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Social Policy in the EU — Reform Barometer 2016

Social Inclusion Monitor Europe

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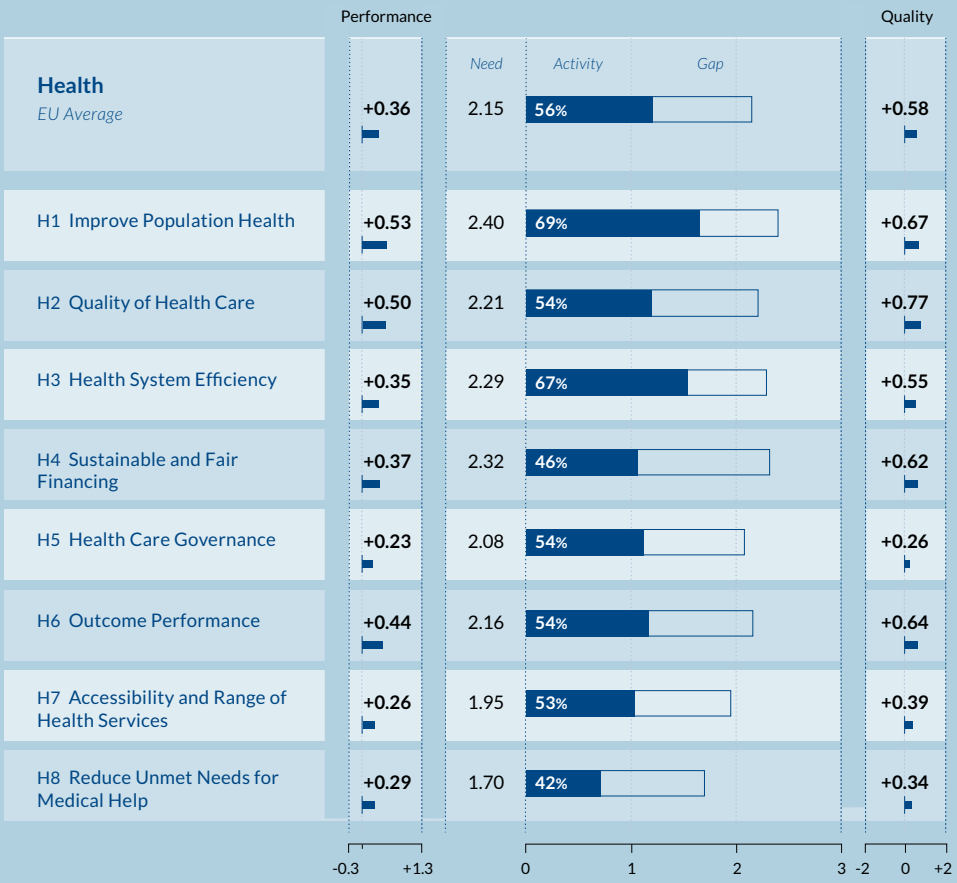
Findings by Dimension

Health



NOTABLE FINDINGS

... for the EU as a whole

- Health shows the highest rate of reform activity.
- The experts give the highest need scores to the policy objectives of improving public health and establishing sustainable and fair financing.
- The most strongly targeted objectives are the improvement of health system efficiency and of population health in general.
- The reduction of unmet needs for medical help is the objective that has both the lowest need score and activity rate.
- The most effectively addressed objective is health care quality.
- The least effectively addressed one by far is the improvement of health care governance (positive exception: Finland).

Social Justice and Reform Performance in Comparison

	Performance	Need	Activity	Quality
FI	1.14	2.28	85%	1.34
HR	0.95	2.23	83%	1.14
CZ	0.70	1.84	70%	1.00
BG	0.62	2.53	78%	0.80
LU	0.61	1.90	46%	1.33
LT	0.59	2.65	72%	0.82
AT	0.43	1.27	75%	0.58
DE	0.37	2.06	53%	0.70
EU	0.36	2.15	56%	0.58
HU	0.36	2.30	55%	0.65
RO	0.32	2.78	62%	0.52
DK	0.32	1.23	58%	0.55
PL	0.26	2.43	47%	0.56
PT	0.17	2.24	54%	0.31
ES	0.15	1.91	24%	0.63
SK	0.10	2.30	19%	0.54
LV	0.00	2.54	54%	0.00
NL	-0.03	1.68	63%	-0.04
IT	-0.06	1.91	24%	-0.25
GR	-0.09	2.74	73%	-0.12

... for selected countries and regions

- The best reform performance here is found in Finland. The country shows the highest degree of reform activity (followed by Croatia, Bulgaria and Austria) and the highest reform quality (followed by Luxembourg).
- Romania, Greece, Lithuania, Latvia and Bulgaria are rated as having the strongest reform need. While reform performance is fourth-best in Bulgaria, Greece scores last.
- Denmark and Austria have by far the lowest need scores here. In particular, the need to improve the accessibility and range of health services in Austria is assessed as being remarkably low.
- Greece's activity rate here is substantially higher than in the other dimensions. According to the experts, the Greek government is fully addressing four out of the eight policy objectives, although rather ineffectively (with the exception of reducing unmet medical needs).
- Reform activity is lowest in Slovakia, Spain and Italy.

HEALTH:
REFORMS APLENTY, BUT DOUBTS ABOUT IMPACT ON EQUITY FOR ALL

by Ulf-Göran Gerdtham and Christian Keuschnigg [1]

1 Introduction: Priorities of health policy

Health is a prime determinant of individual productivity, happiness and welfare. As the Roman poet Virgil (70–19 BC) put it: "The greatest wealth is health." Very poor health, such as chronic sickness or permanent disability, as well as risk factors such as obesity, drug addiction and stress are a source of individual hardship and social exclusion. Premature death often results from a lack of health. An increase or deterioration in health is in most instances not a one-off, but a gradual matter. One can have more or less of it. Given limited resources of individuals and society as a whole, health thus competes with important rival needs and creates difficult trade-offs for individuals as well as society. Undoubtedly, these trade-offs can sometimes present themselves in extreme form and may confront families and decision-makers with stark choices and tough moral dilemmas (for a philosophical discussion, see Sandel 2009) about questions such as: What is the value of life? How many lives should be saved? Which life should be saved? But spending more on health reduces resources that could be spent on other material comforts. In the public sphere, spending more on health means higher taxes and lower private welfare, or crowds out other valuable spending, such as basic research, education and social infrastructure, which are arguably of equal importance for the advancement of society. It may even turn out that generous spending on urgent health problems could create a true moral hazard by facilitating unhealthy lifestyles and diminishing the need for precautionary behaviour, leading to a deterioration of health in the future.

Judgments about the value of health and individual preferences for health spending may differ widely across society. Individuals can privately make different choices on health spending in line with their preferences and personal trade-offs with other urgent needs. In the public sphere, however, there can only be one decision about the way to organise health, which obviously cannot be tailored in the same way to each person's individual needs. As a result, some groups tend to be served better while others find themselves in a neglected minority. Providing in-kind services which are available free or at low subsidised fees typically favours some groups over others and thereby involves an often very implicit and less transparent redistribution of welfare. Such redistribution can be more or less in line with the objectives that are enshrined in the tax transfer mechanism for redistributing income and wealth. There are seemingly important policy complementarities between equity in health and distribution of income and wealth. Bad health reduces labour market access, impairs career progress and reduces upward social mobility, which makes inequality very rigid. Some groups might be caught in a poverty trap arising from a vicious circle of health and income. Bad health can greatly undermine labour market prospects, which leads to poverty, unaffordable medical treatment and unhealthy lifestyles, causing even worse health. Social inclusion and equity in health thus require decisions with distributional consequences about questions such as: Who is given access to scarce health

[1] We are grateful to Brigitte Tschudi for excellent research support.

services? What should be the rate of private out-of-pocket copayment for health services and medicines? Who benefits from publicly funded hospital capacity?

Health policy must pursue equity and efficiency goals. Efficiency in the health domain more narrowly means achieving the best health outcomes with a given level of resources. In a wider sense, efficiency also requires allocating the right amount of resources to health care as opposed to other private and public uses. Health outcomes can be measured by multiple indicators, such as frequency of sicknesses, diseases and epidemics; measures of long-term health risks (e.g. obesity, drug addiction and stress); mortality rates differentiated by different health hazards; and life expectancy. Furthermore, good or poor health is significant beyond individual well-being as it can impose substantial costs on the productive sector and reduce economic performance. Inferior health outcomes may cause frequent absence from work because of sickness, lead to reduced performance on the job, impair the quality of labour supply, diminish access to the labour market, and create barriers to upward social mobility. For all these reasons, it can reduce aggregate labour productivity.

In a frictionless world, the market mechanism could achieve efficiency. Trading on competitive markets would lead households and firms to make the best possible uses of limited resources. But in health care, markets are fraught with frictions and sometimes do not even exist. To ensure desirable and affordable health outcomes, governments must thus step in to organise the health system where markets cannot work and to set appropriate market regulations where unregulated competition creates distorted and less-than-efficient outcomes.

Health outcomes result from the decisions and interactions of several players in the sector – patients, doctors, hospitals, insurers and the government – whose interests diverge and are difficult to align. Relationships are distorted by asymmetric information, which tends to make the overall system more expensive. Some agents know more than their counterparties and can use this informational advantage to their own benefit at others' expense. The need for treatment arises with consumers when a health problem pops up. They may rely on self-treatment, consult practitioners or directly turn to hospitals. Doctors may treat a larger or smaller fraction of more or less standard cases, or else refer their patients to specialists or hospitals. Hospitals are very expensive and may have a limited capacity, depending on prior long-term investments.

The financing of health services stems from out-of-pocket spending by consumers, private and public insurance companies, and the government. Ill-designed market or non-market rules for the interactions of these players can lead to rising health care costs in addition to exogenous determinants of health needs, such as demographic characteristics, pollution, occupational risks and shifting preferences. There are three sources of market failures that require public intervention to achieve better health outcomes: externalities, adverse selection and moral hazard. First, optimal decisions for efficient health outcomes can only result when externalities are absent and decision-makers take into account all relevant consequences of their actions. When consumers pay only a fraction of the cost and the rest is shifted onto taxpayers, one must expect more demand for services, leading to rising health expenditure for the country as a whole. When private hospitals and insurance companies get compensated for only part of the benefits they deliver, one must expect the supply of services to fall short of demand. One possible way to eliminate externalities among different decision-making entities is to merge them into larger integrated organisations.

Second, accidents and illnesses are often unforeseen shocks that require spending way beyond one's own means. Many people may be unable to afford expensive treatments and operations. The ability to smooth income allows one to enjoy economic security and is the key source of welfare gain from reliable insurance. Insurance works well as long as individual risks are statistically independent and offset each other. It does not work with epidemics, where a large part of the population is infected at the same time so that individual risks no longer cancel each other out. In this case, the government must step in and spread the huge costs of rare but large epidemics across time and generations. Private markets might not work well even in the absence of epidemics. Some groups are healthier, need fewer health treatments and are less costly than others. Private insurers naturally compete for good risks and try to avoid persons with frequent health incidents, leaving some of the insurers with an adverse selection of bad risks. If insurance is voluntary, unregulated competition might lead to partial market breakdown and leave some of the population without affordable insurance in spite of an urgent need for it. The key solution is to mandate compulsory insurance of basic risks for essential services, complemented by voluntary private insurance for supplementary services at an additional cost to serve special tastes and needs.

