Fast Forward Foundation
New generation welfare

From Healthcare to Integrated Welfare: perspectives from 9 European countries

2023

IN COLLABORATION WITH

Università Bocconi

CERGAS
Centro di ricerche sulla Gestione dell'Assistenza Sanitaria e Sociale

Fast Forward
Foundation

Fast Forward Foundation - Philanthropic Entity (Italian ETS), formerly known as Fondazione Farmafactoring, boasts a distinguished legacy of fostering and advancing scientific research within the European healthcare domain.

Founded in 2004 in Italy by BFF Bank, with nearly two decades of dedication the Foundation has conducted extensive studies and supported cultural initiatives.

In 2022, it embarked on a transformative journey, recognizing the need for a strategic shift to better serve our global community. The new purpose of the Foundation is to foster the sustainable and inclusive transformation of welfare for the protection of individuals and communities.

This purpose addresses the need to operate at the crossroad of the fields of healthcare, supplementary social protection, and digital payments for financial inclusion to better respond to the challenges of the current historic moment.

As part of this process, the 2023 edition of the Healthcare Report - compiled by CeRGAS - SDA Bocconi research team - began its evolution into an Integrated Welfare Report.

The study offers a comparative analysis of the health systems of nine selected countries (Croatia, Czech Republic, France, Greece, Italy, Poland, Portugal, Slovakia and Spain) and provides updated indications for future research avenues, uncovering any convergences and divergences between those systems, highlighting which general and which context-specific attributes should be addressed to pave the way towards integrated systems.

Reserach team

Giovanni Fattore
Full Professor Bocconi University and CeRGAs Affiliate Researcher

Francesca Meda
Junior Fellow SDA Bocconi and CeRGAs Affiliate Researcher

Luigi Preti
Junior Lecturer SDA Bocconi and CeRGAs Affiliate Researcher

Thanks to our reviewer

Prof. Emanuele Vendramini
Prof. Fabrizio Tediosi
Prof. Tanja Klenk

Fast Forward Foundation

The 2023 edition of the Healthcare Report is particularly important for Fast Forward Foundation. In 2022, the Foundation worked extensively on a repurposing process that realigned its strategic priorities to enable it to respond more effectively to the needs of the international community, tapping synergies with its founder and with key stakeholders in Italy and across Europe.

The theme of integrated welfare is the area on which Fast Forward Foundation has decided to concentrate its efforts in the coming years, in an endeavour to co-generate innovative and transformative initiatives in healthcare management and welfare systems with its stakeholders: NGOs and other corporate foundations, regulators, businesses, governments, universities and research centres.

This is why this paper not only reveals the commonalities and disparities of the nine health systems under examination - shedding light on general attributes while at the same time considering context-specific factors - but also lays the groundwork, by exploring specific examples of successful integration into health systems, for a better understanding of how to improve welfare integration.

Many other areas of research open up before us: the financing models that could link the health and social sectors and the 'costs' associated with health integration; how community involvement can support the design and implementation of social policies; the specific examples of successful integration in health systems around the world that illustrate how integration has improved the quality and accessibility of health services. In the meantime, we continue to involve various stakeholders, believing it is necessary to produce a tangible change in European healthcare systems, in the conviction that, with a long-term vision and a great deal of courage, it is possible to afford new opportunities for our communities.

Livia Piermattei
Chair of the Board of Directors
of Fast Forward Foundation

Fast Forward
Foundation

Abstract

The present report offers a comprehensive reflection on the topic of welfare services integration. The welfare systems of advanced countries are entering a new phase characterized by challenges that will have a significant impact on the needs and expectations of the population. Population aging, a reduction in the working-age population, declining birth rates, the prevalence of chronic diseases and long-term care needs, the development and costs of increasingly advanced health technologies, and more recently, inflationary dynamics, are all factors putting pressure on and raising questions about the sustainability of the architecture of welfare systems as we know them today.

To answer to these challenges, services integration represents a valuable alternative, offering two main advantages: the potential to better utilize resources through greater coordination among stakeholders and the advantage to include in provision, financing, and governance stakeholders (such as service providers, employers, voluntary organizations, unions, etc.) who are different from those traditionally responsible for the architecture and funding of welfare services, namely public institutions.

The objective of the report is twofold: *(i)* offer a comparative assessment of health systems of 9 selected countries; *(ii)* provide updated reflections on future research avenues uncovering possible convergences and divergences between healthcare systems, highlighting which general attributes and those that are more context-specific should be addressed to pave the way for integrated systems.

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Abstract

The structure of the report is divided into 7 sections: Section 1 gives an overview of the background and the reason why integration is necessary and urgent to be implemented; Section 2 summarizes the concept of welfare service integration as discussed in the academic and policy literature, particularly from a health policy perspective. In particular, it explores the multiple definitions of the concept of integration, investigating which are the drivers behind and the promised benefits of it, for individual users, providers of services and also the society as a whole; after having explained the objectives and research method in Section 3, Sections 4 and 5 provide a comparative benchmarking on the countries under examination, including demographic and economic indicators, measures of health status, financing, effectiveness, and resources of the health systems; Section 6 contains the comparative analysis of the healthcare systems of the nine countries examined; finally, Section 7 concludes by introducing future research directions, especially focusing on the following thematic areas: governance, financing, long-term care services and prevention services.

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Giovanni Fattore
Full Professor Bocconi University and CeRGAs Affiliate Researcher

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Background 1

After decades of consolidation, the welfare systems of advanced countries are entering a new phase characterized by challenges that will have a significant impact on the needs and expectations of the population. Challenges such as population aging, a reduction in the working-age population, declining birth rates, the prevalence of chronic diseases and long-term care needs, the development and costs of increasingly advanced health technologies, and more recently, inflationary dynamics, are all factors putting pressure on and raising questions about the sustainability of the architecture of welfare systems as we know them today.

The issue of integration in welfare services has been widely debated for several years. It offers two main advantages: the potential to better utilize resources through greater coordination among stakeholders and the advantage to include in provision, financing, and governance stakeholders (such as service providers, employers, voluntary organizations, unions, etc.) who are different from those traditionally responsible for the architecture and funding of welfare services, namely public institutions. Healthcare systems, along with social security, constitute one of the pillars of welfare systems, and for this reason, this report intends to discuss integration starting from this relevant sector.

The report is structured as follows: Section 2 summarizes the concept of integration as discussed in the academic and policy literature, particularly from a health policy perspective; Section 3 outlines the research objectives and methods of the report; Sections 4 and 5 provide a comparative perspective on the countries under examination, including demographic and economic indicators, measures of health status, financing, effectiveness, and resources of the health systems; Section 6 contains the comparative analysis of the healthcare systems of the nine countries examined; finally, Section 10 concludes by introducing future research directions.

Integration: the theory behind 2

2.1.1 What do we mean by integration of services?

Although there is not a unique definition of integration (Armitage et al., 2009), it can be generally defined as "the act or process of bringing together elements or components that were previously separated" (Minas, 2016, p. 2). In relation to care services, and specifically in the healthcare literature, integration can be understood as "a combined set of methods, processes and models that seek to bring about improved coordination of care" (Shaw et al., 2011, p. 7) or "a coherent set of methods and models on the funding, administrative, organizational service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between [different] actors" (Kodner and Spreeuwenberg, 2002).

The ultimate goal of integration of services is improving quality of care for patients and user groups and improving efficiency in service delivery for providers (ibid.). Indeed, integrated services hold promise in terms of improving outcomes for individuals with multiples and complex needs. By providing access to multiple services (e.g. in one place or/and in a more coordinated, holistic, and person-centered manner), service integration may improve the service experience and quality for individuals or families with complex needs, and in this way improve the short- and long-term outcomes of support measures for these groups (OECD, 2023).

TABLE 2.1
DESCRIPTION OF FIVE MAIN TYPES OF INTEGRATION AND ALLIED INTEGRATIVE PROCESSES

Shaw et al. (2011) identifies five main types of integration, enabled through a range of different integrative processes (Table 2.1), some of which are focused on structures and systems, whereas others on professional behaviors and practices.

Type	Description
SYSTEMIC 1	Coordinating and aligning policies, rules and regulatory frameworks for example, policy levers emphasizing better coordinated care outside of hospitals, central impetus for diversity of providers, development of national incentive schemes or financial incentives to promote downward substitution.
NORMATIVE 2	Developing shared values, culture and vision across organizations, professional groups and individuals for example, developing common integration goals, identifying and addressing communication gaps, building clinical relationships and trust through local events, or involving service users and the wider community.
ORGANIZATIONAL 3	Coordinating structures, governance systems and relationships across organizations for example, developing formal and informal contractual or cooperative arrangements such as pooled budgets or practice-based commissioning; or developing umbrella organizational structures such as primary care federations or local clinical partnerships.
ADMINISTRATIVE 4	Aligning back-office functions, budgets and financial systems across integrating units for example, developing shared accountability mechanisms, funding processes or information systems.
CLINICAL 5	Coordinating information and services and integrating patient care within a single process for example, developing extended clinical roles, guidelines and inter-professional education, or facilitating the role of patients in shared decision-making.

Based on Shaw et al. (2011).

2.1.2 Why do we need an integrated welfare? Reasons and potential benefits of it

The driving forces behind the development of integration efforts are diverse, including demographic changes as population ageing, but also budget constraints, a general fragmentation of social protection schemes, new labor market risks and an increased focus on policy outcomes (Minas, 2016).

Because of these trends, increasing numbers of individuals are affected by a range of different problems and need multiple services (OECD 2015 & 2023) and systems of separated service provision often fail to provide effective support to individuals in vulnerable situations facing multiple barriers (OECD, 2021). Service integration responds primarily to the need of ensuring continuity of care to users, and especially the most vulnerable ones who may experience more severe barriers to care services.

Service integration is expected to be beneficial for target users, services providers and the society as a whole. Indeed, it is surely about creating a better service experience and delivering a higher quality service for individuals and families, but it is also about enabling public authorities to handle sectoral policies in a more coherent and holistic way, thus leading them to better outcomes in terms of cost-effectiveness, accessibility and quality of services (OECD 2015 & 2023).

For **service users**, the integration of services may:

Improve access to services and the individual "service experience": In non-integrated systems, individuals may have to interact with multiple caseworkers and professionals from different organizations and institutions, that may be situated in different structural and geographical locations and follow different procedures. This complexity may result in a bad "service experience" or even impede individuals from seeking help at all. And, as Rosenheck et al. (2003) underline, the longer people in need go without accessing appropriate services, the more severe their needs may become. This in turn may result in increased emergency and inpatient services use and hence increases in costs for the health and care system (Vedel et al., 2011). Integrated service delivery is expected to overcome these challenges and lead to more accessible services and to an individual-centered "service experience".

Improve the quality of service delivery: Models of integrated service delivery should allow professionals to implement a more holistic approach to the individual service user, resulting in more tailor-made services that address the multiple underlying issues of vulnerable individuals simultaneously (Montero et al., 2016). Service users are found to get better outcomes when professionals collaborate and co-operate horizontally, at the point of service delivery, and when vertical integration enables common goals. One common example of collaboration at the service delivery level is case management. Caseworkers are those who help users to navigate across the range of services, facilitating the interactions between users and the answers they need and allowing better and more comprehen-

sive assessment of people's needs. This decreases the risk of accessing the wrong or inappropriate services, thus reducing misinformation, perceived stigma and associated care system failure. In this sense, case management proves to be beneficial both for users and for the care system.

Address multi-generational problems: Integration can be also intended as the capacity to target the entire family rather than the individual users. In this way, service integration for families has the potential to prevent or significantly reduce such transmission of vulnerability from one generation to the next and the development of other types of vulnerabilities later in the lifecycle. This tends to be the case when service integration is combined with an "early years" approach that focuses on tackling or preventing child difficulties before they develop (OECD, 2009).

Produce savings: From a service user's perspective, an integrated approach can save money by providing access to multiple services in one place, or by reducing other transaction costs (telephone calls, other communications, time, and working hours).

For **service providers**, services integration may:

Ensure higher cost-effectiveness of service delivery: Integrated services can act as preventative measures and reduce later service use and costs. For instance, effective discharge plans – including a range of complementary follow-up services – reduce the likelihood of hospital readmissions (Stewart et al., 2012). And fewer readmissions and reduced use of intensive care services and contact with "community crisis teams" have resulted in cost savings (ibid.). In addition, with

integration of services, the risk of over or under-consumption is reduced: integration and collaboration, providing better knowledge on the users' needs across all the different services providers, can reduce gaps in priority services and avoid duplication of generic services from different agencies.

Increase the knowledge and information sharing: Collocation of different providers facilitates information sharing, which can in turn improve knowledge for agencies, promote communication among the different providers, and reduce the time professionals take when assisting service users access the right services (England and Lester, 2005). Better knowledge on users' needs ensure better quality of services and should facilitate the monitoring and evaluation of care pathways.

Improve communication among service providers: When professionals are working together directly, providers save time through direct contact and professional clarity (Maslin-Prothero and Bennion, 2010). It is argued that co-operation itself evolves and becomes more efficient over time and the communication becomes easier and benefits each other (ibid.). Services that are integrated can improve communications among service providers, which strengthen over time, and provide increasing returns. As agencies learn more about each other, the process of referral becomes more efficient.

Improve (local) service innovation: For professionals, integrated service delivery can be perceived as an innovative way of working that differs from traditional bureaucratic structures and approaches by end users. By bringing together professionals from various educational backgrounds and with various policy perspectives, integration may create more opportunities for professionals to think innovatively and test new approaches to

service delivery. At the same time, innovation also appears to be a central factor for the success of integrated service reforms and programmes: it has been argued that one of the main points of integration "is its catalytic role in innovation" in public service delivery (Memon and Kinder, 2017).

Finally, the benefits of integration expand to the **society** as a whole, since integration may:

Improve effectiveness and efficiency of service delivery: Integrated services has the potential to reduce the short-term cost burden of delivering support and care, by providing, for example, multiple services in one place, pooling fragmented resources, eliminating duplication in services and visits and exploiting synergies between related or complementary services, improving information and knowledge sharing between service units and reducing transaction cost (telephone calls, working hours etc. that are spent on information sharing between case workers) (OECD, 2015).

As an example, ideally the establishment of "one-stop-shops" should bring together services that are already available in a fragmented manner, helping to identify duplications and possibly reduce overall staff. Furthermore, one of the work conditions found to be influential on the job satisfaction and turnover intentions of public employees is the intrinsic non-monetary characteristics of their work, including good social relationships with co-workers and the social usefulness of the job (Borzaga and Tortia, 2006). Integration may increase job satisfaction among caseworkers by allowing them to better help and meet the needs of their clients.

Result in long-term budget savings and increase in productivity: Integrated service delivery presents a way for governments to better utilize the same budgets for any target group. By addressing the multiple underlying issues of individuals simultaneously and thus improving the quality rather than the quantity of services while at the same time reducing duplication and transaction costs, integrated service delivery is perceived as a possible way to reduce public spending both in the short and long term. In many ways it presents a move away from the traditional focus on quantity and "cost per service" (e.g. reducing the unit price of a specific active labor market programme) and towards a clearer focus on quality and reducing the overall amount of services by enhancing individuals' capabilities and chances of getting into work.

To sum up, Table 2.2 offers an overview of the principal benefits deriving from services integration.

TABLE 2.2
PRINCIPAL BENEFITS OF SERVICES INTEGRATION BY TARGET GROUP (USERS, PROVIDERS, SOCIETY)

Benefits of services integration by target	Quality of services	Accessibility	Cost-effectiveness
Service users	Improved individual service experience	Improved access to services	"One-stop shops"
Service providers	Improved service innovation	Case management	Reduced use of acute care
Society	Better identification of priorities	Better information and orientation	Greater savings and increased productivity

Based on OECD 2015 & 2023.

2.1.3 How can we achieve and implement integration?

Service integration is a complex concept that covers several conceptual dimensions. These include the policy areas of integration, the target groups of integrated services, the distinction between vertical and horizontal integration, and the kinds of actors or service providers involved in integration. The main dimensions that relate to integration are:

Areas: Service integration is possible for a range of public service areas including health, social, employment, childcare, education, housing, substance abuse, and local development policies.

Target groups: Generally, service integration is said to benefit (especially) the groups in society that tend to struggle with complex challenges and need a range of support measures. This may include parts of socio-demographic groups such as low-skilled, long-term unemployed and economically inactive, persons with disabilities, migrants, youth, elderly, and families.

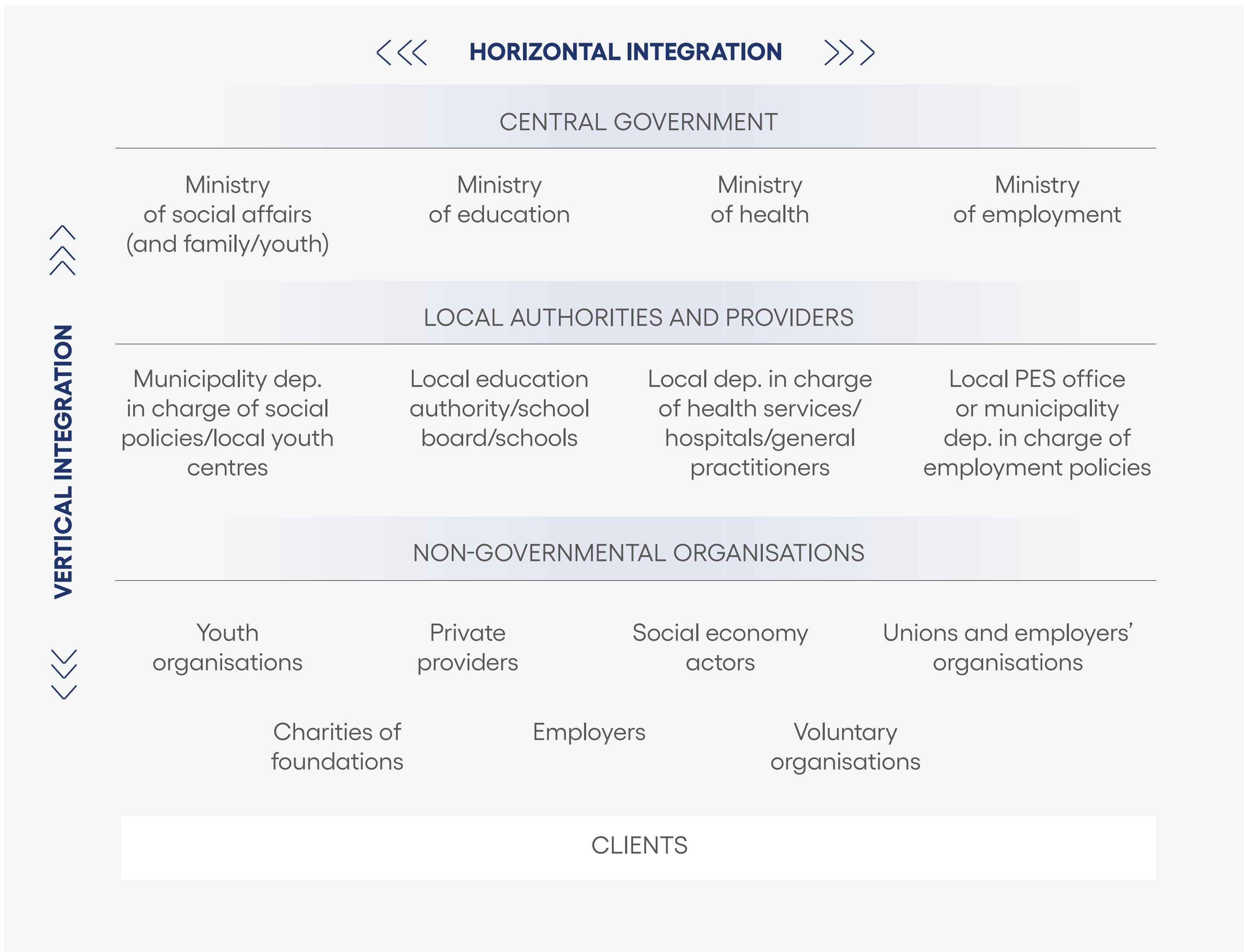
Vertical vs. horizontal integration: Services may be integrated vertically, integrating the hierarchy of governance and finance within one or multiple service areas. They may also be integrated horizontally, bringing together previously separated services, professions, and organizations across different areas at one government level.

