

2014

International Profiles Of Health Care Systems

Australia, Canada, Denmark, England, France,
Germany, Italy, Japan, The Netherlands,
New Zealand, Norway, Singapore, Sweden,
Switzerland, and the United States



JANUARY 2015

EDITED BY

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The Commonwealth Fund

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Abstract: This publication presents overviews of the health care systems of Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Singapore, Sweden, Switzerland, and the United States. Each overview covers health insurance, public and private financing, health system organization and governance, health care quality and coordination, disparities, efficiency and integration, use of information technology and evidence-based practice, cost containment, and recent reforms and innovations. In addition, summary tables provide data on a number of key health system characteristics and performance indicators, including overall health care spending, hospital spending and utilization, health care access, patient safety, care coordination, chronic care management, disease prevention, capacity for quality improvement, and public views.



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Table 1. Health Care System Financing and Coverage in 15 Countries

	HEALTH SYSTEM AND PUBLIC/PRIVATE INSURANCE ROLE			BENEFIT DESIGN	
	Government role	Public system financing	Private insurance role (core benefits; cost-sharing; noncovered benefits; private facilities or amenities; substitute for public insurance)	Caps on cost-sharing	Exemptions and low-income protection
Australia	Regionally administered, joint (national & state) public hospital funding; universal public medical insurance program (Medicare).	General tax revenue; earmarked income tax	~50% buy complementary (e.g., private hospital and dental care, optometry) and supplementary coverage (increased choice)	No. Safety nets include 80% rebate on OOP for payments above AUD1,248.70 [USD827] annually ^a	Low-income and older people: Lower cost-sharing; lower OOP maximum (AUD624.10 [USD413]) for 80% rebate ^a
Canada	Regionally administered universal public insurance program that plans and funds (mainly private) provision.	Provincial/federal general tax revenue	~67% buy complementary coverage for noncovered benefits (e.g., private rooms in hospitals, drugs, dental care, optometry)	No	There is no cost-sharing for publicly covered services; protection for low-income people from cost of prescription drugs varies by region
Denmark	National health care system. Regulation, central planning and funding by national government; provision by regional and municipal authorities.	Earmarked income tax	~40% buy complementary coverage (cost-sharing, non-covered benefits such as physiotherapy), some supplementary coverage (access to private providers)	No. Decreasing copayments with higher drug OOP spending	Drug OOP cap for chronically ill (DKK3,775 [US\$488]); financial assistance for low-income and terminally ill ^a
England	National health service (NHS).	General tax revenue (includes employment-related insurance contributions)	~11% buy supplementary coverage for better access (including to elective treatment in private hospitals)	No general cap for OOP. Prepayment certificate with GBP29 [US\$42] per three months or GBP104 [US\$150] per year ceiling for those needing a large number of prescription drugs ^a	Drug cost-sharing exemption for low-income, older people, children, pregnant women and new mothers, and some disabled/chronically ill; financial assistance with transport costs available to people with low incomes
France	Statutory health insurance system, with all SHI insurers incorporated into a single national exchange.	Employer/employee earmarked income and payroll tax; general tax revenue, earmarked taxes	~90% buy or receive government vouchers for complementary coverage (mainly cost-sharing, some noncovered benefits); limited supplementary insurance	No. €50 [US\$60] cap on deductibles for consultations and services ^a	Exemption for low-income, chronically ill and disabled, and children
Germany	Statutory health insurance system, with 131 competing SHI insurers ("sickness funds" in a national exchange); high income can opt out for private coverage.	Employer/employee earmarked payroll tax; general tax revenue	~11% opt out from statutory insurance and buy substitute coverage. Some complementary (minor benefit exclusions from statutory scheme, copayments) and supplementary coverage (improved amenities)	Yes. 2% of household income; 1% of income for chronically ill	Children and adolescents <18 years of age exempt
Italy	National health care system. Funding and definition of minimum benefit package by national government; planning, regulation and provision by regional governments.	National earmarked corporate and value-added taxes; general tax revenue and regional tax revenue	~15% buy complementary (services excluded from statutory benefits) or supplementary coverage (more amenities in hospitals, wider provider choice)	No. Max €46.15 [USD61] copayment per outpatient specialist consultation or diagnostic procedure; limited copayment (regional rates) on drugs ^a	Exemptions for low-income older people/children, pregnant women, chronic conditions/ disabilities, rare diseases
Japan	Statutory health insurance system, with >3,400 noncompeting public, quasi-public, and employer-based insurers. National government sets provider fees, subsidizes local governments, insurers, and providers and supervises insurers and providers.	General tax revenue; insurance contributions	~70% buy coverage for cash benefits to cover cost-sharing. Limited role of complementary insurance not covered by statutory benefits	Yes. Coinsurance reduced to e.g. 1% after 80,100 yen [USD774] monthly cap, depending on enrollee age and income. Annual cap of total OOP payments at between JPY310,000 [USD2,997] and JPY1.26M [USD12,180] per household, depending on income and ages of household members. ^a	Low-income monthly OOP ceiling: 35,400 yen [US\$441 USD]; reduced cost-sharing for young children, older people, those with chronic conditions/disabilities, and disabilities. Social assistance covers full costs of covered health care. ^a
Netherlands	Statutory health insurance system, with universally-mandated private insurance (national exchange); government regulates and subsidizes insurance.	Earmarked payroll tax; community-rated insurance premiums; general tax revenue	Private plans provide statutory benefits; 85% buy complementary coverage for benefits excluded from statutory package	No. But annual deductible of €360 [USD436] covers most cost-sharing	Children exempt from cost-sharing; premium subsidies for low-income
New Zealand	National health care system. Responsibility for planning, purchasing, and provision devolved to geographically defined District Health Boards.	General tax revenue	~33% buy complementary coverage (for cost-sharing, specialist fees, and elective surgery in private hospitals) and supplementary coverage for faster access to non-urgent treatment	No. Reduced fees after 12 doctor visits per year/patient and no drug copayments after 20 prescriptions per year/family.	No primary care consultation charges for children under 6; subsidies for low-income, some chronic conditions, Maori and Pacific islanders
Norway	National health care system. Some direct funding and provision roles for national government and some responsibilities devolved to Regional Health Authorities and municipalities.	General tax revenue	~7% hold supplementary VHI, mainly bought by employers for providing employees quicker access to publicly covered elective services	Yes. Overall annual cost-sharing ceiling is NOK2,105 [USD234]. ^a	Exemptions for children <16 yrs. somatic, <18 yrs psychiatric, pregnant women and for some communicable diseases (STDs); low-income groups receive free essential drugs and nursing care
Singapore	Government subsidies at public health care institutions and some providers; Medisave: mandatory medical savings program for routine expenses; MediShield: catastrophic health insurance; Medifund: government endowment fund to subsidize health care for low-income and those with large bills. Government regulation of private insurance, central planning and financing of infrastructure and some direct provision through public hospitals and clinics.	General tax revenue	Medisave-approved Integrated Shield Plans (private insurance plans) supplement MediShield coverage to provide catastrophic health coverage for additional ward classes. Other types of private insurance are also available, including private insurance provided by employers.	No.	Subsidized care for low-income population, with income- and asset-based means-test to target subsidies. Medifund as safety net to pay for low-income and people with no means to pay for their health care bills.
Sweden	National health care system. Regulation, supervision and some funding by national government; responsibility for most financing and purchasing/provision devolved to county councils.	Mainly general tax revenue raised by county councils, some national tax revenue	~5% get supplementary coverage from employers for quicker access to a specialists and elective treatment	Yes. SEK1,100 [USD126] for health services and SEK 2,200 [US\$252] for drugs ^a	Some cost-sharing exemptions for children, adolescents, pregnant women and elderly.
Switzerland	Statutory health insurance system, with universally mandated private insurance (regional exchanges); some federal legislation, with cantonal (state) government responsible for provider supervision, capacity planning, and financing through subsidies.	Community-rated insurance premiums; general tax revenue	Private plans provide universal core benefits; some people buy complementary (services not covered by statutory insurance) and supplementary (improved amenities and access); no coverage data available	Yes. 700 CHF [USD504] max after deductible ^a	Some copayment exemptions for <19-year-olds and CHF350 [USD252] cap; income-related premium assistance (30% receive); maternity care fully covered ^a
United States	Medicare: age 65+, some disabled; Medicaid: some low-income; for those without employer coverage, state-level insurance exchanges with income-based subsidies; insurance coverage mandated, with some exemptions (13.4% of adults uninsured).	Medicare: payroll tax, premiums, federal tax revenue; Medicaid: federal, state tax revenue	Primary private insurance covers ~56% of population (employer-based and individual); supplementary for Medicare	Yes for most private insurance plans: \$6,350 yearly limit for individuals; \$12,700 for families as of 2014	Low-income: Medicaid; older people and some disabled: Medicare; premium subsidies and lower cost-sharing for low- and middle-income families on the exchanges; some affordability exemptions from insurance mandate

^a All bracketed figures in USD were converted from local currency using the purchasing power parity conversion rate for GDP in 2013 reported by the Organization for Economic Cooperation and Development (2014).

Table 2. Selected Health Care System Indicators for 15 Countries

		Australia	Canada	Denmark	France	Germany	Italy	Japan	Netherlands	New Zealand	Norway	Singapore	Sweden	Switzerland	United Kingdom	United States
Population, 2012	Total population (millions of people)	22.724	34.881	5.592	65.433	80.426	59.54	127.515	16.755	4.433	5.019	5.312 ^g	9.519	7.997	63.696	313.914
	Percentage of population over age 65	14.20%	14.90%	17.30%	17.30%	21.00%	20.80%	24.10%	16.20%	13.80%	15.30%	10.0% ^g	18.70%	17.10%	16.70%	13.70%
Spending, 2012 unless otherwise noted	Percentage of GDP spent on health care	9.1% ^a	10.90%	11.00%	11.60%	11.30%	9.20%	10.30%	12.1% ^a	10.0% ^a	9.30%	4.7% ^g	9.60%	11.40%	9.30%	16.90%
	Health care spending per capita ^d	\$3,997 ^a	\$4,602	\$4,698	\$4,288	\$4,811	\$3,209	\$3,649	\$5,219 ^a	\$3,172 ^a	\$6,140	\$2,881 ^h	\$4,106	\$6,080	\$3,289	\$8,745
	Average annual growth rate of real health care spending per capita, 2002–2012	2.4% ^c	2.40%	1.80%	1.40%	2.00%	0.70%	3.50%	4.5% ^c	3.5% ^c	1.80%	n/a	1.90%	1.70%	2.70%	2.40%
	Out-of-pocket health care spending per capita ^d	\$731 ^a	\$690	\$584	\$320	\$627	\$603	\$483 ^a	n/a	\$347 ^a	n/a	n/a	\$678	\$1,582	\$297	\$1,045
	Hospital spending per capita ^d	\$1,614 ^a	\$1,310 ^a	\$2,075	\$1,473	\$1,402	n/a	\$1,592 ^a	\$1,759	\$1,239 ^a	\$2,132 ^a	n/a	\$1,804	\$2,253	n/a	\$2,811
	Spending on pharmaceuticals per capita ^d	\$588 ^a	\$771 ^a	\$295	\$651	\$668	\$514	\$718 ^a	\$450	\$297 ^a	\$414	n/a	\$478	\$562	n/a	\$1,010
Physicians, 2012 unless otherwise noted	Number of practicing physicians per 1,000 population	3.31	2.48	n/a	3.08	3.96	3.85	2.29	n/a	2.7	4.23	1.9 ^{g, b}	3.92 ^a	3.92	2.75	2.46 ^a
	Average annual number of physician visits per capita	6.9	7.9 ^a	4.7	6.7	9.7	7.2	13.0 ^a	6.2	3.7	4.4	n/a	n/a	n/a	n/a	4.0 ^b
Hospital spending, utilization, and capacity, 2012 unless otherwise noted	Number of acute care hospital beds per 1,000 population	3.40 ^a	1.72 ^a	2.53 ^a	3.39	5.38	2.73	7.94	3.32	2.61	2.34	2.0 ^{i, a}	1.95	2.98	2.31	2.56 ^b
	Hospital spending per discharge ^d	\$9,346 ^a	\$15,754 ^a	\$11,472 ^b	\$8,785	\$5,586	n/a	\$14,404 ^a	\$14,832	\$8,434 ^a	\$11,363 ^b	n/a	\$9,975 ^b	\$13,540	n/a	\$20,932 ^b
	Hospital discharges per 1,000 population	173 ^a	83 ^a	172 ^b	168	251	129	111 ^a	119	148	175 ^b	n/a	163 ^b	166	142 ^a	125 ^b
	Average length of stay for acute care (days)	4.9 ^a	7.6 ^a	n/a	5.1 ^a	7.8	6.8	17.5	6.4	5.6	5.8	n/a	5.6	6.1	5.9	5.4 ^a
Medical technology, 2012 unless otherwise noted	Magnetic resonance imaging (MRI) machines per million population	15	8.8	n/a	8.7	n/a	24.6	46.9 ^a	11.8	11.1	n/a	8.3 ^{j, b}	n/a	n/a	6.8	34.5
	MRI exams per 1,000 population	26	53.7	67	82	n/a	n/a	n/a	50.0 ^a	n/a	n/a	n/a	n/a	n/a	n/a	104.8
Information technology, 2012	Physicians' use of EMRs (% of primary care physicians) ^f	92%	56%	n/a	67%	82%	n/a	n/a	98%	97%	98%	n/a	88%	41%	97%	69%
Health risk factors, 2012 unless otherwise noted	Percentage of adults who report being daily smokers	15.1% ^b	16.10%	20.9% ^b	24.10%	n/a	22.10%	20.70%	18.40%	16.50%	16.00%	13.3% ^{k, L}	13.10%	20.40%	19.1% ^a	14.20%
	Obesity (BMI >30) prevalence	28.3% ^a	25.4% ^b	13.4% ^{b, e}	14.5% ^e	n/a	10.4% ^e	3.60%	12.0% ^e	28.40%	10.0% ^e	10.8% ^{k, b}	11.8% ^e	10.3% ^e	24.70%	35.30%

Source: OECD Health Data 2014 (June) unless otherwise noted.

^a 2011.

^b 2010.

^c 2002–2011.

^d Adjusted for differences in the cost of living (PPP; purchasing power parity adjustment).

^e Self-reported as opposed to measured data.

^f Source: 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

^g Source: World Bank, 2014.

^h Source: World Bank, 2014; 2005 purchasing power parity (PPP) adjustment.

ⁱ Source: World Bank, 2014; may include chronic care beds as well as acute care beds.

^j Source: World Health Organization, 2014.

^k Source: Singapore Health Promotion Board, 2014.

^L 2013.

Table 3. Selected Health System Performance Indicators for 11 Countries

		Australia	Canada	France	Germany	Netherlands	New Zealand	Norway	Sweden	Switzerland	United Kingdom	United States
Adults' access to care, 2013	Able to get same-/next-day appointment when sick	58%	41%	57%	76%	63%	72%	52%	58%	n/a	52%	48%
	Very/somewhat easy getting care after hours	46%	38%	36%	56%	56%	54%	58%	35%	49%	69%	39%
	Waited 2 months or more for specialist appointment ^a	18%	29%	18%	10%	3%	19%	26%	17%	3%	7%	6%
	Waited 4 months or more for elective surgery ^b	10%	18%	4%	3%	1%	15%	22%	6%	4%	n/a	7%
	Experienced access barrier because of cost in past year ^c	16%	13%	18%	15%	22%	21%	10%	6%	13%	4%	37%
Safety problems among sicker adults, 2011	Experienced medical, medication, or lab test error in past 2 years	19%	21%	13%	16%	20%	22%	25%	20%	9%	8%	22%
Care coordination and transitions among sicker adults, 2011	Experienced coordination problems with medical tests/records in past 2 years ^d	19%	25%	20%	16%	18%	15%	22%	16%	11%	13%	27%
	Key information not shared among providers in past 2 years	12%	14%	13%	23%	15%	12%	19%	18%	10%	7%	17%
	Experienced gaps in hospital discharge planning in past 2 years ^e	55%	50%	73%	61%	66%	51%	71%	67%	48%	26%	29%
Chronic care management, 2011	In past year, health care professional has helped make treatment plan you could carry out in your daily life	61%	63%	53%	49%	52%	58%	41%	40%	74%	80%	71%
	Between visits, has health care professional it is easy to call with questions or to get advice	59%	62%	54%	55%	70%	71%	63%	73%	68%	81%	77%
Primary care practices receive performance feedback, 2012	Routinely receives and reviews clinical outcomes data	42%	23%	14%	54%	81%	64%	24%	78%	12%	84%	47%
	Routinely receives and reviews patient satisfaction and experience data	56%	15%	1%	35%	39%	51%	7%	90%	15%	84%	60%
	Routinely receives data comparing performance to other practices	25%	15%	45%	25%	32%	55%	5%	55%	35%	78%	34%
OECD health care quality indicators ⁱ	Diabetes lower extremity amputation rates per 100,000 population, 2011	4.6 ^l	10	7.1	18.4	13.5 ^j	6.7	8.7	3.3	7.1 ^j	5.1	17.1 ^j
	Breast cancer five-year survival rate, 2007–2012 (or nearest period)	87.70%	87.70%	n/a	85.00%	85.90%	86.40%	86.10%	87.40%	n/a	82.00%	88.70%
	Mortality after admission for acute myocardial infarction per 100 admissions over age 45, 2011 ⁹	4.4 ^l	5.7	6.2 ^j	8.9	6.8 ^j	4.5	4.5	4.5	5.9 ^j	7.8	5.5 ^j
Avoidable deaths, 2006–07	Mortality amenable to health care ^h (deaths per 100,000 population)	57	n/a	55	76	66	79	64	61	n/a	83	96
Prevention, 2012 ⁱ	Percentage of children with measles immunization	94%	98%	89%	97%	96%	92%	94%	97%	92%	93%	92%
	Percentage of population over age 65 with influenza immunization	n/a	64%	53%	n/a	n/a	64%	11%	n/a	46% ^j	76%	67% ^k
Public views of health system, 2013	Works well, minor changes needed	48%	42%	40%	42%	51%	47%	46%	44%	54%	63%	25%
	Fundamental changes needed	43%	50%	49%	48%	44%	45%	42%	46%	40%	33%	48%
	Needs to be completely rebuilt	9%	8%	11%	10%	5%	8%	12%	10%	7%	4%	27%

Sources (unless otherwise noted): 2010, 2011, and 2012 Commonwealth Fund International Health Policy Surveys.

^a Base: Saw or needed to see a specialist in past two years.

^b Base: Needed elective surgery in past two years.

^c Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.

^d Test results/medical records not available at time of appointment and/or doctors ordered medical test that had already been done.

^e Last time hospitalized or had surgery, did NOT: 1) receive instructions about symptoms and when to seek further care; 2) know who to contact for questions about condition or treatment; 3) receive written plan for care after discharge; 4) have arrangements made for follow-up visits; and/or 5) receive very clear instructions about what medicines you should be taking. Base: hospitalized/had surgery in past two years.

^f Base: Has a regular doctor or place of care.

⁹ In-hospital case-fatality rates within 30 days of admission.

^h Source: E. Nolte and M. McKee, "Variations in Amenable Mortality—Trends in 16 High-Income Nations," *Health Policy*, Sept. 12, 2011.

ⁱ Source: OECD Health Data 2014.

^j 2010.

^k 2011.

^l 2012.

Table 4. Provider Organization and Payment in 15 Countries

	Provider Ownership		Provider Payment		Primary Care Role	
	Primary Care	Hospitals	Primary Care Payment	Hospital Payment	Registration with GP Required	Gatekeeping
Australia	Private	Public (~67% of beds), private (~33%)	FFS	Global budgets + case-based payment in public hospitals (includes physician costs); FFS in private hospitals	No	Yes
Canada	Private	Mostly private not-for-profit or public; some private for-profit	Mostly FFS, but some alternatives (e.g., capitation)	Global budgets + case-based payment in some provinces (does not include physician costs)	Not generally, but yes for some capitation models	Incentives, varying across provinces: e.g., in Ontario, specialist physicians have higher fees for patients who have been referred by their GP
Denmark	Private	Almost all public	Mix capitation/FFS	Global budgets + case-based payment (includes physician costs)	Yes (for 98% of population)	Yes (for 98% of population)
England	Mainly private (most GPs are self-employed or partners in privately owned practices)	Mostly public, some private	Mix capitation/FFS/P4P; salary payments for a minority (the salaried GPs are employees of private group practices, not of the NHS)	Mainly case-based payments + service contracts. All include physician costs, drug costs, etc.	Yes	Yes
France	Private	Mostly public or private not-for-profit, some private for-profit	Mix FFS/P4P/flat 40€ bonus per year per patient with chronic disease and regional agreements for salaried GPs	Mainly case-based payments (includes physician costs) + non-activity-based grants for education, research, etc.	Yes (may be with a specialist or GP; in practice over 95% are with GPs)	National incentives: higher cost-sharing for visits and prescriptions without a referral from the gatekeeper
Germany	Private	Public (~50% of beds); private nonprofit (~33%); private for-profit (~17%)	FFS	Global budgets + case-based payment (includes physician costs)	No	In some sickness fund programs
Italy	Private (primary care providers [i.e., GPs and pediatricians] are self-employed)	Mostly public, some private	Mix capitation/FFS	Global budgets + case-based payment (includes physician costs)	Yes	Yes
Japan	Mostly private	Private nonprofit (~55% of beds) and public	Most FFS, some per-case daily or monthly payments	Case-based per diem payments + FFS or FFS (includes physician costs)	No	No
Netherlands	Private	Mostly private, nonprofit	Mix capitation/FFS	Global budgets + case-based payment (include physician costs)	Yes	Yes
New Zealand	Private	Mostly public, some private	Mix capitation/FFS	Global budgets + case-based payment (includes physician costs)	Yes (for 96% of population)	Yes
Norway	Private	Almost all public	Mixed income from municipal contracts, user-charges (in accordance with cost-sharing caps) and government-sponsored FFS payments	Global budgets + case-based payment (40% of DRG; includes physician costs)	Yes	Yes
Singapore	Mixed	Almost all public	Mix capitation/FFS/P4P	Global budgets + case-based payment (includes physician costs)	Yes (except Stockholm)	Some incentives
Sweden	Private	Mostly public, some private	Most FFS, but some capitation	National diagnosis related groups (Swiss DRG) payment system for (somatic) acute inpatient care	No	Free access (without referral) to specialists unless enrolled in a gatekeeping managed care plan
Switzerland	Private	Mostly public or publicly subsidized private (~70%), some private	Most FFS, some capitation in managed care plans offered by insurers	Case-based payments (~50% of total) and subsidies (through various mechanisms) from cantonal government	No, except in some managed care plans offered by insurers	Free access (without referral) to specialists, except in some managed care plans with gatekeeping offered by insurers
United States	Private	Mix of nonprofit (~70% of beds), public (~15%), and for-profit (~15%)	Most FFS, some capitation with private plans; some incentive payments	Mostly per-diem and case-based payments (usually does not include physician costs)	No	In some insurance programs

The Australian Health Care System, 2014

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What is the role of government?

Pursuant to the act of federation in 1901, Australia's states retained their responsibility for health services, apart from quarantine. The Australian Parliament, however, is empowered by the Australian Constitution "to make laws with respect to... pharmaceutical, sickness and hospital benefits, medical and dental services." Federal government plays a strong role in national policymaking but generally funds, rather than provides, health services. It funds and administers Medicare, the national medical insurance scheme; supplies pharmaceutical benefits; funds public hospitals and population health programs (with the states and territories); regulates much of the health system, including private health insurance, pharmaceuticals, and medical services; and has the main funding and regulatory responsibility for government-subsidized residential care facilities. Under the 2011 National Health Reform Agreement, the role of the Australian government has been strengthened in relation to the funding of public hospitals and funding and governance of primary care (COAG, 2011). The six states and two territories administer public hospitals and regulate all hospitals and community-based health services, largely through regional networks termed Local Hospital Networks. Local government is involved in environmental health and some public health programs, but not clinical services.



Who is covered?

Australia's national public health insurance scheme, Medicare, provides automatic universal health coverage for citizens and permanent residents, as well as automatic coverage for people with temporary visas from countries with whom Australia has reciprocal arrangements. All overseas students are required to enroll in Overseas Student Health Cover. The Department of Veterans' Affairs covers eligible veterans and dependents by directly purchasing public and private health care services. The Australian government provides some assistance for asylum seekers while their applications are being processed. Undocumented immigrants are not covered.

Voluntary private health insurance plays a mixed complementary and supplementary role. Policies are taken out by individuals or families, encouraged through tax incentives. Just over 47 percent of the population had private health insurance in June 2014 (PHIAC, 2014b).



What is covered?

Services: Public inpatient care in public hospitals is free, but people may choose to pay for private care in public or private hospitals. Medicare provides free or subsidized access to comprehensive medical services where the doctor deems there is a medical need (AIHW, 2014b). Copayments are at doctors' discretion, but no copayment is charged for the majority (83%) of general practice and diagnostic services, and most specialists do not charge a copayment to welfare recipients in financial hardship (DHS, 2014a). Medicare also provides optometry, and some allied health services if the patient is referred by a medical practitioner. The Australian government defines Medicare subsidies for outpatient care and outpatient physician services under the Medicare Benefits Schedule published by the Department of Health (DoH), and for medication under the Schedule of Pharmaceutical Benefits, published by the DoH; home health care and other services to support older people in their homes are provided through the Home and Community Care Program. The Australian government also funds a wide range of other health services, including comprehensive health services for war veterans and (usually jointly with the state and territory governments) population health and health promotion services, mental health, limited dental and physical therapy services, and rural and indigenous health programs.

Cost-sharing and out-of-pocket spending: Medicare usually reimburses 85 percent to 100 percent of its fee schedule for ambulatory services. It also reimburses 75 percent of the medical fee schedule (but not accommodation, surgery theater fees, or medicines) for private patients (inpatient care for public patients being free of charge) in public and private hospitals—any amount above this is paid by patients, as are any deductibles specified in their insurance policy. Doctors can treat patients and bill Medicare directly for the amount of the subsidy with no patient charge, referred to as “bulk-billing” (changes announced by the government in the 2014 budget include a AUD\$7.00 (USD5.00)* copayment for GP, radiology, and pathology services, and bulk-billing incentives will be changed into low-gap incentives, payable only if the copayment is charged). Doctors’ fees are not otherwise regulated, and they are free to charge above the Medicare fee schedule. However, incentive schemes offer additional payment for bulk-billing the care provided to concession card holders (low-income, older people), children under 16 years of age, and residents of rural and remote areas. Prescription pharmaceuticals approved by the Pharmaceutical Benefits Scheme (PBS) have a standard copayment (in 2014) of AUD36.90 (about USD24.00) for each item prescribed for the general public, with a reduced rate of AUD6.00 (USD4.00) for concession card holders (DoH, 2014c). The copayment rate is the same whatever the cost of the drug, and if the cost of the drug is less than the copayment, no benefit is paid.

When the annual threshold of AUD430.90 (USD285.00) for “gap expenses”—the difference between the Medicare benefit and the fee schedule—is reached, the Medicare payment is increased from 85 percent to 100 percent of the Medicare fee schedule for the remainder of the calendar year, irrespective of income. The Extended Medicare Safety Net provides additional coverage for patients who incur high health care costs; once a threshold for total out-of-pocket costs is reached (AUD624.10 [USD413.00] for individuals with concession cards and low-income families, and AUD1,248.70 [USD827.00] for general patients), the patient has 80 percent of his or her out-of-pocket costs reimbursed for the remainder of the calendar year (DHS, 2014a). Families can register to have their gap expenses and out-of-pocket costs combined to reach the applicable threshold amount sooner. Approximately 4.5 percent of the estimated resident population (991,000 people [AIHW, 2014c, appendix D]) benefited from the safety net in 2010 (DHS, 2012).

People who exceed an annual threshold for pharmaceutical costs (PBS-listed medicines) are eligible for additional subsidies; the patient copayment per item decreases to the concessional rate of AUD6.00 (USD3.98) once expenditure exceeds AUD1,421.20 (USD941.00) within a calendar year. For concessional patients, the copayment is not required once expenditure on PBS items exceeds AUD360 (USD238) (DoH, 2014c).

Direct out-of-pocket payments by individuals accounted for 17.8 percent of total health expenditure in 2012–2013 (AIHW, 2014c, p. 50), and of this 38.2 percent was on medicines, 19.0 percent on dental, and 11.6 percent on medical services.

Safety net: Apart from the overall copayment ceilings described above, no further “safety net” policies are in place.



How is the health system financed?

Publicly financed health care: Australia spent 9.67 percent of GDP on health care in 2012–2013 (AIHW, 2014c). Medicare is funded mostly from general tax revenue, including a value-added tax; from patient fees and other private sources; and from a 2 percent “Medicare Levy” on taxable income, with some exceptions for low-income individuals. The levy was increased from 1.5 percent to 2.0 percent on July 1, 2014, as part of the 2014 federal budget, and despite its name is not hypothecated for health purposes. For the financial year 2012–2013, government funding amounted to 68.3 percent of total health expenditure—41.4 percent by the Australian government and 26.9 percent by the states and territories. In 2012–2013, total taxation in Australia was 27 percent of GDP—22 percent raised by the Commonwealth, 4 percent by the states and territories, and 1 percent by local government (ABS, 2014b). State and territory funding is sourced partly from Commonwealth taxation receipts that are transferred to the states and territories by the Commonwealth Grants Commission

* Please note that throughout this profile, all figures in USD were converted from AUD at a rate of about AUD1.51 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for Australia.

(see www.cgc.gov.au) to equalize their ability to provide services, given their varying need and capacity to raise their own revenue.

Privately financed health care: Nongovernment sources provided 31.6 percent of health expenditure in 2012–2013, including out-of-pocket spending. Private health insurance offers private care in public hospitals, as well as choice among private hospitals, in-hospital specialists, and practitioners of ancillary services such as dental care, optometry, and complementary medicine. It also offers choice in the timing of procedures; there is little waiting time for private procedures, as compared with the public system, in which waits for nonurgent elective procedures can be substantial. Private insurers are able to cover out-of-hospital services that substitute for or prevent in-hospital care, and disease management programs are offered by most insurers. Private health insurance accounted for 8 percent of total health expenditure in 2012–2013 (AIHW, 2014c, p. 36).

Government policy encourages people to take out private health insurance early in life, and regulates premiums; the Lifetime Health Coverage program offers people who join a private insurance fund before age 31 a relatively lower premium throughout their lives, regardless of health status, as they can renew their policy annually at the initial rate. Insurers must accept all comers and cannot discriminate on the basis of health status or any factor that may affect health status. They can only discriminate in relation to age under the Lifetime Health Cover rules. People over age 30 face a 2 percent increase in premiums over the base rate for every year they delay joining, with a maximum loading of 70 percent. The Commonwealth offers a premium subsidy for private health insurance holders with low to middle incomes. Those with higher incomes who do not take out private hospital insurance pay a tax surcharge of an additional 1.0 percent to 1.5 percent of taxable income (Private Healthcare Australia, 2014; Private Health Insurance Ombudsman, 2014). The combined effect of these incentives is that private health insurance participation increases markedly at around age 30 and rolls off sharply after retirement. The majority of private health insurers are not-for-profit, but they only represent about 30 percent of market share (PHIAC, 2014a).



How is the delivery system organized and financed?

Primary care: In 2013, there were 25,702 general practitioners (GPs) and 27,279 other specialists employed in health occupations (AIHW, 2014d). The split of GPs to specialists is 48.5 percent to 51.5 percent. Most GPs are self-employed and work in multiprovider practices with an average of four full-time-equivalent GPs per practice, including GPs in training (DoH, 2014a; DHS, 2014b). Corporate aggregation has been progressing slowly for 20 years, and is continuing with the entry in 2013 of large private health insurers into direct provision of general practice services in after-hours and aged care settings (Heath, 2014). Regional primary health organizations provide a limited range of primary care services through participating practices, including care coordination, after-hours services, practice support services including IT, and a limited selection of allied health services. Specific arrangements vary widely by region according to local need and historical arrangements.

GPs are paid largely fee-for-service (90% of total payments) but also receive incentive payments (10%) for being accredited as meeting the Royal Australian College of General Practitioners practice standards, meeting certain benchmarks for health information technology, providing appropriate care for some chronic diseases, teaching students, and performing some other activities (Auditor General, 2010). The Commonwealth puts out a recommended fee schedule for both service and incentives through legislation on advice from the Department of Health. Care coordination is incentivized by way of specific Medicare benefits for integrated care plans for complex patients. Individuals are not required to register with a GP and are free to consult any GP, to seek a second opinion, or to switch to another practice at any time. The great majority of people use the same practice for most of their practice visits (McRae et al., 2010). Doctors with busy practices may decide not to accept new patients. GPs play a gatekeeping role, as Medicare pays benefits for specialist and diagnostic services only upon medical referral. Nurses play an important role in the majority of practices, where they are funded by practice earnings and some nurse-specific Medicare benefits and incentive payments for coordinating care. Medicare also pays benefits for pharmacist medication reviews as well as optometrist, psychologist, and some other allied health services.

Outpatient specialist care: Medicare allows individuals to choose their specialist for out-of-hospital care, although their general practitioner must provide a letter of referral to the specialist. Specialists are paid fee-for-service, with benefit levels set by the Commonwealth (through the same process as for primary care, described above) and patient copayments agreed between the doctor and the patient. Many specialists practice in both the private and the public sector. In the private sector, consulting specialists work largely in single-specialty small-group practices in which they share premises and business functions, but practice individually.

Administrative mechanisms for paying primary care doctors and specialists: Doctors invoice patients after each visit and usually expect immediate payment. Patients can assign their anticipated Medicare benefit to the doctor, who can “bulk-bill” the government for all assigned benefits if no copayment is charged. If a copayment is charged, the patient pays the full amount and claims reimbursement. This claim can be made at the doctor’s office (if the doctor has the facilities—more common among GPs than among specialists) and paid on the spot, effectively meaning the patient pays only the copayment.

After-hours care: The Royal Australian College of General Practitioners standards for general practice require practices to ensure that after-hours care arrangements are in place for their patients, and the Commonwealth Practice Incentive Payments, claimed by most practices, are linked with adherence to these standards. GP clinics vary considerably as to the ways in which they meet this standard and the extent to which they provide after-hours care themselves. It is often provided by a private company through arrangements with GP practices or through a cooperative of local practitioners. After-hours billing arrangements for GP services are the same as those for regular hours; however, copayments are usually higher. In rural towns, GPs often participate in a roster for the emergency department at the local public hospital. The Australian government also has offered grants through primary health organizations of around AUD50,000 (USD33,100) annually per practice for selected general practices to provide after-hours services (grants vary significantly by region). Nurse-led clinics offer extended-hours coverage in some metropolitan centers. Healthdirect Australia (see www.healthdirect.gov.au) is a national 24-hour emergency phone line that provides nursing and medical advice or can triage calls to appropriate services. Public hospital emergency departments offer 24-hour free access. All after-hours services routinely communicate back to the patient’s GP.

Hospitals: There is a mix of public, private, and not-for-profit hospitals. In 2012–2013, there were 729 public acute hospitals, 17 public psychiatric hospitals, 319 private day hospitals, and 282 other private hospitals. Public hospitals are funded jointly by the Australian government and the state and territory governments in addition to receiving funds from treating private patients. Private hospitals (including freestanding ambulatory day centers) can be either for-profit or nonprofit, and their income is derived chiefly from patients with private health insurance.

Public hospitals are organized into 136 local hospital networks, with wide variation in the number of public hospitals in each network, many with ancillary community-based services, run by boards with local clinician input. State health departments manage public hospitals and fund those hospitals largely on a prospective, capped activity-based formula using diagnosis-related groups. Specific payment methods and the weighting given to the activity-based component of the global hospital budget vary considerably by state. For 2014–15 to 2016–17, through the National Hospital Funding Body (see www.nhfb.gov.au), the national government will pay state governments a percentage based on the level of base funding plus 45 percent of the “efficient” growth in cost (the effective percentage rate will vary between states from 23% to almost 45%), calculated by the Independent Hospital Pricing Authority (see www.ihpa.gov.au), for services to public patients, including all physician costs. The remaining costs are paid by state governments and cover the whole episode of care for each hospitalization, as public hospital services are free to the public. Arrangements for transition to retrospective, open-ended activity-based funding for hospitals have also been in place for the Commonwealth’s share of funding, provided to the states through the Council of Australian Governments Health Reform Agreement (August 2011).

Physicians in public hospitals either are salaried (but may also have private practices and fee-for-service income, of which they usually contribute a portion to the hospital) or are private specialist physicians who do some work in public hospitals, where they are paid on a per-session or fee-for-service basis for treating public patients. This public and private mix of hospital-based medical practice has been a long-standing feature of the Australian health system, and is well accepted. Many specialist physicians work purely in private practice, with admitting

rights at several private hospitals. Rural general practitioners often have admitting rights at their local public hospital, but this arrangement is rare in urban areas.

Mental health care: A variety of public and private health care providers deliver mental health services. Nonspecialized services are offered through GPs, who also frequently coordinate the care of their mentally ill patients. Specialized services are provided through psychiatrists (usually upon referral from GPs), psychologists, community-based mental health services, psychiatric hospitals, psychiatric units within general acute hospitals, and residential care facilities. Mental health–related GP, psychiatrist, and some psychologist consultations are reimbursed by Medicare. Inpatient admissions to public hospitals for mental health problems are free to patients and funded through intergovernmental funding agreements. The 17 stand-alone public psychiatric hospitals treat and care for admitted patients with psychiatric, mental, or behavioral disorders. Most other public hospitals and many private ones also admit psychiatric patients. Private insurers pay benefits for admissions to private hospitals for their insured. Community services include crisis, mobile assessment, and treatment services, as well as day programs, outreach services, and consultation services. Nongovernmental organizations also provide information, treatment, and advocacy services for mental health care.

Long-term care and social supports: The majority of care for older people with long-term health conditions is provided by relatives and friends. The government finances family and informal care through a range of payments including Carer Payment, for those unable to work full-time because of substantial caregiver commitments; Carer Allowance, which is a supplementary tax-free payment for additional daily care free of income- or asset-testing; and other targeted supplements. For people assessed as having a high level of dependency, the Australian government subsidizes assistance through either community care services or residential aged care homes. The government subsidy for aged residential care is means-tested, and the amount of subsidy is based on the extent of a person's dependency (low, medium, high) and total assessable income (DoH, 2014d). In 2011, 60 percent of residential aged care providers were not-for-profit (such as religious and community organizations), 30 percent were private for-profit, and the remaining 10 percent were state and local government facilities (AIHW, 2012, p. 19).

The Home and Community Care (HACC) program (DoH, 2014b) subsidizes services that aim to support older people in their own homes. The Australian government fully funds HACC services in all states and territories. A comprehensive range of services is covered, including home nursing, allied health, home modification and some equipment, cleaning, and meal delivery. Case managers can tailor a package of services to a patient's needs. Copayments are often required, and can vary according to the arrangements of local HACC providers. The HACC program is complemented by several smaller Commonwealth and state programs.

Palliative care services are provided by government and nongovernment providers to people in their own homes, in community-based settings such as nursing homes, in palliative care units, and in hospitals.



What are the key entities for health system governance?