Third, bad health is not entirely a matter of fate, but also the result of individually chosen lifestyle and preventive efforts. While generous health care and insurance provide economic security and yield important welfare gains, they also create a moral hazard by reducing private incentives for precautionary behaviour. Ready access to health care and palliative drugs at little extra private cost makes people suffer less from a loss of health and accidents, allows for faster recovery, and thus impairs private incentives and the need for preventive measures. The consequent increase in the frequency of health incidents inflates costs and makes insurance and health care less affordable. The obvious measures to contain costs are to make people more cost-sensitive by limiting the extent of insurance and introducing deductibles and other forms of cost-sharing. In the end, the design of policy must strike a balance between incentives and insurance.

For reasons of equity and efficiency in health, the public sector must step in to regulate private markets and to offer public services where markets cannot work. Policymakers face difficult challenges and trade-offs in designing non-market organisations, in replacing the price mechanism by regulating access with quantity rationing (e.g. the gatekeeper function of practitioners), and in deciding about the right mix between private and public provision of health care. However, the problems leading to market failure do not simply disappear with nationalisation and public decision-making. Public supply of health care and mandatory insurance suffer in the same way from moral hazard. Adverse selection in private insurance results from cross-subsidisation across more or less healthy groups, which continues to be a problem even with compulsory public insurance. It leads to redistribution among groups that is less transparent and may run counter to or magnify in an unwanted manner the desired redistribution via the tax transfer mechanism. And externalities among different decision-making units might lead to distorted choices in the public sector, as well.

International comparisons show a huge variety in the size and organisation of health sectors (see e.g. Gerdtham and Jönsson 2000; Moreno-Serra 2014; De la Maisonneuve et al. 2016; OECD 2015; and WHO 2015). Health systems respond to external trends in demand and changes in supply caused by the

availability of new drugs and technological improvements. The autonomous development of the system is interrupted and corrected by larger attempts at reform when budget pressure builds up and calls for cost-containing action. Health systems are thus shaped more by an evolutionary process of trial and error and political compromise, and rather less by the outcome of a big, systemic policy design. Even if there existed an optimal system design, it would certainly not be a one-size-fits-all solution, but would necessarily reflect different country characteristics. Even within a country, optimal design could never be a once-and-for-all solution, but would still need to be continuously adjusted in response to a changing environment. Health policy must sooner or later adjust to the availability of new technology and drugs; the emergence of new diseases and epidemics; gradually evolving population characteristics; changing resource constraints due to economic developments; changing lifestyles and attitudes; varying political consensus; and, last but not least, new empirical evidence with regard to policy consequences.

A country's health policy thus needs to be continuously re-evaluated and revised. Cross-country comparisons can help identify good practice in health policy and thereby lead to new insights and policy innovations in other countries. In light of the permanent need for reform, the SIM Europe Reform Barometer aims to shed light on the capacity of EU countries to achieve reform, as evidenced by recent activities or the absence of reform in the past. In the realm of health policy, this chapter proceeds by briefly describing EU activity in Section 2, and then reporting the results of the expert survey across member states and policy objectives in Sections 3 and 4. The reform activity assessed by the experts spans the period from July 2014 to January 2016. Section 5 provides a summary discussion, and Section 6 conclusions.

2 EU activity in the field

Health outcomes are measured by various indicators, such as child mortality rates, life expectancy, frequency of certain diseases and risk indicators (e.g. rates of obesity, burnout and drug use). These health measures vary substantially across countries. Most importantly, the level of income determines the amount of available resources for spending on health, with higher levels having an obviously more positive effect on the quality of health. In fact, empirical research has shown that 80 to 90 percent of the total variance in international health spending per capita is explained by GDP per capita. Also, the share of public health in total health spending tends to be positively related to GDP per capita. As shown in Table 1 (see Haigner et al. 2016 for more discussion and statistical cross-country documentation), per capita income in the EU-28 varies, from €46,200 in Denmark to €5,900 in Bulgaria. The cost of health care determines relative prices and thereby influences how much of income is spent on health as opposed to other things. Observed differences also reflect other determinants, such as diverging preferences, attitudes and lifestyles of the population; pollution and other environmental risks; demographic characteristics (e.g. age and skill structure); and adoption of technological progress in medicine. Countries thus differ substantially in the amount of money they spend on health. Sweden and Romania spend the largest and smallest shares of GDP on private and public health care (at 11.9 and 5.6%, respectively). Countries also differ in terms of the relative shares of public and private health care provision (e.g. public spending is 87% in the Netherlands, but only 45% in Cyprus) as well as in terms of institutional char-

Table H1

Cross-country comparison of health sector in EU-28

	GDP per capita, 2014, in €	Total health expenditure in percent of GDP, 2014	Public health expenditure in percent of total health expenditure, 2014	Dependency ratio (>64 in percent of population 15-64), 2014	Life expectancy at birth, 2014	Heart diseases per 100,000, 2013 (or nearest year)	Obesity rate, percent of adults, 2013 (or nearest year)	Unmet medical needs, percent of population, lowest quintile	Unmet medical needs, percent of population, highest quintile
LU	87,600	6.9	83.9	20.1	82.2	65.6	22.7	2.5	0.1
DK	46,200	10.8	84.8	28.7	80.6	70.6	14.2	1.6	0.7
SE	44,400	11.9	84.0	31.0	82.0	104.7	11.7	3.2	1.0
IE	41,000	7.8	66.1	19.3	81.2	135.9	23.0	3.8	1.5
NL	39,300	10.9	87.0	27.0	81.3	49.8	11.1	0.8	0.3
AT	38,500	11.2	77.9	27.7	81.3	139.5	12.4	1.0	0.2
FI	37,600	9.7	75.3	31.0	81.1	153.9	24.8	6.0	2.3
DE	36,000	11.3	77.0	31.9	80.8	115.2	23.6	3.3	0.8
BE	35,900	10.6	77.9	27.7	80.6	62.6	13.7	5.5	0.1
UK	34,900	9.1	83.1	27.0	81.1	97.6	24.9	1.5	1.3
FR	32,200	11.5	78.2	29.7	82.4	42.5	14.5	5.7	0.7
EU	27,500	8.7	73.4	27.1	79.5	97.3	18.0	5.7	1.4
IT	26,500	9.3	75.6	34.3	82.7	84.1	10.3	14.6	1.8
ES	22,400	9.0	70.9	27.7	83.1	55.9	16.6	1.6	0.2
CY	20,400	7.4	45.2	17.8	80.1	–	–	–	–
MT	18,900	9.8	61.2	28.0	81.7	–	–	–	–
SI	18,100	9.2	71.7	26.0	80.5	93.9	18.3	–	–
PT	16,700	9.5	64.8	31.1	80.7	50.5	15.4	5.1	0.9
EL	16,300	8.1	61.7	32.4	81.3	83.3	19.6	14.9	1.0
EE	15,200	6.4	78.8	28.2	77.2	259.5	19.0	10.8	6.3
CZ	14,700	7.4	84.5	25.9	78.3	260.0	21.0	1.9	0.7
SK	13,900	8.1	72.5	18.8	76.7	404.4	16.9	2.9	1.3
LT	12,400	6.6	67.9	27.8	74.0	–	25.7	4.6	2.0
LV	11,800	5.9	63.2	29.1	74.2	–	23.6	25.4	4.3
PL	10,700	6.4	71.0	21.4	77.3	106.4	15.8	11.8	6.3
HU	10,600	7.4	66.0	25.8	75.9	297.4	28.5	6.5	0.3
HR	10,200	7.8	81.9	28.0	77.3	–	–	–	–
RO	7,500	5.6	80.4	25.1	75.1	–	–	–	–
BG	5,900	8.4	54.6	29.8	75.4	–	–	–	–

Eurostat (2016), OECD (2015) and World Bank (2016)

acteristics, regulatory approaches and incentives, all of which shape the relations and interactions between patients, practitioners, hospitals, insurers and the government. Such differences obviously result in equally large differences in health outcomes. Life expectancy at birth is 83 years in Spain, but only 74 in Lithuania. Slovakia records 404 cases of heart disease per 100,000 residents, while the analogous figure for France is only 42. Statistics indicate that 25 percent of the lowest income quintile of the population faces unmet medical needs in Latvia, while it is 0.8 percent in the Netherlands.

Substantial empirical research has identified key drivers of health spending, the effects of policy interventions on health outcomes, and best practice measures for cost containment (see e.g. Gerdtham and Jönsson 2000; Moreno-Serra 2014; and De la Maisonneuve et al. 2016). A robust result of cross-country

comparisons is that higher income (GDP per capita) explains a large part of the increase in health spending, with elasticity estimates varying around one. Institutional variables significantly shift health spending, as well. The use of primary care 'gatekeepers' results in lower health spending. Systems in which patients must first pay providers and then seek reimbursement have lower health spending on average than other systems. Remunerating physicians in the ambulatory care sector with a capitation system leads to lower spending compared to fee-for-services systems. A higher share of inpatient relative to total health expenditure is associated with higher spending since inpatient care is rather more expensive than ambulatory care. Some evidence finds that public-sector provision of health services, using the ratio of public beds to total beds as a proxy, tends to be somewhat cheaper (although Gerdtham and Jönsson (2000) note that this finding must be interpreted with caution since many 'private' beds in the voluntary sector are quasi-integrated into the public sector or face the same fixed reimbursement rates). The organisation of ambulatory care – the first point of contact with the health system for most people – is particularly important in containing health expenditure. This conclusion is supported by evidence of the cost-saving effects of the gatekeeper role, capitation-based remuneration systems for practitioners, and up-front payments by patients with subsequent remuneration by insurers.