Types of service providers: Integration may involve only public authorities/actors or also involve private actors and actors from the social economy (e.g. social enterprises, NGOs, etc.) that to some extent are involved in service provision. As many OECD countries have mixed systems of welfare provision where a range of public, private, and not-for-profit actors are involved in service delivery, therefore service integration usually goes beyond public authorities.

Figure 2.1 offers a synthetic scheme of vertical and horizontal integration of services. In healthcare, vertical integration has been referred to as “bringing together different levels in the care hierarchy” (England and Lester, 2005). For instance, this could mean integrating the hospital and community-based health services to ensure the continuum of care. Vertical integration is critical for developing efficiencies and savings, and can be used to address global policy questions such as “who pays for what and when?”, “what is trying to be achieved?”, and “where should the potential savings for integration accrue?”.

On the other hand, horizontal integration brings together previously separated policy groups, services, professions and organizations across different sectors to better serve users with multiple disadvantages and complex needs (Munday, 2007). Horizontal integration can occur at national, regional, local or delivery levels.

FIGURE 2.1 EXAMPLE OF VERTICAL AND HORIZONTAL INTEGRATION OF SERVICES



Based on OECD, 2023.

While horizontal integration focuses on competing or collaborating organizations, networks or groups in the health economy and might involve, for instance, grouping outpatient clinics within a geographic network of providers, vertical integration focuses on networks and groups at different stages of care within the health economy (what some commentators refer to as the supply chain or care pathway) and might involve, for instance, the drawing together of a hospital with local community services.

Regardless whether vertical or horizontal, integration can occur at **different degrees of intensity.** Munday (2007) speaks about "ladder of integration", where the choice of method depends on the specific needs, circumstances, and possibilities. Integration can range from almost complete separation/fragmentation over multidisciplinary teams and multi-service agencies to integration of government ministries and policies. Leutz (1999) identifies three different levels of integration, from the least intense to the most intense:

(i) **Linkage,** taking place between existing organizational units with a view to referring users to the right unit at the right time, and facilitating communication between professionals involved in order to promote continuity of care;

(ii) **Coordination,** operating through existing organizational units so as to coordinate different health and care services, share clinical information and manage transition of users and patients between different units (for example chains of care, care networks);

(iii) **Full integration,** formally pooling resources, allowing a new organization to be created alongside development of comprehensive services attuned to the needs of specific patient groups.

Focusing specifically on horizontal integration, Sloper (2004) identifies three forms or levels of integration, corresponding to:

(i) **Collocation,** that refers to having all agencies (legal, health, housing, social or case management services) in one location, thus reducing the complexity and the travel and time costs associated with take-up for users. Collocation also should improve accessibility between agencies that can help to promote collaboration among groups of service providers and professionals;

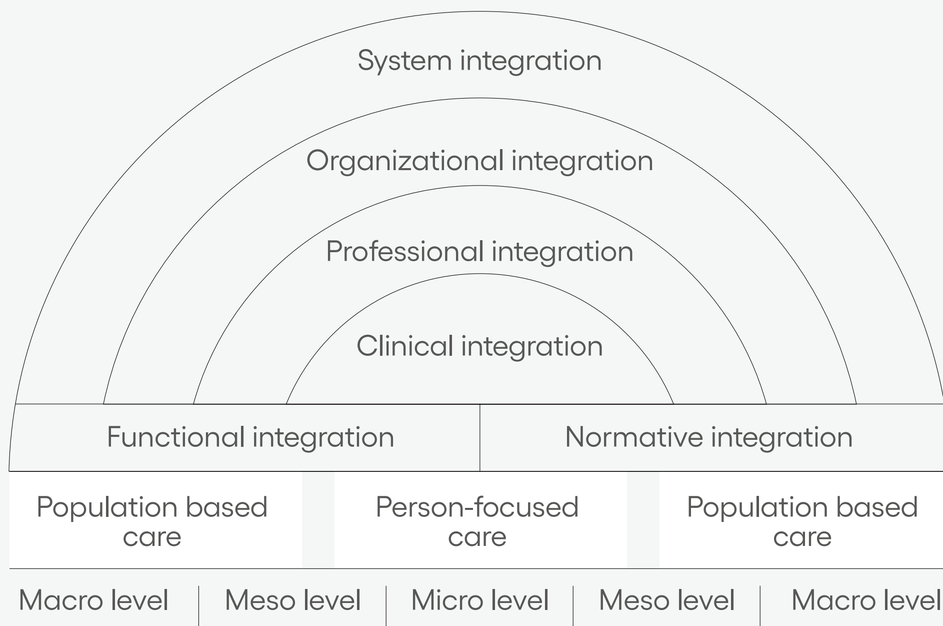
(ii) **Collaboration,** that refers to agencies working together through information sharing and creating a network of agencies to improve service user experience. By sharing knowledge, agencies and professionals can improve the referral process to other services offered by the center. The more knowledge professionals have about the different services, the better "needs-based" recommendations are available to service users;

(iii) **Cooperation,** defined as professionals communicating and working together. Effective co-operation, through good communication, can be central to improving service users' outcomes. If professionals work well together, costs can be lowered as services are not duplicated, and the identification and response to service users' needs can occur more quickly.

2.1.4 A (comprehensive) framework for integration

As already mentioned, integration of services can be conceived in many different ways. Valentijn et al. (2013) developed a conceptual framework for describing in a comprehensive way service integration (Figure 2.2).

FIGURE 2.2 CONCEPTUAL FRAMEWORK FOR SERVICES INTEGRATION



Based on Valentijn et al. (2013)

The fundamental premise of the framework is the difference between person-focused care and population-based care. The former is based on personal needs and individual preferences and reflect one perspective on the causes and possible solutions for certain problems. The latter in contrast addresses the needs and characteristics of a defined population (including political, economic, social, and environmental characteristics) and implies the distribution of services to the whole population. A population-based service model refers to assessing the needs of a specific population and making decisions for this population as distinct from caring for an individual member of that population.

Further, integration can take place at different levels; macro (system), meso (organizational and professional), and micro (client) level. Integration at the macro level incorporates the notion that what is best for individuals within a population is best for the population. Integration at the meso level requires professional and organizational integration to facilitate the continuous, comprehensive, and coordinated delivery of services to a defined population.

The needs of a population require the collective actions of organizations across the entire welfare service continuum, as they have a collective responsibility for the well-being of a defined population. Integration at the micro level is, in turn, based on a person-focused service perspective, and can facilitate the continuous, comprehensive, and coordinated delivery of services at an individual level. This may mean that integration may be pursued at the macro and meso levels, when services from other providers or organizations are required and are supposed to reach large segments of people.

Looking from a horizontal perspective, integration can be functional or normative. Functional integration refers to the coordination of key support functions such as financial management, human resources, strategic planning, information management and quality improvement.

It includes key support functions and activities (i.e., financial, management and information systems) structured around the primary process of service delivery, to coordinate and support accountability and decision-making between organizations and professionals to add overall value to the system. In contrast, normative integration refers to the development and maintenance of a common frame of reference (i.e., shared mission, vision, values and culture) between organizations, professional groups and individuals. In other words, spanning micro, meso and macro levels, normative integration facilitates inter-sectorial collaboration and ensure consistency between all the levels of an integrated system.

The framework is descriptive and does not imply any causal relationships between the variables, rather it helps in giving conceptual categories to the various forms and levels of integration.

2.1.5 Which challenges may we face with integration?

Services integration offers many promising improvements in terms of better quality of services, cost-effectiveness, savings, etc., but it does not come without costs and challenges. Among the main challenges in this process are complex governance structures/multi-stakeholder service provision, differences in financing models, incompatible rules and regulations, professional differences, IT and data sharing, management and skills, third-party involvement and political differences (OECD, 2023):

Complex governance structures: Authorities and service providers at each level of government are characterized by their own organization, financing, management, interests and incentives. This may serve as a barrier to integration as it often entails significant structural and organizational changes. In countries where service delivery is spread across multiple public, private and not-for-profit providers, integration is more challenging and can be difficult for both local and national governments to pursue. Another concern arises from the typical situation where central governments maintain a primary responsibility on governance and financing while delegating local governments the role of service providers. This setup can create incentives to prioritize services funded by central governments over those funded by local budgets, especially when the last are dealing with significant budget limitations. Consequently, services that rely more on local government funding may face a risk of being under-provided or under-funded. For these reasons, clear incentives, responsibilities and mechanisms for monitoring results must be in place to guarantee co-operation in these cases. This does not preclude variations at the regional or local level in the implementation of integration measures, but strong accountability or transparent benchmarking is needed. In countries where most services are decentralized, subnational governments have more room to push forward horizontal integration, including through interaction with local providers. Yet, even in these systems there may be disincentives to service integration locally, including due to differences in culture or working methods and disagreement on management and leadership locally.

National strategies without implementation frameworks: National strategies to promote cooperation between national ministries and other national actors can be important to pursue service integration also at local level. Yet, co-operation

at the national level does not necessarily translate into increased co-operation locally. Often national strategies come without implementation frameworks that set out the details of how integration should work in practice, or how to consider local variations, or without the budget needs to transform service provision locally.

Differences in financing models: Integrated service models often require a large, fixed capital investment as well as running costs. Often the funding of these costs will come from different authorities (e.g. shared financing between national and local government or between different administrations or service areas within the municipality), that work according to their own (constrained) budgets. If financial responsibilities are spread across different levels of government, there may be perverse incentives to shift costs to make more use of services funded by another level of government. In other words, it can make emerge the “wrong pockets problems” (OECD, 2015), i.e. when multiple financial and management arrangements between coordinated groups can result in cost shifting between groups, but also under-investment within any given group when the returns from investment are not shared equally or proportionally between the coordinating bodies.

In addition, depending on how the returns from investment in services are shared between government levels, there may be disincentives for governments to increase investment if other government levels would benefit more. When integrating services, authorities need to find ways to pool their resources in a way that reflects the efforts that they put into the system and develop a model that provides adequate sources of finance and sustainable commitments to all involved actors.

Incompatible rules and regulations: Even when the financial and organizational set-up are in place, differences in the legal texts may pose a significant barrier to practical integration on the ground. Service integration may be difficult due to incompatible objectives (e.g. a focus on activation and employment in the employment legislation vs. a focus on well-being in the social policy legislation) and priorities of services (e.g. whether to start with family counselling, housing support, career guidance or adult learning).

Professional differences: Integration implies co-operation between a range of professionals with very different educational backgrounds, skills, culture, pay-levels, employment conditions and regulations of professions. Differences in skills and culture can make it difficult for professionals to understand and trust each other and can result in controversies over the right approach to individual cases (Maslin-Prothero and Bennion, 2010). As an example, approaches to employment support for youth range from more "human-capital centered" approaches (focusing on training and social development as a precursor to employment) to "work first" approaches (where rapid entry to work is prioritized). Moreover, differences in terms of pay and employment conditions may create internal hierarchies and result in disincentives to collaboration (Munday, 2007).

IT and data sharing: Data systems play a central role in todays' public service delivery. Often, the different IT systems are built to fit the needs and work methods of a specific organization and they are not capable of being adapted, integrated or even interfacing with other service systems. However, the effectiveness of integrated service delivery relies on the ability and willingness of professionals to share data and

information across organizations. Without this, each case worker only has access to a subset of knowledge which can negatively affect the quality of the overall support system. This requires integration of the underlying IT systems as well as legal adjustments to overcome issues related to service user's information and privacy (Maslin-Prothero and Bennion, 2010). However, IT system integration often takes time and is costly, which can make subnational governments refrain from engaging in these types of projects.

Management and skills: The success of integration also very much depends on the interest and capabilities of management as well as clear assignment of responsibilities to avoid management gaps. When undertaking integration reforms, it is important to clarify questions such as who is ultimately responsible for administering the service, how are assigned budgets managed, and to whom is performance reported? Moreover, it is important to be aware that integrated services often require new types of professionals and inter-professional teams, which might require re- and upskilling (Hunt, 2012).

Third-party involvement: In today's mixed service economies, private and voluntary or informal carers play an increasing role in providing public services. In addition, in many countries, national or subnational governments contract the provision of services, including employment and social services, out to third party providers (Langenbucher and Vodopivec, 2022). The increasing number of actors may further complicate effective integration, but their presence also makes integration more relevant than ever. When designing reforms, policymakers must be aware of the role of third parties in

integrated settings and of how to regulate and monitor the quality and continuity of their service delivery.

Political opposition: Service integration is a complex reform exercise that typically involves and affects a range of stakeholders. The parliamentary system and the constellation of government as well as the economic and social situation may influence the ability to get such comprehensive reforms through the political system. Moreover, as with any other welfare reforms, differences in the view and interests of citizen groups may pose a significant barrier to change.

As an example, organizations representing individuals in vulnerable situations may fear that the introduction of more flexible and active inclusion service systems will result in a loss of rights to benefits and services for their members and the introduction of stricter activation requirements. The same kind of political opposition to integration reforms may be found at the subnational government level, where party politics remain and where decisions are even closer to citizens and their organizations of interest. In addition, the risk of misalignment between short-term costs and long-term benefits as well as the uncertainty about the expected outcomes of welfare reform may introduce a political status quo bias against change (European Commission, 2015).

In addition to all the above-mentioned potential challenges, it is necessary to remark that service integration implies complex and long processes, requiring large investments and fixed capital costs to set up equipment

and competences needed to deliver services in an integrated way. In this regard, integration requires sustainable funding streams, but also it often requires significant structural and organizational changes, that are not easy to be politically communicated and understood by the population. While it is accurate that integration policies can yield cost savings in the long term, such as by avoiding unnecessary duplicate treatments, the initial establishment of integrated governance structures comes with additional costs. These costs include expenses related to agencies and staff responsible for coordinating and assessing integration efforts, as well as investments in technology and staff training.

This pertains not only to financial considerations but also to social dimensions, including potential power struggles within different organizations or groups of professionals. Indeed, the potential of divisions between different professions may remain a significant barrier to integrated working. Differences in culture, skills or work conditions between professionals can impede joint working.

Finally, the greatest challenges may be faced when pursuing full integration between public and private (profit and no-profit) providers, since managing collaboration and competition at the same time is challenging, due the multitude of actors and administrations involved (Munday, 2007).

Research objectives 3

The present report has two main research objectives:

1. The comparative analysis of the health systems of a set of 9 selected countries: Italy, Croatia, France, Greece, Poland, Portugal, Czech Republic, Slovakia and Spain. The analysis is divided into two main parts: the first provides a comparative assessment of the 9 countries analyzing them with respect to the European average and a sub-set of Northern European countries (e.g., Sweden, UK, Netherlands, Norway). Countries are analyzed and compared over different dimensions relative to population structure and economic dimension, as well as the health status of the population, health expenditure and financing, effectiveness of care provided and availability of resources.

The objective is to offer a comprehensive overview of the different dimensions of performance of the health care systems, with a comparative view with respect to other territorial and institutional contexts. The second part of this first chapter is focused on analyzing the 9 country "profiles", providing evidence on the features of their health care systems. In particular, the report analyzes the governance schemes and the organizational models of the health systems of the 9 countries, the financing mechanisms, the provision and services delivery models, and, finally, it offers two thematic focuses on public health and prevention and long-term care (LTC).

2. The formulation of future research avenues and hypotheses to investigate, thanks to the comparative assessment conducted in the first phase. The comparative analysis is indeed preparatory for developing and formulating research avenues and recommendations especially relative to the following topics: governance, financing schemes, long-term services and prevention. Cross-country benchmarking should stimulate reflection on possible convergences and divergences between healthcare systems, highlighting which general attributes and those that are more context-specific should be addressed to pave the way for integrated systems.

The two research objectives are interconnected and complementary since the first section offers the necessary information of the selected countries, initially framed in the broader context and compared with other benchmark countries (as UK, Norway, Sweden, etc.) and secondly, deeply analyzed with respect to their healthcare systems (organization, governance, financing, quality of care and provision, and the two main focuses of LTC and prevention). These pieces of evidence are necessary information for the second section to formulate coherent and innovative proposals regarding future avenues of research, investigation and development, building upon the definition, elements, and challenges of welfare service integration discussed in the second section.

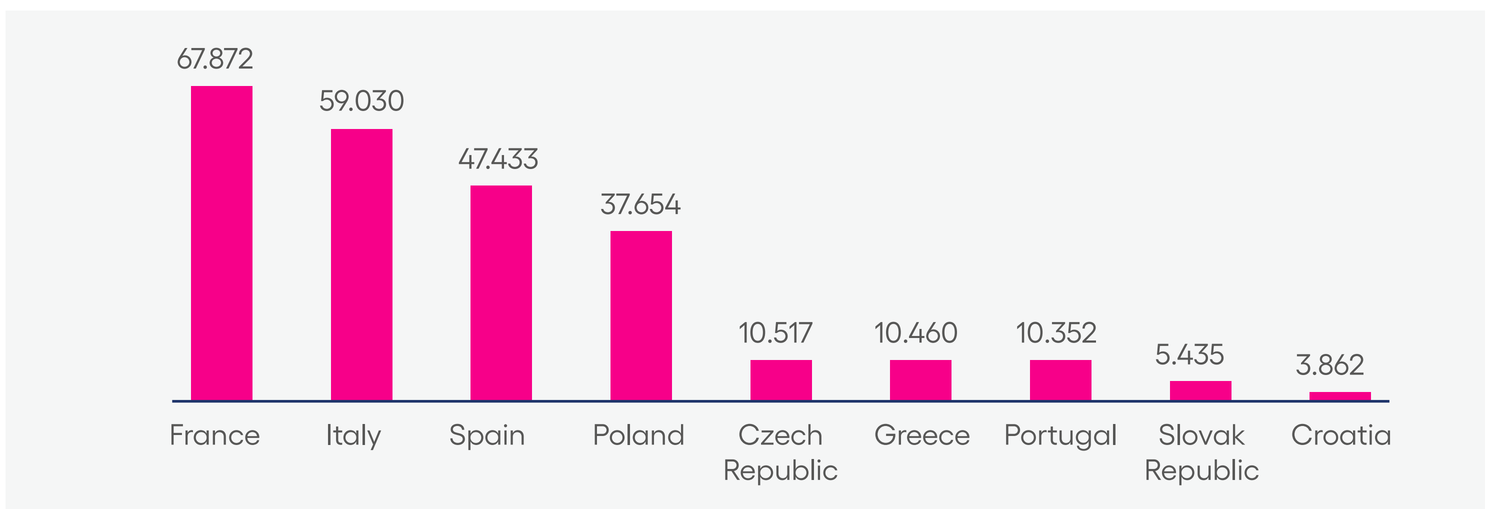
The analysis relies on both national sources, reports edited by international institutions (WHO Country Profiles, EOHSP Health Systems in Transition Series, etc.) and academic literature, and analyzes the main characteristics and the recent evolution of the health systems of the above-mentioned countries.

Demographic and economic background 4

The following two sections aim to comparatively present some indicators that represent the diversity of the observed countries. The first section presents and discusses indicators of an economic and demographic nature.

The countries under examination collectively represent over 250 million inhabitants, approximately 57% of the resident population in the European Union in 2022. Among these, three distinct blocks are clearly distinguished (Figure 4.1): large countries with a population exceeding 30 million inhabitants (France, Italy, Spain, and Poland), medium-sized countries (Czech Republic, Greece, and Portugal) with a population of around 10 million inhabitants, and small-sized countries (Slovak Republic and Croatia).

