes to

the achievement of excellence levels in the response that is given to users. This strategy should encourage the adoption of procedures that contribute to improved levels of quality of care provide and to foster a culture of commitment, responsibility and assessment of results in the RNCCI.

The implementation of contracting processes with the LTC providers should allow to match the adequacy of care to the needs of people who are dependent and to foster the consolidation of the RNCCI, based on an expansion and sustainable development in financial terms and also consistent with its mission.

The working group presented a proposal with a set of measures on the implementation of the contracting process with the RNCCI LTC providers; study the different methods of payment applied to LTC; propose initiatives that promote improved quality of care in RNCCI and enhance the gains for users, and; promote the participation of various actors.

Strengthening the outpatient component

There is commitment to push forward the outpatient component of RNCCI through the implementation of "Day and Promotion of Autonomy Units" (UDPA - Unidades de Dia e de (431) ISS, IP data.

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Promoção da Autonomia) and strengthen of

"Home Long Term Care Multidisciplinary Teams"

(ECCI), making them effective, as opposed to institutionalisation of patients as recommended internationally.

Therefore, it is planned to return the underlying intervention principles of the ECCI creation, i.e. focusing on the integration dimension / joint health and social support, which will enable complementarity with a more effective impatient response as the already existing ones, namely UMDR and ULDM, as well as promoting higher mobility of users in the case of discharge

preparations, and ensuring continuity of care.

Regarding UDPA, these units may contribute to maintaining at home and at their usual environment people who are currently referred to other types of network. These units can also have a quality response to the needs of the population, if they are directed towards to a more specialised support in the area of dementia. This is an issue of proximity, so its implementation should be based on knowledge of the territory, accessibility, issues of economic and preferences of patients and family.

Quality and continuous improvement

On the one hand, a national project to encourage quality, that ensures the specific regional characteristics, is useful, using common indicators and methodologies as a way that will increase the understanding of the reality of LTC, introducing benchmarking techniques, and developing measures of continuous improvement, among others.

On the other hand, evaluation and monitoring of

quality parameters is useful as it provides information to users and family, allowing putting into practice the principle of preference and also the informed choice principle, as well as the development of strategies concerning the rights of long term care users.

Paediatric long-term care

A working group was created (Ministerial Order No. 11420/2014 of 11 September) with the purpose of presenting a national strategy which contributes to the achievement of excellence levels in the response of this age group. The working group presented the final report by the end of 2014, focusing responses at home and ambulatory level with multidisciplinary teams, and inpatient facilities of medium term duration for those that cannot be cared at home or in ambulatory care.

The implementation has begun in 2016.

Adult Mental health long-term care

It is planned to implement a network of care, from long-term home care to institutional settings,

connected to Local Mental Services (SLSM – Serviços locais de saúde Mental), aiming to respond to the different needs of this population.

The implementation is set to begin in 2016.

Challenges

The main challenges of the system appear to be:

- Improving the governance framework: To establish a coherent and integrated legal and governance framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of RNCCI services and its financing; To establish good information platforms; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; To share data between government administrations; To improve administrative efficiency; To deal with costshifting incentives across health and care.
- Improving financing arrangements: To face

the increased RNCCI costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private RNCCI insurance as a supplementary financing tool; To determine the extent of user cost-sharing on RNCCI benefits.

- Providing adequate levels of care to those in need of care: To adapt and improve RNCCI coverage schemes, setting the need-level triggering entitlement to coverage; the breadth

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of coverage, that is, setting the extent of user cost-sharing on RNCCI benefits; and the depth of coverage, that is, setting the types of services included into the coverage; To reduce the risk of impoverishment of recipients and informal carers.

- Further encouraging independent living: To

continue providing effective home care, telecare

and information to recipients, as well as

improving home and general living

environment design.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care; To seek options to increase the

productivity of LTC workers.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: Establish better co-ordination of **care**

pathways and along the **care** continuum; To facilitate appropriate utilisation across health and long-term **care**; To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute **care** use for RNCCI; To create better rules, improving (and securing) safe **care** pathways and information delivered to chronically-ill people or circulated through the system; To steer RNCCI users towards appropriate settings.

- Changing payment incentives for providers:

To consider fee-for-service to pay RNCCI

workers in home-**care** settings and capitation

payments; To consider a focused use of

budgets negotiated ex-ante or based on a prefixed

share of high-need users.

- Improving value for money: To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; To

invest in ICT as an important source of

information, care management and

coordination.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

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Table 2.22.8: Statistical Annex – Portugal

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 146 152 159 166 175 179 175 180 176 168 170 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 19.4 19.4 20.3 20.7 21.2 20.7 19.8 20.5 20.4 20.7 20.3 26.8 27.6 28.0 28.1 27.9

Population, in millions 10.4 10.5 10.5 10.5 10.5 10.6 10.6 10.6 10.6 10.5 10.5 502 503 504 506 507

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Public expenditure on long-term care

As % of GDP 0.3 0.3 0.3 0.3 0.4 0.4 0.4 0.4 0.5 : : 1.0 1.0 1.0 1.0 :

Per capita PPS 49.1 53.5 58.5 61.0 65.8 72.9 79.2 85.0 90.0 : : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 0.7 0.7 0.8 0.8 0.9 0.9 0.9 1.0 : : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 80.8 81.8 81.5 82.5 82.5 82.7 82.8 83.2 83.8 83.6 84.0 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 74.2 75.0 74.9 75.5 75.9 76.2 76.5 76.8 77.3 77.3 77.6 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 61.8 52.4 57.1 57.9 57.9 57.6 56.4 56.7 58.6 62.6 62.2 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 59.8 55.4 58.6 60.0 58.5 59.2 58.3 59.3 60.7 64.5 63.9 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 32.2 32.2 30.9 33.2 33.3 34.1 33.9 34.7 37.1 39.8 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 13.0 12.2 11.6 12.9 12.0 10.9 9.4 9.3 9.0 9.3 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 62 61 60 60 61 62 23 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 140 124 109 93 95 96 14 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 1.9 1.8 1.6 1.4 1.5 1.5 0.4 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

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Number of informal carers, in thousands : : : : : : : : : : :

Number of formal carers, in thousands : : : : : : : 11 : : : : :

Long-term care systems

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Table 2.22.9: Statistical Annex - continued – Portugal

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 10.1 9.8 9.4 8.8 8.2

Dependency

Number of dependents in millions 0.96 1.03 1.10 1.13 1.10

Share of dependents, in % 9.4 10.6 11.8 12.8 13.4

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.5 0.6 0.7 0.8 0.9

AWG risk scenario 0.6 0.7 1.0 1.5 2.6

Coverage

Number of people receiving care in an institution 24,409 26,652 29,382 30,890 29,932

Number of people receiving care at home 14,358 15,127 16,642 17,526 17,234

Number of people receiving cash benefits 293,150 323,348 363,413 400,603 417,809

% of pop. receiving formal LTC in-kind and/or cash benefits 3.3 3.7 4.4 5.1 5.7

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% of dependents receiving formal LTC in-kind and/or cash benefits 34.7 35.3 37.2 39.8 42.3

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 99.3 99.3 99.3 99.3 99.3

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 0.7 0.7 0.7 0.7 0.7

Public spending on institutional care (% of tot. publ. spending LTC) 31.9 31.7 31.0 30.4 29.7

Public spending on home care (% of tot. publ. spending LTC in-kind) 68.1 68.3 69.0 69.6 70.3

Unit costs of institutional care per recipient, as % of GDP per capita 66.4 63.7 65.5 68.6 69.1

Unit costs of home care per recipient, as % of GDP per capita 240.9 241.3 257.6 277.3 284.6

Unit costs of cash benefits per recipient, as % of GDP per capita 0.1 0.1 0.1 0.1 0.1

2013

MS Change

2013-2060

EU Change 2013-2060

10.5 -22% 3%

0.89 23% 40%

8.5 57% 36%

0.5 86% 40%

0.5 461% 149%

22,744 32% 79%

13,962 23% 78%

267,581 56% 68%

2.9 95% 68%

34.1 24% 23%

99.3 0% 1%

0.7 7% -5%

31.8 -7% 1%

68.2 3% -1%

66.8 3% -2%

233.3 22% -3%

0.1 0% -2%

2.23. ROMANIA

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General context: Expenditure, fiscal

sustainability and demographic trends

GDP per capita in PPS is at 12,700 and far below the EU average of 27,900 in 2013. Romania has a population of 20 million inhabitants. During the coming decennia the population will steadily decrease, from 20.1 million inhabitants in 2013 to 17.4 million inhabitants in 2060. Thus, in Romania the population is expected to decrease by 13%, while it is expected to increase at the EU level by 3%.

Health status

Life expectancy at birth for both women and men is respectively 78.7 years and 71.6 years in 2013 and is below the EU average for women and above the EU average for men (83.3 and 77.8 years respectively). Healthy life years at birth are, with 57.9 years (women) and 58.6 years (men), far below the EU-averages (61.5 and 61.4, respectively). The percentage of the Romanian population having a long-standing illness or health problem is considerably lower than in the Union (19.5% in Romania versus 32.5% in the EU). The percentage of the population indicating a selfperceived severe limitation in daily activities stands at 8.3%, which is lower than the EUaverage (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase over the coming 50 years. From 1.5 million residents living with strong limitations due to health problems in 2013, an increase of 36% is envisaged until 2060, to slightly more than 2

million. That is a less steep increase than in the EU

as a whole (40%). However, due to the population

decline, when measured as a share of the

population, the dependents are becoming a bigger

group, from 7.7% to 12%, an increase of 56%.

This is more than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

"AWG reference scenario", public long-term

expenditure is driven by the combination of

changes in the population structure and by a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of about 0.9 pps

of GDP by 2060 (432). The "AWG risk scenario",

which in comparison to the "AWG reference

scenario" captures the impact of additional cost

drivers to demography and health status, i.e. the

possible effect of a cost and coverage convergence,

projects an increase in spending of 3.2 pps of GDP

by 2060. This reflects the fact that coverage and

unit costs of care are comparatively low in Romania, and may experience an upward trend in future, driven by demand side factors. Sustainability risks appear for Romania over the long run. These risks derive primarily from the unfavourable initial budgetary position, compounded by age-related public spending, notably for healthcare and long-term care (433).

System Characteristics

There is no explicit and separate long-term care insurance scheme in Romania. Long-term care is fragmented and governed by several laws relating to healthcare, social assistance, pensions and rehabilitation. In most cases, families take care of elderly and dependent people. Medical long-term care needs are covered mostly in the formal health care sector.

Most formal long-term care responsibilities are assumed by local authorities. Financing is provided via central and local resources. NGOs

play an important role in the delivery of services.

At the central level, financing is shared by the state

budget and the National Health Insurance Fund

(NHIF), with the latter providing resources for

medical services. As from the second half of 2015,

Romania has eliminated the restriction of social

services to be provided by the profit-making

companies. Consequently, the potential of the

private social service suppliers, related to the long

term **care** of dependent elderly, is likely to

increase. Out-of-pocket-payments complement

public resources; their level is set by the local

authorities

(432) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(433) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

Long-term **care** systems

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Depending on the nature of the benefit provided,

financing is ensured from the public pension

budget (pensions- only disability pensions), the

NHIF (medical services), local budgets (home

attendance), and the funds allocated from the state

budget to the Ministry of Labour, Family, Social

Protection and Aged Persons (MLFSPAP)

(indemnities and allowances).

Public spending on long-term care was at the level

of 0.7% of GDP in 2013, much below EU average

of 1.6% of GDP. Virtually 100% of this

expenditure was spent on in-kind benefits (EU:

80%), while close to zero spending was provided

via cash-benefits (EU: 20%). Thus, Romania does

basically not use cash benefits.

In the EU, 53% of dependents are receiving formal

in-kind LTC services or cash-benefits for longterm

care. This share is, with 55%, higher in

Romania. Overall, 4.3% of the population (aged

15+) receive formal long-term care in-kind and/or

cash benefits (EU: 4.2%).

The expenditure for institutional (in-kind) services

makes up only 12% of public in-kind expenditure

(EU: 61%). Thus, relative to other Member States,

Romania has a very low focus on institutional care,

which is basically reflecting the low coverage with

formal institutional care benefits. However, lots of

long-term care spending may not be accounted for

as such, as it will be provided in acute care

settings, thus being effectively registered as health

care expenditure. In this case, there is need to shift

long-term care patients out of acute care to longterm

care service providers.

Types of care

According to Law 17/2000, which regulates the

social care for elderly persons, long-term care for

this category provides three types of community

services: temporary or permanent home

attendance; temporary or permanent attendance in

a residential centre; attendance in daily centres.

Home attendance implies the provision of:

household services (prevention of social

marginalisation and supporting social

reintegration, legal and administrative counselling, payment of certain household obligations, catering, etc.); socio-medical services (personal hygiene, socio-cultural activities, etc.); medical services (medical consultations, medicine administration, etc.).

According to the Social Assistance Law no. 292/2011, any dependent person is entitled to personal care services, provided according to his/her individual need of aid to accomplish the daily activities, to his/her family according to the socio-economic situation and to his/her personal life environment. Long-term care represents the personal care lasting more than 60 days. The beneficiaries of personal care are the elderly, the disabled and those suffering from chronic disease.

Personal care services can be also organised and provided in an integrated form, together with medical care, rehabilitation and environment adaptation or other recovery services.

The home care services are presently financed

from the National Health Insurance Fund, while the expenditures incurred with the social services of personal care are ensured from the local or central budget (in the forms of indemnification/payment of salaries for professional formal care givers and/or finance/subsidies for the services rendered by authorised providers), as well as from the contributions made by the beneficiaries.

The long-term care of disabled persons is coordinated by the National Authority for the Protection of Persons with Disabilities, coordinated by the Ministry of Labour, Family, Social Protection and Aged Persons (MLFSPAP).

Disabled persons are entitled to cash benefits (monthly disability indemnity, additional monthly personal budget, allowances and other indemnities and facilities) and in-kind services of social and medical nature. Two types of services are provided: primary, aimed at preventing the social exclusion, and specialised, to ameliorate the

individual's physical and psychical capacities.

Concretely, the services provided to disabled

persons are the same as those delivered to aged

people.

There are no cash benefits for the informal care of

elderly people, but only for persons who are

officially recognised as having a disability.

However, older persons who are chronically or

terminally ill or have multiple comorbidities may

be assessed as presenting a degree of disability. In

Long-term care systems

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this way, they can benefit from care allowances

usually granted to a member of their family. The

personal care involving aid for accomplishing the

daily instrumental activities is provided by formal

caregivers, only if no informal or volunteer

caregivers are available.

Eligibility criteria and user choices:

dependency, care needs, income

Benefits and services for the persons with disability are granted on the basis of a certificate attesting the disability, as follows: cash benefits and social services granted in home or in residential/day care centres. The person with a severe disability, according to its nature and to the specific care needs can be assisted at home by a family member or another person employed as a personal assistant. The recipient of care can also choose to receive a monthly indemnity.

Local budgets can grant allowances to the spouse or a relative who takes care of a dependent older person, but this is subject to local initiative. If the carer is salaried and working part-time, he can apply for support equal to the remainder of the salary - equivalent of a gross monthly salary of a newly qualified social assistant with an intermediate level of training. In all cases, the allowance is granted on the basis of a means-tested assessment.

Prevention and rehabilitation measures

The Strategy for Social Inclusion of Persons with

Disabilities 2014-2020 is under development, continuing and developing the approach initiated by the National Strategy for protection, integration and social inclusion of people with disabilities in the period 2006 – 2013.

The Strategy is related to the principles and obligations arising from the ratification of the UN Convention on the Rights of Persons with Disabilities. The UN Convention provides a framework for developing public policy and for the modernisation of practices, tools and methods to support the community, leading to a barrier-free participation of persons with disabilities in society, to a dignified and fulfilled life in the community.

The Strategy for Social Inclusion of Persons with Disabilities 2014-2020 will be divided into nine main areas of reference: 1. accessibility; 2. participation; 3. equality; 4. quality community based services; 5. employment; 6. education and training; 7. social protection; 8. health; 9 international cooperation.

There is a medium-term (2016-2018) operational action plan underway to be legislated, in order to

fulfil the objectives established by the National Strategy for Promoting the Active Ageing and the Protection of Elderly 2015-2020 and by the Strategic Action Plan 2015-2020. This project stipulates, among others, the establishment within the Ministry of Labour of a long-term care Directorate, responsible for the coordination, planning and settlement of all the LTC issues and for the joint development (together with the Ministry of Health) of a “Long-term Care Program”, which is meant to integrate all the benefits and services afferent to LTC, under a unified system.

Formal/informal caregiving

Most of dependent elderly people benefit from the

care services provided inside the family.