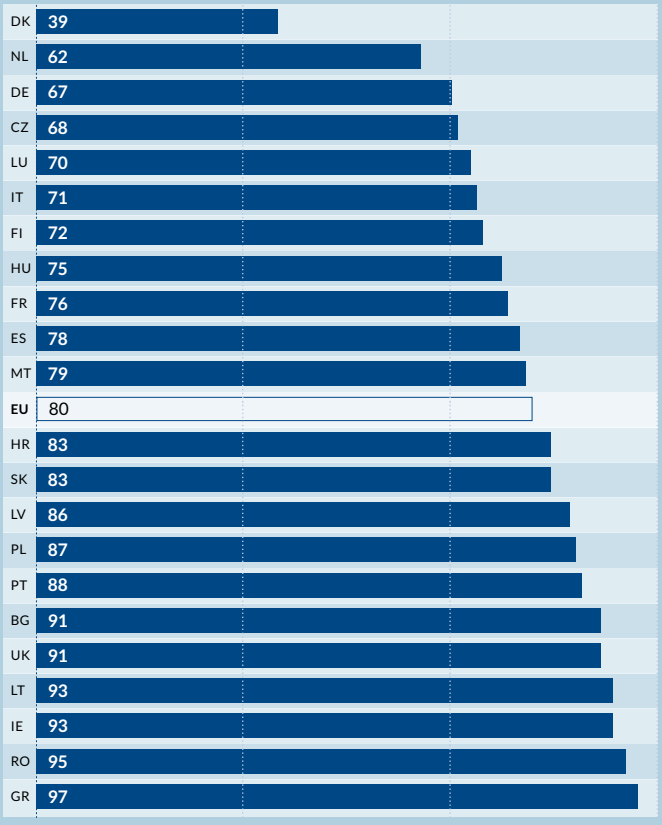
Health policy in the EU is predominantly the responsibility of member states. The role of the European Commission is mainly supportive and complementary. Its 2007 white paper on health introduces the pillars of the EU health strategy, and the follow-up document from 2013 extends the strategy to the 2014–2020 period (European Commission 2007, 2013). Major health threats (e.g. epidemics, pollution or climate change) have consequences beyond national borders. National health policy can have cross-border spillovers and may create costs or benefits for other member states. Such externalities require transnational coordination and information exchange, which naturally defines responsibilities at the level of the EU. The coordinating role starts with the collection of comparable data and exchange of health-related information. Innovations in national policymaking are often encouraged and initiated by comparisons with best practices in other member states, which requires a system of comparable health indicators.

The common market principle of free movement of goods, services, capital and people naturally extends to the health sector. A common market in medical goods and services needs harmonised regulations on product safety; an effective process of one-time product admission that is valid in all member states; and an EU competition and antitrust policy to prevent market barriers for pharmaceutical and other medical products and services. Health companies and organisations need unrestricted market access in all countries so that competition can result in better services and products for patients at competitive prices. Access to a large common market supports the entry, growth and innovation of firms in the pharmaceutical and medical appliances industries. Tighter competition imposes market discipline, resulting in the benefits of larger quality improvements and cost savings in the health sector. Innovation is key to achieving larger productivity gains and is supported by a common EU patent policy. The availability of big data on patients, the possibilities of the internet, and the use of robots for diagnostics and standard medical services will greatly expand the use of e-health. A common legal and technological infrastructure that connects the entire EU is required to reap the full potential of productivity gains.

Good health improves the employability and productivity of people. The free movement of people in an unrestricted common labour market boosts opportunities for citizens, increases the opportunities for firms to hire the most suitable workers with the right mix of skills, and thereby raises productivity and growth in the entire EU. One critical factor of support for the mobility of labour is the portability of social security benefits, which must allow unrestricted access to health services in other countries independently of where patients are insured. Common rules for charging and reimbursing health expenditures and a well-functioning and cost-efficient settlement system are key for labour mobility, as are common standards for health and safety at work. Clearly, the European Commission plays a substantial coordinating and supportive role in the health sector. The major share of health spending, however, addresses national needs and has local effects only. The subsidiarity principle thus implies that most spending decisions are taken at the national level, as well.

Figure H1

Need for improvement in health, strong and very strong
(in percent)



Not included due to insufficient data: AT, BE, CY, EE, SE, UK

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3 Survey results across member states

To draw an overall picture of the results of the expert survey, Figure H1 first reports averages over all eight policy objectives. Survey results indicate a substantial need for reform, although with considerable variation across member states. In the EU-28, 80 percent of experts believed that the current situation requires strong or even very strong improvement, implying that 20 percent consider reform less than urgent (assigning a value of only 0 or 1).[2] Almost half of them stated that reform is indeed very urgent (i.e. 48 percent marked the maximum value of 3, for very strong need, which is not reported in Figure H1). The SIM Europe Reform Barometer 2016 seems to suggest that the health sector has been denied 'urgent treatment' and consequently suffers from a 'high temperature'. Not very surprisingly, the need for reform is perceived to be highest in Eastern European member states, where per capita income is low and the health sector is underdeveloped and still in need of post-transition modernisation. For example, 95 percent of the experts in Romania, 93 percent in Lithuania and 91 percent in Bulgaria perceived a strong or very strong need for reform. The Czech Republic and Hungary are exceptions and fare better than the EU average. Cohesion and convergence in Europe make it a priority to invest in the health, productivity and well-being of Eastern European member states.

2 In this chapter, such percentages refer to shares among all experts regardless of the country for which they answered the respective question.

More surprising is the sense of urgency felt in the UK, which enjoys a per capita income that is way above average. The high levels of dissatisfaction in Greece, Ireland and Portugal – which are still much richer than Eastern European countries – may be a legacy of the financial and economic crisis. A country-specific investigation of the performance in different policy areas of health should clarify the sources and validity of that judgment. Expert opinion rated the health sectors in Germany and the Netherlands quite favourably, where the need for reform was perceived to be much less urgent. At the top of the league was Denmark, for which only 39 percent of the experts considered reform to be urgent or very urgent.

With regard to the question of whether reform actually happened between July 2014 and January 2016, the frequency of 'don't know' answers was relatively high. On average, about half of all respondents (excluding those who marked 'don't know') reported that reform had taken place (see Figure H2b). In Croatia and Bulgaria, 81 and 82 percent of experts, respectively, and 79 percent in Finland reported that there was ongoing reform activity. Croatia and Bulgaria are also countries with large perceived need for reform. In principle, one would expect that reform happens where the need for reform is highest, and that less happens where there is little perceived need for it. But this expectation might not hold true: While reform takes a long time – from design to democratic decision-making to implementation – the time frame of this survey is quite short. In consequence, the survey yields a number of answers that seem surprising at first sight. For example, 67 percent of German experts perceived a need for reform, but only 44 percent of them actually recognised some reform activity. More worryingly, the perceived need for reform was among the highest in Poland, Portugal and Romania (87, 88 and 95%, respectively), but reform activity in these countries was at best average or even below average (47, 54 and 57%, respectively). Even more startlingly, the very high perceived need for reform (83%) in Slovakia contrasts sharply with actual reform inactivity (only 23% answered 'yes'), according to expert opinion.

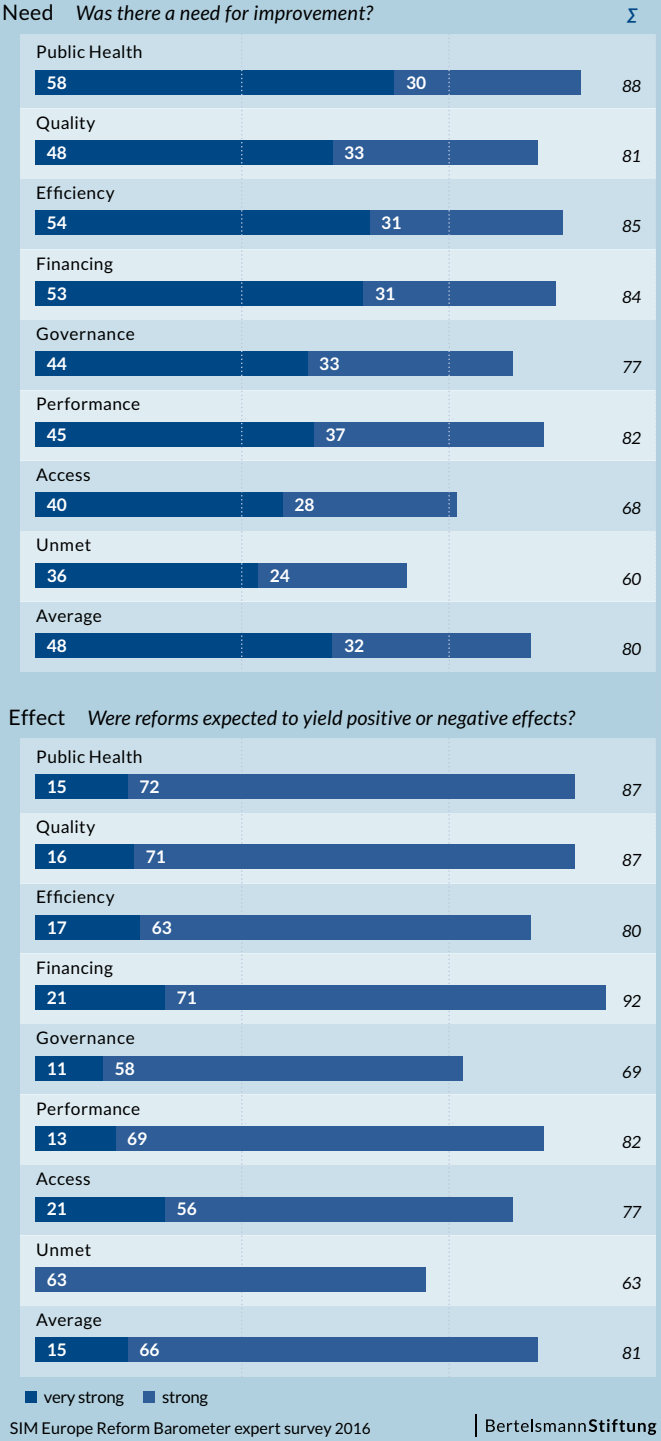
Finally, experts were asked to rate the effectiveness of any health care reform. On average, 66 percent of the experts reported positive or even strong positive effects, implying that 34 percent considered actual reform to yield no effect or even to be counterproductive. Variation across member states is large. One could, in principle, and somewhat speculatively, postulate a law of 'decreasing returns from reform', meaning that reform should have the largest effect in a country where the health system is underdeveloped and the need for reform is perceived to be urgent. Again, the effects of recently enacted reforms probably take a long time – and much longer than the survey period – to fully unfold. Hence, one must expect the law of decreasing returns to come through tenuously at best. A leader in terms of policy effectiveness seems to be Finland, where 91 percent of experts believed that reform has had positive effects even though the need for it is below average. In Poland, Portugal and Romania, reform is urgent, but the effect is slightly less than the EU average even though it should be large. Experts in Latvia pointed out an even larger discrepancy between need for reform and policy effectiveness; while 86 percent of them recognised a high need, only 33 percent could identify some positive effect of reform. For many countries, not enough answers were available on this last survey question to support a reliable discussion.

4 Survey results across policy objectives

The overarching objectives of efficiency and equity in health are made operational by specifying a number of more concrete objectives. The SIM Europe Reform Barometer lists eight objectives for health policy: H1 Improvement of public health; H2: Quality of health care; H3: Health system efficiency; H4: Sustainable and fair health financing; H5: Health care governance; H6: Outcome performance of health; H7: Accessibility and range of health services; and H8: Unmet needs for medical help. For each of these eight policy objectives, experts answered the three survey questions separately: Was there a need to improve the situation? Were there any policy reforms addressing the specific objective? Are these reforms expected to yield positive or negative effects? Figure H2a summarises expert ratings on average across Europe.