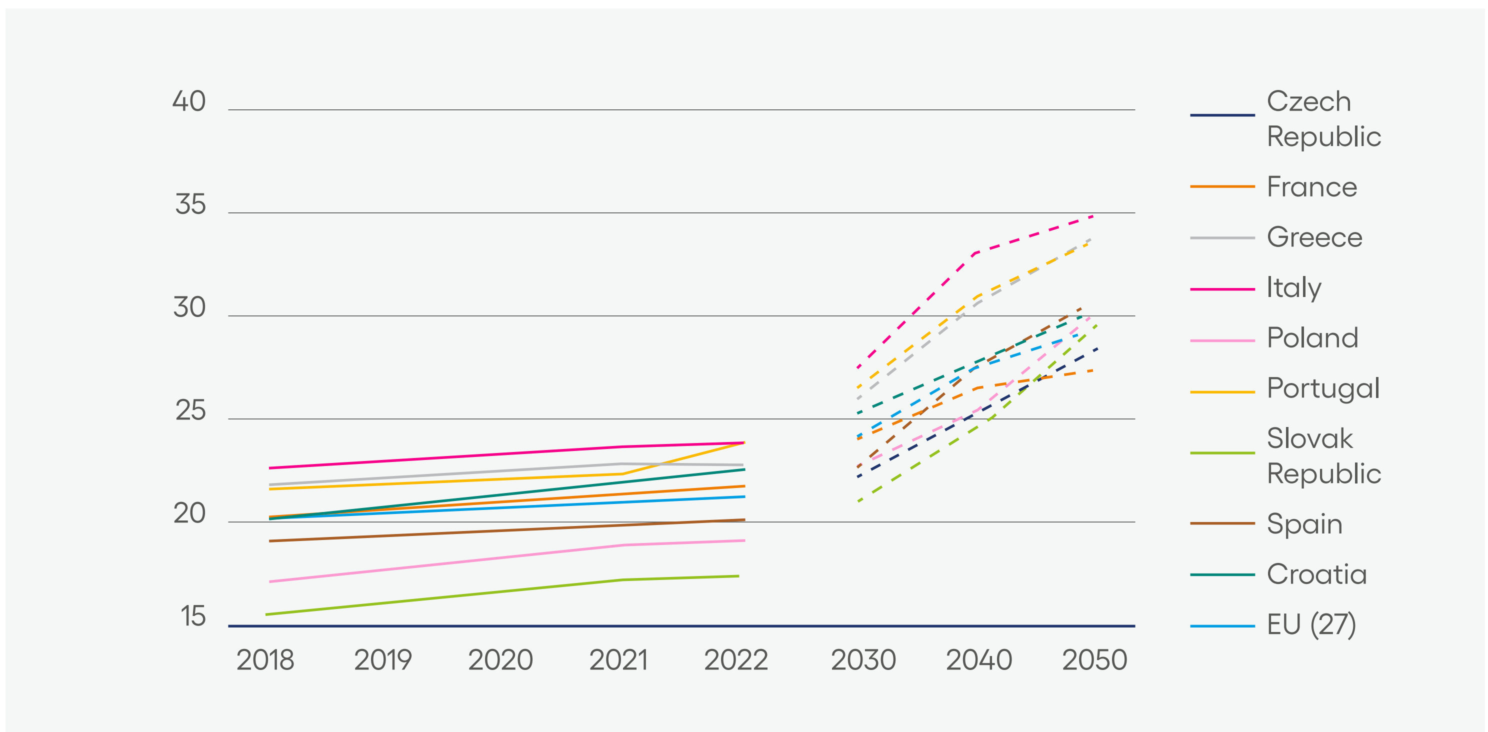
FIGURE 4.1 TOTAL POPULATION (THOUSANDS), 2022



Source: OECD

In addition to size, countries also significantly differ in terms of population structure. In 2022, the percentage of the population over 65 exceeded 21% in the European Union, steadily increasing in recent years. Southern European countries such as Italy, Portugal, Greece, and Croatia have an even more skewed population structure towards the elderly (respectively, 23.8%, 23.7%, 22.7%, and 22.5% of over 65s in the resident population), while relatively younger countries like the Slovak Republic and Poland remain (respectively, 17.4% and 19.1% of over 65s). Projections for all countries show a significant growth in the population over 65, which in Europe is expected to reach nearly 30% of the total population by 2050, with peaks of 35% in Italy (Figure 4.2).

FIGURE 4.2
PERCENTAGE OF OVER 65 ON TOTAL POPULATION, 2018-2022 AND PROJECTIONS (2030-2050)

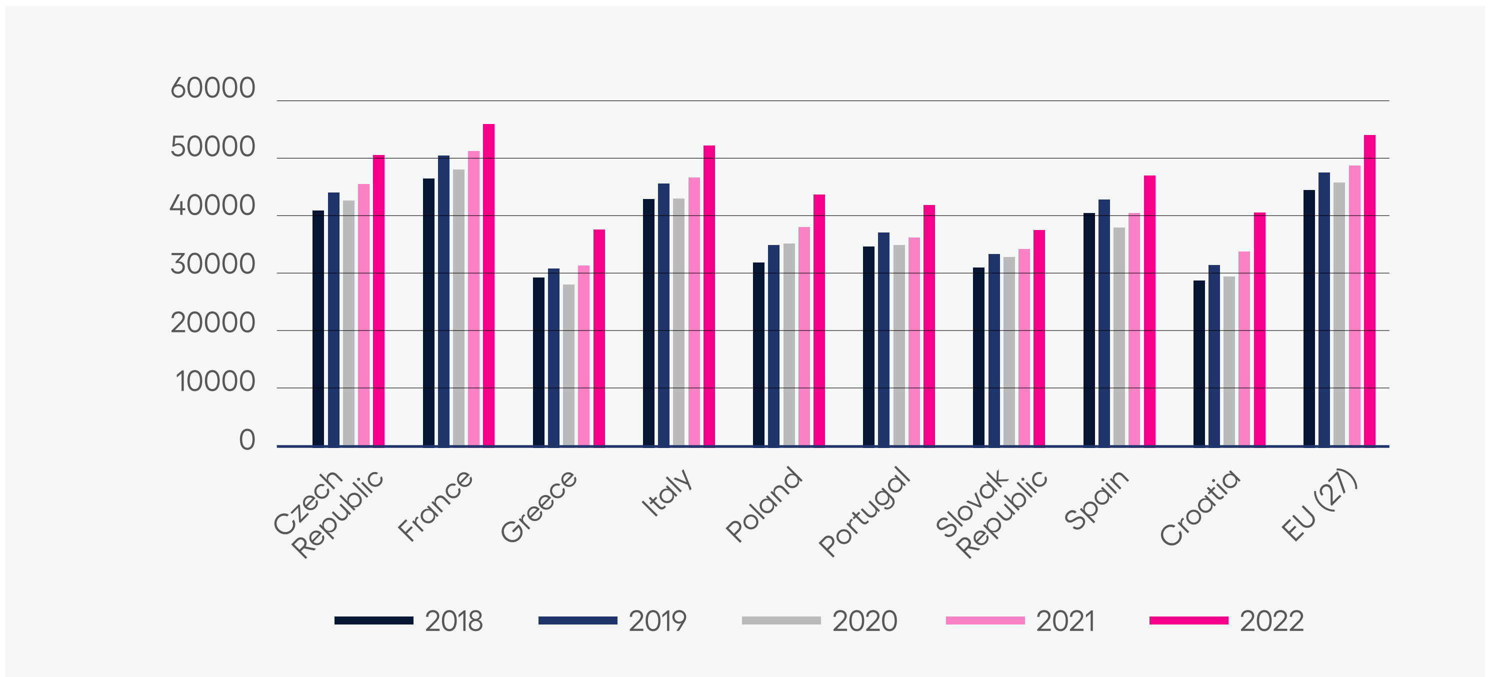


Source: elaboration on OECD and Eurostat data

As a result, the old age dependency ratio (defined as the ratio between the population over 65 and the population aged 15 to 64) is expected to increase in Europe from approximately 32% in 2022 to 39% in 2030, and even further to 52% in 2050, with peaks of 63% in Greece and Portugal, and 61% in Italy. The low birth rates that characterize many European countries also contribute to reaching this scenario. In 2021, the total fertility rate in Europe (the average number of children per woman aged 15 to 49) stood at 1.5. In countries like the Czech Republic and France, where the value exceeds 1.8, this can still be considered relatively high, differently from countries like Italy and Spain, where the statistic approaches the threshold of one child per woman (1.3 and 1.2, respectively).

In economic terms, measured as Gross Domestic Product (GDP), the observed countries represented just half of the European Union's economy in 2022 (47%), a figure lower than that recorded at the beginning of the previous decade (51% in 2011). In relative terms (GDP per capita, using $ in Purchasing Power Parity – PPP – for more appropriate comparisons), there are significant variations. The countries with the lowest GDP per capita are Greece and the Slovak Republic, with values slightly above 37,000 PPP$ in 2022. France, on the other hand, is significantly wealthier, with a GDP per capita exceeding 56,000 $PPP, surpassing the European average (54,249 $PPP). In addition to differing values, countries also vary in recent trends. While countries like Poland and Croatia exhibit large growth rates (37% and 41% between 2018 and 2022, respectively), others, like Italy, Spain and Portugal, are characterized by a less dynamic economies with modest GDP per capita growth rates (22%, 15% and 20%, respectively). It's worth considering the varying ability of countries to respond to the recession triggered by the Covid-19 pandemic between 2020 and 2021 (Figure 4.3).

FIGURE 4.3 GDP PER CAPITA ($PPP), 2018-2022



Source: elaboration on OECD and WB data

Health indicators: a cross-country comparison 5

The following section introduces and discusses key indicators regarding the health status, financing, and performance of the healthcare systems of the observed countries. For the sake of a comprehensive comparisons, Nordic countries (primarily Denmark, Sweden, and Norway, depending on data availability), traditionally considered as reference models for welfare states, are included in the sample of countries. The United Kingdom is also included as the primary reference for Beveridge-type healthcare systems (with the first and most famous case in Europe being the English NHS, established in 1948 under the influence of the report drafted by Lord Beveridge).

The data in this section predominantly originate from the OECD report “Health at a Glance Europe 2022” (OECD & European Union, 2022) and the OECD Health Statistics portal updated in 2023 (OECD, 2023), often referring to data from 2021, the year for which information is available for most countries.

This paragraph is structured into the following subsections:

1. Population health status
2. Healthcare system expenditure and financing
3. Effectiveness and performance of the systems
4. Available resources.

5.1 Health Status

The health status of a population is a multi-dimensional variable that is challenging to synthesize into a few indicators. Typically, the primary indicator for international comparisons of health status is life expectancy, which quantitatively represents the average number of years that a person can expect to live based on current mortality rates. In 2021, the average life expectancy in the European Union was 80.1 years.

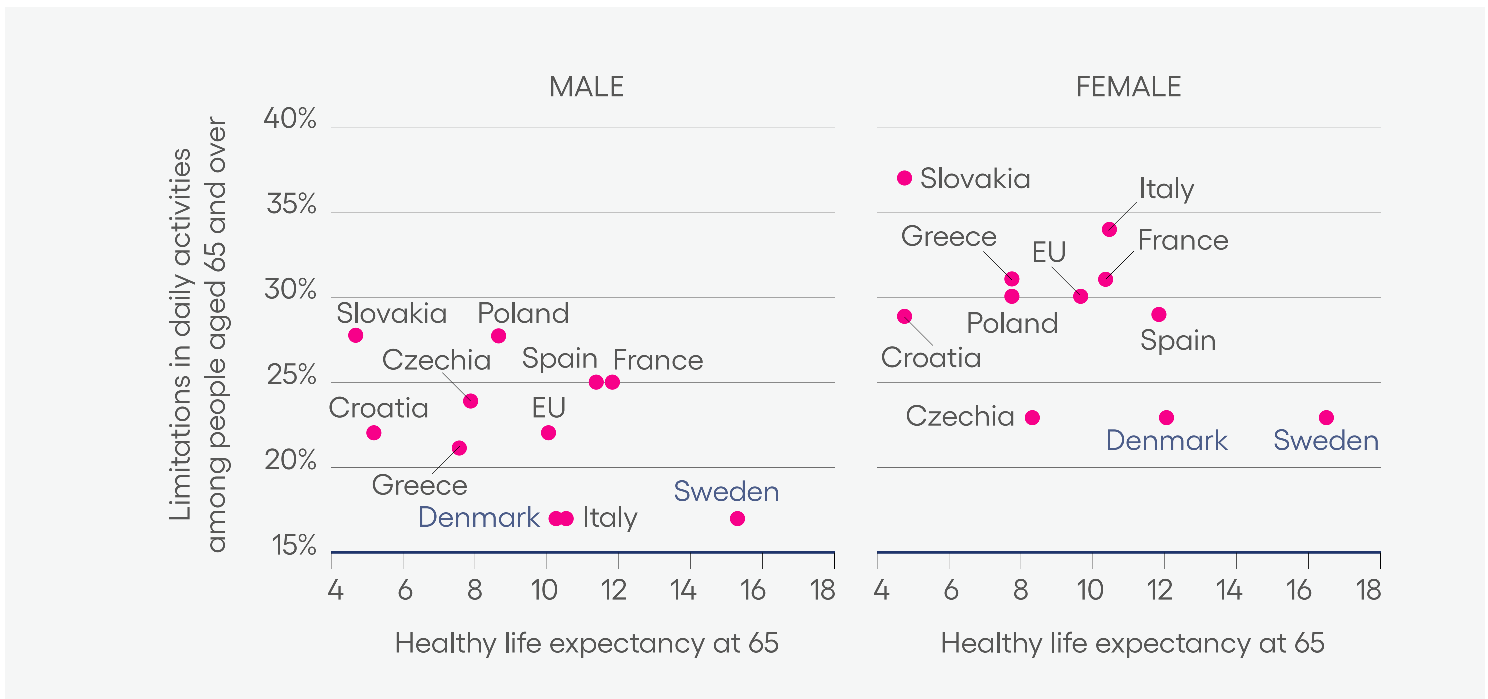
Historically, this data significantly differs between males and females, with the latter (82.8 years) having an average life expectancy in the EU that is 5.6 years higher than males (77.2 years). Among the observed countries, Spain (83.3 years) and Italy (82.9 years) have the highest average life expectancy (alongside Sweden and Norway at 83.2 years). In contrast, Croatia (76.8 years), Poland (75.6 years), and Slovakia (74.8 years) have the lowest.

Another interesting indicator is life expectancy at 65 years, especially when associated with the percentage of people with limitations in daily activities. This provides not only a quantitative but also a qualitative indication of the health status of a population, and in particular for the elderly population. Looking at the first indicator, Spain maintains its top position with an average life expectancy at 65 years of 11.5 years for males and 11.6 years for females. The lowest-ranking country is Slovakia, with 4.7 and 4.6 years for males and females, respectively (Sweden serves as a benchmark in this dimension, with an average value of about 16 years).

In the second dimension, the percentage of those over 65 with limitations in daily activities, Slovakia (28% for males and 37% for females) and Poland (28% for males and 31% for females) exhibit the worst performances, while the Czech Republic, among the observed countries, has the best performance on average (24% for males and 23% for females), with Denmark and Sweden as benchmark countries in this dimension (20% overall).

When relating these variables, a negative relationship emerges, indicating that, on average, a higher life expectancy at 65 years corresponds to a lower percentage of people with limitations in daily activities, demonstrating how quantity and quality of life go hand in hand (Figure 5.1).

FIGURE 5.1
HEALTHY LIFE EXPECTANCY AND LIMITATIONS IN DAILY ACTIVITIES AT 65, BY GENDER (2021, OR LAST YEAR AVAILABLE)



Source: elaboration on OECD

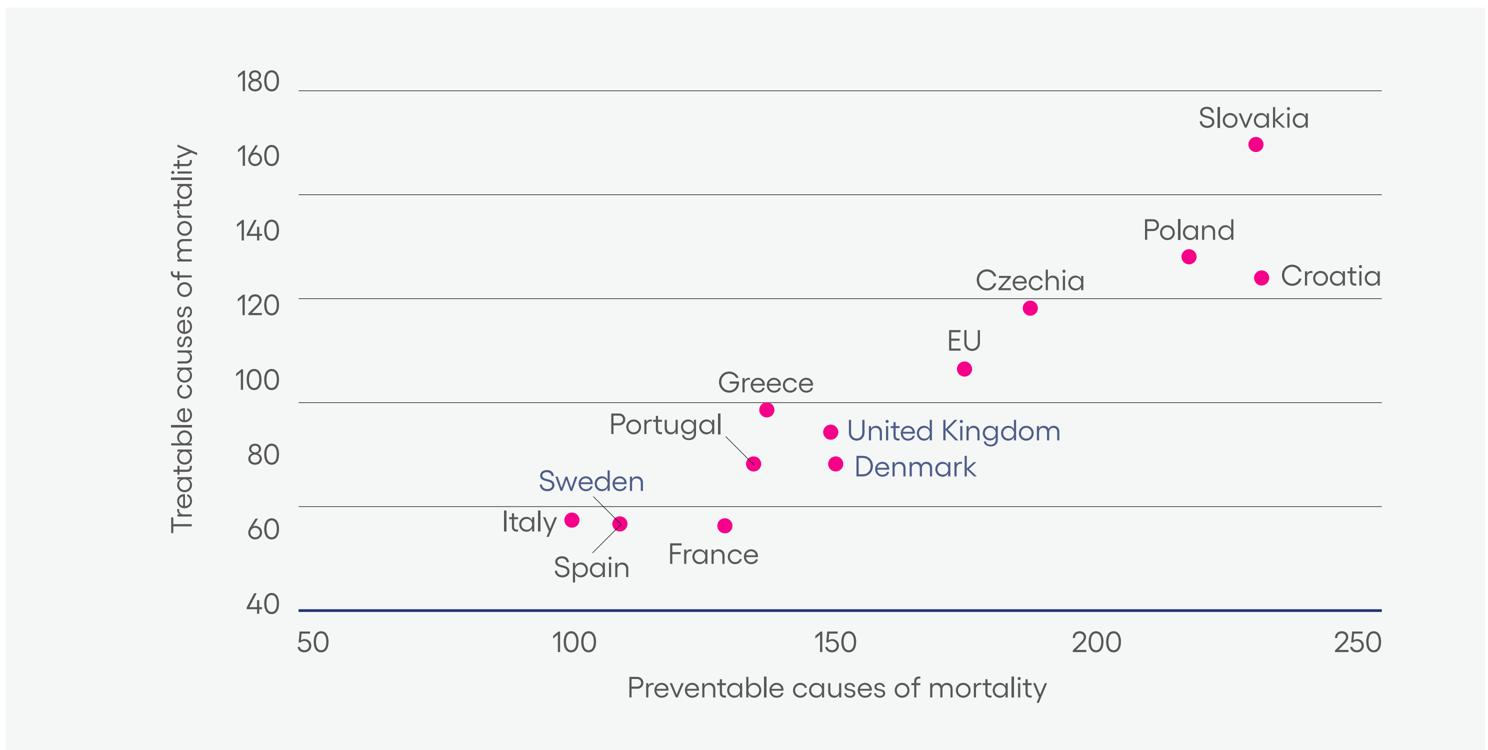
Deaths and the causes of death are another interesting indicator to observe, not only for describing the health of populations but also for evaluating the effectiveness of healthcare systems in preventing certain diseases from causing an excessive number of premature deaths. Causes of death are classified using the ICD-10 codes (International Classification of Diseases, 10th version), and they distinguish a particular category of causes referred to as “avoidable” or “premature” (because they occur before the age of 75), particularly distinguishing between “preventable” and “treatable” causes.

Preventable causes are those that can be avoided through effective preventive interventions (infectious diseases, certain types of cancer such as lung, liver, and skin cancer, etc.). Treatable causes are those that can be avoided through timely and effective healthcare interventions (some types of cancer like breast cancer, acute cardiovascular diseases, etc.). The European average for avoidable mortality is 280 deaths per 100,000 inhabitants, consisting of 176 preventable deaths and 104 treatable deaths.