Recently legislated and/or planned policy

reforms

The National Health Strategy 2014-2020 outlines a

specific objective on increasing access to quality

services for rehabilitation, palliative and long-term

care adapted to the demographic ageing

phenomenon and epidemiological profile of

morbidity:

13. Development of a National Plan for medium

and long term on rehabilitation services,

palliative care and long-term including a

- review of the regulatory framework regarding the organisation, financing and delivery of long term;

- hospital network reorganisation of chronic diseases and medical and social assistance;

Classification of providing long-term care

according to levels and types of care, with

continued reduction for acute beds at more than

4.5 per 1,000 population in 2020;

diversification of funding sources, including

Long-term care systems

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accessing funds repayable grants or by

supporting private investment in the

construction and equipping of facilities

providing long-term care.

14. The implementation of the National Plan on

rehabilitation services, palliative and longterm

care:

- identification, reorganisation and rehabilitation

of infrastructure at county / regional / national

hospitals for chronic diseases, rehabilitation

centres according to demographic and

morbidity profile;

- increasing access to programs of continued

medical education and training diversified and

focused on development needs and the needs of

patients served;

- development and implementation of standards

of organisation and operation, practice

guidelines and procedures "therapeutic

pathway;

- developing mechanisms, standards or

institutional work procedures that ensure an

integrated and effective response on the

rehabilitation of adults and children with

disabilities.

Challenges

Romania has a relatively fragmented system of

long-term care, with low coverage and a large

provision of informal care that is privately

financed. The main challenges of the system

appear to be:

- Improving the governance framework: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services, such opening the market for private providers of care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and

policies on the formal provision of LTC

services and its financing; to establish good

information platforms for LTC users and

providers; to set guidelines to steer decisionmaking

at local level or by practising

providers; to use care planning processes,

based on individualised need assessments,

involving health and care providers and linking

need assessment to resource allocation; to share

data within government administrations to

facilitate the management of potential

interactions between LTC financing, targeted

personal-income tax measures and transfers

(e.g. pensions), and existing social-assistance

or housing subsidy programmes; to deal with

cost-shifting incentives across health and care.

- Improving financing arrangements: to face

the increased LTC costs in the future e.g. by

tax-broadening, which means financing beyond

revenues earned by the working-age

population; To foster pre-funding elements,

which implies setting aside some funds to pay

for future obligations; To explore the potential

of private LTC insurance as a supplementary

financing tool.

- Providing adequate levels of care to those in

need of care: To adapt and improve LTC

coverage schemes, setting the need-level

triggering entitlement to coverage; the depth of

coverage, that is, setting the extent of user costsharing

on LTC benefits; and the scope of

coverage, that is, setting the types of services

included into the coverage as stipulated in the

actual legislation. To provide targeted benefits

to those with highest LTC needs; to reduce the

risk of impoverishment of recipients and

informal carers

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care; to improve recruitment efforts,

including through the migration of LTC

workers and the extension of recruitment pools

of workers.

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- Supporting family carers: to establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: To establish better coordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To create better

rules, improving (and securing) safe care

pathways and information delivered to

chronically-ill people or circulated through the

system; To steer LTC users towards

appropriate settings.

- Improving value for money: to invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; to

invest in ICT as an important source of

information, care management and

coordination.

- Prevention: to promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; to employ prevention

and health-promotion policies and to identify

risk groups and detect morbidity patterns

earlier.

Long-term care systems

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Table 2.23.1: Statistical Annex – Romania

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 53 61 80 98 125 142 120 127 133 134 144 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 13.5 13.4 12.8 13.4 13.7 13.8 12.5 12.6 12.7 13.0 12.7 26.8 27.6 28.0 28.1 27.9

Population, in millions 21.6 21.5 21.4 21.3 21.1 20.6 20.4 20.3 20.2 20.1 20.0 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.5 0.5 0.5 0.5 0.5 0.7 0.8 0.8 0.7 0.6 : 1.0 1.0 1.0 1.0 :

Per capita PPS 34.5 38.2 40.8 48.1 56.3 79.0 88.0 92.4 87.2 84.2 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 1.5 1.5 1.5 1.4 1.7 1.9 1.9 1.8 1.7 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 74.8 75.1 75.4 76.1 76.8 77.5 77.7 77.7 78.2 78.1 78.7 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 67.4 67.8 68.4 69.0 69.5 69.7 69.8 70.0 70.8 70.9 71.6 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : : 62.5 62.9 61.7 57.5 57.0 57.7 57.9 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : : 60.5 60.0 59.8 57.3 57.4 57.6 58.6 : 61.8 61.7 61.5 61.4

People having self-perceived severe limitations in daily activities (% of pop.) : : : 7.1 6.7 6.7 7.1 8.2 8.0 8.3 : 8.1
8.3 8.6 8.7

Coverage (Based on data from Ageing Reports)

Number of people receiving **care** in an institution, in thousands : : : 86 97 108 119 121 122 189 3,433 3,771 3,851 3,931 4,183

Number of people receiving **care** at home, in thousands : : : 120 142 164 186 189 192 204 6,442 7,296 7,444
7.569 6.700

% of pop. receiving formal LTC in-kind : : : 1.0 1.2 1.3 1.5 1.5 1.6 2.0 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of **care** recipients

Providers

Number of informal carers, in thousands : : : : :

Number of formal carers, in thousands : : : : :

Long-term ***care*** systems

2.23. Romania

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Table 2.23.2: Statistical Annex - continued – Romania

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

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Population projection in millions 19.7 19.0 18.4 17.9 17.4

Dependency

Number of dependents in millions 1.62 1.77 1.90 2.00 2.08

Share of dependents, in % 8.2 9.3 10.3 11.1 12.0

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.8 1.0 1.2 1.4 1.6

AWG risk scenario 0.9 1.1 1.7 2.4 3.9

Coverage

Number of people receiving care in an institution 203,088 217,519 243,638 261,342 287,329

Number of people receiving care at home 222,667 244,389 280,163 306,177 342,537

Number of people receiving cash benefits 491,451 523,717 575,315 616,482 669,935

% of pop. receiving formal LTC in-kind and/or cash benefits 4.7 5.2 6.0 6.6 7.5

% of dependents receiving formal LTC in-kind and/or cash benefits 56.6 55.7 57.9 59.3 62.5

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 98.7 98.8 98.9 98.9 98.9

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 1.3 1.2 1.1 1.1 1.1

Public spending on institutional care (% of tot. publ. spending LTC) 11.5 11.1 10.5 10.2 9.8

Public spending on home care (% of tot. publ. spending LTC in-kind) 88.5 88.9 89.5 89.8 90.2

Unit costs of institutional care per recipient, as % of GDP per capita 9.0 9.2 9.3 9.4 9.1

Unit costs of home care per recipient, as % of GDP per capita 63.3 65.4 68.8 70.8 70.7

Unit costs of cash benefits per recipient, as % of GDP per capita 0.4 0.4 0.4 0.4 0.4

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2013

MS Change

2013-2060

EU Change 2013-2060

20.0 -13% 3%

1.53 36% 40%

7.7 56% 36%

0.7 124% 40%

0.7 465% 149%

188,846 52% 79%

204,489 68% 78%

459,602 46% 68%

4.3 75% 68%

55.7 12% 23%

98.8 0% 1%

1.2 -16% -5%

11.8 -17% 1%

88.2 2% -1%

8.6 6% -2%

59.2 19% -3%

0.4 13% -2%

2.24. SLOVAKIA

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General context: Expenditure, fiscal

sustainability and demographic trends

GDP per capita in PPS is at 19.6 and below EU

average of 27.9 in 2013. Slovakia currently has a

population of 5.4 million inhabitants and is

projected to reach 4.6 million in 2060, a decrease

of 16%.

Health status

Life expectancy at birth for both women and men

is respectively 80.1 years and 72.9 years in 2013

and is below the EU averages (83.3 and 77.8 years

respectively). Healthy life years at birth are with

54.3 years (women) and 54.5 years (men) far

below the EU-averages (61.5 and 61.4

respectively). The percentage of the Slovak

population having a long-standing illness or health

problem is slightly lower than in the Union (30.7%

in Slovakia versus 32.5% in the EU). The

percentage of the population indicating a selfperceived

severe limitation in its daily activities

stands at 9.6%, which is higher than the EUaverage

(8.7%).

Dependency trends

Dependency is expected to increase in Slovakia.

The number of people in dependency is forecasted

to increase from 0.52 million in 2013 to 0.85

million in 2060, a 63% change, higher than the

increase in the EU (40%). Additionally, the

proportion of the population being dependent in

terms of severe limitations in daily activities is

projected to increase from 9.6 to 18.6%, giving a

93% increase, compared to the more modest EU

trend of 36%.

Expenditure projections and fiscal sustainability

When it comes to public expenditure on long-term

care as a percentage of GDP, rising trends are

expected. (434) In the AWG reference scenario,

encapsulating health-status and demographic cost

drivers, Slovakia's public expenditure is expected

to increase from 0.2 to 0.6 pps of GDP until 2060.

The "AWG risk scenario", which in comparison to

the "AWG reference scenario" captures the impact

of additional cost drivers to demography and

(434) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending up to 4.7 pps of GDP by 2060. Over the long run, sustainability risks appear for the Slovak Republic. These risks derive primarily from the projected impact of age-related public spending (notably healthcare and pensions), compounded by the unfavourable initial budgetary position. (435)

System Characteristics

LTC in is legislated by separate pieces of legislation. LTC is in the competence of the Ministry of Health in cooperation with the Ministry of Labour, Social Affairs and Family. The Ministry of Labour, Social Affairs and Family is specifically in charge of: 1) Compensations of social consequences of a severe disability mainly in the field of self-service including necessary tools, providing monetary contribution for caretaking and monetary contribution for personal assistance; 2) Providing or ensuring social services in home background, mainly home nursing services. In institutionalised background –

providing social services in a social service facility, in an outpatient or hospitalised form, weekly or yearly. Developing an integrated legal framework for LTC remains one of the key policy challenges.

All available evidence points to a poor coordination between health and social long-term care, but lack of coordination is perceptible also between state administration and regional/local administration. There is an acute demand for measures integrating health and social care into one institution.

Public spending on LTC reached 0.2% of GDP in 2013 far below EU average of 1.1% of GDP. The low level of funding implies that a considerable part of current LTC needs are not covered by public means. Thus, informal care provided by family members or close non-relatives plays a decisive role in Slovakia. (436) Slovakia seems to (435) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

(436) There are LTC expenditures that are not included in this number, in particular a large share of the in-kind benefits of the Ministry of Labour, Social Affairs and Family or the municipalities. These are not classified as expenditures on LTC in the SHA, though they should be considered LTC expenditure according to the definition below (page 1&2).

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have an average usage of cash benefits compared to the EU. In fact, 23% of public LTC spending is done via cash benefits (EU: 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC.

This share is with 53.6% the same in Slovakia. It

means that 1 out of 2 individuals aged 15 or more and declaring themselves as severely dependent,

would receive some kind of formal care (at home or in institution, in kind or in cash). Overall, 5.2%

of the population (aged 15+) receive formal LTC

in-kind and/or cash benefits, which is significantly

below the EU average coverage (EU: 4%).

The expenditure for institutional (in-kind) services

makes up 42.6% of public LTC expenditure (EU:

61%), 57.4% being spent for LTC services

provided at home (EU: 39%). Thus, within its

relatively low spending envelope, relative to other

Member States Slovakia has a focus on home care.

Types of care, eligibility criteria and user

choices: dependency, care needs, income

LTC in the area of health is provided in the form

of geriatric care in outpatient departments,

specialised hospital departments, day care centres,

home nursing agencies, hospices and other

facilities. Day care centres and nursing homes are

financed from public health insurance resources –

these belong to scope of the Ministry of Labour,

Social Affairs and Family and are financed by

municipalities, payments from clients and

subsidies of the Ministry of Labour, Social Affairs

and Family.

Social LTC benefits are provided in the form of

benefits in kind and cash benefits. Social services are financed by local and regional selfgovernments, state subsidies, and payments by

care recipients. Cash benefits are financed by the

State and provided through a network of local offices of labour, social affairs and family.

However, there is no stable concept of LTC in Slovakia and therefore it is difficult to define which of these expenditures should be included and also to quantify the impact using a national methodology. For example, there are homes of social services that provide other kind of services apart from the long-term care but this is not distinguished in the statistics.

Legislation defines the minimum duration of a functional disease and the minimum degree of dependence for the provision of the various benefits. The entitlement to cash benefits is means tested. The recipients' income and assets are taken into account in the eligibility of public benefits.

Co-payments apply for recipients of benefits in kind usually up to the level of "economically justified" costs. The entitlement to and level of

cash benefits are subject to a person's income and

assets not exceeding a certain ceiling. Higher

income thresholds are applied to benefits for

children needing care. Benefits in kind (social

service) are also subject to a means test, but under

a different procedure. The income shall be

considered as the total income excluding one-off

state social benefits, child benefit, tax bonuses,

scholarships etc. Assets are not counted e.g.:

property used for permanent housing, land for own

use, or car used by severely disabled persons. The

cash benefit is reduced as income increases and

when income is over 5-times the subsistence

minimum, the cash benefit is withhold.

Payment for social services to the level of

economically justified costs only relates to

providing of social services and not

compensations. In all-year residential facilities of

social services, the law regulates protection of

income to the level of 25% of living wage. In case

of home nursing service, there is a guaranteed

balance of income in the height of 1.4 multiple of

living wage.

Prevention and rehabilitation measures

The system of social services encompasses

facilities and activities focused on social

prevention and rehabilitation and support to

independent living (e.g. rehabilitation centres,

daily care stations, specialised activities such as

ergotherapy, access to ICT and cultural events,

social counselling). Compensatory cash benefits

enable disabled persons to adjust their housing or

improve mobility to reduce dependence on other

person's assistance. However, preventive and

rehabilitative activities comprise only a minor part

of social LTC.

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Formal/informal caregiving

There are four major classes of LTC carers:

(1) Informal carers - nearly 60,000; they receive

cash benefits for care, whereas only about 2% are

working at the same time. During the caregiving

period, the health and pension insurance is being

paid by the state and they are entitled to use public

supportive services, which are currently used

marginally. Families are mostly reluctant to use

professional LTC services if they are able to

provide care "on their own".

(2) Home nursing - done by approx. 6,300

employees of municipalities or private providers.

The extent of the service depends on the client's

needs that are assessed by a medical expert. Home

nursing is funded from health insurance.

(3) Personnel within residential care - circa 18,000

employees in permanent residential care in

different types of social services for adults and

seniors; short-term services (care (437) on a daily or

weekly basis) are used only occasionally.

Additionally:

(4) Volunteers – only registered at non-public

residential providers, in 2008-2010 they

represented nearly 30% of workers working for

private providers of LTC.

Recently legislated and/or planned policy

reforms

The crucial role of informal (family) care in the

Slovak LTC system is generally acknowledged.

However, policy reforms in the past years were

targeted almost exclusively on the formal sector of

LTC, and improvement of informal care is still

outstanding. The Ministry of Health plans to cover

additional nursing services (treatment of bedsores,

positioning the patient, application of drugs,

nursing rehabilitation, etc.) concerning LTC in

social residential facilities in the form of

reimbursement from health insurance. This change

will come into force next year.

(437) Providing LTC is not yet based on a comprehensive

legislative framework (see planned policy reforms), such

that the types of care are not precisely defined. This issue

falls within the competence of the Ministry of Health.

The Institute of Health Policy of the Ministry of

Health currently co-operates with the Ministry of

Labour, Social Affairs and Family to prepare a

strategy for LTC. The strategy aims to create the

optimal integrated model of LTC care. The

National Programme for Active Ageing 2014-2020, which was approved by a government resolution in 2013, gives the possibility to eventually introduce insurance for LTC by 2020 by the Ministry of Labour, Social Affairs and Family in cooperation with the Ministry of Finance. The strategy of de-institutionalisation of social services and strengthening of care, approved by a government resolution end-2011, foresees a systemic transition from institutional to community-based care. (438) It includes limits on capacity of institutions and restrictions on the yearround provision of care in certain types of facilities (e.g. homes of social services shall provide only care on a daily or weekly basis). In addition, new types of services aim to support independent living of persons with disabilities and strengthen social prevention and early intervention.

Challenges

The main challenges of the system appear to be:

- Improving the governance framework: To establish a coherent and integrated legal and

governance framework for a clear delineation of responsibilities of state authorities with respect to the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To establish

(438) Piloting de-institutionalisation is the main goal of a project called “Supporting the process of de-institutionalisation and transformation of the social services system –NP DI”. The Ministry of Labour ran the project from 2013 to 2015. The project was successfully finished and will be followed by two other projects cofounded by the EU structural funds.

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good information platforms for LTC users and providers;

- Improving financing arrangements: To face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private LTC insurance as a supplementary financing tool.

- Encouraging home care: To develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage

home care; to monitor and evaluate alternative

services, including incentives for use of

alternative settings.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care.

- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

- Facilitating appropriate utilisation across

health and long-term care: To arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; To steer LTC users towards

appropriate settings.