The main national governance agencies are the Council of Australian Governments' Health Ministers Conference and its extensive committee structure, together with the Department of Health. The Commonwealth's medical and pharmaceutical benefits scheme, combined with its financial agreement with the states and territories for public hospital care, gives it a substantial funding control ability. The Health Minister also has statutory power to approve private health insurance premium increases. Public health and clinical guidelines are produced by the National Health and Medical Research Council and professional associations.

The Therapeutic Goods Administration (an operating division of the DoH) is responsible for technology assessment, marketing approval, and postmarketing surveillance of therapeutic goods including pharmaceuticals, devices, and information technology for direct patient care. The Pharmaceutical Benefits Advisory Committee (an independent statutory body) advises the national Health Minister on the evaluation of the comparative effectiveness and cost-effectiveness of drugs proposed for the government subsidy list. The DoH uses these assessments to negotiate prices with manufacturers. The Independent Hospital Pricing

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Authority was established by the Commonwealth, with the agreement of the states and territories, in 2011 to set the national “efficient” price for public hospital services, although each state or territory takes its own approach to pricing hospital services, and the private health insurers continue to pay for hospital services on a bed-day basis. The National Health Performance Authority was established as a statutory authority in 2011 to report on the performance of all local hospital networks, public and private hospitals, and primary health organizations. The Australian Health Practitioners Regulation Agency (established in 2010) is a registration and oversight body for the 14 current health professions.

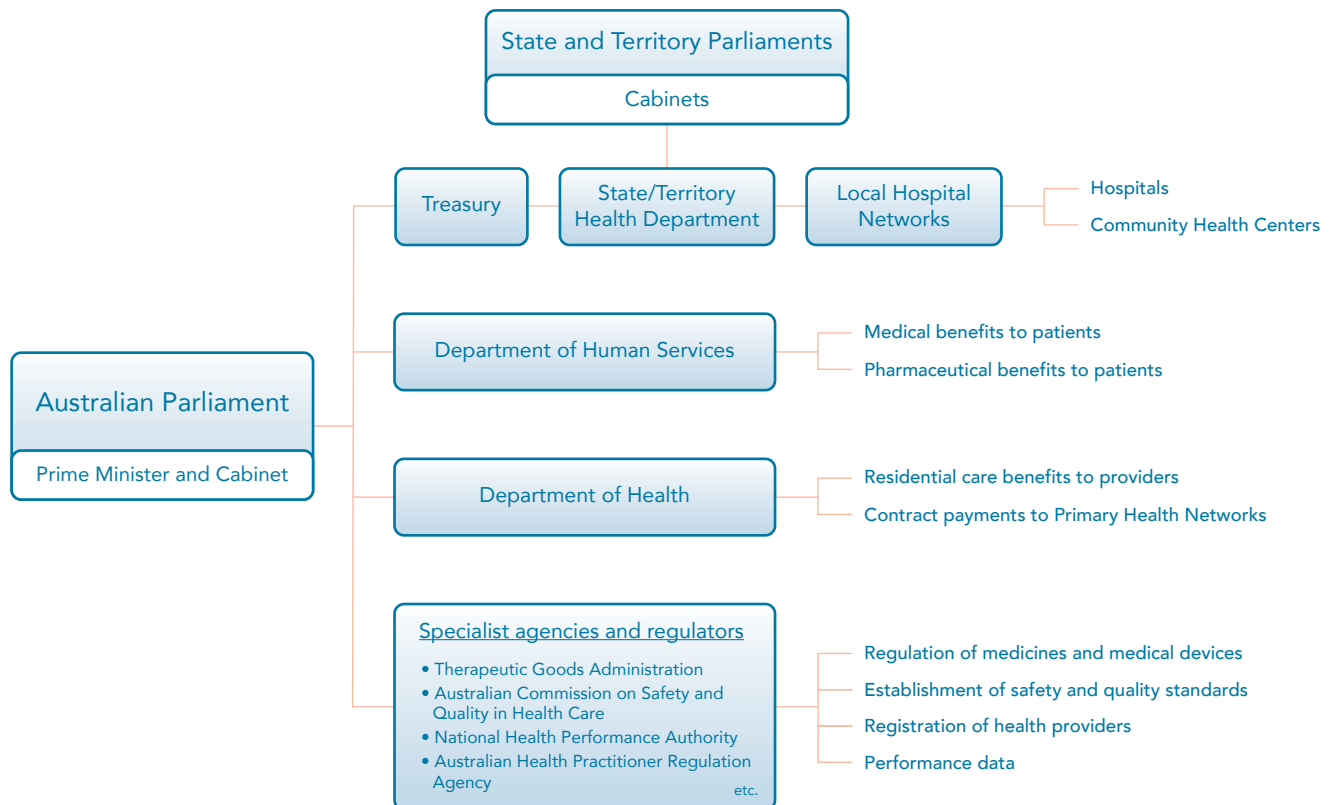
Although no single entity is responsible for public engagement and information, there has been continual improvement in the data made available by the above agencies, and the data availability and transparency of governmental agencies has outstripped the ability of the universities, not-for-profit agencies, and media to analyze it in public debate. On the other hand, there is a vibrant collection of consumer rights and patient advocacy not-for-profits in Australia, including the Consumers Health Forum of Australia, the Australian Council on the Ageing, and disease-specific advocacy groups that receive government and private funding, while retaining an autonomous voice in public debate.



What are the major strategies to ensure quality of care?

The past decade has seen more attention paid by regulatory actors and strategies to ensuring quality of care (Healy, 2011). The principal government body in this area, the Australian Commission on Safety and Quality in Healthcare (ACSQHC, which became a statutory body in 2011), publicly reports on safety and quality against national standards, disseminates knowledge, identifies policy directions, and develops and promotes programs.

Organization of the Health System in Australia



Source: P. Dugdale and J. Healy, Australian National University, 2014.

The National Health Performance Authority monitors trends in the performance of health service providers against standards set out in the National Health Performance Framework. A start has been made in publishing hospital-level data through the www.myhospitals.gov.au website, much of it at the specialty-unit (but not at the individual doctor) level. The National Safety and Quality Health Service Standards were endorsed by health ministers in 2011. The Australian Council on Healthcare Standards, a nongovernment organization, is the main accreditation body for hospitals and other health facilities and sets its own standards, which it has aligned with the ACSQHC standards. The Aged Care Standards and Accreditation Agency (a government-owned company) accredits aged care services as set out in the 2011 Accreditation Grant Principles; residential aged care must be accredited to be eligible for government subsidies. The Commonwealth and state and territory governments have agreed on eight national health priority areas covering the major causes of chronic disease morbidity: asthma, diabetes, cardiovascular health, cancer, mental health including depression, injury prevention, arthritis and musculoskeletal conditions, and dementia. There are national plans for each, and evaluative data are collected and made available by the Australian Institute of Health and Welfare. There is also a national primary health care strategic framework (Standing Council on Health, 2013) and a framework for Australian clinical quality registries (ACSQHC, 2014) for various government-funded disease, surgery, and device registries.

The ACSQHC sets quality standards that all hospitals and day surgery centers must meet in order to be accredited. The standards include the use of patient surveys, and the Australian Bureau of Statistics conducts an annual patient experience survey. Over 85 percent of general practices are accredited using standards set by the Royal Australian College of General Practitioners. Medicare also offers financial incentives, rewarding practices deemed to be working toward meeting the College's standards.

Health care organizations as employers run a variety of quality improvement programs. All professional boards, associations, and colleges (doctors, nurses, dentists, therapists, etc.) require members to participate in annual professional development programs in order to maintain professional registration, and require submission of evidence of participation measured against a points system.



What is being done to reduce disparities?

The Australian government and the states work in partnership with indigenous communities in order to close long-standing health gaps through a range of programs and targeted health care funding. Extra subsidies for services, training programs, and outreach services are also directed to people in rural areas, and a safety net is in place to improve access to care for low-income people. The reporting framework of the National Health Performance Authority requires government service providers to report on measures of equity and access, including reporting targeted toward particular groups such as indigenous Australians. The Australian Institute of Health and Welfare publishes regular reports on indigenous Australians.



What is being done to promote delivery system integration and care coordination?

The Commonwealth government provides funds to operate primary health networks centered around general practitioners. These organizations have a representational and planning role in primary care, and some also provide services such as after-hours care or care coordination. Multidisciplinary teams are the norm in state- and territory-funded community health centers. Chronic disease management programs are provided by most private health insurers, the Department of Veterans' Affairs and a growing number of local hospital networks. These programs are driven by state and territory governments to varying degrees, but there is an absence of national policy to support care integration for people with multimorbidity (Veronesi et al., 2014). On the other hand, there is good coordination between health care and long-term social support for people over 65 through the Aged Care Assessment Teams, which provide the gateway assessment to long-term support (AIHW, 2013).



What is the status of electronic health records?

Most general practices and many public providers use electronic health records (EHRs). In his review of the Practice Incentives Program, the Australian Auditor-General found that in 2009–2010, 82 percent of GP services were provided by practices that participated in the program, and of those 90 percent maintained electronic patient records and IT security (Auditor General, 2010, Chapter 5). The National E-Health Transition Authority has been set up as part of the National E-Health Strategy, and has developed standards for patient identifiers, interoperable systems between providers (although use of this standard is quite limited), and clinical and medicines terminology sets. The Commonwealth government offers personally controlled EHRs to consumers on an opt-in basis, using unique patient and provider identifiers. By the end of 2013, 1.2 million consumers had registered for one; however, meaningful use has been limited, and the program, still in its early stages, is under review, with specific consideration being given to offering the EHRs on an opt-out rather than an opt-in basis (PCEHR Review Panel, 2013).



How are costs contained?

Costs are controlled by various market, financing, and managerial mechanisms. Australia has a mature generic pharmaceuticals market. The Australian government has a near-monopsony on purchasing patent medicines, which, combined with tight prescribing requirements, allows it to control pharmaceutical pricing. Patient copayments for pharmaceuticals under the Pharmaceutical Benefits Scheme help control volumes. New pharmaceuticals have to meet cost-effectiveness criteria and are subject to nationally negotiated pricing before inclusion in the formulary of publicly subsidized medicines. Public hospitals are managed with broadly capped global prospective budgets that effectively control costs (as hospitals bear the risk when budgets are exceeded) but have at times led to waiting lists for elective access. Health insurance funds negotiate and publish agreed-upon prices with their preferred private hospitals and other service providers. Additional measures include: controlling the growth in cost of some large-volume diagnostic services through industry agreements with the relevant medical specialty; controlling access to specialist services through gatekeeping; and limiting the number of providers with access to some “high-tech” services, such as MRIs.



What major innovations and reforms have been introduced?

The National Mental Health Commission (NMHC) was set up in January 2012 to examine mental health services and programs across the government. In February 2014, it was commissioned to report on the implementation of mental health reforms (see www.mentalhealthcommission.gov.au), examining existing mental health services and programs across the government, private, and nongovernment sectors. The focus of the review is to assess the efficiency and effectiveness of programs and services that support individuals experiencing mental ill health, and their families and other supporters, in leading a productive life and engaging in the community. The Commission expects to report on the review by the end of 2014. The NMHC also publishes an annual national report card on mental health and suicide prevention, benchmarks Australia’s performance against best practice, supports a knowledge exchange center, improves intergovernmental and interagency collaboration, and undertakes and disseminates research, analysis, and evaluation of key priorities and data gaps (NMHC, 2014).

The National Disability Insurance Agency was established by the Australian government in 2013 to implement the National Disability Insurance Scheme (NDIS) (see www.ndis.gov.au). The Scheme is an economic and social reform aimed at optimizing social and economic independence and achieving full participation by people with permanent and significant disability in their own care over the ensuing three years. These goals will be reached through long-term actuarial insurance that invests in research and innovation, and promotes stakeholder participation in choice of services and in the Scheme’s governance (NDIS, 2013). The NDIS aims to provide support by improving referral and access to existing services and by providing direct support for equipment and services. The first stage was launched in July 2013 in several states to provide care and support, initially for an estimated 20,000 people. Full implementation is anticipated by mid-2019.

The Commonwealth government announced plans in the 2014 budget to create a health productivity commission within the next year that would bring together a number of national health agencies, including the Australian Institute of Health and Welfare, the Australian Quality and Safety Commission, and the Australian Health Performance Authority. The Australian National Preventive Health Agency has been abolished and its functions absorbed into the Department of Health. The aim of these administrative reforms is to consolidate the function of these bodies to improve effectiveness, efficiency, standards of safety, and quality in health care through reduction of the administrative and bureaucratic burden on state governments (Cormann and Dutton, 2014). There is cause for optimism that the health productivity commission could create synergies in data availability, interpretation, and transparency.

Finally, private health insurers are significantly increasing their offerings in chronic disease management. This has been allowed since the Commonwealth's 2007 Broader Health Cover reform, aimed at promoting programs by health insurers that better manage chronic conditions and prevent hospitalizations, and at allowing private health insurers to cover programs such as tailored health coaching that were not allowed previously. The federal Parliament has accepted that overseas evidence indicates that patients covered by such programs stay healthier longer and have their chronic conditions better managed, leading to fewer, less expensive health insurance claims (Biggs, 2013). Participation in chronic disease management programs and the benefits paid to members undertaking these programs by insurers have escalated accordingly in recent years.

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The Canadian Health Care System, 2014

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What is the role of government?

Provinces and territories have primary responsibility for organizing and delivering health services and supervising health care providers. Many provinces and territories have established regional health authorities that plan and deliver publicly funded services locally. Generally, these authorities are responsible for the funding and delivery of hospital, community, and long-term care, and mental and public health services. Health care providers are almost entirely private. Federal government cofinances provincial and territorial programs, with conditions on adherence to the five underlying principles of the Canada Health Act, the law that sets pan-Canadian standards for medically necessary hospital, diagnostic, and physician services. Principles state that each provincial health care insurance plan needs to be: publicly administered, comprehensive in coverage, universal, portable across provinces, and accessible (meaning that there are no user fees). Federal government also regulates the safety and efficacy of medical devices, pharmaceuticals, and natural health products; funds health research; and administers several public health functions.



Who is covered?

The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents according to their own residency requirements (Health Canada 2013a). Undocumented immigrants, including denied refugee claimants, those who stay in Canada beyond the duration of a legal permit, and those who enter the country “illegally,” are not covered in any federal or provincial program, although provinces and territories provide some limited services. Federal government administers a range of services, such as prescription drugs and ancillary and community health services for First Nations and Inuit,¹ members of the Royal Canadian Mounted Police and the Canadian Forces, veterans, refugee claimants,² and inmates in federal penitentiaries. Around two-thirds of Canadians also have private health insurance, which covers services not covered under the public programs.



What is covered?

Services: To qualify for federal financial contributions under the Canada Health Transfer, provincial and territorial insurance plans must provide first-dollar coverage of medically necessary physician, diagnostic, and hospital services (including inpatient prescription drugs) for all eligible residents. There is no nationally defined statutory benefits package; most public coverage decisions are made by provincial and territorial governments in conjunction with the medical profession. Provincial and territorial governments provide varying levels of additional benefits, such as outpatient prescription drugs, nonphysician mental health care, vision care, dental

1 In British Columbia, the funding and governance of aboriginal health care will be transferred from the federal government to the newly formed First Nations Health Authority in 2013, including CAD2.5 billion (USD2 billion) over the next five years.

Please note that throughout this profile, all figures in USD were converted from CAD at a rate of about CAD1.24 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014b) for Canada.

2 In June 2012 the federal government implemented changes to health coverage for refugee claimants. All refugee claimants lost access to medication, vision, and dental coverage; and claimants from designated countries—those not determined by the Minister of Citizenship and Immigration to be refugee-producing countries—lost access to all health coverage unless their conditions pose a public safety concern or a risk to public health. These changes effectively devolve costs onto provinces and hospitals.

care, home health care, physiotherapy, aids to independent living, and ambulance services. They also provide public health and prevention services (including immunizations) as part of their public programs, while the federal government directly provides and funds a wide range of preventive services through the Public Health Agency.

Cost-sharing and out-of-pocket spending: There is no cost-sharing for publicly insured physician, diagnostic, and hospital services. All prescription drugs provided in hospitals are covered publicly, with outpatient coverage varying by province or territory. Physicians are not allowed to charge patients prices above the negotiated fee schedule. In 2012, out-of-pocket payments represented about 15 percent of total health spending (OECD, 2014), spent mainly on prescription drugs (22%), nonhospital institutions (mainly long-term care homes) (21%), dental care (16%), vision care (11%), and over-the-counter medications (10%) (Canadian Institute for Health Information, 2013).

Safety net: Cost-sharing exemptions vary among provinces and territories. With regard to prescription drugs, provincial plans have in place a range of programs to protect lower-income groups. For example, in Ontario, the provincial program covers all people aged 65 and over, residents of long-term care homes, recipients of home care services and social assistance, and people with high drug costs in relation to their income (a catastrophic insurance plan). Low-income seniors and social assistance recipients in Ontario are exempt from all cost-sharing except a CAD2.00 (USD1.60) copayment that is often waived by pharmacies. Low-income is defined as annual household income that is below CAD16,018 (about USD12,950) for single people and below CAD24,175 (USD19,540) for couples.

There are no caps on out-of-pocket spending. However, the federal Medical Expense Tax Credit supports tax credits for individuals whose medical expenses, for themselves or their dependents, are significant (above 3% of income). A disability tax credit and an attendant care expense deduction also provide relief to individuals (or their dependents) who have prolonged mental or physical impairments, and to those who incur expenses for care that is needed to allow them to work.



How is the health system financed?

Publicly financed health care: Public funding accounted for an estimated 70 percent of total health expenditures in 2012 (OECD, 2014). Public programs are funded by general provincial and federal taxation. Federal government contributes cash funding to the provinces and territories on a per-capita basis through the Canada Health Transfer—block grants were estimated to account for 21 percent of total provincial and territorial health expenditures in 2012–2013 (Canadian Institute for Health Information, 2013; Government of Canada, 2013).

Privately financed health care: Private insurance covers services excluded from public reimbursement such as vision and dental care, prescription drugs, rehabilitation services, home care, and private rooms in hospitals. There is no market for substitutive insurance: In five provinces, private insurance for hospital or physician services is illegal,³ and in the remainder there are regulations that make such a market unattractive, for example, those prohibiting physicians who opt out of the public insurance plan from billing more than the prices in the public fee schedule (Flood and Archibald, 2001).

In 2011, approximately 91 percent of premiums for private health plans were paid through group contracts with employers, unions, or other organizations (Canadian Life and Health Insurance Association, 2013). Private insurance to provide faster access to publicly funded physician and hospital services is not available. Providers set their own fees for services covered by private insurance, and each insurer sets its own reimbursement level (e.g., based on the lowest fee among representative providers in a geographical area). Contributions to employer-sponsored private insurance are deductible from federal income tax, and from provincial tax in all provinces but Quebec. Premiums paid to any private plan qualify as expenses eligible for the federal Medical

3 Quebec's legislation prohibiting duplicative private health insurance was overturned in 2005 by a ruling by the Supreme Court of Canada stating that this law was in violation of that province's Charter of Human Rights and Freedoms as of 2005 (Chaoulli v. Quebec [Attorney General] [2005]).

Expense Tax Credit. In 2010, private health insurance accounted for approximately 12 percent of total health spending (Canadian Institute for Health Information, 2013). The majority of insurers are for-profit.



How is the delivery system organized and financed?

Primary care: In 2012, about half of all practicing physicians (2.48 per 1,000 population) were general practitioners and half were specialists (Canadian Institute for Health Information, 2012a; Organization for Economic Cooperation and Development, 2014). Primary care physicians act largely as gatekeepers, and many provinces pay lower fees to specialists for nonreferred consultations. Most physicians are self-employed in private practices and paid fee-for-service, although over the past 15 years there has been a movement toward group practice and alternative forms of payment such as capitation, salary, and blended funding. In 2010–2011, fee-for-service payments made up 50 percent of payments to general practitioners in Ontario, compared with 70 percent in Quebec and 86 percent in British Columbia (Canadian Institute for Health Information, 2012b). Physicians in community clinics are salaried. In some provinces, such as Ontario, some new primary care teams paid partly by capitation must require patients to register in order to receive those partial payments; otherwise, registration is not required.

In several provinces, networks of general practitioners work together and share resources. For instance, Primary Care Networks in Alberta and Family Health Teams in Ontario receive additional funding to hire interdisciplinary health professionals (e.g., nurses, pharmacists, and dietitians). In Ontario, the minimum practice size for physicians in alternative payment models (i.e., not fee-for-service) is three. In Family Health Teams the average practice size is approximately 10 physicians, and ranges from seven to 14 physicians in other models⁴ (Rudoler et al., 2014). Team composition varies across practices, and interdisciplinary providers are generally salaried employees of the practice. In addition, providers in these practices often share resources and responsibility for patient care, including the delivery of after-hours care (see below, “After-hours care”).

Patients have free choice of primary care doctor, although in some areas choices are restricted owing to limited supply. Several provinces, such as Quebec, British Columbia, and Ontario, have initiated programs to help individuals without a regular doctor to register with one.

Provincial and territorial ministries of health negotiate physician fee schedules (for primary and specialist care) with provincial and territorial medical associations. In some provinces, such as British Columbia and Ontario, payment incentives have been linked to performance, and to encourage the provision of a number of services including, but not limited to, delivering “guideline-based” care for specified chronic conditions, offering preventive services, developing care plans for patients with complex needs, contacting patients to schedule appointments, and registering complex or vulnerable patients (see below, “Delivery system integration and care coordination”).

Outpatient specialist care: The majority of specialist care is provided in hospitals, although there is a trend toward providing services in private nonhospital facilities. Specialists are paid mostly on a fee-for-service basis, and in most provinces they have the same fee schedule as primary care physicians. Patients can choose, and have direct access to, a specialist, but it is common for general practitioners to refer patients to specialty care because many provinces pay lower fees for nonreferred consultations. Specialists who work in the public system are not permitted to receive payment from private patients for publicly insured services. There are few formal multispecialty clinics in Canada, although in some provinces, such as Ontario, there are informal, or virtual, networks of specialists that share patients and information (Stukel et al., 2013).

Administrative mechanisms for paying primary care doctors and specialists: The majority of physicians and specialists bill provincial governments directly, although some are paid a salary by a hospital or facility. There are no direct payments from patients to physicians; there is no cost-sharing, although patients may be required to pay for medically unnecessary services—for instance, physician letters sent to employers when employees are ill.

4 A description of the different primary care models can be found here: Government of Ontario (2014).

After-hours care: After-hours care is provided generally by physician-led (and mainly privately owned) walk-in clinics and hospital emergency rooms. In most provinces and regions a free telephone service (“telehealth”) is available 24 hours a day for health advice from a registered nurse. Traditionally, primary care physicians were not required to provide after-hours care, although many of the government-enabled group practice arrangements have requirements or financial incentives for providing after-hours care to registered patients. For example, in Ontario, many primary care physicians receive a 20 percent premium for after-hours provision of specific services. The 2012 Commonwealth Fund International Survey of Primary Care Doctors found that only 46 percent of physician practices in Canada had arrangements for patients to see a doctor or nurse after hours, with the highest rate in Ontario, at 67 percent (Health Council of Canada, 2013). The same survey found that only 30 percent of physicians received notification of hospital emergency department visits by their patients and about a quarter received a full report on specialist consultations.

Hospitals: Hospitals are a mix of public and private, predominantly not-for-profit, organizations, often managed locally by regional authorities or hospital boards representing the community. In provinces with regional health authorities, many hospitals are publicly owned (Marchildon, 2013), whereas in other provinces, such as Ontario, they are predominantly private, nonprofit corporations. There are no data on the number of private for-profit clinics (mostly diagnostic and surgical). In Ontario, government provides funding to 145 not-for-profit hospital corporations (with 224 different facilities/sites), and six private for-profit hospitals (Ontario Ministry of Health and Long-Term Care, 2014).

Hospitals in Canada generally operate under annual, global budgets, negotiated with the provincial or territorial ministry of health or regional health authority. However, several provinces have considered introducing activity-based funding for hospitals, including Ontario, Alberta, and British Columbia (see below, “What major innovations and reforms have been introduced?”) (Sutherland, 2013a). In British Columbia, the government introduced some activity-based funding for the 23 largest hospitals in the province in 2010, with the aim that by 2012–2013 around 20 percent of eligible acute care spending would be attributable to activity-based funding (called “patient-focused funding”) (British Columbia Ministry of Health Services, 2010). However, in 2013 the organization that was set up to oversee the implementation of this new funding model was closed, suggesting that the government may be moving away from this approach (Mickleburgh, 2013). Activity-based funding has been used in national efforts to incentivize targeted services and to address waiting times for services such as cancer treatment and cataract surgery. Hospital-based physicians generally are not hospital employees and are paid directly by the government on a fee-for-service basis.

Mental health care: There is universal coverage for physician-provided mental health care, alongside a fragmented system of allied services. Hospital mental health care is provided in specialty psychiatric hospitals and in general hospitals with adult mental health beds. The Canada Health Act does not mandate public coverage of nonphysician mental health services (such as the services of psychologists or social workers) outside of hospitals, but the provinces and territories all provide a range of community mental health and addiction services (Goering et al., 2000). Community mental health services include case management, community-based crisis response, and supported housing (Goering et al., 2000). Psychologists may work privately, and are paid out-of-pocket or through private insurance, or under salary in publicly funded organizations. Mental health has not been formally integrated into primary care; any coordination or colocation of mental health services within primary care is unique to each practice. In Ontario, the government introduced an intersectoral mental health strategy in 2010, which, among other things, aims to better integrate mental health care into primary care (Government of Ontario, 2010).

Long-term care and social supports: Long-term care and end-of-life care provided in nonhospital facilities and in the community are not considered insured services under the Canada Health Act. Provinces and territories can choose to fund services, and all do, but coverage varies among and within them. All provinces provide some nursing home care and some combination of case management and nursing care for home care clients; however, outside of this (e.g., for medical equipment, supplies, and home support) there is considerable variation, and many jurisdictions require client contributions (OECD, 2011). About half of the provinces and

territories provide some home care without means-testing, but access may depend both on assessed priority and on availability within capped budgets (Health Canada, 2013b).

Eligibility criteria for home and institutional long-term care services vary across provinces, but generally include a needs assessment based on health status and functional impairment, often a version of the Resident Assessment Instrument. Also, some provinces have established minimum residency periods as an eligibility condition for admission to a facility.

Spending on nonhospital institutions, of which the majority are long-term care facilities, accounted for just over 10 percent of total health expenditures in 2011, with financing mostly from public sources (71%) (Canadian Institute for Health Information, 2013).

A mix of private for-profit, private not-for-profit, and public facilities provide long-term care, with variation in ownership across the country. The increase in beds available since 2000 has been largely in the private for-profit sector (facilities that are contracted and partially funded by the provincial governments) (McGregor and Ronald, 2011). In 2008, over half of publicly funded long-term care beds were in for-profit facilities in Ontario, compared with 8 percent in Saskatchewan, 23 percent in Quebec, and 31 percent in British Columbia. In 2010, 22 percent to 27 percent of home and community care was paid through private sources (Hermus et al., 2012).

Public funding of home care comes either through provincial or territorial government contracts with an agency to deliver services (e.g., the Community Care Access Centres, in Ontario) or through government stipends to patients to purchase their own services (e.g., the “Choice in Support for Independent Living” program in British Columbia).

Provinces and territories are responsible for delivering palliative and end-of-life care in hospitals, and the majority of costs occur in institutions, but many provide some coverage for services outside those settings, such as doctors, nurses, and drug coverage in hospices, nursing facilities, and the home.

The majority of care for the elderly (estimated to be between 66 percent and 84 percent) is delivered by informal caregivers (Grignon and Bernier, 2012). Supports for informal caregivers vary by province and territory; in Ontario, for example, there is a Family Caregiver Leave Bill, which offers job protection to caregivers. There are some federal programs, including the Family Caregiver Tax Credit (up to CAD2,040 [USD1,650]) and the Employment Insurance Compassionate Care Benefit (Canada Revenue Agency, 2014; Government of Canada, 2014).



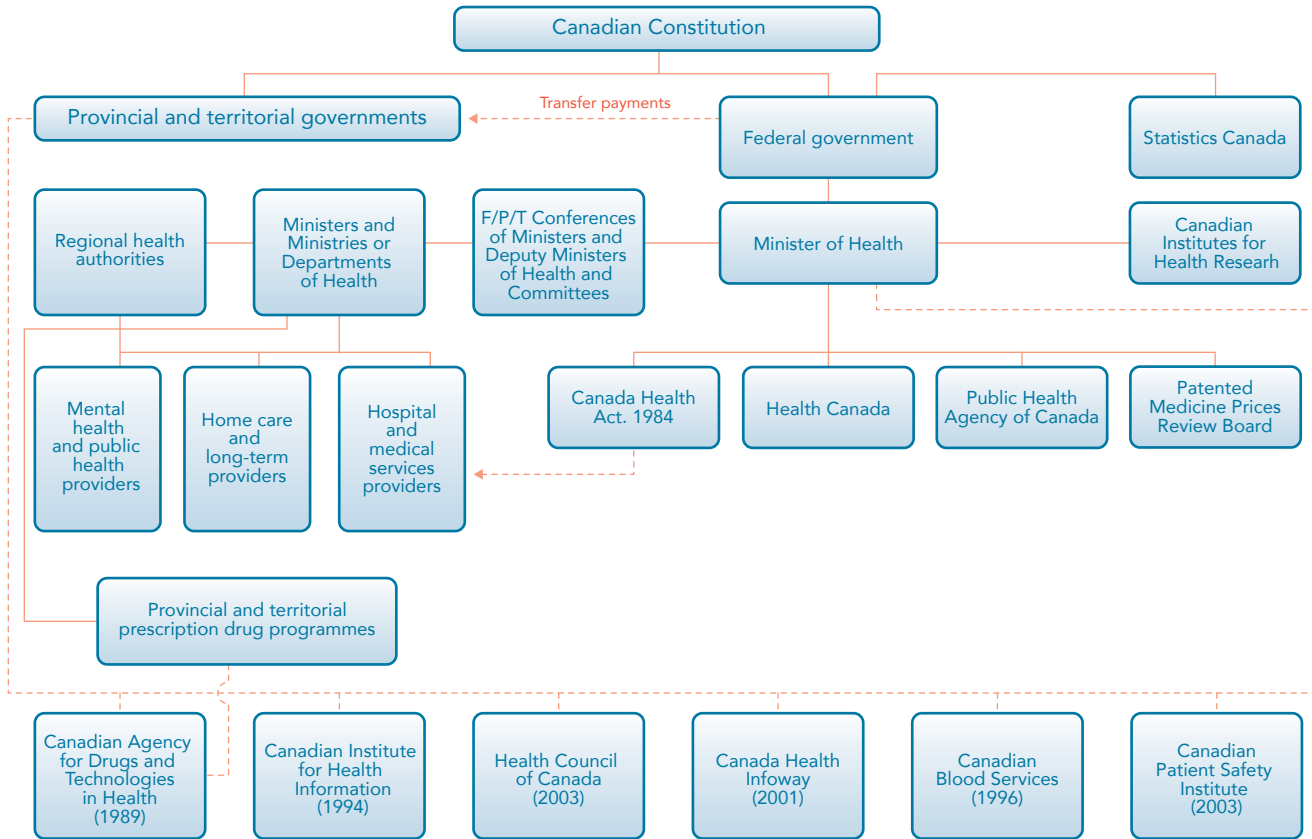
What are the key entities for health system governance?

Because of the high level of decentralization, provinces have primary jurisdiction over administration and governance of their health systems. Most have established statutory relationships with devolved purchasing organizations; some of these arrangements include performance management within the broader context of accountability agreements. The federal Ministry of Health, Health Canada, plays a role in promoting health, disease surveillance and control, food and drug safety, and the review of medical devices and technology. The Public Health Agency of Canada is responsible for public health, emergency preparedness and response, and infectious and chronic disease control and prevention.

At the national level, several intergovernmental nonprofit organizations (which included the Health Council of Canada, closed in 2014) aim to improve governance by monitoring and reporting on health system performance; disseminating best practice in patient safety (the Canadian Patient Safety Institute); providing information to the public on health and health care and standardizing health data collection (the Canadian Institute for Health Information); and providing funding and support for provincial health information systems (Canada Health Infoway).

The Canadian Agency for Drugs and Technologies in Health oversees the national health technology assessment process, which produces information about the clinical effectiveness, cost-effectiveness, and broader impact of drugs, medical technologies, and health systems. There is increasing use of health

Organization of the Health System in Canada



Note: Solid lines represent direct relationships of accountability while dotted lines indicate more indirect or arm's length relationships.

Source: Adapted from G. P. Marchildon, "Canada: Health System Review," *Health Systems in Transition*, vol. 15, no. 1, 2013, p. 22.

technology assessment to support and inform purchasing decisions, service management, and clinical practice. The Agency's Common Drug Review reviews the clinical effectiveness and cost-effectiveness of drugs, and provides common formulary recommendations to the publicly funded provincial drug plans (except in Quebec). These nonbinding recommendations support greater consistency of public drug plan access and evidence-based resource allocation.

Nongovernmental organizations with important roles in system governance include professional organizations (e.g., the Canadian Medical Association), provincial regulatory colleges, which are responsible for licensing professions and developing and enforcing standards of practice, and Accreditation Canada (see next section). Most providers are self-governing under provincial and territorial law; they are registered with professional associations that ensure that education, training, and quality-of-care standards are met. The professional associations for physicians (e.g., the Ontario Medication Association) are responsible for negotiating physician fee schedules with the provincial ministries of health.

Additionally, most provinces have an ombudsperson providing patient advocacy.



What are the major strategies to ensure quality of care?

As part of the latest 10-Year Plan to Strengthen Health Care (2004–2014), the federal government has increasingly earmarked some of the funds it provides to the provinces and territories for supporting innovation and stimulating systemwide improvements in quality. For example, the federal Wait Time Reduction Fund

(CAD5.5 billion [USD4.5 billion] over 10 years) led to significant, though mostly short-term, reductions in surgical and diagnostic wait times in its priority areas (cancer care, cardiac care, sight restoration, joint replacement, and imaging) (Canadian Institute for Health Information, 2014). All provinces publicly report waiting-time data and provide the Canadian Institute for Health Information with comparable data; however, the waiting time between a patient receiving a referral and the subsequent visit with a specialist is not yet measured systematically.

Some provinces also have agencies responsible for producing health care system reports and for monitoring system performance, and many quality improvement initiatives take place at the provincial and territorial level. Examples include the Saskatchewan Health Quality Council, Health Quality Ontario, the British Columbia Patient Safety & Quality Council, and the New Brunswick Health Council.

The federally funded Canadian Patient Safety Institute promotes best practices and develops strategies, standards, and tools. The Optimal Use Projects program, operated by the Canadian Agency for Drugs and Technologies in Health, provides recommendations (though not formal clinical guidelines) to providers and consumers in order to encourage the appropriate prescribing, purchasing, and use of medications. The Canadian Institute for Health Information produces regular reports on health system performance. There is no system of professional revalidation for physicians in Canada, but each province has its own process of ensuring that physicians engage in lifelong learning, such as a requirement that they participate in a continuing education program, and peer review. There is no information available on doctors' performance.

There is no public hospital accreditation organization in Canada; however, Accreditation Canada—a not-for-profit organization—provides voluntary accreditation services to about 1,200 health care organizations across Canada, including regional health authorities, hospitals, long-term care facilities, and community organizations. Few formal disease registries exist, although many provincial cancer care systems maintain some type of patient registry. Provincial cancer registries feed data to the Canadian Cancer Registry, a national administrative survey that collects incidence data. There is no national patient survey, although a standardized acute-care hospital inpatient survey developed by the Canadian Institute for Health Information has been implemented in several provinces.



What is being done to reduce disparities?

Health disparities are a significant issue in health policy, as some demographic groups suffer from a higher burden of illness than others. Poor people, homeless people, and the approximately 1 million Canadian aboriginals face, on average, poorer housing conditions, fewer educational and employment opportunities, and a significantly higher burden of illness than the general population. There is no single body responsible for addressing health disparities, but several provincial or territorial governments have departments and agencies devoted to addressing population health and health inequities.

Aboriginal health is a priority for both the federal and provincial and territorial governments; recent federal initiatives include the Aboriginal Diabetes Initiative, the National Aboriginal Youth Suicide Prevention Strategy, and the Maternal Child Health Program. Recent federal budgets have aimed at improving health and living conditions of First Nations, and at supporting local efforts to tackle homelessness. The Public Health Agency of Canada includes in its mandate reporting on health disparities. Also, the Canadian Institute for Health Information hosts the Canadian Population Health Initiative, established to examine population health patterns and help inform policies to reduce inequities and improve health.



What is being done to promote delivery system integration and care coordination?

Provinces and territories have introduced several initiatives to improve integration and coordination of care for chronically ill patients with complex needs. In 2004, as part of the 10-Year Plan to Strengthen Health Care, all provincial and territorial governments agreed to provide at least half of their respective populations with access to multidisciplinary primary care teams by 2011. By 2007, about three-quarters of family physicians were working in physician-led, multiprofessional practices (Marchildon, 2013). Other initiatives that aim to better

integrate care and improve coordination include Divisions of Family Practice (British Columbia), the Regulated Health Professions Network (Nova Scotia), and Health Links (Ontario) (see below, “What major innovations and reforms have been introduced?”). Also, Ontario has alternative primary care models that are community-based and multidisciplinary, and serve primarily vulnerable populations; these include Community Health Centres and Aboriginal Health Access Centres.

There are significant financial incentives to participate in these multiprofessional practices, and many programs include incentive payments for physicians aimed at improving systematic disease management (see above, “Primary care”). In Ontario, for example, with the shift from fee-for-service to blended capitation funding models, there was a 58 percent increase (inflation-adjusted) in payments to physicians in the five-year period between 2003–04 and 2008–09 (Henry et al., 2012).



What is the status of electronic health records?

Uptake of health information technologies has been slowly increasing in recent years. The 2012 Commonwealth Fund International Survey of Primary Care Doctors showed that 57 percent of primary care physicians used computerized patient charts, with a range of 26 percent to 74 percent across the provinces (Health Council of Canada, 2013). Provinces and territories are responsible for developing their electronic health information systems, with support from Canada Health Infoway; however, there is no national strategy for implementing electronic health records and there is no national patient identifier. Six electronic data collection categories have been identified as requisites of an electronic health record: client demographics, provider demographics, diagnostic images, dispensed drugs, laboratory test results, and clinical reports on immunizations. According to Canada Health Infoway, provinces have systems for collecting these data in place for the majority of their populations (Canada Health Infoway, 2014); however, interoperability is limited (Ogilvie and Eggleton, 2012), and no data are available on the extent to which interoperability has been achieved. Patient access to personal medical records has not been standardized and varies across jurisdictions and systems.



How are costs contained?

Costs are controlled principally through single-payer purchasing power, and increases in real spending mainly reflect government investment decisions and/or budgetary overruns. Cost control measures include mandatory global budgets for hospitals and regional health authorities, negotiated fee schedules for providers, drug formularies, and resource restrictions vis-à-vis physicians and nurses. The national health technology assessment process is one of the mechanisms for containing the costs of new technologies (see above, “What are the key entities for health system governance?”).