When considering both dimensions, there is a significant divide among the countries under analysis: on one hand, Eastern European countries all have higher rates of avoidable mortality than the European average, both for treatable and preventable mortality; on the other hand, Western, Northern and Mediterranean European countries all show rates below the average. Among all the countries compared, Italy has the best performance, with treatable mortality at 64 deaths (on par with Spain) per 100,000 inhabitants and

FIGURE 5.2
AVOIDABLE CAUSES OF MORTALITY PER 100,000 THOUSAND INHABITANTS (2019, OR LAST YEAR AVAILABLE)

preventable mortality at 101 deaths. It is evident, therefore, that in terms of healthcare system treatment capacity (treatable and preventable mortality) and population lifestyles (preventable mortality), countries like the Czech Republic, Slovakia, Poland, and Croatia are still lagging behind compared to other European realities (Figure 5.2).



Source: elaboration on OECD

5.2 Health expenditure and financing

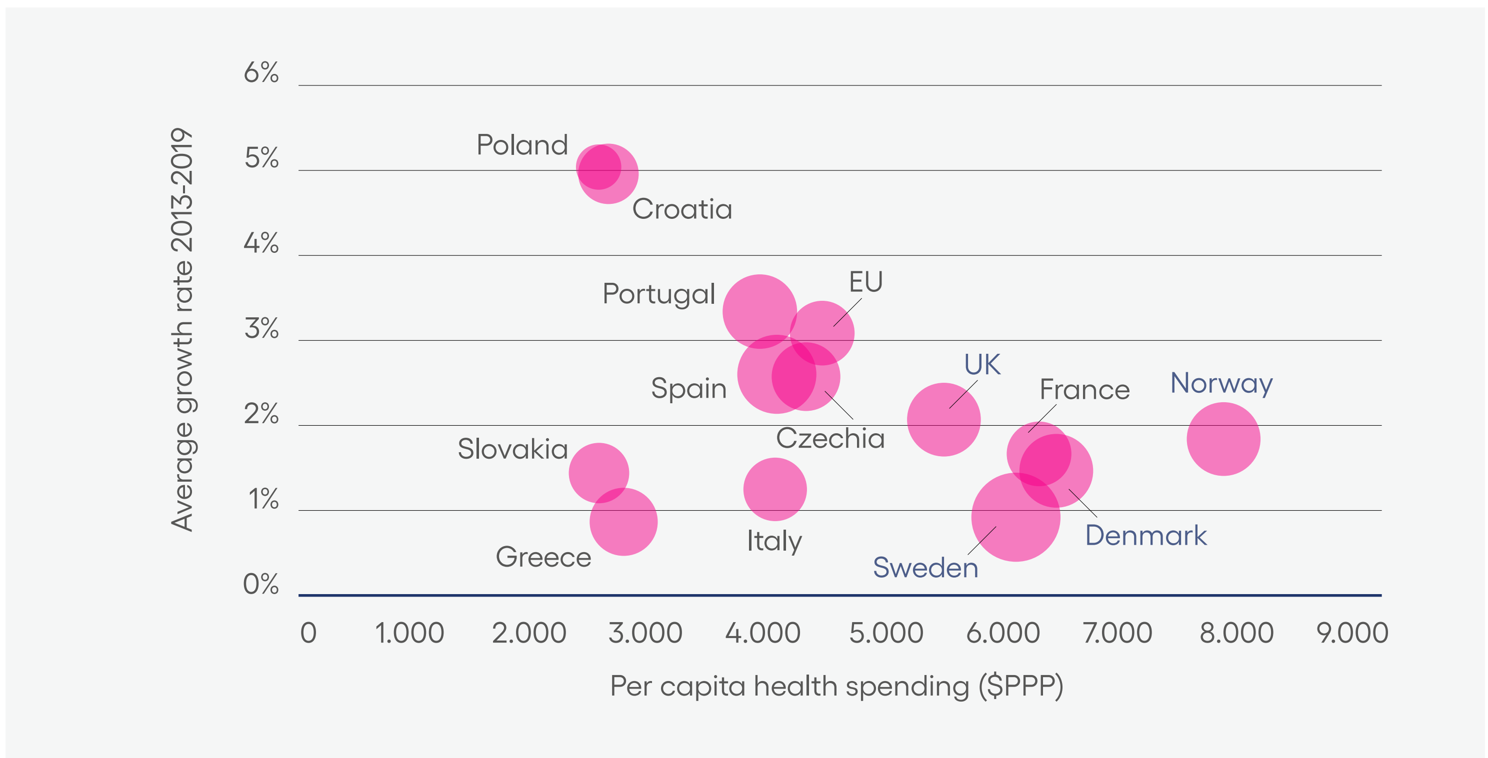
The levels and trends of healthcare expenditure depend on a range of contingent and structural factors that characterize individual countries and the historical period under consideration. When comparing countries, commonly adopted measures include per capita spending and spending as a proportion of GDP. There are significant differences in the amount of resources that healthcare systems allocate to healthcare when considering all sources of financing.

In Europe, the countries that allocate the most resources in terms of both per capita and GDP-related spending are the Nordic countries, and among those observed in this report, France, all with per capita spending levels exceeding $4,500 PPP, which is above the European average. Below the average are the Southern European countries (Portugal, Spain, Italy, and Greece), and especially those in Eastern Europe, which, with the exception of the Czech Republic, are at the bottom of the ranking (Poland and Croatia have spending levels of $2,500 and $2,600 PPP, respectively).

The situation is even more diversified when considering GDP-related spending, with countries like the Nordic ones and, in particular, France (12.3%), confirming high levels of relative spending, and those in Eastern and Mediterranean Europe with low relative spending levels (Poland has a minimum value of 6.4% overall). Observing the trend in the 6 years preceding the Covid-19 pandemic (2013-2019), an interesting convergence process emerges, with countries generally having lower spending levels recording growth rates

FIGURE 5.3
PER CAPITA HEALTH SPENDING (2021, X), AVERAGE GROWTH RATE (2013-2019, Y), AND HEALTH SPENDING ON GDP (2021, SIZE)

above the average: Poland and Croatia recorded average growth values of 4.9% and 4.8% annually, more than five times that of France (and three times that of Norway). Italy, Greece, and Slovakia represent exceptions to this trend. The first two, in particular, experienced a severe financial crisis at the beginning of the last decade, leading to a profound rationalization of public budgets, especially in the healthcare sector, which continues to have lasting effects (Figure 5.3).



Source: elaboration on OECD

It is also useful to examine the sources of funding for healthcare systems. While avoiding a detailed discussion of revenues collection methods, which will be addressed in a specific section (Section 4), it is important here to highlight the nature of funding, distinguishing between public or compulsory sources (i.e., those of a private nature but mandated by law to be part of the system, such as compulsory health insurance) and private resources, which can be further classified into voluntary funding schemes (mostly voluntary health insurance, but also employer spending on occupational health) and out-of-pocket expenditures by citizens, i.e., expenses paid directly by individuals without any form of intermediation. The sum of the latter two generally makes up what the debate refers to as private healthcare spending.

The first message concerns the weight of public healthcare spending, which in Europe is never less than 60% of the total resources (62% in Greece and 63% in Portugal). Several countries, such as the Nordic ones but also Croatia, the Czech Republic, and France, reach or exceed 85% of public (or mandatory) resources. Spain (72%), Poland (72%), and Italy (along with Greece and Portugal) fall below the European average.

Another point of consideration is the weight of the intermediated component (employer- or contract-based spending) within private healthcare spending. Notably, out-of-pocket spending is the most susceptible to sacrifices and inequalities, as it is entirely linked to the ability and willingness of households and individuals to pay. The country with the highest share of voluntary intermediate funding schemes is France, where 41% of private spending falls under a voluntary financing scheme. The Czech Republic and Slovakia

(along with the Nordic countries) are among the countries where the vast majority of private resources come directly out of citizens' pockets (6% and 4%, respectively). In Europe, on average, one euro out of five is intermediated through a voluntary financing scheme (Figure 5.4).

FIGURE 5.4
HEALTH EXPENDITURE BY TYPE OF FINANCING (2021)

Source: elaboration on OECD

Another aspect to carefully consider is the function of healthcare spending, specifically the areas of care to which it is allocated (Figure 5.5). The classification used by international organizations distinguishes healthcare functions into inpatient and outpatient care, long-term care (LTC) services, ancillary services (primarily imaging and laboratory diagnostics), and medical goods (both durable and single-use items). It is straightforward that there is a clear distinction in the functions served between public and private spending.

In all analyzed countries and for the European average, public (or compulsory private) spending primarily covers inpatient and outpatient care services. EU countries allocate an average 30% of public resources to inpatient services and 23% to outpatient services. In countries with lower expenditure levels, such as Greece and Poland, there is a greater emphasis on hospital care (43% and 41%, respectively). This is not surprising, as hospital services represent the most complex and high-risk component in terms of potential catastrophic expenses for individuals. Therefore, even systems with fewer resources tend to prioritize this area of care. In contrast, countries like Croatia and France allocate only a quarter of public resources to hospital care (24% and 26%, respectively).

The allocation of funding to areas such as LTC and medical goods varies significantly among countries. For the LTC component, the European average stands at 14% of public resources, but it ranges from negligible amounts in Slovakia (1%) and Croatia (3%) to values slightly above the European average, such as in France (14%) and the Czech Republic (15%). Nordic countries are an exception in this regard, as they allocate significantly more public resources to LTC than the European average and any other country under analysis (32% in Norway, 27% in Sweden,

21% in Denmark). As for durable medical goods, Nordic countries allocate the lowest proportion of public resources, falling below the European average of 12%, while countries like Greece (26%) and Slovakia (21%) exceed this value.

The situation is dramatically different when it comes to private voluntary spending (voluntary financing mechanisms and out-of-pocket expenses). First and foremost, the inpatient component is less significant, standing at 10% in the EU, but driven by particularly isolated cases such as Greece (37%). Among the countries observed, Italy has the lowest share of private spending on hospital activities (3%), which is even lower than the UK but still higher than Nordic countries where private spending on hospitalizations is negligible. Notably, private spending on outpatient services assumes a significant share (35%) in the EU. Countries like Italy (36%), Poland (33%), Spain (37%), and Croatia (38%) are close to the average (similar to Nordic countries), while France (24%), Greece (21%), and Slovakia (16%) fall below European values. It is worth highlighting the role played by dental care in this context, as in many countries they are either excluded or only partially included in basic benefits packages and represent a substantial expense category for individuals and families.

Private spending on LTC services is also highly heterogeneous. While the European average stands at 10%, in countries like Greece, the Czech Republic, Slovakia, and Croatia, the percentage is negligible, while in France (and also the UK), it represents one of the primary categories of private spending (24%). This topic will be further explored in a dedicated

section (Section 4.4), but it is worth noting that the minimal private spending allocated to LTC indicates that this area of care is often left within the realm of informal caregiving, which is not quantified within these reporting systems. Finally, the significance of spending on medical goods is a common feature across all the observed countries. In Slovakia, in particular, 62% of private resources are allocated to the purchase of products, nearly double the European average.

FIGURE 5.5
SHARE OF HEALTH SPENDING BY FUNCTION (2021)

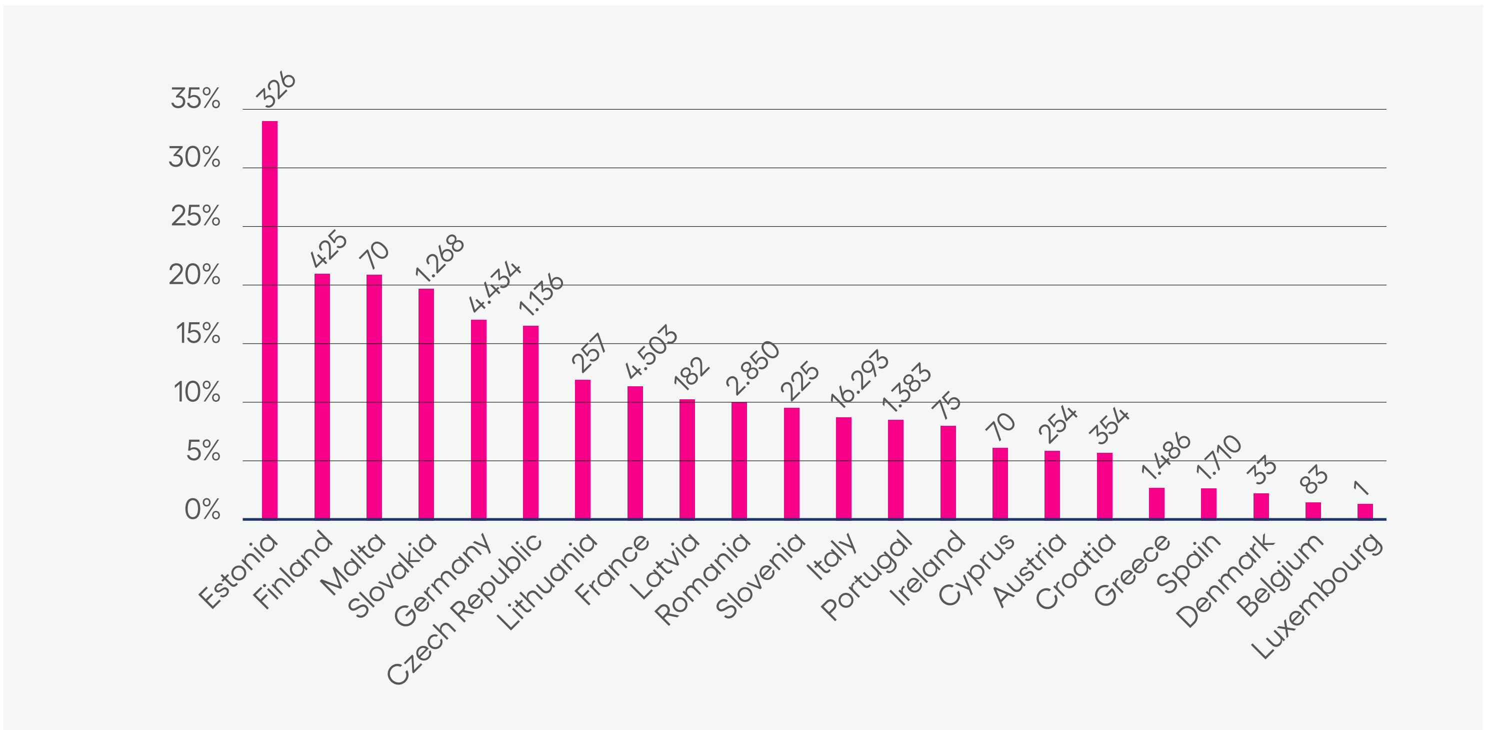
Government/Compulsory
Voluntary/OOP
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0
Croatia Czechia France Greece Italy Poland Portugal Slovakia Spain EU Denmark Sweden Norway UK
Croatia Czechia France Greece Italy Poland Portugal Slovakia Spain EU Denmark Sweden Norway UK
Inpatients
Outpatients
LTC
Ancillary
Medical Goods

Source: elaboration on OECD

Lastly, an element of interest in the context of recent and future developments is derived from observing the attention that countries have directed towards their healthcare systems in the aftermath of the Covid-19 health crisis. In 2020, the European Union established the Recovery and Resilience Facility (RRF), a fund aimed at supporting the resilience of the socio-economic systems of its member countries, with a particular emphasis on green and digital transitions. One of the missions of the RRF was to enhance the resilience of healthcare systems. An analysis by the European Commission published in 2021 shows that 22 countries under review allocated specific resources to measures aimed at strengthening their healthcare systems, with a total amount of around 37 billion euros (approximately 8% of the fund). Member states included a wide range of measures to be funded, ranging from strengthening primary care to transitioning from hospital to community-based care, enhancing hospital networks, prevention measures, and e-health initiatives.

In terms of total resources, Italy, the primary recipient of the RRF, is the country that will invest the most in its healthcare system, with over 16 billion euros allocated between 2021 and 2026 (43% of the total), followed by France (4.5 billion), Germany (4.4 billion), Romania (2.9 billion), Spain (1.7 billion), and Greece (1.5 billion) (Figure 5.6). For a more detailed analysis of national plans, it is advisable to refer to official documents. However, it is worth noting here that some countries have placed the topics of primary care, prevention, and long-term care at the center of their plans, with interventions and reforms aimed at improving accessibility, coverage, and health outcomes in these areas of care. Notably, Slovakia, Portugal, Greece, and Italy have emphasized these themes in their plans.

FIGURE 5.6 PERCENTAGE OF FUNDING FOR HEALTHCARE IN THE RECOVERY AND RESILIENCE PLANS (LABELS REPRESENT THE AMOUNTS IN MILLION €)



Source: European Commission

5.3 Effectiveness

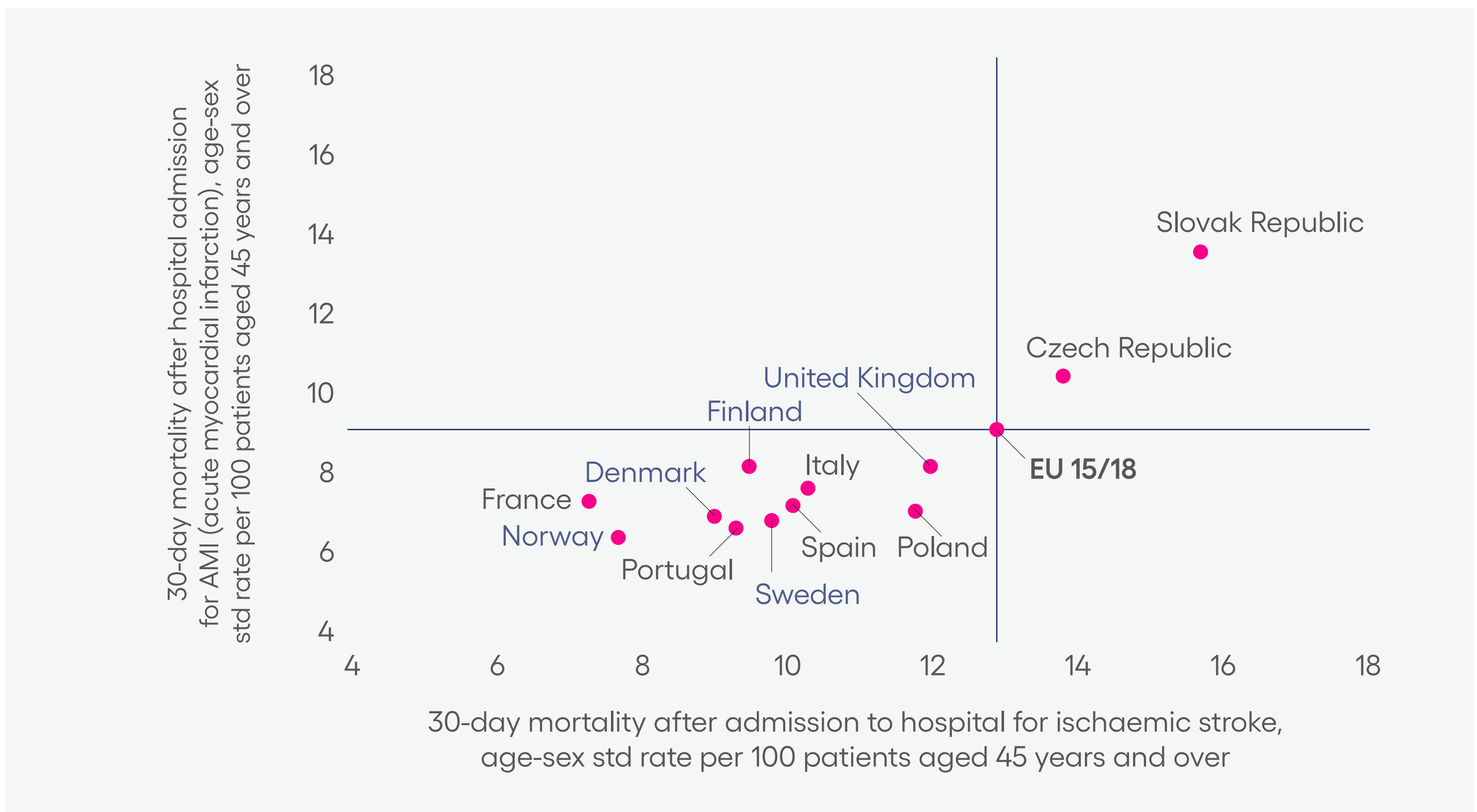
This subsection presents and discusses some indicators related to the performance of healthcare systems in three specific areas of care: hospital care, primary care, and secondary prevention.