- Improving value for money: To invest in ICT

as an important source of information, care

management and coordination.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

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Table 2.24.1: Statistical Annex – Slovakia

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 30 35 39 45 56 66 64 67 70 72 74 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 13.5 13.7 14.7 15.8 17.7 18.4 17.4 18.6 18.7 19.2 19.6 26.8 27.6 28.0 28.1 27.9

Population, in millions 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5.4 502 503 504 506 507

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Public expenditure on long-term care

As % of GDP : : 0.0 0.2 0.0 0.2 0.2 0.2 0.2 : : 1.0 1.0 1.0 1.0 :

Per capita PPS : : 4.9 32.2 4.8 35.4 38.9 40.9 42.3 : : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : : 0.1 0.6 0.1 0.5 0.6 0.6 0.6 : : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 77.7 78.0 78.1 78.4 78.4 79.0 79.1 79.3 79.8 79.9 80.1 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 69.8 70.3 70.2 70.4 70.6 70.9 71.4 71.8 72.3 72.5 72.9 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females : : 56.6 54.6 56.1 52.5 52.6 52.0 52.3 53.1 54.3 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males : : 55.2 54.5 55.6 52.1 52.4 52.4 52.1 53.4 54.5 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 26.8 27.5 27.3 29.6 29.5 30.7 31.6 29.8 30.7 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 10.2 11.1 10.4 11.2 10.8 10.4 10.2 10.0 9.6 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 10 20 30 31 31 45 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 28 34 41 47 48 49 62 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 0.5 0.8 1.1 1.4 1.5 1.5 2.0 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : 30 44 49 51 50 54 57 58 : : : : :

Number of formal carers, in thousands : 20 15 12 10 11 11 11 11 : : : : :

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Table 2.24.2: Statistical Annex - continued – Slovakia

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 5.4 5.3 5.1 4.9 4.6

Dependency

Number of dependents in millions 0.58 0.67 0.76 0.81 0.85

Share of dependents, in % 10.6 12.7 14.9 16.6 18.6

Projected public expenditure on LTC as % of GDP

AWG reference scenario 0.3 0.4 0.5 0.6 0.6

AWG risk scenario 0.4 0.8 1.4 2.6 4.7

Coverage

Number of people receiving care in an institution 49,618 58,140 69,580 76,798 83,881

Number of people receiving care at home 67,933 82,006 100,808 113,445 127,410

Number of people receiving cash benefits 188,499 214,531 235,044 247,700 254,669

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% of pop. receiving formal LTC in-kind and/or cash benefits 5.7 6.7 7.9 9.0 10.2

% of dependents receiving formal LTC in-kind and/or cash benefits 53.2 52.7 53.4 54.3 55.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 76.8 77.5 78.6 79.9 81.2

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 23.2 22.5 21.4 20.1 18.8

Public spending on institutional care (% of tot. publ. spending LTC) 42.2 40.7 39.0 37.9 36.5

Public spending on home care (% of tot. publ. spending LTC in-kind) 57.8 59.3 61.0 62.1 63.5

Unit costs of institutional care per recipient, as % of GDP per capita 11.4 11.1 10.5 10.6 10.5

Unit costs of home care per recipient, as % of GDP per capita 11.4 11.5 11.3 11.7 12.0

Unit costs of cash benefits per recipient, as % of GDP per capita 2.1 2.1 2.2 2.2 2.2

2013

MS Change

2013-2060

EU Change 2013-2060

5.4 -16% 3%

0.52 63% 40%

9.6 93% 36%

0.2 181% 40%

0.2 1913% 149%

45,275 85% 79%

61,665 107% 78%

172,396 48% 68%

5.2 98% 68%

53.6 3% 23%

76.5 6% 1%

23.5 -20% -5%

42.6 -14% 1%

57.4 11% -1%

9.0 16% -2%

8.9 34% -3%

1.7 28% -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

Slovenia, member of the European Union since

2004, has a population of just above 2 million

inhabitants, which is slightly less than 0.4% of the

EU population. With a GDP of 38.5 billion (439), or

22,600 PPS per capita in 2014 it scores lower than

the EU weighted average (27,900). When looking

at the unweighted average and at the median level

though, respectively 25,200 and 22,100 PPS,

Slovenia faces a significantly lower gap, standing

at 89.7% of the average, and closely resembling

the median. However measured, this gap is mainly

due to the economic crisis which since 2008

reduced the national income, whereas in 2008

Slovenia's GDP level in PPS per capita was 91%

that of the EU average. Total public expenditure

on long-term care is with 1% of GDP in 2013 (440)

slightly under the EU average in the previous years

(1.0%).

Health status

Life expectancy at birth for both men and women

was respectively 77.2 years (78.0 in 2014) and

83.6 years (83.7 in 2014) in 2013 and is similar to

the EU average (77.8 and 83.3 years for men and

women respectively). Nevertheless, in 2013 the

healthy life years at birth for both sexes were, 59.5

years (women) and 57.6 years (men), substantially

lower than the EU-average (61.5 and 61.4

respectively). At the same time the percentage of

the population having a long-standing illness or

health problem was in 2013 slightly lower than in

the EU as a whole (31.6% and 32.5%

respectively). (441) The percentage of the

population indicating a self-perceived longstanding

severe limitation in its daily activities has

been slightly increasing since 2005 (from 9.5% in

2005 to 13% in 2011), but despite remaining above

the EU-average of 8.7%, the trend seems to have

(439) Statistical Office of the Republic of Slovenia (SURS) first

estimate, February 2016

(440) Total long-term care expenditure [http://www.oecdilibrary.org/social-issues-migration-health/data/oecdhealth-](http://www.oecdilibrary.org/social-issues-migration-health/data/oecdhealth-statistics/system-of-health-accounts-healthexpenditure-by-function_data-00349-en?isPartOf=/content/datacollection/health_e_f-data-en)

[statistics/system-of-health-accounts-healthexpenditure-](http://www.oecdilibrary.org/social-issues-migration-health/data/oecdhealth-statistics/system-of-health-accounts-healthexpenditure-by-function_data-00349-en?isPartOf=/content/datacollection/health_e_f-data-en)

[by-function_data-00349-](http://www.oecdilibrary.org/social-issues-migration-health/data/oecdhealth-statistics/system-of-health-accounts-healthexpenditure-by-function_data-00349-en?isPartOf=/content/datacollection/health_e_f-data-en)

[en?isPartOf=/content/datacollection/health_e_f-data-en,](http://www.oecdilibrary.org/social-issues-migration-health/data/oecdhealth-statistics/system-of-health-accounts-healthexpenditure-by-function_data-00349-en?isPartOf=/content/datacollection/health_e_f-data-en)

[en?isPartOf=/content/datacollection/health_e_f-data-en,](http://www.oecdilibrary.org/social-issues-migration-health/data/oecdhealth-statistics/system-of-health-accounts-healthexpenditure-by-function_data-00349-en?isPartOf=/content/datacollection/health_e_f-data-en)

SURS: [http://www.stat.si/StatWeb/en/shownews?](http://www.stat.si/StatWeb/en/shownews?id=5306&idp=10&headerbar=15)

[id=5306&idp=10&headerbar=15](http://www.stat.si/StatWeb/en/shownews?id=5306&idp=10&headerbar=15)

(441) Source Eurostat, People having a long-standing illness or

health problem, by sex, age and labour status

[hlth_silc_04], Last update 23.03.15, Extracted February

2016 .

changed in the last years (11.5% in 2012 and 9.5%

in 2013) (442).

Dependency trends

The number of people depending on others to carry

out activities of daily living increases significantly over the coming 50 years. From 230 residents living with strong limitations due to health problems in 2013, an increase of 30% is envisaged until 2060 to around 300 thousand. This applies to the "demographic scenario" of the 2015 Ageing Report, which assumes that the dependent population evolves in line with the total elderly population and all gains in life expectancy are spent in bad health. That is less steep an increase than in the EU as a whole (40%). In a less pessimistic scenario, and assuming that half of the projected gains in life expectancy are spent without disability (AWG reference scenario), the number of the dependent population reaches 282 thousands, i.e. a 21.5%. Also as a share of the population, the dependents are becoming a bigger group and an increase of 31% is projected (from 11.3% to 14.8%), below the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability) status. The joint impact of those factors is a projected increase in spending of 1.5 pp, bringing Slovenia from 1.4 (443) to 2.9% of GDP spent on long-term care in the period 2013-2060 of GDP by 2060. (444) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, (442) According to EU-SILC Survey 2013 (Eurostat Database- Population and Social Conditions- Health- Health Status).. (443) Including public expenditure on LTC (1% of GDP) according to SHA (health and social part) and cash-benefits for economic integration for handicapped from ESSPROS disability function (0.4% of GDP). (444) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

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projects an increase in spending of 2.8 pps of GDP

by 2060 (expenditure projected to increase to 4.2%

GDP). Overall, projected long-term care

expenditure increase is expected to add to

budgetary pressure on medium and long run.

Sustainability risks appear over the medium and

the long run due to the projected increase in age-related

public spending, notably deriving from

long-term care, healthcare and pensions). (445)

System Characteristics

Administrative organisation

Currently, there is no uniform system of long-term

care (LTC) in Slovenia. Different forms of LTC

services and benefits are provided within the

health care system, social and parental protection

system, pension and disability system and the

system of care for the disabled, and are regulated

by different acts from these areas. Over the last ten

years the government has been preparing a new umbrella regulation, which would bring all the different recipients and benefits under one rule. The last draft version of the legislation was in public discussion in 2010. Adoption was postponed, also due to lack of insight in the financial/fiscal implications. Preparations of the law have again intensified in the autumn of 2013 aiming to prepare financial projections in order to support the legislation, as financial sustainability is one of the critical issues of this legislation. In the spring of 2015, a comprehensive analysis of the Slovenian health care system has started, in the context of which an analysis of long-term care was also carried out. The analysis was completed in December 2015. Key findings are hereby presented. (446)

– LTC expenditure in Slovenia represents only a small component of GDP, and is much lower than health care spending, but is growing much more rapidly. Even on optimistic assumptions about the levels of disability, the effects of

demographic change will be to increase

(445) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf.

(446) Analysis of Health **Care** System in Slovenia. European

Observatory for Health **Care** Systems, WHO and the

Ministry of Health of the RS. Available at :

<http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/An>

aliza/24_11_2015/Long_Term_**Care**_in_Slovenia_Charles

_Normand.pdf.

expenditure on LTC by more than 50% by

2035.

– There are four main public funding sources for

LTC, but nearly half of the public LTC

spending is by the Health Insurance Institute.

– The Health Insurance Institute will see the

largest absolute growth in LTC spending

because of its focus on LTC for older people.

The Ministry of Labour will see only a smaller

increase given the focus on LTC for nonelderly

people.

– Private spending on LTC is almost all out-of-pocket

spending by recipients and this has been

growing significantly. On current policy and

practice this would increase rapidly (given that

the services paid for privately are likely to

grow rapidly) and this might not be sustainable.

– There is unnecessary complexity in the current

public funding of LTC that leads to confusion

about entitlements, difficulty in brokering

access to combinations of services needed by

users, and this may be a factor in the over

reliance on residential care.

– Consideration should be given to reducing the

complexity of (particularly the public) funding

of LTC. This might be achieved either by

shifting responsibility to a single government

department and/or agency, or by mechanisms

that aim to co-ordinate the spending and

entitlements between the different funding

organisations.

– This report shows that LTC spending is likely

to grow rapidly, and that the rate of growth will

vary hugely between the different public

funders of care. With a much longer time scale

it would be possible to derive more precise

estimates of the changing costs to the different

drivers, but the current calculations display

clearly the patterns of likely change.

Long-term care in Slovenia includes benefits in

kind (health care and/or social services in a form

of institutional or home care) and cash benefits.

Currently, LTC is regulated by several acts in the

field of social security, such as health care and

health insurance, pension and disability insurance

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and social assistance. Cash benefits and

institutional care are organised centrally whereas

home care services and community are provided

on a local level.

Funding for LTC expenditure comes from several

sources. Health care benefits in kind (institutional

and community)(services) are financed from the compulsory (99%) and the complementary (1%) health care insurance. Currently, the regulation of obligatory social insurances is made in a way that contributions are paid by both employers and employees (including self-employed). Inactive persons are insured either through their active close relatives (children and youngsters in fulltime education) or the reduced contributions for them are paid from the state and municipalities' budgets (pensioners, the unemployed, beneficiaries of minimum income)(447). Cash-benefits which are directed to persons with limitation in performing basic activities of daily living (ADL) (448), are financed from the Pension and Disability Fund and partially by the state budget (Ministry of Labour, Family, Social Affairs and Equal Opportunities). Social LTC services are partially financed from the state and the municipalities' budgets, and partially paid by the users (recipients). Out-of-pocket payments for social care LTC services depend on the financial situation of a person in need. In case a

person has insufficient financial means, the relatives and/or the municipality cover expenses of residential or home care services. Health and social care LTC services for disabled children and disabled youth in full-time education are entirely (in the case of youngsters in full-time tertiary (447) For example, in Slovenia there are more than 400,000 pensioners, and they do not pay directly any public social insurance contributions (part of compulsory health insurance for them is covered from the state budget) and are nearly 100% included in the voluntary private additional health care insurance.

(448) Basic Activities of Daily Living (ADL) include bathing, dressing, eating, getting in and getting into and out of bed or chair, moving around and using the bathroom. Often they are referred to as »personal care«.(Colombo et al. 2011). According to the System of Health Accounts methodology (OECD, WHO, Eurostat, 2011) expenditure related to provide help to people with ADL limitations are classified under code HC.3 as LTC health expenditure which means that are included also in health expenditure.

However, expenditure for LTC social services (related to IADL limitation – Instrumental Activities of Daily Living) are classified under code HC.R.1. LTC social expenditure are included in total LTC expenditure (HC.3 plus HC.R.1), but excluded from health expenditure.

education only partially) covered by the health

care insurance and the state budget.

Providers guaranteeing different services within

the scope of institutional forms of assistance

integrate health care and social areas, while the

assistance has not been integrated in the context of

forms provided in the living home environment.

Types of care

For systematic statistics and monitoring of

performance and development of LTC an interinstitutional

working group for statistical

monitoring of LTC was set up in 2012(449). The

first LTC report prepared by working group was

issued in 2014 (450).

Four modes of LTC provision are carried out in the

current system of LTC (by following SHA

framework): in-patient care (institutions), day-case

care, home care and cash benefits.

Inpatient LTC (institutional care) is organised by

homes for elderly, special social institutions,

centres for training, occupation and care and

centres for education of children with special

needs. There were 21 902 people altogether

residing in these institutions at the end of 2013;

mainly in homes for elderly. Inpatient LTC was

provided for 4.9% of population aged 65 years and

over. (451)

There were less than 500 users of organised day

care, which accounts to 0.1% of population aged

65 years and over. They were mainly included in

day care organised by homes for elderly.

(449) Appointed by Statistical Office of the Republic of Slovenia

and led by Social Protection Institute of the Republic of

Slovenia. The working group includes representatives of all

main actors providing data on long-term care (in addition

to already mentioned institutions, the Institute of

Macroeconomic Analysis and Development, the Ministry

of Labour, Family Social Affairs and Equal Opportunities,

the Ministry of Health, the Slovenian Community of Social Institutions, the National Institute of Public Health, the Pension and Disability Insurance Institute, the Institute for Economic Research and the Health Insurance Institute of Slovenia).

(450) Source: Nagode, Mateja, Eva Zver, Stane Marn, Anita

Jacovič, Davor Dominkuš. Long-term care – use of international definition in Slovenia. Working paper No. 2/2014 XXIII. Ljubljana: IMAD.

(451) Source: Statistical Office of the RS (2015). Available at:

[http://www.stat.si/StatWeb/en/shownews?](http://www.stat.si/StatWeb/en/shownews?id=4933&idp=21&headerbar=17)

[id=4933&idp=21&headerbar=17](http://www.stat.si/StatWeb/en/shownews?id=4933&idp=21&headerbar=17).

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Home-based LTC is organised by community

nursing care, home help, family assistant, personal

assistance and housing groups. More than 20 700

people received home-based LTC services at the

end of 2013; mostly community nursing care and

home help. Home-based care was provided to

4.5% of population aged 65 years and over.

Regarding the total number of cash benefits

recipients in 2013 there were more than 40.000

recipients of cash benefits (Attendance and

Allowance Supplement based on 6 different acts),

of which around 60% were aged 65 years and over

and 35% were aged more than 80 years; about

60% were women and 40% men. However, if we

are taking into account overlapping between cash

benefits and services in kind, there were only

17.181 recipients of cash benefits who only

received cash benefit and were not included in any

other LTC service. Cash benefits only were

received by 1.9% of the population aged 65 years

and over.

It is estimated that there were altogether 60 312

recipients of formal LTC services and cash

benefits at the end of 2013; this accounts for

11.4% of population aged 65 years and over.

Inpatient LTC (in institutions) is very well

developed and spread in Slovenia. It has a long

tradition. Community nursing care is also well

spread and developed. On the other hand, homebased

social LTC started to develop approx. 20

years ago and it is still not well developed. Even

though the number of people receiving homebased

LTC is relatively high, the care is not as

intensive and comprehensive as in the case of

institutional care and services of health and social

care are not integrated.

Eligibility criteria

There is no unified entry point or a model of LTC

needs assessment. The eligibility for a service is

linked to the service in question and is made by an

expert team (in the case of institutional care) or by

an individual expert (in the case of home care).