The federal Patented Medicine Prices Review Board, an independent, quasijudicial body, regulates the introductory prices of new patented medications. This process ensures that prices are not “excessive,” on the basis of their “degree of innovation” and through a comparison with prices of existing medicines in Canada and in seven other countries including the United States and the United Kingdom. The Board regulates “factory gate” prices but does not have jurisdiction over wholesale or pharmacy prices, or over pharmacists’ professional fees. However, prices of all patented drugs are reviewed regularly, and the Board can intervene if price increases are deemed excessive. Since 2010, the Pan-Canadian Pricing Alliance also coordinates, across provinces, negotiations to reduce the prices of branded drugs. Jurisdiction over prices of generics and control over pricing and purchasing under public drug plans (and, in some cases, pricing under private plans) is held by provinces, leading to some interprovincial variation.

Cost-sharing has been used to a limited extent as a tool to contain costs. For instance, in Ontario the government introduced cost-sharing in 1996 in its universal program that covers the population aged 65 and older, and in 2014 introduced an additional income-scaled deductible for high-income seniors.



What major innovations and reforms have been introduced?

Canada: Since April 2014, federal funding, through the Canada Health Transfer, is being distributed to provinces on a purely per-capita basis, ending previous compensations for variations in tax bases that benefited the less wealthy provinces. The objective was to improve equity, although the reform has been criticized on the grounds that it reduces funding to less populated provinces with older populations and higher costs (Marchildon and Mou, 2013).

There have been efforts across provinces to reduce the prices of generic drugs. Several provinces have significantly reduced prices in recent years; in Ontario, in 2010, the price ceiling was lowered to 25 percent of the price of the equivalent brand-name drug, and British Columbia lowered its price ceiling to 20 percent in 2014. In addition, in 2013 all provinces and territories but Quebec initiated bulk purchasing of six of the highest-selling generic drugs, and increased it to 10 in 2014.

Primary care reform has been under way across provinces since 2000, when the federal government invested CAD800 million (USD647 million) over six years through the Primary Care Transition Fund. Each province continues to reform its primary care systems, including provider payment methods, and to incentivize movement from solo to team-based practice, chronic disease management, and coordination of care with other health care providers (Hutchison et al., 2011; Sweetman and Buckley, 2014) (see above, “Primary care” and “Delivery system integration and care coordination”).

Alberta: In 2010, Alberta began implementing patient-based funding for long-term care to increase cost-efficiency and provide incentives to improve quality. It will be phased in by 2016–2017, and is designed to share funding among providers based on the expected utilization of each long-term care resident. Case mix is determined using the resident assessment instrument. However, there are concerns about how prepared providers are for this reform, and there have been some implementation challenges (Sutherland et al., 2013b).

In 2012, Alberta Health Services created new structures called Strategic Clinical Networks (Alberta Health Services, 2014), which are multidisciplinary groups tasked with designing and recommending improvements to health care delivery across the province. Members include health care professionals, researchers, and patients and their family members. The Strategic Clinical Networks were created to address issues regarding addiction and mental health, cancer, and seniors’ health, among others.

Ontario: In 2012, Ontario published a new health strategy that included several reform initiatives aimed at improving efficiency and quality of care, among other things (Government of Ontario, 2012). As part of the strategy, a funding reform shifts funding of hospitals and other health care organizations away from global budgets toward a mix of capitation and activity-based payments. The stated objective is to improve efficiency and “patient-centered care” by tying funding more directly to delivered services and population needs. Implementation occurs over four years, with the target that global budgets account for 30 percent of total hospital funding by 2015–2016, with the remainder coming from new types of payments—40 percent from a prospective population-based model (called the Health-Based Allocation Model) and 30 percent from activity-based payments for a selection of procedures (e.g., joint replacements).

Also as part of the strategy, to improve integration, Ontario’s government announced the creation of “Health Links,” which aim to improve the coordination of care for the small proportion of the population that consumes a disproportionately high share of health care resources, by giving joint responsibility to organizations across multiple sectors. The objective is to improve efficiency by reducing unnecessary hospitalizations and readmissions, emergency department visits, and wait times for specialists, and to improve the patient experience. Lead organizations have been assigned to pull together these partners, on a voluntary basis, to help coordinate care in a given geographic location. In 2014, there were 47 Health Links, with more planned. Implementation is at the regional (Local Health Integration Network) level. In the Toronto Central Local Health Integration Network there were four Health Links in 2012–2013, with plans for a total of nine to be fully implemented by 2015 (Toronto Central LHIN, 2013).

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The Danish Health Care System, 2014

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What is the role of government?

The underlying principle of Danish health care is to provide universal access for all citizens, inscribed in the “Health Law” as the obligation to promote population health, and prevent and treat illness, suffering, and functional limitations for individuals. Core principles of the law include easy and equal access, high quality, integration of services, choice, transparency, access to information, and short waiting times. The law establishes the obligation for regions and municipalities in delivering health services.

The national government sets the regulatory framework of health services, and is in charge of general planning and supervision. Five administrative regions governed by democratically elected councils are mainly responsible for planning and delivery of specialized services, but also have tasks related to specialized social care and coordinating business.

Regions own, manage, and finance hospitals and the majority of services delivered by general practitioners, office-based specialists, physiotherapists, dentists, and pharmacists. Municipalities are responsible for financing and delivering nursing home care, home nurses, health visitors, municipal dentistry (children’s dentists and home dental services for physically and/or mentally disabled people), school health services, home help, and the treatment of drug and alcohol abuse. The municipalities are also responsible for general prevention and rehabilitation tasks, while regions provide specialized rehabilitation.



Who is covered?

Coverage is universal. All registered as residents are automatically entitled to publicly financed health care that is largely free at the point of use. In principle, undocumented immigrants or visitors (estimated to number below 2,000) are not covered, but a national voluntary and privately funded initiative by Danish doctors provides access to health care for that population; the Doctors’ Association, the Danish Red Cross, and Danish Refugee Aid also support participating clinics.

Complementary private voluntary health insurance, provided by a not-for-profit organization, “Danmark,” covers cost-sharing for pharmaceuticals, dental care, physiotherapy, and corrective lenses. Almost 40 percent of the population is covered by this type of insurance. Various supplementary voluntary health insurance plans, offered typically as a fringe benefit, provide access to private treatment facilities and lump sums in case of critical illness. This type of insurance is held mostly by persons employed in the private sector through employment contracts, although some public sector employees are also covered. Persons outside the job market—students, pensioners, the unemployed—are generally not covered.



What is covered?

Services: The publicly financed health system covers all primary, specialist, hospital, preventive, mental health, and long-term care. Dental services are fully covered for children under 18. There is subsidized coverage of outpatient prescription drugs, adult dental care, physiotherapy, home care, and optometry services as described below. Temporary home care is not covered, but permanent home care coverage provided by the municipalities is need-based (and not means-tested). Municipalities are obliged to organize markets for home care services, and patients may choose between public or private providers. In practice, it has been difficult to attract private

providers to some remote municipalities, while that “market” functions relatively well in other municipalities; a considerable number of the elderly choose private providers.

Decisions about service level and the introduction of new medical treatments are made by the regions, within a framework of national legislation, agreements, guidelines, and standards. Municipalities decide on the service level for most other welfare services including social care, care for older people, prevention, and some rehabilitation. There is no defined benefits package, but very few restrictions exist for treatments that are evidence-based and clinically proven.

Cost-sharing and out-of-pocket spending: There is no cost-sharing for hospital and primary care services. Cost-sharing is applied to dental care for those age 18 and older (coinsurance of 35% to 60% of total cost), outpatient prescriptions, and corrective lenses. Out-of-pocket payments represented 12.4 percent of total health expenditures; expenditure for outpatient drugs, corrective lenses and hearing aids, and doctor and dentist treatments accounted for 4.2 percent, 2.4 percent, and 6.0 percent, respectively. An individual’s annual outpatient drug expenditure is reimbursed at the following levels: below DKK865 (about USD112*), no reimbursement (60% reimbursement for minors); DKK865–1,410 (USD112–182), 50 percent reimbursement (60% reimbursement for minors); DKK1,410–DKK3,045 (USD182–394), 75 percent reimbursement; above DKK3,045 (USD394), 85 percent reimbursement (Mutual Information System on Social Protection, 2011). Private specialists, hospitals, and dentists are free to set their own fees for private patients, who often pay out-of-pocket for minor interventions but are usually covered through voluntary health insurance for major (inpatient) interventions (OECD, 2014).

Safety net: There are cost-sharing caps for children, and municipalities provide means-tested social assistance to older persons (85% of all prescription drug costs are covered if personal wealth is DKK77,500 [USD10,020] or below). Chronically ill people with high prescription drug usage and costs can apply for full drug expenditure reimbursement above an annual out-of-pocket ceiling of DKK3,775 (USD488). The terminally ill can also apply for full coverage of prescriptions. Municipalities may grant financial assistance to persons certified as otherwise unable to pay for needed medicine.



How is the health system financed?

Publicly financed health care: Public expenditure accounted for around 85.8 percent of total health expenditure in 2011 (OECD, 2014). Total health expenditure was 11 percent of GDP in 2012 (USD4,698 per capita at PPP) (OECD, 2014). However, these comparative figures should be interpreted with caution as the Danish reporting practices in the grey zone of long-term care tend to include more activities than in many other Organization for Economic Cooperation and Development countries (Søgaard, 2014).

Health care is financed mainly through a centrally collected “health tax” set at 8 percent of taxable income. Central government reallocates tax income to the regions and municipalities, mostly as block grants based on a formula accounting for demographic and social differences between municipalities and regions (a sort of risk-adjusted capitation formula) which finances around 77 percent of regional activities. A minor portion of state funding for regional and municipal activities is activity-based or tied to specific priority areas, which are often defined in the annual “economic agreements” between the national government and the municipalities/regions (approximately three). The remaining 20 percent of financing for regional activities comes from municipal activity-based payment to the regions. The municipalities finance this out of their general budgets, raised in turn through a combination of local taxes and block grants.

Privately financed health care: The share of private expenditure for health care was 14.2 percent in 2012 (OECD, 2014). Complementary voluntary insurance, purchased on an individual basis and covering the costs of statutory copayments (mainly for pharmaceuticals and dental care) and services not fully covered by the state (e.g., some physiotherapy), is provided almost exclusively by the not-for-profit organization Danmark.

* Please note that throughout this profile, all figures in USD were converted from DKK at a rate of about DKK7.73 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for Denmark.

The past decade has seen rapid growth in supplementary insurance coverage offering access to private providers; the number of insured rose from 130,000 in 2002 to almost 1 million in 2008. Policies are purchased mostly from among seven for-profit insurers on a group basis and are provided through employers as a fringe benefit. A further 2.2 million policies provide a lump sum in case of critical illness. One goal of the liberal-conservative government (2002–2011) was to facilitate a stronger role for private actors in health care, for example, by exempting supplementary insurance provided by employers from taxation. Interestingly, this type of voluntary health insurance has declined only slightly since removal of the tax exemption in 2011.



How is the delivery system organized and financed?

Primary care: All general practitioners (GPs) are self-employed and are paid by the regions via a combination of capitation (about 30% of their income) and fee-for-service (the remaining 70%). Rates are generally set through national agreements with the doctors associations. The fee-for-service system provides some limited financial incentives used as a tool to prioritize services. General national fees are paid per consultation, e-consultation, and home visit, among other services. Specific national fees are paid for services such as blood tests, wounds, minor surgery, and diagnostic tests. Each region may enter agreements with their GPs for further specific tasks; for example, specific coordination functions, participation in meetings, and services to specific institutions.

The practice structure is gradually shifting from solo to group practice; more and more practices operate in teams consisting of several GPs, nursing, and support staff. The number of nurses employed in general practice has increased in the past decade. They are paid by the practice and have gradually taken over some tasks such as blood sampling and vaccination. Colocation is also on the rise, with municipal services, physiotherapists, GPs, and office-based specialists operating from the same facilities but with separate management.

Registration with a GP is required for anyone who chooses Group 1 coverage option (98% of the population), under which GPs act as gatekeepers for secondary care. People can register with any available local GP. The alternative is Group 2 coverage, which provides free choice of GP and access to practicing specialists without a referral but requires a copayment. Under both groups, access to hospitals requires a referral.

Outpatient specialist care: Outpatient specialist care is delivered through hospital-based ambulatory clinics (fully integrated and funded, as other public hospital services) or by self-employed specialists in privately owned facilities. Private self-employed practices can be full-time or part-time. Full-time practices are not allowed to have other full-time jobs. Part-time practices also may work in the hospital sector, but their activity level is monitored by the regions and they are subject to “codes of conduct.” The regions also limit the incomes of part-time practices. Practices may be colocated, but normally do not operate in formal multispecialty groups.

Services from self-employed private providers are paid by the regions on a fee-for-service basis for referred public patients. Fees are set through negotiations with the regions and are based on regional priorities and resource assessments. Private specialists also receive patients paying out-of-pocket or through voluntary insurance based on individual or contract-based fee-for-service rates. Finally, private practitioners may receive patients referred because of the legislation on patients’ rights to diagnostic assessment within 30 days in the public sector and paid through specific agreements with the regions.

Patients have a choice of private outpatient specialists on referral (group 1) or without referral (group 2).

Administrative mechanisms for paying primary care doctors and specialists: There is no out-of-pocket payment for medical services for patients in group 1. Primary care doctors and specialists are paid by the regions when registering service provided in their e-health systems. Group 2 patients pay a copayment out of pocket to supplement the automatic payment for services registered in their e-health systems (Strandberg-Larsen et al., 2007).

After-hours care: Regions are required to organize after-hours care. In most regions this is done by agreement with general practitioners (GPs) on a collective basis, while the Copenhagen region has employed staff, including specialized nurses who do the initial screening of calls. GPs can volunteer to take on more or less

responsibility within this scheme, and receive a higher rate of payment for after-hours than for normal care. Capitation does not apply for after-hours care, since it is voluntary and patients are not enlisted with particular after-hours doctors. The first line of contact is a regional phone service, with a GP (or a nurse in the Copenhagen region) deciding whether to refer the patient for a home visit or to an after-hours clinic, which is usually colocated with hospital emergency departments. Home visits are carried out for acute cases and for patients who are not mobile. Information on patient visits is sent routinely to GPs.

Hospitals: Approximately 97 percent of hospital beds are publicly owned. Regions decide on budgeting mechanisms and generally use a combination of fixed-budget and activity-based funding based on diagnosis-related groups where the fixed budget makes up the bulk of the funding, although with significant variations across specialties, hospitals, and over time. Activity-based funding is usually combined with target levels of activity and declining rates to control expenditure. This strategy has succeeded in increasing activity and productivity by an average of 5 percent annually from 2009 to 2011 and 1.4 percent from 2011 to 2012. Bundled payments are considered, but are not yet used extensively. Hospital physicians are salaried and employed by the regions. Health care professionals in hospitals and in most municipal health services are paid a salary. Patients can choose among public hospitals on referral, and payment follows the patient to the receiving hospital if the hospital is located in another region. New legislation on patients' rights to diagnostic assessment for patients referred by a general practitioner to a public hospital came into force in 2013 (see section on reforms). Physicians at public hospitals are not allowed to see private patients within the hospital.

Mental health care: There is no cost-sharing for inpatient psychiatric care, which is organized regionally as part of the hospital system and funded by diagnosis-related groups, but there is some cost-sharing (which may be covered by voluntary health insurance) for psychologists in private practice. Some general practitioners offer specific therapeutic consultations, but their main role in mental health care is early detection and referral.

Social psychiatry and care are a responsibility of the municipalities, which can choose to contract with a combination of private and public service providers, but most are public and work on a salary basis. A right to diagnostic assessment for psychiatry within two months of referral was introduced in 2014. This period will be shortened to one month from September 1, 2015. This is followed by a right to treatment within two months for less serious conditions and one month for more serious conditions.

Long-term care and social supports: Responsibility for chronic care is shared between regional hospitals, general practitioners, and municipal institutional and home-based services. Hospital-based ambulatory chronic care is financed in the same way as other hospital services. Long-term care outside of hospitals is need-based, and is organized and funded by the municipalities. Most municipal long-term care takes place in citizens' own homes, while the role of institutionalized care, such as nursing homes, has been reduced over the past decades in conscious policy efforts to support citizens in "staying home" as long as possible. Home nursing (*hjemmesygepleje*) is fully funded after medical referral. Permanent home care (*hjemmehjælp*) is free of charge, while temporary home care can qualify for cost-sharing if income is above DKK138,600 (USD17,919) for singles and DKK208,200 (USD26,917) for couples. Municipalities are obliged to organize markets with open access for both public and private providers of home care, in order to accommodate choice of home care services. Some municipalities also have contracted with private institutions for institutional care of older people, but more than 90 percent of residential care institutions (nursing homes) remain public. Providers are paid directly from municipalities and no cash benefits are paid to patients. Public providers are employed by the municipalities. Citizens pay 10 percent of their income (20% of income above DKK145,600 [USD18,824]) plus heating and electricity charges for staying in residential care institutions.

Relatives of seriously ill persons may take paid leave of absence for up to nine months. The period can be split over time and between several relatives. A similar scheme exists for terminally ill patients that no longer receive treatment.

Hospices are organized by regions and funded by regions and municipalities, and may be public or private. There is free choice of hospice on referral.

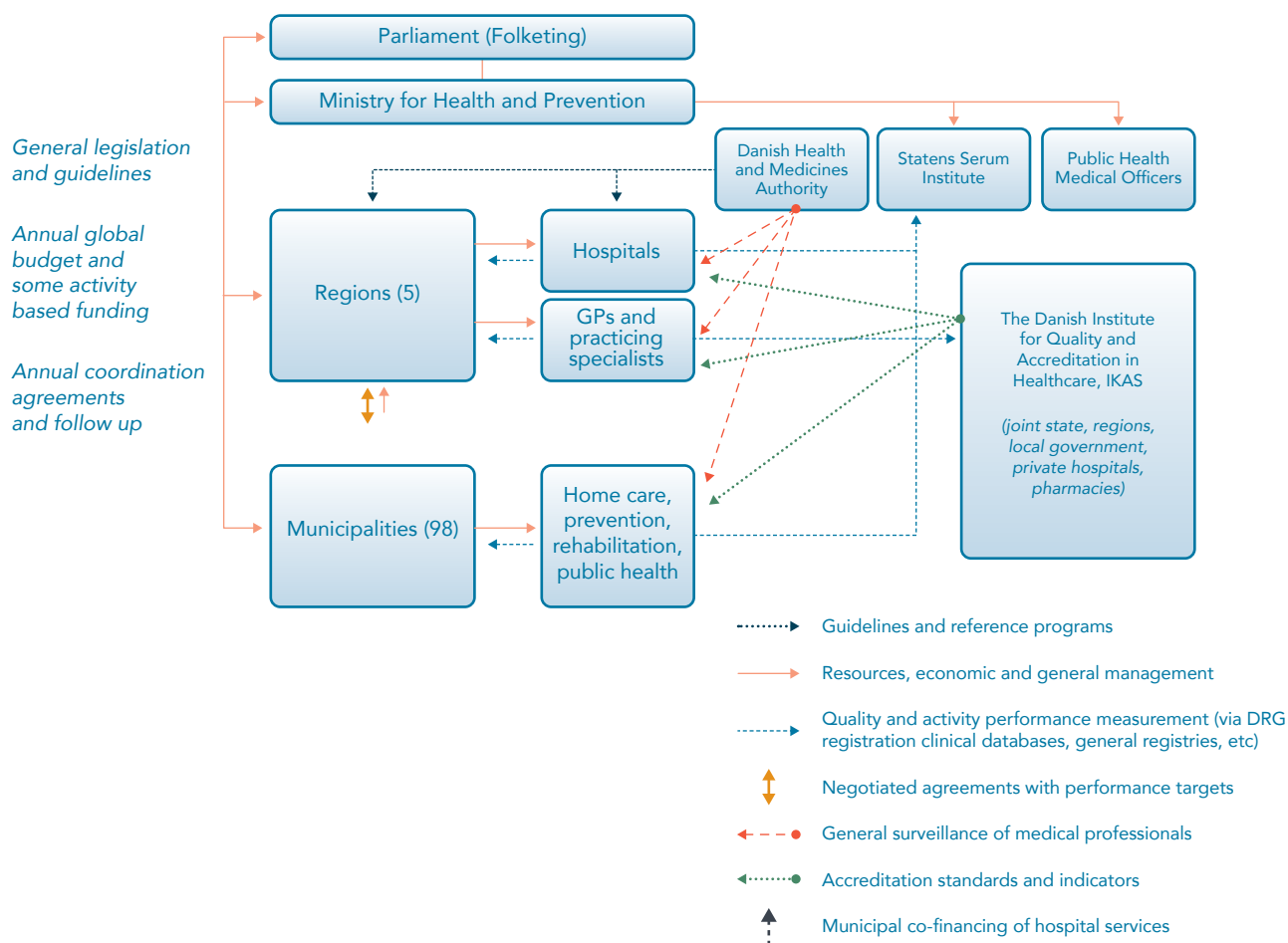


What are the key entities for health system governance?

General regulation, planning, and supervision of health services take place at the national level through the Ministry of Health and the Danish Health and Medicines Authority. This includes various cost control mechanisms, involving national and regional levels of government (refer to section on cost control). The Danish Health and Medicines Authority is responsible for general supervision of health personnel and undertakes important tasks in developing quality management in line with national clinical guidelines and standards for the national quality program. These activities usually take place in close collaboration with representatives from medical societies. The Danish Health and Medicines Authority also has important roles in planning the location of specialist services, approving regional hospital plans, and making mandatory “health agreements” between regions and municipalities to coordinate service delivery. Hospital productivity comparisons are published on a regular basis by the Authority, allowing regions and hospital managers to benchmark performance of individual hospital departments.

Regions are in charge of defining and running hospital services and supervising and paying general practitioners and specialists. Municipalities have important roles with regard to prevention, health promotion, and long-term care. Rates for general practitioners and practicing specialists are set through national agreements. The doctors associations negotiate with a collective body of the regions, also including state representatives. Regions may enter additional regional agreements for specific services.

Organization of the Health System in Denmark



Source: K. Vrangbaek, University of Copenhagen, 2014.

Diagnosis-related group rates for hospital services are calculated nationally by the Danish Health and Medicines Agency based on average cost estimates. They are used for cross-regional payments, while regions apply different payment and incentive schemes internally for their hospitals (see below about cost control).

A national website (sundhed.dk) supports patient choice (see below). Organized patient groups engage with policymaking at national, regional, and municipal levels. A patient ombudsman handles patient complaints and compensation claims. The ombudsman also collects information for systematic learning about errors and mistakes and provides information about treatment abroad.

The regions do systematic benchmarking amongst themselves. Specific benchmarking results are published online and include:

- Regional administration expenditure;
- Regional expenditure for support functions (washing and cleaning);
- Handling and organization of free choice (of private providers); and
- Psychiatry, obesity operations, selected medical treatments, knee operations, shoulder operations, heat treatment, back operations (Danske Regioner, 2014c).



What are the major strategies to ensure quality of care?

The Danish Healthcare Quality Programme (DDKM), based on extensive accreditation standards, has been implemented in all hospitals and is in the process of being introduced in primary care and pharmacies (www.ikas.dk). DDKM is developed, planned, and managed by the Danish Institute for Quality and Accreditation in Healthcare (IKAS), a board that comprises representatives from the Danish Health and Medicines Authority, regions, and the Ministry of Health. The International Society for Quality in Healthcare in turn oversees both DDKM and IKAS. DDKM aims to include all providers, and applies both organizational and clinical standards. The core of the program is a system of accreditation based on annual self-assessment and external evaluation (every third year) by a professional body.

Quality data for a number of treatment areas are captured in clinical databases (registries) and published online. Patient experiences are collected through biannual national surveys and various local and regional surveys.

Standard treatment packages (patient pathway descriptions) have been established, with priorities that include targeting chronic diseases with prevention and follow-up interventions. By 2008, pathways for 34 cancers were finalized and implemented, covering almost all cancer patients. The Danish Health and Medicines Authority monitors the pathways and the speed at which patients are diagnosed and treated. DDKM standards enforce the use of pathway programs and national clinical guidelines, where available. A national unit within the Danish Health and Medicines Authority is gradually developing such guidelines for all major disease types. The regions develop more specific practice guidelines for hospitals and other organizations, based on general national recommendations. There are no explicit standardized sanctions or economic rewards tied to performance monitoring. Regions take action in case of poor results, and may fire hospital managers or introduce other measures to support quality improvement. The Danish Health and Medicines Authority may step in if entire regions fail to live up to standards.

One of the Danish Health and Medicines Authority's main responsibilities, supported by the regions, is patient safety. Health care staff members at all levels (including general practitioners and municipal health services staff) are obliged to report accidents and near-accidents to regional authorities, who evaluate incidents and send anonymized reports to the Danish Health and Medicines Authority. The information is published in an annual database, geared toward learning rather than sanctioning.



What is being done to reduce disparities?

A government-initiated report in 2011 on the determinants of health disparities led to the formulation of an action plan with initiatives including higher taxes on tobacco; targeted interventions to promote smoking cessation; prohibition of the sale of strong alcohol to young people; establishment of anti-alcohol policies in all educational institutions; further encouragement of municipal disease prevention activities (e.g., through increased municipal cofinancing of hospitals, creating economic incentives for municipalities to keep citizens healthy and out of hospitals); improved psychiatric care; and a mapping of health profiles in all municipalities, to be used as a tool for targeting municipal disease prevention and health promotion activities. The introduction of pathway descriptions (see above) is reported to have increased equity.



What is being done to promote delivery system integration and care coordination?

Current mandatory health agreements between municipalities and regions on coordination of care include a number of topics related to admission and discharge from hospitals, rehabilitation, prevention, psychiatric care, and IT support systems. Formal targets for progress must be included in the next generation of agreements to be finalized at the end of 2014. Agreements are formalized at least once per four-year election term for municipal and regional councils, generally take the form of shared standards for action in different parts of the patient journeys in the system, and must be approved by the Danish Health and Medicines Authority. They are partially supported by IT systems with information that is shared between the different caregivers. Performance of regions and municipalities in reaching the goals is measured by national indicators published online (www.esundhed.dk).

Regions and municipalities have implemented different organizational measures to promote care integration. Examples include the use of outreach teams from hospitals doing follow-up home visits after discharge; training programs for nursing and care staff; establishing municipal units located within hospitals to facilitate communication, particularly with regard to discharge; and the use of “general practitioner practice coordinators.” Many coordination initiatives are general but with a special emphasis on citizens with chronic care needs, multimorbidity, or frailty because of ageing or mental health conditions (Økonomi-og Indenrigsministeriet, 2013). The Danish municipalities are in charge of a range of services, including social care, elderly care, and employment services, and most municipalities are currently working on models for integrating these services better, whether through joint administration, shared resources, or formalized communication procedures.

More and more practices employ specialized nurses, and several municipalities and regions have provided financial support to set up multispecialty facilities, commonly called “health houses.” Models vary, but often include general practitioners (GPs), practicing specialists, physiotherapists, and others. GPs in medical homes are encouraged to function as coordinators of care for patients, and to develop a comprehensive view of their patients’ individual needs in terms of both prevention and care. This principle is commonly accepted, and is supported by the general national-level agreements between GPs and regions. GPs participate in various formal and informal network structures and are included in the health service agreements made between regions and municipalities to facilitate cooperation and improve patient pathways. All GPs access electronic information systems that provide discharge letters and are used for electronic referrals and prescriptions.



What is the status of electronic health records?

Information technology (IT) is used at all levels of the health system. The national strategy for use of IT in health care is supported by the National Agency for Health IT. Each region has developed its own electronic patient record system for hospitals, with adherence to national standards for compatibility. Danish general practitioners were ranked first in a 2008 report by the European Commission on the use of health IT. All citizens in Denmark have a unique personal ID, which is used for identification in all public registries, including health databases. A shared, e-based “medical card” with all information on a person’s prescriptions and use of drugs is being implemented (with some delays). General practitioners also have access to an online medical handbook with

updated information on diagnosis and treatment recommendations. Another initiative is the gradual implementation of clinical databases to monitor quality in primary care (DataFangst).

Sundhed.dk is a national IT portal, with differentiated access for health staff and the wider public, that provides general information on health and treatment options and access to individuals' own medical records and history. For professionals, the site serves as an entry to medical handbooks, scientific articles, treatment guidelines, hospital waiting times, and treatments offered. They also may use the system to view records and laboratory test results for their own patients. The portal also provides access to the available quality data for primary care clinics, all of which use IT for electronic records and communication with regions, hospitals, and pharmacies.



How are costs contained?

The overall framework for controlling health care expenditures is outlined in a "budget law," which sets budgets for regions and municipalities and specifies automatic sanctions if they are exceeded. These agreements are a cornerstone in the governance structure and have been instrumental in controlling expenditures and introducing new policy initiatives.

Regions are funded by a combination of block grants, activity-based payment, and municipal payment for hospitalization of citizens from within their municipality. Block grants are conditional on annual increases in productivity of 2 percent on the basis of diagnosis-related groups and are withheld if productivity demands are not met. Even though the activity-based portion is small it makes up regions' marginal income and has strong influence (Danske Regioner, 2014a). Furthermore, regions are under pressure to deliver good performance as they can be shut down if they do not deliver.

At the regional level, management tools to control hospital cost include a combination of global budgets and specific activity-related incentives (see section on hospitals).

Pharmaceutical expenditure at the hospital level is controlled through national guidelines and clinical monitoring combined with collective purchasing. Two specific units have been established to evaluate and coordinate the introduction of "expensive pharmaceutical products" (RADS) and "cancer medicine" (KRIS).

Policies to control outpatient pharmaceutical expenditure include generic substitution, prescribing guidelines, and assessment by regions of deviations in prescribing behavior. Pharmaceutical companies report to the Danish Health and Medicines Authority a monthly price list, and pharmacies are obliged to choose the cheapest alternative with the same active ingredient, unless a specific drug is prescribed. Patients may choose more expensive drugs but have to pay the difference.

Collective agreements with general practitioners and specialists include various types of clauses about rate reductions if overall expenditures exceed given levels. Regions also monitor the activity level of individual practices and may intervene, if they deviate significantly from the average.

Health technology assessment and cost-effectiveness information, produced nationally and regionally, is an integrated part of the decision-making process for new treatments and guidelines for professionals.

Regions may enter contracts with private providers to deliver diagnostic and curative procedures. This is commonly used as a buffer in relation to the guarantee for diagnostic procedures and the subsequent treatment guarantee. Prices for these services are negotiated between regions and private providers and can be below rates in the public sector.

All in all these measures have been relatively successful in controlling expenditures and driving up activity levels. The result has been general productivity increases in the hospital sector of close to 20 percent from 2008 to 2012 while maintaining high patient satisfaction and also reducing hospital standardized mortality rates (Danske Regioner, 2014b, 2014c).



What major innovations and reforms have been introduced?

A major reform of the administrative and political landscape in Denmark was introduced in 2007, with the objective of centralizing and modernizing the hospital sector while increasing the role for municipalities in providing health care close to homes and living environments of citizens. Many subsequent policy initiatives relate to this reform and present follow-up measures. Another main objective of the reform was to improve coordination across different levels of the public sector and policy areas; one immediate outcome was to merge 14 counties to create five regions and reduce the number of municipalities from 275 to 98.

Policy initiatives following the structural reform include a major reorganization of the hospital infrastructure. All five regions are in the process of closing or amalgamating small hospitals and building new hospitals at a total cost of DKK40B (USD5.2 billion). A central part of this process is the reorganization of acute care with stronger prehospital services and larger specialized emergency departments. The idea is to create better-quality emergency care by involving specialists and senior-level staff earlier in the acute care, and to reduce the number of unnecessary admissions to wards.

Another important follow-up has been the development of mandatory “health agreements” as key tools to improve coordination between municipalities and regions. The third generation of agreements are currently negotiated (2014) based on a national template that includes specific focus on coordinating procedures and resources in regards to prevention, admission, and discharge procedures, training and rehabilitation, health IT, and work processes.

A final set of key follow-up initiatives relate to municipal health services. All municipalities have introduced new forms of “temporary care units” to provide a better transition to and from hospitals and to prevent “unnecessary” admissions to regional hospitals. Many municipalities are also experimenting with establishing “health centers” with colocation of municipal, private, and regional health providers. At the same time municipalities are employing more nursing staff and public health specialists to provide more systematic population health services (Rigsrevisionen, 2013).

New legislation on patients’ rights to diagnostic assessment came into force in 2013 as a revision of the previous general waiting time guarantee of one month. By law, the diagnostic processes for patients referred by a general practitioner to a public hospital for examination must be finished within four weeks (including weekends and holidays) of the hospital’s reception of the referral. It is the responsibility of the region to find a hospital, public or private, to perform diagnostic processes. If it is not possible—for medical reasons—to establish a diagnosis within 30 days the public hospital must, within the time limit, provide the patient with a plan in writing for further diagnostic procedures, including where and when these procedures will be performed. After receiving a diagnosis a right to treatment enters into effect with time limits of two months for less serious conditions, and shorter for more serious conditions. A similar set of guarantees were introduced for psychiatric care in 2014.

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The English Health Care System, 2014

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What is the role of government?

Responsibility for health legislation and general policy rests with Parliament, the Secretary of State for Health, and the Department of Health.¹ Under the terms of the Health Act (2006) the Secretary of State has a legal duty to promote a comprehensive health service, providing services free of charge, except for charges already in place. Rights for those eligible for National Health Service (NHS) care are summarized in the NHS Constitution, and include access to care without discrimination and within certain time frames for some categories, such as emergency and planned hospital care (Department of Health, 2013b). Under the NHS Health and Social Care Act 2012, day-to-day responsibility for running the NHS has been handed over to a new governmental organization, the NHS Commissioning Board, subsequently renamed NHS England.

NHS England is responsible for managing the NHS budget, overseeing the 211 local Clinical Commissioning Groups, and ensuring that the objectives set out in a mandate by the Secretary of State for Health are met, including both efficiency and health goals. Budgets for public health are now held by local government authorities; the 2012 Act requires them to establish “health and wellbeing boards” to improve coordination of local services and reduce health disparities.



Who is covered?

Coverage is universal. All those “ordinarily resident” in England are automatically entitled to health care, largely free at the point of use, through the NHS. Nonresidents with a European Health Insurance Card are also entitled to free care. Only treatment in an emergency department and for certain infectious diseases is free to other people, such as non-European visitors or illegal immigrants (Department of Health, 2013a). Most private hospital care—largely for elective conditions—is financed through supplementary private voluntary health insurance, which covered 10.9 percent of the U.K. population in 2012. The bulk of this was provided through companies (3.97 million policies) versus individual policies (0.97 million) (Nuffield Trust, 2013).



What is covered?

Services: The precise scope of the NHS is not defined in statute or by legislation, and there is no absolute right for patients to receive a particular treatment. However, the statutory duty of the Secretary for Health is to take active steps to expand comprehensive coverage, in terms of both the number of people and the services or illnesses covered. In practice, the NHS provides or pays for: preventive services, including screening, immunization, and vaccination programs; inpatient and outpatient hospital care; physician services; inpatient and outpatient drugs; clinically necessary dental care; some eye care; mental health care, including some care for those with learning disabilities; palliative care; some long-term care; rehabilitation, including physiotherapy (e.g., after-stroke care); and home visits by community-based nurses.

The volume and scope of these services are generally a matter for local decision-making, but the NHS Constitution also states that patients have a right to drugs or treatment approved in technology appraisals carried out by the National Institute of Health and Clinical Excellence (NICE), where recommended by their clinician (Department of Health, 2013b). For other drugs or treatments that have not been appraised by NICE,

1 In cases where data for England are unavailable (e.g., financial or funding data), U.K. data are used instead.

since appraisals are time-consuming and generally focus on new treatments,¹ the NHS Constitution states that local clinical commissioning groups shall make rational, evidence-based decisions (Department of Health, 2013b). It is not known how individual clinical commissioning groups make decisions, but a study of procedures in predecessor organizations found considerable variations (Nuffield Trust, 2011). There is also evidence of wide variations in access to some treatments, for example in thresholds for access to surgical procedures such as hip replacements (Royal College of Surgeons in England, 2014).

Cost-sharing and out-of-pocket spending: There are limited cost-sharing arrangements for publicly covered services. Outpatient prescription drugs are subject to a copayment (currently GBP8.05 [about USD12.00] per prescription item in England); drugs prescribed in NHS hospitals are free. NHS dentistry services are subject to copayments of up to a maximum of GBP219 (USD315) per course of treatment.² These charges are set nationally by the Department of Health. Out-of-pocket expenditure on health (based on OECD data) accounted for 9 percent of total expenditure in the U.K. in 2012 (OECD, 2014a). In 2012, the largest proportion of out-of-pocket spending (53%) was on medical appliances and equipment, followed by about 30 percent on pharmaceuticals (Office for National Statistics, 2013).³

Safety net: The following people are exempt from prescription drug copayments: children under the age of 16 and those in full-time education ages 16–18; people age 60 or older; people with low income; pregnant women and those who have had a baby in the past 12 months; and people with cancer, certain other long-term conditions, and/or disabilities. Patients who need a large number of prescription drugs can buy prepayment certificates costing GBP29.10 (USD42.00) for a period of three months and GBP104 (USD150) for 12 months. Users incur no further charges for the duration of the certificate, regardless of how many prescriptions they need. In 2013, 90 percent of prescriptions in England were dispensed free of charge (Health and Social Care Information Centre, 2014a). Young people, students, pregnant and recently pregnant women, prisoners, and those with low incomes are not liable for dental copayments. Sight tests are free for young people, those over 60, and people with low incomes, and financial support is available to young people and those with low incomes to meet the cost of corrective lenses. Transportation costs to and from provider sites also are covered for people who qualify for the NHS Low Income Scheme.



How is the health system financed?

Publicly financed health care: In 2012, the U.K. spent about 9.3 percent of GDP on health care, of which public expenditure, mainly on the NHS, accounted for about 84 percent (OECD, 2014a). The majority of funding comes from general taxation, and a smaller proportion from national insurance (a payroll tax); in 2006–2007 (the latest year for which data are available in this form), 76 percent came from general taxation and 18 percent from national insurance (Boyle, 2011). The NHS also receives income from copayments, those using NHS services as private patients, and some other minor sources.

Privately financed health care: Most private expenditure is for over-the-counter drugs and other medical products (which together account for just over half of private spending) and private hospital care, including both insured and uninsured costs. Most private hospital care, largely for elective treatment, is financed through voluntary health insurance, which offers more rapid and convenient access to care. Routine data on the providers of private insurance are not freely available in the U.K. The Competition and Markets Authority, however, has published a review of the private health care market in 2014. According to the review, four insurers account for 87.5 percent of the private medical insurance market, with small providers making up the rest (Competition and Markets Authority 2014).

2 A total of 533 appraisals have been carried out between March 2000 and August 2014.

3 Throughout this profile, all figures in USD were converted from GBP at a rate of GBP0.70 per USD1.00, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014b).

4 Including consumer spending on drugs and medical products not covered by the NHS, such as glasses, dental treatment, and spending on hospital and outpatient care.



How is the delivery system organized and financed?