The first two indicators are measures of the timeliness of response and the effectiveness of hospital facilities and the emergency system, as both involve acute conditions, the treatment of which within the so-called golden hour significantly impacts the final outcome of the intervention (in this case, 30-day mortality after admission). The two conditions under consideration are acute myocardial infarction (AMI) and ischemic stroke. For better comparability, data from 2019 have been used as a reference to avoid the effects of the Covid-19 emergency on the functioning of emergency systems and hospitals.

The comparison shows that the two measures are positively correlated with each other. Among the countries observed, the Czech Republic and Slovakia have worse performance than the European average (9% for AMI and 12.9% for ischemic stroke). Portugal has the overall best performance (6.6% and 9.3% respectively for AMI and stroke), although France performs better in terms of post-ischemic stroke mortality (7.3%) (Figure 5.7).

FIGURE 5.7
30-DAY MORTALITY AFTER ADMISSION TO HOSPITAL FOR ISCHEMIC STROKE & AMI (2019, OR LAST YEAR AVAILABLE)

It is worth noting that the European average data is based on data from only 18 countries. This is because these are the countries that make linked indicators available, which means mortality measures that do not exclusively consider in-hospital mortality but also include out-of-hospital mortality, by considering sources of information beyond healthcare systems. The availability of these indicators represents the system's capacity to integrate various administrative sources for public health and reporting purposes.

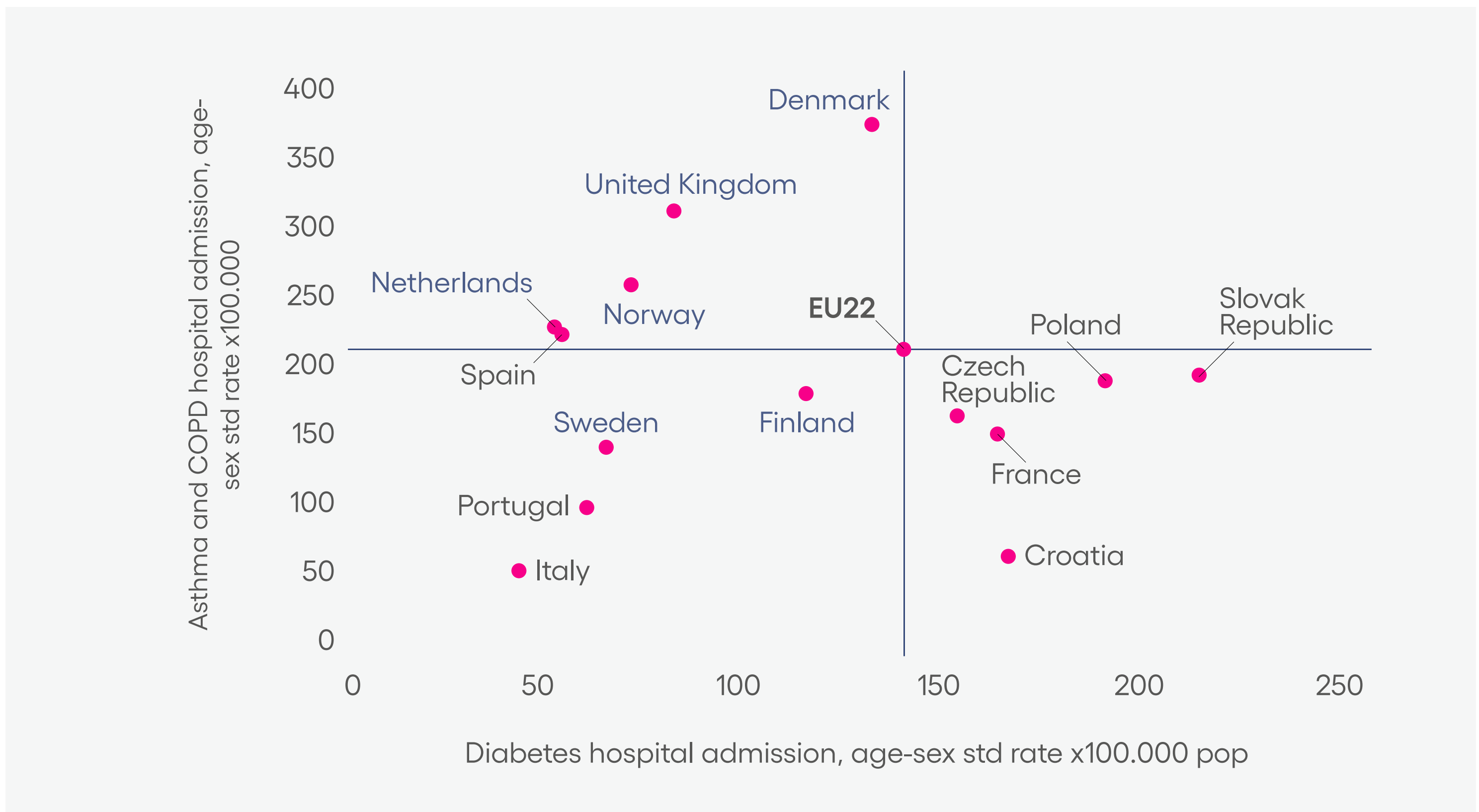


Source: elaboration on OECD

It is challenging to identify indicators related to primary care due to its patient-centered and holistic approach (as opposed to a disease-centered approach). For this reason, avoidable hospitalizations for specific diseases are often used as performance measures for primary care. These diseases include asthma, COPD, and diabetes, among those with the highest prevalence. There is also extensive literature demonstrating that effective management in primary care can help reduce deteriorations that lead to the need for hospitalization.

When comparing indicators for these three diseases (two respiratory diseases, asthma and COPD, on one side, and diabetes on the other), a highly varied picture emerges. First, there is a heterogeneous group of countries that have worse performance than the European average (210 per 100,000 for asthma and COPD and 139 per 100,000 for diabetes) for the diabetes indicator but perform better in managing asthma and COPD. Among these are Eastern European countries such as Poland, Slovakia, the Czech Republic, and Croatia, as well as France. Italy and Portugal serve as benchmarks in this context. Italy, in particular, has the lowest rate of avoidable hospitalizations for both asthma and COPD and for diabetes (42.6 and 50.8, respectively) among the countries observed. Finally, Spain, along with the Nordic countries and the UK, is among the countries with better performance for diabetes but worse performance for asthma and COPD (Figure 5.8). The lack of a clear relationship between countries and diseases highlights how the performance of primary care is influenced by a range of variables related to context, lifestyle, socio-economic determinants of health, making the management of diseases that affect a large segment of the population particularly complex.

FIGURE 5.8 AVOIDABLE HOSPITAL ADMISSION: ASTHMA AND COPD VS. DIABETES HOSPITAL ADMISSION IN ADULTS (2019, OR LAST YEAR AVAILABLE)



Source: elaboration on OECD

The last area of care for which a comparative evaluation is proposed is secondary prevention. The target of secondary prevention is the population that has not yet shown clinical manifestations of diseases, and the goal is to anticipate diagnosis as much as possible to maximize the effectiveness of treatments. A cornerstone of secondary prevention is the screening, which is a medical examination aimed at early detection of diseases. Screening campaigns are an important public health tool and

are widely implemented in advanced healthcare systems, also thanks to European-level initiatives. For example, the Council of the European Union recommended in 2003 that member countries introduce colorectal cancer screening programs, and the European Commission Initiative on Breast Cancer has promoted breast cancer screening programs (which have been widely used since the 1980s).

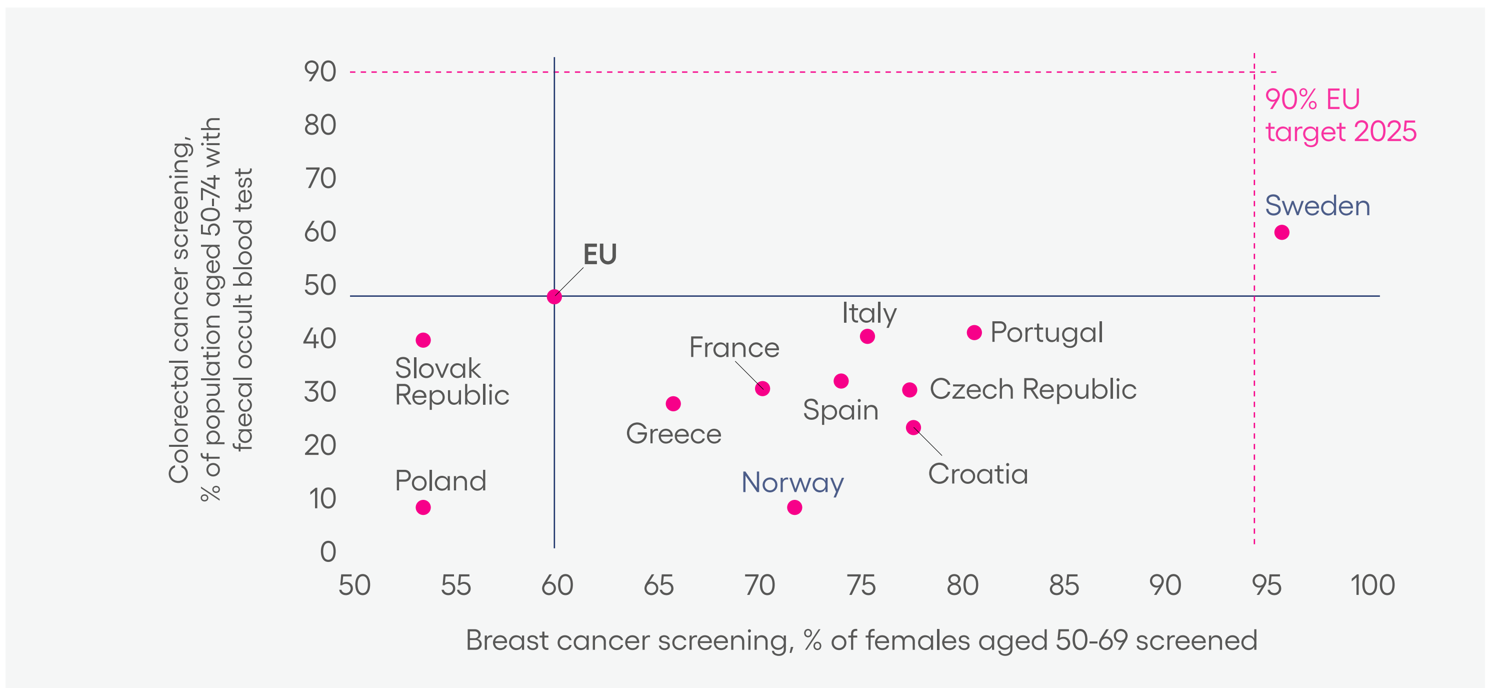
The in-depth analysis of prevention (Section 4.5) contains the list of countries that have introduced cancer screening within their basic benefits packages. The most common and well-established screenings, for which there is large evidence of effectiveness and cost-effectiveness, are breast cancer screening (typically targeting the female population aged 50 to 69), cervical cancer screening (typically targeting females aged 20 to 69, often associated with HPV vaccination programs), and colorectal cancer screening (typically targeting the general population aged 50 to 79).

It should be noted that the data presented in the Figure 5.9 are both based on official administrative data from prevention programs as well as periodic surveys such as the European Health Interview Survey (EHIS). Therefore, comparisons over time and between countries are may be influenced by this factor. The European Union set a target in 2021, within the Europe's Beating Cancer Plan, aiming for a 90% participation rate among the target population for the three main cancer screening programs by 2025. With the exception of Sweden in breast cancer screening (95.2%), all countries are still far from this target, especially regarding colorectal cancer screening.

Most of the observed countries have better performance than the European average (60% for breast cancer and 48% for colorectal cancer) in breast cancer screening (countries like Portugal, the Czech Republic, Croatia, and Italy exceed 75%). However, outcomes for colorectal cancer screening are less favorable. Italy and Portugal have the highest adherence rates (40.5% and 41.1%, respectively), although these figures are below the EU average and the target set by European institutions.

Data from 2020 showed a general decline in these figures due to the limitations imposed in response to the Covid-19 pandemic. It is evident, however, that there is still a long way to go to reach the set targets, and significant efforts are needed in terms of supply availability and awareness among at-risk individuals.

FIGURE 5.9
BREAST CANCER AND COLORECTAL CANCER SCREENING WITHIN THE PAST TWO YEARS (2019, OR LAST YEAR AVAILABLE)



Source: elaboration on OECD

5.4 Health resources

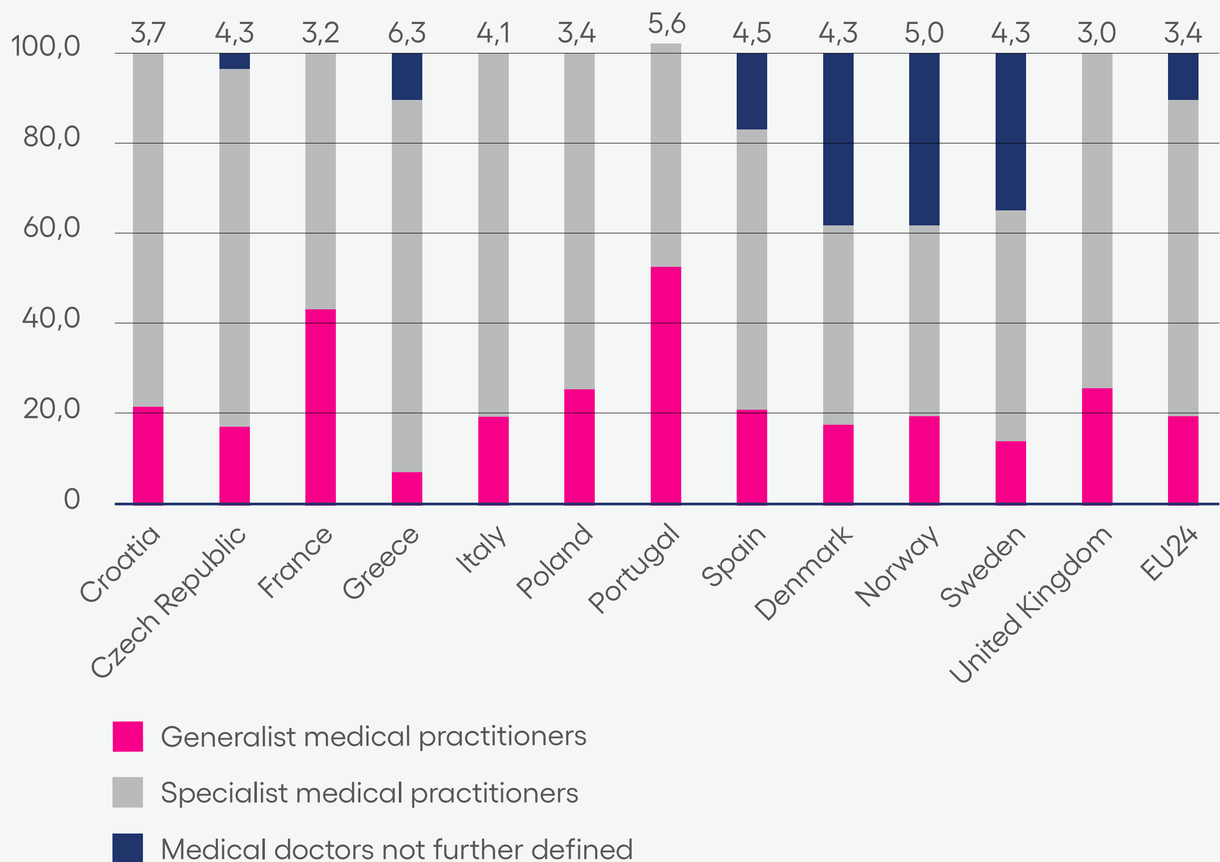
The effectiveness of healthcare systems depends on their ability to make the best use of available resources. Among the resources available to healthcare systems, human resources play a crucial role. At the international level, it is simpler to categorize the two main categories of healthcare professionals (HCPs): doctors and nurses. Doctors are typically distinguished between specialists and general practitioners (GPs), as training and professional development paths for this category are less heterogeneous internationally, unlike nurses or other HCP categories like healthcare assistants, which are often trained and utilized differently in various countries. To maximize the effectiveness of care and ensure more appropriate access to healthcare, an adequate number of healthcare professionals and a mix that can respond to people's needs are required, both within the same profession (e.g., the mix between specialists and GPs) and between professions (e.g., the mix between doctors and nurses).

The number of practicing doctors[1] in Europe is 3.4 per 1,000 inhabitants. There is a considerable degree of variability among the observed countries. Greece has the highest number of doctors per capita (6.3), while Poland has the lowest (3.4), with the United Kingdom ranking the last (3.0) among the reference countries. These values correspond to a very diverse mix of specialists and GPs. Some countries, like Portugal and France, have over 50% and 40% of GPs, respectively, while in Greece, the vast majority of medical practitioners (82%) have specialist training. The European average consists of a mix with 20% GPs and 69% specialist doctors, and countries like Italy, Croatia, Spain, the Nordic countries, and the United Kingdom have similar levels.

[1] According to the OECD definition, practicing nurses and doctors are those who provide services for individual patients. These categories exclude students who have not yet graduated, dentists, individuals working in health administration, research or other activities not directly in contact with patients, unemployed and retired professionals.

FIGURE 5.10
PRACTICING DOCTORS PER 1,000 POPULATION AND SHARE OF DIFFERENT CATEGORIES OF DOCTORS (2021, OR LAST YEAR AVAILABLE)

Many countries are concerned about the future availability of GPs, as they play a crucial role in managing chronic conditions. The availability of doctors is also greatly influenced by their distribution within territories, considering that urban and metropolitan areas, which are typically more attractive, tend to have a higher density of specialist medical practitioners.



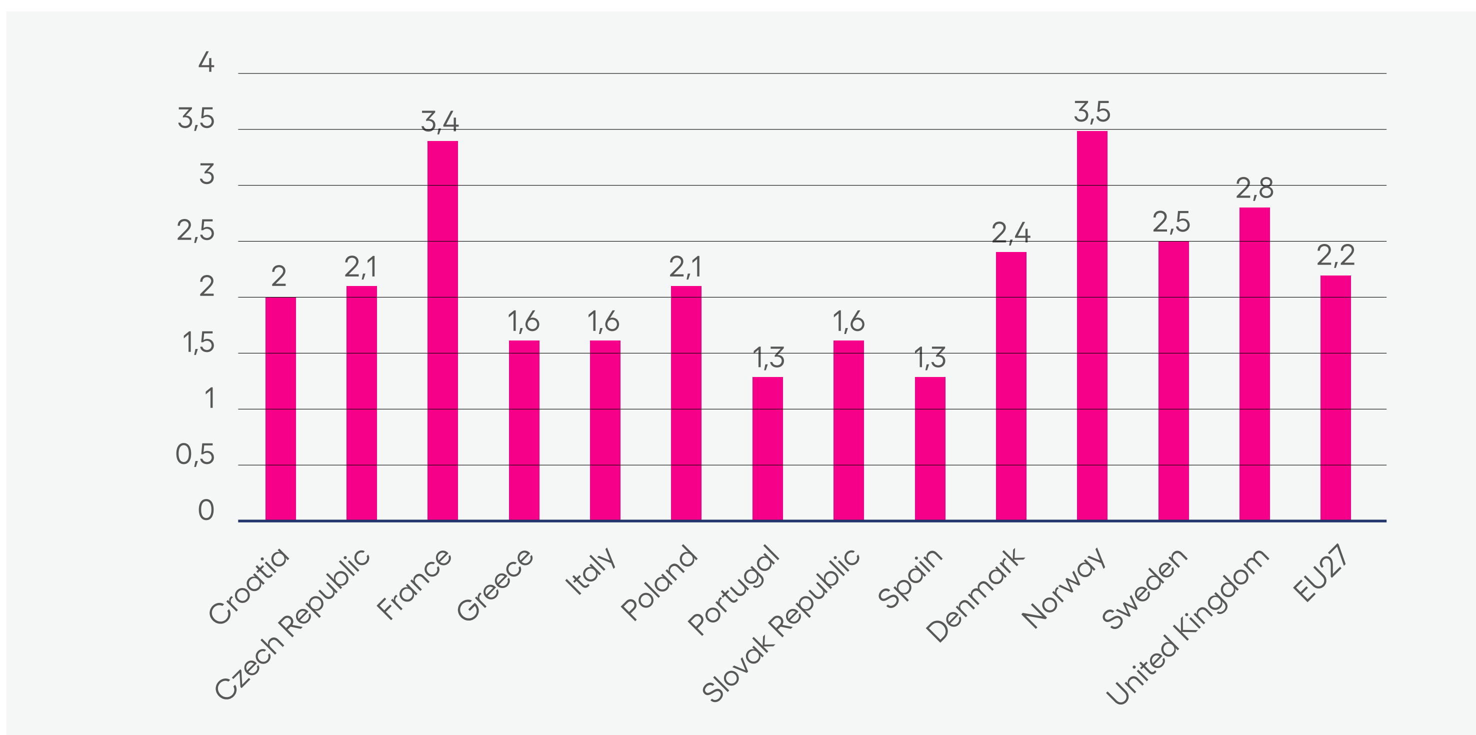
Source: elaboration on OECD

Also, the distribution of nurses is highly relevant as they represent the primary category of healthcare workers and for the crucial role of nursing care for an aging population with long-term care needs.