Cash benefits are granted upon application and

approval of the expert team (assessing the care needs).

Co-payments, out of the pocket expenses and

private insurance

Benefits in kind are income tested, taking into

account recipient, spouse and young adult

(children).

Out-of-pocket payments depend on the financial

ability of a person entitled. In case a person

entitled has insufficient financial means

municipalities cover expenses of residential or

home care services.

Based on the rules set by the government (Decree

on criteria for defining exemptions in the payment

of the services, OG RS 110/04,124/04,114/06) the

competent local "Centre for Social Work" decides

on partial or complete exempt of the user from the

payment of the services. The decree defines the

border of social security, set as an amount of

money that has to remain at disposal of the user of

the service after the payment of the LTC services.

Further on, the decree defines the ability to pay as

the maximum amount up to which the user is able

to participate in the payment of the LTC service.

The payment contribution is the amount that needs

to be paid to the provider of the LTC service and

the exempt from the payment is defined as the

amount which the user of the service is not able to

pay according to his/her calculated ability to pay.

The exempt from the payment is defined as the difference between the value of the service and user's contribution, whereas the exempt of the one, who is liable to pay for the services, is defined as the difference between the amount of the exempt of the payment of the user of the services and the payment contribution. The one being liable for the payment is a physical or legal entity that is not a family member and is obliged to pay the costs of the services. If the contributions of the user and the liable person do not cover the costs of the services, the difference between the value of the services and both contributions is paid by the local community or the state. In this case the user must ask the competent "Centre for Social Work" for the exempt from payment of all the costs.

Additionally to the criteria defined in the aforementioned decree, the local communities can decide on additional exemptions from payment of the costs of home care services.

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If the user of the LTC service who is asking for the exemption from payment of the services is the owner of a real estate property, the issuing of the written order on exemption from payment contains the prohibition from alienation or burdening of this real estate to the credit of the municipality which finances the institutional care of the user. If the user asks for the exemption from the payment of home care LTC services, the prohibition from alienation or burdening is issued only for real estate in the property of the user which is not used as the permanent residence of the user.

A family assistant has a right to the partial coverage of the lost income on the level of the minimal wage or to the proportional coverage of the lost income if he/she stays in a shorter than full time employment. The family assistant has full pension and disability insurance contributions paid as well as contribution for the case of unemployment and parental leave. The time spent

for providing the services as family assistant is included into the pensionable period (which is a condition for receiving old age pension after retirement).

Total (public and private) expenditure on LTC in 2013 amounted to roughly 1.3% of GDP. (452) The expenditure for LTC is increasing over the years, from 1.08% GDP recorded in 2005. This is mainly due to an increased number of users. In addition, private expenditure has been increasing much faster than public expenditure. Hence, in terms of financing sources, the share of total LTC accounted for by private expenditure increased in the period 2005-2013(453), which has important implications from the social point of view, i.e.

affordability of formal care and quality monitoring of informal care.(454)

(452) 1.31% of GDP in 2013 (2012: 1.33%), of which public expenditure was 0.95% and private expenditure 0.36% of

GDP. Data are based on the OECD, Eurostat, WHO

System of Health Accounts methodology. Source:

Statistical Office of the RS (2015)

[http://www.stat.si/StatWeb/en/shownews?](http://www.stat.si/StatWeb/en/shownews?id=5306&idp=10&headerbar=15)

id=5306&idp=10&headerbar=15

(453) From 22.2% to 27.5%, respectively. Source: Statistical

office of RS – Expenditure on health 2003-2013, July

2015. Note: Data are based on the OECD, Eurostat, WHO

System of Health Accounts methodology.

(454) Note that at-risk-of-poverty rates among elderly people are

over-average and the average monthly pensions are relative

low (EUR 565 in 2013). In this context the increase in the

out-of-the-pocket contributions can lead to social problems

Role of the private sector

The providers of LTC services can be public or

private entities. Private providers are selected

through public tenders and are granted concession

with limited duration; they have to fulfil the same

conditions as public providers. The standards for

provision of LTC services are quite strict

(regarding the number of staff, qualifications,

procedures, technical equipment and premises) and

are defined by the state in the case of social **care**

services (both institutional and home-based **care**),

and by the Health Insurance Institute in the case of

health care (institutional and community) services.

Institutional care is organised within the network of institutions for elderly, disabled adults and severely disabled children (455). Persons staying in residential care are provided with integrated health and social care services. The costs of accommodation are also part of institutional LTC service.

Community nursing and home help are regulated within different regulatory systems. Therefore providers are not the same and operate separately under different regulatory systems. Community health LTC services are provided by community nurses who are employed by local health centres or are given concession. They perform preventive and health education services, health-related services at home and to a certain extent also home help services. They are one of the first professional workers to identify health and social hardship as well as the needs of individual persons and their families for home and long-term care.

Home help is adjusted to the needs of an individual

and includes housework assistance (IADL);

assistance in essential daily activities (ADL) and

assistance in maintaining social contacts. The

"Social Protection Institute" carried out a few

analysis of the situation of home care in Slovenia.

in the future as it puts affordability of formal care at risk. In

the situation of a lasting economic crisis the problem of

out-of-the-pocket payments already became visible in

decreasing scope of formal LTC, especially institutional

(decreasing number of people in old-people care

institutions: 3% in 2013 returned to their homes).

(455) At the end of 2012 there were 20.077 available places in 99

institutions for elderly and adults (people over 18). These

institutions comprise 55 public institutions for elderly, 39

private institutions for elderly and 5 special institutions.

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The last analysis (Lebar et al, 2015(456) showed

that home help is provided mainly by public

agencies (i.e. centres for social work and homes

for older people) and only few were private

organisations with concessions.

Formal/informal caregiving

Formal LTC caregivers (457) must meet in relation

to education and other working conditions strict

rules. Some non-professional providers (family

assistant or personal assistant) must already take

part in special education programs. Educational

programs and their frequency are defined by the

"Social Chamber" and approved by the "National

Professional Council".

Until few years ago, Slovenia had no national

policy that would deal with informal family carers

(458) directly. There were some acts, which

(456) Lebar, L., Kovač, N., Nagode, M. (2015) Izvajanje pomoči

na domu. Analiza stanja za leto 2014. Ljubljana: Inštitut

RS za socialno varstvo. Available at:

[https://www.irssv.si/upload2/pnd/IRSSV%20Izvajanje%20](https://www.irssv.si/upload2/pnd/IRSSV%20Izvajanje%20pomoci%20na%20domu%20-%20analiza%20stanja%20v%20letu2014_koncno.pdf)

[pomoci%20na%20domu%20-](https://www.irssv.si/upload2/pnd/IRSSV%20Izvajanje%20pomoci%20na%20domu%20-%20analiza%20stanja%20v%20letu2014_koncno.pdf)

[%20analiza%20stanja%20v%20letu2014_koncno.pdf](https://www.irssv.si/upload2/pnd/IRSSV%20Izvajanje%20pomoci%20na%20domu%20-%20analiza%20stanja%20v%20letu2014_koncno.pdf).

(457) Carers in inpatient LTC (in institutions): Data of

Associations of social institutions of Slovenia indicate that

there were 9943 people employed in homes for elderly and

special social institutions in December 2012. Out of these,

there were 4.823 people employed in social care and 4776

people in health care (344 in others). According to the data

of Statistical Office of the Republic of Slovenia there were

1.036 carers employed in centres for protection and

training – 907 in social services, 61 in health care services

and 68 in training services (employment).

Carers in home-based LTC: According to the data of Social

Protection Institute of the Republic of Slovenia there were

62.4 coordinators of home help at the end of 2012. Home

help was carried out by 911 carers, 92.7% of them were

regularly employed. In 10.6% local municipalities there

was a shortage of carers. According to the data of National

Institute of Public Health there were altogether 821

community nurses in Slovenia at the end of 2012 (covering

the whole field of community nursing and home care not

only LTC). Ministry of Labour, Family, Social Affairs and

Equal Opportunities reports that there were 745 family

assistants in 2012 and around 800 personal assistants.

(458) Informal carers: The results of SHARE survey for 2013

show that in Slovenia around 48.000 people aged 50 or

more provided personal care or home help to a person outside their own household (6.5 % of respondents) and around 37.000 people aged 50 and over provided personal care within their own household (6.1 % of respondents).

Similar share of respondents was for countries in Continental Europe (5-8 %), lower in Scandinavian countries (3.5 %) and higher in Southern European countries (9-11 %). (Nagode, M. in Srakar, A, 2015.

Značilnosti starejšega prebivalstva v Sloveniji – prvi rezultati raziskave Share, Institut za ekonomske raziskave, 2015). Research done by Anton Trstenjak Institute of indirectly concerned informal family carers:

Pension and Disability Insurance Act mentions the right to attendance allowance; Health Care and Health Insurance Act the right to compensation for

care-giving to a close family member, with whom the insured lives in a common household and Act

Amending the Social Security Act that enables family carers as family assistants to get, under specific rules, a financial compensation. Since

2006 several strategic documents were adopted that emphasise the importance of informal carers,

mainly to give adequate training and services on the local level (day care, respite care) to the families who care for a disabled elderly family member and to support measures allowing more flexible working arrangements (the right for parttime work without the danger that the carer would lose social security).

Prevention and rehabilitation

policies/measures

The area of prevention and rehabilitation in the context of long-term care in Slovenia has not yet been systematically regulated. Prevention projects/activities are primarily funded by the ministry responsible for social welfare and, some local communities. For several years the "Institute Anton Trstenjaka" is successfully conducting a special program designed to prevent falls of the elderly in local communities. Within the framework of activities of the "Institute Emonicum" a similar program for nursing homes started in 2014. The ministry in collaboration with some local communities promotes various

prevention programs in relation to the treatment of persons with dementia.

In 2011, Slovenia started to develop the network reference dispensaries within which the preventive activities for the chronically ill or users of long term care in the home environment are exercised.

More than 340 reference dispensaries are already operating.

gerontology and intergenerational relations show similar

situation hat in Slovenia more than 55.000 people aged 50

or more is taking care of their parents and more than

50.000 of their frail partner⁴⁵⁸. (Ramovš, J., Lipar, T.,

Ramovš, M. (2014) Oskrba v onemoglosti. V: Ramovš,

Jože (ur) Staranje v Sloveniji – raziskava o potrebah,

zmožnostih in stališčih nad 50 let starih prebivalcev

Slovenije. Ljubljana: Inštitut Antona Trstenjaka).

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Rehabilitation programs related to long-term care

are systematically carried out in the framework of

the activities of homes for the elderly and are

funded by health insurance institute there is a lack of such programs in local communities.

Recently legislated and/or planned policy reforms

Over the last 10 years there were several attempts to prepare the LTC system reform. Several drafts of the act that would regulate the whole system of LTC and the potential (new) insurance for LTC were prepared by different stakeholders (Ministry of Labour, Family, Social Affairs and Equal Opportunities, Association of Providers of Institutional Care, NGO Pensioner's Association).

The differences between different draft acts prepared by different stakeholders were not so much in the content (arrangements of the system), but mostly in the approach to financing the LTC system.

The need for LTC system reform and plans for it also became part of strategic documents, such as the main national development strategy in the area of social protection, the "Resolution on the National Programme of Social Protection for the

period 2013-2020" (passed in the parliament in April 2013). Besides the plan for LTC reform it emphasises the development of community based services and unification of health and social home care services. In the draft operational programme for the use of structural EU funds in the new financial perspective, the emphasis is also on deinstitutionalisation and support for development of community based services (such as day centres, smaller residential units, etc.).

Since 2012, the LTC reform is high on the political agenda again. A working group for the methodological, statistical and financial issues regarding LTC was established in 2012. (459) At the end of 2013, the government adopted the starting points of the reform of LTC system, including the calendar for the reform. It was agreed that the first step of the reform will be the preparation and adoption of new legislation covering the whole LTC system and thus unifying it. A working group for the preparation of the new legislative act was established, composed by (459) See reference 8.

representatives of three ministries (covering areas of health, social affairs and finances), different associations of users, different associations of service providers, the Health Insurance Institute, the Pension Insurance Institut and, the Institute of Macroeconomic Analysis and Development.

However, for different reasons (also collision of interests and lack of political agreement) the health

care reform was stopped and is again planned in the coalition agreement to be carried out by the current government. In the spring of 2015, a comprehensive analysis of the health care system has started, in the context of which an analysis of long-term care was carried out. The analysis was completed in December 2015. One of the main conclusions of the analysis of the health care system was that the reform of the health system and the system of LTC should be prepared in a coordinated manner and that the activities in this regard should be carried out in 2016. Drafting of a new law on long-term care is one of the important

tasks of the national government in the year 2016.

Key actors in this area are, in addition to many other stakeholders, the ministry responsible for social affairs and the ministry responsible for health.

With the new legislation, Slovenia will introduce solidarity-based financing of LTC, based on the principles of social-risk insurance. The main aim of the LTC reform is to ensure fiscal sustainability of the LTC system, on the one hand, and to increase social security and quality of life of persons depending on care and assistance of other people for performing basic and supportive life activities, on the other hand. The new (reformed) system should provide the access to and availability of quality services of LTC that will enable care and support to individuals in need, especially in home and local community environment.

The reformed LTC system should also have a positive effect on the reduction of poverty among elderly people (which is above average now). As

pensions are relatively low, and the extent of out-of-pocket payments of people in need has been increasing, this currently means a strong pressure on the budgets of elderly and their families. With the planned system of financing the LTC, the out-of-pocket contributions will be reduced

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significantly and for some categories of users will not be necessary any more.

The draft act is based on the agreement that the need for LTC is a new social risk for which the residents of Slovenia have to be insured within the system of public social insurances. The new act will also deal with new arrangements of LTC provision in a way that the users will have the access to quality integrated services, mainly in the local environment (community and home based services) or cash benefits or a combination of both.

The new act will be titled "Act on long-term care" and will regulate both the LTC content (services)

and stable financing of the system: with
introduction of public compulsory insurance, and
additional possibility of voluntary private
insurance for non-standard LTC services and
accommodation costs in institutional **care** facilities.

Thus the Act will regulate:

- LTC insurance and financing of activities;
- definition of beneficiaries and rights (services);
- procedure of claiming the rights (including
needs assessment);
- provision of LTC services, and;
- providers of LTC insurance and providers of
LTC services.

The draft act envisages a single entry point and a
uniform expert procedure for LTC needs
assessment. The person in need will take part in
the needs assessment procedure and will at the end
decide for the type of **care** and support needed and
preferred (services or cash-benefit or a
combination of both or technical aid including the
possibility of adaptation of the place of residence).
If the person in need decides for cash-benefits to

be used for informal domestic care, the informal carer has the right to appropriate training and advice. Other planned elements of the system are the supervision over the domestic care, the final decision on the threshold of the need of ADL services, the scope and the content of the rights and provisions, These will be decided after the findings of a project based on a micro-simulation model carried out by the Institute for Economic Research are available.

The new system should encourage more responsible health behaviour of individuals (through differentiated insurance payments), and enable introduction of systematic prevention, development of rehabilitation services and the use of ICT in the LTC.

Merging of different sources of financing of LTC system should provide more transparency and effectiveness of financing of this area.

Individual planning, participation of users in the process of preparation of personal care plans and the responsibility of providers for realisation of

individual care plans are the planned mechanisms

that should also ensure more effective use of

funds.

The reorientation from currently prevailing

institutional (residential) care to more community

based and home based care should as well have

positive financial effects on the budget (less new

investments for institutional infrastructure and

redirection of funds to new jobs in community and

home based services). More systematic preventive

activities (healthy ageing), rehabilitation and the

use of ICT should additionally decrease the costs

of LTC.

However, one of the crucial issues related to the

reform of LTC is still how to separate the costs of

LTC system from the costs of the health care

system and how to ensure additional, stable source

which would slow down rapidly increasing annual

household expenditures for long-term care.

Challenges

Slovenia has a relatively fragmented system of

LTC, with future sustainability concerns,

especially in light of high out-of-pocket payments.

The main challenges of the system in appear to be:

- Improving the governance framework: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. to the provision of long-term care services; to set the public and private financing mix and organise formal workforce supply to face the growing

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number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and

providers; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social assistance or housing subsidy programmes;

- Improving financing arrangements: to foster pre-funding elements, which implies setting aside some funds to pay for future obligations.
- Providing adequate levels of care to those in need of care: to adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost sharing on LTC benefits; and the scope of coverage, that is, setting the types of services included into the coverage; to reduce the risk of impoverishment of recipients and informal carers.

- Encouraging home care and independent living: to develop alternatives to institutional care by e.g. developing new legislative

frameworks encouraging home care and
regulation controlling admissions to
institutional care or the establishment of
additional payments, cash benefits or financial
incentives to encourage home care; to monitor
and evaluate alternative services, including
incentives for use of alternative settings; to
provide effective home care, tele-care and
information to recipients, as well as improving
home and general living environment design.