Primary care: Primary care is delivered mainly through general practitioners, who act as gatekeepers for secondary care. In 2013, there were 40,236 general practitioners in 7,962 practices, with an average of 7,034 patients per practice and 1,575 patients per GP. This compares with 41,220 hospital consultants (specialists) and a further 54,576 hospital doctors in training (Health and Social Care Information Service, 2014b, 2014c). The number of solo practices is currently 1,404, while there are now 3,537 practices with five or more general practitioners (Health and Social Care Information Service, 2014b). General practices are normally patients' first point of contact, and people are required to register with a local practice. In principle, patients are allowed to choose their practice, but in reality choice is limited because many practices have a full panel and do not accept new patients. In some areas, walk-in centers offer primary care services, for which registration is not required. Out-of-pocket payments for general practice are limited to services that fall outside the remit of the NHS, including medical examinations for employment or insurance purposes, and providing certificates for travel or insurance.

Most general practitioners (66%) are private contractors, and approximately 60 percent of practices operate under the nationally negotiated General Medical Services contracts. These provide payment using a mixture of capitation to cover essential services, optional fee-for-service payments for additional services (e.g., vaccines for at-risk populations and early diagnosis and support for dementia), and an optional performance-related scheme. Capitation is based on the number of registered patients, adjusted for age and gender, local levels of morbidity and mortality, the number of patients in nursing and residential homes, patient list turnover, and a market-forces factor for staff costs as compared with those of other practices. It is reviewed quarterly to account for changes in the practice's patient population. The performance bonuses (under the "Quality and Outcomes Framework") currently account for about one-quarter of income and mainly relate to evidence-based clinical interventions for illnesses such as diabetes, asthma, and other long-term conditions; some points are linked to the organization and to patient experience. The proportion of income from these bonuses will fall when the new 2014–2015 contract is implemented, as the number of bonus-related services is reduced and funding rerouted into capitation. The scope and content of the contract, additional services, and performance-related payments are negotiated between the British Medical Association (representing doctors) and government.

The proportion of general practitioners (around 20%) employed in practices or on a salaried basis as locums (e.g., standing in when other general practitioners are unavailable) is increasing. A few private providers of general practice services, who set their own fee-for-service rates, are believed to carry out fewer than 3 percent of consultations (Competition and Markets Authority, 2014). Most NHS general practices employ other professionals such as nurses (about 15,000 full-time-equivalents in 2013), who monitor patients for such things as blood pressure and provide minor treatments such as wound dressing. The structure of general practice is changing, away from the single-handed "corner shop" model toward a growing number of networked practices, including larger multipractice organizations or federations of practices. Many of these are characterized by multidisciplinary teams, which include specialists, pharmacists, and social workers (King's Fund and Nuffield Trust, 2013).

Outpatient specialist care: Nearly all specialists are salaried employees of NHS hospitals. They are free to engage in private practice within specially designated wards in NHS or in private hospitals; the most recent estimates (2006) were that 55 percent of doctors performed some private work and that the proportion was declining as the earnings gap between public and private practice was narrowing (GHK and Office of Fair Trading, 2011). For NHS-funded services, payments for outpatient consultations are made to hospitals by clinical commissioning groups at nationally determined rates. Patients are able to choose which hospital to visit, and government has introduced the right to choose a particular specialist within a hospital (not yet fully implemented). Most outpatient specialist consultations are carried out in hospitals, although consultation may take place in general practices. Some general practitioners, called general practitioners with specialist interests, also offer specialist consultations, paid on a per-session or fee-for-service basis.

Administrative mechanisms for paying primary care doctors and specialists: The bulk of general practices are reimbursed monthly for the services they deliver on the basis of data extracted automatically from practices'

electronic records. Some payments may require practices to enter data manually on the number of patients screened or treated for “enhanced services,” which qualify for additional payments, such as diagnosis and support for patients with dementia. These data are collated and validated by NHS England.

After-hours care: General practitioners are no longer required personally to provide after-hours care to their patients (a small minority still do), but are required to ensure that adequate arrangements for its provision are in place. In practice, this means that clinical commissioning groups contract mainly with general practitioner cooperatives and private companies, both of which usually pay general practitioners on a per-session basis. Serious emergencies are handled by hospital emergency departments. In some areas, less serious cases are seen in urgent care centers or minor-injury units, which are staffed in a variety of ways, and include nurse-led and general practitioner-led centers. Telephone advice is available on a 24-hour basis through NHS 111, a service introduced in 2013 to replace NHS Direct, for those with an urgent but not life-threatening condition. Details of the care provided by these services are usually sent to the patient’s general practice.

Hospitals: Publicly owned hospitals are organized either as NHS trusts directly accountable to the Department of Health (currently 102) or as foundation trusts (currently 147) regulated by Monitor, an economic regulator of public and private providers. Foundation trusts enjoy greater freedom from central control, have easier access to capital funding, and are able to accumulate surpluses or run (temporary) deficits. Government wants all hospitals (including those providing mental health and ambulance services) to become foundation trusts in the near future.

Both trusts and foundation trust hospitals contract with local commissioners to provide services and are reimbursed mainly at nationally determined diagnosis-related group rates, which include medical staff costs and account for about 60 percent of income. Responsibility for setting those rates is shared between NHS England and Monitor. In some areas, rates are not applied and payments are made for a whole service, such as emergency care. Also at the local level, fees for “years of care”—for example, for the total cost of the care a diabetic patient receives over 12 months—are being developed, but are not yet in widespread use. There is no cap on hospital incomes.

An estimated 548 private hospitals and between 500 and 600 clinics in the U.K. offer a full range of services, including treatments either unavailable in the NHS or subject to long waiting times (e.g., cosmetic and bariatric surgery and fertility treatment) (Competition and Markets Authority, 2014), but generally do not have emergency, trauma, or intensive-care facilities. Private providers must be registered with the Care Quality Commission and with Monitor, but their charges to private patients are not regulated and there are no public subsidies. Public funds have always been used to purchase some private hospital care, such as for mental health patients. Although this trend has increased recently—including for routine elective surgery and diagnostic services—NHS use of private hospital services remains low—3.6 percent of overall spending on hospital services by commissioners in 2012–2013 (Nuffield Trust, 2014a).

Mental health care: Mental health care is an integral part of the NHS, including a full range of services, with prescription drugs covered under the same terms as other NHS drugs. Less serious illnesses, including chronic conditions such as mild depressive and anxiety disorders, are usually dealt with by general practitioners, but those requiring more advanced treatment, including inpatient care, are treated by mental health or hospital trusts. Some of these services are provided by community-based staff. About a quarter of NHS-funded, hospital-based mental health services are provided by the private sector. Over the past decade, policy has focused on increasing access to psychological therapies for mild to moderate mental health problems, but there can still be long waiting times in some areas. There have also been policies to improve the care of more severe conditions in the community through outreach and early intervention, along with an overarching aim to ensure “parity of esteem” between mental health and other kinds of health services. A review conducted in 2012 suggested that, given the disease burden they represent, mental health services have been underfunded compared with those for physical illnesses (Centre for Economic Performance, 2012).

Long-term care and social supports: The NHS pays for some long-term care (e.g., for those with continuing medical or skilled nursing needs), but in recent years payments have been substantially reduced. Most

long-term care is provided by local authorities and the private sector. Local authorities are legally obliged to assess the needs of all people who request it, but, unlike NHS services, state-funded social care is not universal. With the exception of time-limited “reablement” services, some equipment and home modifications (in some areas), and information services, residential and home care are needs- and means-tested. Full state support for residential care, for example, is available only to those with less than GBP14,250 (USD20,500) in assets (including the value of their house, if they own one) who also have high levels of need, as assessed by their local council. A sliding scale applies to assets of up to GBP23,250 (USD33,500), with those above this limit paying for their care in full. There is a national framework for assessing need, but local councils are free to set the eligibility threshold for access to funds, which has become progressively tighter (Nuffield Trust, 2014b). Those eligible for state support are still liable for some copayments, for example contributing almost all of their “assessed income” including pensions; GBP24.40 (USD35.00) can be retained by users as a personal expense allowance. Beneficiaries can receive personal budgets to purchase their own care, but can also opt to have the local authority arrange it on their behalf. Some additional allowances paid to users and carers are exempt from means testing, such as “attendance allowance,” worth a maximum of GBP81.30 (USD117) a week.

An unknown number of people fund their own care; a minority of these are faced with substantial costs if needs are high but they also exceed the means threshold. The 2014 Care Act aims to limit individuals’ risk of catastrophic long-term care costs by imposing a cap on expenditure (set at GBP72,000, or USD104,000) starting in 2016, but needs-based eligibility criteria will still apply and are unlikely to become more generous (King’s Fund, 2014a).

Most long-term care, whether paid privately or publicly, is provided by the private sector. In 2009, the private sector provided 78 percent of residential care places for the elderly and physically handicapped in the U.K., with 8 percent and 14 percent provided by local authorities and the voluntary sector (Laing and Buisson, 2013). The NHS provides end-of-life palliative care at patients’ homes, in hospices (usually run by charitable organizations), in care homes, or in hospitals. Separate government funding is available for working-age people with disabilities in accordance with national eligibility criteria.



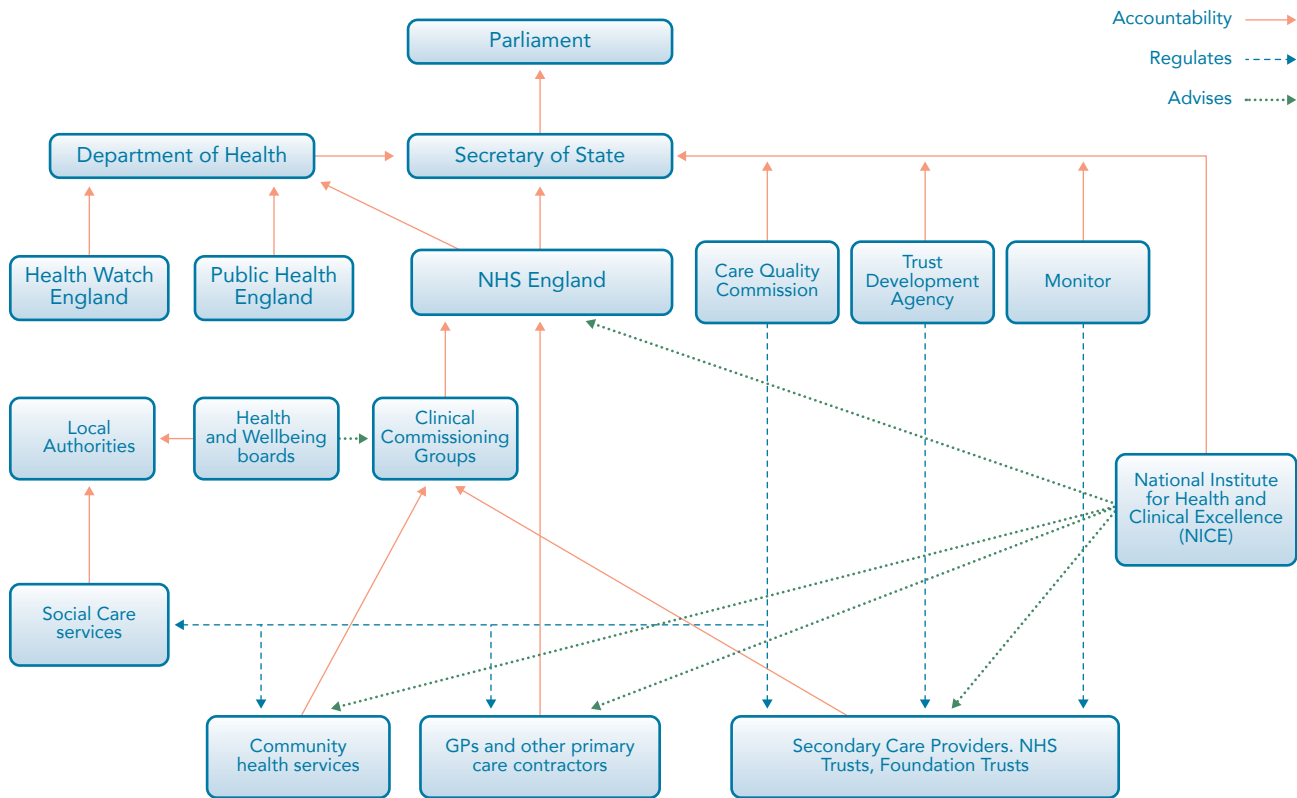
What are the key entities for health system governance?

The Department of Health and the Secretary of State for Health are ultimately responsible for the management of the health system as a whole. The Health and Social Care Act 2012 transferred important functions to the new NHS England, including overall budgetary control and, along with Monitor (described below), responsibility for setting diagnosis-related group rates for provision of NHS services. NHS England also commissions some specialized low-volume services such as pediatric heart surgery, national immunization and screening programs, and primary care services including general practice, dentistry, and pharmacy. The National Institute for Health and Clinical Excellence (NICE) sets guidelines on clinically effective treatments and appraises new health technologies for their efficacy and cost-effectiveness. The Care Quality Commission ensures basic standards of safety and quality through provider registration, and monitors care standards achieved (described further below). It can require closure of services if serious quality concerns are identified.

Monitor is responsible for authorizing NHS trusts to become foundation trusts and for monitoring their finances, with powers to intervene if performance deteriorates significantly. The 2012 Act extended Monitor’s role to being the economic regulator of public and private providers. It licenses all providers of NHS-funded care and may investigate potential breaches of NHS cooperation and competition rules (a form of antitrust code), as well as investigating mergers involving NHS foundation trusts. Where such mergers are found to be prima facie undesirable, they are referred to the two national competition authorities, the Office of Fair Trading and the Competition Commission.

In addition to its role in supervising clinical commissioning groups and the direct commissioning of specialist care, NHS England is responsible for setting the strategic direction of health information technology, including the development of online services to book appointments, the setting of quality standards for electronic medical record-keeping and prescribing, and the commissioning of the NHS IT infrastructure.

Organization of the Health System in England



Source: R. Thorlby and S. Arora, Nuffield Trust, 2014.

The 2012 Act established a new national body, Healthwatch England, to promote patient interests and to establish “Healthwatches” in each locality. The local Healthwatches support people who make complaints about services, and may report quality concerns to Healthwatch England, which can then recommend that the Care Quality Commission take action. In addition, local NHS bodies, including general practices, hospital trusts, and commissioning groups, are expected to support their own patient engagement groups and initiatives. The Department of Health owns NHS Choices, the primary website for public information about the location and quality of health services, health conditions, and other information, and offers a platform for user feedback. The website received 27 million visits a month in 2012–2013 (NHS Choices, 2013).



What are the major strategies to ensure quality of care?

The Care Quality Commission has responsibility for the regulation of all health and adult social care in England, including care provided by the NHS, local authorities, the private sector, and the voluntary sector. All providers, including institutions, individual partnerships, and sole practitioners, must be registered with the Care Quality Commission, which monitors performance using nationally set quality standards, and investigates individual providers when concerns have been raised (e.g., by patients). It can close down poorly performing services. The monitoring process includes results of national patient experience surveys conducted for inpatient, outpatient, and general practice services.

The National Institute for Health and Clinical Excellence develops quality standards covering the most common conditions occurring in primary, secondary, and social care. National strategies have been published for a range of conditions including cancer, trauma, and stroke. There are national registries for key disease groups and procedures, for example the National Cancer Registry and the National Joint Registry. Maximum waiting times

have been set for cancer treatment and elective treatments such as orthopedic procedures, and for emergency room treatment. A website, NHS Evidence, provides professionals and patients with up-to-date clinical guidelines. Support is also provided by NHS Quality Improvement, part of NHS England.

Information on the quality of services is published on NHS Choices, which provides information at the organization, department, and (for some procedures) physician levels. Results of inspections by the Care Quality Commission are also publicly accessible. The Quality and Outcomes Framework provides general practices with financial incentives to improve quality. General practices are awarded points (determining part of their remuneration) for keeping a disease register of patients with certain diseases or conditions, managing and treating patients with those conditions, and improving the health of affected patients by, for example, helping them to control their blood pressure or cholesterol levels. For hospitals, 2.5 percent of contract value is linked to the achievement of a limited number of quality goals through a scheme known as Commissioning for Quality and Innovation. In addition, diagnosis-related group rates for some procedures are linked to best practice.

The regime of inspections by the Care Quality Commission has been intensified since 2013, partly in response to failures in care at Mid Staffordshire NHS trust, and has been extended to social care and general practice. Hospitals are rated on inspection results. New “fundamental standards” for all health and social care have been developed and will come into force in 2015 (Department of Health, 2014a).

All doctors practicing in the U.K. are required by law to have a license to practice from the General Medical Council. Similar requirements apply to all professions working in the health sector. A process of revalidation every five years is being introduced for doctors.



What is being done to reduce disparities?

The 2012 Act places duties on the Secretary of State, NHS England, and clinical commissioning groups to “have regard” for the need to reduce health disparities, although this does not entail specific courses of action. Also, a new body, Public Health England, has been established to support the public health functions of local authorities, including that of reducing health disparities. As noted above, financing will be allocated directly to local authorities to pay for public health programs.



What is being done to promote delivery system integration and care coordination?

General practitioners (GPs) increasingly work in multipartner practices that employ nurses and other clinical staff, who carry out much of the routine monitoring of patients with long-term conditions. These practices also contain some of the features of a medical home—that is, they direct patients to specialists in hospitals or to community-based professionals like dietitians and community nurses and hold treatment records of their patients. GPs are responsible for care coordination as part of their overall contract; to improve coordination for older patients, the latest version of the contract (2014–2015) requires practices to have a “named accountable general practitioner” for all patients over 75. GPs also have financial incentives to provide continuous monitoring of patients with the most common chronic conditions, such as diabetes and heart disease.

The 2012 Act charged NHS England, Monitor, and clinical commissioning groups with promoting integrated care—closer links between hospital- and community-based health services, including primary and social care. The health and wellbeing boards within local authorities are intended to promote integration between NHS and local authority services, particularly at the interface between hospital and social care.

Government took additional action in 2013 to stimulate integration. It announced the selection of 14 “Pioneer” integration pilots, aimed at improving coordination of health and care service for patients most at risk of needing unplanned or emergency treatment where services are fragmented. The Better Care Fund provides a GBP3.8 billion (USD5.5 billion) budget, pooled from existing health and social care budgets, for integration projects by local health and social care commissioners starting in 2015–2016. Health and wellbeing boards have

submitted plans for these funds with a range of objectives, including a reduction in emergency hospital admissions by 3.5 percent (Local Government Association, 2013).



What is the status of electronic health records?

Every patient registered with the NHS receives an NHS number, serving as a unique identifier. Most general practice patient records are computerized. Some practices use electronic systems to allow patients to make appointments or e-mail their general practitioner, but there is no requirement for practices to have that capability. The current aim is for all hospitals to keep patient records in electronic form. However, hospital and general practice records are not integrated into a single system.

All NHS patients have the right to access their own health records (in some cases this is possible electronically), and can apply in writing to have a copy of their records held by their general practice, hospital, or dentist. Records are not routinely linked between providers. A previous project to introduce a record covering all providers had to be abandoned because of cost and contractor failures. The current government is introducing the Summary Care Record, which will store a limited range of data (current medication, adverse reactions, and allergies) for all patients except those who opt out. By 2013, nearly half the population of England had a Summary Care Record. Electronic transfers (from general practices to pharmacies) are widely used for prescriptions and for the storage and distribution of digital images (e.g., scans, X-rays). The Choose and Book system allows patients to choose online the hospital where they want to be treated. The national program leading these prior developments under the Department of Health has now been dismantled, so any new developments will be left to localities.

NHS England has been developing a program of data collection and linkage of electronic records for the purpose of planning and research in health and social care services. The program, known as care.data, will link patient data from general practice with that from hospitals and other care settings (NHS England, 2014). Full implementation has been delayed while concerns about confidentiality are resolved, but data collection from between 100 and 500 general practices is beginning as of autumn 2014 to test and evaluate the process.



How are costs contained?

NHS budgets are set at the national level, usually on a three-year cycle. The clinical commissioning groups are allocated funds by NHS England, which closely monitors their financial performance to avoid overspending. They are expected to achieve financial balance each year.

The current economic situation has resulted in a largely static NHS budget, but demand continues to rise. Government-funded health spending in England fell in 2010–2011 but has risen since then to a total of GBP105 billion (USD152 billion) in 2012–2013 (Department of Health, 2014b). The projected gap between anticipated funding and demand was quantified, in 2010, as about GBP20 billion (USD29 billion), requiring savings of that magnitude to be achieved over the four financial years up to 2014–2015 to cope with rising demand. A number of initiatives were put in place to help the NHS meet this target, including strict limits on pay increases, improvements to purchasing of NHS supplies, support for increased use of generic drugs, reductions in the diagnosis-related group payments for hospital activity, and measures to improve operational efficiency, including competition in both hospital- and community-based services. Although a proportion of the savings targets have been met and the quality of services has broadly held up over this period, there are signs of financial distress, with 65 hospital trusts in deficit in 2013–2014 (Nuffield Trust, 2014a) and indications of growing numbers of patients waiting for treatment in hospitals (King's Fund, 2014b).



What major innovations and reforms have been introduced?

The purchasing and regulatory structures of the NHS in England have been significantly reformed under the Health and Social Care Act 2012. The Act abolished 150 “primary care trusts” and replaced them with clinical

commissioning groups (of which there are currently 211 across England), with the goal of having these clinically led bodies make better use of resources in decisions about planning and purchasing a wide range of care for their local populations. Clinical commissioning groups differ from primary care trusts in their governance; all general practices are required to belong to a clinical commissioning group, and the groups' governing body must be chaired by a general practitioner and include other clinicians alongside managers. In 2013–2014, clinical commissioning groups controlled about half of the total NHS budget.

Their work is overseen by NHS England—a nondepartmental body also established by the Act and accountable to the Secretary of State for Health through the annual “mandate” setting its objectives—which began formal operations in April 2013. NHS England was created to give those involved in the day-to-day running of the NHS more freedom from government ministerial intervention. Reforms also envisaged that all hospitals would become semiautonomous foundation trusts, and that clinical commissioning groups would have more freedom to commission different kinds of providers, including non-NHS private and voluntary sector providers, under the overall regulation provided by Monitor's expanded role. Consumer and public scrutiny would be enhanced through the new Healthwatch bodies.

It is too early to assess the full impact of the reforms. The National Audit Office assessed the implementation process in 2012–2013 and noted that the abolition of 170 organizations and creation of 240 new ones had led to 10,000 staff redundancies by March 2013 (19 percent of whom were reemployed). Evaluating the impact of the reform on costs, health, and care quality will be complex, not least in the disentangling of the effects of the reform from the impact of financial pressures on health and social care services (National Audit Office, 2013).

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The French Health Care System, 2014

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What is the role of government?

Provision of health care is a national responsibility. The Ministry of Social Affairs, Health and Women's Rights is responsible for defining the national health strategy (Touraine, 2014). Planning and regulation involve negotiations among provider representatives, the state, and statutory health insurers. The outcome of these negotiations is translated into laws passed by Parliament. The role of the state has expanded over the past two decades, as it pursues efforts to control expenditure and the increasing deficit of statutory health insurers.

In addition to setting national strategy, the responsibilities of central government include allocating the budgeted expenditure among the various sectors (hospitals, ambulatory care, mental health care, and social and health services for people with disabilities) and, with respect to hospitals, among regions.

At the regional level, the Administration of Health and Social Affairs is represented by the Regional Health Agencies, which are responsible for the health and health care of the population. Health and social care institutions and services for elderly and disabled people come under the jurisdiction of the General Council, which is the governing body at the local level.



Who is covered?

Coverage is universal and compulsory, and is provided to all residents by noncompetitive statutory health insurance (SHI) funds. SHI eligibility is either gained through employment or granted as a benefit to persons who have lost their jobs but were formerly employed (and their families), to students, and to retired persons. Citizens cannot opt out of SHI except in very rare cases of French citizens working for foreign companies.

The state covers the health insurance costs of residents not eligible for statutory health insurance (people who have never worked or have been unemployed for over two years) and finances health services for illegal residents who have applied for residency. Visitors from the European Union (EU) are covered by an EU insurance card. Non-EU visitors are covered for emergency care only.

Most voluntary health insurance is complementary, providing mainly reimbursement for copayments; 92 percent of the population is covered either through employers or via means-tested vouchers. Some supplementary insurance covers a limited list of services.



What is covered?

Services: Statutory health insurance covers hospital care and treatment in public or private rehabilitation or physiotherapy institutions; outpatient care provided by general practitioners, specialists, dentists, and midwives; diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals; prescription drugs, medical appliances, and prostheses that have been approved for reimbursement; and prescribed health care-related transport. It also partially covers long-term care and mental health care, and provides minimal coverage of outpatient vision and dental care.

While preventive services in general receive limited coverage, there is full reimbursement for certain services for defined target populations, e.g., immunization, mammography, and colorectal cancer screenings.

Positive lists are defined at the national level and apply to all regions. Drugs and medical devices are added to the list by the Ministry of Health, while procedures are added by the statutory health insurance funds, following recommendation by the National Authority for Health on the basis of technology assessment results. The Ministry of Health, the pricing committee, and the statutory health insurance funds are the key actors involved in defining the benefit package, the rate of coverage, and pricing decisions.

Cost-sharing and out-of-pocket spending: Cost-sharing takes three forms: coinsurance, copayments, and balance billing. In 2012, total out-of-pocket spending made up 9.6 percent of total health expenditures (excluding the portion covered by complementary insurance) (DREES, 2013). The official fees for dental and optical services are very low, no more than a few euros for glasses or hearing aids and a maximum of €200 (USD 237*) for dental prostheses, but these are commonly balance-billed at amounts over 10 times the official fee.

Coinsurance rates are applied to all health services and drugs listed in the benefit package, and vary by:

- type of care: inpatient care (20%), doctor visits (30%), and dental care (30%);
- effectiveness of prescription drugs: highly effective drugs (0%); all other items require coinsurance rates of between 40 percent and 100 percent, based on their therapeutic value; and
- compliance with the recently implemented gatekeeping system.

The following nonreimbursable copayments apply up to an annual ceiling of €50 (about USD60): €18.00 (USD21.00) for each inpatient hospital day (€13.50 [USD16.00] in psychiatric wards), €1.00 (USD1.20) per doctor visit, €0.50 (USD0.60) per prescription drug, €2.00 (USD2.40) per ambulance call, and €18.00 (USD21.00) for hospital treatment above €120.00 (USD142.00). These copayments have not changed since their initiation in 2008. There are no deductibles.

Safety net: Since 2000, people with low incomes are entitled to free or state-sponsored voluntary health insurance and free vision and dental care, and cannot be balance-billed. Exemptions from coinsurance apply to: individuals with any of 32 chronic illnesses (13% of the population, limited to the treatments for those conditions); individuals who benefit from either complete state-sponsored medical coverage (3% of the population) or means-tested vouchers for complementary health insurance (48% of the population); and individuals receiving invalidity- and work injury-related benefits. Hospital coinsurance applies only to the first 31 days in hospital, and some surgical interventions are exempt. Children and people with low incomes are exempt from paying nonreimbursable copayments. The threshold for state-sponsored complementary health insurance eligibility was raised in 2013, e.g., to €720 (USD852) per month for one person, to allow 500,000 more beneficiaries (CMU Fund, 2014).



How is the health system financed?

Publicly financed health care: Public expenditure accounted for 77 percent of total health costs in 2012, or 9 percent of GDP (DREES, 2013).

Statutory health insurance is financed by employer and employee payroll taxes (64%); a national earmarked income tax (16%); revenue from taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies (12%); state subsidies (2%); and transfers from other branches of social security (6%) (Sécurité Sociale, 2014).

Privately financed health care: People take out voluntary health insurance (VHI) because of balance-billing, cost-sharing on usual care, and poorly covered eye and dental care. Complementary insurance is provided mainly by not-for-profit, employment-based mutual associations or provident institutions, which are only allowed

* Please note that throughout this profile, all figures in USD were converted from EUR at a rate of about €0.85 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for France.

to cover copayments under statutory health insurance (SHI). Private for-profit companies offer both supplementary and complementary health insurance, but only for a limited list of services.

VHI finances 13 percent of total health expenditure. The extent of VHI coverage varies widely, but all VHI contracts cover the difference between the SHI reimbursement rate and the service fee (i.e., according to the official fee schedule). Coverage-of-balance billing is also commonly offered; it is usually described as the percentage of the SHI fee that will be covered. Most VHI contracts cover 200 percent to 300 percent of the official fee.



How is the delivery system organized and financed?

Collective agreements between the statutory health insurance funds and representatives of the health professions, signed at the national level, apply to all professionals unless they expressly opt out.

Primary care: There are roughly 200,000 physicians in France: 92,000 primary care physicians and 108,000 specialists. Most physicians are self-employed (46% exclusively and 10% in mixed employment), although more general practitioners (GPs) are self-employed (59%) than specialists (36%) (CISS, 2014). Forty-two percent of GPs, mostly younger doctors, are in group practices. An average practice consists of two or three physicians, and three-quarters of practices consist of physicians only. In the rest, the composition is highly variable and can include a range of allied health professionals, typically paid on a fee-for-service basis. Self-employed physicians are paid mostly fee-for-service; in addition, they are eligible for a yearly capitated payment of €40 (USD47) per patient with a chronic condition as well as pay-for-performance bonuses. Fees are set by the Ministry of Health and the statutory health insurers.

Experimental GP networks are financed by earmarked funds from the Regional Health Agencies. These networks provide a variety of services that are not listed on the SHI benefit schedule, including psychologist and dietician services and care coordination for chronic conditions (Nolte, 2008).

The 2004 health financing reform law introduced a voluntary gatekeeping system for adults (aged 16 years and over), with financial incentives to register (such as lower copayments for visits and prescriptions with a referral). About 85 percent of the population is registered with a gatekeeper, of which 90 percent chose a GP, although specialists can also be chosen.

In April 2009, statutory health insurers launched individual contracts with office-based physicians that included a pay-per-performance mechanism. Following a successful pilot project on pay-per-performance, under which physicians could earn up to €5,000 (USD5,915) annually for the achievement of targets, an agreement between the insurers and physicians' unions was signed in 2012 applying pay-for-performance targets to all GPs. In addition to target payments, GPs may receive a yearly €40 (USD47) per patient for coordination of care for patients suffering from chronic conditions (Assurance Maladie, 2012).

Outpatient specialist care: Outpatient specialist care can be provided by office-based or hospital-based physicians. Thirty-six percent of specialists have an exclusively office-based, self-employed practice. Payment for specialists depends on their type of practice; self-employed specialists and specialists working in private clinics are paid on a fee-for-service basis, while hospital specialists are salaried. Patients can choose their specialist, but referral for most specialist consultations has to be issued by a primary care physician. Direct access is possible for the following specialties: gynecology, ophthalmology, psychiatry, and stomatology (Assurance Maladie, 2014). However, bypassing the primary care physician results in incomplete SHI coverage for the patient.

The fee schedule is set by the statutory health insurers; the specialist fee is €28 (USD33), but specialists can balance-bill.

Fifty-two percent of specialists are in group practices, a trend that is increasing (+18% from 2000 to 2003), particularly among specialties that require major investments, such as nuclear medicine, radiotherapy, pathology, and digestive surgery (Sénat, 2014).

Specialist doctors working in public hospitals may have private patients both for outpatient and inpatient care. A 2013 report to the Ministry of Health estimated that 10 percent of the 46,000 hospital specialists (in surgery, radiology, cardiology, and obstetrics) treated private patients. Physicians pay back a percentage of their fees to the hospital. The mounting discontent over 1) excessive balance-billing revealed in the press, and 2) the claim of unfair competition made by private clinics prompted several public enquiries, the latest of which resulted in recommendations to increase public control over this practice (Ministère de la Santé, 2013).

Administrative mechanisms for paying primary care doctors and specialists: Until now, patients pay the full fee (official fee and balance billing, if any) and submit their claim. The reimbursement covers the full sum or less, depending on the coverage, minus €1.00 (USD1.20) nonrefundable (capped to a maximum €50 [USD59]) per patient per year. There are plans to replace this arrangement with the “third-party payer” system (see below, “What major innovations and reforms have been introduced?”).

After-hours care: After-hours care is delivered by the emergency departments of public hospitals, by private hospitals that have signed an agreement with the Regional Health Agency and receive financial compensation, by self-employed physicians who work for emergency services, and, more recently, by public facilities financed by SHI funds and staffed by health professionals on a voluntary basis. Physicians are paid an hourly rate, regardless of the number of patients seen. Emergency services can be accessed via the national emergency phone number, 15, which is staffed with trained professionals who determine the type of response needed, from general practitioner visits to resuscitation ambulance services. Currently under assessment is the feasibility of telephone or telemedicine advice, which would include sharing information of the electronic patient record with the patient’s primary care doctor. Publicly funded multidisciplinary health centers with self-employed health professionals (physicians and nonphysicians) offer better after-hours access to care in addition to more comprehensive care; fee-for-service payment is the rule for these centers (IRDES, 2010).

Hospitals: Public hospitals account for nearly two-thirds of acute medical care capacity (67% of inpatient beds and 50% of outpatient beds) and are responsible for 65 percent of inpatient and 42 percent of outpatient episodes. Private for-profit hospitals account for 25 percent of inpatient beds and 40 percent of outpatient beds, and provide 27 percent of inpatient episodes and 50 percent of outpatient episodes; they specialize in a small number of technical procedures for which there are profit opportunities, such as invasive diagnostic procedures (e.g., endoscopy and coronarography). All other acute medical activity is performed by the private not-for-profit sector, which includes the main providers of cancer treatment.

Since 2008, all hospitals and clinics are reimbursed via the diagnosis-related group (DRG) prospective payment system, which applies to all inpatient and outpatient admissions and is set by the Ministry of Health. DRG payments cover physicians’ salaries. No bundled payment by episode of care exists. Public hospitals are funded by statutory health insurance (80%) and voluntary insurance and direct patient payment (20%). Public and private not-for-profit hospitals also benefit from additional non-activity-based grants that compensate research and teaching (up to an additional 13% of the budget) and the provision of emergency services, organ harvesting, and transplantation (on average, an additional 10%–11% of a hospital’s budget). Private for-profit clinics owned either by individuals or, increasingly, by large corporations have the same funding mechanism as public hospitals, but the respective share of payers differs. Doctors’ fees are billed in addition to the DRG in private clinics. DRG payments for private clinics are lower than those for public or not-for-profit hospitals. This difference is justified by differences in the size of facilities, the DRG mix, and the patient population (age, comorbid conditions, and socioeconomic status) (IRDES, 2013). Rehabilitative hospitals also have a prospective payment system based on length of stay and care intensity.

Mental health care: Services for mentally ill people are provided by the health care sector, and for the disabled by the social and health care sectors, with an emphasis on community-based provision. The total expenditure for mentally ill patients is estimated to be 16 percent of total health expenditures (Sécurité Sociale, 2014 [2]).

Services provided by the health care sector take the form of both public and private outpatient and inpatient care. Public care is provided within geographical areas and includes a wide range of preventive, diagnostic, and therapeutic services, which are provided in both inpatient and outpatient settings. Ambulatory care centers

provide primary ambulatory mental health care, including home visits. Integration with primary care is not formally organized.

A large number of psychological disorders are also treated on an outpatient basis by general practitioners or private psychiatrists or psychologists, some of them practicing psychotherapy and, occasionally, psychoanalysis. In 2012, there were 12,400 practicing psychiatrists, the majority of whom (57%) were salaried doctors in hospitals; the rest were in private and mixed practices.

Care provided by general practitioners and psychiatrists in private practice, in public mental health care dispensaries, or in private psychiatric hospitals, for both adults and children, is covered by statutory health insurance. In addition, copayments are fully covered for people with long-term psychiatric conditions. Care provided by psychotherapists or psychoanalysts is fully financed by patients.

Both the *copayment* and the flat-rate fee for accommodation can be fully covered by voluntary health insurance.

Long-term care and social supports: Long-term care for the elderly and disabled belongs to the “health and social care sector,” split into two subsectors that encompass care for the elderly as well as for disabled people. Care may be provided at home or in residences.

Home care for the elderly is provided mainly by self-employed physicians and nurses and, to a lesser extent, by community nursing services. These services are need-based, as opposed to means-tested.

Long-term care in institutions is provided in retirement homes and long-term care units, totaling roughly 10,000 institutions and 720,000 beds. Of these, 54 percent are public, 28 percent are private not-for-profit, and 18 percent are for-profit. The share of for-profit long-term care institutions is increasing (DREES, 2014).

Statutory health insurance covers the cost of medical care, while the housing costs in hospices and other long-term facilities (on average €1,500 [USD1,775] per month) are incurred by families (Ministère de la Santé, 2013 [2]). End-of-life care in hospitals is fully covered.

In addition, temporary care for dependent patients and respite services for their caregivers are covered without restrictions.

Means-tested monetary allowances are provided for the frail elderly. The allowance is adjusted according to an individual’s dependence level, living conditions, and needs, as assessed by a joint health and social care team, and may be used for any chosen service and provider. About 1.1 percent of the total population is estimated to be eligible. Informal caregivers also benefit from tax deductions.

Funding for long-term care for the elderly and disabled is partly ensured by a dedicated fund, the National Solidarity Fund for Autonomy, created in 2004. Its resources come from statutory health insurance and from revenue from a once-yearly unpaid working day, or “solidarity day.” Local authorities, the general councils, and households also participate in financing these categories of care.



What are the key entities for health system governance?

The Ministry of Health is responsible for preparing and implementing government policy in the areas of public health and the organization and financing of the health care system, within the framework of the Public Health Act. It controls in large part the regulation of health care expenditures on the basis of the overall framework established by Parliament. This task includes a shared responsibility with statutory health insurers for defining the benefit package and setting prices and provider fees (including diagnosis-related group fees and copayments).

The French Health Products Safety Agency is the competent authority for all safety decisions taken concerning health products, from manufacturing through marketing. The Agency also coordinates vigilance activities relating to all relevant products.