An effective measure of nurse availability, in addition to the number of nurses per capita (approximately 7,5 per 1,000 inhabitants in Europe), is the ratio of medical staff to nurses. In the European Union, there are approximately 2.1 nurses for each doctor. Southern European countries have less favorable nurse-to-doctor ratios: Spain and Portugal have 1.3 nurses per doctor, and Italy has only 1.6 nurses per doctor, similar to Greece.

Higher ratios are observed in Central and Northern Europe, with a maximum value of 3.4 observed in France (and 3.5 in Norway). In Eastern Europe, Croatia, Poland, and the Czech Republic have ratios in line with the European average (Figure 5.11). There is a significant debate in Europe about the evolving role of nurses and how to adjust this mix to better meet healthcare needs.

FIGURE 5.11 RATIO OF NURSES TO DOCTORS (2021, OR LAST YEAR AVAILABLE)



Source: elaboration on OECD

Finally, in terms of structural resources, it is useful to mention two indicators related to hospital beds, generally recognized as measures of a healthcare system's productive capacity, for two distinct areas of care: hospital beds and beds in LTC residential facilities, which are facilities that provide inpatient care to disabled and non-self-sufficient people.

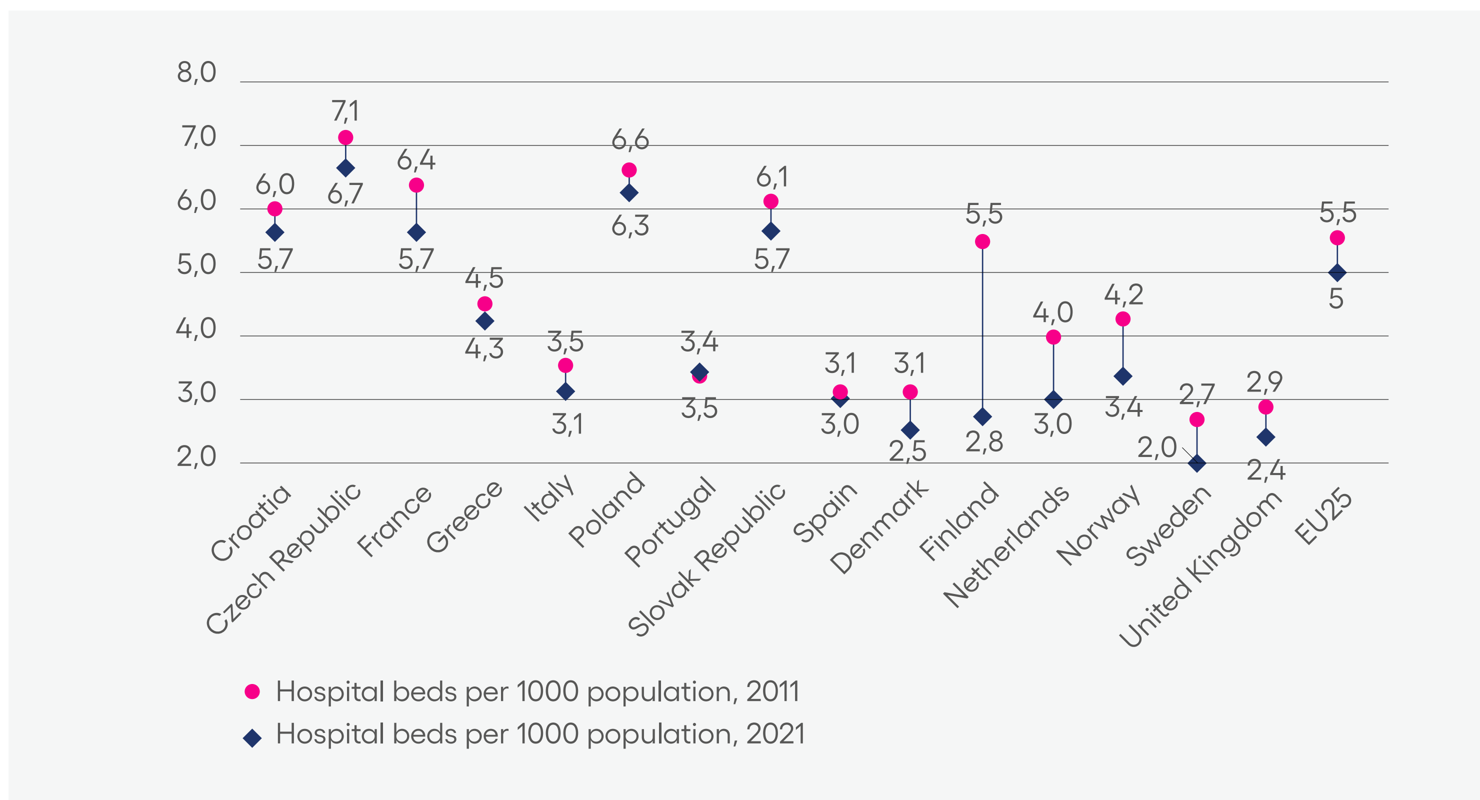
In Europe, there are approximately 5 hospital beds per 1,000 inhabitants. All European countries have seen a decreasing trend in the number of hospital beds over the last 10 years (-9% in Europe), as hospitalizations have decreased in favor of less complex and costly care regimens such

as outpatient care. The situation in Europe is highly diverse. Among the countries included in the analysis, Italy (3.1) and Spain (3.0) have the lowest number of hospital beds, a situation shared with other reference countries such as the United Kingdom (2.4), Sweden (2.0), and Denmark (2.5), which have even lower values. France (5.7) and Eastern European countries like the Czech Republic (6.7) and Poland (6.3) have much higher values (Figure 5.12).

The European situation shows that it is complex to identify optimal values for the structural provision of hospital beds, as this depends on available resources (both human and technological), as well as the organization of work and services.

The reduction in the number of hospital beds has also been driven by economic reasons aimed at improving system efficiency by increasing the occupancy rates of available beds. This topic has been widely debated during the Covid-19 pandemic when all healthcare systems had to deal with a sudden and dramatic increase in demand for hospital services (and beds).

FIGURE 5.12 HOSPITAL BEDS PER 1,000 INHABITANTS (2011 AND 2021)

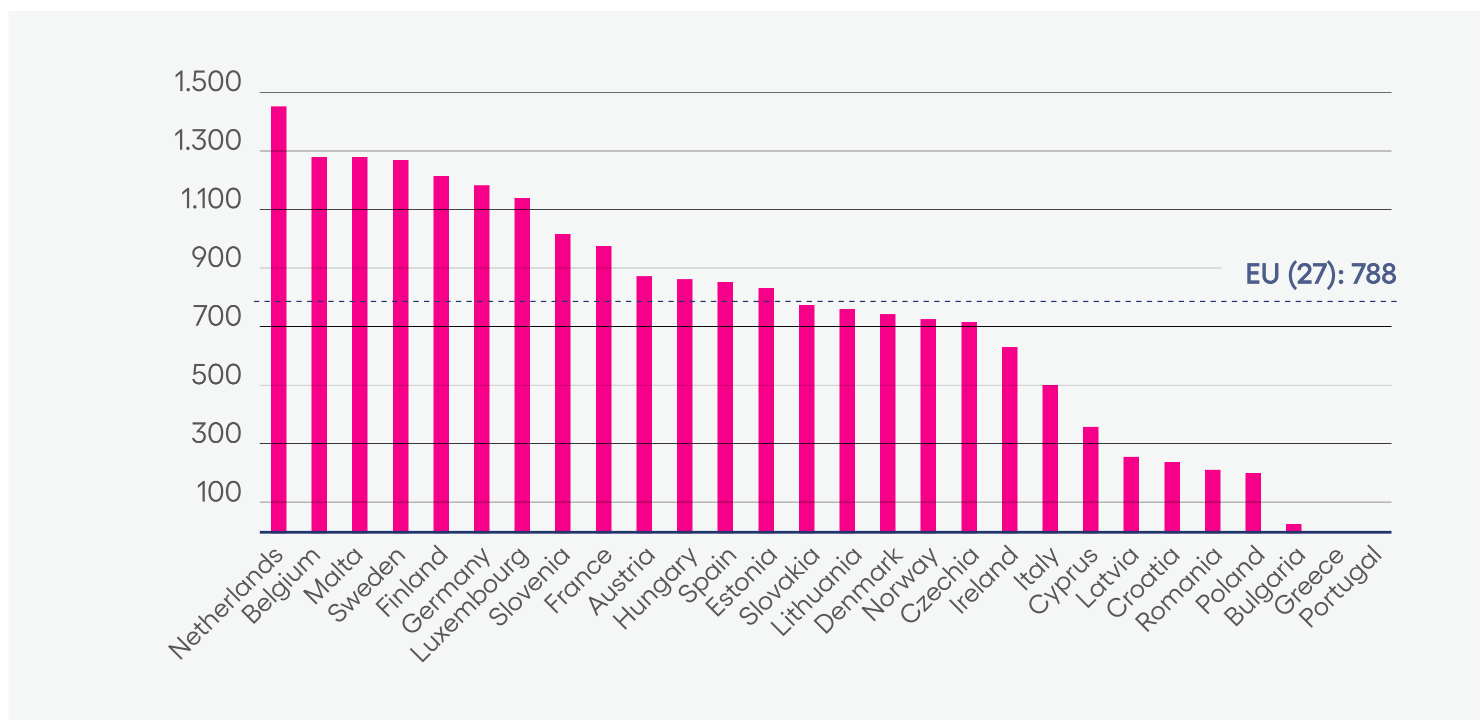


Source: elaboration on OECD

The last issue concerns the availability of beds in LTC residences (Figure 5.13). In 2020, there were 780 beds available in care facilities in Europe per 100,000 inhabitants, however with important differences by country, with the numbers going from 28 in Bulgaria to 1,374 in the Netherlands. These differences reflect both the availability of LTC, the care setting (home, residential and community based) and its degree of formality. It is possible that is some contexts, it is preferred to invest in community- or home-based care and less on residential care.

Over time, there has been a modest increase in the average number of beds in most EU States, so that, in the last decade, 64 additional beds have been made available for 100,000 population. With respect to the countries in analysis, it is possible to highlight significant differences in beds availability: from 194 in Poland, to 441 in Italy and 246 in Croatia, 703 in Czech Republic, 777 in Slovakia, 843 in Spain, 979 in France. Only Slovakia, Spain and France register data in line or above the European average.

FIGURE 5.13 LTC BEDS PER 100,000 INHABITANTS (2020, OR LAST YEAR AVAILABLE)



Source: elaboration on Eurostat

Countries profiles: health systems comparison 6

In this section, we present a comparative analysis of the nine countries under study, focusing on the dimensions of governance and organization, financing, provision, as well as two key areas of interest: long-term care (LTC) and prevention. The approach is comparative in nature, but the has been collected and reported for each individual country. The primary source of data for this analysis are the EOHSP Health in Transition Reports. Specific sources have been used to obtain more recent or detailed information when necessary.

6.1 Governance and organization

The selected countries exhibit different governance systems and organizational structures for healthcare services provision, with respect to the levels and models of statutory coverage, the centralization or decentralization of responsibilities and the regulatory schemes for stakeholders and third-parties (see Table 6.1).

With respect to **statutory coverage,** three countries (Italy, Portugal, Spain), that mainly rely on general taxation for financing healthcare expenditure (see Section 6.2), ensure universal coverage to their citizens. The Italian National Health Service (NHS) has been founded as a Beveridge system and provides universal coverage to all citizens and legal foreign resi-

dents. Portugal's NHS is a universal tax-financed health system, covering all country residents. Together with the universal NHS, the Portuguese healthcare system is also characterized by the presence of two other co-existing and overlapping sub-systems: health insurance schemes, for which membership is based on professional/occupational group or company and private voluntary health insurance (VHI). In the statutory Spanish NHS, coverage is virtually universal, mainly funded from taxes, and care is predominantly provided within the public sector.

Differently from Italy, Portugal and Spain, other countries, adopting a Bismarckian model (with the first European case being launched in Germany by Chancellor Bismarck in 1883), require mandatory social health insurance to their citizens. In Poland, all citizens, regardless of their financial conditions, have the right to equal access to publicly funded health services and the entitlement to health services covered by the National Health Fund (NFZ) is based on the insurance status. Insurance in the NFZ is mandatory for the vast majority of the (resident) population without the possibility to opt out. Even Croatia has a mandatory social health insurance system, with the Croatian Health Insurance Fund (CHIF) being the single purchaser of publicly funded health services and offering also complementary insurance. In Czech Republic, the entitlement to statutory health insurance (SHI) coverage is based on permanent residence and individuals who are not permanent residents are also covered if they are working for a Czech-based employer. Slovakia operates a compulsory SHI system, with several competing health insurance companies that negotiate contracts with health providers based on quality, prices and volumes. All residents in Slovakia are

entitled to SHI, that is universal and guarantees free choice of health insurance companies for every insured. Payment of contributions is a condition for receiving health care benefits based on SHI.

Finally, in France and Greece, the health system is of a mixed type. In France, the health system is structurally based on a Bismarckian approach, with Beveridge goals represented by the single public payer model. All persons residing or working in the country are covered under SHI, where enrolment is mandatory and determined by the employment status. Individuals cannot choose their scheme or insurer, nor can they opt out; therefore, there are no competing health insurance markets for SHI. There are three main SHI schemes, that cover almost the entire French population: (i) the general scheme, that covers all salaried workers and their dependents, as well as all persons who have lived legally in France for more than three months and, since 2018, even self-employed professionals; (ii) the agricultural scheme, that covers farmers and agricultural employees and is managed by a dedicated fund; (iii) special schemes dedicated to specific types of workers and professions, such as civic servants, notaries, etc.

In Greece, the National Health Service system coexists with a SHI model. The health coverage is mainly linked to employment status through SHI for employees and members of their family. Since 2011, population coverage for health care is undertaken by a single entity, the National Organization for the Provision of Health Services, which covers the insured and their dependents. After retirement, former employees continue to be covered by the fund to which their employer belongs, and their contribution is deducted from their pension.

Together with employment, another basis of entitlement for health coverage is Greek citizenship (or citizenship of another EU Member State), which allows free access to primary/ambulatory care and specialist outpatient services provided by the Greek NHS.

With respect to the **degree of centralization or decentralization** of the healthcare system, it has been noted that, in the last decades, reform trends in many European countries have pushed, with different methods and intensity levels, towards decentralization as an effective way to improve service delivery, to better allocate resources according to needs, to involve the community in health decision-making, and to reduce health inequities (OECD, 2015). Nevertheless, if in some countries this decentralization process produced real changes in the governance schemes transferring responsibilities and tasks from the central to the local levels (as in Italy and Spain), in others, despite these attempts to reform, the health systems remain substantially centralized (e.g. Portugal).

The Italian NHS is highly decentralized, with most of the legislative and executive powers assigned to the regional level of governance with the central government taking on a stewardship role. The national benefits package is established by the central government, which also oversees and allocates funding for regional health systems. The regions, through local health authorities, are in charge of financing, planning and provision of services at the local level. The central government is responsible for defining health policy strategies, the national benefits package and the per capita budget, although this decision-making process is undertaken in collaboration with the regions. It maintains a stewardship function to monitor expenditure and reduce geographical inequalities. Even the Spanish NHS is highly decentralized, where health competences

have been transferred to the 17 Autonomous Communities, with the national level being responsible, under the governance of the Interterritorial Council for the NHS, for certain strategic areas as well as for the overall coordination of the health system, and the national monitoring of health system performance. The Autonomous Communities have full responsibility for planning and the provision of public health and health care services, with capacity of regulation, planning and financial autonomy.

In Poland, after a process of progressive decentralization, public responsibilities have been divided between central government and territorial self-governments. The former is responsible of financing healthcare services (via the NFZ) and establishing the statutory package or list of benefits; the territorial self-government, in contrast, are asked to implement the National Health Policy program in their territory and maintaining the infrastructure of healthcare providers for which they are the founders. They are also responsible, together with counties and municipalities, for monitoring, organization and governance of health care provision at various levels. Similarly, in Slovakia, the decentralization process in the health sector focused on the partial delegation of state power to eight self-governing regions and the transfer of ownership of the majority of state health care facilities.

The self-governing regions' responsibilities include issuing permits for the operation of health care facilities, appointing ethical committees, maintaining health documentation and securing health care provision resulting from a provider's temporary hold of permit or license. The Ministry of Health has responsibilities on drafting health policy and legislation,

regulating health care provision, managing national health programs, participating in management of health education, managing national health registers, determining the scope of the basic benefits package, defining health indicators and setting minimum quality criteria. In Czech Republic, a decentralization process passed authority and responsibilities from the central government to 14 Regional Public Health Authorities, assigning to them the supervision and ownership of healthcare providers. At the same time, highly specialized care in some selected medical fields was centralized to improve safety and quality of care.

The Portuguese healthcare system is formally decentralized with the regional level (represented by five Regional Health Administrations) having the responsibility for the health status of the corresponding population, the coordination of the health services provision at all levels, and the allocation of financial resources according to the population needs. In practice, however, responsibility for planning and resource allocation has remained highly centralized, with the Minister of Health appointing the directive body of each Regional Health Administration whose autonomy over budget setting and spending is limited de facto to primary care, because hospital budgets continue to be defined and allocated by the central authority, which also appoints hospital administration boards.

On the other hand, countries as Croatia, Greece and France exhibit a centralized health system. In Croatia, The Ministry of Health is charged with the governance of the health system, being responsible for health policy, planning and evaluation, drafting of legislation, regulation of standards

for health services, and training of health workers; public health programs, including monitoring and surveillance; and regulation of capital investments of publicly owned health care providers. Local governments are responsible for the organization and management of primary and secondary care, operating facilities as general and specialized hospitals, health centers, and other care facilities. In Greece, despite several attempts to introduce greater decentralization in the system, the central government retain the majority of powers.

The Ministry of Health is indeed responsible for ensuring the general objectives and fundamental principles of the health system, such as free and equitable access to quality health services for all citizens. The Ministry makes decisions on health policy issues and the overall planning and implementation of national health strategies. It sets priorities at the national level, defines funding for proposed activities and allocates relevant resources, proposes changes in the legislative framework and undertakes the implementation of laws and reforms. The centralization derives also from the institution of a single purchaser for all health services. Finally, in France, the Ministry of Health has substantial control over the health system, since it is responsible for preparing and implementing government policy, organization and financing of the healthcare system. At regional levels, the regional health agencies are responsible for ensuring that the provision of healthcare services meets the needs of the population by improving the coordination between the ambulatory and hospital sectors and health and social care sector services, while respecting national objectives for SHI spending.