- Ensuring availability of formal carers and
support to family carers: to determine current
and future needs for qualified human resources
and facilities for long-term care; to improve
recruitment efforts, including through the
migration of LTC workers and the extension of
recruitment pools of workers; in addition, to
continue supporting informal carers, such as
through flexible working conditions, while
ensuring that incentives for employment of
carers are not diminished and women are not
encouraged to withdraw from the labour

market for caring reasons.

- Ensuring coordination and continuity of

care: to establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: to steer LTC users

towards appropriate settings.

- Changing payment incentives for providers:

to consider a focused use of budgets negotiated

ex-ante or based on a pre-fixed share of highneed

users.

- Improving value for money: to encourage

competition across LTC providers to stimulate

productivity enhancements. to invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services.

- Prevention: to further the efforts in promoting

healthy ageing and preventing physical and

mental deterioration of people with chronic

care; to employ prevention and healthpromotion

policies and identify risk groups and

detect morbidity patterns earlier.

- Improving administrative efficiency.

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Table 2.25.1: Statistical Annex – Slovenia

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 26 28 29 32 35 38 36 36 37 36 36 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 21.1 22.1 22.8 23.4 24.0 23.7 20.5 21.1 21.3 21.3 21.0 26.8 27.6 28.0 28.1 27.9

Population, in millions 2.0 2.0 2.0 2.0 2.0 2.0 2.0 2.1 2.1 2.1 502 503 504 506 507

Public expenditure on long-term care

Number of informal carers, in thousands : : : : :

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Number of formal carers, in thousands : : : : : : : : :

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Table 2.25.2: Statistical Annex - continued – Slovenia

(1) Projected public expenditure as % GDP includes public expenditure on long-term care based on SHA (1.0%) and also a component from ESSPROS (economic integratoin of the

handicapped, 0.4%).

S B d t h E C i i (DG ECFIN) EPC (AWG) "Th 2015 A i R t E i d b d t j t i f t h 28 EU M b St t (2013 2060)"

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 2.1 2.1 2.1 2.1 2.0

Dependency

Number of dependents in millions 0.25 0.28 0.29 0.30 0.30

Share of dependents, in % 12.1 13.2 14.2 14.6 14.8

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.7 1.9 2.4 2.7 2.9

AWG risk scenario 1.7 2.2 2.9 3.6 4.2

Coverage

Number of people receiving care in an institution 24,722 29,383 36,239 41,040 43,292

Number of people receiving care at home 44,467 50,743 58,739 63,705 65,890

Number of people receiving cash benefits 55,494 65,594 78,845 92,761 99,637

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% of pop. receiving formal LTC in-kind and/or cash benefits 6.0 7.0 8.4 9.5 10.2

% of dependents receiving formal LTC in-kind and/or cash benefits 49.5 52.9 58.9 65.5 69.3

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 63.6 62.9 63.2 61.4 60.0

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 36.4 37.1 36.8 38.6 40.0

Public spending on institutional care (% of tot. publ. spending LTC) 67.4 68.2 69.5 70.0 70.3

Public spending on home care (% of tot. publ. spending LTC in-kind) 32.6 31.8 30.5 30.0 29.7

Unit costs of institutional care per recipient, as % of GDP per capita 60.2 59.4 60.3 59.5 57.8

Unit costs of home care per recipient, as % of GDP per capita 16.2 16.0 16.3 16.4 16.1

Unit costs of cash benefits per recipient, as % of GDP per capita 22.8 23.0 23.2 23.6 23.9

2013

MS Change

2013-2060

EU Change 2013-2060

2.1 -1% 3%

0.23 30% 40%

11.3 31% 36%

1.4 103% 40%

1.4 190% 149%

21,902 98% 79%

38,410 72% 78%

46,851 113% 68%

5.2 97% 68%

46.2 50% 23%

64.5 -7% 1%

35.5 13% -5%

66.8 5% 1%

33.2 -10% -1%

58.2 -1% -2%

16.5 -2% -3%

22.4 7% -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

Spain has a population of almost 46.7 million

inhabitants in 2013 (according to Eurostat data).

Over the next decades, this is expected to decrease

to 46.1 million by 2060. With a GDP of more than

EUR 1,031 bn, or EUR 24.1 thousand PPS per

capita it is below the EU average GDP per capita

of EUR 27.9 thousand.

Health Status

Life expectancy at birth for both men and women

was, in 2013, respectively 80.2 years and 86.1 years and is above the EU average (77.8 and 83.3 years respectively). Similarly, healthy life years at birth for both sexes are 64.7 years (women) and 63.9 years (men) significantly above the EU average (61.5 and 61.4 respectively). The percentage of the Spanish population having a long-standing illness or health problem is lower than in the Union as a whole (31.6% and 32.5% respectively in 2012). The percentage of the population indicating a self-perceived severe limitation in its daily activities has decreased since 2004, and is significantly lower than the EU average (5.4% against 8.7%).

Dependency trends

The share of dependents in Spain is set to increase from 5.3% in 2013 to 8.6% of the total population in 2060, an increase of 64%. This is higher than the EU-average increase of 36%. From less than 2.5 million residents living with strong limitations due to health problems in 2010, an increase of 64% is envisaged until 2060 to slightly below 4 million.

That is a much steeper increase than in the EU as a whole (36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected

public expenditure on long-term care as a

percentage of GDP is steadily increasing. In the

AWG reference scenario, public long-term

expenditure is driven by the combination of

changes in the population structure and a

moderately positive evolution of the health (nondisability)

status. The joint impact of those factors

is a projected increase in spending of 1.4 pps of

GDP to about 2.4 pps of GDP by 2060. (460) The

"AWG risk scenario", which in comparison to the

"AWG reference scenario" captures the impact of

additional cost drivers to demography and health

status, i.e. the possible effect of a cost and

coverage convergence, projects an increase in

spending of 2.9 pp taking expenditure to 3.9 pps of

GDP by 2060.

Overall, for Spain no significant short-term risks of

fiscal stress arise, though some variables point to

possible short-term challenges. Risks appear, on

the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the stock of debt still high at the end of projections (2026). No sustainability risks appear for Spain over the long run notably thanks to reforms containing long-term expenditure pressures, in particular pension expenditures. (461)

System Characteristics (462)

It is arguable that the first long-term care system as such in Spain was established in 2007, with the approval of the Law 39/2006 Ley de Promoción de la Autonomía Personal y Atención a las Personas en situación de Dependencia (Law of Promotion of the Autonomy and Care of People in a Dependent Situation, LAPAD), which established the System for Autonomy and Care for Dependency (SAAD).

Prior to Law 39/2006 of December 2006, LTC

care was provided through the basic social services of regions and municipalities, and by programmes towards people with disability benefits. This provision only partly met the LTC needs of the

population. The Social security system provided benefits for individuals with severe levels of disability as well as allowances through the noncontributory disability pension and family benefits for parents of disabled children.

It is estimated that only around 12% of elderly dependants received any kind of support that was publicly financed in 2000. The role of the public sector was secondary, provided only in cases where informal **care** was not possible or

(460) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

(461) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(462) This section draws on OECD (2011b) and ASISP (2014).

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insufficient and the level of support depended on the economic capacity of the recipient.

Furthermore, competences for social services had been decentralised to regional and local level, so important differences existed across territories.

The SAAD was created in 2007 in line with the LAPAD and the objective of promoting personal autonomy and ensuring the necessary attention and protection of all dependants in Spain, through the necessary collaboration of all public administration levels. A graduate calendar of implementation to cover all existing dependants was established with an original end-date of 2015, later to be delayed.

Within the SAAD dependency is split into three different degrees of dependency: Degree I – moderate dependency; Degree II – severe dependency; and Degree III – high dependency.

Each degree is in turn divided into two levels of increasing severity. During the progressive implementation period, only Degree III could apply during the 2007 (the first year), then Degree II level 2 in 2008, Degree II level 1 in 2009-2010 and finally moderate dependants (Degree I) in 2011-2012 (level 2) and 2013-2014 (level 1) would follow. However, as explained above, this

plan was delayed later.

Managing the SAAD is as for the previous LTC

service provision, the competence of the regional

Governments. As a consequence, many differences

in its application can be observed across the

different regions. Whereas 2.0% of population is

recognised as being dependent in Spain, the ratio

across regions varies from 2.7% in Andalucía and

Cantabria, to only 1.4% in Navarra, 1.3% in the

Comunitat Valenciana and only 1.1% in Canarias.

According to SAAD statistics, in July 2016 in

Spain there were 1.21 million dependants.

Specifically, 366,764 people were recognised as

high dependents (30%), 454,751 as severe

dependents (37%) and the rest (391,407, 32%) as

moderate dependents. In total, 837,321 are

receiving benefits, while the other 375,601 (31%)

are on the waiting list.

On average each beneficiary receives 1.24 benefits

(including in-kind and cash benefits), although this

figure varies across regions. In terms of provision,

the most important benefit is the cash benefit for

home care. According to July 2016 SAAD statistics, 357,984 recipients (34.6% of the services provided) are receiving it. The incidence of in-kind benefits is relatively lower: residential care made up 14.4% of services provided, home care represented 15.8%, tele-care was 14.6% and day care centres 8.45%.

Public spending on LTC reached 0.7% (463) of GDP in 2012 in Spain, below the EU average of 1 % of GDP. 32.6% of public LTC spending is done via cash benefits (Above the EU average of 20%).

In Spain, 60.8% of dependents are receiving formal in-kind LTC services or cash benefits for LTC, above the EU average of 53%. Overall, 3.2% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

In-kind benefits are provided to 2.1% of the

population. The expenditure for institutional (in-kind) services makes up 72.7% of public in-kind expenditure (EU: 61%), 27.3% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States Spain has a focus on institutional care, which may be inefficient, as institutional care is relatively costly with respect to other types of care.

Administrative organisation

The system is funded through taxation and financed by funds from the central government and regions. The central government then allocates funds to each region based on the number of dependents, their degree of disability and the level of assistance they require. Regions can decide whether to allocate additional funding to provide additional services.

Types of care

As mentioned in the previous section, the benefits provided include a range of in-kind and cash benefits. A list is provided in Chapter 15 of the

(463) It should be noted that the definition of LTC expenditure

used for these expenditure variables differs from the

definition used for the Ageing Report 2015.

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LAPAD, which details a wide range of services to

be carried out through a social services public

network of social services under the control

controlled of the regional governments to be

subsidised by the public sector.

Services include tele-care, home care, personal

care help, residential care and day as well as night

residential services. These services are provided by

a network of public institutions of regional

governments, local organisations, state reference

centres and licensed private providers. Cash

benefits are granted based on the recipient's degree

of dependency and their economic means.

According to the LAPAD, they include a home

care cash benefit and a cash benefit for personal

assistance.

1) Allowance for the care recipient to hire services.

This allowance enables the care recipient to

contract services from private licensed providers

when the public sector is not able to provide this.

Benefit levels range from EUR 400/month for

degree II level 1, to EUR 831 for degree III, level

2, in 2012 for those who already have an assessed

degree and level, and for new recipients from

August 2012 it goes from EUR 300,00 for grade I

to EUR 715,07 for grade III.

2) Allowance for informal care. The informal carer

needs to be a relative of the care recipient,

although if services are not available in the area,

the informal carer can be a resident of the same (or

neighbouring) municipality. The allowance

compensates to some extent the service provided

by the informal carer. Benefit levels range from

EUR 255,77 /month for degree II level 1, to EUR

442,59 for degree III, level 2, in 2012 those who

already have a recognised degree and level, and for

new recipients from August 2012 is from EUR

153,00 for grade I to EUR 387,64 for grade III.

3) Allowance for personal assistance. This allowance enables recipients individuals with a high degree of disability (Group III) to hire personal help to improve their personal autonomy, access to work/ education as well as to provide help with daily activities. A contract has to be provided and the carer needs to have appropriate professional qualifications. Benefit levels range from EUR 609 /month for degree III level 1, to 812 for degree III level 2, in 2012 those who already have a recognised degree and level, and for new recipients from August 2012 is from EUR 300,00 for grade I to EUR 715,07 for grade III.

Home-care provision includes prevention and promotion of personal autonomy, help with personal care and with instrumental activities of daily living. All persons below the minimum income threshold are automatically guaranteed home care.

Institutional LTC service providers include regional and municipal centres as well as private sector institutions. Providers are required to have

minimum ratios of workers per care recipient and

by type of worker for carers and geriatricians.

Most institutions are private with only 24% of

residences being publicly-owned (although 22%

additional residents receive a public subsidy to be

placed in a private centre). Providers often receive

substantial government subsidies in order to make

their service more affordable for recipients. There

are large regional disparities in the distribution of

beds and services offered as well as in term of their

prices.

Day care centres are also largely private (65%) but

are publicly subsidised at 60% and have seen large

increases in the past (there were 36,000 new places

between 2002 and 2007).

Eligibility criteria

Spain applies means-tested criteria, for both in-kind

and cash benefits. In addition, users are not

given a choice between cash and in-kind benefits

nor can they accumulate them, and they do not

have a discretionary use of cash benefits.

Benefits are universal and cover all Spanish

nationals or those who have been residents of

Spain for at least 5 years (of which at least the last 2 before filing the claim need to have been spent in Spain). Eligibility is determined through an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency (Established in the Royal Decree 740/2011). As mentioned before, there are three degrees of disability, with 2 sub-levels within each grade.

They are defined as follows:

- Degree I (Moderate Disability): the individual requires help for several basic activities of daily living at least once a day, or needs help

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on a sporadic basis or limited to personal autonomy.

- Degree II (Severe Disability): the individual needs help for several activities of daily living, two or three times a day but does not need permanent help from a carer nor extensive help to ensure personal autonomy.

– Degree III (High dependency): the individual needs help for several activities of daily living several times per day, and because of total loss of physical, mental, intellectual or sensorial autonomy, s/he needs permanent help from a carer or needs generalised help to ensure personal autonomy.

The assessment is expressed as a numerical score according to the eligibility scale, and individuals with a score below 25 are not entitled to public services or allowances.

Again, the responsibility for the assessment belongs to the .regions. Once an individual has been assessed as being in need of care, an individual plan is prepared by the social services, including a list of appropriate services for the level of disability and dependency, as well as entitlement to allowances, in line with the legislation (Royal decree 1051/2013).

Co-payments, out of the pocket expenses and private insurance

All the potential recipients below a specified minimum income are guaranteed provision home

care. Cost-sharing by recipients for the benefits

they receive is determined according to their

economic status up to a maximum of 90% of the

service cost.

For all other services allowances are means-tested

and the remainder needs to be paid by the care

recipient or their relatives.

Role of the private sector

As explained in previous sections, the private

sector is involved in the provision of several types

of care. In institutional care it is the main provider,

although often benefitting from subsidies meant to

increase the affordability of services to recipients. .

Formal/informal caregiving

At present there is no allowance directly directed

to family carers directly as the care allowance that

exists currently is provided to the care recipient.

Informal carers can benefit from pension rights

and other social contributions if they subscribe a

special agreement with the Social Security body.

Assisting informal carers through training and

provision of information is one of the objectives of the SAAD, and common standards were adopted in 2009.

All formal workers are required to hold relevant professional qualifications including carers in residential institutions, home carers, personal assistants as well as the directors of institutions.

Since 2015 professional profiles are determined as well as the duties to be performed and they are based on qualifications that need to be demonstrated by the appropriate Vocational Training Diplomas or Professional Certificate.

Since this Resolution there have been some calls by the regional authorities for guarantees on the expertise of these professionals, in order to certify that their qualifications fulfil the necessary requirements.

From the beginning of 2007 to the end of 2013, the number of long term care formal workers has increased by approximately 50.9%, with 116,507 new members being registered as working in the Social Security records.

Prevention and rehabilitation

policies/measures

Some prevention services do exist and are

subsidised. Home-care services also include

prevention and promotion of personal autonomy.

Recently legislated and/or planned policy

reforms

The Territorial Council of Social Services and of

the System for the Autonomy and Care of

Dependent Persons (SAAD), cooperation body

where the Central Government, the Autonomous

Regions and the Local Government are

represented, in its session of 10 July 2012 has

approved measures to improve the System and

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make it more transparent, with better quality,

improved care of dependent persons, and also to

guarantee its current and future financial

sustainability, with criteria that guarantee equality

in the granting of the benefits throughout Spain,

and with impact on employment, respecting the principles set down in the Dependency Act. These measures are applicable in the Autonomous Regions.

The Resolutions of said Territorial Council where said measures were approved have been expressed by the Government in the following general legislation for the whole of Spain and applicable by the Autonomous Regions in each one of its territories:

- Royal Decree-Law 20/2012, modifying Act 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care of people in situation of dependency.
- This regulation abolishes the classification by levels within each degree of dependency, since it lengthened the procedure and consumed added resources without giving rise to any differentiation in terms of the benefits acknowledged. It also established a calendar for grade I to 1 July 2015, to give priority care to people with greater degree of dependency

and it established the maximum amounts of the financial benefits for each of the degrees of dependency.