FRANCE

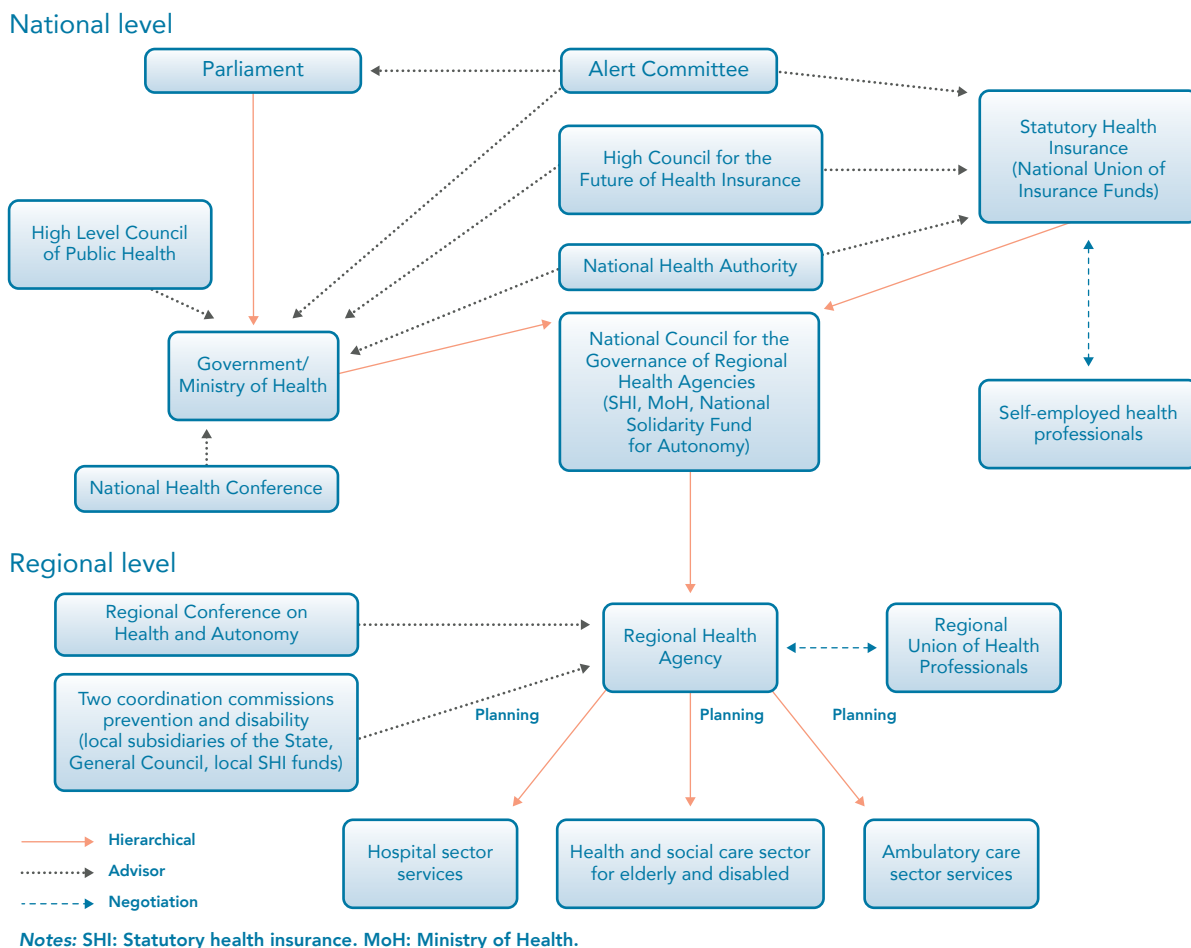
The Agency for Information on Hospital Care manages the information systematically collected from all hospital admissions and used for hospital planning and financing.

The National Agency to Support the Performance of Health and Social Care provides advice and support to health and social care organizations for internal reorganization plans; for asset management, when facing financial difficulties; for merger and acquisition programs; for assessment, audit, and effectiveness of strategic plans, with a particular focus on buildings, equipment, and information systems; and for audits of performance.

The remit of the National Agency for the Quality Assessment of Health and Social Care Organizations encompasses the promotion of patients' rights and the development of preventive measures to avoid mistreatment, particularly in vulnerable populations such as the elderly, the disabled, children, adolescents, and socially marginalized people. The agency produces practice guidelines for the health and social care sector and evaluates organizations and services.

The governance and organization of health technology assessment are defined by the government and by the statutory health insurers. The major health technology assessment body in France is the National Authority for Health (HAS), which has in-house expertise as well as the authority to commission assessments from external groups such as academic centers and professional societies. The HAS's remit is diverse, ranging from the assessment of drugs, medical devices, and procedures to the publication of guidelines for health care

Organization of the Health System in France



Source: Adapted from K. Chevreur, I. Durand-Zaleski, S. B. Bahrami et al., "France: Health System Review," *Health Systems in Transition*, vol. 12, no. 6, 2010, pp. xxi–xxii.

organizations, their accreditation, and the certification of doctors. Drugs and other health technologies undergo a safety assessment either through the European Medicines Agency or through its French counterpart, the French Health Products Safety Agency (see above), before the HAS undertakes an assessment of medical benefits. The results of these assessments will determine the reimbursement rate and will be used by the pricing committee in price negotiations with the manufacturer.

The Parliamentary “alert committee” was established in 2004 to provide a midyear assessment of health care expenditures and to propose corrective measures in case of excessive overspending (0.75% over the spending target).

There is no competition among the statutory health insurers that provide core health insurance. Among private insurers selling voluntary supplementary health coverage, competition is only limited; these insurers are under an umbrella organization, the National Union of Complementary Health Insurance Organizations, and are controlled by the Mutual Insurance Funds Control Authority (the VHI counterpart of the National Union of Insurance Funds).



What are the major strategies to ensure quality of care?

National plans are developed for the treatment of a number of chronic conditions (e.g., cancer, Alzheimer’s disease, rare chronic diseases) and for prevention and healthy aging, in addition to the 104 targets set by the 2004 Public Health Act. These plans establish new governance (e.g., the cancer plan set up by the National Cancer Institute to coordinate research on and treatment of cancer) and new tools, and/or coordinate existing organizations. All plans emphasize the importance of supporting carers and ensuring patients’ quality of life, in addition to enforcing compliance with guidelines and promoting evidence-based practice.

Disease management programs: The National Authority for Health published an evidence-based basic benefit package for 32 chronic conditions. Further guidance has since been published on recommended care pathways for chronic obstructive pulmonary disease, heart failure, Parkinson’s disease, and end-stage renal disease (Assurance Maladie, 2014 [2]).

Statutory health insurance and the Ministry of Health have funded “provider networks” for the past decade, in which participating professionals share guidelines and protocols, agree on best practice, and have access to a common patient record.

Regional Health Agencies are funding telemedicine experiments to improve care coordination and access to care for specific conditions (e.g., stroke) or populations (e.g., neonates, the elderly, and prisoners).

Disease and medical device registries: The 2004 Public Health Act underlined the need for larger national cohorts for disease and medical device registries, which are now being recruited. However, they are still considered too few in number and not representative enough to ensure sufficient quality of care. Medical device registries have been set up for drug-eluting stents, implantable cardiac defibrillators, and transcatheter aortic valve implantation.

National patient survey: Beginning in 1998, a national survey has been undertaken twice yearly to assess the population’s self-reported health, access to care, and care coverage. The results are public, upon request (IRDES, 2104).

Physician recertification/revalidation to ensure competency: There is no formal recertification or relicensing process. However, in order to ensure lifelong quality of practice, doctors, midwives, dentists, pharmacists, biologists, nurses, physiotherapists, and podiatrists must undergo continuous learning activities, which are audited every fourth or fifth year. Within this process, there is optional accreditation for a limited number of high-risk medical specialties (e.g., obstetrics and gynecology, surgery, interventional radiology, anesthesiology, and cardiology). Accredited physicians can claim a deduction on the premium they pay for their professional insurance. The accreditation process includes a registry of adverse events or “near misses,” adherence to practice guidelines and review criteria, and participation in educational sessions in risk reduction.

For self-employed physicians, certification and revalidation are organized by an independent body approved by the National Authority for Health. For hospital physicians, both can be performed as part of the hospital accreditation process.

Hospital accreditation: Hospitals must be accredited every four years; criteria and accreditation reports are publicly available on the National Authority for Health website (www.has-sante.fr). A national program called CompaqH also reports results on selected indicators. Quality assurance and risk management in hospitals are monitored nationally by the Ministry of Health, which publishes online technical information, data on hospital activity, and data on control of hospital-acquired infections. There is also a yearly nonofficial hospital ranking by two news magazines. Currently, financial rewards or penalties are not linked to public reporting, although this issue remains contested.

Information on individual physicians is not available.



What is being done to reduce disparities?

The 2004 Public Health Act set targets for reducing “geographic inequities in access to medical care” (so far, only nurses have agreed to limit new practices in overserved areas); “financial inequities” (out-of-pocket payments will be limited by state-sponsored complementary insurance); and “inequities in prevention” (e.g., related to obesity, screening, immunization).

The 2014 national health strategy has set the reduction of health inequities as its major target. There is a seven-year gap between the life expectancies of males in the highest and lowest social categories. Beneficiaries of state-sponsored complementary insurance and those without any complementary insurance report poorer health than do those with commercial complementary insurance (approximately 38% and 27% report bad or very bad health, respectively), a discrepancy that may be the result of differences in access to care (IRDES, 2011). To identify and eliminate discriminatory practices, the 2009 Hospital, Patients, Health, Territories Reform Act allowed random testing of office-based physicians’ practices; if denial of care is proven, penalties are imposed.

At the regional level, Regional Health Agencies have been given a specific mandate to reduce health inequities.



What is being done to promote delivery system integration and care coordination?

The objective of the chronic-illness plan (see above, “What are the major strategies to ensure quality of care?”) is to integrate hospital and out-of-hospital care and social care. The National Authority for Health has developed patient pathway guides that provide detailed information on the roles of each professional (HAS, 2013). At the regional level, a call for proposals was issued in 2012 to experiment with care coordination using telemedicine. Both health and social care services were eligible, and target populations were identified by the Regional Health Agencies based on their priorities. In the Paris region, the vulnerable populations were infants, prisoners, handicapped persons, and elderly persons in institutions. Experiments are currently under way and their assessment is planned in 2016.



What is the status of electronic health records?

A high-level project to establish an electronic health network was begun in 2008 and is currently being extended across the entire country. As of September 2014, a total of 483,576 patients, or 0.7 percent of the population, have an electronic health record.

The Agency for Health Information Systems, created for the purpose of expanding uptake and interoperability of existing systems, presented the preliminary results of tests on interoperability software to connect hospitals, pharmacies, doctors’ offices, imaging platforms and laboratories. The timeline for conducting the tests is 2014–2015 (ASIP, 2014).

By law, patients can request access to their medical records either directly or through their primary care physician. All “structured documents” included in e-records must be communicated. (“Structured documents” include all documentation except handwritten notes in the medical charts.)



How are costs contained?

The health insurance scheme has faced large deficits over the past 20 years. Recently, however, the health insurance scheme’s deficit has fallen, from an annual €10 billion–€12 billion (USD11.8 billion–USD14.2 billion) in 2003 to €6.2 billion (USD7.3 billion) in 2014. The trend of increasing deficits has been reversed by a number of initiatives that can be grouped into the categories of “tax” and “regulate.” These initiatives include: a reduction in the number of acute-care hospital beds; the removal of 600 drugs from public reimbursement in the past few years; an increase in generic prescribing and use of over-the-counter drugs; a reduction in the price of generic drugs (by €1 billion [USD1.2 billion]); and a reduction of the official fees for self-employed radiologists and biology labs by an estimated €130 million (USD154 million). Other cost-containment measures include centralizing purchasing to better negotiate costs, increasing the share of outpatient surgery, and reducing testing redundancy (€440 million [USD521 million]). Competition is not used as a cost-control mechanism. Global budgets are not used except when price-volume agreements are negotiated for drugs or devices. Price incentives directed toward patients have included the above-mentioned nonreimbursable copayments and increased copayments for patients who refuse generics or do not use the gatekeeping system (Sénat, 2013).



What major innovations and reforms have been introduced?

The 2009 Hospital, Patients, Health, Territories Reform Act merged most regional institutions into single regional “one-stop shops,” the Regional Health Agencies (*agences régionales de santé*, or ARSs). Cutting across the traditional boundaries of the health care, public health, and health and social care sectors, ARSs have responsibility for ensuring that health care provision meets the needs of the population by improving articulation between the ambulatory and hospital sectors and the health and social care sector, while respecting national health expenditure objectives. The ARSs are now fully operational.

Price control: The most effective cost control for drugs has been the implementation in September 2012 of the “generic versus third party” scheme. According to this scheme, patients who agree to generic substitution are not subject to copayments. The rate of substitution jumped from 71 percent to 84 percent in one year, resulting in cost savings of more than €200 million (USD237 million).

In hospitals, stricter definitions of outpatient admission versus clinic visits resulted in lower payments for treatments.

Volume control: In April 2014, experimentation with drug depackaging began, authorizing pharmacists to sell a given list of antibiotics and drugs by unit and not by box, with the aim of diminishing waste and therefore cost. The three-year experimentation was initiated in four regions in April 2014 (Legifrance, 2014).

Equity: In 2012, the Socialist government made a pledge to reduce excessive balance-billing. Under the provisional agreement signed in October 2012 and fully deployed in December 2013, physicians agree to limit their balance-billing to €70 (USD83) in exchange for reduced social insurance premiums and higher fees for procedures. The number of signatures was 10,700, or just under one-half of the total number of physicians allowed balance-billing in France in March 2014 (Ortiz, 2014).

Provision of an adequate level of employer-sponsored voluntary health insurance for all workers was mandated in 2013, in order to reduce the inequities resulting from differential access to and variation in coverage of such insurance. The June 14, 2013, law (*la loi sur la sécurisation de l’emploi*) mandates that by 2016 all employees will benefit from an employer-sponsored (50% of the cost) insurance that will cover at least 125 percent of statutory health insurance fees for dental care and at least €100 (USD118) per year for eye care. The estimated population of beneficiaries of the proposed reform is about 4 million. In practice, employers have to offer

complementary insurance to their employees, but the choice of insurance plan is determined by the industry to which the employer belongs.

When unveiling the national health strategy in 2014, the Minister of Health announced that by 2017 the third-party payer system would be fully deployed, as part of the strategy to reduce inequities. It will reduce the amount patients pay up front to a €1.00 (USD1.20) deductible plus the noncovered share of balance-billing (Touraine, 2014; Ministère du Travail, 2013). The arrangement was opposed by physicians on the grounds of complexity, risk of overuse if patients do not have to pay, and the resulting threat to self-employment (IGAS, 2013).

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The German Health Care System, 2014

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What is the role of government?

Responsibilities in the German health system follow the separation of powers between the federal government, the states, and the corporatist level. Federal law sets basic definitions in the Social Code Book V (SGB V) and delegates details and their implementation to various corporatist institutions. Health insurance is provided by competing, not-for-profit, nongovernmental health insurance funds called “sickness funds” (there were 131 as of July 2014) in the statutory health insurance (SHI) scheme, or by substitutive private health insurance (PHI) (Federal Association of Sickness Funds, 2014). States own most university hospitals, while municipalities play a role in public health activities and own about half of hospital beds. The various levels of government have virtually no role in the direct financing or delivery of health care. A large degree of regulation is delegated to self-governing associations of the sickness funds and the provider associations. The most important body is the Federal Joint Committee (see below).



Who is covered?

Coverage is universal for all legal residents. All employed citizens (and other groups such as pensioners) earning less than €4,462.50 (about USD5,695) per month (€53,550 [about USD68,336] per year) as of 2014 are mandatorily covered by SHI, and their nonearning dependents are covered free of charge.* Individuals whose gross wages exceed the threshold, civil servants, and the self-employed can choose either to remain in the publicly financed scheme voluntarily (and 75% do) or to purchase substitutive PHI. Especially for young people with a good income, PHI is attractive, as the insurance may offer contracts with more extensive ranges of services and lower premiums. PHI is complementary as well as supplementary. About 86 percent of the population receives their primary coverage through SHI and 11 percent through substitutive PHI (Federal Ministry of Health, 2013). The remainder (e.g., soldiers and policemen) are covered under special programs. Health insurance is mandatory for all citizens and permanent residents of Germany. Visitors are not covered through German SHI. Undocumented immigrants are covered by social security in case of acute illness and pain, as well as pregnancy and childbirth. Services are provided by the responsible authorities or physicians and hospitals.



What is covered?

Services: SHI covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, physical therapy, prescription drugs, medical aids, rehabilitation, hospice and palliative care, and sick leave compensation. SHI preventive services include regular dental checkups, well-child checkups, basic immunizations, checkups for chronic diseases, and cancer screening at certain ages. All prescription drugs—including newly licensed ones—are covered unless explicitly excluded by law (mainly so-called lifestyle drugs) or pending evaluation. While the broad contents of the benefits package are legally defined at the national level, specifics are decided on by the Federal Joint Committee (see below). Long-term care services are covered separately by the long-term care insurance scheme (see below).

Cost-sharing and out-of-pocket spending: Within SHI, there were few cost-sharing provisions (mainly for pharmaceuticals and dental care) until 2004, when copayments were introduced for ambulatory care office visits

* Please note that throughout this profile, all figures in USD were converted from EUR at a rate of about €0.78 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for Germany.

(to general practitioners, specialists, and dentists) for adults age 18 years and older (€10 [USD13] for the first visit per quarter or subsequent visits without referral). These copayments were subsequently removed in 2013, but other remaining copayments include €5 (USD6.50) to €10 per outpatient prescription (unless the price is at least 30% below the reference price, meaning that over 5,000 drugs are effectively free of charge), €10 per inpatient day for hospital and rehabilitation stays (for the first 28 days per year), and €5 to €10 for prescribed medical aids. Sickness funds offer selectable rates with a range of deductibles and no-claims bonuses. Preventive services do not count toward the deductible. SHI-contracted physicians are not allowed to charge above the fee schedule for services in the SHI benefit catalogue. However, a list of “individual health services” outside the comprehensive range of SHI coverage may be offered to patients paying out-of-pocket. Out-of-pocket spending accounted for 12.9 percent of total health spending in 2013, mostly on nursing homes, pharmaceuticals, and medical aids. For adults, there is an annual cap on cost-sharing equal to 2 percent of household income; part of a household’s income is excluded from this calculation for additional family members. About 0.5 million SHI insurees exceeded the 2 percent cap in 2012 and were exempted from cost-sharing (Federal Statistical Office, 2014).

Safety net: Children under 18 years of age are exempt from cost-sharing. The above-mentioned annual cap on cost-sharing is lowered to 1 percent of annual gross income for qualifying chronically ill people; to qualify, these people have to demonstrate that they attended recommended counseling or screening procedures prior to becoming ill. Nearly 7 million people have benefitted from this regulation in 2012, which is around 10 percent of all people with SHI. Unemployed people contribute to SHI in proportion to their unemployment entitlements. For the long-term unemployed, government contributes on their behalf.



How is the health system financed?

Publicly financed health care: In 2012, total health expenditure accounted for 11.3 percent of GDP (OECD, 2014). Spending by SHI accounted for 57.4 percent of total expenditure (total public spending on health, including statutory long-term care insurance, statutory retirement insurance, statutory accident insurance, and taxes, constituted 72.9%) (Federal Statistical Office, 2014). Sickness funds are funded by compulsory contributions levied as a percentage of gross wages up to a ceiling of €48,600 (USD62,020) annually (as of 2014), earnings above which are exempt. In 2009 and 2010, a uniform contribution rate was set by government (and by federal law since 2011). As of 2011, insured employees or pensioners contribute 8.2 percent of their gross wages, while the employer, or the pension fund, add another 7.3 percent. The combined maximum contribution is around €630 (USD804) per month in 2014. This contribution also covers dependents (nonearning spouses and children). Contributions are centrally pooled and then reallocated to each sickness fund based on a risk-adjusted capitation formula, taking into account age, sex, and morbidity from 80 chronic and/or serious illnesses.

Sickness funds are able to charge the insured person an additional nominal premium if a sickness fund’s revenue is insufficient (or to pay out a bonus in the case of surplus revenue). In March 2011, 13 of the then 156 sickness funds charged an additional premium, between €8 (USD10) and €15 (USD19) per month. In 2014 no sickness fund has to raise additional premiums, but around 20 (including the largest fund) pay an annual bonus between €30 (USD38) and €263 (USD336) to their insureds. In April 2014 the government passed a bill containing future changes in the way of collecting and sharing contributions (see section on major innovations and reforms). There is also (general) tax-financed federal spending on “insurance-extraneous” benefits provided by SHI (e.g., coverage for children), which amounted to €14 billion (USD17.9 billion) in 2014.

Privately financed health care: There were 43 substitutive PHI companies in 2012, of which 24 were for-profit and 19 were mutual insurance companies. Substitutive PHI covers the two groups that are exempt from SHI (civil servants, whose health care costs are partly refunded by their employer, and the self-employed) and those who have chosen to opt out of SHI. All PHI insured pay a risk-related premium, with separate premiums for dependents; risk is assessed only on entry, and contracts are based on lifetime underwriting. The employer pays the equivalent of the maximum contribution to SHI (€295.65 [USD377] per month in 2014), but no more than 50 percent of the employee’s premium. PHI is regulated by the government to ensure that the insured do not face

large premium increases as they age and are not overburdened by premiums if their income decreases. Private insurers offering substitutive PHI coverage are required to take part in a risk-adjustment scheme (separate from SHI) to be able to offer basic insurance for people with ill health who are not eligible to return to SHI (e.g., because of their status as being either a pensioner or self-employed) and who cannot afford a risk-related premium. Legislation also has aimed to intensify competition between insurers. In order to slow the increase of premiums with age, private insurers are forced by law to set aside savings (aging reserves) from when the insured are young for use when those insured grow older. Individual aging reserves are now transferable, while previously they remained with the insurer if a person cancelled a policy or switched insurer.

PHI also plays a mixed complementary and supplementary role, covering minor benefits not covered by SHI, access to better amenities, and some copayments (e.g., for dental care). The federal government determines obligatory provider fees in substitutive, complementary, and supplementary PHI through a specific fee schedule. There are no government subsidies for complementary and supplementary PHI. In 2012, all forms of PHI accounted for 9.3 percent of total health expenditure.



How is the delivery system organized and financed?

Primary/ambulatory care: General practitioners and specialists in ambulatory care who get reimbursed by SHI are by law mandatory members of regional associations that negotiate contracts with the sickness funds. Regional associations of SHI-accredited physicians are responsible for coordinating care requirements within their region, and act as financial intermediaries to the sickness funds and physicians. However, ambulatory physicians typically work in their own private practices—around 60 percent solo and 25 percent in dual practices.

Most physicians employ doctors' assistants or nurses, while other nonphysicians (e.g., physiotherapists) have their own premises. In 2013, of 133,100 SHI-accredited physicians practicing in ambulatory care, almost 41,000 (31%) were general practitioners and physicians without any specialist qualification while around 92,000 (69%) held a specialist degree; about 60,600 (46%) were practicing as family physicians (i.e., general practitioners), including doctors with specialist training as pediatricians and internists, and 72,500 (54%) as specialists. Since the introduction of multispecialty clinics in ambulatory care in 2004, their number had grown from 70 clinics and 251 working physicians to 2,006 clinics and almost 13,000 physicians (10% of ambulatory care physicians) by 2013 (Federal Association of SHI Physicians, 2013). Around 11,000 physicians in multispecialty clinics are salaried employees. Specialized outpatient care provided by hospital specialists also was introduced in 2004. It includes treatment of severe progressive forms of disease and of rare diseases, as well as highly specialized procedures. Details of this and qualifications requirements are defined by the Federal Joint Committee.

Individuals have free choice among general practitioners, specialists, and, if referred to inpatient care, hospitals. Registration with a primary care physician is not required and general practitioners have no formal gatekeeping function. However, sickness funds are required to offer their members the option to enroll in a "family physician care model," which has been shown to provide better services and often also provides incentives for complying with gatekeeping rules.

SHI-accredited physicians in ambulatory care (general practitioners and specialists) provide services for patients insured through SHI as well as PHI. They are generally reimbursed on a fee-for-service basis with a uniform fee schedule negotiated between sickness funds and physicians (see below). Payments are limited to a predefined maximum number of patients per practice and reimbursement points per patient, setting thresholds on the number of patients and treatments per patient for which a physician can be reimbursed. Pay-for-performance has not been established yet.

General practitioners receive a financial bonus for patients enrolled in a disease management program, in which sickness funds pay the physician an annual lump sum; in return the physician provides patient training and documents patient data. Bundled payments are not the common way of remuneration except for some regional initiatives (refer to section on care coordination).

Outpatient specialist care: There is a very strong ambulatory care sector in Germany and physicians offer not only primary but almost all specialties in ambulatory care. For details on outpatient specialist care please see section on primary/ambulatory care.

Administrative mechanisms for paying primary care doctors and specialists: SHI physicians in ambulatory care are not directly paid by sickness funds. Instead, sickness funds make total payments to the regional associations of SHI-accredited physicians. In a second step, physicians bill their regional association according to a uniform fee schedule. Copayments or services that are not included in the benefit catalogue are paid directly to the provider. In case of PHI, the patient pays up front and submits claims to the insurance company for reimbursement.

After-hours care: After-hours care is organized by the regional associations of SHI-accredited physicians to ensure access to ambulatory care around the clock. Physicians are obliged to provide after-hours care, with differing regional regulations. In some areas (e.g., Berlin), after-hours care has been delegated to hospitals, which are also responsible for serious emergency cases. The patient is given an overview of the visit afterwards to hand to his or her general practitioner. There is also a tight network of emergency care providers (the responsibility of the municipalities). After-hours care assistance is available via a nationwide telephone hotline. Payment of ambulatory after-hours care is based on the above-mentioned fee schedules, again with differences in the amount of reimbursement for SHI and PHI.

Hospitals: Public hospitals make up about half of all beds, while private not-for-profits account for about a third. The number of private, for-profit hospitals has been growing in recent years (around one-sixth of all beds). Regardless of ownership, hospitals are staffed principally by salaried doctors. Doctors in hospitals are typically not allowed to treat patients outside of the hospital (similar to the United States), but exceptions are made if necessary care cannot be provided by office-based specialists. Senior doctors can treat privately insured patients on a fee-for-service basis. Hospitals also can provide certain highly specialized services on an outpatient basis.

The 16 state governments determine hospital capacity, while ambulatory care capacity is subject to rules set by the Federal Joint Committee. Inpatient care is paid per admission through a system of diagnosis-related groups (DRGs), currently based on around 1,200 DRG categories. The system is revised annually to account for new technologies, changes in treatment patterns, and associated costs. DRGs also cover all physician costs. Other payment systems like pay-for-performance or bundled payments have yet to be implemented in hospitals (Busse and Blümel, 2014).

Mental health care: During the process of dehospitalization in the 1990s, acute psychiatric inpatient care was largely shifted to psychiatric wards in general (acute) hospitals and the number of hospitals providing care only for patients with psychiatric and/or neurological illness fell, while the number of office-based psychiatrists, neurologists, and psychotherapists working in the ambulatory care sector (all funded by both SHI and PHI, and paid fee-for-service) increased. Ambulatory psychiatrists coordinate a set of SHI-financed benefits called “sociotherapeutic care” (which requires referral by a general practitioner), to encourage the chronically mentally ill to use necessary care and to avoid unnecessary hospitalizations. To further promote outpatient care for psychiatric patients (particularly in rural areas with a low density of psychiatrists in ambulatory care), hospitals can be authorized to offer treatment in outpatient psychiatric departments. Less serious illnesses are often treated by general practitioners, but, in general, mental health care is provided by psychotherapists, psychiatrists, or other specialists. SHI covers comprehensive psychological therapy, psychoanalysis, and behavioral therapy, if needed.

Long-term care and social supports: Long-term care insurance (LTCI) is mandatory and usually provided by the same insurer as health insurance, that is, by a similar public–private insurance mix. The contribution rate of 2.05 percent of gross salary is shared between employers and employees; people without children pay an additional 0.25 percent. Everybody with a physical or mental illness or disability (who has contributed for at least two years) can apply for benefits. Unlike SHI benefits, however, LTCI benefits are 1) dependent on an evaluation of individual need by the SHI Medical Review Board for SHI- as well as PHI-insured (leading either to a denial or to

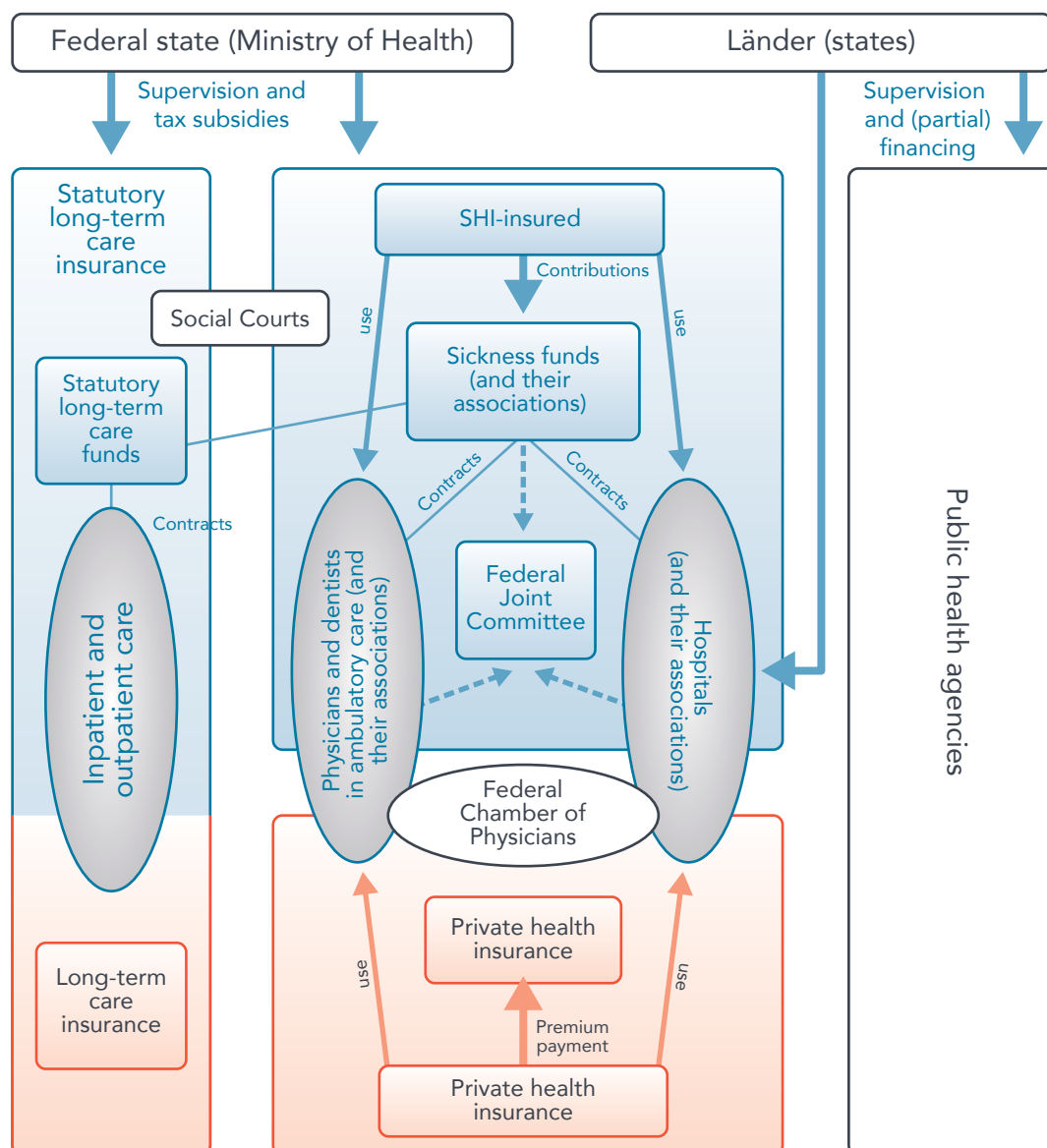
a grouping into one of three levels of care), and 2) limited to certain maximum amounts, depending on the level of care. Beneficiaries can choose between in-kind benefits and cash payments (around a quarter of LTCI expenditure goes to cash payments). Both home care and institutional care are provided almost exclusively by private not-for-profit and for-profit providers. As benefits usually cover approximately 50 percent of institutional care costs only, people are advised to buy supplementary private LTCI. End-of-life palliative care and hospice care is covered under SHI.



What are the key entities for health system governance?

The German health care system is notable for two essential characteristics: 1) the sharing of decision-making powers between states, the federal government, and the self-regulated organizations of payers and providers; and 2) the separation between SHI (including the social long-term care insurance; blue in Figure 1) and PHI (including the private long-term care insurance; orange in Figure 1). Figure 1 provides a complete overview of

Organization of the Health System in Germany



Source: Adapted from R. Busse and M. Blümel, "Germany: Health System Review," *Health Systems in Transition*, vol. 16, no. 2, 2014, p. 20.

the German health system. It also shows that SHI and PHI (as well as the two long-term care insurance schemes) use the same providers, meaning hospitals and physicians treat both statutorily and privately insured patients, which is a difference between Germany and many other countries.

Within the legal framework set by the ministry of health, the Federal Joint Committee has wide-ranging regulatory power to determine the services to be covered by sickness funds and to set quality measures for providers (see below). To the extent possible, coverage decisions are based on evidence from health technology assessments and comparative-effectiveness reviews. The Federal Joint Committee is supported by the Institute for Quality and Efficiency, a foundation legally charged with evaluating the cost-effectiveness of drugs with added therapeutic benefits, and the Institute for Applied Quality Improvement and Research in Health Care. Since 2008, the Federal Joint Committee has had 13 voting members: five from the Federal Association of Sickness Funds, two each from the Federal Association of SHI Physicians and the German Hospital Federation, one from the Federal Association of SHI Dentists, and three who are unaffiliated. Five patient representatives have an advisory role but no vote.

The Federal Association of Sickness Funds works with the Federal Association of SHI Physicians and the German Hospital Federation to develop the SHI ambulatory care fee schedule and the diagnosis-related group catalogue, which are then adopted by bilateral joint committees. To extend competition beyond these jointly regulated issues, some purchasing powers have been handed over to the sickness funds—for instance, to contract providers selectively within an integrated-care contract or to negotiate rebates with pharmaceutical companies. Cost-control measures are included in the legal framework (Social Code Book V).

The Ministry of Health is assisted by subordinated agencies with different functions. The Federal Centre for Health Education develops and disseminates health education material. The German Institute for Medical Documentation and Information provides the public with health information on all areas of medicine and the life sciences. Patients are organized in about 40,000 self-help groups of which some 360 are organized at the federal level. Since 2004 a Federal Commissioner for the Concerns of Patients has been assigned to the Ministry of Health, who serves as patient advocate.



What are the major strategies to ensure quality of care?

Quality of care is addressed through a range of measures broadly defined by law, and in more detail by the Federal Joint Committee. Since January 2010, the Institute for Applied Quality Improvement and Research in Health Care has been charged with developing quality assurance across ambulatory and inpatient care. Structural quality is ensured by the requirement that providers have a quality management system, that all physicians continue their medical education, by health technology assessments for drugs, and the implementation of clinical guidelines. All new diagnostic and therapeutic procedures applied in ambulatory care must be positively evaluated in terms of benefits and efficiency before they can be reimbursed by sickness funds. Hospital accreditation is voluntary. Volume thresholds have been introduced for a number of complex procedures (e.g., transplantations), requiring a minimum number of such procedures for hospitals to be reimbursed. Process and (partly) outcome quality is addressed through the mandatory quality reporting system for acute-care hospitals.

All hospitals are required to publish results on 182 selected indicators defined by the Federal Office for Quality Assurance, enabling a comparison of hospitals. Many institutions and health service providers include complaint management systems as part of their quality management programs, which in 2013 were made obligatory for hospitals. At the state level, professional providers' organizations are urged to establish complaint systems and arbitration boards for the extrajudicial resolution of medical malpractice claims.

Although there are several approaches and associations to ensure quality of care and patient safety, a national safety agency does not yet exist. However, the government plans to strengthen quality by law. For this purpose, it has commissioned the Federal Joint Committee in 2014 to establish the Institute for Quality Assurance and

Transparency in Health Care. The Institute's task will be to develop indicators for quality assurance which might provide an additional criterion for decisions of hospital planning and payment.

The Robert Koch Institute, an agency subordinate to the Federal Ministry of Health and responsible for the control of infectious diseases and health reporting, conducts national patient surveys and publishes epidemiological, public health, and health care data. Registries for specific diseases, such as certain cancers, are usually organized regionally. In August 2012, as part of the National Cancer Plan, the federal government introduced a draft bill that proposes the implementation of a nationwide standardized cancer registry in 2018 to improve the quality of cancer care; every hospital will be obliged to document the incidence, treatment, and course of the disease.



What is being done to reduce disparities?

Strategies to reduce disparities are mainly delegated to public health services, and the levels at which they are carried out differ from state to state. Health disparities are implicitly mentioned in the national health targets. In 2001, the Federal Center for Health Education initiated a network of 53 health-related institutions (e.g., sickness funds and their associations) to promote the health of the socially deprived. Primary prevention is mandatory by law for sickness funds; detailed regulations are delegated to the Federal Association of Sickness Funds, which has developed guidelines regarding need, target groups, and access, as well as content and methods. Sickness funds support 22,000 health-related programs, for example, in nurseries and schools.



What is being done to promote delivery system integration and care coordination?

Many efforts to improve care coordination are being implemented. As an example, SHI funds offer integrated-care contracts: GPs receive an average flat rate of approximately €100 (USD128) per year for each patient enrolled in such a contract. "Healthy Kinzigtal" (*Gesundes Kinzigtal*), provides an example of an integrated-care model offering primary care doctors and other providers financial incentives for a shared-savings model across providers and services. The remuneration of the health care providers in Kinzigtal is based on a four-stage model: 1) regular payment through SHI; 2) fee-for-service (e.g., for a regular health checkup); 3) performance-based remuneration according to specific structural and quality characteristics; and 4) profit-sharing between sickness fund and the network of health care providers.

Legislation in 2002 introduced SHI disease management programs for chronic illnesses to improve the provision of care for chronically ill patients and to improve care coordination between providers in the ambulatory sector. Disease management programs for diabetes types 1 and 2, breast cancer, coronary heart disease, asthma, and chronic obstructive pulmonary disease are modeled on evidence-based treatment recommendations, with mandatory documentation and quality assurance. Physicians receive an extra payment for their efforts in documentation. Nonbinding clinical guidelines are produced by the Physicians' Agency for Quality in Medicine and by professional societies. By 2013, 10,501 registered regional disease management programs had enrolled about 6 million patients (more than 8% of all SHI-insured).

Participating in such a program is voluntary for patients and can be done through general practitioners as well as specialists. Sickness funds are free to give patients incentives to enroll, such as exemptions from copayments for pharmaceuticals. Until 2009, participation in disease management programs was a separate category in the risk adjustment scheme, giving sickness funds a strong incentive to implement them. Since risk adjustment was strengthened in 2009, sickness funds receive only a per-capita administration compensation of €147.87 (USD189) per year for each insured enrolled in a program.



What is the status of electronic health records?

About 90 percent of physicians in private practice use electronic health records (EHRs) to help with billing, documentation, tracking of laboratory data, and quality assurance. In some regions, about 60 percent of physicians use online services to transmit billing information and documentation from disease management programs. Hospitals have implemented EHRs to varying degrees. However, Germany still lags in the implementation of a comprehensive EHR. The greatest problem is the incompatibility of the different programs within and between hospitals, and between hospitals and ambulatory care. A unique patient identifier does not exist, as data safety concerns represent a significant obstacle.

A national strategy to create an electronic medical chip card was implemented in October 2011, and the new electronic medical chip card will be fully implemented by January 2015. The card contains the insured person's name, address, date of birth, and sickness fund, along with details of insurance coverage and status regarding supplementary charges. In the future, it may store EHR data, information on emergency care and pharmacotherapy, or explanations of organ and tissue donation. Patients choose the scope of the data stored and have the right to obtain their EHRs at any time.



How are costs contained?

The SHI Modernization Act of 2004 had a substantial impact on copayments made by patients. Costs were shifted to users via increased copayments or the exclusion of benefits (for example, eyeglasses, transport to ambulatory care, and over-the-counter medications). Copayment amounts were increased and standardized to €10 (USD13) per inpatient day and to between €5 (USD6.5) and €10 for services and products in ambulatory care. Until the end of 2012, copayments of €10 per quarter also applied to the first contact at a physician's (not necessarily a GP) or dentist's office and when other physicians were seen without referral during the same quarter.