To sum up, it is possible to divide the countries in three main clusters according to their degree of decentralization: highly decentralized system (Italy and Spain); partially decentralized (Poland, Slovakia and Czech Republic); centralized system (Portugal being centralized de facto even if formally decentralized, Croatia, Greece and France).

Finally, relatively to **stakeholders and third-parties regulation,** it is possible to affirm that countries exhibit different regulatory schemes, mainly following the distribution of power and responsibilities between central and local governments. Indeed, regulation of non-state providers in terms of authorization, accreditation or contracting is usually defined at central level for those countries whose system is centralized (as France and Greece); whereas, in more decentralized contexts, this authority and mandate is transferred to the regional level (e.g. Italy, Spain and also Portugal).

For example, in Italy most regions use a “local health authority-centered model”, where local health authorities act both as service providers and (limitedly) as purchasers of hospital trusts’ services. Some smaller regions adopt a “region-centered model”, where most purchasing is regional, while local health authorities are mostly providers. Health care providers can be both public and private and structural, organizational and operational standards are mainly assured through the following procedures, all regionally defined: (i) authorization procedures grant permission to deliver health care services, according to the structural, technological and organizational criteria required under Italian law; (ii) NHS accreditation is the public licensing necessary to provide health care services on behalf

of the NHS, considering more extensive quality criteria; (iii) the final step to operate under the NHS is to agree on financing conditions with regional and local authorities through contracts, which detail operational and financial information. In Spain, the role of third-parties payers in the health system is mainly assumed by regional governments (Autonomous Communities).

Health Departments of Autonomous Communities act, both, as public insurers (warranting the access to the package of benefits covered by the public system) and services' funders (allocating the share of the regional public budget devoted to health, contracting services to public and private providers). In Portugal, the regional health agencies play an essential role in the contracting of health care providers to work with the NHS. They are responsible for setting up (and paying for) contracts (i.e. the contracting of private sector providers to provide NHS patients with specific health care services) and contracts with the hospitals (based on cost history, utilization and complexity variables).

Differently from Italy, Spain and Portugal, in Croatia the Ministry of Health defines the Plan and Program of Health Care Measures covered by the mandatory health insurance scheme, which are then paid for by the Health Insurance Fund according to contracts agreed upon with health care providers. These contracts determine the services to be provided, as well as their scope and quality. Privately owned providers can enter into contracts with the Health Insurance Fund and become part of the publicly funded system.

TABLE 6.1 HEALTH CARE GOVERNANCE: COMPARISON OF STATUTORY COVERAGE, DEGREE OF CENTRALIZATION VS DECENTRALIZATION AND STAKEHOLDERS' REGULATION

Country	Statutory coverage	Centralization vs decentralization	Stakeholder regulation
Croatia	Mandatory residence-based health insurance. CHIF is the single purchaser. Negative lists for exclusions.	Central level defines the BP and budget. Regional level has organization and management responsibilities. Local level runs health facilities.	CHIF contracts private providers after public competition. VHI is under the supervision of the central government.
Czechia	Mandatory membership to one of the seven competing HIF. Negative lists for inpatient and outpatient, positive list for drugs and dental care.	Central levels provide strategic guidance and supervision of professionals and HIF, and administers larger hospitals. Regional level runs facilities.	Regulation of non-public state providers is defined at regional level. HIF contracts private providers. HIF are under the supervision of central government.
France	Statutory residence-based coverage through three non-competing funds. Positive lists for inclusions.	The system is highly centralized with marginal functions assigned to the regional level.	Regulation and authorization of providers is at central level as well as supervision of health insurance.
Greece	Mix of employment-based and citizen-based entitlement through a single purchaser EOPYY. Limitations are in force since the great recession of 2012.	The system is highly centralized with regulation, financing and provision assigned to the central level (MoH and EOPYY)	Regulation is under the central government. Accreditation and contracts of private providers is under EOPYY.
Italy	Universal residence-based statutory coverage. Positive lists outpatient services and medicines, dental care and medical products.	Central level defines policy strategies and budget allocation. Organization and management are highly decentralized to regional governments that runs local health authorities and larger hospitals.	Regulation for authorization, accreditation and contracting is defined at regional level. Medical products regulation is at central level. VHI is under the supervision of the central government.
Poland	Mandatory employment or residence-based insurance. NZF is the single payer. Positive list for most of goods and services.	The system is decentralized with the responsibilities divided between MoH and territorial self-governments	The MoH supervises providers and local branches of NZF are responsible for contracts.
Portugal	Universal residence-based entitlement. Positive list for drugs and non-explicit exclusions.	Central levels retain planning and overall regulations. Organization and management between regional and local authorities.	The regulation and contracting of providers are mainly under the regional authorities.
Slovakia	Compulsory residence-based entitlement with three competing HIC. Non-explicit exclusion.	Central levels retain regulation and running of larger hospitals while other facilities delegated to regional (hospital) and local (primary care) level.	A central authority is responsible for supervision and regulation of HIC and providers. HIC contracts health providers.
Spain	Universal residence-based entitlement. Non-explicit exclusion.	Basic regulation and planning at central level, all the other functions at regional level.	Planning, accreditation, contracts and financing of providers at regional level

6.2 Financing

Healthcare systems can collect resources through a highly diversified set of financial arrangements. As demonstrated within Section 3.2, which presented healthcare expenditure data related to various financing mechanisms, international literature recognizes at least four distinct mechanisms that, along with entitlement rules, contribute to defining the nature of healthcare systems (Mossialos et al., 2002).

To fund healthcare expenses, some countries resort to **general taxation,** ensuring that all citizens contribute to financing the system. In many cases, this involves income or value-added taxes (VAT), but also purpose-specific taxes, often regarding health-related behaviors (such as taxes on tobacco or alcohol consumption), are common. Countries that primarily use taxation as a financing mechanism are typically those that adopt Beveridge-type systems.

Countries adopting public **social health insurance mechanisms** – whose systems are attributed to the Bismarckian model – manage to isolate healthcare resources collected from other items in public budgets (such as social security, education, etc.). These are essentially contributory mechanisms to which the entire population or a portion thereof is subject, often in the form of deductions from earned income or wages.

Other countries involve private entities – particularly insurance companies – as the primary means of financing their healthcare systems. In many cases, these are private insurance policies that are mandatory for the entire population

or a portion of it (the most famous and recent non-European case being the Affordable Care Act in the USA, which in 2011 made insurance enrollment mandatory for a significant portion of the population).

Other non-mandatory forms of financing are usually complementary to the primary financing mechanisms, although in some countries they play a significant role in funding certain areas of healthcare services (such as dental care and long-term care), as seen in Section 3.2. User charges, payments borne by users when they access services or goods covered by basic benefit packages, also play a significant role in many countries. Originally intended as a means to encourage responsible consumption, over time they have evolved into substantial sources of funding for healthcare systems.

Table 6.2 displays information for the nine analyzed countries gathered based on three overarching themes: the source of revenues of the system, the role of user charges, and the relevance of out-of-pocket expenses (OOP) and voluntary health insurance (VHI).

First and foremost, through the examination of the **source of revenues,** it is immediately possible to cluster the countries in terms of prevalent financing mechanisms. One can readily distinguish countries that primarily rely on general taxation from those that use public social insurance (with no countries in our sample relying on mandatory private insurance as the primary source of financing). In the former group, we find Italy, Portugal, and Spain, while the remaining countries signif-

icantly utilize mandatory social contributions, collected by one (Croatia, Greece, France, and Poland) or multiple health funds (Czech Republic and Slovakia).

It is important to note, however, that in all countries with mandatory social insurance, a substantial portion of financing comes from general taxation. This is evident, for instance, in the case of France, where as much as 67% of resources come from various forms of taxation or the state budget. In Greece, state contributions account for 50%, whereas in Eastern European countries like Croatia (12%), Poland (13%), Czech Republic (23%), and Slovakia (30%), they are lower.

The primary reason why a significant portion in these countries also comes from the state budget is the need to provide insurance coverage for vulnerable groups, such as the unemployed, disabled individuals, or the elderly. Another reason is that, since the social insurance contribution is proportional to workers' income or salary, the growth of healthcare resources is dependent on income and wage increases.

This can be a concern in countries where wage growth rates are modest or even negative. In real terms, in France wages increased by 21% between 2000 and 2022, whereas in Italy and Greece they actually decreased. In countries like the Czech Republic, Slovakia, and Poland, wages increased by over 50% in the same period (OECD, 2023). Another issue concerns the size of the funding base: in rapidly aging countries, it is expected that the number of workers able to contribute to the system through social contributions is likely to decrease (Edwards, 2022). These are, for example, the reason

why in the last decades France shifted a significant portion of its revenue collection from contribution mechanisms to taxes, particularly earmarked taxes designed exclusively to fund healthcare. This is the opposite of what has occurred recently in Croatia, where since 2015 the country has primarily financed its Croatian Health Insurance Fund (CHIF) through health insurance contributions rather than solely relying on the state budget.

User charges as an additional form of financing for goods and services included in the basic benefits package, paid by users, are a supplementary financing mechanism present in all the observed countries. There are primarily three forms of user charges: co-insurance (a percentage of the total cost of treatment), co-payment (a flat rate payment for each good or service), and deductible (a fixed amount that the user must always pay before insurance coverage kicks in). Both co-insurance and co-payment are relatively common in the observed countries, while the deductibles (common in systems based on mandatory private insurance, such as in the Netherlands) are absent.

Most countries impose user charges for outpatient services and outpatient prescription medicines (i.e., drugs purchased at a pharmacy and not used during a hospitalization). This is done in the form of a flat rate (co-payment) in countries like Croatia, the Czech Republic, and Italy. Countries like Greece and Poland opt for co-insurance for these types of goods and services. User charges for inpatient hospital services, on the other hand, are present in a limited number of countries, such

as in Croatia as a form of co-insurance (3% of the daily rate) and in France, both as a fixed daily fee to cover catering costs and as co-insurance (20% of the daily rate). In the case of France, it's worth noting that a significant portion of the population is also covered for user charges by mandatory private complementary insurance.

Regarding the magnitude and allocation of **private expenditures,** it has already been discussed within Section 3.2, which highlighted how **OOP** and **VHI** spending are, in most cases, complementary components of health financing, as they usually cover goods and services not included in the basic benefits packages, with the significant exception of Greece, where a substantial portion of OOP spending is allocated to covering hospitalization costs. In several countries like Italy, Croatia, and Greece, OOP spending also plays a significant role in financing private practice, which refers to healthcare services that would be included in the benefits package but that users decide to access privately due to various barriers to access.

The development of insurance markets in the observed countries varies considerably. One common element among many of the examined countries is that the development of voluntary insurance almost never occurs in the individual market but rather as employer-sponsored contracts, with contributions that are usually subject to tax incentives. The only exception is Spain, where the development of voluntary insurance has been primarily driven by individually subscribed policies, with only one-third of policies offered through employment contracts.

The role of insurance must also be distinguished between supplementary and complementary. In the former case, it refers to coverages that provide better access conditions to services for policyholders (such as shorter waiting times), while in the latter case, it refers to contracts that cover everything not included in the basic benefits packages, including user charges.

Three interesting cases are those of Croatia, France, and Portugal. In the case of Croatia, it is the CHIF itself that provides voluntary complementary coverages as add-ons to statutory coverage. In France, complementary coverages provided by private insurers are effectively mandatory for most workers and are subsidized by the state for the non-active population. However, the same companies offer additional voluntary supplementary coverages as add-ons to the mandatory complementary coverage.

In Portugal, voluntary supplementary insurance has seen significant growth, in part due to the existence of several parallel coverage subsystems that coexist with statutory insurance for certain professional categories, including civil servants (see Section 6.1 for more details). A unique situation is found in Poland, where legislation explicitly prohibits insurance companies from offering complementary policies and the supplementary insurance market is negligible, taking the form of pre-paid medical services, which are baskets of services purchased and paid for in advance of their utilization.

The comparison of funding sources and mechanisms reveals a highly diverse landscape, yet it also highlights trends that are shared by many countries. Firstly, in all countries, there exists a significant component of expenditure covered by the state budget, which, even when not the primary source, is a crucial element in ensuring universal coverage. Secondly, the mix of funding sources depends greatly on a country's economic and financial context, with variables such as debt, GDP growth, and wage trends being highly relevant factors in resource allocation decisions for countries.

Thirdly, a substantial portion of private spending always serves a complementary function, covering those services otherwise excluded. However, there are significant exceptions where private spending also plays a supplementary role, particularly when there are significant barriers to accessing services included in the basic benefits package. Lastly, in the development of insurance coverage, both in supplementary and complementary forms, the role of employers is crucial, even in countries where funding is primarily based on general taxation.

TABLE 6.2 HEALTH CARE FINANCING: COMPARISON OF SOURCES OF REVENUES, USER CHARGES AND THE ROLE OF OOP AND VHI

Country	Source of revenues	User charges	OOP and VHI
Croatia	CHIF collects mandatory health insurance contributions (80%), state budget (12%) and complementary insurance contributions (8%).	Co-insurance for inpatient and dental care. Co-payment for primary and outpatient medicines.	OOP for private practice and cost-sharing. Complementary VHI covered by CHIF. Private supplementary insurance.
Czechia	7 HIF collects insurance contributions (77%) and state budget transfers (23%).	Co-payments for outpatient services and medicines. Annual ceiling.	OOP for cost-sharing and non-SHI services. Poor VHI market.
France	CNAM collects social insurance contributions (33%), earmarked taxes (59%), and state budget transfers (8%).	Co-payments for outpatient services, medicines and cost-insurance and daily fee for inpatient activities. Annual ceiling.	Low OOP. CHI covers co-payments for included services and non-included services. Supplementary VHI as an add-on for CHI.
Greece	EOPYY collects heath insurance contributions and state budget transfers. General taxation covers 50%.	Co-insurance on outpatient medicines and diagnostics.	Large share of OOP for excluded services and private practice. Large share of informal payments. Minor role of supplementary VHI.
Italy	NHS financing is based on general taxation.	Co-payment for outpatient services and medicines.	Large share of OOP for private practice, dental services and excluded outpatient medicines. Increasing role of employer-sponsored VHI.
Poland	NZF collects statutory income-related contributions (87%) and state-budget transfers (13%)	Co-payment and co-insurance for outpatient medicines.	Low OOP mainly for medicines. Complementary VHI is forbidden by low. Insignificant VHI market.
Portugal	NHS financing is based on general taxation.	Co-payment on primary and secondary care visits. Co-insurance on outpatient medicines.	OOP for dental care, outpatient visits and LTC. Supplementary VHI has a relevant role thanks to the sub-systems in place.
Slovakia	3 HIF collects health insurance contributions (70%). The remaining is state-budget from general taxation (30%).	Co-payments for prescribed outpatient medicines.	Large OOP for medicines and health services. Minor role of VHI.
Spain	Health system financing is based on general taxation (95%), a special regime for civil servants (3%) and contributions for work injuries (2%)	Co-payment for outpatient prescribed medicines and orthopedic medical products.	Large OOP mainly for dental care and medicines. Large supplementary VHI.

6.3 Provision

Relatively to services provision it is possible to analyze and classify the countries according to their different delivery models (Table 6.3). In the analysis, the report focuses on three main areas of health services: primary care, outpatient care and inpatient care, highlighting the main differences and commonalities between countries.

Relatively to **primary care,** the countries exhibit extremely heterogeneous situations. In Italy, patients obtain access to health services through their general practitioners (GPs) and pediatricians who act as gatekeepers. GPs provide ambulatory or home visits, prescriptions for medications, referrals to specialists, as well as for laboratory or diagnostic tests. GPs and pediatricians work as independent professionals under the NHS and are mainly paid on a capitation basis with additional payment for home visits. In Spain, primary health care is essentially provided by public providers, specialized family doctors and nurses composing the primary health care teams.

Primary health care teams are the basic care structure of the NHS.Depending on planning criteria, they might be complemented with pediatricians and specialized pediatric nurses, physiotherapists, dentists, psychologists and social workers. As in the Italian system GPs operate as gatekeepers of the system. Similarly, in Poland, primary healthcare, mainly organized in teams comprehending a physician, a nurse, a school nurse and a midwife and physical therapist, constitute the main entry to the healthcare system. The

scope of services covers diagnostics, treatment, rehabilitation, and nursing services in the scope of general medicine, family medicine and pediatrics; as well as health promotion and disease prevention.

In Portugal, a mix of public and private health service providers deliver primary care. These include primary care units integrated in the NHS, the private sector (both profit and non-profit) and groups of professionals in private offices. The primary care network ensures, simultaneously, health promotion and disease prevention, including the management of health problems, through a person-centered approach oriented towards the individual, the family and the community. In Croatia, primary care services are provided by a network of first-contact doctors and nurses contracted by the Health Insurance Fund. Every insured citizen is required to register with a family physician or a pediatrician, whom they can choose freely.

They serve as gatekeepers to secondary and tertiary levels of care. In Czech Republic, the goals of primary care are to provide preventive care (immunizations and screenings), diagnostic, therapeutic and assessment care and consultations, and coordination and continuity of health services with other providers. In Slovakia, primary care is provided predominantly in privately owned health care facilities. In cities GP practices are often linked to a local polyclinic with specialists. In rural areas GPs often work in solo practices.

In France primary care refers to the first level of care and services, including comprehensive general medical care (i.e., acute and chronic care, health promotion, prevention and therapeutic education) for common conditions and injuries, provided in the community near the patients' place of residence. In France primary care is provided by GPs and some medical specialists practicing in ambulatory settings (especially pediatricians, gynecologists and ophthalmologists), as well as allied health professionals such as dentists, pharmacists, midwives, nurses and physiotherapists. The responsibility of the local strategy for primary care capacity and investment planning relies on the regional agencies.

Outpatient care can assume the most heterogeneous declinations, given the extreme variety of health facilities and structures involved in the delivery process. In Poland, after having been provided in hospital structures, nowadays outpatient specialist care is prevalently provided in private settings. In contrast, in Croatia, specialized outpatient care, such as consultations provided by secondary care specialists, is mostly delivered in hospital outpatient departments. Other settings include specialized ambulatory care units in public polyclinics and county health centers (usually linked to general and clinical hospitals) or private facilities. Provision of publicly paid services is subject to a contract with the Health Insurance Fund.

Patients need a referral from a primary care physician to access specialized ambulatory care. In Italy, outpatient care is divided into clinical activity (such as firs visits, therapeutics, rehabilitation) and diagnostics. The provision of outpatient services can occur in hospitals, clinics or polyclinics, either public or private-accredited facilities. Access usually occurs through a GP's referral, but specialist doctors can directly prescribe additional interventions where more detailed examinations are needed. In Czech Republic, the goals of primary care are to provide preventive care (immunizations and screenings), diagnostic, therapeutic and assessment care and consultations, and coordination and continuity of health services with other providers. Primary care physicians also perform several tasks related to assessing and verifying health status, including dependency status and other social protection measures linked to health or disability status, along with fitness for employment. Most primary care physicians are self-employed in solo practices, typically employing a nurse who also has administrative duties

Relatively to **inpatient care,** in Italy it is provided through a network of public and private hospitals and hospitals are divided into three categories with increasing level of complexity: basic hospital facilities, first level and second level hospitals. In Croatia, inpatient secondary care facilities include general hospitals and specialized hospitals. All general and the majority of specialized hospitals are owned by the counties. While general hospitals primarily serve the population of their respective counties, specialist hospitals serve the entire population. All general hospitals must have the following departments: obstetrics and gynecology, internal medicine, surgery and inpatient pediatric care.

Other departments are optional and depend on the needs of the county population and the availability of hospitals or polyclinics in neighboring counties. Specialist hospitals are organized around specific acute diseases, chronic illnesses or population groups. In Slovakia, hospitals are divided into general and specialized hospitals (e.g. cancer institutes, stroke centers) depending on the services they offer. Hospitals have an ambulatory component, in which hospital-based specialists provide specialized ambulatory care. In Poland, there have been some attempts to shift care from inpatient to cheaper outpatient and/or home care.