- Decision of 23 April 2013, of the State Secretariat for Social Services and Equality, publishes the Resolution of the Territorial Council of Social Services and of the System for the Autonomy and Care of Dependent Persons regarding criteria, recommendations and minimum conditions for the preparation of Plans for Prevention of Situations of Dependency and the Promotion of Personal Autonomy, which includes a Catalogue of reference of social services.
- With the purpose of preventing the appearance or worsening of diseases or disabilities and their after-effects, by the coordinated development, between social and health services, of actions to promote healthy living conditions, specific preventive and rehabilitation programs aimed at the elderly and disabled people and those who are affected by complex hospitalisation processes.

- Decision of 25 July 2013, of the State

Secretariat for Social Services and Equality,

publishes the Resolution on common criteria,

recommendations and minimum conditions of

the comprehensive care plans for children

under the age of three in situations of

dependency or at risk in application of Act

39/2006, of 14 December, on the Promotion of

Personal Autonomy and Care of people in

situation of dependency.

- The aim and purpose of this resolution is to promote their personal autonomy, so that they can enhance their capacity for development and wellbeing, enabling their inclusion in the family, school and social spheres.

- These Plans shall be developed by the Autonomous Regions and are aimed at children under the age of three certified to be in situation of dependency or at risk of developing it.

- These Comprehensive Care Plans also consider

the necessary strategies aimed at facilitating the support and participation of the family, guardians and/or carers, as well as the specific characteristics of the environment.

– Royal Decree 1050/2013, of 27 December 2013, governing the minimum level of protection established in Promotion of Personal Autonomy and Care of Persons in a Situation of Dependence Act 39/2006, of 14 December 2006.

– Royal Decree 1051/2013, of 27 December 2013, governing the provisions of the System for the Autonomy and Care of Dependent Persons, as established in the Promotion of Personal Autonomy and Care of Persons in a Situation of Dependence Act 39/2006, of 14 December 2006.

- Order SSI/2371/2013, of 17 December, regulating the Information System of the System for the Autonomy and Care of Dependent Persons (SISAAD), which defines Long-term care systems

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the set of data necessary for the payment of the minimum level in addition to those that are necessary for management, statistics and studies.

All this new legislation seeks to clarify, make more transparent the Information System, to ensure their safety and to check and compare the data entered into the system by Regional Communities, and that these data are equal and homogeneous.

On the other hand, the above regulations and commitments culminate and consolidate the measures adopted by the Territorial Council. Other improvements are not foreseen in the dependency system, making possible to keep the SAAD with higher quality and a better professional care.

Challenges

Spain has taken significant steps to establish a social care system that provides coverage to the population. The main challenges of the system

appear to be:

- Improving the governance framework: To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities with respect to the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To establish good information platforms for LTC users and providers; To set guidelines to steer decisionmaking at local level or by practising providers; To share data within government

administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social assistance or housing subsidy programmes.

- Improving financing arrangements: To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private LTC insurance as a supplementary financing tool; To determine the extent of user cost sharing on LTC benefits.

- Providing adequate levels of care to those in need of care: To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the depth of coverage, that is, setting the types of services included into the coverage; To reduce the risk of impoverishment of recipients and informal carers.

- Encouraging home care: To develop

alternatives to institutional care by e.g.

developing new legislative frameworks

encouraging home care and regulation

controlling admissions to institutional care or

the establishment of additional payments, cash

benefits or financial incentives to encourage

home care; To monitor and evaluate alternative

services, including incentives for use of

alternative settings.
- Encouraging independent living: To provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design.
- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care.
- Supporting family carers: To establish

policies for supporting informal carers, such as

through flexible working conditions, respite

care, carer's allowances replacing lost wages or

covering expenses incurred due to caring, cash

benefits paid to the care recipients, while

ensuring that incentives for employment of

carers are not diminished and women are not

encouraged to withdraw from the labour

market for caring reasons.

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- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- Facilitating appropriate utilisation across

health and long-term care: To create better

rules, improving (and securing) safe care

pathways and information delivered to

chronically-ill people or circulated through the

system; To steer LTC users towards

appropriate settings.

- Changing payment incentives for providers:

To consider a focused use of budgets

negotiated ex-ante or based on a pre-fixed

share of high-need users.

- Improving value for money: To invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; To

invest in ICT as an important source of

information, care management and

coordination.

- Prevention: To promote healthy ageing and

preventing physical and mental deterioration of

people with chronic care; To employ

prevention and health-promotion policies and

identify risk groups and detect morbidity

patterns earlier.

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Table 2.26.1: Statistical Annex – Spain

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU
2012 EU 2013

GDP, in billion euro, current prices 803 861 931 1,008 1,081 1,116 1,079 1,081 1,070 1,043 1,031 9,289 9,545
9,800 9,835 9,934

GDP per capita, PPS 25.5 25.6 25.7 26.6 27.3 26.4 24.7 24.7 24.5 24.4 24.1 26.8 27.6 28.0 28.1 27.9

Population, in millions 41.8 42.5 43.3 44.0 44.8 45.7 46.2 46.5 46.7 46.8 46.7 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 0.5 0.5 0.5 0.6 0.6 0.6 0.7 0.8 0.7 0.7 : 1.0 1.0 1.0 1.0 :

Per capita PPS 96.8 112.0 125.6 141.6 150.4 154.6 169.0 184.9 161.0 163.9 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 1.3 1.4 1.5 1.5 1.5 1.6 1.7 1.5 1.5 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 83.0 83.7 83.6 84.4 84.4 84.6 85.0 85.5 85.6 85.5 86.1 82.6 82.8 83.1 83.1
83.3

Life expectancy at birth for males 76.4 77.0 77.0 77.8 77.9 78.3 78.8 79.2 79.5 79.5 80.2 76.6 76.9 77.3 77.4 77.8

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Healthy life years at birth for females 70.2 62.7 63.4 63.5 63.2 63.7 62.1 63.8 65.6 65.8 63.9 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 66.8 62.6 63.3 63.9 63.5 64.0 63.1 64.5 65.4 64.8 64.7 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 26.2 24.0 23.7 25.1 29.8 30.3 29.5 23.0 26.2 31.6 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 9.2 9.0 8.5 9.1 5.4 5.7 5.4 4.7 5.1 5.4 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : : 180 208 235 262 267 272 307 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : : 181 258 334 411 419 427 693 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 0.8 1.0 1.2 1.4 1.5 1.5 2.1 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : : 280 385 423 427 : : : : :

Number of formal carers, in thousands : : : : : 322 340 338 336 : : : : :

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Table 2.26.2: Statistical Annex - continued – Spain

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)

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PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 45.7 44.5 44.7 45.6 46.1

Dependency

Number of dependents in millions 2.66 2.94 3.35 3.76 3.97

Share of dependents, in % 5.8 6.6 7.5 8.2 8.6

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.2 1.3 1.6 2.1 2.4

AWG risk scenario 1.3 1.5 2.1 3.0 3.9

Coverage

Number of people receiving care in an institution 354,020 387,101 470,022 589,292 717,580

Number of people receiving care at home 826,063 945,286 1,202,018 1,560,354 1,910,449

Number of people receiving cash benefits 573,724 644,428 796,502 1,006,566 1,222,908

% of pop. receiving formal LTC in-kind and/or cash benefits 3.8 4.4 5.5 6.9 8.3

% of dependents receiving formal LTC in-kind and/or cash benefits 65.9 67.2 73.8 84.0 97.0

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 68.5 66.2 66.3 68.0 67.4

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 31.5 33.8 33.7 32.0 32.6

Public spending on institutional care (% of tot. publ. spending LTC) 73.9 73.3 72.8 72.5 72.7

Public spending on home care (% of tot. publ. spending LTC in-kind) 26.1 26.7 27.2 27.5 27.3

Unit costs of institutional care per recipient, as % of GDP per capita 77.4 71.0 72.3 78.4 76.5

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Unit costs of home care per recipient, as % of GDP per capita 11.7 10.6 10.6 11.2 10.8

Unit costs of cash benefits per recipient, as % of GDP per capita 29.7 29.7 29.8 29.8 29.9

2013

MS Change

2013-2060

EU Change 2013-2060

46.7 -1% 3%

2.45 62% 40%

5.3 64% 36%

1.0 147% 40%

1.0 294% 149%

307,300 134% 79%

692,532 176% 78%

490,357 149% 68%

3.2 161% 68%

60.8 60% 23%

68.3 -1% 1%

31.7 3% -5%

74.1 -2% 1%

25.9 5% -1%

75.6 1% -2%

11.7 -8% -3%

29.7 1% -2%

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General context: Expenditure, fiscal

sustainability and demographic trends

Sweden had a population of almost 9.6 million inhabitants in 2013, which is expected to reach 13.1 million in 2060. This is a 36% increase that is contrast with the 3% overall increase in the EU over this period. With a GDP of more than EUR 436 billion, or 32,200 PPS per capita, it is above the EU average of 27,900 PPS per capita.

Health status

Life expectancy at birth for both men and women is respectively 80.2 years and 83.8 years and is above the EU average (77.8 and 83.3 years, respectively). Even more so, the healthy life years at birth for both sexes are 66.0 years (women) and 66.9 years (men) and substantially higher than the EU-average (61.5 and 61.4, respectively). At the same time the percentage of the Swedish population having a long-standing illness or health problem is slightly higher than in the EU as a

whole (35.3% and 32.5%, respectively). The percentage of the population indicating a selfperceived severe limitation in its daily activities has been decreasing in the last few years, and is lower than the EU-average (7.0% against 8.7%).

Dependency trends

The amount of people that depend on others to carry out activities of daily living increases significantly over the coming 50 years.(464) From less than 620 thousand residents living with strong limitations due to health problems in 2013, an increase of 62% is envisaged until 2060 to slightly more than 1 million. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 6.5% to 7.7%, an increase of 19%. This is nevertheless less than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing, from 3.6

percent in 2013, to 5.1 percent in 2060 in the

(464) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

"AWG reference scenario", corresponding to a

41% increase, about the same level as the EU. In

the "AWG risk scenario", expenditure is projected

to grow from 3.6 to 7.5, attaining a differential of

106%, lower than the EU average of 149%.

Risks also appear to be low in the medium-term

from a debt sustainability analysis perspective due

to the relatively low stock of debt at the end of

projections (2026), even when considering

possible shocks to nominal growth and interest

rates. Medium sustainability risks appear over the

long run due to both the relatively unfavourable

initial budgetary position and the projected impact

of age-related public spending (in particular, longterm

care spending). (465)

System Characteristics (466)

According to the Social Services Act (1982),

Swedish older people have the right to claim

public service and help to support themselves in

their day-to-day existence “if their needs cannot be met in any other way”. The Swedish system of LTC is under the responsibility of municipalities and is mainly financed from local taxation.

According to 2013 data from the OECD, some 10% of the total cost of LTC is financed through co-payments and charges, while the rest is covered by public funds, mainly through local taxes.

Around 10% of the local authorities' total funding (not only LTC) comes from central government grants. Some 5% of the total cost of LTC is financed through co-payments and charges, while the rest is covered by public funds, mainly through local taxes with some 10-12% funding coming from central government grants to municipalities.

Public spending on LTC reached 3.7% of GDP in 2012, above the average EU level of 1.0% of GDP.

96.4% of the benefits were in-kind, while 3.6% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC.

This share is with 83.4% much higher in Sweden.

Overall, 5.4% of the population (aged 15+) receive

formal LTC in-kind and/or cash benefits (EU:

(465) Fiscal Sustainability Report 2015:

http://ec.europa.eu/economy_finance/publications/eeip/pdf/

ip018_en.pdf

(466) This section draws on WHO/Europe (2012), Fukushima et

al (2010) , OECD (2011b) and ASISP (2014).

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4.2%). On the one hand, low shares of coverage

may indicate a situation of under-provision of LTC

services. On the other hand, higher coverage rates

may imply an increased fiscal pressure on

government budgets, possibly calling for greater

needs of policy reform.

The expenditure for institutional (in-kind) services

makes up 50.3% of public in-kind expenditure

(EU: 61%), 49.7% being spent for LTC services

provided at home (EU: 39%).

Administrative organisation

At central government level, the Ministry of

Health and Social Affairs (Socialdepartementet) is responsible for developing legislation on health care, social insurance and social issues. These laws and regulations are the basis for the planning, funding and provision of LTC services through the cooperation of 20 county councils and 290 municipalities. The central government is in constant dialogue with the Swedish Association of Local Authorities and Regions (SALAR), a cooperative national organisation that represents all county councils and municipalities. County councils and municipalities are highly autonomous with respect to central government. Both have elected assemblies and have the right to levy and collect taxes. County councils and municipalities can, within the limits established in legislation, decide what level of priority they will assign to the elderly versus other age groups. The fact that LTC is mainly funded by local taxation underlines the independence of the local authorities from national government. County councils are responsible for providing

healthcare (whether through family doctors,

hospitals, health centres, or other providers).

Municipalities offer a number of social services to

assist elderly living at home, including home help

services, daytime community activities, etc. With

the 1992 reform municipalities were also handed

responsibility over local nursing homes and other

forms of institutional LTC. In contrast, the

responsibility for health care belongs to the county

councils. In local nursing homes the municipalities

are by law responsible for providing home health

care including all medical staff and excluding

doctors only. Over the years, all county councils

and municipalities, except the municipalities

within Stockholm county, have formed agreements

on transferring the responsibility for home health

care also in all ordinary homes from the county

councils to the municipalities. This has led to a

more coherent organisation. However, county

councils are still responsible for patients until they

are discharged from hospital. The responsibility of

medical care and rehabilitation for elderly in

ordinary homes is shared between municipalities and county councils. This places high demands on the coordination of care between municipalities and county councils. Lack of coordination may lead to an inefficient use of resources, cooperation issues and lack of continuity as well as attempts by county councils and municipalities to transfer both responsibilities and costs to one another.

From 1 January 2010, local authorities have to draw up an individualised care plan for each recipient. The care plan states clearly each step of the required services and treatment. The plan also identifies the official in charge of the case and specifies which authority is responsible for which component of the services and care provided.

Types of care

The primary LTC service is home care, comprising help with daily activities such as shopping, cooking, cleaning and laundry. It also includes personal care, such as help with bathing, going to the toilet, getting dressed and getting in and out of

bed.

As well as home care, the following LTC services

are also available in Sweden: institutional care, day

care, home nursing care, meal services, home

adaptation and personal safety alarms. There are

also transportation services for care recipients who

are unable to use public transport. In addition, the

local authorities also provide non-means tested

grants to assist the disabled to use their homes in

an efficient manner (Fukushima, 2010).

The expenditure on LTC for older people in

2006 (467) was distributed as follows: about 60%

was spent on nursing homes, almost 39% on home

care and less than 2% allocated to "other services".

Public provision of home care in Sweden was at its

highest in 1978, with 352 000 clients. Since the

(467) WHO/Europe, 2012.

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1980s, a decrease in public involvement in the

provision of LTC was driven by a significant improvement in the health status of the elderly and their standard of living as well as the will to avoid the oversupply of the previous decade. In the 1990s, Sweden suffered its deepest recession since the 1930s. This economic crisis gave rise to serious public sector financial problems. As a result, the public provision of long-term-care continued to fall, and the provision of care focused on those with the greatest need. At the same time, the Swedish model based on the monopoly of public sector provision was challenged and share of private caregivers increased by 100% in the 1990s.

Eligibility criteria

Permanent residents who suffer from some degree of dependency are eligible for care, determined only by an assessment of their need for care. There is therefore no means-testing criterion applied to the provision of long-term care. Need for care is either assessed by a general practitioner or through a request for assessment by the relevant local

authority. For direct requests to the authority, the potential recipient as well any eventual relatives are interviewed by an evaluator in order to determine the extent of support required, and whether the care can be provided in recipient's own home or not.

Nowadays, even relatively severe dependency cases needing extensive medical care can be treated in the home of the recipient. Home help is offered in flexible hours, in some cases including up to seven visits per day or more. In some cases, however, home care will not be advisable (for instance due to the inadequacy of the home) and institutional care will be considered as a last resort policy. The National Board of Health and Welfare (NBHW) introduced a standardised instrument for needs assessment in 2012. The tool for needs assessment is based on the International Classification of Functioning, Disability and Health (ICF) standard. The government have commissioned the NBHW to implement the new

tool and financially supported activities such as training of process-leaders. In cases where citizens disagree with the care-manager's decisions, they can appeal to an administrative court. The number of successful appeals is very low, but the right to appeal is perceived as providing personal security to individuals.

Co-payments, out of the pocket expenses and private insurance

Cost-sharing for LTC services is set according to the Social Services Act with the aim of protecting recipients from excessive fees. A ceiling fee is set annually by the government, representing the maximum amount that a recipient can be charged.

This ceiling is set without means-testing in principle, although it may be reduced if the recipient's monthly income is below the minimum cost of living as defined by the government (also on an annual basis).

Within these rules, each municipality will determine their own schedule of cost-sharing fees for recipients. In 2006 (468), around 19% of

recipients of home care did not pay any fees, as

their income was below the threshold.

There are no private insurances for the cost of LTC

in Sweden, so care is financed exclusively from

taxation, cost-sharing and other out-of-pocket

payments.