Figure H2 a

Summary of expert ratings on average and across policy objectives.
Averages across 28 EU member states (in percent)



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The survey also included open comments, both in general and specifically relating to the policy objectives. Several general comments are noteworthy. Some experts felt that health prevention should receive a larger policy priority. Health education and information for consumers about health risks could facilitate prevention and strengthen the patient's role in the system. Health systems might also become more migrant-friendly. Migrants are new to the system and thereby particularly in need of being informed about their health-related rights as well as their personal responsibilities to protect the system's financial sustainability. The large regional inequalities in Europe can encourage people to migrate and lead to a brain drain of nurses, doctors and medical scientists in poorer countries, slowing down the process of catch-up and convergence in health.

Similarly, the financial and economic crisis has given rise to a surge in unemployment and poverty and tightened public budgets, leaving disadvantaged groups more vulnerable. Fighting inequality and social exclusion has become more urgent, but also more difficult to reconcile with the need to allocate more resources to investment and growth in the economy so as to strengthen the financial solidity of the system. In some countries, experts felt that the health system has become too fragmented and complex, creating all kinds of cost-inflating and quality-reducing distortions in the relationships between patients, doctors, hospitals, insurers and the government. Harmonisation of service subsystems could make the health system more simple, transparent and efficient.

4.1 Improvement of public health

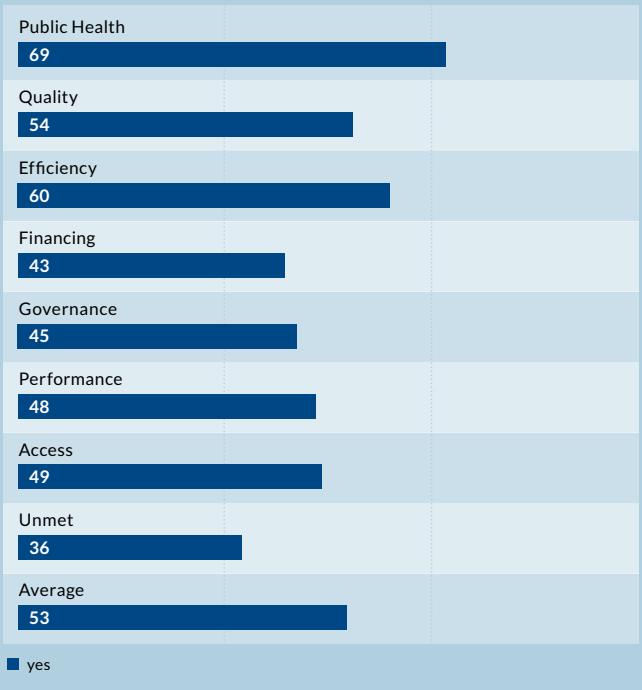
The first health policy objective is rather general and calls for a summary evaluation. Of all 186 experts who answered this question in the entire EU-28, 88 percent perceived at least a strong need, and 58 percent even a very strong need for improvement. Figure H3 shows large variation across member states. One should note that more expert answers are available for large member states, while only a few answers are recorded for small ones. The judgments for small countries might to some extent be subjective and reflect a personal bias, while ratings in large countries are probably more reliable as a larger number of experts tends to even out individual bias.[4] Keeping these limitations in mind, one finds in Figure H3 a pattern that is roughly similar to the one plotted in Figure H1, which averaged over all eight health policy objectives. This might partly reflect the general nature of the question, leading to similar ratings. Experts perceive a high need for improvement in public health in Eastern Europe as well as the UK. Portugal switched from an above-average need for reform in general to a below-average need for improvement in public health, based on 13 expert opinions. Improvement seems least urgent in Austria, Denmark, Germany and Spain, which are rich countries with seemingly well-developed health care systems. Spain's income per capita is below the EU average but still substantially above those in Eastern Europe.

A policy objective with a strong need for improvement should receive more attention and priority from policymakers and trigger more reform activity. In the entire EU, 69 percent of experts reported active reform, with substantial variation across countries. It appears that reform comes discretely and infrequently so that a short time period cannot capture the true zeal for reform. For example, no concrete reform might be introduced in the reporting period even though the government is heavily engaged in expert hearings, investigations and negotiations to prepare a new initiative to be launched in the following period. Regarding the impact, many experts who rated the need for improvement declined to evaluate the effect of policy reform. Out of the much smaller number of answers, 72 percent[4] indicated a positive and only 15 percent a strong positive effect. There seems to be no clear statistical pattern in how reform activity and the effect of reforms are related to the perceived need for improvement.

Quite a number of survey participants added written comments. Some experts criticised a lack of evidence-based decision-making. Governments need to prioritise this policy objective and should

Figure H2 b

Summary of expert ratings on average and across policy objectives.
Averages across 28 EU member states (in percent)



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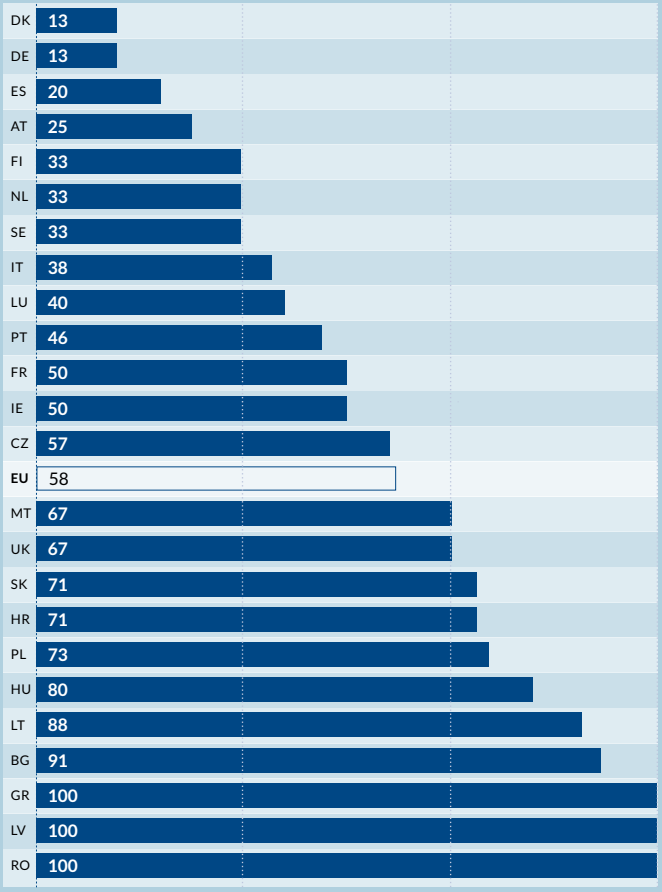
3 For this reason, we neither comment on nor plot any country-specific results with fewer than three responses. All our qualitative statements about health reform in individual countries are based on expert comments. They are neither complete nor based on independent analysis of new legislation, and should only be viewed as informative examples of different policy solutions and reform gaps across EU member states.

Figure H3

Very strong need for improvement in public health
(in percent)



Not included due to insufficient data: BE, CY, EE, SI

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be willing to invest significant resources for strong positive effects to be realistic. In some countries, it appears to be easier to overcome inactivity and resistance to reform if the EU exerts pressure or provides incentives. In Bulgaria, a very strong need for reform is perceived, and 100 percent of the 11 experts reported reform activity. In 2015, Bulgaria launched a new national strategy, 'Health 2020', which includes a variety of measures, such as a special tax on unhealthy food and drugs, development of e-health, regulations on regional health inspectorates and a mix of other preventive and curative measures to improve the amount of effective care for vulnerable groups. The strategy seems to address public health in a systemic and comprehensive way. Adoption of the strategy was one of the prerequisites for EU funding. Of all eight Bulgarian experts providing an answer, 75 percent rated reforms to have positive and 38 percent strong positive effects, which is way above the EU average.

In 2014, the Romanian government also adopted a 'National Health Strategy 2014–2020', which covered development of public health and health services as well as system-wide measures. All experts from Romania perceived a very strong need for reform, but only 71 percent reported reform activity, presumably because the decision was slightly prior to the reporting period of the survey. Respondents were somewhat less frequently optimistic about the prospects of success, with 60 percent expecting positive and 0 percent strong positive effects. They mentioned a severe shortage of financial resources and a lack of specialised human resources, partly due to a medical brain drain to Western Europe. EU regulation could improve prospects for better outcomes by countering the negative influence of political instability and lack of enforcement. In the Czech Republic, the perceived need for improvement was near the EU average; 57 percent of experts reported reform activity, and 67 percent of them expected positive effects. In 2014, the Czech government reduced out-of-pocket fees and co-payments, even fully eliminating them in some cases. The following year, it also approved a 'Health 2020' national strategy and adopted 20 action plans to implement the strategy. In Finland, a major social and health service reform is in preparation and should go into effect by 2019. Not surprisingly, 100 percent of the Finnish experts reported reform activity, and 100 percent expected positive effects (though none of them expected strong positive effects). Experts located problems at the municipal level, with municipalities being too small to efficiently organise services that are equally available.

4 Here and in the remainder of this chapter, this percentage includes all respondents who indicated that they expect a positive or a strongly positive effect of reforms.

4.2 Quality of health care

The same survey questions were posed with regard to quality of health care, but the frequency of answers was substantially lower compared to the first policy objective (136 instead of 186 in the entire EU-28). There are more countries now with no responses. For the entire EU-28, 81 percent of experts perceived at least a strong and 48 percent a very strong need for improvement, and 54 percent reported reform activity to improve quality in health care. Substantially fewer answers were provided to rate the effects of reforms, with no ratings available in quite a number of countries. From all responses collected over the entire EU-28, 71 percent expected some moderate quality improvements, while only 16 percent expected strong positive effects.

Experts offered numerous written remarks. In Bulgaria, 88 percent of experts felt there is a need for improvement, and 67 percent reported reform activity (eight ratings). The health ministry issues standards of care. Based on these standards, the National Health Insurance Fund decides on payments to health care providers. A point of criticism is the poor methodology of measuring patient satisfaction. In 2015, Romania created a National Authority for Quality Management in Health Care that is supposed to elaborate and draft legislative proposals relating to compliance with international regulations, accreditation standards, payment methods for health care providers, training and technical consultancy, the accrediting and re-evaluating of health providers, and the monitoring of quality standards. In the Czech Republic, an Act on Health Services was passed in 2011 that obliges hospitals to introduce internal quality assurance, and was subsequently complemented by guidelines and rules to provide a standardisation of quality management and assure implementation. Experts rated the need for improvement below average; 67 percent of the answers indicated reform activity, and all of those answering expected a positive outcome. Hungary introduced a new system of provider accreditation, but experts opted not to predict effects at this early stage of implementation. Latvia has a new mandatory quality assurance system for general practitioners comprising 14 quality criteria. Some hospitals have internal quality assessment schemes. In Lithuania, infrastructure is being modernised. In 2015, the government approved the public health care development programme for the 2016–2023 period, whose specific objectives are strengthening health through healthier lifestyles and health literacy. A health restructuring plan aims to further reduce the number of hospital beds and strengthen out-patient care, but measures to strengthen primary health care seem to be insufficient. Lithuanian experts noted that quality needs to be better operationalised, and that policy should attach higher priority to professional and peer expertise instead of to excessive regulation. The e-health system is unfinished and needs to be improved. In Poland, accreditation is not obligatory, and certified hospitals do not get any financial reward in terms of contracts with public payers. The biggest problem of hospital directors, however, is not how to increase quality, but how to stop the emigration of qualified personnel. Long waiting times for publicly provided services make wealthier people migrate to the private sector, resulting in growing inequality in terms of access to health. Polish experts identified a need for improvement that is urgent and clearly above the EU average. Nevertheless, only 33 percent of the respondents recognised reform activity, and out of these only a third perceived any positive effect (and none perceived a strong positive effect).