All drugs, both patented and generic, are placed into groups with a reference price serving as a maximum level for reimbursement, unless they can demonstrate added medical benefit. The Institute for Quality and Efficiency is legally charged with evaluating cost effectiveness of drugs with added therapeutic benefits, leading to either inclusion in the reference group in case of no added benefit, or price negotiations between the manufacturer and the Federal Association of Sickness Funds. Drug companies are required to produce scientific dossiers for all new drugs demonstrating a drug's added medical benefit, which is then evaluated by the Federal Joint Committee and the Institute for Quality and Efficiency within a three-month period. For drugs with added benefit, the Federal Association of Sickness Funds negotiates a rebate on the manufacturer's price, which is applied to all patients. In addition, rebates are negotiated between individual sickness funds and pharmaceutical manufacturers to lower prices below the reference price.

Recently, reliance on overall budgets for ambulatory physicians and hospitals and collective regional prescription caps for physicians has been replaced by emphasis on quality and efficiency. However, physicians are still financially liable if they exceed regular volumes for their patient mix above the prescription cap.



What major innovations and reforms have been introduced?

The General Law on Patients' Rights came into effect in 2013. It includes several measures designed to strengthen patients' rights. The most important one is the incorporation of the treatment agreement into the Civil Code, in which the rights, duties, and forms of etiquette emerging from the relationship between provider and patient are established, as well as a statutory duty to provide information and documentation to patients on their request.

In July 2014, the Federal Cabinet passed the Bill of the First Act to Strengthen Long-Term Care, to be implemented in January 2015. It aims to support families that provide care at home, for example, through more day care and short-term care opportunities, and by increasing the number of additional caregivers. Long-term care benefits and services are to increase by 20 percent. To this end, LTCI contributions will rise by 0.3

percentage points in January 2015 and by a further 0.2 percentage points during the following two years. The Second Act to Strengthen Long-Term Care is intended to redefine what constitutes need for such care in order to reflect the growing number of dementia patients. It is planned to go into effect before 2017.

The coalition agreement plan from 2013 includes proposals for various measures with a focus on the promotion of quality. In June 2014, the Federal Joint Committee was commissioned to establish the Institute for Quality Assurance and Transparency in Health Care (see above).

Furthermore, a new bill changes the way SHI contribution rates are determined and shared between employer and employee to contain indirect labor costs. Beginning in 2015, the general contribution rate (14.6%) will be kept but both the special contribution rate for employees only (0.9%) as well as the supplementary premiums (and necessary specific social protection mechanisms) will be abolished. The latter two will be replaced by a supplementary income-dependent contribution rate, which will be determined by each sickness fund individually. For 2015, it is expected to be, on average, lower than 0.9 percent—that is, SHI-insured will pay less than in 2014.

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The Italian Health Care System, 2014

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What is the role of government?

The Italian National Health Service (*Servizio Sanitario Nazionale*) is regionally based and organized at the national, regional, and local levels. Under the Italian constitution, responsibility for health care is shared by the national government and the 19 regions and 2 autonomous provinces. The central government controls the distribution of tax revenue for publicly financed health care and defines a national statutory benefits package to be offered to all residents in every region—the “essential levels of care” (*livelli essenziali di assistenza*). The 19 regions and two autonomous provinces have responsibility for the organization and delivery of health services through local health units. Regions enjoy significant autonomy in determining the macro structure of their health systems. Local health units are managed by a general manager appointed by the governor of the region, and deliver primary care, hospital care, outpatient specialist care, public health care, and health care related to social care.



Who is covered?

The National Health Service covers all citizens and legal foreign residents. Coverage is automatic and universal. Since 1998, undocumented immigrants have access to urgent and essential services. Temporary visitors can receive health services by paying for the costs of treatment.

Since the National Health Service does not allow members to opt out of the system and seek only private care, substitutive insurance does not exist. At the same time, complementary and supplementary private health insurance is available. Approximately 15 percent of the population has some form of private insurance.



What is covered?

Services: Primary and inpatient care are free at the point of use. Positive and negative lists are defined using criteria related to medical necessity, effectiveness, human dignity, appropriateness, and efficiency in delivery. Positive lists identify services (e.g., pharmaceuticals, inpatient care, preventive medicine, outpatient specialist care, home care, primary care) offered to all residents. Outpatient optometrist visits are covered, while corrective lenses are not. Negative lists, on the other hand, identify services not offered to patients (e.g., cosmetic surgery), services covered only on a case-by-case basis (e.g., orthodontics and laser eye surgery) and services for which hospital admissions are likely to be inappropriate (e.g., cataract surgery). Regions can choose to offer services not included in the essential levels of care but must finance them themselves.

Essential levels of care do not include a specific list of mental health, preventive, public health, or long-term care services. Rather, national legislation defines an organizational framework for mental health services, with local health authorities obliged to define the diagnostic, curative, and rehabilitative services available. Essential levels of care also outline general community and individual levels of preventive services to be covered by the National Health Service, including hygiene and public health, immunization, and early diagnosis tools. They broadly state that rehabilitative and long-term inpatient care are to be delivered as part of a standard, inpatient curative care program.

Prescription drugs are divided into three tiers according to clinical effectiveness and, in part, cost-effectiveness. The first tier is covered in all cases; the second, only in hospitals; and the third tier is not covered. For some categories of drugs, therapeutic plans are mandated, and prescriptions must follow clinical guidelines.

Dental care is included in the essential levels of care for specific populations such as children (up to 16 years old), vulnerable people (the disabled, people with HIV, those with rare diseases), people in economic need, and individuals with urgent/emergency need. For others, dental care is generally not covered and is paid for out-of-pocket.

Cost-sharing and out-of-pocket spending: Procedures and specialist visits can be prescribed either by a general practitioner (GP) or by a specialist. While there are no user charges for GP consultations and hospital admission stays, patients pay a copayment for procedures and specialist visits up to a ceiling determined by law—currently, at €36.15 (USD48) per prescription.* Therefore, a patient who receives two separate prescriptions (e.g., an MRI scan and a laboratory test) after a visit pays €36.15 (USD48) for each prescription.

To address rising public debt, in July 2011 the government introduced, along with other economic initiatives, an additional €10 (USD13) copayment for each prescription. Copayments have also been applied to outpatient drugs at the regional level, and a €25 (USD33) copayment has been introduced for “inappropriate” use of emergency services (although some regions have not enforced this copayment). No other forms of deductibles exist. Public and private providers under a contractual agreement with the National Health Service are not allowed to charge above the scheduled fees.

All individuals with out-of-pocket payments over €129 (USD170) in a given year are eligible for a tax credit equal to roughly one-fifth of their spending, but there are no caps.

In 2013, 18 percent of total health spending was paid out-of-pocket, mainly for drugs not covered by the public system and for dental care (OECD, 2014). Out-of-pocket payments can be used to access specialist care and, to a lesser extent, inpatient care delivered in private and public facilities to paying patients.

Safety net: Exemptions from cost-sharing are applied to people over age 65 and under age 6 who live in households with a gross income below a nationally defined threshold (approximately €36,000 [USD47,360]); people with severe disabilities, as well as prisoners, are exempt from any cost-sharing. People with chronic or rare diseases, people who are HIV-positive, and pregnant women are exempt from cost-sharing for treatment related to their condition. Most screening services are provided free of charge.



How is the health system financed?

Publicly financed health care: Public financing accounted for 78 percent of total health spending in 2013, with total expenditure standing at 9.1 percent of GDP (OECD, 2014). The public system is financed primarily through a corporate tax (approximately 35.6% of the overall funding in 2012) pooled nationally and allocated back to regions, typically the source region (there are large interregional gaps in the corporate tax base, leading to financing inequalities), and a fixed proportion of national value-added tax revenue (approximately 47.3% of the total in 2012) collected by the central government and redistributed to regions unable to raise sufficient resources to provide the essential levels of care (Ministero dell’Economia e delle Finanze, 2012).

Regions are allowed to generate their own additional revenue, leading to further interregional financing differences. Every year the Standing Conference on Relations between the State, Regions, and Autonomous Provinces (with the presidents of the regions and representatives from central government as its members) sets the criteria (usually population size and age demographics) to allocate funding to regions. Local health units are funded mainly through capitated budgets.

The 2008 financial law established that regions would be financed through standard rates set on the basis of actual costs in the regions considered to be the most efficient. Established in legislation, this policy is not operating yet.

* Please note that throughout this profile, all figures in USD were converted from EUR at a rate of about €0.76 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014b) for Italy.

Privately financed health care: Private health insurance plays a limited role in the health system, accounting for roughly 1 percent of total spending in 2009. Private health insurance generally covers services excluded under the LEA, to offer a higher standard of comfort and privacy in hospital facilities, and wider choice among public and private providers. Some private health insurance policies also cover copayments for privately provided services, or a daily rate of compensation during hospitalization (Thomson et al., 2009). Tax benefits favor complementary over supplementary voluntary insurance.

There are two types of private health insurance: corporate, where companies cover employees and sometimes their families; and noncorporate, with individuals buying insurance for themselves or for their family. Policies, either collective or individual, are supplied by for-profit and nonprofit organizations. The market is characterized by the presence of three types of nonprofit organizations: voluntary mutual insurance organizations, and corporate and collective funds organized by employers/professional categories for their employees/members.

Approximately 74 percent of policies are purchased by individuals, while the remaining 26 percent are purchased by groups.



How is the delivery system organized and financed?

Primary care: Primary care is provided by self-employed and independent physicians, general practitioners (GP) and pediatricians, under contract and paid a capitation fee based on the number of people on their list (Lo Scalzo et al., 2009). Local health units also can pay additional allowances for the delivery of planned care to specific patients (e.g., home care for chronically ill patients), for reaching performance targets (e.g., to reward effective cost containment on pharmaceuticals, laboratory tests, and therapeutic treatments prescribed), or for delivering additional treatments (e.g., medications, flu vaccinations). Capitation is adjusted for age and accounts for approximately 70 percent of the overall payment. The variable portion comprises fee-for-service payment for specific treatments, including minor surgery, home care, preventive activities, and taking care of chronically ill patients.

Payment levels, duties, and responsibilities of GPs are determined in a collective agreement signed every three years by consultation between central government and the GPs' trade unions. In addition regions and local health units can sign contracts covering additional services.

In 2011, there were approximately 53,800 GPs and pediatricians (33.5%) and 106,800 hospital clinicians (66.5%) (Ministero della Salute, 2014). Patients are required to register with a gatekeeping GP, who has incentives to prescribe and refer only as appropriate: in most cases incentives are awarded only to those GPs and pediatricians who achieve a predetermined spending or consumption target (e.g., per capita spending on drugs or diagnostic imaging). People may choose any physician whose list has not reached the maximum number of patients allowed (1,500 for GPs and 800 for pediatricians) and may switch at any time.

In recent years the solo practice model has been progressively modified toward group practice, particularly in the northern part of the country. Legislation encourages GPs and pediatricians to work in three ways: base group practice, where GPs from different offices share clinical experiences, develop guidelines, and participate in workshops that assess performance; network group practice, which functions like base group practice but allows GPs/pediatricians to access the same patient electronic health record system; and advanced group practice, where GPs/pediatricians share the same office and patient health record system, and are able to provide care to patients beyond individual catchment areas. In 2010, approximately 67 percent of GPs and 60 percent of pediatricians were working in a team (Ministero della Salute, 2014). Group practices typically range from three to eight GPs.

General practitioners working in base group practices receive an additional €2.58 (USD3.4) per patient, while GPs in a network practice receive €4.7 (USD6.2) (the payment for pediatricians is €8 [USD11]). Lastly, GPs working in a group practice receive €7 (USD9) (€9 [USD12] for pediatricians). General practitioners or pediatricians employing a nurse or secretary receive an additional payment of €4 (USD5.3) for nurses and €3.5 (USD4.6) for a secretary.

Some regions are promoting care coordination by asking their GPs to work in groups involving specialists, nurses, and social workers. The aim is for each group to be in charge of all the health needs of its assigned population. This is encouraged by additional payments to GPs (e.g., paying each GP €1.3 (USD1.7) per patient in Emilia-Romagna) and supplying teams with personnel, in most cases nurses and social workers.

Outpatient specialist care: Outpatient specialist care is generally provided by local health units or by public and private accredited hospitals under contract with them. Once referred, patients are given choice of any public or private accredited hospital, but are not allowed to choose a specific specialist. Outpatient specialist visits are generally provided by self-employed specialists working under contract with the National Health Service. They are paid an hourly fee contracted nationally between the government and the trade unions; the current rate is approximately €32 (USD42). Outpatient specialists can see private patients without any limitations, whereas specialists employed by local health units and public hospitals cannot. Multispecialty groups are more common in northern regions of the country.

Administrative mechanisms for paying primary care doctors and specialists: Patient copayment is limited to outpatient specialist visits and diagnostic testing, while primary care visits are provided free of charge. Copayments are usually paid by the patient before receiving the visit/test.

After-hours care: After-hours centers are generally located in local health unit–owned premises and staffed only by doctors employed on an hourly basis by the local health unit. The hourly rate, negotiated between the GP trade unions and government, is approximately equal to €25 (USD33). Following examination and initial treatment, the doctor can prescribe medications, issue employees' medical certificates, and recommend hospital admission. *Guardia medica* is a free telephone health service for emergency cases. It normally operates at night and on weekends, and the doctor on duty usually provides advice, in addition to home visits if needed. Information on a patient's visit is not routinely sent to the patient's GP. To improve accessibility, government and GP associations are trying to promote a model where GPs, specialists, and nurses coordinate to ensure 24-hour access and avoid unnecessary use of hospital emergency departments. Implementation is uneven across regions.

Hospitals: Depending on the region, public funds are allocated by local health units to public and accredited private hospitals. In 2011 there were approximately 194,000 beds in public hospitals and 47,500 in private accredited hospitals (Ministero della Salute, 2014). Public hospitals either are managed directly by the local health units or operate as semi-independent public enterprises. A diagnosis-related group-based prospective payment system operates across the country and accounts for most hospital revenue but is generally not applied to hospitals run directly by local health units, where global budgets are common. Rates include all hospital costs, including those of physicians. Teaching hospitals receive additional payments (typically 8% to 10% of overall revenue) to cover extra costs related to teaching. There are considerable interregional variations in the prospective payment system, such as how the fees are set, which services are excluded, and what tools are employed to influence patterns of care. However, all regions have mechanisms for cutting fees once a spending threshold is reached, to contain costs and incentives to increase admissions.

In all regions, a portion of funding is administered outside the prospective payment system (e.g., funding of specific functions such as emergency departments and teaching programs).

Hospital-based physicians are salaried employees. Public hospital physicians are prohibited from treating patients in private hospitals; all public physicians who see private patients in public hospitals pay a portion of their extra income to the hospital.

Mental health care: Mental health care is provided by the National Health Service in a variety of community-based, publicly funded settings, including community mental health centers, community psychiatric diagnostic centers, general hospital inpatient wards, and residential and semiresidential facilities. In 2010 there were 1,737 residential facilities and 784 semiresidential facilities providing care to approximately 60,000 patients. Promotion and coordination of mental illness prevention, care, and rehabilitation are the responsibility of specific mental health departments in local health units. These are based on a multidisciplinary team, including psychiatrists, psychologists, nurses, social workers, educators, occupational therapists, people with training in psychosocial

rehabilitation, and secretarial staff. In most cases primary care does not play a role in provision of mental health care; a few regions have experimented with assigning the responsibility of low-complexity cases (mild depression) to general practitioners (Lo Scalzo et al., 2009).

Long-term care and social supports: Patients are generally treated in residential (approximately 221,000 beds in 2011) or semiresidential (50,000 beds) facilities, or in community home care (approximately 606,000 cases). Residential and semiresidential services provide nurses, physicians, specialist care, rehabilitation services, medical therapies, and devices. Patients must be referred in order to receive residential care. Cost-sharing for residential services varies widely according to region, but is generally determined by patient income. Community home care is funded publicly, whereas residential facilities are managed by a mixture of public and private, for-profit and nonprofit organizations. Community home care is not designed to provide physical or mental care services but to provide additional assistance during a treatment or therapy. In spite of government provision of residential and home care services, long-term care in Italy has traditionally been characterized by a low degree of public financing and provision as compared with other European countries.

Financial assistance for patients can take two forms:

- *Accompanying allowance:* Awarded by the National Pension Institute to all Italian citizens who need continuous assistance. The allowance, which is related to need but not to income or age, amounts to approximately €500 (USD658) per month.
- *Care voucher:* Awarded by municipalities on the basis of income, need, and clinical severity only to residents of those municipalities offering the service. The amount ranges between €300 and €600 (USD395 to USD789) per month.

Voluntary organizations still play a crucial role in the delivery of palliative care. A national policy on palliative care has been in place since the end of the 1990s and has contributed to an increase in services such as hospices, day care centers, and palliative care units within hospitals. In 2011 there were 158 hospices, with approximately 1,700 beds. But much still needs to be done to ensure the diffusion of palliative care services and disparities persist: northern regions cared, on average, for 51 patients per 100,000 residents, while in central and southern regions the rate fell to 25 patients.



What are the key entities for health system governance?

The Ministry of Health is currently structured into 12 directorates that oversee specific areas of health care (health care planning; essential levels of care and health system ethics; human resources and health professionals; information systems; pharmaceuticals and medical devices) or supervise the main institutions related to the Ministry of Health (e.g., National Health Council, National Institute of Health).

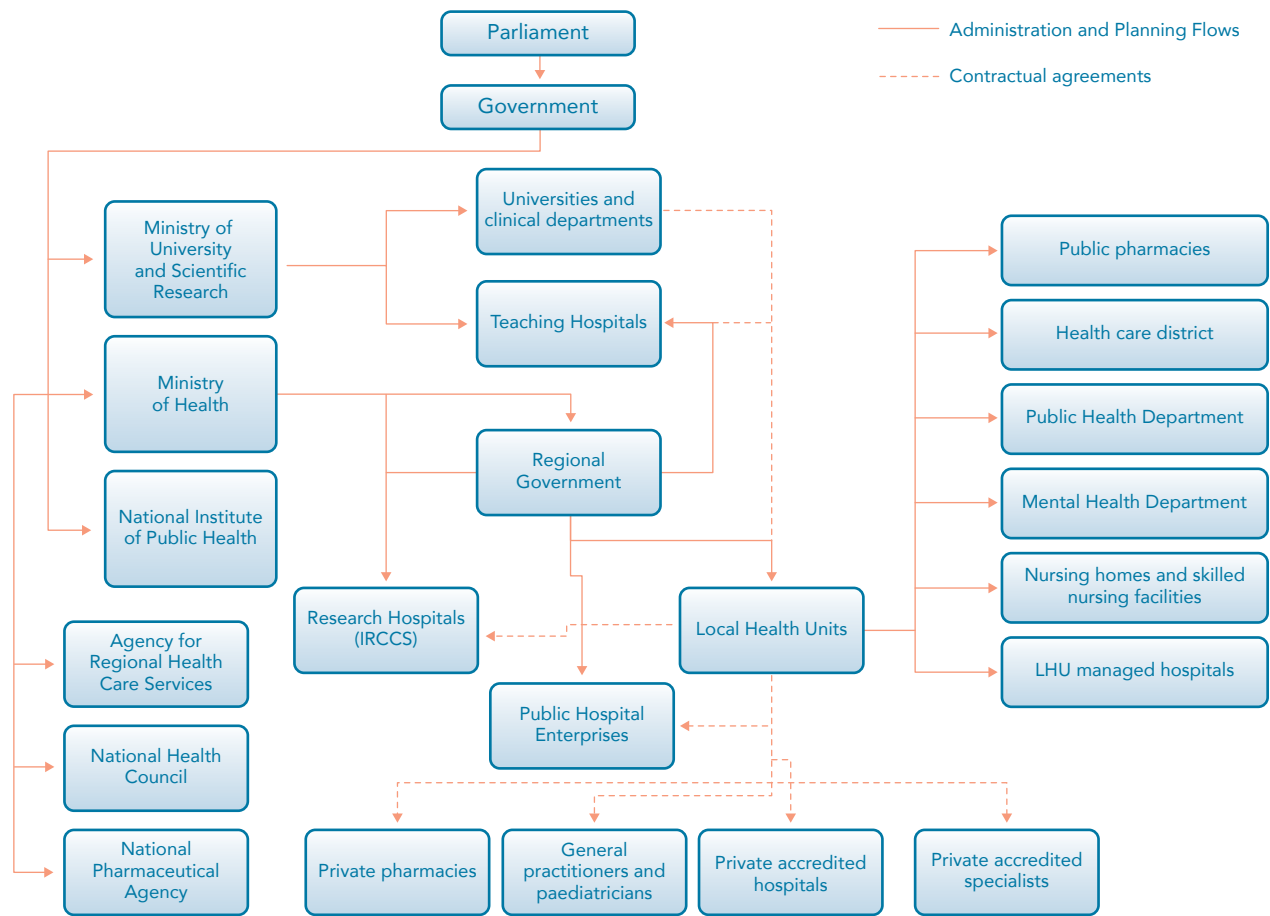
Key nongovernmental entities supporting the Ministry of Health include the National Health Council (which provides support for national health planning, hygiene and public health, pharmacology and pharmaco-epidemiology, continuing medical education for health care professionals, and information systems) and the National Institute of Public Health (which provides recommendations and control in the area of public health).

The National Committee for Medical Devices develops cost-benefit analyses and determines reference prices for medical devices. The Agency for Regional Health Services is the sole institution responsible for conducting comparative effectiveness analysis and is accountable to the regions and the Ministry of Health.

The National Pharmaceutical Agency is responsible for all matters related to the pharmaceutical industry, including prescription drug pricing and reimbursement policies. It is accountable to the Ministry of Health and the Ministry of Economy and Finance (Lo Scalzo et al., 2009).

Payment rates for hospital and outpatient specialist care are determined by each region, with national rates (determined by the Ministry of Health) as a reference.

Organization of the Health System in Italy



Source: A. Donatini, Emilia-Romagna Regional Health Authority, 2014.

Some regional governments have established agencies to evaluate and monitor health care quality and to provide comparative effectiveness assessments and scientific support to regional health departments (see below). Regional governments periodically sign with the national government “Pacts for Health” linking additional resources to the achievement of health care planning and expenditure goals (see below).

Safeguarding of patients’ rights has not been uniform and has depended on the level of effort of individual regions. Regions have implemented different models of empowerment: some through standing committees, which include members from citizens’ associations, as an institutional means of patient involvement, while others have emphasized systematic patient satisfaction surveys.

Each public institution has an office for public relations (*Ufficio Relazioni con il Pubblico*) providing information to citizens and, in many cases, monitoring quality of services from the citizens’ point of view.



What are the major strategies to ensure quality of care?

National and regional governments, responsible for upholding quality, ensure that services included in the essential levels of care are provided and waiting times are monitored. Several regions have introduced programs for prioritizing delivery of care on the basis of clinical appropriateness of services prescribed and patient severity (France et al., 2005). All doctors under contract with the National Health Service must be certified, and all National Health Service staff participate in compulsory continuing education. The National

Commission for Accreditation and Quality of Care is responsible for outlining the criteria used to select providers and for evaluating regional accreditation models (including private hospitals), which vary considerably across the system. These models do not usually include periodic reaccreditation.

Legislation passed during the 1990s covers three main components of quality: input (quality of infrastructure and human resources); process (appropriateness and timeliness of interventions); and outcome (health status and patient satisfaction) (Lo Scalzo et al., 2009).

National legislation requires all public health care providers to issue a “health service chart” with information on service performance, quality indicators, waiting times, quality assurance strategies, and the process for patient complaints. These charts also have been adopted by the private sector for its accreditation process, and must be published annually, although dissemination methods are decided regionally. Most providers issue data through leaflets and the Internet, while nurses and other medical staff are offered financial performance incentives (linked to manager evaluations but not to publicly reported data).

The National Plan for Clinical Guidelines (*Piano Nazionale Linee Guida*) has been implemented in recent years and has produced guidelines on topics ranging from cardiology to cancer prevention and from appropriate use of antibiotics to cesarean delivery.

Some regions have introduced disease management programs, are experimenting with chronic care models (refer to the section on coordination) and maintain registries, mainly for cancer patients and diabetes. No national registries exist. Patient surveys are not used for quality control.



What is being done to reduce disparities?

Interregional inequity is a long-standing concern. The less affluent south trails the north in number of beds and availability of advanced medical equipment, has more private facilities, and less-developed community care services. Data show a rise in interregional mobility in the 1990s, with movement particularly from southern to central and northern regions (France, 1997) and an increasing gap between the north and south (Toth, 2014).

Income-related disparities in self-reported health status are significant, though similar to those in the Netherlands, Germany, and other European countries (Van Doorslaer and Koolman, 2004).

The National Health Plan for 2006–2008 cites overcoming large regional discrepancies in care quality as key objective for reform. Directing EU resources toward health services in eight regions in the south was a first step in 2007 in reducing this persistent variation. Regions receive a proportion of funding from an equalization fund (the National Solidarity Fund), which aims to reduce inequalities. Aggregate funding for the regions is set by the Ministry of the Economy and Finance, and the resource allocation mechanism is based on capitation adjusted for demographic characteristics and use of health services by age and sex.



What is being done to promote delivery system integration and care coordination?

Integration of health and social care services has recently improved, with a significant shift of long-term care from institutions to the communities, with an emphasis on home care. Community home care establishes a home care network that integrates the competencies of nurses, GPs, and specialist physicians with the needs and involvement of the family. General practitioners oversee the home care network, liaise with social workers and other sectors of care, and take responsibility for patient outcomes.

Regions have chronic patient management programs, dealing mainly with high-prevalence conditions such as diabetes, congestive heart failure, and respiratory conditions. All programs involve different competencies although the degree of evolution is varied across regions. Some regions are also trying to set up disease management programs based on the chronic care model.

The most recent Pact for Health, signed in July 2014, is a significant step toward care integration (see below): all regions must establish “primary care complex units” (*Unità Complesse di Cure Primarie*) involving GPs, specialists, nurses, and social workers.

Given that, traditionally, Italian GPs work in solo practice, shifting to this new organizational arrangement will require considerable effort. To further promote integration and adoption of multidisciplinary teams, medical homes are being encouraged in some regions. (Tuscany and Emilia-Romagna have invested considerable resources in activating and promoting medical homes. In Emilia-Romagna, for example, there are currently 62 medical homes providing multispecialty care to approximately 1 million people.)



What is the status of electronic health records?

The New Health Information System has been implemented incrementally since 2002 to establish a universal system of electronic records connecting every level of care. It provides information on the services, resource use, and costs, but does not cover all areas of health care; in particular, primary care is not covered, while hospital, emergency, outpatient specialist, residential and palliative care, and pharmaceuticals are. It currently contains administrative information on care delivered, as medical information appears more difficult to gather. No unique patient identifier exists at the national level.

A core component of the New Health Information System is the nationwide clinical coding program known as “bricks,” one of the most mature elements of Italy’s developing electronic health program. It aims at defining a common language to classify and codify concepts; at sharing methodologies for measuring quality, efficiency, and appropriateness of care; and at allowing an efficient exchange of information between the national level and regional authorities.

Some regions have developed computerized networks to facilitate communication between physicians, pediatricians, hospitals, and territorial services and to improve continuity of care. These networks allow automatic transfer of patient registers, services provided, prescriptions for specialist visits and diagnostics, and laboratory and radiology test outcomes. A few regions also have developed a personal electronic health record, accessible by patients, that contains all patient medical information, such as outpatient specialty care results, medical prescriptions, and hospital discharge instructions. Personal electronic health records should provide support to patients and clinicians across the whole process of care but diffusion is still limited.

There is also a slow movement from paper to electronic prescriptions. By the end of 2014, 80 percent of all prescriptions (drugs and specialist care) were to be issued electronically, but only five regions declared that they were able to reach the goal on time.



How are costs contained?

Containing health costs is a core concern of central government, as Italy’s public debt is among the highest in industrialized nations. Fiscal capacity varies greatly across regions. To meet cost containment objectives, the central government can impose recovery plans on regions with health care expenditure deficits. These identify tools and measures needed to achieve economic balance: revision of hospital and diagnostic fees, reduction of the number of beds, increased copayments for pharmaceuticals, and reduction of human resources through limited turnover.

The Agency for Regional Health Services, in collaboration with the Ministry of Health, has authority to conduct health technology assessments and implement its findings at the regional level, but these are not yet formalized or undertaken systematically. Few regional health technology assessment agencies currently exist, and their primary function is to evaluate individual technologies. Assessments are not mandatory for new or referred procedures and devices. However, reference prices for medical devices and pharmaceuticals are set according to cost-effectiveness studies carried out by the National Committee for Medical Devices and the National Drugs Agency. Furthermore, the National Pharmaceutical Formulary bases coverage decisions in part on clinical

effectiveness and cost-effectiveness. Prices for reimbursable drugs are set in negotiations between government and the manufacturer according to the following criteria: cost-effectiveness where no effective alternative therapies exist; comparison of prices of alternative therapies for the same condition; costs per day compared with those of products of the same effectiveness; financial impact on the health system; estimated market share of the new drug; and average prices and consumption data from other European countries. Prices for nonreimbursable drugs are set by the market.



What major innovations and reforms have been introduced?

Because of the regionalization of the health system, most innovations in the delivery of care take place at the regional rather than the national level, with some regions viewed as leaders in innovation. Significant innovations can be found in:

- *Pharmaceuticals*: Both the National Drugs Agency and the regions are particularly active in coordinating guidelines and rules to promote appropriate and cost-effective prescribing.
- *Hospital care*: Various innovations have been introduced concerning the overall organization, management of operations (e.g., planning of surgical theaters and delivery of drugs), and health information technology (e.g., electronic medical records, automation of administrative and clinical activities).

In August 2012 the parliament passed a law aimed at curbing and rationalizing public expenditure (the so-called spending review). The law promoted the prescription of generic drugs, cut the hospital bed ratio from 4 per 1,000 people to 3.7, and reduced public financing of the National Health Service by between €900M (USD1.2B) and €2.1B (USD2.8B) annually between 2012 and 2015. Many of the requirements of the law are still in the process of being implemented and effects have not yet been evaluated.

In 2012, the government approved a decree (named after Renato Balduzzi, who was health minister at that time) to reorganize health care at the regional level, with the introduction of teams of primary health care professionals to ensure 24-hour coverage; to update health care fees; to restructure governance of hospitals and local health units; to revise the list of reimbursable pharmaceuticals; and to introduce health technology assessment as a tool for renegotiating the price of less effective medicines. Evaluations of the impact of both laws are not yet available as their implementation is still under way.

The July 2014 Pact for Health defines funding (between €109B [USD143.4B] and €115B [USD151.3B] annually) for the years 2014 to 2016. In return, regions make explicit commitments to:

- Reduce hospitalizations through appropriate use of hospitals, with progress toward home care and the creation of community hospitals offering subacute care.
- Reorganize primary care: All regions will have to establish primary care complex units (*Unità Complesse di Cure Primarie*) (as described in the section on care integration) to replace all other forms of general practice networks (base group practice, network group practice, and advanced group practice).
- Revise hospital and specialist care fees in line with health inflation and with the underlying structure of health care costs.
- Revise copayments for outpatient specialist care to promote more equitable access. Copayments currently represent a barrier for disadvantaged sectors of the population.
- Strengthen the electronic records system.

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The Japanese Health Care System, 2014

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What is the role of government?

The government regulates almost all aspects of the universal public health insurance system. By law, the national and local governments endeavor to ensure to the nation a system that will efficiently provide high-quality, appropriate medical care (Medical Care Law, Article 1-3). The national government sets the fee schedule and subsidizes local governments, insurers, and providers. It also establishes and enforces detailed regulations for insurers and providers. Japan's 47 prefectures (regions) implement regulations for health care providers and insurers, and develop regional health care delivery with funds allocated by the national government. More than 1,700 municipalities operate parts of the public health insurance system and long-term care insurance and organize health promotion activities for their residents (Tatara and Okamoto, 2009).



Who is covered?

The public health insurance system—there are more than 3,400 insurers—provides universal primary coverage (National Institute of Population and Social Security Research, 2014). Citizens are not free to choose; a citizen is required to enroll in one of the public health insurance system plans according to his/her employment status and/or place of residence. Resident noncitizens also are required to obtain coverage; undocumented immigrants and visitors are not covered. Those who neglect to enroll must pay up to two years of back premiums when they reenter the system. Recipients of public assistance are means-tested and their benefit covers health insurance. Citizens and resident noncitizens either enrolled in the public health insurance system and/or aged 65 and over are mandatorily enrolled in long-term care insurance.

Voluntary supplementary private health insurance (described further below) is held by the majority (more than 70 percent) of the adult population to provide additional income in case of sickness, mainly in the form of lump-sum payments, such as daily amounts during hospitalization (Life Insurance Association of Japan, 2013). Complementary insurance, sold by private insurance companies, has a minor role and substitutive insurance is not present.



What is covered?

Services: All plans provide the same national benefits package, which covers hospital care, ambulatory care, mental health care, approved prescription drugs, home care, physiotherapy, and most dental care; it does not cover corrective lenses unless recommended by physicians for children under 9 years old. A number of preventive measures are publicly provided to those aged 40 and older, including screening, health education, and counseling. Since 2000, long-term care has been covered by long-term care insurance, administered by municipalities. It provides personal budgets for patients to arrange their own services or have them organized by care managers. Benefit levels of the public health insurance system and long-term care insurance are decided by the national government.

Cost-sharing and out-of-pocket spending: A 30 percent copayment for services and goods covered applies to all enrollees, except for children under 3 years old (20%), people aged 70 to 74 with lower incomes (20%), and people aged 75 and over with lower incomes (10%). There are no deductibles. Annual expenditure on health services and goods, including copayments and payments for balance-billing and over-the-counter drugs, between JPY100,000 (USD967) and JPY2M (USD19,334), can be deducted from taxable income after

subtracting JPY100,000.¹ In 2011, out-of-pocket payments for cost-sharing accounted for 14.0 percent of total health expenditures (OECD, 2014). Some employer-based health insurance plans offer reduced cost-sharing. Providers are prohibited from charging extra fees except for some services specified by the Ministry of Health, Labor and Welfare, including amenity beds, experimental treatments, the outpatient services of large multispecialty hospitals, after-hours services, and hospitalizations of 180 days or more.

Safety net: Catastrophic coverage stipulates a monthly out-of-pocket threshold, which varies according to enrollee age and income (e.g., JPY80,100 [USD774] for people under age 75 with an average income); above this threshold, a 1 percent copayment is applied. Alternatively, the threshold works as a ceiling for low-income people, who do not pay more than JPY35,400 (USD342) a month. Subsidies (mostly restricted to low-income households) reduce the burden of cost-sharing for people with disabilities, mental illness, and specified chronic conditions.

There is an annual ceiling for household health and out-of-pocket payments for long-term care, which varies between JPY310,000 (USD2,997) and JPY1.26M (USD12,180) per enrollee according to their income and age, above which such payments can be reimbursed. Enrollees with employer-based insurance who are on parental leave are exempt from premiums. Enrollees with Citizens Health Insurance (for unemployed, self-employed, retired, and others under age 75) with low incomes, and those with moderate incomes who face sharp, unexpected income reductions, are eligible for reduced premium payments.



How is the health system financed?

Publicly financed health care: In 2012, total health expenditure amounted to 10.3 percent of GDP. Most of the expenditure was publicly financed (82.1%), mainly through the public health insurance system (OECD, 2014). Within the public health insurance system, premiums, subsidies from tax, and user charges accounted for 48.8 percent, 38.4 percent, and 12.3 percent of the sum of health expenditures, respectively (Ministry of Health, Welfare and Labor, 2014c). Citizens Health Insurance insurers levy premiums on a per-capita, per-household, income-related, and asset-related basis. Employer-based insurers levy premiums on wages. Rates also vary between municipalities, albeit on a smaller scale.

Employers pay half of these premiums for their employees. Premiums for employer-based plans vary between 3 percent and 10 percent of income. Rates for employees of small- and medium-sized employers, insured by the Japan Health Insurance Association, are around 10 percent. Government employees are covered by their own system of insurers (known as Mutual Aid Societies), as are some groups of professionals (e.g., doctors in private practice). Government subsidies, funded from the general budget, are provided mainly to Citizens Health Insurance insurers, Health Insurance for the Old-Old insurers, and, to a lesser extent, the Japan Health Insurance Association. There are cross-subsidies from Citizens Health Insurance and employer-based insurance to Health Insurance for the Old-Old, and between Citizens Health Insurance and employer-based insurance.

Privately financed health care: Privately funded health care has been limited to services such as dental orthodontics and expensive artificial teeth, and treatments of traffic accident injuries. (These treatments, however, are usually paid for by compulsory and/or voluntary automobile insurance.) Private health insurance developed, historically, as a supplement to life insurance. It usually pays a lump sum when insured persons are hospitalized over a defined period and/or diagnosed with cancer or any of a number of other specified chronic diseases. More than 70 percent of adults hold this kind of insurance for protection against high out-of-pocket expenditures, particularly in case of hospitalization.

In the past decade, however, the sale of complementary private health insurance policies separate from life insurance has been slightly on the rise owing to population aging, unstable economic conditions, and insurance company marketing. Both for-profit companies and nonprofit organizations operate private health insurance. More than 27 million independent medical life policies were valid in 2012 and most are issued to individuals (Life Insurance Association of Japan, 2013). Part of an individual's life insurance premium (up to JPY40,000

¹ Please note that throughout this profile, all figures in USD were converted from JPY at a rate of about JPY103.45 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014b) for Japan.

[USD387]) can be deducted from taxable income. Small discounts also can be applied to the employees whose employers have collective contracts with insurance companies.



How is the delivery system organized and financed?

Primary care: Primary care and specialist care are not regarded as distinct disciplines, although it has been argued that they should be. Most clinics and some hospitals provide primary care services. Approximately one-third of physicians are salaried employees of clinics, and virtually all others are self-employed. Clinics are often owned by physicians or by medical corporations (special legal entities for health care management, usually controlled by physicians, which own hospitals as well as clinics), but sometimes by local governments or public agencies. Primary and specialist care are provided at clinics, although specialist care requiring hospitalization and the use of expensive medical devices is usually provided at hospitals.

Primary care practices typically include teams with a physician and a few employed nurses. In 2011, the average clinic had 7.2 full-time-equivalent workers, including 1.2 physicians, 1.8 nurses, and 2.1 clerks (Ministry of Health, Welfare and Labor, 2012). Care coordination has been incentivized by top-up fees for coordinating activities. Clinics can dispense medication (which doctors can provide directly to patients). The use of pharmacists, however, has been growing; more than 60 percent of prescriptions were filled at pharmacies in 2009. Registration is not required, but the government asks patients to choose their family physician. Patients can choose and drop in at any clinic except clinics requiring reservations.

An entity managing many clinics can share those resources, but there is no cross-entity resource sharing. There is no strict gatekeeping, although the government encourages patients to choose their family doctor and charges extra for the first consultation at some large-scale providers with many specialties (e.g., educational hospitals) for self-referral, which may provide some patient incentives. Balance-billing is prohibited in principle.