Role of the private sector

Municipalities and county councils can decide on

how to organise the provision of LTC, including

collaboration with different providers. Institutional

and home care may be provided either by a

municipality or a private provider (which can

include private companies but also trusts and cooperatives).

However, even when care is actually

provided by the private sector, municipalities and

country councils still have the exclusive

responsibility for ensuring financing, provision and

ensuring an adequate level of quality.

The introduction of choice for the individual is by

far the main driving force behind the expansion of

privately run (but publicly financed) institutions.

Another reason has been the assumption that

competition will be good for quality, effectiveness

and the career possibilities for the mainly female

staff in elderly **care**.

(468) Fukushima et al, 2010.

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Formal/informal caregiving

Municipalities are required by law (since 1 July

2009) to provide support to informal carers.

According to the Social Services Act,

municipalities need to respect and cooperate with

informal carers, offering support tailored to their

needs. The aim is to alleviate the workload of

carers and its impact on their health status, as well

as providing them with necessary information and

knowledge. The Act also aims to provide

recognition of the work provided by carers and

acknowledge its importance.

In accordance with the above, support for informal

carers takes different forms. Carers have the right

in some circumstances to take leave from their

work in order to provide care for an elderly or terminally ill relative. Some municipalities have cash benefits that the recipients of care can use to compensate the carer. Municipalities can also compensate informal carers directly under certain circumstances. In 2003, around 5500 people aged 65 years and over were entitled to this type of cash benefits. Additionally, 2000 people received help from relatives that were employed by the municipalities. (469)

Municipalities also provide support groups or centres for carers, which can be a source of mutual support. Municipalities can provide "Respite leave", giving carers temporary leave from their caring responsibilities, with the latter being taken

over by home care providers or charities over that period (provided for free in about 50% of municipalities, in others a small charge is required) or by institutional providers on a temporary basis.

In addition, there are different services that provide informal carers with advice, including one-on-one sessions, websites and assistance from volunteers.

Some municipalities also organise services for carers, including spa treatments, massage and health consultations. (470)

Prevention and rehabilitation policies/measures

Prevention is dealt with by the public health system in Sweden.

(469) WHO/Europe (2012).

(470) Fukushima et al. (2010).

Recently legislated and/or planned policy reforms

The Act on System of Choice in the Public Sector

In order to stimulate a greater variety of LTC providers and increase the quality of services provided, the government introduced a new law in 2009, the "Act of System of Choice in the Public Sector". Its aim was to make it easier for a variety of commercial providers to enter the market of service and care for the elderly. The law worked as a voluntary tool for those municipalities who wanted to let recipients choose suppliers, and to expose public sector providers to competition from

the private sector. The law is an alternative to the Swedish Public Procurement Act (2007:1091) for public sector provision and may be implemented regarding elderly and disabled care as well as health and medical services (where it is mandatory).

The act ensures equal opportunities for all providers, and it facilitates the provision of LTC and health care by for small companies and nonprofit organisations.

The local municipality must specify in the contract the requirements that providers must meet. The requirements need to be compliant with community law principles, such as, nondiscrimination, transparency, and proportionality.

The contract does not in itself guarantee any volume or compensation and the latter depends exclusively on the number of recipients the provider is able to attract.

Choice is presented as an opportunity for the user.

Recipients who are not able or who do not want to choose are also not obliged to do so. A no-choice

alternative should be presented in advance to recipients. The providers presented as the nochoice alternative need to fulfil the same quality requirements as the rest.

By October 2013, 181 of the country's 290 municipalities had introduced or decided to introduce free choice of providers within at least one service area. Before the act entered into force, only 40 municipalities offered various forms of customer choice. The reform is financed through taxation.

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Currently, some 900 providers are active within this system. They provide a variety of services, with providers specialising and including provision in different languages, others focusing on specific treatments or diets, and some offering services for particular cultural or religious groups.

A greater diversity of providers increases the possibility for recipients to find providers that suits

their preferences and needs, which can also improve the quality of the services. The legislation has the purpose of promoting freedom of choice for recipients and to increase their power to make their own choices. The reform is based on a clear ideological view that recipients of LTC should remain in charge of their own life. Evaluations have so far shown that users do value this aspect.

Dignity – National set of values for elderly care

The national set of values for the elderly is expressed in the Social Services Act (2001:453) since 2010. The Social Services Act also clarifies that the elderly should be given increased opportunities for influence on the social services.

The national set of values basically means that care services for the elderly should focus on enabling elderly to live with dignity and to experience wellbeing.

This means among other things that the elderly care services should uphold and respect everyone's right to privacy and bodily integrity, autonomy, participation and personalisation.

Health and social care should help the individual to

feel safe and experience meaningfulness. Services

within elderly care must be of good quality.

Older people should have influence over when and

how services should be carried out.

The right for older couples to continue to live

together

Today spouses can choose to continue to live

together even when one of the spouses is in need

of care in special housing. The right came into

force in 2012 after an amendment to the Social

Services Act.

Government grant to support increased

staffing

A sufficient level of staffing is recognised by the

government as a crucial part of quality in elderly

care. It is important to create safety and quality to

the elderly, as well as good working conditions for

the staff. A government grant to the municipalities

of two billion SEK yearly, under the period 2016-

2018, is supposed to increase the number of staff

working closest to the elderly. The staff is

supposed to have relevant education or should be

offered introduction and at work education. The grant will be offered provided that this is approved by the Parliament.

Possible future changes

An inquiry chair is to propose measures to secure good quality in the future elderly care. The inquiry is to focus on quality, efficiency, improved prevention and rehabilitation, secured work force supply for elderly care and need for special housing. The analysis is to be done from a gender equality perspective, as well as equality in general. The inquiry report will be presented no later than 31 March 2017.

Challenges

- Improving the governance framework: To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal

framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To deal with cost-shifting incentives across health and care.

- Improving financing arrangements: To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore advantages, disadvantages and preconditions of private LTC insurance as a supplementary financing tool; To determine the extent of user costsharing on LTC benefits; To include assets in Long-term care systems

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the means-test used to determine individual cost-sharing (or entitlement to public support) for B&L costs better reflects the distribution of economic welfare among individuals.

- Providing adequate levels of care to those in

need of care: To adapt and improve LTC

coverage schemes, setting the need-level

triggering entitlement to coverage; the breadth

of coverage, that is, setting the extent of user

cost-sharing on LTC benefits; and the depth of

coverage, that is, setting the types of services

included into the coverage; To provide targeted

benefits to those with highest LTC needs.

- Encouraging independent living: To provide

effective home care, tele-care and information

to recipients, as well as improving home and

general living environment design.

- Ensuring availability of formal carers: To

determine current and future needs for

qualified human resources and facilities for

long-term care; To seek options to increase the

productivity of LTC workers;

- Ensuring coordination and continuity of

care: To establish better co-ordination of care

pathways and along the care continuum, such

as through a single point of access to

information, the allocation of care coordination

responsibilities to providers or to

care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: To arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; To create better rules, improving

(and securing) safe care pathways and

information delivered to chronically-ill people

or circulated through the system; To steer LTC

users towards appropriate settings.

- Changing payment incentives for providers:

To consider fee-for-service to pay LTC

workers in home-care settings and capitation

payments; To consider a focused use of

budgets negotiated ex-ante or based on a prefixed

share of high-need users.

- Improving value for money: To encourage competition across LTC providers to stimulate productivity enhancements; To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and coordination between health and care services; To invest in ICT as an important source of information, care management and coordination.
- Prevention: To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

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Table 2.27.1: Statistical Annex – Sweden

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 293 307 313 335 356 352 310 369 405 423 436 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 30.6 32.5 32.2 33.6 35.2 33.8 30.1 31.8 32.6 32.9 32.2 26.8 27.6 28.0 28.1 27.9

Population, in millions 8.9 9.0 9.0 9.0 9.1 9.2 9.3 9.3 9.4 9.5 9.6 502 503 504 506 507

Public expenditure on long-term care

As % of GDP 3.8 3.7 3.7 3.6 3.6 3.7 3.8 3.7 3.7 3.7 : 1.0 1.0 1.0 1.0 :

Per capita PPS 950.7 984.1 975.9 1030.0 1093.3 1122.2 1083.1 1102.8 1146.7 1185.2 : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : 6.9 6.8 6.9 7.0 7.1 7.0 7.1 7.2 7.2 : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

Life expectancy at birth for females 82.5 82.8 82.9 83.1 83.1 83.3 83.5 83.6 83.8 83.6 83.8 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 78.0 78.4 78.5 78.8 79.0 79.2 79.4 79.6 79.9 79.9 80.2 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 62.2 60.8 63.2 67.5 66.8 69.0 69.6 66.4 65.5 : 66.0 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 62.5 62.0 64.5 67.3 67.7 69.4 70.7 67.0 67.0 : 66.9 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : 49.9 41.8 35.2 34.8 33.0 32.4 30.7 32.4 34.1 35.3 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : 14.0 11.2 8.2 7.8 7.0 6.1 7.7 7.4 : 7.0 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 97 140 184 227 230 232 87 3,433 3,771 3,851 3,931 4,183

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care at home, in thousands : : : : 222 223 224 225 227 229 206 6,442 7,296 7,444
7,569 6,700

% of pop. receiving formal LTC in-kind : : : : 3.5 4.0 4.4 4.8 4.8 4.9 3.1 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : 186 : 200 : : : : : : : :

Number of formal carers, in thousands 218 218 223 224 224 222 217 221 222 : : : : : :

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Table 2.27.2: Statistical Annex - continued – Sweden

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 10.2 11.0 11.8 12.5 13.1

Dependency

Number of dependents in millions 0.70 0.79 0.86 0.94 1.00

Share of dependents, in % 6.9 7.2 7.3 7.5 7.7

Projected public expenditure on LTC as % of GDP

AWG reference scenario 3.9 4.4 4.6 4.8 5.1

AWG risk scenario 4.1 4.9 5.7 6.4 7.5

Coverage

Council of the European Union: Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability ST 12735 2016 ADD 1

Number of people receiving care in an institution 96,502 121,831 143,436 159,973 179,065

Number of people receiving care at home 231,777 283,148 317,277 347,962 379,217

Number of people receiving cash benefits 251,336 303,892 347,310 380,103 420,009

% of pop. receiving formal LTC in-kind and/or cash benefits 5.7 6.4 6.9 7.1 7.5

% of dependents receiving formal LTC in-kind and/or cash benefits 82.9 89.7 93.5 94.6 97.4

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 96.4 96.5 96.4 96.4 96.5

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 3.6 3.5 3.6 3.6 3.5

Public spending on institutional care (% of tot. publ. spending LTC) 50.5 50.7 51.8 52.0 52.5

Public spending on home care (% of tot. publ. spending LTC in-kind) 49.5 49.3 48.2 48.0 47.5

Unit costs of institutional care per recipient, as % of GDP per capita 199.6 193.1 190.0 187.1 189.1

Unit costs of home care per recipient, as % of GDP per capita 81.6 80.7 80.0 79.3 80.6

Unit costs of cash benefits per recipient, as % of GDP per capita 5.6 5.6 5.6 5.6 5.6

2013

MS Change

2013-2060

EU Change 2013-2060

9.6 37% 3%

0.62 62% 40%

6.5 19% 36%

3.6 41% 40%

3.6 106% 149%

86,795 106% 79%

206,253 84% 78%

223,843 88% 68%

5.4 39% 68%

83.4 17% 23%

96.4 0% 1%

3.6 -2% -5%

50.3 5% 1%

49.7 -5% -1%

194.0 -3% -2%

80.8 0% -3%

5.6 0% -2%

2.28. UNITED KINGDOM

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General context: Expenditure, fiscal

sustainability and demographic trends

The United Kingdom has a population of around

63.9 million inhabitants, which is roughly 12.6%

of the EU population. With a GDP of around EUR

2,043 bn, or 27,300 PPS per capita it is in line with

the EU average GDP per capita of EUR 27,900.

Public expenditure on long-term care is with 1.2%

GDP (471), slightly higher than EU average in the previous years (around 1% in 2012). During the coming decades the population of the UK is set to increase, from 63.9 million inhabitants in 2013 to 80.1 million inhabitants in 2060. This 25% increase is well above the EU average change of 3%.

Health status

Life expectancy at birth for both women and men was, in 2013, respectively 82.9 and 79.2 years, respectively below and above the EU average (83.3 and 77.8 years, respectively, for women and men). However, the healthy life years at birth were 64.8 years (women) and 64.4 years (men) are both above the EU-average (61.5 and 61.4 respectively). The percentage of the UK population having a long-standing illness or health problem is in line with the EU average (32.5% like for the whole EU 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities is above the EUaverage (10.2% against 8.7% in 2012).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 5.47 million residents living with strong limitations due to health problems in 2013, an increase of 49% is envisaged until 2060 to around 8.15 million. That is a steeper increase than in the EU as a whole (EU 40%). Also as a share of the population, the dependents are becoming a bigger group, going from 8.5% to 10.2%, with an increase of 19% (lower than the EU average of 36%).

(471) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term **care** as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term **care** expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (nondisability)

status. The joint impact of those factors is a projected increase in spending of about 0.3 pps of GDP by 2060. (472) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.1 pps of GDP by 2060. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. Sustainability risks appear over the long run due to the projected increase in age-related public spending, although the latter is driven primarily by pensions and health care, with a weaker contribution from long-term care. (473)

System Characteristics

Public spending on LTC reached 1.2% of GDP in 2013 in the UK, below the EU average of 1% of GDP. Around 1.06% of GDP was spent on in-kind benefits in 2013 with 0.14% being spent on cashbenefits.

(474)

In the United Kingdom, 50.6% of dependents are receiving formal in-kind LTC services or cash benefits for LTC. Overall, 4.3% of the population receive formal LTC in-kind and/or cash benefits.

(475) Low shares of coverage may indicate a situation of under-provision of LTC services.

However higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 47.4% of public in-kind expenditure (EU: 60%), 52.6% being spent for LTC services provided at home. With more than a half spent on

(472) The 2015 Ageing Report.

(473) Fiscal Sustainability Report 2015:

[http://ec.europa.eu/economy_finance/publications/eeip/pdf/](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf)

ip018_en.pdf.

(474) The 2015 Ageing Report:

http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

(475) The 2015 Ageing Report.

Long-term **care** systems

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home care, the United Kingdom appears to be more focussed on home care than the average, which may be more efficient, as institutional care is relatively costly with respect to other types of care.

The United Kingdom has a devolved long-term care (LTC) system where Wales, England, Scotland and Northern Ireland manage their LTC systems separately. Considering that 83% of the United Kingdom's elderly, representing, though not the only one (476), a very important source of long-term care expenditure, reside in England, the majority of service use and expenditure relates to England. A large part of the fiscal responsibility for LTC used to lie with the individual; but there is also considerable public support for the financing of LTC and the provision of LTC services(477). Scotland has introduced a free and universal system in 2002. (478) The Department of Health, Social Services and Public Safety in Northern

Ireland has recently carried out a consultation on

adult social care reform. (479)

Administrative organisation

Unlike health care in England and Wales, adult

social care is strictly means-tested by local

authorities. Care support is provided only for those

with the high needs and the lowest means. In

Scotland care is provided free to everyone in

need (480), while Northern Ireland is considering

the introduction of free care.

Types of care

Home care: In order to receive home care the

elderly or those with qualifying care needs have to

request this kind of service from the council,

which will proceed to verifying entitlement and,

(476) Working age population with chronic conditions, including

learning disabilities, represent an important source of nonage-

related spending.

(477) OECD Fact Sheet, (May 2011)

(478) For details of the legislation see

<http://www.scottish.parliament.uk/visitandlearn/Education/15870.aspx>, accessed Oct 18, 2013.

(479) For further details see

<http://www.dhsspsni.gov.uk/showconsultations?txtid=5850>

1, accessed Oct. 18, 2013

(480) (further information about the Scottish system is available

at [http://www.scotland.gov.uk/Topics/Health/Support-](http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/Free-Personal-Nursing-Care)

Social-**Care**/Support/Older-People/Free-Personal-Nursing-

Care, accessed October 18, 2013).

upon confirmation, would make the necessary

arrangements.

Institutional **care**: Most institutional **care** facilities,

not unlike in the case of non-institutionalised **care**,

are privately run with only a few being entirely

publicly run. Private institutions nevertheless are

in most cases commissioned through the local

authorities. There are three types of institutional

care in the United Kingdom, residential **care**

homes, nursing homes and long-stay hospital

provision.

Private Sector

According to the OECD Fact Sheet, May 2011

most services are provided by the private sector

however, in the private services have clients which

are separated in two distinct categories. Publicly

funded clients and privately funded clients. Since

the majority of the clients are classified as publicly

funded clients this means that the private sector is

financed to a great extent by the public sector.

Eligibility criteria, co-payments, out of the

pocket expenses and private insurance

Local authorities receive a finite amount of

funding from central Government but may also

raise their own revenue through business rates and

council tax. They determine how to distribute and

set budgets for expenditure on adult social care.