Among the 'healthier' countries, Finland is planning a comprehensive health care reform whose priorities include, among other things, reducing the differ-

ences in quality of primary care services. One problem is the poor access to primary care given by health centres which seem to mainly serve the economically inactive population, as opposed to occupational health services. Experts indicated above-average activity and effects of reforms, even though the need for improvement is felt to be below the European average. In France, survey participants noted the importance of training, professionalisation and research to take people's special needs into better account. Experts noted some need for improvement but a lack of reform. Austria would need a better culture to deal with errors in hospitals and elsewhere, according to expert opinion, and policy measures should be systematically evaluated. The 'Inpatient Quality Indicator' project is yielding comprehensive results, but only a few are publicly accessible. Such indicators should facilitate benchmarking exercises to allow comparison with the best practice of successful peers. In 2015, Germany introduced a law on hospital reform which includes the introduction of an option to use quality elements in future financing arrangements. An expert noted that existing research finds that establishing pay-for-performance, including pay for quality, is extremely difficult to achieve. More experiments and research might have helped identify effective solutions. In 2015, the Netherlands introduced a new financing system for general practitioners, specifying payments for integrated care, pay-for-performance and innovation. The system should improve quality by promoting coordination and innovation in care. A critical issue is that competing health insurance companies purchase health care even though information about quality of care is insufficient and often lacking. Experts mentioned that the definition and measurement of quality is a concept under construction, and that the main focus must be on clients.

4.3 Health system efficiency

The frequency of answers to the survey questions on this policy objective dropped further, from 136 to 125 in the total EU-28, and only 59 provided a rating on the impact of reforms, leaving a number of countries with no rating at all. For the entire EU-28, 85 percent of experts perceived at least a strong and 54 percent a very strong need for improvement; 60 percent reported at least some reform activity to improve system efficiency, of which 63 percent expected some moderate improvements, while only 17 percent expected strong positive effects. Problems and proposed improvements to health system efficiency vary widely across member states. A number of aspects were already discussed in the preceding two policy objectives and therefore not repeated. In many countries, fiscal budget pressure and the need for cost containment motivated various attempts to improve efficiency.

In Bulgaria, the national health insurance benefits will be split by 2016 into basic and complementary parts. Regional health maps are being implemented to better address the needs of the population for outpatient and inpatient care. In 2015, there was the introduction of compulsory centralised bargaining over discounts for medicines in the national health insurance reimbursement list. The government also aims at efficiency gains by expanding the use of e-health. Romania started with electronic health cards to obtain a clearer picture of health services provided to patients and avoid fraud, but the service is still not fully functional. It recently initiated a number of cost-saving reforms, such as modifying the reference price system, moving to the e-prescription of drugs, expanding the use of e-health services, and introducing monthly monitoring of health care expenditures. The Croatian state insurance agency HZZO started in

2015 to manage mandatory health insurance payments to health providers based on key performance indicators. In 2016, the Czech Republic will start having competitive public procurement for health devices, making contracts publicly available. Latvia is embarking on a gradual reform of the hospital payment system as global budget allocations seem to be effective in cost containment, but arguably do not provide good incentives for greater efficiency and higher quality. Lithuania introduced some new quality indicators for primary health care (e.g. avoidable hospitalisation) and launched some preventive programmes. Experts criticised the fact that a clear concept and transparent decision-making as well as an independent and trusted evaluation process were missing. In 2015, Poland introduced a regulation for developing a regional health needs map to gain better planning of hospital bed capacity and to avoid unnecessary duplication of investments in neighbouring hospitals. One expert called for an open discussion about sensible rationing methods when resources are tight, and pointed out the apparent policy contradiction in guaranteeing broad services while having inadequate funding.

The Austrian health system is more complex and fragmented than those of other OECD countries. Experts reported that new legislation adopted in 2013 is now being implemented to enhance efficiency, for example, through better balancing of care provision across providers based on relative efficiency and by promoting new primary care models. The Netherlands transferred long-term care from a centralised to a decentralised system in 2015; only inpatient long-term care remains centrally organised, based on the idea that municipalities are in closer touch with the needs and desires of citizens and can organise related matters more efficiently. The reform also involves a major budget cut. Experts expected that new players will need time to develop the required competencies. Decentralisation might also lead to substantial differences between municipalities and thereby create regional inequalities in health care.

4.4 Sustainable and fair health financing

The response rate on this policy objective dropped further, to 121, and left only 41 ratings on the impact of reforms. For the entire EU-28, 84 percent of experts perceived at least a strong and 53 percent a very strong need for improvement; only 43 percent noted some reform activity, of which 71 percent expected moderate improvements in fair and sustainable health financing, while only 21 percent expected strong positive effects. Answers varied substantially across member states. Clearly, budget constraints are tighter in some countries than others, necessitating more or less drastic reform for cost containment and efficiency improvements, and imposing on governments and decision-makers a difficult equity/efficiency trade-off in health. Equity and distribution involve value judgments which cannot be unanimous and tend to create distributional conflicts. A number of selected comments by experts illustrated diverging priorities and necessities in different member states.

In 2015, Bulgaria increased state contributions to non-insured individuals covered by state budgets, such as children and pensioners. At the same time, developing the health map for better coordination of regional expenditure and measures pushing for e-health, reinforcing outpatient care and putting a greater focus on prevention and health promotion are expected to yield efficiency gains and make health financing more sustainable. Croatia separated the compulsory health insurance fund from the state budget in 2015, which is expected to yield positive financial effects and yield more

resources for the hospital and primary health care sectors. Competitive public procurement for hospitals generates additional savings. The Czech Republic, among other measures, aims at more efficient hospital reimbursement by improving the DRG (diagnosis-related group)-based payment system, which should be fully functional by 2017. The debate in Latvia is about moving from tax financing to compulsory health insurance since government financing of health care in the last few years has been inadequate. Experts feel, however, that the government should rather stick to the tax-funded system, but allocate more resources to health and work on improving efficiency. Other recent reforms resulted in higher co-payments and reduced access to health care, thereby undermining equity in health. Experts from Malta indicated that tax revenue is an insufficient source for financing public health services and should be supplemented by compulsory health insurance. In Poland, to the contrary, experts criticised the high share of private out-of-pocket spending, which already accounts for 30 percent of all spending, limits access and thereby reduces equity in health. Another Polish expert, however, found payroll-tax funding neither sustainable nor fair, and suggested instead strengthening the insurance principle in addition to increasing pay-as-you-use and the individual responsibility for health with co-payments.

Experts suggested that Italy should update the basic benefit package as well as reduce the financing of private occupational welfare schemes, shifting resources to public health care services instead. In Portugal, the crisis dictated spending cuts for purely financial reasons, and there was not much assessment of potential health outcomes. Similar arguments on the equity/efficiency trade-off in health care were reiterated in many other member states, depending on the level of income, the generosity of the health system inherited from the past, and the tightness of individual and aggregate resource constraints.

4.5 Health care governance

For the entire EU-28, 77 percent of experts indicated at least a strong and 44 percent a very strong need for improvement. However only 45 percent noted some reform activity, of which 58 percent expected moderate improvements, but only 11 percent expected strong positive effects. Thus, the picture for this policy objective is somewhat more pessimistic. A mechanical summary of results shows the same heterogeneity across member states, but results are difficult to interpret since only few expert ratings (or even none at all) are available at the individual country level. The written expert statements shed some light on the challenges of health care governance in different countries, but were also somewhat scarcer than they were for other objectives.

Good governance in any organisation requires clearly stated goals and well-defined rules that lead autonomous decision-makers to internalise and take account of all the benefits and costs of their actions. This will often require incentives, such as performance pay, combined with monitoring and sanctions when evaluation is unsatisfactory. To attract talent and qualified human resources and prevent brain drain, salaries and career prospects must be competitive. The health care sector poses particularly difficult governance problems. Experts all over Europe reiterated that good governance in health care starts with clearly stated goals that derive from a systemic approach of policymaking that favours equity and efficiency in health. They emphasised the need for better inter-agency cooperation and coordination between hos-

pitals and the extra-mural sector (mentioned by experts from Austria and Lithuania), which should be the result of a mutually consistent, systemic design. Policy initiatives and legislation should be consistent (Bulgaria). A lack of a long-term plan leads to erratic decision-making and policy reversals (Poland). Political instability often favours reform inactivity and a lack of implementation and enforcement, which can be mitigated by pressure from the EU (Romania). A coherent long-term plan with broad backing needs an extensive reform dialogue (Latvia) that brings all stakeholders and affected groups to the negotiating table. In practice, systems are often strongly driven by special interests of the involved organisations, but such 'closed-shop behaviour' must be eradicated (Germany).

The design of rules should assign clear responsibilities and disentangle joint responsibilities shared with different units. Health management is difficult if responsibilities are intertwined and require the consent of many persons in daily management affairs. In reality, the organisation of the health sector is often too complex (Finland). One aspect of governance is the right level of decentralisation. A decentralised system is closer to the needs of citizens and could involve less bureaucracy and better cooperation between services and departments (France, Netherlands). Apart from the design and governance of the system, experts mentioned the need for human resources development through training; the introduction of an appraisal system; monitoring and performance evaluation; and, last but not least, competitive wages aimed at retaining talent and preventing brain drain (Portugal, Poland, Romania). Politics should not interfere in management autonomy, including the selection of directors of local health agencies (Italy). Exploiting the possibilities of information systems and e-health, imposing health care quality assurance, improving on DRG payment systems for hospitals, and insisting on open procurement for hospitals (Latvia, Slovakia) also help boost the efficiency of the health sector.

4.6 Outcome performance of health

Regarding this policy objective, 82 percent of all EU-28 experts perceived at least a strong and 45 percent a very strong need for improvement; 48 percent recognised reform activity, of which 69 percent expected moderately rising outcome performance of the health system, while only 13 percent expected strong positive effects of reform. These ratings varied substantially across member states. Instead of using graphical plotting, as was done with Figure H1 and Figure H3, we discuss written survey statements to illustrate diverging priorities and necessities in different member states. Expert statements almost unanimously agreed on the need for performance evaluation, but noted varying government activities in this direction. Comments predominantly centred on how to measure performance and organise the evaluation process.