For example, elements of coordinated care for certain conditions have been piloted since 2017 and a coordinated fast track pathway for cancer patients has been available since January 2015. Further, financial incentives to shift patients from hospital to outpatient care (for services provided within the network) were introduced within the hospital network, which has been implemented since 2017.

TABLE 6.3 HEALTH CARE PROVISION: COMPARISON OF PRIMARY, OUTPATIENT AND INPATIENT CARE SERVICES

Country	Primary care	Outpatient care	Inpatient care
Croatia	GP/PED mandatory and gatekeeper. Solo or group practice. Community nursing	Specialized care mostly in hospital setting and contracted by CHIF.	General and specialized hospitals mostly public.
Czechia	Voluntary enrollment to independent GPs mainly working in solo practice. Primary care centers equipped for basic diagnostic and treatment.	Specialized care mostly offered in independent specialist solo practice without referral.	General and specialized hospitals and referral is required.
France	Enrollment to GPs and gatekeeping is voluntary but almost universal. GPs work in solo or group practice and community care facilities.	Specialized care offered by independent professionals, outpatient or inpatient facilities, with or without referral.	High recourse to hospitalization. General and proximity hospitals.
Greece	No formal gatekeeping and enrollment to GPs. Outpatient facilities.	Specialized care offered by contracted private solo or group practice and outpatient hospital departments.	General and specialized hospitals and referral is required.
Italy	GP/PED mandatory and gatekeeper. Independent professionals in solo or group practice.	Specialized care offered by public or contracted private hospitals and outpatient facilities. Large use of private non-NHS professionals.	Public and private general, specialized and community hospitals. Referral is required.
Poland	GPs act as gatekeepers and provides basic diagnostic and treatment services.	Specialized care mainly provided in private practice.	Mostly public hospital with fragmented ownership.
Portugal	Mandatory enrollment to GPs and gatekeeping. Primary care services provided by GPs in public and private primary care units and networks integrated in the NHS.	Specialized care provided in hospitals, primary care centers and contracted private practice.	Hospitals in four different categories for complexity and services provided according to an integrated model.
Slovakia	GPs working in private practice have the obligation to enroll insured people. Gatekeeping has a minor role.	Specialized care mainly provided in outpatient departments in contracted hospitals.	General and specialized contracted hospitals.
Spain	Primary healthcare doctors working in primary care teams serve as gatekeepers.	Specialized care mainly offered in hospital departments.	Great variety of hospitals according to dimension and ownership.

6.4 *Focus 1:* Long-term Care

In the definition of WHO, **long term care** "includes a broad range of personal, social, and medical services and support that ensure people with, or at risk of, a significant loss of intrinsic capacity (due to mental or physical illness and disability) can maintain a level of functional ability consistent with their basic rights and human dignity. Long-term care is provided over extended periods of time by family members, friends or other community members (also called informal caregivers) or by care professionals (also called formal caregivers). Formal long-term care aims to prevent, reduce, or rehabilitate functional decline and it can be provided in different settings, such as home care, community-based care, residential care, or hospital care."[2] It is estimated that 27% of the EU population aged 65 or over living in private households report permanent and severe difficulties with personal care or household activities and the number of people aged 50+ with long-term care needs will increase by approximately +24% by 2050 and +36% by 2070, with population ageing being the primary driver of LTC services demand (Eurostat, 2022).

The analysis of the countries underlines common aspects in the provision of LTC services (Table 6.4): they are generally underdeveloped or insufficient to cover the (increasing) demand, with scarce coordination between social welfare sector and healthcare, between institutional levels (national, regional and municipal) and between public and private (profit and no-profit) providers. In terms of **governance of LTC services,** in Poland, for example, there is no statutory LTC insurance or any specific piece of legislation comprehensive-

[2] Cfr. https://www.who.int/europe/news-room/questions-and-answers/item/long-term-care.

ly regulating LTC. Formal LTC is provided in both the health sector and the social assistance sector, with poor coordination between them. In Spain, LTC services are provided through a network of social centers and services available in the Autonomous Communities, including regional public institutions, services provided by the municipalities, national reference centers for support of specific causes of disability, as well as accredited partner private centers. Autonomous Communities have total freedom to set up this network of providers where nongovernmental organizations and not-for-profit institutions are considered as priority partners (compared with for-profit providers). Services are co-paid according to the type of service required and the ability to pay.

Generally, the LTC system comprehends a combination of **LTC benefits** that are both in-cash and in-kind. The case of Croatia for example: two are in-cash benefits (assistance and care allowance and personal disability allowance), while five benefits are in-kind services consisting of help at home (home assistance allowance and organized housing) or in residential settings, such as nursing homes, family homes and adult foster families. In some countries the presence of charitable organizations is extremely relevant as they are key providers of LTC services.

This is the case of Portugal, for instance, where the *Misericórdias,* and other independent charitable organizations offer LTC assistance in day centers, nursing homes and residences for the elderly with a range of services including activities, meals, food to take home, laundry services, bathing and even assistance obtaining medication and attendance at primary care centers.

In Greece, there is a combination of community and residential care. More precisely, there are four types of community care services: (i) open care centers for the elderly: these are public law entities, financed by the Ministry of Health and run by municipalities and provide psychosocial support, health education, preventive medical services for older people and recreational services, thus improving patients' well-being while they continue to live in their own personal and social settings; (ii) friendship clubs: the clubs operate at the neighborhood level and offer services to senior citizens, including creative pursuits, occupational therapy, physiotherapy, cultural venue visits, artistic endeavors, day trips, walking tours and assistance with adapting to age-related conditions in later life; (iii) Home Help for the Retired programme: this aims to provide home care to retired elderly people, mainly the frail and those who live alone, in order to improve their quality of life, to ensure that they maintain their independence and to keep them active in their family and social environment, thus reducing the need for institutional hospital care; (iv) day care centers for the elderly: this alternative form of public support and protection is offered to the elderly with the aim of keeping them within their family environment.

This service is provided to people aged over 65 years suffering from chronic or acute physical or mental disorders who depend on others for care, have economic problems and face social and family problems. Services include daily care and coverage of basic needs, psychological and emotional support, plus assured delivery of pharmaceutical care.

Across countries there are significant differences relative to the **financing mechanisms** to sustain and provide LTC services, often combining resources from the central government's budget with regional or even municipal funding. In Poland, for example, long-term care services have a medical nature and are financed by the NFZ, whereas LTC within the social assistance system is organized and largely financed by the territorial self-governments. This is also the case of Slovakia where LTC is partially provided both in the health and social system, lacking integrated models of provision.

Understanding the definition of LTC adopted in each country, as well as the differences in the institutional arrangements and mix in financing and service provisions is crucial to help policymakers and stakeholders to design potential approaches for reforms. Such a diversity highlights the importance of tailoring LTC services to individual needs and circumstances and of leveraging partnership from service providers, organized communities charitable organizations.

TABLE 6.4 LONG-TERM CARE: COMPARISON OF SOURCES OF GOVERNANCE, FINANCING MECHANISMS AND SERVICES PROVISION

Country	Governance	Financing mechanisms	Main included benefits
Croatia	Poor coordination. Health care needs under the CHIF. Residential homes under regional level.	Funding provided by CHIF for the health component.	Cash and in-kind benefits mostly provided in different institutional settings.
Czechia	Fragmentation between social and health care. Facilities managed at regional and local level and split between social facilities and LTC hospitals.	Funding provided by statutory health insurance and state, regions and municipal budget (social).	Cash and in-kind benefits mostly provided through LTC hospitals and nursing homecare.
France	Autonomous branch of the social security system. Still poor coordination in provision between health (national) and social care services (local).	Social security contributions and local taxes.	Cash (means and needs-tested) and in-kind benefits. Medical and non-medical health facilities, home care and home support services.
Greece	Activities decentralized to local provision and experiences.	State budget and fees from the EOPYY.	Community and residential care delivering both health, social and recreational daily activities.
Italy	Several ministries involved in regulation. Health component included in the benefit package. Social component under municipalities.	Funding provided by stage budget, local health authorities, municipalities and patients.	Cash and in-kind benefits mostly provided in LTC residences, LTC departments of hospitals and home care.
Poland	Absence of specific legislation on LTC. Poor coordination between health and social care (local level).	Funding from NZF and local municipalities budgets.	Cash and in-kind benefits. Formal institutional and home care is underdeveloped.
Portugal	Coordination delegated to RNCCI.	Funding from state-level budgets (MoH and Social Security) and patients.	In-kind benefits include day centers, nursing homes, and residences.
Slovakia	Separation and poor coordination between health and social care.	Funding by self-governing regions, municipalities and state budget, and patient cost-sharing.	Poor institutional and residential services. Residential LTC provided by both health and social care facilities.
Spain	Organization and coordination at regional level.	Funding from regional and local budgets with patient co-payments	Residential services in both hospitals and residential facilities.

6.5 *Focus 2:* Public health and prevention

Public health is a function of healthcare systems that focuses on preventing diseases and promoting community-based health through organized approaches (Acheson, 1988). The areas that public health addresses are extremely diverse and generally encompass all determinants of people's health, ranging from workplace environments, daily living conditions, food safety, and animal production to environmental protection. This increasingly holistic approach aligns with the paradigm of the so-called "one health", a perspective that advocates for the need to balance human health with that of animals and ecosystems (One Health High-Level Expert Panel (OHHLEP) et al., 2022).

Being one of the core functions of health systems, the characteristics of public health functions overlap with those of the overall system, especially concerning system governance and financing mechanisms. Firstly, it is important to highlight how defining the boundaries of public health systems can be complex, as it involves various diverse topics that are often within the exclusive jurisdiction of technical organizations. Internationally, it is emblematic, for example, how the United States has assigned the responsibility for food safety to the same agency responsible for drug control and supervision, the Food and Drug Administration (FDA). In contrast, the European Union has chosen a different approach: despite having the European Medicine Agency (EMA), food safety functions were assigned to a separate agency, the European Food Safety Authority (EFSA).

In terms of **governance,** in many countries, even for strictly health-related functions like infectious disease surveillance or cancer screenings, the allocation of functions to public health agencies is common. These technical bodies fall within the scope of healthcare institutions but are not primarily responsible for delivering healthcare services (inpatient, outpatient, etc.). There are examples of countries where many public health functions are entrusted to a national agency, like France.

There are others where, although centralized, functions are divided among various agencies, like Poland. In some cases, functions are attributed at the regional level, like Spain. Generally, political-level institutions (the Ministry of Health or regional governments) maintain a stewardship and coordination role for public health systems. An interesting case is Italy, where the Ministry of Health (and regional governments) maintains a stewardship role, but many functions are assigned to local health authorities, which not only perform public health functions but are also the main healthcare service providers.

Comparing **financing mechanisms,** being public health functions often delegated to technical agencies these are funded through the state budget, although primary prevention healthcare services (such as vaccinations) or secondary prevention services (such as cancer screenings) are often covered by the basic benefits package and therefore funded by the main health financing schemes. Programs in public health typically have a collective basis, meaning they are designed for

specific populations that, based on available evidence, are at a higher risk of developing certain diseases (such as women aged 50 to 69 for breast cancer). Preventive activities carried out on an individual basis are usually not covered.

Regarding **included services,** as previously mentioned in Section 3.3, most countries include the three main cancer screenings: breast cancer, cervical cancer, and colorectal cancer. The only country that did not have population-wide screening campaigns as of 2021 was Greece; however, the country had individual participation rates not significantly different from other countries.

In terms of vaccines, all the analyzed countries recommend and cover major childhood vaccinations (poliomyelitis, hepatitis B, diphtheria, tetanus, pertussis, etc.), and many have mandatory vaccination programs (Czech Republic, France, Italy, Poland, and Slovakia). While it cannot be ruled out a priori, given the earlier discussion about how challenging is defining the boundaries of public health systems, it should be noted that two countries, Italy and Poland, explicitly refer to occupational health among their public health functions and that it is typically under the financial coverage of employers, distinguishing it from other public health functions.

From the comparison, several considerations emerge. Firstly, it is clear that the representation of public health systems is highly complex, not only when comparing different countries but even when attempting to describe their functioning within a single country, due to the breadth of functions and the interdisciplinary nature of some activities.

Secondly, the more technical functions often find their place within agencies or authorities that, by nature and definition, do not have direct relationships with individuals or the general population. Those functions more closely linked to healthcare professionals, such as vaccination campaigns and screenings, as well as health education activities, are often provided in local facilities, frequently by GPs or primary care centers, regardless of the entity that oversees these activities.

Thirdly, given the cross-cutting and significant role of prevention activities throughout life, it is important to actively engage employers and firms in prevention efforts. This already frequently occurs for occupational health, but there is room for further development in initiatives related to health promotion, healthy lifestyles, and individual prevention activities when they are not covered by public health programs designed for at-risk populations (Table 6.5).

TABLE 6.5 PUBLIC HEALTH AND PREVENTION: GOVERNANCE, FINANCING MECHANISMS AND MAIN INCLUDED BENEFITS

Country	Governance	Financing mechanisms	Main included benefits
Croatia	Planning at national level. National and country level public health institutes.	CHIF and state budget.	Traditional activities delivered in primary care setting. Three cancer screening programs.
Czechia	National Health Institute promotes and coordinates public health activities.	HIF and state budget.	6 mandatory vaccinations and 3 screening programs are included. Primary care centers involved in delivery.
France	National public health agency promotes and coordinates initiatives. Some traditional functions assigned to municipalities.	SHI, state, regional and municipal budget and user charges. Occupational health on employers.	11 mandatory vaccines and 3 cancer screening programs are delivered.
Greece	Local public health organizations under the supervision of the central level.	SHI budget.	No mandatory immunization program nor population-based cancer screening initiatives.
Italy	Strategic stewardship at national level and local delivery (local health authorities).	NHS budget. Occupational health on employers.	10 mandatory vaccines and 3 cancer screening programs.
Poland	Several central-level agency responsible for promotion of activities with local authorities delivering and financing.	SHI and state budget. Occupational health on employers	Combination of mandatory and recommended vaccinations. 3 cancer screening programs. Occupational health.
Portugal	Programming and promotion at national level and local delivery.	NHS budget.	Recommended but not mandatory vaccines. Three cancer screening programs.
Slovakia	A national public health authority supervises regional health authorities, separate from the curative health system.	State budget.	Compulsory vaccinations and 3 cancer screening programs. Delivery in public health centers under public health authorities.
Spain	Separation of functions between national and regional authorities, with local delivery.	NHS budget.	Recommended vaccinations and 3 cancer screening programs.

Conclusions and future research directions 7

The analysis conducted so far allowed us to highlight common characteristics and elements of divergence among the healthcare systems of the countries under consideration. The diversity of these countries enables us to construct a rich and diverse framework of experiences and contexts, making it challenging to envision one-size-fits-all solutions. However, it also allows us to attempt to generalize some concepts that will need to be explored at different levels and intensities. By combining the information derived from the analyses with what has emerged in recent years from the debate on these subjects, the following research perspectives can be synthesized. The considerations in this paragraph are highly dependent on the information and evidences analyzed in the previous ones, with regard especially the topics that have been explored: governance, financing, LTC and prevention.

On the basis of the data and evidences reported, these are indeed the areas in which it has been considered as mostly impellent and urgent to intervene in order to foster integration policies. Governance mechanisms and financing schemes are indeed the fundamental "infrastructures" on which every healthcare service is built, thus the degree of services integration will highly depend on how these two "infrastructures" are designed and defined. It means to design power and responsibility relations between system actors in a way that favors integration. Then, LTC and prevention have been cho-

sen as primary areas of intervention, since they will handle great part of the healthcare needs of the future, due to demographic and epidemiologic trends. These are the areas, in other words, that may be benefited by a strong push for integration and that may produce advantages and positive spill-over effects also for other parts of the healthcare systems.

Regardless of the aforementioned dimensions, a first research area that requires attention pertains to the **framing** of integration policies. A recurring argument in integration is that it serves for a more efficient utilization of scarce resources (i.e. cost-containment), rather than merely aiming for improved social outcomes. While efficiency and cost-optimization may be a valuable goal in the medium to long term, it is not necessarily the case in the short run, as integration efforts may indeed lead to increased resource requirements in terms of skill development or physical and IT infrastructure construction. Understanding how integration policies can be framed in relation to the expected benefits and costs for the community is a primary research topic.

Governance: exploring the governance conditions that either promote or hinder the integration of services is a crucial venture. Several countries have successfully promoted integration initiatives, starting from the development of integrated care pathways (healthcare) and extending towards the establishment of comprehensive health and social care pathways. These stories should provide valuable insights on how to pursue integrated welfare systems from an institutional and organizational perspective. Institutional fragmentation and decentralization of competences are a common – although not universal – attributes in health and social

care. Effective governance necessitates clear coordination and collaboration mechanisms among various government agencies, institutional levels and all the stakeholder potentially involved in welfare service provision. In this context, collaborative governance plays a central role, as it “brings public and private stakeholders together in collective forums with public agencies to engage in consensus-oriented decision making” (Ansell and Gash, 2008).

Future research should examine which are the institutional and organizational variables that potentially facilitate or hinder integration through collaborative efforts. Research should also delve into identifying the most effective coordination and integration mechanisms (from informal integration practices to institutional mergers) for aligning the diverse stakeholders, including institutions, service providers, professionals, and communities. Research should also investigate the optimal scale at which integration efforts are effective, determining whether and to what extent decentralization supports or undermines the logic of integration of welfare systems.

Financing: the question of financial sustainability is at the forefront as governments seek to balance the trade-off between extending benefits and the economic realities they face. Across the observed countries, the allocation of increasing resources on health and social care is a prevailing trend. Nevertheless, some countries are experiencing minimal growth rate due to challenging financial conditions. These pose a critical set of questions. Firstly, there is a need to assess whether existing funding mechanisms are adequate to maintain the current levels of coverage in health and social care coverage. Secondly, research should delve into devel-

oping adaptable and well-suited in the specific institutional settings funding mechanisms that bridge the gap between health and social care and understand whether and how non-public resources can be leveraged effectively, all while maintaining financial protection for the most vulnerable individuals.

Long-term care: LTC presents a significant challenge for developed and developing countries, with common characteristics in terms of both horizontal (health and social care) and vertical fragmentation (national, regional and local level), the combination of cash and in-kind services, and the relevance of informal care. The challenges of integration in this context span from governance and resource collection to the types of services to be provided:

• *Governance:* identifying intra- and inter-institutional collaboration mechanisms that can promote greater policy development and implementation and service integration

• *Financing:* exploring new financing formulas in a forward-looking perspective, resembling social security systems, potentially incorporating innovative financial products and evaluating the possibility to mandate participation of workers

• *Provision:* assessing the optimal combination of formal and informal care, cash transfers, in-kind services and work-life balance policies, and additionally evaluate whether and how integration can improve the quality of care and help to ensure adequate coverage levels.

Prevention: prevention constitutes a highly diverse landscape of services and institutional configurations, often dominated by technical bodies operating at national, regional, or local levels to promote and coordinate initiatives. While vaccination programs and cancer screening efforts are consistent focal points, heterogeneity prevails in initiatives related to health education of individual behaviors and lifestyles, chronic disease prevention, and the inclusion of individual preventive activities. Within this context, exploring opportunities for inter-institutional integration in the delivery of preventive services, even involving non-public entities, becomes intriguing. There are several areas suitable for reasoning about integration:

• An intriguing area of application pertains to the workplaces. It has been previously discussed the existence and relevance of occupational health, which is the sole domain of public health that already falls broadly under the responsibility and funding of employers. It would be interesting to explore the use of occupational health and the relationship between employers and the health system as a framework to enhance integration into a broader spectrum of activities. These activities range from health education focused on individual behaviors and lifestyles to prevention efforts of a more individual nature or those linked to specific risks associated with the industry and category in question.

• Another promising avenue to explore is the role of community building and engagement as those activities aimed at integrating organized forms of community, such as NGOs, local associations, and patient groups. These entities, as well as personal social networks, can be harnessed and actively participate in the design and delivery of welfare services to improve the effectiveness of health and social care, to promote coordination of welfare systems and better address the needs of the communities they represent.

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