Funding comes from a combination of central

taxation (formula and specific grant to local

authorities-block grants), local taxation (council

tax and business rates) and user charges for social

care services. The majority of central government

grants received are not earmarked for particular

services and local authorities can decide how to

allocate the overall budget to various public

services including social services.

Health services provided under the National Health

Service (NHS) are free at the point of delivery,

irrespective of the financial means of the user.

Social services arranged by local authorities attract

user charges depending on the user's financial

means. The means-test takes account of the

person's assets (including in some cases, the total

value of the persons' home). The assets of spouses,

children and other relatives are not taken into

account. Those with assets below this level will get

help to cover LTC costs mainly according to their

Long-term care systems

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incomes. In response to the Royal Commission,

the Government funds a part of the nursing home

fees that is meant to reflect the nursing input in the

care provided. In the United Kingdom, private

long-term care insurance is minimal. (481)

Institutional care

In the United Kingdom, local authorities negotiate the fees that are paid to the providers of publicly subsidised residential care and home-care services.

As local authorities are in many areas the main purchaser of care from local providers, they have considerable market power to negotiate fees at relatively low levels. Along with a general policy shift towards maintaining people's independence in the community, these fee levels seem to be one of the reasons for the decline in around 1998 to 2000 in the numbers of residential care and nursing home places. As well as low fees, the reimbursement and contract arrangements, which consist of a lot of spot contracts, can present a problem for providers. Private residential care and nursing home providers often charge higher fees to individuals who fund their own care. This means that, effectively, privately funded residents may be subsidising the care of publicly funded residents. (482)

Formal/informal caregiving

In terms of financial eligibility for residential care, for example, currently an individual must have assets less than £118,000 in England to qualify for local authority placement into a care home that is fully funded by the local authority and partial financial help may be provided also above the threshold. Still, much of the needed care is provided informally. There are approximately six million unpaid carers in the UK with important variations among this dedicated group of people. 1.5 million are themselves over 60, 60% are women, and there are particularly high instances of caring in some black, minority and ethnic communities (twice as many Pakistani women, for example, are carers compared to the national average). (483)

(481) OECD Fact Sheet, May 2011.

(482) OECD Fact Sheet, May 2011.

(483) Centre for Social Justice (2010).

Prevention and rehabilitation

policies/measures

Some services which are preventative or rehabilitative in nature are fully funded by the state.

Recently legislated and/or planned policy reforms

The UK has recently passed legislation which consolidates existing law into a single, unified, modern statute. The legislation focuses on promoting people's well-being by enabling them to prevent and postpone the need for long term care and to pursue education, employment and other opportunities to realise their potential. The changes being made include:

- introduction of a new national minimum eligibility criteria, which defines the minimum level of need for support an individual should be assessed as having before they are entitled to publicly funded care, rather than allowing this to be set at the discretion of local government; (from April 2015);
- informal carers will be treated as equal to the person they care for, including the same rights

to assessment and broadened entitlements to

publicly funded support (from April 2015);

- rebalancing the focus of services to promote

wellbeing and prevention or delaying of needs

in order to reduce dependency, rather than only

intervening at crisis point; (from April 2015);

- a new offer that the state will defer the costs of

residential care in return for a charge against

the person's house, so that no-one will be

forced to sell their home in their lifetime to pay

for residential care (from April 2015).

Challenges

The UK has a relatively fragmented system of

LTC, with high costs and heavy reliance on

informal care. As it stands, the main challenges of

the system appear to be:

- Improving the governance framework: to

define a comprehensive approach covering

both policies for informal (family and friends)

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carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- Improving financing arrangements: to foster pre-funding elements, which implies setting aside some funds to pay for future obligations.
- Providing adequate levels of care to those in need of care: to adapt and improve LTC coverage schemes, setting the depth of coverage, that is, setting the extent of user costsharing on LTC benefits; and the scope of

coverage, that is, setting the types of services included into the coverage, to reduce the risk of impoverishment of recipients and informal carers.

- Ensuring availability of formal carers: to determine current and future needs for qualified human resources and facilities for long-term care; to improve recruitment efforts, including through the migration of LTC workers and the extension of recruitment pools of workers; to increase the retention of successfully recruited LTC workers, by further improving the pay and working conditions of the LTC workforce building on the horizontal improvements brought about for all categories by the National Living Wage, training opportunities, more responsibilities on-the-job, feedback support and supervision, to seek options to increase the productivity of LTC workers.

- Supporting family carers: to further the efforts on establishing policies for supporting

informal carers, as envisaged by the future carers strategy, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- Encouraging independent living: to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- Ensuring coordination and continuity of care: to further the efforts towards better coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care coordination responsibilities to providers or to care managers, via dedicated governance

structures for care co-ordination and the

integration of health and care to facilitate care

co-ordination.

- To facilitate appropriate utilisation across

health and long-term care: to arrange for

adequate supply of services and support outside

hospitals, changing payment systems and

financial incentives to discourage acute care

use for LTC; to create better rules, improving

(and securing) safe care pathways and

information delivered to chronically-ill people

or circulated through the system; to steer LTC

users towards appropriate settings.

- Improving value for money: to invest in

assistive devices, which for example, facilitate

self-care, patient centeredness, and coordination

between health and care services; to

invest in ICT as an important source of

information, care management and

coordination.

- Prevention: to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Long-term care systems

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Table 2.28.1: Statistical Annex –United Kingdom

Source: EUROSTAT, OECD and WHO

GENERAL CONTEXT

GDP and Population 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

GDP, in billion euro, current prices 1,720 1,849 1,946 2,063 2,169 1,908 1,668 1,813 1,866 2,054 2,043 9,289 9,545 9,800 9,835 9,934

GDP per capita, PPS 31.9 32.9 33.2 33.4 32.9 31.0 28.2 27.4 27.0 27.4 27.3 26.8 27.6 28.0 28.1 27.9

Population, in millions 59.5 59.8 60.2 60.6 61.1 61.6 62.0 62.5 63.0 63.5 63.9 502 503 504 506 507

Public expenditure on long-term care

As % of GDP : : : : : 1.0 1.0 1.0 1.0 :

Per capita PPS : : : : : 297.1 316.7 328.5 317.8 :

As % of total government expenditure : : : : : 2.1 2.2 2.2 2.1 :

Note: Based on OECD, Eurostat - System of Health Accounts

Health status

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Life expectancy at birth for females 80.5 81.1 81.3 81.6 81.8 81.8 82.4 82.6 83.0 82.8 82.9 82.6 82.8 83.1 83.1 83.3

Life expectancy at birth for males 76.2 76.8 77.0 77.3 77.6 77.7 78.3 78.6 79.0 79.1 79.2 76.6 76.9 77.3 77.4 77.8

Healthy life years at birth for females 60.9 : 65.5 64.9 66.0 66.3 66.1 65.6 65.2 64.5 64.8 : 62.6 62.1 62.1 61.5

Healthy life years at birth for males 61.5 : 64.2 64.8 64.6 65.0 65.0 64.9 65.2 64.6 64.4 : 61.8 61.7 61.5 61.4

People having a long-standing illness or health problem, in % of pop. : : 37.4 38.0 35.8 33.9 35.8 34.5 36.0 32.9 32.5 : 31.4 31.8 31.5 32.5

People having self-perceived severe limitations in daily activities (% of pop.) : : 9.4 9.2 9.0 8.8 9.6 9.2 9.1 10.6 10.2 : 8.1 8.3 8.6 8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 EU 2009 EU 2010 EU 2011 EU 2012 EU 2013

Number of people receiving care in an institution, in thousands : : : 318 288 259 230 234 238 243 3,433 3,771 3,851 3,931 4,183

Number of people receiving care at home, in thousands : : : 847 899 951 1,003 1,017 1,032 1,020 6,442 7,296 7,444 7,569 6,700

% of pop. receiving formal LTC in-kind : : : 1.9 1.9 2.0 2.0 2.0 2.0 2.0 2.0 2.2 2.2 2.3 2.1

Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients

Providers

Number of informal carers, in thousands : : : : 5,550 : : : : :

Number of formal carers, in thousands : : : : : : : : :

Long-term care systems

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Table 2.28.2: Statistical Annex - continued – United Kingdom

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".

PROJECTIONS

Population

2020 2030 2040 2050 2060

Population projection in millions 66.9 70.6 74.0 77.3 80.1

Dependency

Number of dependents in millions 5.94 6.61 7.23 7.76 8.15

Share of dependents, in % 8.9 9.4 9.8 10.0 10.2

Projected public expenditure on LTC as % of GDP

AWG reference scenario 1.2 1.3 1.4 1.5 1.5

AWG risk scenario 1.3 1.5 1.7 2.0 2.3

Coverage

Number of people receiving care in an institution 265,143 304,866 339,403 359,715 378,875

Number of people receiving care at home 1,107,112 1,264,021 1,422,183 1,533,700 1,605,348

Number of people receiving cash benefits 1,661,344 1,964,768 2,302,408 2,633,305 2,852,580

% of pop. receiving formal LTC in-kind and/or cash benefits 4.5 5.0 5.5 5.9 6.0

% of dependents receiving formal LTC in-kind and/or cash benefits 51.1 53.4 56.2 58.3 59.4

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind (% of tot. publ. spending LTC) 88.6 88.5 87.9 87.2 86.9

Public spending on LTC related cash benefits (% of tot. publ. spending LTC) 11.4 11.5 12.1 12.8 13.1

Public spending on institutional care (% of tot. publ. spending LTC) 47.5 47.1 46.5 45.3 45.6

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Public spending on home care (% of tot. publ. spending LTC in-kind) 52.5 52.9 53.5 54.7 54.4

Unit costs of institutional care per recipient, as % of GDP per capita 128.5 128.7 126.4 125.0 126.4

Unit costs of home care per recipient, as % of GDP per capita 34.0 34.9 34.7 35.3 35.6

Unit costs of cash benefits per recipient, as % of GDP per capita 5.5 5.5 5.5 5.5 5.6

33.9 5% -3%

5.6 0% -2%

52.6 3% -1%

128.4 -2% -2%

11.3 16% -5%

47.4 -4% 1%

50.6 17% 23%

88.7 -2% 1%

1,508,174 89% 68%

4.3 40% 68%

242,704 56% 79%

1,020,055 57% 78%

1.2 30% 40%

1.2 97% 149%

5.47 49% 40%

8.5 19% 36%

2013

MS Change

2013-2060

EU Change 2013-2060

63.9 25% 3%

ANNEX

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Health care - data sources by indicator (484)

(484) The cut-off date for incorporating international database updates was set at April 2016. Later updates of the data were only

taken in consideration on a case by case basis, where it was deemed that omitting the update would compromise the accuracy of

GDP

GDP, in billion Euro, current prices Eurostat

GDP per capita PPS (thousands) Ameco

Real GDP grow th (% year-on-year) per capita Eurostat

Real total health expenditure grow th (% year-on-year) per capita Eurostat

Expenditure on health*

Total as % of GDP Eurostat and WHO

Total current as % of GDP Eurostat, OECD and WHO

Total capital investment as % of GDP Eurostat, OECD and WHO

Total current per capita PPS Eurostat, OECD, WHO and AMECO

Public as % of GDP Eurostat, OECD and WHO

Public current as % of GDP Eurostat and OECD

Public current per capita PPS Eurostat, OECD and AMECO

Public capital investment as % of GDP Eurostat, OECD and WHO

Public as % total expenditure on health Eurostat, OECD and WHO

Public expenditure on health in % of total government expenditure Eurostat

Proportion of the population covered by public or primary private health insurance OECD

Out-of-pocket expenditure on health as % of total expenditure on health Eurostat and WHO

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts.

Population and health status

Population, current (millions) Eurostat

Life expectancy at birth for females Eurostat

Life expectancy at birth for males Eurostat

Healthy life years at birth females Eurostat

Healthy life years at birth males Eurostat

Amenable mortality rates per 100 000 inhabitants* Eurostat

Infant mortality rate per 1 000 live births Eurostat

System characteristics

Composition of total or public current expenditure as % of GDP and as % of total current health expenditure

Inpatient curative and rehabilitative care Eurostat, OECD and WHO

Day cases curative and rehabilitative care Eurostat, OECD and WHO

Out-patient curative and rehabilitative care Eurostat, OECD and WHO

Pharmaceuticals and other medical non-durables Eurostat, OECD and WHO

Therapeutic appliances and other medical durables Eurostat, OECD and WHO

Prevention and public health services Eurostat, OECD and WHO

Health administration and health insurance Eurostat, OECD and WHO

Expenditure drivers (technology, life style)

MRI units per 100 000 inhabitants Eurostat

Angiography units per 100 000 inhabitants Eurostat

CTS per 100 000 inhabitants Eurostat

PET scanners per 100 000 inhabitants Eurostat

Proportion of the population that is obese OECD

Proportion of the population that is a regular smoker Eurostat and OECD

Alcohol consumption litres per capita OECD and WHO

Providers

Practising physicians per 100 000 inhabitants Eurostat and OECD

Practising nurses per 100 000 inhabitants Eurostat and OECD

General practitioners per 100 000 inhabitants Eurostat and OECD

Acute hospital beds per 100 000 inhabitants Eurostat, OECD and AMECO

Outputs

Doctors consultations per capita Eurostat and OECD

Hospital inpatient discharges per 100 inhabitants Eurostat

Day cases discharges per 100 000 inhabitants Eurostat

Acute care bed occupancy rates Eurostat and WHO

Hospital curative average length of stay Eurostat

Day cases as % of all hospital discharges Eurostat and AMECO

Population and Expenditure projections

AWG reference scenario Ageing report 2015

AWG risk scenario Ageing report 2015

Sources: 2012 EC-EPC Ageing Report

Note: *Excluding expenditure on medical long-term care component.

Population projections until 2060 (millions) Ageing report 2015

Projected public expenditure on healthcare as % of GDP*

Population projections

Sources: EUROSTAT, OECD and WHO

Annex

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Long-term care - data sources by indicator (485)

the message.

(485) The cut-off date for incorporating international database updates was set at April 2016. Later updates of the data were only

taken in consideration on a case by case basis, where it was deemed that omitting the update would compromise the accuracy of

the message.

Indicator SOURCE

GDP and Population

GDP, in billion euro, current prices Eurostat

GDP per capita, PPS Ameco

Population, in millions Eurostat

Public expenditure on long-term care

As % of GDP EUROSTAT

Per capita PPS

EUROSTAT

As % of total government expenditure

EUROSTAT

Health status

Life expectancy at birth, females EUROSTAT

Life expectancy at birth, males EUROSTAT

Healthy life years at birth, females EUROSTAT

Healthy life years at birth, males EUROSTAT

People having a long-standing illness or health problem, in % of pop. EUROSTAT

People having self-perceived severe limitations in daily activities (% of pop.) EUROSTAT

Coverage (Based on data from Ageing Reports)

Number of people receiving care in an institution (thousands) Ageing Report 2015

Number of people receiving care at home (thousands) Ageing Report 2015

% of pop. receiving formal LTC in-kind

Ageing Report 2015 and

Eurostat

Providers

Number of informal carers (thousands) (OECD) OECD

Number of formal carers (thousands) (OECD) OECD

Population

Population projection in millions (Europop2013) EUROSTAT

Dependency

Number of dependents in millions (2015 Ageing Report) Ageing Report 2015

Share of dependents (% , 2015 Ageing Report) Ageing Report 2015

Projected public expenditure on LTC as % of GDP

AWG reference scenario Ageing Report 2015

AWG risk scenario Ageing Report 2015

Coverage

Number of people receiving care in an institution Ageing Report 2015

Number of people receiving care at home Ageing Report 2015

Number of people receiving cash benefits Ageing Report 2015

% of pop. receiving formal LTC in-kind and/or cash benefits Ageing Report 2015

% of dependents receiving formal LTC in-kind and/or cash benefits Ageing Report 2015

Composition of public expenditure and unit costs

Public spending on formal LTC in-kind as % of total public spending on LTC Ageing Report 2015

Public spending on LTC related cash benefits as % of total public spending on LTC Ageing Report 2015

Public spending on institutional care as % of total public spending on LTC in-kind Ageing Report 2015

Public spending on home care as % of total public spending on LTC in-kind Ageing Report 2015

Unit costs of institutional care per recipient, as % of GDP per capita Ageing Report 2015

Unit costs of home care per recipient, as % of GDP per capita Ageing Report 2015

Unit costs of cash benefits per recipient, as % of GDP per capita Ageing Report 2015

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Industry: LONG TERM HEALTH **CARE** (90%); NURSES & NURSING (90%); HEALTH INSURANCE (90%); LONG TERM **CARE** INSURANCE (90%); HEALTH **CARE** (90%); PHYSICIANS & SURGEONS (89%); BUDGETS (89%); FOOD & BEVERAGE CONSUMPTION (78%); EURO ZONE (78%); BUDGET FORECASTS (77%); HEALTH **CARE** RATIONING (77%); HOSPITAL OCCUPANCY RATES (76%); MONETARY UNIONS (73%); DIAGNOSTIC IMAGING (68%); FOOD SAFETY (50%); COMPUTER SCANNERS (50%)

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