First of all, performance evaluation requires extensive and easily accessible data. If there are no data, there cannot be any reliable performance measurement. An expert in Slovakia criticised the fact that outcome indicators are not regularly reported, that the statistical system is obsolete, that health insurance data are not accessible, and that the oldest oncology register is dysfunctional. Health providers must also be willing to provide data and information, but might be hesitant to do so. In the Netherlands, for example, hospitals often refuse to publish mortality rates. Furthermore, the relevant stakeholders must agree on which outcome measures are chosen. Otherwise,

there cannot be a commonly accepted assessment of whether performance is good and the proposed measures are successful. In the Netherlands, for example, several initiatives to improve outcome performance have been proposed, according to expert opinion, but not one major reform has addressed this issue. The sector is struggling with how to develop outcome measures and improve performance along these measures.

To obtain unbiased results, the tasks of monitoring and performance measurement should be allocated to an independent agency. Policy-makers should not rely on self-evaluations of health providers (Czech Republic). Further, undistorted decision-making requires a unified or at least comparable performance measurement of different health outputs. In reality, outcomes are measured more frequently and reliably in some parts of the health system than in others, making relative judgments and priority-setting difficult. In Austria, expert opinion indicated that the Inpatient Care Indicator Project measures performance at the level of hospitals, while ambulatory care quality is poorly monitored. Finally, the results of performance measurement should be publicly available so that all stakeholders can draw conclusions. The first-ever health system performance assessment in Malta was executed with the assistance of the World Health Organization (WHO) and completed by mid-2015, but the government still has not published the report. An Italian expert similarly argued that outcome evaluation in primary and hospital care should not only be reinforced, but also have public reporting as an integral part of it.

A German expert felt that there is a lack of incentives for competitive innovations that explore alternative solutions, but noted some attempts among private hospital providers. In Hungary, relevant statistical data proved the poor health status of the population. Experts noted a strong influence of social status on health outcomes. In Ireland, centres of excellence are working well, while the performance of general hospitals is poor. The expert noted a lack of hospital capacity and of community-based services that could prevent the need for hospital access. A huge problem in Poland is waiting times. A waiting list regulation was proposed in 2014 as a first step towards a national strategy for reducing waiting times for specialist care in Poland. The goal is to shift patients to the lowest-possible level of care. The initiative triggered heavy protests among primary care doctors, who criticised the fact that additional tasks were allocated to them without additional funding. In the end, the regulations implemented in 2015 focused on oncological care alone. Patients who were believed to have cancer could immediately receive diagnosis and treatment. Since no additional funds were made available, this improvement for (presumed) cancer patients came at the expense of other patients. In general, experts criticised a lack of understanding of the need for preventive care and positive health promotion in Poland.

4.7 Accessibility and range of health services

On average across all member states, 68 percent of experts perceived at least a strong and 40 percent a very strong need for improvement; 49 percent recognised reform activity, of which 56 percent saw moderately rising outcome performance of the health system and 21 percent expected strong positive effects of reform. Experts noted that inadequate accessibility of health services differs across geographical areas and socioeconomic groups, and that it may partly arise from a lack of information, as well.

In remote areas, a lack of infrastructure, financial resources and motivation on the part of health care providers can impair accessibility. In Romania, an objective of the National Health Strategy 2014–2020 is to ensure equitable access to health services. For reasons of cost-effectiveness, the government closed a number of municipal hospitals and ambulatory clinics, but failed to plan for alternative solutions in the affected regions. The gap in health care accessibility between large urban communities and small towns in rural areas increased. The health map introduced in Bulgaria is a basic tool to identify regional bottlenecks and allow better planning of access and availability of medical services. Croatia started emergency helicopter services for remote areas, such as the islands and the Adriatic coast. The new government cut the service owing to its high costs and will partly rely on the military. The shortage of doctors and nurses in the entire Czech Republic escalated in border areas, where the few doctors available are retiring at a high rate. Long waiting times for examinations and surgeries, as well as long distances to health care providers, lead to unequal access. As a partial solution, an expert mentioned more cross-border cooperation and incentives for graduating medical students to settle in border regions. Experts report that Denmark similarly faces a problem of incentivising general practitioners to establish practices in fringe areas. Specialisation and efficiency call for centralisation, but they come at the cost of more restricted access in less populated areas. Due to deprivation and an unfavourable demographic composition, the population in fringe areas tends to have more need and at the same time more problems accessing health care. Accessibility of health services is getting worse in France. Indeed, more and more people are giving up on health treatment because of difficult and frustrating access problems. Limited access for deprived people may also result in part from a lack of information. According to expert opinion, accessibility and regional health inequalities in Hungary have got worse since poor working conditions and low pay encourage many doctors and nurses to migrate to Western Europe.

Experts mentioned that more than 50 percent of health care services in Latvia are paid for out-of-pocket due to an underfinanced public health system. One possibility to be evaluated is the introduction of mandatory health insurance. In 2015, daily inpatient fees were cut, but access may not improve owing to very restrictive quotas, and it cannot improve as long as the government fails to invest more in health care capacity. An expert in Luxembourg argued that the development of e-applications could improve accessibility of health services and relieve some bottlenecks. In general, accessibility depends on social position. Problem areas to be addressed include, for example, long-term housing for medically fragile people and basic access to health for homeless drug addicts. In the Netherlands, fiscal pressure led the government to restrict long-term care to people who need 24-hour supervision, which shifts a large burden onto informal carers (e.g. families) for the remaining cases.

Governments must balance generous access to services with affordable capacity. An expert in Slovenia stated that the range of promised services became too wide, led to much longer waiting times and thereby diminished effective access. Offering too much to keep up the fiction of universal access ultimately results in offering effectively nothing when needy people simply give up. Long waiting times are the key problem in Poland, as well, though there was some relief in 2015 in the field of oncology. In turn, access remains limited and has even worsened in other fields. Relying on the expansion of the private sector improves access only for the better-off, leading to more

inequity in health. One expert concluded that "the state cannot guarantee everything to everybody", and that the accessibility of health services relative to real possibilities in a relatively poor country are not that bad.

4.8 Unmet needs for medical help

The response rate on this policy objective dropped to 106 for the entire 28 member states and left only a total of 26 ratings on the impact of reforms. On average, 60 percent of experts perceived at least a strong and 36 percent a very strong need for improvement; only 36 percent noted some reform activity, of which 63 percent expected moderate improvements in unmet needs for medical help, but none anticipated strong positive effects. We discuss a number of selected expert comments to illustrate the diverging priorities and necessities in different member states.

Many statements on long waiting times and regional disparities overlap with preceding policy objectives. Czech experts further mentioned that some insurance funds have set better reimbursement rates for ambulatory doctors who settle in border areas. There is no general regulation, though, and experts were sceptical that slightly higher reimbursement rates alone will have a big effect. Some gaps were perceived with respect to long-term care of the elderly and disabled. In general, unmet medical needs are more likely when insurance is not compulsory or when there are significant gaps in coverage (Poland). In Lithuania, only a very low percentage (not more than 2 percent) of the population is not covered by national health insurance. Unmet needs for medical consultation thus seem not to be a big problem, although slightly more so for dental treatment. Copayments are a substantial hurdle, particularly for vulnerable groups. In Latvia, there have been attempts to reduce patients' copayments, but probably not effectively enough to make a difference. More state financing should primarily address the needs of patients and the salaries of doctors to retain medical talent rather than going towards new equipment purchases. Experts identify a need for more auditing of spending. The basket of available services also needs an adjustment.

Experts mention an alarming demographic situation in Bulgaria. An improvement in maternal and child health will decrease child mortality and should alleviate problems with low fertility and chronic diseases. Experts suspect that people in the Netherlands refrain from seeking care owing to an increase in mandatory deductibles in insurance, which leads to higher private costs. About 27 percent of those living in underprivileged neighbourhoods do not follow up on a referral to secondary care, though it is not known whether this is due to financial reasons or other hurdles. Unmet needs among migrants and ethnic minorities are seldom even investigated. In the same vein, a Romanian expert emphasised that a lack of data leads to uninformed decision-making and unsolved problems, and suspected that the most vulnerable group is the Roma minority. They have to struggle with social, financial and ethnic barriers when accessing health care, but it seems very difficult to address and engage this group.

5 Discussion

Health is a prime determinant of individual welfare. Given obvious market imperfections and the difficulties that low-income individuals and families face in affording acceptable standards of medical protection, the government must

step in to organise the health sector by designing appropriate market regulations, mandating compulsory insurance and providing public services. Tight resource constraints confront decision-makers with difficult equity/efficiency trade-offs. What is spent on health cannot be spent on other valuable private or public uses, such as education, research or culture, which are arguably of equal importance to the advancement of society. Like distribution in general, equity in access to health involves widely diverging value judgments. To support social cohesion, society must arrive at a compromise that is acceptable to all and widely supported. The results of the expert survey illustrate these trade-offs in the presence of tight budget constraints, and reveal diverging national approaches and substantial heterogeneity across member states. Reform is a matter of priority and political will. While health is predominantly a national responsibility with a limited and mainly coordinating and supportive role for the EU, it turns out that EU pressure and the conditionality of EU funds can help overcome barriers to reform at the national level.

Better health requires preventive and curative investments. Where there is little money, there is little investment and little improvement in health. Empirically, per capita income explains a large part of a country's health expenditure as well as the share of public spending within total health spending. This correlation appears in the expert survey, as well. With some exceptions, experts from low-income countries in Eastern Europe and the southern periphery considered the need for reform to be much more urgent than their colleagues from high-income countries, such as Austria, Germany, the Netherlands and the Nordic states. A logical implication of such differences in a country's resources is that convergence in health will depend in good part on the convergence of per capita income in Europe.

Still, ensuring equity in health remains a challenge even in rich member states. Governments must balance generosity in access with affordable capacity. Clearly, higher out-of-pocket expenses and co-payments might be needed for incentive-related reasons to prevent over-consumption and contain expenditure growth. But such solutions are a much bigger problem for low-income people. Mandatory insurance for basic protection helps ensure access to health services. But even if insurance coverage is universal and public health care financing dominates, long waiting times owing to limited affordable capacity may effectively ration access to health care relatively more for low-income groups. Given pressing alternative needs for public and private resources, low-income countries can afford substantially smaller health capacity. Long waiting times thus appear on a much larger scale. Some member states have responded by offering guarantees for treatment to everyone within a maximum waiting time, which must, of course, be supported by sufficient capacity. In any case, the better-off parts of the population frequently buy supplementary private insurance to ensure that they receive faster, higher-quality treatment. Demand-driven differences undermine, to some extent, equity and inclusiveness in health. Such differences extend the inequality in income and general living standards to the realm of health care. This begs the question of whether inequality in health protection is more or less acceptable than inequality in income and general living standards, and of whether redistribution should be in terms of money or in-kind services.