Payments for primary care are principally based on a complex national fee-for-service schedule, which includes financial incentives for coordinating the care of patients with chronic diseases, and for team ambulatory and home care. Per-case payments can be chosen by providers in selected cases: daily payments for pediatrics care and monthly payments for treating patients with diabetes, hyperlipidemia, and hypertension. The fee schedule, decided by the government (explained below), includes both primary care and specialist services, which have common prices for common services. It is a sum of fees for consultations, examinations, laboratory tests, imaging tests, defined chronic disease management, and certain other services. Bundled payments are not used.

Outpatient specialist care: Most outpatient specialist care is provided at hospital outpatient departments, where patients can visit without referral and often drop in, but is also available at clinics, where patients can visit without referral. Some hospitals, particularly educational hospitals, bill patients extra for the first consultation with a specialist if they visit without a referral from a primary care physician. Fees are set by the same public health insurance schedule, not according to who conducts the services but by what services are provided, although some services must be provided by specialists to be covered by public health insurance. There are no collective regulations on payments for specialists. At hospitals they usually are paid a salary, with such additional payments as night duty allowance. Specialists working at public hospitals can work at other health care institutions if their hospital approves.

Administrative mechanisms for paying primary care doctors and specialists: Self-employed clinic-based primary care physicians and specialists receive all payments for their services through the fee-for-service schedule, pay for employees and other inputs, allocate funds for investments, and take remaining funds for themselves. While those employed by medical corporations are salaried, their allocating processes can be similar because employed physicians are often presidents of the medical corporations that employ them. Specialists working at hospitals are mostly salaried by legal entities managing them at their own discretion. Legal entities managing clinics and hospitals send insurance claims mostly through the Internet to insurers in the public health insurance system. They receive fees from insurers and corresponding copayments from patients.

Patients, in principle, are liable for copayments at the point of service. In practice, claims and fees are mediated by statutory bodies.

After-hours care: This is provided by hospital outpatient departments, where on-call physicians are available, and by some regular clinics and after-hours care clinics. “Top-up” fees paid to hospitals and clinics for after-hours care include telephone consultations, but there is no strict formal requirement for clinics to provide such service. Patients can walk-in at those hospitals and clinics. Usually, after-hours care clinics are owned by local governments, and local medical societies provide the staff (physicians and nurses). The national government grants subsidies to local governments for these clinics, which will furnish information about patients to family physicians if necessary (often this information is handed to patients to show to family physicians). There is a national after-hours pediatric medical advice telephone line called Telephone Advice on Children’s Medical Emergencies.

Hospitals: In 2013, 15 percent of hospitals were owned by national and local governments and closely related agencies (Ministry of Health, Welfare and Labor, 2014b); most of the rest are private not-for-profit, some of which are designated as partly having public roles and receiving subsidies. More than 20 percent of hospital beds are in public hospitals; the rest are in not-for-profit hospitals. The entry of private for-profit companies into the hospital sector is virtually prohibited, while existing hospitals owned by for-profit companies for their employees (e.g., Toyota) are allowed to continue. Payments to hospitals from the public health insurance system include costs for physicians, who are usually employed by the hospital on a salary basis. Public-hospital physicians can practice privately with approval from their hospitals, but in such cases they usually provide services covered by the public system.

The fees for consultation for large hospitals and academic medical centers are lower than small hospitals and clinics. Hospitals having 200 or more beds charge extra fees to patients not referred by a physician for the first consultation, except in the case of emergency, while patients in general are free to self-refer. More than half of all acute-care hospital beds are paid for using the Diagnosis Procedure Combination modification, a case-mix classification similar to that of diagnosis-related groups (Matsuda et al., 2008). The other half are paid for solely according to fee-for-service (FFS). Hospitals voluntarily elect to receive the Diagnosis Procedure Combination payments or remain under FFS. The Diagnosis Procedure Combination payment consists of a Diagnosis Procedure Combination component and a fee-for-service component.

A *per diem* payment determined by the Diagnosis Procedure Combination grouping is used for the Diagnosis Procedure Combination component, which includes basic hospital services and less expensive treatments; the fee-for-service component includes surgical procedures, rehabilitative services, and other specified expensive services (OECD, 2009). Diagnosis Procedure Combination rates are multiplied by a hospital-specific coefficient, so as to keep them relatively in line with fee-for-service payments, and may limit the incentives for providers to contain cost; this, however, has not yet been formally evaluated. Episode-based payments are not used.

Mental health care: Mental health care is covered under the public health insurance system, along with the standard 30 percent copayment, although financial protections include reduced cost-sharing for patients recently discharged from psychiatric institutions. Japan has the largest number of psychiatric beds per capita in the world, but has been taking some steps in the past decade to move mental health care into the community. Approximately 80 percent of psychiatric beds are in private not-for-profit hospitals, and providers are generally paid on a fee-for-service basis. Outpatient and home mental health services, including psychological therapies, also are covered. Some mental health services, including treatment of minor depression and dementia, are integrated in primary care, while others are independent.

Long-term care and social supports: Since 2000, the national compulsory long-term care insurance scheme, administered by the municipalities, has covered those age 65 and older and some disabled people ages 40 to 64. It covers nursing services, home help, home nursing, respite care, domiciliary care, disability equipment, assistive devices, and home modification. Medical services are covered by the public health insurance system, as are palliative and hospice care provided in hospitals and medical services provided as part of home palliative care. Long-term care insurance home care services can be used as a part of home hospice services if dying patients become eligible.

Roughly half of the financing comes through taxation and half through premiums. Citizens aged 40 and over have to pay premiums. Premiums for those aged 65 and older are decided by municipalities based on estimated expenditures and are linked to the income (including pensions) of the insured. Premiums for long-term care for those ages 40 to 64 are collected with health insurance premiums. Employers split premium payments evenly with their employees. A 10 percent copayment applies to all covered services, up to an income-related ceiling. There is an additional copayment for bed and board in institutional care, but it is waived or reduced for those with low income (all costs for those with means-tested social assistance are paid from local and national tax revenue).

In home care, private providers are dominant. For example, 62.6, 36.4, and 0.4 percent of home help service providers were for-profit, not-for-profit, and public, respectively, in 2012 (Ministry of Health, Labor and Welfare, 2014a). While for-profits are not allowed in institutional care under long-term care insurance, there are private nursing homes for which residents pay full costs (Ministry of Health, Labor and Welfare 2013).

Under long-term care insurance, eligible people are entitled to use long-term services, up to certain ceilings. The ceilings, called care levels, are decided by the government and vary according to need. Local long-term care insurance boards determine patient care levels by assessing patients' physical and mental condition. People are not allowed to use long-term care insurance to buy unlisted services or services from non-long-term-care insurance providers, but they can purchase such services with their own money. Care management—covered by long-term care insurance and offered by public, not-for-profit, and for-profit providers—is available to help people make choices regarding long-term care services.

Employees are entitled to up to three months of family care leave benefits (part of employment insurance) to care for a family member. Additionally, more than half of municipalities have established marginal financial supports, mostly limited to those with lower incomes, which they finance and legislate (Kwon, 2014).



What are the key entities for health system governance?

The Social Security Council, a statutory body within the Ministry of Health, Labor and Welfare, is in charge of developing national strategies on quality and safety, cost control, and making guidelines for setting provider fees. Within the ministry, the Central Social Insurance Medical Council, also a statutory body, consists of representatives of statutory insurers, health care providers, and experts, and is responsible for revising the fee schedule, which determines coverage of and fees for health care services.

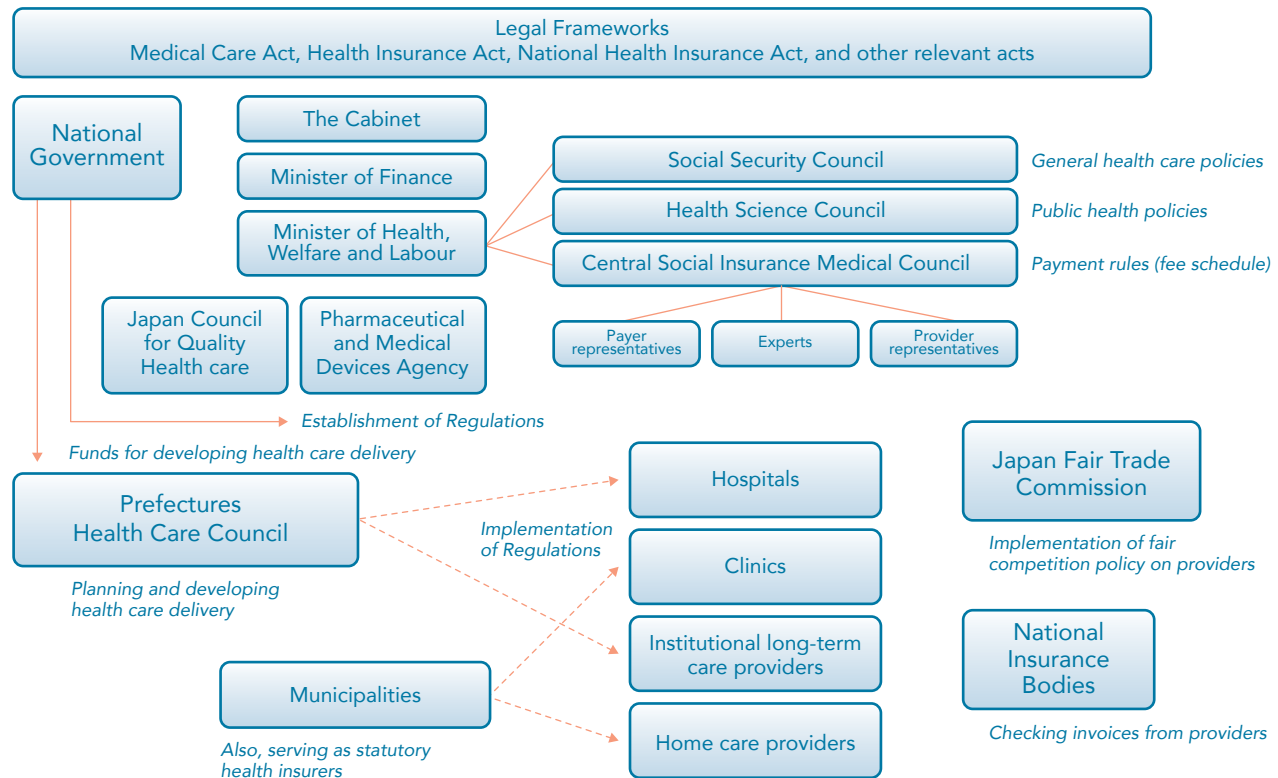
The Health Science Council is responsible for public health policies. The national government and prefectures make cost-control plans (described further below). The Japan Council for Quality Health Care, a nonprofit organization, works to improve quality throughout the health system and to develop clinical guidelines, although it does not have any regulatory power to penalize poorly performing providers. Specialist societies themselves also produce clinical guidelines.

Technology assessment of pharmaceuticals and medical devices is conducted by the Pharmaceutical and Medical Devices Agency, a regulatory agency of the government. It also sets the Public Health Insurance Drug Price List, which is a list of pharmaceuticals and their prices covered by the public health insurance system (English Regulatory Information Task Force Japan Pharmaceutical Manufacturers Association, 2012). The criteria of coverage include clinical effectiveness and social acceptability, but there is no economic appraisal. Since 2012, the council has been discussing possible application of comparative cost-effectiveness studies in its decision-making.

Nonprofit organizations work for public engagement and patient advocacy, and every prefecture establishes a health care council to discuss the local health care plan. Under the Medical Care Law, these councils must have members representing patients.

The Japan Fair Trade Commission is tasked with promoting fair competition among providers and medical device companies.

Organization of the Health System in Japan



Notes: This chart illustrates a very simplified structure of the complex health care governance in Japan.

Source: R. Matsuda, College of Social Sciences, Ritsumeikan University, 2014.



What are the major strategies to ensure quality of care?

Under law, prefectures are responsible for health care delivery “visions,” which include detailed planning for cancer, stroke, acute myocardial infarction, diabetes mellitus, psychiatric disease, emergency medicine, pediatrics, prenatal medicine, rural medicine, disaster medicine, and home care. These visions include structural, process, and outcome indicators, as well as strategies for effective and high-quality delivery. Prefectures promote collaboration between providers to achieve them, with or without subsidies. Waiting times, in general, are not monitored by the government, although there is cause for concern in some clinical areas, such as palliative care.

There are structural health care delivery regulations, including those concerning work force, infrastructure, and medical devices, but relatively few apply to process and outcomes. Prefectures are in charge of annual inspection of hospitals. Hospitals can be sanctioned through reduced reimbursement rates if staffing per bed falls below a certain ratio.

Hospital accreditation, on the other hand, is voluntary and undertaken largely as an improvement exercise; roughly one-third of hospitals are accredited by the Japan Council for Quality Health Care. It does not, however, disclose names of hospitals that have failed the accreditation process. Since 2010 the Ministry of Health, Labor and Welfare has organized and financially supported a benchmarking project, in which hospitals voluntarily have participated and publicly reported their quality indicators on their websites. Voluntary disease and medical device registries have been developed, possibly to be used for quality improvement in the future. No regular national surveys of patients are conducted.

A physician needs a national license obtained through national examination to practice. No revalidation of licenses is required, so far. However, specialist societies have introduced revalidation. Clinical audits are voluntary. Public reporting on performance has been discussed, but is not yet available.

Every prefecture has a medical safety support center for handling complaints and promoting safety. Since 2004, advanced academic and public hospitals have been required to report adverse events to the Japan Council for Quality Health Care.



What is being done to reduce disparities?

In 2012, the government revised its health promotion objectives, known as Health Japan 21, and made reducing health disparities between population groups a general goal. Although the objectives refer to disparities created by socioeconomic status, the two explicit targets directly related to them are reduction of disparities in healthy life expectancies between prefectures and increase in number of local government entities that make efforts to solve health disparity issues (Ministry of Health, Labor and Welfare, 2012b). Local governments are beginning to discuss how to involve citizens to achieve the goals. There is another plan to reduce disparities in cancer treatment delivery between prefectures.



What is being done to promote delivery system integration and care coordination?

Care coordination has developed differently in different areas, with different utilization of information technology. Clinics are mostly physician-led, with nurses playing less of a role in caring for patients. Multispecialty groups or clinics are not common. Rather, physicians refer patients to each other. Although little information has been available on communication between physicians, organized coordination involving multiple providers seems to have been increasing during the past five years (Ueno, 2013).

The government emphasizes care coordination in general, including coordination in mental health care, and introduced financial incentives to facilitate it. For example, in 2008, financial incentives involving hospitals and clinics together were introduced in order to try to improve care coordination, particularly in cancer care, stroke care, cardiac care, and palliative care. Hospitals admitting stroke victims or patients with hip fractures can receive additional fees if they use post-discharge protocols and make contracts with clinic physicians (for which those physician also receive additional fees) to provide effective follow-up.

The government has developed other subsidies for leading providers in the community to facilitate care coordination. In 2014, government introduced a new monthly payment into the fee schedule for clinics with three and more physicians and small-scale hospitals that provide designated services to promote care coordination (e.g., 24/7 services). The monthly payment can be claimed for basic consultations and examinations of patients with comorbidity and efforts to coordinate care for them.

There are more than 4,000 “community comprehensive support centers” to coordinate services, particularly for those with long-term conditions. The community comprehensive support centers have care managers, social workers, and long-term care support specialists and are funded by long-term care insurance.



What is the status of electronic health records?

In 2013, almost all hospitals used electronic billing, compared with 85.6 percent of medical clinics, 47.2 percent of dental clinics, and 94.8 percent of pharmacies (National Insurance Claims Review and Reimbursement Services, 2013). The government has made electronic billing obligatory in the public health insurance system for all providers except those without the necessary staffing and instruments. Despite a number of initiatives over the past decade, electronic health record networks have developed only as experiments in selected areas. Interoperability between providers has not been generally established.

Online appointment systems are available at less than half of all hospitals. Currently, experiments are being carried out to make personal health information available to patients and providers via cloud computing. With the National Identification Number Act passed in 2013, the government is planning to use unique identifiers for financial transfers beginning in 2016. Additionally, the government declared a goal of establishing a country-wide health information network by FY 2018. Whether the identifiers will be used for medical records, however, remains unclear.



How are costs contained?

Price regulation for all health care services included in the national benefits package is a critical cost-containment mechanism (Ikegami and Anderson, 2012). All health insurers in the public health insurance system pay providers according to a national fee schedule that is revised every two years. After informal negotiations with stakeholders, the cabinet estimates the overall rate of change in public health care expenditures, and then the rates of changes in expenditure for medical services, dental services, pharmacy services, and pharmaceuticals and devices.

For medical, dental, and pharmacy services, the Central Social Insurance Medical Council revises fees on an item-by-item basis in order to meet overall spending targets set by the cabinet. Highly profitable categories see larger reductions in the fee schedule. The revisions to drug and device prices in the public health insurance system are then determined based on a market survey of their actual current prices (which are often less than the listed prices). Furthermore, drug prices can be revised downward for new drugs selling in greater volume than expected and for brand-name drugs when generic equivalents hit the market. Prices of medical devices in other countries are now also considered in the revision.

Another cost-containment strategy is to limit services, such as magnetic resonance imaging or certain expensive drugs that are deemed to be inflating costs. Peer review committees in each prefecture also monitor claims and may deny payment for services deemed inappropriate. There also have been constraints on the number of hospital beds and physicians; the number of hospital beds is regulated by prefectures in accordance with national guidelines. Hospital mergers and acquisitions have been facilitated by the government. The number of physicians was strictly restricted in the past, but because of an increased demand for physicians, the number of places for medical students has been increasing since 2007.

The government's Cost-Containment Plan for Health Care focuses on promoting healthy behavior, shortening hospital stays through care coordination and home care development, and increasing generic substitution. Each prefecture makes its cost-control plan in accordance with the national policy. Financial incentives in the fee schedule and other incentives, including education and trainings, are used to contain costs.



What major innovations and reforms have been introduced?

The 2014 Health and Long-Term Care Act, amended Medical Care Act, and other related legislation aims to accelerate the restructuring of health care delivery in preparation for projected increases in health and long-term care needs and expenditures. The overall policy aims are to increase efficiency within the hospital sector and to shift resources from the hospital sector to the home care sector in order to develop an "Integrated Community Care System," defined as "a system in the community in which various life support services, including medical care, long-term care, preventive care, and welfare service, are provided within the elderly's living areas, for the purpose of ensuring safety/sense of security/health in their lives, with the provision of housing in accordance with their needs as a precondition" (Ministry of Health, Labor and Welfare, 2013).

A mechanism is being developed to achieve those aims. With the amendment, prefectures have more power to collect hospital performance data and regulate hospital beds. Financial incentives have been introduced in the fee schedules of the public health insurance system and will be introduced in long-term care insurance in the near future. The existing community comprehensive support centers, described above, are also expected to play a role in developing the Integrated Community Care System.

Another new policy is the establishment of a new grant for developing local health and long-term care delivery, a subsidy from the national government to prefectures. To get the grant, prefectures need to establish a health care “vision” with newly available data on hospital bed functions. The policy aims to develop and/or restructure local health delivery systems by allocating resources according to prefecture initiatives.

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The Dutch Health Care System, 2014

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What is the role of government?

The national government has overall responsibility for setting health care priorities and may, when necessary, introduce legislation in order to do so. The government safeguards the process from a distance by monitoring access, quality, and costs. It also finances social health insurance for the basic benefit package and the compulsory social health insurance scheme for long-term care. Prevention and social support are not part of social health insurance, but are financed through general taxation.

The 2006 reforms introduced a prominent role for health insurers. Under the Health Insurance Act (*Zorgverzekeringswet*), statutory coverage is provided by private insurers and regulated under public law. Health insurers are given the task of increasing health system efficiency through prudent purchasing of health services on behalf of their enrollees.



Who is covered?

Since 2006, all residents (and nonresidents who pay Dutch income tax) are mandated to purchase statutory health insurance from private insurers. People who conscientiously object to insurance and active members of the armed forces (who are covered by the Ministry of Defense) are exempt. Insurers are required to accept all applicants, and enrollees have the right to change insurer each year. In 2013, 30,000 people (less than 0.2% of the Dutch population) were uninsured. In June 2014, 325,000 (2%) defaulted on or failed to pay their premium for at least six months. (Defaulters remain covered for statutory benefits, but insurers have the right to discontinue voluntary benefits.) The number of people defaulting on payment had been increasing slightly for several years, leading up to the 325,000 in 2014 mentioned above. Health insurers report defaulters to the National Health Care Institute (*Zorginstituut Nederland*), which automatically deducts a premium from income equal to 130 percent of the standard premium. Once the defaulter has paid the debt to the insurer, the premium returns to the standard amount. Asylum seekers are covered by government, and several mechanisms are in place to reimburse the health care costs of illegal immigrants unable to pay. Permanent residents (less than three months) are obliged to purchase private insurance coverage. Visitors are required to purchase insurance for the duration of their visit if not covered through their home country.

In addition to statutory coverage, most of the population (85%) purchases a mixture of complementary and supplementary voluntary insurance.



What is covered?

Services: In defining the statutory benefits package, government relies on advice from the National Health Care Institute. Health insurers are legally required to provide a standard benefits package covering medical care, including care provided by general practitioners, hospitals, specialists, and midwives; dental care through age 18 (coverage after age 18 is confined to specialist dental care and dentures); medical aids and devices; prescription drugs; maternity care; ambulance and patient transport services; paramedical care (limited physical/ remedial therapy, speech therapy, occupational therapy, and dietary advice); basic ambulatory mental health care for mild to moderate mental disorders, including a maximum of five sessions with a primary care psychologist); and specialized outpatient and inpatient mental care for complicated and severe mental disorders. If the last of these continues for more than 365 days (starting in 2015, more than three years), the

Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten; see below) takes over, as care is considered long-term care.

Some treatments are only partially covered or are excluded. Since 2012, physiotherapy is not covered, except treatments (after the first 20) for some people with specific chronic conditions, and pelvic physiotherapy (up to nine treatments) for urinary incontinence. Some elective procedures are excluded (e.g., cosmetic plastic surgery without a medical indication), as are dental care above age 18 and optometry. Only the first three attempts are included for in vitro fertilization. Sleep medication and antacids were excluded in 2012 for most patients, and walkers and other simple mobility aids are no longer covered. A limited number of effective health improvement programs (e.g., smoking cessation) are covered, and weight management advice is limited to three hours per year.

Long-term disability protection is organized separately from health insurance. People residing legally in the Netherlands and nonresidents who pay Dutch payroll tax are compulsorily insured for long-term care under the Exceptional Medical Expenses Act.

Cost-sharing and out-of-pocket spending: Every insured person over age 18 must pay an annual deductible of €360 (USD436) (as of 2014) for health care costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits.* Apart from the overall deductible, patients are required to share some of the costs of selected services, such as medical transportation, via copayments, coinsurance, or direct payments for services that are subsidized to a certain limit. A reimbursement limit is set for drugs in equivalent-drug groups. Costs above that limit are not reimbursed. Providers are not allowed to balance-bill patients—that is, they are not allowed to charge above the fee schedule. Patients with an in-kind insurance policy may be required to share the costs of care from a provider that is not contracted by the insurance company. Out-of-pocket expenses represented 11.9 percent of health care spending in 2011 (author's calculation).

Safety net: GP care and children's health care are exempt from cost-sharing. The government also pays for children's coverage up to the age of 18 and provides subsidies ("health care allowances") to cover community-rated premiums for low-income families (singles with annual income of less than €28,482 [USD34,405] and households with income less than €37,145 [USD44,956]); approximately 5 million people receive the allowance. Since 2013, health care allowances are subject to asset testing. The actual allowance is on a sliding scale ranging from €2.00 (USD2.50) to €72.00 (USD87.00) per month, depending on income.



How is the health system financed?

Publicly financed health care: The statutory health insurance system is financed under the Health Insurance Act through a nationally defined, income-related contribution, a government grant for the insured below age 18, and community-rated premiums set by each insurer (everyone with the same insurer pays the same premium, regardless of age or health status). As of 2014, the average annual community-rated premium for adults is €1,100 (USD1,331). The income-related contribution is set at 7.75 percent of annual taxable income up to €51,414 (USD62,224) (as of 2014). Employers must reimburse employees for this contribution, and employees pay tax on the reimbursement. For those without an employer who do not receive unemployment benefits, such as the self-employed, the income-related contribution is 5.4 percent. Contributions are collected centrally and distributed among insurers in accordance with a risk-adjusted capitation formula that considers age, gender, labor force status, region, and health risk (based on past drug and hospital utilization).

Insurers or payers are supposed to engage in strategic purchasing, and contracted providers are supposed to provide their enrollees selectively with the best value, with regard to both quality and cost. The insurance market is dominated by the four largest insurer conglomerates, which account for 95 percent of all enrollees. Among these four, only one operates for profit; the others are nonprofit. In 2011, total health care spending accounted for 12.1 percent of GDP (OECD, 2014).

* Please note that throughout this profile, all figures in USD were converted from EUR at a rate of about €0.83 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for the Netherlands.

A large part of long-term care is financed through the Exceptional Medical Expenses Act, a statutory social insurance scheme for those whose chronic conditions require continuous care and have considerable financial consequences (Schäfer et al., 2010). It is a largely contribution-based scheme and operates nationally. The remainder is financed through the Social Support Act, from general taxation.

Privately financed health care: Voluntary insurance covers benefits such as dental care, alternative medicine, physiotherapy, spectacles and lenses, contraceptives, and the full cost of copayments for medicines (excess costs above the limit for equivalent drugs). Insurance premiums and products are not regulated; insurers are allowed to screen applicants based on risk factors. Insurers can offer both statutory and voluntary benefits. Voluntary health insurance may cover additional benefits not covered in the compulsory scheme. People with voluntary health insurance do not receive faster access to any type of care, nor do they have increased choice of specialist or hospital. Many people purchase complementary coverage because they (often wrongly) believe they are at risk of incurring high health care costs. In 2010, voluntary insurance accounted for 7.8 percent of total health spending.



How is the delivery system organized and financed?

Primary care: In 2013, there were over 40,000 registered doctors, including 12,195 primary care doctors and more than 20,000 specialists. The general practitioner (GP) is the central figure in primary care; other primary care providers include dentists, midwives, and physiotherapists. Hospital and specialist care (except emergency care) are accessible only upon GP referral; only 4 percent of appointments with a GP result in a referral to secondary care. All citizens are registered with a GP of their choice, usually in their own neighborhood. On average, patients contact their GP five times per year; a full-time GP has a practice list of approximately 1,900 patients.

Patients can switch GP without formal restriction. In 2013, there were 8,865 practicing GPs: 36.4 percent worked in group practices of three to seven, 37.9 percent worked in two-person practices, and 25.7 percent worked solo. Most GPs work independently or in a partnership (self-employed); only a small number (11%) are employed in a practice owned by another GP.

GP remuneration includes capitation (37.3% of income, on average) and fee-for-service payment (33% of income). Many GPs employ nurses and primary care psychologists on salary; reimbursement for the nurse is received by the GP, so any productivity gains that result from substituting a nurse for a doctor accrue to the GP. At present, the role of district nurses is being strengthened, as their activities will be financed under the Health Insurance Act via spending arrangements similar to those in the curative sector. To incentivize care coordination, there are bundled payments for some chronic diseases (diabetes, cardiovascular risk management, and COPD), and efforts are under way to implement them for heart failure and depression. There are ongoing experiments with pay-for-performance and population management to improve quality in primary and hospital care.

In 2015, a new funding model comprising three segments will be introduced to all GPs. Segment 1 funds the core of primary care, and consists of a capitation fee per registered patient, a consultation fee for GPs (including phone consultation), and provision for ambulatory mental health care at the GP practice. The Dutch Health Care Authority (Nederlandse Zorgautoriteit) determines national provider fees for this segment. Segment 2 consists of funding for programmatic multidisciplinary care for diabetes, asthma, and chronic obstructive pulmonary disease, and for cardiovascular risk management. GPs have to negotiate prices and volumes with insurers for this segment. Segment 3 provides GPs and insurers with the opportunity to negotiate additional contracts—including prices and volumes—for pay-for-performance and innovation. The Dutch Health Care Authority expects that the first segment will represent 75 percent of spending, the second segment 15 percent, and the third 10 percent.

Outpatient specialist care: Almost all specialists are hospital-based, and are either in group practice (40%–45%, paid under fee-for-service) or on salary (most but not all in university clinics). Specialist fees (as part of “diagnosis–treatment combinations,” similar to diagnosis-related groups) are set nationally, but as of 2015 will be freely negotiable as a part of hospital payment. During the past decade, the proportion of specialists

working on salary has increased considerably. There is a nascent trend toward working outside of hospitals—for example, in growing numbers of ambulatory surgery centers—but this shift is marginal, and most ambulatory surgery centers remain tied to hospitals. Ambulatory surgery center specialists are paid fee-for-service, and the fee schedule is negotiated with insurers. Patients are free to choose their provider (following referral), but insurers may vary restrictions (cost-sharing) on choice within their policies (Schäfer et al., 2010). In 2016, a third insurance type (basically a variant of the restitution policy) will be introduced that aims to control health care costs by providing more opportunity for selective contracting. In the so-called “budget policy,” choice of specialist is restricted to contracted specialists, with no reimbursement for noncontracted care.

Administrative mechanisms for paying primary care doctors and specialists: The annual deductible (see above, “Cost-sharing and out-of-pocket spending”) is paid to the insurer. The insured have the option of paying for the deductible before or after health care use, and may choose to pay all at once or in installments.

After-hours care: After-hours primary care is organized at the municipal level in general practitioner “posts”—centralized services, typically run by a nearby hospital, that provide primary care between 5 p.m. and 8 a.m. Specially trained assistants answer the phone and perform triage. GPs decide whether patients need to be referred to the hospital. The GP post sends the information regarding a patient’s visit to his or her regular GP. Doctors are compensated per hourly rates for after-hours care, and must provide at least 50 hours of after-hours care annually to maintain their registration as general practitioner. There is no national medical telephone line.

Emergency care is provided by GPs, emergency departments, and trauma centers, and is covered under statutory insurance. Depending on urgency, patients or their representatives can contact their GP (or a GP post for after-hours care), call an ambulance, or visit a hospital emergency department (Schäfer et al., 2010). The great majority of hospitals have emergency departments, and all have a GP post.

Hospitals: In 2013, there were 131 hospitals and 106 outpatient specialty clinics spread among 86 organizations, including eight university medical centers. Practically all organizations were private and nonprofit. In 2010, there were also more than 170 independent private and nonprofit treatment centers whose services were limited to same-day admissions for nonacute, elective care (e.g., eye clinics, orthopedic surgery centers) covered by statutory insurance. In 2011, there were 83 private clinics specializing in care outside the benefit package and an unknown number of self-employed specialists with their own private practice.

Hospitals’ budgets are determined through negotiations between insurers and hospitals over price and volume (2008). The great majority of payments take place through the case-based diagnosis treatment combination system, and the rates for approximately 70 percent of hospital services are freely negotiable; each hospital negotiates with each insurer to set the rates. The remaining 30 percent are set nationally. In 2012, the diagnosis treatment combination system was fundamentally reformed, and the number of diagnosis treatment combinations reduced from 30,000 to 4,400. Diagnosis treatment combinations cover both outpatient and inpatient as well as specialist costs, thereby strengthening the integration of specialist care in the hospital organization.

Mental health care: Mental health care is provided in primary and secondary care. Primary care providers of mental health care include general practitioners, psychologists, and psychotherapists. When more specialized care is required, the general practitioner refers the patient to a psychologist, an independent psychotherapist, or a specialized mental health care institution.

In 2011, around 865,000 people were treated in specialized mental health care organizations. Around 92 percent of them received ambulatory treatment and 8 percent received inpatient care. About 35,000 individuals receive long-term (lasting more than 365 days) mental health care annually. Preventive mental health care is provided by municipalities and governed by the Social Support Act.

Further integration of general practice and mental health center services was agreed to by the Ministry of Health, insurers, and providers in 2012. This policy has two aims: to ensure that patients receive timely care from the right source, and to reduce the need for specialized mental health care. For several years, policy has been aiming, and continues to aim, to substitute inpatient mental health care for outpatient care.

Long-term care and social supports: Long-term care, financed by the Exceptional Medical Expenses Act and Social Support Act, accounts for 44 percent of government's total health care budget. It is provided in institutions (residential care) and in communities (home care), mainly to elderly persons, patients with psychiatric disorders, and persons with learning, sensory, or disability conditions. The Exceptional Medical Expenses Act covers most expenditures, such as the costs of personal and nursing care, counseling, medical treatment, and accommodation. Cost-sharing for long-term care depends on the number of people within the household, annual income, indication, and assets, as well as the duration of care. In 2011, copayments covered 7.2 percent of total spending.

Health insurers are formally responsible for implementing the Exceptional Medical Expenses Act, but delegate this task to regional care offices (Zorgkantoren). The Center for Needs Assessment (Centrum Indicatiestelling Zorg) is commissioned by government to carry out eligibility assessments, which take into account a patient's situation and needs and the ability of informal caregivers to help. Patients, their relatives, or their health care providers can file a request with the Center for Needs Assessment, which then sends its decision to a care office (Zorgkantoor).

Municipalities are responsible for household services, medical aids, home modifications, services for informal caregivers, preventive mental health care, transportation, and other assistance, in accordance with the Social Support Act (Wet Maatschappelijke Ondersteuning). They are supported through the Municipality Fund, which is financed by national and local taxes. Because municipalities have a great deal of freedom to organize services, including needs assessments, there are variations and, to some extent, inequalities in access to care.

Home care is provided by private, not-for-profit organizations including home care organizations, residential homes, and nursing homes. In 2009, there were 479 nursing homes, 1,131 residential homes, and 290 combined institutions. Most palliative care is integrated into the health system and is delivered by general practitioners, home care providers, nursing homes, specialists, and volunteer workers. Health care providers, palliative units, and hospices participate in regional networks in order to promote integration and coordination of care. The number of hospices and palliative units is growing; in 2013, there were 123 hospices, 143 nursing or residential homes, and 15 hospitals with special departments for symptom control and stabilization. Still, less than 5 percent of the population currently dies in a hospice.

Under both the Social Support Act and the Exceptional Medical Expenses Act, personal budgets are provided for patients to buy and organize their own long-term care, and are set at 66 percent of rates paid for in-kind services. Centers for Needs Assessments and municipalities carry out assessments for personal budgets, just as they do for in-kind care.

Patients receiving long-term care at home may apply for an allowance of €200 (USD242) per year (*mantelzorgcompliment*) for their caregiver. In 2015, this allowance will cease to be provided under the current arrangement, and will fall to the responsibility of the municipalities. Municipalities will have a great deal of freedom in how to support caregivers.

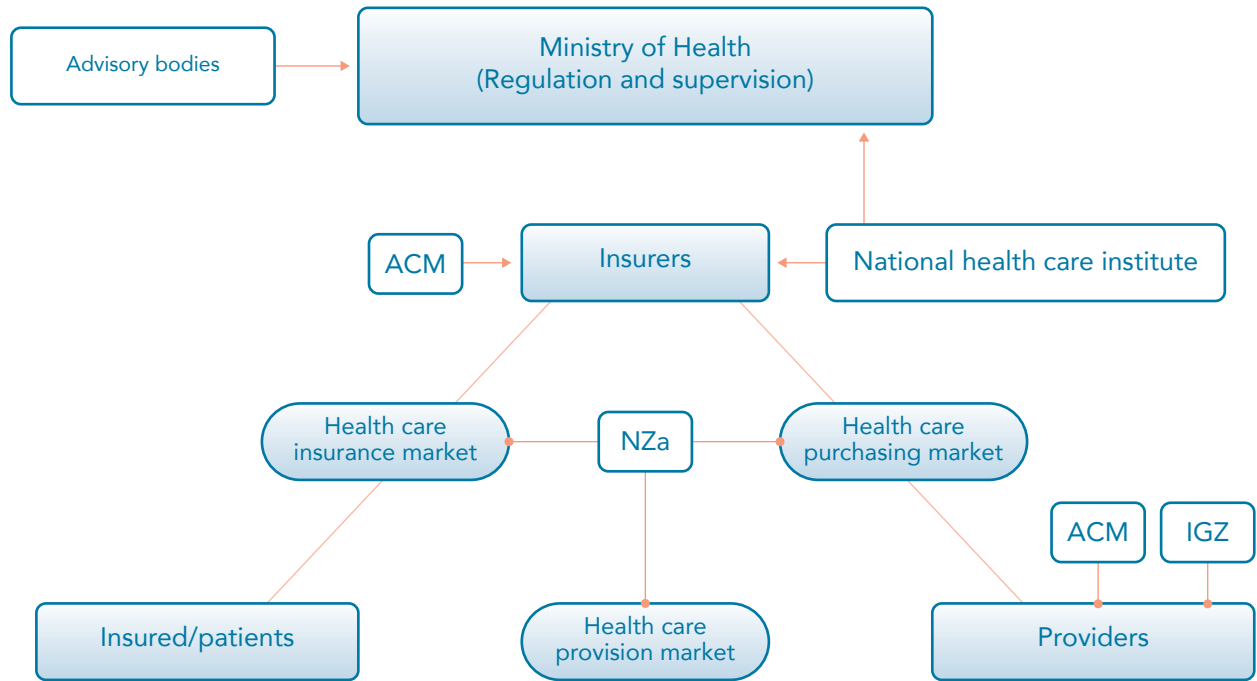


What are the key entities for health system governance?

The 2006 reform dramatically changed the governance structure, especially with regard to the Ministry of Health, whose role changed from directly steering the process to safeguarding it from a distance. The Minister of Health is responsible for the preconditions pertaining to access, quality, and cost of the health system, has an overall responsibility for priority-setting, and may, when necessary, introduce legislation to set strategic priorities.

A number of arm's-length agencies are responsible for setting operational priorities. At the national level, the Health Council advises government on evidence-based medicine, health care, public health, and environmental protection; the newly established National Health Care Institute (formerly known as the Health Care Insurance Board) integrates knowledge about the various institutes involved and has the power to inform change. The institute advises government on the components of the statutory benefits package and has various tasks relating to quality of care, professions and training, and the insurance system (risk adjustment). The Medicines Evaluation Board oversees the efficacy, safety, and quality of medicines. Health technology assessments (HTAs,

Organization of the Health System in the Netherlands



Source: J. Wammes, P. Jeurissen, and G. Westert, Radboud University Medical Center, 2014.

including cost-effectiveness analysis) are carried out by the Health Council and the Health Care Institute, but decisions about the benefits package rest with the Minister (advice is not binding). The Dutch Health Care Authority has primary responsibility for ensuring that the health insurance market, the health care purchasing market, and the health care delivery market function appropriately (e.g., they set the prices for 30 percent of diagnosis treatment combinations), while the Dutch Competition Authority (Autoriteit Consument en Markt) enforces antitrust laws among both insurers and providers.

Diagnosis Treatment Combination Maintenance (DBC-Onderhoud) is an independent organization responsible for the design, construction, and maintenance of the diagnosis treatment combination system. In the near future, DBC-Onderhoud will be integrated with the Health Care Authority. Self-regulation of Dutch medical doctors is also an important aspect of the Dutch system (Smith et al., 2012).