Health outcomes are not just a matter of health spending, but may also be influenced by environmental factors, working conditions, lifestyles and cultural habits. Risk factors are thus endogenous to preventive efforts, such as work safety regulations, information campaigns, health education and

regular health checks for the early identification of risk factors. This resonates well with the emphasis of many experts on the need for preventive rather than only curative health spending. A lack of preventive efforts may lead to high and mostly curative health spending without substantially improving outcomes, such as healthy years of life. Indeed, the Social Justice Index of the Bertelsmann Stiftung (Schraad-Tischler and Kroll 2014, Figure 32) reports healthy life expectancy with rather high rankings for some low-income countries. Malta scores rank 1 and 72.1 years of healthy life; Spain rank 5 and 65.2 years; Greece rank 7 and 64.9 years; Bulgaria rank 9 and 63.9 years; Croatia rank 11 and 63.3 years. This means that all of them exceeded the EU average of 61.9 years of healthy life. In contrast, some high-income countries – which tend to spend more on health care and are often endowed with better-developed health systems – fare substantially worse than the EU average in terms of this measure of health outcome. For example, Austria scores only rank 15 and 61.4 years of healthy life; the Netherlands rank 16 and 61.2 years; Denmark rank 18 and 61.0 years; and Germany rank 23 and 57.7 years. Hence, rankings of health outcomes are only imperfectly correlated with actual health expenditure and income per capita as well as the expert ratings of the survey with regard to the need for reform.

6 Conclusions

Health significantly influences individual well-being. In affecting work capacity in firms, absence from work and individual career prospects, health can have a great impact on a country's economic performance. Health spending competes with other valuable private and public needs. Limited resources, unequal access to basic health services and market imperfections call for government to play an important role in regulating the private health sector and supplying public services. Health policy is thereby confronted with difficult equity/efficiency trade-offs. Ageing populations create new challenges, such as long-term care.

National health systems are diverse, reflecting different policy priorities and levels of economic development. To inform policymakers about alternative solutions in health policy, cross-country comparisons based on statistical data and empirical evidence are indispensable. However, they may also be limited by a lack of hard data and the simple fact that not all aspects of health policy and institutional characteristics are easily captured with quantitative measures. The key aims of the present expert survey are to provide a valuable complement to data collection by capturing much more institutional detail beyond a simple statistical portrayal, and to more fully inform policymakers. Comparing best practice and learning about alternative solutions in other member states should arguably stimulate policy innovations in Europe.

7 References

De la Maisonneuve, Christine, Rodrigo Moreno-Serra, Fabrice Murtin and Joaquim Oliveira Martins (2016): *The Drivers of Public Health Spending.* OECD Economics Department Working Papers No. 1283.

European Commission (2007): *Together for Health: A Strategic Approach for the EU 2008–2013.* COM(2007) 630 final, White Paper.

European Commission (2013): *Investing in Health.* SWD (2013) 43 final.

Eurostat (2016): *National Accounts.*

Gerdtham, Ulf-Göran, and Bengt Jönsson (2000): *International Comparisons of Health Expenditure: Theory, Data and Econometric Analysis*, in Anthony J. Culyer and Joseph P. Newhouse (eds.), *Handbook of Health Economics 1A.* Amsterdam: Elsevier Science, 11–53.

Haigner, Stefan, Stefan Jenewein, Christian Keuschnigg, Viktor Steiner and Florian Wakolbinger (2016): *Comparing Social Policy in Europe. A Statistical Documentation.* Wirtschaftspolitisches Zentrum Wien St. Gallen. www.wpz-fgn.com/wp-content/uploads/SIM-Statistical Documentation20160405-1.pdf.

Moreno-Serra, Rodrigo (2014): *The Impact of Cost-Containment Policies on Health Expenditure: Evidence from Recent OECD Experience.* OECD Journal of Budgeting 2013/3: 1–29.

OECD (2015): *Health at a Glance 2015: OECD Indicators.* Paris: OECD.

Sandel, Michael J. (2009): *Justice: What's the Right Thing to Do?* New York: Farrar, Straus and Giroux.

Schraad-Tischler, Daniel, and Christian Kroll (2014): *Social Justice in the EU – A Cross-national Comparison. Social Inclusion Monitor Europe – Index Report.* Gütersloh: Bertelsmann Stiftung.

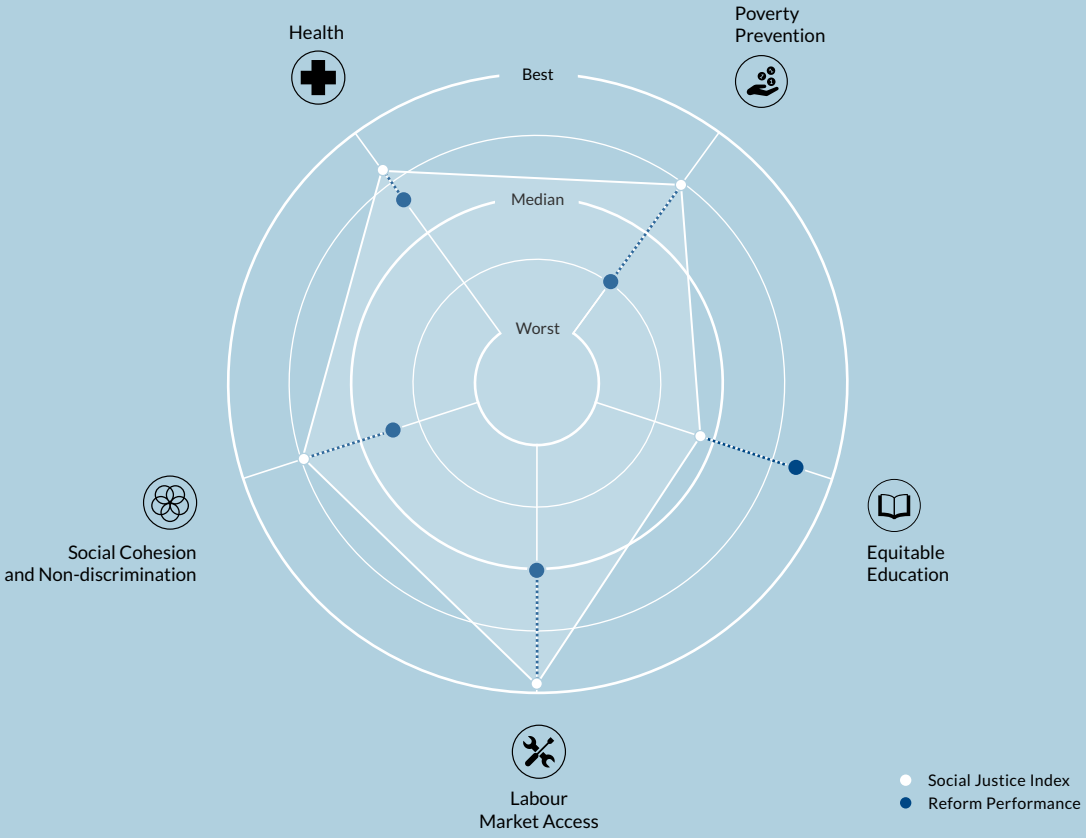
WHO (2015): *World Health Statistics 2015.* Geneva: WHO.

World Bank (2016): *World DataBank, World Development Indicators.*

Findings by Country

Austria

How does the country rank in the EU?



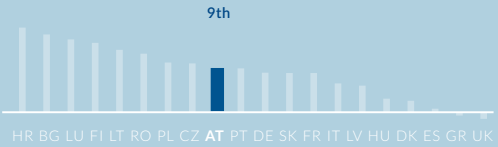
Overall Findings

Need With an overall score of 1.91, Austria ranks 7th among the 23 EU countries examined regarding the need for social reforms. This clearly reflects its good performance in the 2015 Social Justice Index (SJI), where the country ranks 6th. Looking at the dimensions, the experts see a more or less pressing need to ensure Equitable Education (2.24, rank 14/22) and to improve social Cohesion (2.31, rank 14/18). On the other hand, they see quite a low need for improvement with regard to Health (1.27, rank 2/20). The need for reforms in the dimensions of Poverty Prevention (1.87, rank 9/27) and Labour Market Access (1.87, rank 5/19) is mediocre in absolute terms, but relatively low compared to other countries, which again reflects Austria's good performance in the SJI, where it comes in 8th in the dimension of Poverty Prevention and 2nd in the Labour Market dimension.

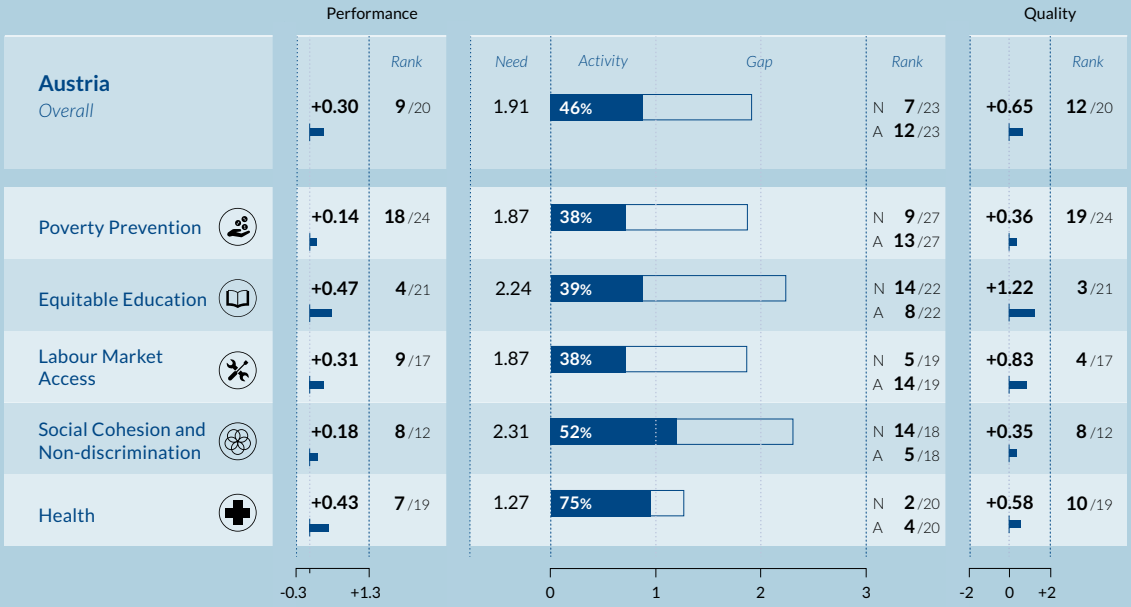
Regarding all dimensions, the most pressing challenges for the Austrian government are to:

- safeguard independence of learning success from children's socioeconomic background (2.83)

Overall Reform Performance Ranking



Overview of Reform Barometer Scores



- increase employment levels among senior citizens (2.81), refugees (2.50), the foreign-born population (2.47) and low-skilled people (2.40)
- improve integration of refugees (2.71) and reduce poverty among them (2.43)

Activity According to the experts, 46 percent of the overall reform need has been addressed in order to improve social inclusion in Austria. This is exactly the EU median, ranking the country 12th out of 23 and way behind the leading countries (e.g. Luxembourg's is 65%). Looking at the individual dimensions, the activity rates do not differ significantly. With regard to Poverty Prevention, Equitable Education and Labour Market Access, the related activity rates are about 40 percent, for social cohesion about 50 percent.

When considering the most required reforms, the experts' opinions on how these are being addressed differ somewhat. With regard to the policy objectives 'improve integration of refugees' (63%, rank 4) and 'increase job chances for elderly people' (74%, rank 5), activity rates are quite high. For 'safeguarding educational mobility' (41%, rank 7) and 'reducing poverty among refugees' (37%, rank 5), activity rates are mediocre in absolute terms, but quite high relatively. The rate in improving labour market access for refugees is rather low (20%), but still higher than in many other countries (rank 7).

Quality The experts assess the overall reform quality as (slightly) positive with a score of 0.65 (rank 12/20). The reforms aimed at ensuring Equitable Education (1.22, rank 3/21) and improving Labour Market Access (0.83, rank 4/17) are expected to have quite positive effects. For Poverty Prevention (0.36, rank 19/24) and Social Cohesion (0.35, rank 8/12), the assessed reform quality is much lower. Looking at the main pressing challenges, the reform quality differs very strongly. While the reforms aimed at ensuring educational mobility (1.14, rank 3/16), improving integration of refugees in the education system (1.0, rank 1/15) and increasing job chances for elderly people (0.85, rank 5/14) are expected to have quite positive effects, the experts think the initiatives concerning the integration of refugees (-0.42, rank 10/11) and poverty among refugees (-0.52, rank 12/13) will exacerbate the situation.

Dimension Findings

Poverty Prevention

Need The experts reported a high need to reduce poverty among refugees (2.43, rank 21) and single parents (2.22). On the other hand, the need for reforms to tackle poverty among the total population (1.22, rank 5) and young people (1.63, rank 3) is rather low. For seniors (1.71) and foreign-born people (2.0), the need is modest.

Activity In this dimension, all activity rates are between 28 percent (children, foreign-born) and 58 percent (total population). With regard to poverty among refugees, the activity rate is 37 percent, ranking Austria 5th. The experts report several government activities aimed at reducing poverty. One of these is a "tax reform lowering the lowest tax rate and increasing tax-free income, in force since the beginning of 2016." Another is a payment to seniors (Ausgleichszulage), which serves as a de facto minimum pension. One expert reports that, in 2016, some regional states started capping the needs-based minimum benefit (Bedarfsorientierte Mindestsicherung, BMS), a nationwide unified social assistance programme targeting refugees and the foreign-born population. Furthermore, he observes that there are "several social assistance programmes in cash and kind at the regional state level."[1]

Quality The quality scores in this dimension differ greatly. On the one hand, the experts think the reforms initiated so far will have positive effects for single parents (1.17), elderly people (0.96), children (0.81) and the total population (0.66). On the other hand, the measures aimed at tackling poverty among refugees (-0.52) and the foreign-born population (-1.06) are expected to significantly worsen the situation, ranking Austria second to last (refugees) and last (foreign-born).

One expert thinks that "the capping of the BMS will hit first and primarily the refugees, but also the migrant population and, finally, all recipients." Another expert explains that "the reforms do not target specific groups, like foreign-born or refugees; they benefit the general population."

Many experts recommend introducing an unconditional basic income for all population groups. One expert explains that this "would help those who

[1] Max Preglau, Department of Sociology, University of Innsbruck

are outside collective agreements." Another expert observes that "the opposite is discussed (cutting back guaranteed minimum income, especially for refugees)." A third expert has several ideas about what should be done: "Create decent jobs and pay for work already done unpaid (e.g. in care, integration of refugees, education etc.); raise rather than lower unemployment subsidies; taxation of wealth, capital gains, inheritance and gifts; promote access to social assistance (reducing non-take-up) by different measures (positive campaigning, easy and decent access, information in foreign languages); enhance social housing for low-income groups and poor people; higher minimum pensions."[2]

Equitable Education

Need The overall need in this dimension is 2.24 (rank 14/22), which reflects Austria's performance in the 2015 SJI, where the country ranks 16th with regard to Equitable Education. The most pressing need is seen as safeguarding independence of learning success from children's socioeconomic background (2.83). But the experts also see a more or less pressing need for government action for the policy objectives 'ensure equal opportunities' (2.14), 'improve structural conditions' (2.09), 'reduce the number of early school leavers' (2.25) and 'improve integration of refugees' (2.42). With regard to educational mobility, one expert explains that "secondary schools in Austria are still de facto segregated between a track leading to higher education (Gymnasium) and a track almost excluding students from higher education (Hauptschule). This split reflects social segregation – children from families with a higher (material, non-material) status have a significantly higher chance of going to university."

Activity The activity rate to improve structural conditions is rather low (23%). For the other five policy objectives, the rates are mediocre but relatively high compared to other countries (between 37 and 50%). One expert explains: "In November 2015, the government presented plans for a national educational reform. Part of the reform is to take action to improve upward educational mobility, which Austria is regularly criticized for in international comparative studies. This should be achieved by increasing the share of joint schools for pupils aged 6 to 14 and by postponing the selection of children in the education system." Another expert sees "first steps to improve the education of kindergarten teachers with the purpose of providing an academic education for kindergarten educators." Furthermore, an expert reports the introduction of a mandatory and free kindergarten year, with a second compulsory year under discussion. With regard to structural conditions, one expert reports that "additional national money was provided when doubled by the states for improving the quality of kindergarten."

Quality The experts expect the activities in this dimension to have (strong) positive effects on Equitable Education (1.22, rank 3/21). This is true for all policy objectives, as all quality scores are > 1.0, ranking Austria between 1st and 5th for each of them. The best effects are expected with regard to the

[2] Helmut P. Gaisbauer, Centre for Ethics and Poverty Research, University of Salzburg

policy objectives 'improve structural conditions' (1.58) and 'reduce number of early school leavers' (1.45). A rather low reform quality is seen in ensuring equal opportunities at the secondary stage (0.37), as many experts are quite sceptical that the new school organisation will lead to any significant improvement. One expert recommends establishing "a real joint school, meaning that all pupils from 6 to 14 visit the same school type – without differentiating between 'new middle schools' and 'grammar schools'." Another expert recommends that "schools with pupils from disadvantaged backgrounds should get more funding from the state. Distributing financial resources to schools based on a 'social disadvantage index', which is based on the socioeconomic background of pupils, parents' educational level, migration background and non-native speakers in a school." A third expert would like to "abolish early streaming in the Austrian school system, as it is of great disadvantage for young people from a poor social background." Yet another recommends compulsory education until the age of 18 in order to prevent early school leaving.

Labour Market Access

Need The overall need for reforms in the Labour Market dimension is rather modest (1.87, rank 5). This is not surprising, as Austria comes in 2nd in the 2015 SJI Labour Market dimension. With regard to the policy objective 'increase employment/decrease unemployment', the experts see only a small need to increase employment levels among the total population (1.56, rank 5). On the other hand, they report a pressing need to improve job chances for elderly people (2.81, rank 21/22) as well as for refugees/foreign-born people, the low-skilled, the long-term unemployed and young people (all need scores between 2.13 and 2.50). For the latter two, the need scores are somewhat surprising, as they are quite high in absolute terms even though Austria ranks 1st (long-term unemployment) and 2nd (youth unemployment) in the SJI. On the other hand, the need scores are rather low compared to those of other countries, ranking Austria 5th (long-term unemployment) and 3rd (youth unemployment) in this reform barometer. For the policy objectives about tackling 'precarious employment' (1.73, rank 3/16) and 'in-work poverty' (1.64, rank 3/18), the experts see a relatively low need for government action.

Activity The highest activity rates in increasing employment levels can be observed with regard to young people (89%) and senior citizens (74%). For the foreign-born population (53%), the long-term unemployed (55%) and women (62%), government activity is rated modest in absolute terms but relatively high for women (rank 4) and the foreign-born (rank 6). This is also true for refugees, where the activity rate was 20 percent, ranking Austria 7th. Furthermore, 34 percent of the need to tackle precarious employment have been met; for in-work poverty this rate was 17 percent. Concerning elderly people, one expert reports that "a policy was taken up to try and retrain people, instead of retiring them, if they are no longer able to work in their old profession (because of health reasons)."

Quality The overall quality score for Austria in this dimension is 0.83 (rank 4/17), which means that the experts expect the reforms to have positive effects. This is also true for most of the specific subgroups of the labour market,

such as seniors (0.85), young people (0.81) and the long-term unemployed (1.0). On the other hand, the experts think the reform initiatives aimed at increasing job opportunities for foreign-born people will only have slightly positive effects (0.30). One expert has some suggestions for improving labour market access: "Refugees: programme for a step-by-step labour market integration process, accompanied by tailor-made support offers. Women: improved child care infrastructure; implementation of a child care allowance reform (e.g. introduction of a child care allowance account); Low-skilled citizens: extension of basic education, special counselling offers; appropriate training programmes with special principles of didactics." With regard to precarious employment, one expert recommends introducing "incentives for employers to reduce overtime work and to change temporary contracts into regular contracts."

Social Cohesion and Non-discrimination

Need According to the experts, there is a pressing need to improve integration policies (2.43), especially with regard to refugees (2.71). Furthermore, they see a more or less urgent need to tackle income inequality and gender inequality (2.4 each). With regard to NEETs, the related need score is also rather high in absolute terms (2.0) but otherwise relatively low (rank 4), reflecting Austria's good performance in the 2015 SJI, where it also comes in 4th regarding the number of NEETs.

Activity The overall activity in this dimension is 52 percent, ranking Austria 5th out of 18 countries. Looking at the four policy objectives, activity rates do not differ that much, as they are between 43 and 63 percent, putting Austria between rank 3 (integration of foreign-born population) and rank 11 (income inequality). With regard to the latter objective, some experts report that there is a small tax reform for labour incomes. Measures aimed at ensuring gender equality are the expansion of institutional child care, the introduction of a law governing sexual offences, and making the child allowance more flexible. With regard to integration policies, the experts report that "several measures have been introduced to help refugees to be able to find a job", such as language courses and skill evaluations at the public employment service.

Quality The quality scores differ strongly with regard to Social Cohesion. While the experts expect the initiatives in tackling income inequality (0.40) and gender inequality (0.75) as well as preventing early school leaving (1.0, rank 1) to have (slightly) positive effects, they think the measures concerning integration policies will worsen the situation (-0.47).

With regard to gender equality, one expert explains that the "reforms will contribute to the redistribution of paid labour and unpaid care work and to the work-life balance. They will improve the career prospects of women and enrich fatherhood."[3]

Some experts recommend changing income distribution as a way of tackling income inequalities, for example, with the help of taxes on capital, wealth and inheritance. One expert explains: "There is a serious gap in gender-re-

3 Max Preglau, Department of Sociology, University of Innsbruck

lated income inequalities, and the same goes for nationals/non-nationals. My main point would be more equal opportunities on the labour market (fight against precarious, atypical and half-time jobs) etc."

With regard to integration policies, the experts are quite critical. One explains that "the government was in a first phase open to a fair policy. But, under the pressure of a successful right-wing party, the government turned around 180 degrees."[4] Other experts think that "these reforms have been mainly restrictive for newcomers and asylum-seekers" or "the measures taken often seem to be much more a punishment than supportive."

4 Paul M. Zulehner, University of Vienna