The patient movement consists of a wide range of organizations, some for specific diseases and some functioning as umbrella organizations. These organizations offer support for patients, provide information, and increasingly look after patients' interests by participating in quality-of-care projects (Peeters, Delnoij, and Friele, 2014). The patient umbrella organization Nederlandse Patiënten Consumenten Federatie conducts a range of activities to promote transparency. Various other parties are involved in informing the public, including medical doctors through their Dutch Choosing Wisely campaign.



What are the major strategies to ensure quality of care?

The *Dutch Health Care Performance Report 2010* provided indisputable evidence that the quality and price of Dutch health services vary substantially among providers, and that more needs to be done to address the variation in quality (Westert et al., 2010).

At the system level, quality is ensured through legislation governing professional performance, quality in health care institutions, patient rights, and health technologies. The Dutch Health Care Inspectorate (Inspectie

Gezondheidszorg) is responsible for monitoring quality and safety. Most quality assurance is carried out by providers, sometimes in close cooperation with patient and consumer organizations and insurers. Disease management for the chronically ill has been a prominent theme for years. In the past few years, many parties have been working on quality registries. Mechanisms to ensure the quality of care provided by individual professionals include reregistration or revalidation of specialists based on compulsory continuous medical education; regular on-site peer assessments by professional bodies; and profession-owned clinical guidelines, indicators, and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programs based on the breakthrough method *sneller beter* (“faster, better”). Patient experiences also are systematically assessed and, since 2007, a national center has been working with validated measurement instruments in an approach comparable to that of the Consumer Assessment of Healthcare Providers and Systems, in the United States. To inform consumer choice, the center also generates publicly available information on waiting lists, patient satisfaction, and a few quality indicators. The Dutch Patient organization launched a website for public reporting on quality of care and provider performance.

The Ministry of Health issued a directive to Parliament stating that, from 2014, a central body (the National Health Care Institute) needs to be established to further accelerate the process of quality improvement and to encourage evidence-based practice. In 2013, the Ministry of Health and a number of national representative organizations signed a covenant that effectively sets a limit for the annual growth rate of spending, to be realized through improvements in quality and efficiency. Most notably, the covenant included fewer referrals to hospitals, further concentration of top clinical care, more stringent compliance with guidelines, and a critical use of resources-appropriate care. In October 2013, a range of representative organizations launched a Dutch version of the Choosing Wisely campaign in the United States. The campaign is aimed at stimulating “wise choices” and supporting medical specialists and their patients in shared decisions about appropriate use of care.



What is being done to reduce disparities?

Smoking is still a leading cause of death, followed by obesity. For many determinants, lower socioeconomic groups do worse on all fronts. However, the current government does not have a specific policy to overcome health disparities, as the cornerstone of present policy is an emphasis on people’s personal responsibility for healthy lifestyles. In 2013, government decided to include diet advice and smoking cessation programs in the statutory benefits package.



What is being done to promote delivery system integration and care coordination?

A bundled-payment approach to integrated chronic care is applied nationwide for diabetes, chronic obstructive pulmonary disease, and cardiovascular risk management. Under this system, insurers pay a single fee to a principal contracting entity—the “care group”—to cover a full range of chronic disease services for a fixed period. The care group is a legal entity formed by multiple health care providers, often exclusively general practitioners, that assumes clinical and financial responsibility for all assigned patients in the care program and either delivers services itself or subcontracts with other providers. The bundled-payment approach supersedes traditional health care purchasing for the condition and divides the market into two segments—one in which health insurers contract care from care groups, the other in which care groups contract services from individual providers. The price for the bundle is freely negotiated by insurers and care groups, and fees for the subcontracted providers are also freely negotiated by the care group and the providers (Struijs, 2011). An initial evaluation of the new payments system indicated that it improved the organization and coordination of care, but no improvement in health outcomes was reported (de Bakker, 2012). At present, the role of district nurses is being strengthened, with the aim of reaching vulnerable populations and providing a better alignment of care.



What is the status of electronic health records?

Authorities are working to establish a central health information technology network to enable information exchange across providers. All Dutch patients have a unique identification number (*burgerservicenummer*). Virtually all general practitioners have a degree of electronic information capacity—for example, they use an electronic health record, and can order prescriptions and receive lab results electronically. At present, all hospitals have an electronic health record.

Electronic records for the most part are not nationally standardized or interoperable between domains of care, reflecting their historic development as regional initiatives. In 2011, hospitals, pharmacies, after-hours general practice cooperatives, and organizations representing general practitioners set up the Union of Providers for Health Care Communication (De Vereniging van Zorgaanbieders voor Zorgcommunicatie), responsible for the exchange of data via an IT infrastructure named AORTA; data are not stored centrally. Patients must approve their participation in this exchange, and have the right to withdraw. The network stores a patient's general practice file and information about use of medications. Patients need to ask a provider for access to the medical file. In 2012, the previously mentioned four parties, organizations representing insurers and patients (Nederlandse Patiënten Consumenten Federatie), and several others signed an agreement to promote further development of the national health care IT infrastructure.



How are costs contained?

Bending the cost curve was one of the most significant themes in public debate surrounding the most recent elections (2012). The most recent national figures on annual expenditure from indicate that growth has fallen significantly, to 1.6 percent.

The pharmaceutical sector is generally considered to have contributed significantly to the decrease in spending growth. In 2013, use of pharmaceuticals, as well as their average prices, decreased. The policy by insurers to reimburse only the lowest-price generic drugs has contributed to the decrease in average price. As of 2012, reimbursement for expensive drugs has to be negotiated between hospital and insurer. There is some concern that this and other factors may reduce access to expensive drugs in the near future.

The annual deductible, which is responsible for the majority of patient cost-sharing, more than doubled from 2008 to 2014, from €170 (USD206) to €360 (USD436). There are some worries that this increase has led to greater numbers of people abstaining from or postponing needed medical care.

Health technology assessment is gaining in importance, and is used mainly for decisions on the benefit package and on the appropriate use of medical devices. Additionally, the Minister of Health launched a call for suggestions in 2013 on how to reduce the scope of the benefit package or, alternatively, how to improve efficiency and reduce waste.

When the 2006 reforms were first introduced, government aimed to allow market forces to operate. The main approach to controlling costs rests on regulating competition between insurers and improving efficiency of care through the use of performance indicators. In addition, provider payment reforms, including a shift from a budget-oriented reimbursement system to a performance- and outcome-driven approach, have been implemented; costs are increasingly expected to be controlled by the new diagnosis treatment combination system, in which hospitals must compete on the prices of specific services; and various local and national programs aim to improve health care logistics.

In 2013, an agreement signed by the Minister of Health, all health care providers, and insurers set a voluntary ceiling for the annual growth of hospital and mental care volume. When macro-costs exceed this limit, government has the ability to control spending via generic budget cuts. However, this agreement included an extra 1 percent spending growth allowance for primary care practices in 2014 and 1.5 percent in 2015–2017, provided that they demonstrate that services are a substitute for hospital care.



What major innovations and reforms have been introduced?

Growing dissatisfaction with the dual system of public and private coverage eventually led to the 2006 reform and the introduction of the Health Insurance Act. The underlying logic of managed competition is that consumers who have the right to exercise choice induce competition among insurers, and insurers will therefore push health care providers to increase the quality and efficiency of their services (Westert et al., 2009). In recent years, steps have been taken to further stimulate competition among insurers and providers. For example, in 2011, the ex-post risk adjustment to limit insurers' financial risk was abolished. In addition, under very strict conditions, hospitals are allowed to operate for profit.

Long-term care is undergoing fundamental reform. All extramural care that is currently covered by the Exceptional Medical Expenses Act will be transferred to the Social Support Act and the Health Insurance Act. The second and third year of inpatient mental health care will shift to the Health Insurance Act, and sheltered living to the Social Support Act. As a result, the former Exceptional Medical Expenses Act will account for a far smaller provision of support for people requiring intramural long-term care (Wet Langdurige Zorg). As of January 2015, municipalities will be responsible for all social support and assistance under the adjusted Social Support Act, while all nursing and care activities will fall under the Health Insurance Act.

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The New Zealand Health Care System, 2014

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What is the role of government?

There is a bipartisan consensus in New Zealand, built since the passage of the Social Security Act (1938), that government has a fundamental place in providing for the spectrum of the population's health care needs, while also supporting various private arrangements. The government plays a central role in setting the health policy agenda and service requirements for the health system, and in setting the annual publicly funded health budget. Responsibility for planning, purchasing, and providing health services and disability support services for those over age 65 lies with 20 geographically defined district health boards (DHBs). DHBs comprise seven members elected by the people in their area and up to four members appointed by the Minister of Health. They pursue government objectives, targets, and service requirements while operating government-owned hospitals and health centers, providing community services, and purchasing services from nongovernment and private providers.



Who is covered?

All permanent residents have access to a broad range of health and disability services that are largely publicly financed through general taxes. As of July 2014, New Zealand's 4.55 million residents were eligible for publicly funded health services. Nonresidents, such as tourists and illegal immigrants, are charged the full cost for services provided by public hospitals or primary medical care providers, unless their health needs are the result of an accident, in which case they are covered by New Zealand's no-fault accident compensation scheme.

Complementary and supplementary private voluntary health insurance is used mostly to cover cost-sharing requirements, elective surgery in private hospitals, and private outpatient specialist consultations. Private payment tends to secure faster access to treatment for nonurgent care in the private sector. In December 2013, just over 1.33 million New Zealanders (30% of the population) had some private health insurance.



What is covered?

Services: The publicly funded system covers preventive care, inpatient and outpatient hospital care, primary care services (via private providers and excluding some services such as optometry care, adult dental services, orthodontics, and physiotherapy), inpatient and outpatient prescription drugs included in the national formulary (described further below), mental health care, dental care for schoolchildren, long-term care, home help, and disability support services. The government sets an annual global, or overall, budget, based largely on political priorities, for most publicly funded health services and sets national requirements for those services, to be implemented by the 20 DHBs. Rationing and prioritization are applied largely to nonurgent services, and vary by DHB.

Cost-sharing and out-of-pocket spending: Copayments exist for General Practitioner (GP) services and many nursing services provided in GP clinics, as capitation funding covers only a portion of costs; copayments for after-hours consultations are generally higher. Some private health insurance packages cover such costs, but most patients pay at point of service. The average fee for an adult's GP consultation ranges between NZD15–NZD40 (USD10–USD27), but fees vary significantly as GPs set their own fees, over which there are no limits—the exception being fees for the one-third of New Zealanders in the aforementioned low-cost areas, where the maximum adult fee is NZD17.50 (USD12.00) per visit, with government subsidies making up for lost fee

income.¹ GP copayments fell during a period (2002–2008) of significant increases in government funding for primary care, but have been increasing since then.

Copayments also are required for drugs prescribed by GPs and private specialists (NZD5.00 [USD3.40] per item); after copayments are made for 20 items per family per year, items are free. There are no GP charges for children under age 6 (to be extended to under 13 in mid-2015), and no charges for any New Zealand resident treated in a public hospital. There are various means-tested subsidies, meaning some copayments, for long-term care, as discussed in the relevant section below.

Out-of-pocket payments, including both cost-sharing and other costs paid directly by private households, accounted for approximately 10.9 percent of total health expenditure in 2011 (OECD, 2014a) with the largest portion of this going to outpatient services.

Safety net: Primary care—largely privately provided—is mostly free for children age 6 and under (from mid-2015 this will be extended to those under 13) and is subsidized for the 98 percent of the population enrolled in the networks of self-employed providers known as primary health organizations (PHOs). PHOs include general practitioners (GPs), practice nurses, and allied practitioners. Additional PHO funding and services are available for treating people with chronic conditions and for improving access to care for groups with high health needs. Around 30 percent of all primary care practices, those usually found in poorer communities with high health needs, operate in a “very low-cost access” environment where a higher per-annum, per-patient capitation rate is paid, and in return patient fees are capped. A “high-use health card” is also available upon application to patients who have had more than 12 GP visits in a year. Subsequent capitation payments to the GP for those patients are then set at a higher level to reflect this high-utilization pattern, although patients continue to pay GP copayments. Public hospital clinical services are free, although there are some user charges, such as those for crutches and other aids supplied to patients upon discharge.



How is the health system financed?

Publicly financed health care: Public spending, generated through general taxes, accounted for 82.7 percent of total health spending (10% of GDP) in 2011 (OECD, 2014a) and was distributed as follows.

- 87.8 percent to the New Zealand Ministry of Health, which in turn distributed about 80 percent of that amount to District Health Boards using a weighted, population-based funding formula, and the remaining 20 percent directly to service providers.
- 9.4 percent to the Accident Compensation Corporation (ACC), the government-run no-fault all settings insurance scheme that provides funding for accident and injury care. ACC is funded from levies on people’s earnings, businesses’ payrolls, petrol, and fees from vehicle licensing, as well as from government funding.
- 2.8 percent to other central, regional, and local government services.

Privately financed health care: Private health insurance is offered by a variety of organizations, from nonprofits and “Friendly Societies” to companies listed on the stock market. It accounts for about 5 percent of total health expenditure and is used mostly to cover cost-sharing requirements, elective surgery in private hospitals, and private outpatient specialist consultations, as well as often offering faster access to nonurgent treatment. About one-third of the population has some form of private health insurance, which is purchased predominantly by individuals. Insurers reimburse providers up to company-specific maximums.

¹ Please note that throughout this profile, all figures in USD were converted from NZD at a rate of about NZD1.46 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014b) for New Zealand.



How is the delivery system organized and financed?

Primary care: New Zealand's ratio of general practitioners to specialists is around 1:1.5. GPs act as gatekeepers to specialist care and are usually independent, self-employed providers, compensated by a capitated government-determined subsidy, paid through primary health organizations, that provides, roughly speaking, around half their income; patient copayments, set by individual GPs, provide the rest. GPs work together with practice nurses, with an average of 3.48 GPs per practice. Nurses are salaried and paid by GPs; these nurses have a significant role in the management of long-term conditions (e.g., diabetes), incentivized by specific government funding for chronic care patient management. Patient registration is not mandatory, but GPs and PHOs must have a formally registered patient list to be eligible for government subsidies. Patients enroll with a GP of their choice; in smaller communities, choice is often limited.

Since 2001, there has been substantial new funding to subsidize primary care services and improve access. PHOs receive additional per-capita funding for promoting health, coordinating care, reducing barriers to care for the people who can least afford primary health care, and providing additional services for people with chronic conditions. In some cases, this has led to the development of multidisciplinary care teams that may include specialists such as nutritionists or podiatrists, which is being further driven by new alliance arrangements (outlined below). PHOs also receive funding if GPs collectively reach quality and service delivery targets for cancer, diabetes, and cardiovascular disease screening and follow-up, as well as for vaccinations. Most GPs belong to an organized network that provides management and other clinical support services. The larger networks represent several hundred GPs each.

Outpatient specialist care: New Zealand has "dual practice" in specialist care, meaning that most specialists are employed by District Health Boards and salaried for working in a public hospital, but are also able to work privately in their own private clinics or treat patients in private hospitals, where they are paid on a fee-for-service basis. The impact this has on the public sector remains underresearched and underdebated (Gauld, 2013). Many specialists will be based in multispecialty clinics but work independently, renting their office from the clinic. Private specialists are concentrated mostly in larger urban centers, and set their own fees, which vary considerably; insurance companies have little, if any, control over those fees, although insurers will pay only up to a maximum amount, meaning that patients pay any difference. In public hospitals, patients generally have limited choice of specialist.

Administrative mechanisms for paying primary care doctors and specialists: As noted above, GP income comes from a mix of government subsidies (including payments from the Accident Compensation Corporation in cases of accidents) and patient copayments at the point of service. Depending on the level of private insurance, if a patient subscribes to it, he or she may be eligible to claim for the copayment. The full cost of a private specialist visit is the patient's responsibility unless the service is funded by the Accident Compensation Corporation or private insurance. If a specialist or private hospital holds a contract with a patient's insurer, there may be no direct patient charge. Where such a contract does not exist, patients may need to pay up front and seek reimbursement from their insurer.

After-hours care: GPs are required in their funding contracts to provide after-hours care or arrange for its provision, and they receive a separate government subsidy for doing so, which is effectively higher per patient than the general capitation rate. In rural areas and small towns, GPs work on call; in some, a nurse practitioner with prescribing rights may provide first-contact care. In cities, GPs tend to provide after-hours service on a roster at purpose-built, privately owned clinics in which they are shareholders. These facilities employ their own support staff such as nurses, but patients will usually see a GP in the first instance. Patient charges at these clinics are higher than for services during the day (although 95 percent of children under age 6 can access free GP after-hours services). Consequently, some patients will visit the hospital emergency department instead, or avoid after-hours service altogether. A patient's usual GP routinely receives information on after-hours encounters. The public also has access to the 24-hour, seven-day-a-week phone-based Healthline, staffed by nurses who provide advice for general health questions. Plunketline provides a similar service for child and parenting problems.

Hospitals: New Zealand has a mix of public and private hospitals, but public hospitals are the majority, providing all emergency and intensive care. Public hospitals receive a budget from their owners, the District Health Boards, based on historic utilization patterns, population needs projections, and government goals in areas such as elective surgery. This budget includes the costs of health professionals and other staff, who are all salaried. Within a DHB hospital, the budget tends to be allocated to the various inpatient services using a case-mix funding system. A proportion of DHBs' funding for elective surgery is held by the Ministry of Health, and payments are made upon delivery of surgery. Certain areas of funding, such as mental health, are ring-fenced, meaning the DHB must spend the money on a specified range of inputs.

Private-hospital patients with complications are often admitted to public hospitals, in which case the costs are absorbed by the public sector. Specialists who receive salaries in public hospitals can maintain their own private clinics or treat patients in private hospitals, where income is on a fee-for-service basis. Public-hospital services are provided largely by consultant specialists, specialist registrars, and house surgeons.

Mental health care: Most people access mental health care through primary mental health services in the community, often through their GP, who will then coordinate any referred services, but also through school-based health services and community services provided by nongovernment agencies, which are all publicly funded. DHBs deliver a range of mental health services (including secondary services), such as forensic services, acute inpatient services, community-based services, and support to primary care providers. DHBs also fund nongovernment organizations to provide a range of community-based mental health services. New Zealand has limited private provision of mental health services. One hospital (Tamahere Hospital, owned by a Maori provider) has services ranging from subacute to long-term rehabilitation. Ashburn Clinic is a private psychiatric hospital, funded primarily through its contract with the Ministry of Health and by private clients.

Long-term care and social supports: DHBs fund long-term care for patients on the basis of needs assessments, age requirements, and a means test. They fund these services for those over age 65 and those "close in age and interest" (e.g., people with early-onset dementia or a severe age-related physical disability requiring long-term care). Those eligible receive comprehensive services including medical care; many older or disabled people receive in-home care. Some younger disabled recipients opt for individual budgets to arrange their own in-home care providers. Respite care is available to relieve informal or family carers, and in some circumstances there is ongoing financial support. Residential facilities, mostly private, provide long-term care. DHBs also provide hospital- and community-based palliative care. A network of hospices provides end-of-life care, with approximately 70 percent of its funding coming from DHBs and the remainder through fundraising. Palliative care is also provided in the community.

Long-term care subsidies for older people are means-tested. Residents with assets over a given national threshold pay the cost of their care up to a maximum contribution. Residents with assets under the allowable threshold contribute all their income except for a small personal allowance. DHBs cover the difference between what the resident pays and what the contract price is for residential care. For people in their own homes, household management (e.g., cleaning), which accounts for less than one-third of home support funding, is income-tested. Personal care (e.g., showering) is provided free of charge.

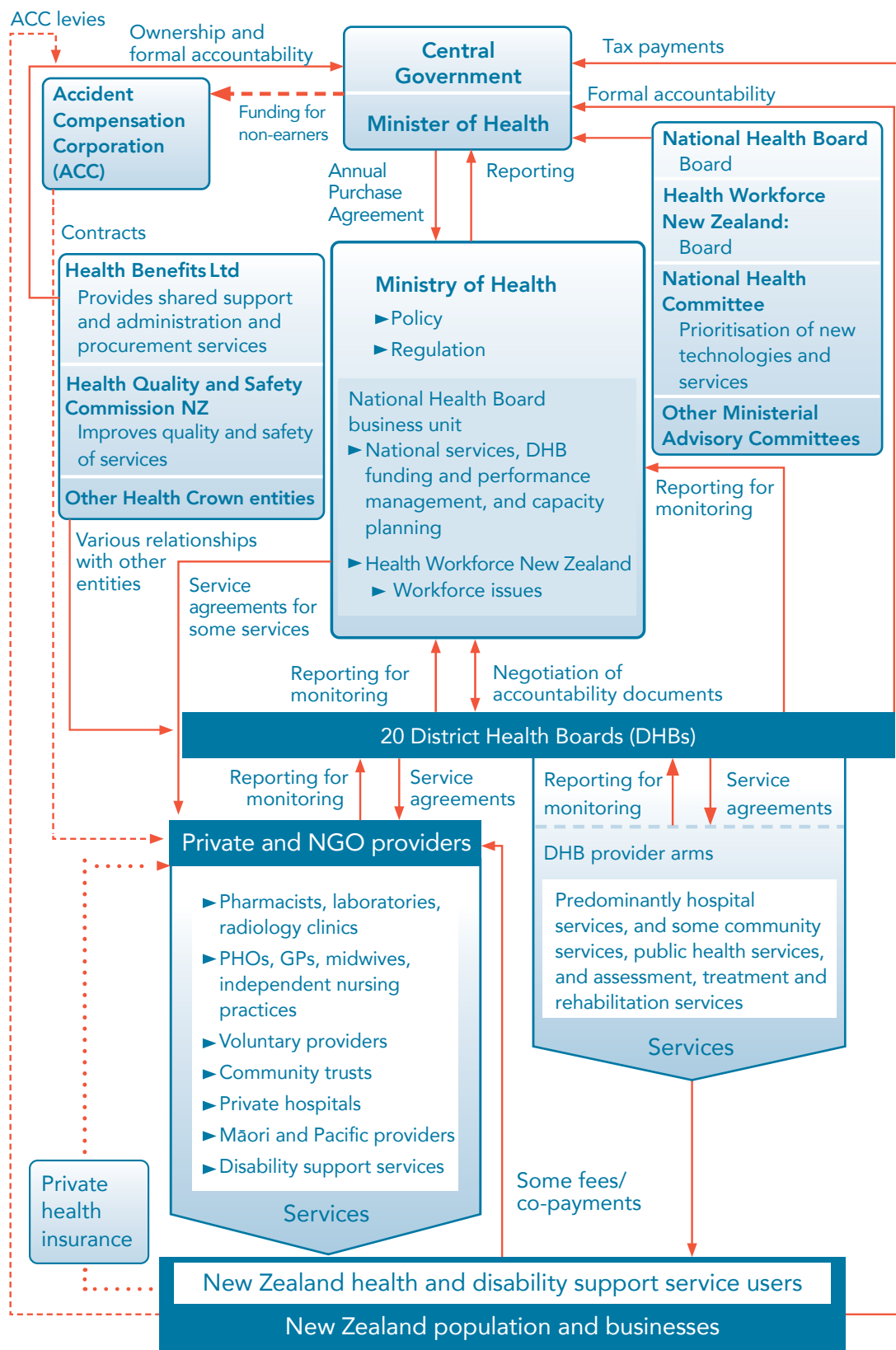


What are the key entities for health system governance?

As the health system is controlled and financed primarily through the public sector, government-funded and -appointed entities dominate governance structures. Some, like the Health and Disability Commissioner (whose function is to champion consumers' rights in the health sector), sit at arm's length from central government. Others are "Crown Entities" with their own boards, and are required to follow government policy directions through letters of expectation. Key national arrangements are:

- The Ministry of Health is the Government's principal agent in the New Zealand Health and Disability system and has overall responsibility for the stewardship of that system. The Ministry acts as the Minister's principal advisor on health policy, and has a role in the health sector as a funder, monitor, purchaser and regulator of

Organization of the Health System in New Zealand



Source: New Zealand Ministry of Health, 2014.

health and disability services. The Ministry provides leadership across the system and is the Government's primary agent for implementing the Government's health priorities and policies within the system.

- The National Health Board (NHB): Established by the government in November 2009, the NHB aims to improve the quality, safety, and sustainability of health care for New Zealanders by actively engaging with clinicians and the wider health sector. The NHB's role is to provide advice to the Minister and the Director-General of Health on all of the aforementioned matters. The NHB has two subcommittees: the Capital Investment Committee, which provides advice on matters relating to capital investment and infrastructure in the public health sector in line with the Government's service planning direction; and the National Health IT Board, which provides advice on the implementation and use of IT systems across the sector.
- Health Benefits Limited, established in July 2010, supports DHBs in delivering shared services and reducing costs by identifying opportunities for savings in administrative, support, and procurement services for the health sector. It also leads initiatives that reduce duplication and result in savings and efficiencies for DHBs in their nonclinical and back-office functions.
- The Pharmaceutical Management Agency of New Zealand assesses the effectiveness of drugs; distributes prescribing guidelines; determines the inclusion of drugs on the national formulary, with relative cost-effectiveness being one of nine criteria for inclusion; and, since 2010, has added certain medical devices to their schedule. The nine criteria are used to underpin decisions and may be weighted differently, depending on context (Gauld, 2014).
- The Health Quality and Safety Commission was established in 2010 to ensure that all New Zealanders receive the best health and disability care possible with the resources available. It is also working toward what is known as the New Zealand Triple Aim—improved quality, safety, and experience of care; improved health and equity for all populations; and better value for public health system resources.
- The National Health Committee (NHC) advises the government on priorities for new and existing health technologies. All new diagnostic and nonpharmaceutical treatment services and significant expansions of existing services are referred to the NHC for evaluation and advice. The Committee also provides advice on what technologies are obsolete or are no longer providing value for money.



What are the major strategies to ensure quality of care?

The aforementioned Health and Disability Commissioner investigates and reports on patient complaints. The Commissioner reports directly to Parliament and has been important in promoting quality and patient-safety improvements.

District Health Boards are held formally accountable to the government for delivering efficient, high-quality care in hospitals, as measured by the achievement of targets across a range of indicators. These include six "health targets," published quarterly, with the aim of inducing competition among DHBs.² DHBs can be punished financially for failure to meet targets. In addition, DHB performance with regard to waiting times, access to primary care, and mental health outcomes is publicly disclosed. Data comparing the performance of primary health organizations are also publicly reported, including information such as the percentage of patients screened for chronic diseases, but data on individual doctors' performance are not routinely available. As noted above, PHOs and GPs receive performance payments for achieving various targets. The DHBs and individual GP clinics and networks run various chronic disease management programs. There are national registries for some diseases including diabetes, cardiovascular disease, and cancers. Public hospitals have historically surveyed patients on care and facility quality in an ad hoc manner for their own purposes. As of late 2014, they will be required to conduct a nationally standardized survey of a random sample of patients and submit data to the Health Quality and Safety Commission, which will be made public and permit hospital comparison.

² The six targets are: shorter stays in emergency departments; improved access to elective surgery; shorter waits for cancer treatment; increased immunization; better help for smokers to quit; and more diabetes and heart checks.

Certification and recertification by the Ministry of Health is mandatory for hospitals, nursing homes, and assisted-living facilities, which must meet published and defined health and disability standards. Certification audits are often performed, in conjunction with accreditation, by third parties. All practicing health professionals must be certified annually by the relevant registration authority (e.g., for doctors, the Medical Council of New Zealand), which has ongoing responsibility for ensuring professional standards and providing accreditation. Registration authorities provide supervision of individual professionals where appropriate.

The Health Quality and Safety Commission is intended to increase the focus on quality and coordinate the varied approaches to quality improvement across DHBs, such as those aimed at improving the patient journey, ensuring safer medication management, reducing rates of health care–acquired infection, and standardizing national incident reporting. Other initiatives include ongoing development of: the Atlas of Healthcare Variation (an online tool aimed at highlighting variations in the provision and use of services by geographic area); a series of standard quality and safety indicators for DHBs based on routinely collected data; a program for consumer involvement in service design; and advice for DHBs on how to prepare annual “Quality Accounts,” required since 2012–2013. Much like a financial account, these report on how the DHB has approached quality improvement, including descriptions of key initiatives and their results. In 2013, the commission launched a national patient safety campaign, “Open for Better Care,” focused on reducing the negative consequences associated with falls, surgery, health care–associated infections, and medications (see hqsc.govt.nz).

The National Health Board is also working on quality improvement in DHBs, with a particular focus on management systems, clinical services, and patient pathways. “Clinical governance” has been implemented in most DHBs, meaning that management and health professionals are assuming joint accountability for quality, patient safety, and financial performance.



What is being done to reduce disparities?

Since the late 1990s, governments have made reducing disparities a policy priority (Ministry of Health, 2013). Disparities in health are a central concern in New Zealand, as Maori and people of Pacific Island origin have shorter life expectancies than other New Zealanders (Maori by seven years, Pacific Islanders by six years). Maori and Pacific people are also known to experience greater difficulty accessing health services. The formula by which DHBs are funded assigns specific categories and weights to recognize the additional resources required to provide services for Maori and other underserved populations. As noted, there are higher GP subsidies for those on lower incomes and those with higher health needs.

Through much of the 2000s, a multisector policy approach saw investments in housing, education, and health, as DHBs and primary health organizations were required to develop strategies for reducing disparities. Many PHOs were created especially to serve Maori or Pacific populations.

The post-2008 government has been more focused on specific initiatives such as Whanau Ora, a policy designed to integrate the various providers of social services, including health, for disadvantaged Maori, who often fall outside the boundaries of other agencies. The aim here has been to develop multiagency approaches to service provision and joint responsibility for outcomes.



What is being done to promote delivery system integration and care coordination?

Since 2008, the government has started to develop larger Integrated Family Health Centers (IFHCs), in line with its “Better, Sooner, More Convenient” policy, which aims to improve access to integrated care provided by DHBs and PHOs by establishing more-convenient locations for patients (outside of hospital settings) and bringing a stronger focus on chronic disease management (Ryall, 2008; Ministerial Review Group, 2009). IFHCs provide comprehensive primary care and care coordination, after-hours services, and some minor elective procedures for an enrolled population. The new facilities will see services and providers colocated, or coordination of services improved, with funding from both primary care budgets and DHBs.

Patients enrolled in PHOs have a medical home, but PHOs vary widely in their size, performance, and activities. The highest-performing provide a model that, if nationally emulated, would result in all enrollees having a fully functional, multidisciplinary medical home, although institutional barriers to integrating primary and hospital care remain.

The government is accelerating the drive for clinical integration to create a more patient-centered health system. It is also ensuring that all DHBs' annual plans include proposals for integration to drive change at a local level. These directions have been propelled by a new PHO contract in place since mid-2013 that requires alliance-governance arrangements modeled after IFHC pilot programs. There is considerable scope for these alliances to integrate health and social services (further discussed below). Some specialized providers under contract with the government that focus on vulnerable populations, such as Maori and Pacific people, work to coordinate health and social services. Whanau Ora, described in the next section, is aimed specifically at such coordination.



What is the status of electronic health records?

New Zealand has one of the world's highest rates of information technology (IT) use among primary care physicians, with an almost 100 percent uptake rate. The government's goal is that all New Zealanders have electronic access to a core set of their personal health information by 2014, but that goal is unlikely to be met owing to the complexity of implementing a national patient portal. Since the National Health IT Plan was launched in September 2010, there has been progress toward the 2014 goal. Clinicians and vendors are working together on numerous projects: There is a larger focus on supporting and enabling integrated care, and a shift toward regional investment decisions and solutions. However, challenges with legacy systems remain.

Increasingly, primary care IT systems provide services such as the capability for structured electronic transfer of patient health records, electronic referrals, decision support tools with patient safety features, and patient access to health information in a secure environment.

More generally, the focus for the future is on facilitating secure sharing of patient health information between community, hospital, and specialist settings, including common clinical information; providing all consumers with an online view of their information; and supporting the development of shared-care plans (in which a number of health professionals are involved in a person's care). However, it would be fair to state that current levels of interoperability are limited.

The National Health IT Board works with a number of sector groups and receives advice from others, including clinicians, consumers, and vendors. The Health Information Standards Organization (HISO) supports and promotes the development and use of health information standards to ensure interoperability between systems. Every person who uses health and disability support services in New Zealand has a unique national health number, thereby facilitating the process of building interoperable IT systems.



How are costs contained?

The financial sustainability of publicly funded health care is a top governmental priority. To support this goal, the government has implemented a range of measures to manage key pressures, including four-year planning to align expenditure with priorities over a longer period and improving regional collaboration to drive efficiencies. All new proposals must be integral to a four-year plan and must demonstrate their fit with the strategic direction of the health sector over the next four years.

Cost control in District Health Boards has been closely monitored by the Ministry of Health, with a significant reduction in deficits over the last five years, from NZD154.8M (USD106.4M) in 2008–2009 to NZD18.9M (USD13M) in 2012–2013. These reductions are achieved largely through efficiency gains and cuts in spending on staff, services, and equipment. As New Zealand's public hospitals are essentially free of charge, there is no mechanism to shift costs to patients. There have been experiments with shared-savings arrangements in the past, with contracted providers such as GP networks.

In its shared services role, Health Benefits Limited has been charged with finding cost-savings for DHBs, with a target of NZD700M (USD481.1M) over five years across procurement, financial management, and information systems.

The National Health Committee has been established to prioritize health technologies and provide advice as to which technologies no longer offer value for money. It will increasingly use comparative-effectiveness research methods to evaluate existing and new interventions and technologies.

The Pharmaceutical Management Agency uses a range of tactics, such as reference pricing and competitive tendering, to set prices for publicly subsidized drugs dispensed through community pharmacies and hospitals (Gauld, 2014). If patients prefer unsubsidized medicines (there are no clinical indications that these would be more effective), they pay the full cost. Such strategies have helped drive down pharmaceutical costs and, as a result, New Zealand's drug expenditure per capita was the fourth-lowest in the OECD in 2012 (OECD, 2014a).



What major innovations and reforms have been introduced?

Reforms over the past two years have been mostly adjustments to existing arrangements, with one standout. As noted, in mid-2013, a new national Primary Health Organization contract was issued with new minimum PHO standards and the requirement for DHBs and PHOs to enter into alliances. The rationale for this was to join up the different parts of the health system—GPs and public hospitals in particular—that operate largely separately but with common populations in a region. The context for these alliances is the increasing government concern over chronic disease and complex patient management, with a focus on better supporting patients and their providers in primary care settings. The alliance concept derives from the construction industry, where independent companies work collaboratively and share resources to ensure that projects are successfully completed.

Alliances reflect an important shift in the governance model and structures for designing and delivering health services in New Zealand, as each alliance must take a “whole of system” approach. In this process, each brings together clinical leaders, managers, and community representatives from across the local health system to focus on how services should look from a patient perspective. An alliance's focus is primarily integration, with the alliance setting service priorities, making decisions by consensus as to how these will be delivered on, and then sharing financial and other resources to drive implementation. Many alliances are creating further clinically led “service level alliances” focused on different areas of care design; many also govern health pathway development, which is rapidly expanding across New Zealand. Pathways are clinically agreed, evidence-based guidelines for treating patients with integrated care requirements.

Underpinning the resourcing of alliances has been a new “flexible funding” arrangement that allows for the PHO to allocate previously ring-fenced funding (such as “care plus,” for additional services for enrolled patients with chronic conditions) to new priority areas, with DHBs contributing to the arrangement. Also in development to support the alliances is a new “Integrated Performance and Incentive Framework,” which will measure and reward performance against measures that reflect the level of integration within the district. This new framework, which should be implemented in 2015, aims to encourage districts and their alliances to improve their performance. While three pilot alliances (Integrated Family Health Centers) have been evaluated, there are no plans yet to evaluate the national rollout.

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The Norwegian Health Care System, 2014

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What is the role of government?

The government is responsible overall for providing health care to Norway's population. For secondary care, the Ministry of Health and Care Services (MoH) has a direct role, through legislation, funding, ownership of hospitals, and provision of directives to the boards of the regional health care authorities (RHAs). Norway's 428 municipalities are responsible for providing primary care, in which the ministry has a less direct role, mainly through legislation and funding mechanisms. The municipality has to provide care according to current legislation and to written directives from the Directorate for Health, based on the MoH's priorities and demands. Public dental care and public health tasks are the responsibility of the 19 counties.

Since the 2002 Norwegian Hospital Reform, the RHAs (now four in all), which are corporations fully owned by the state, have been responsible for supervising inpatient and specialist somatic care, psychiatric care, and treatment for alcohol and substance use disorders. The MoH provides the RHAs' budgets, and issues a yearly document instructing the RHAs as to aims and priorities.



Who is covered?

Coverage is universal. The nationally managed and financed health system is built on the principle of equal access for all citizens regardless of socioeconomic status, ethnicity, and area of residence. European Union (EU) residents have, through common agreements, the same access to health services as Norwegians, as do other residents with a permit to stay and work in Norway. Other visitors are charged in full. For undocumented immigrants, access is limited to emergency acute care. Private health insurance is slowly growing, but only about 7 percent of the population has some sort of insurance coverage.



What is covered?

Services: Parliament determines what is covered and establishes the criteria for cost-sharing and safety nets. There is no defined benefits package. In practice, statutory national health insurance covers primary care, hospital care, ambulatory care, and outpatient prescription drugs on the formulary (the "blue list"). It also covers dental care services for children and other prioritized groups. It does not cover nonmedical eye care or cosmetic surgery. A physician must consider certain treatments, such as plastic surgery, to be medically essential if they are to qualify for public coverage. All inpatient care in a public hospital, including use of pharmaceuticals, is free of charge for the patients. Complementary medicine is not covered.

Primary care (services by general practitioners, physiotherapists, and chiropractors), preventive care (immunization of infants and schoolchildren, checkups, and screening), and nursing care are organized at the local level by the municipalities. The municipality, often in cooperation with the county, also decides on public health initiatives or campaigns to promote a healthy lifestyle and reduce social health disparities. Preventive services for mental health are directed toward children and adolescents through the school system. Primary care for mental health is provided by general practitioners and municipality-employed psychologists. Provision of long-term care is needs-based, as described below.

The health budget for these services is decided locally, with a number of services being statutory for the municipalities, particularly those related to pediatric care.

Cost-sharing and out-of pocket spending: General practitioner and specialist visits, including outpatient hospital care and same-day surgery, require copayments of NOK141 and NOK320 (about USD16 and USD35) per visit, respectively, as of 2014, as do physiotherapy visits (varying amounts), covered prescription drugs (up to NOK520, or USD57, per prescription), and radiology and laboratory tests (NOK227 and NOK50, or USD25 and USD6, respectively).^{*} Providers cannot, as long as they are a part of the public system, charge the patient more than these amounts, unless charging for bandages and other disposable materials. Out-of-pocket payments account for less than 15 percent of the total health care budget. Home-based and long-term institutional care for older or disabled people requires high cost-sharing (up to 85% of personal income), and is means-tested.

There is an annual maximum for many cost-sharing requirements, above which out-of-pocket costs are waived; for 2014, the cost-sharing ceiling, set by Parliament, is NOK2,105 (USD234). A second ceiling is set at NOK2,675 (USD296), and includes services such as physiotherapy and certain dental services. Long-term care and prescription drugs outside the “blue list” do not qualify toward these ceilings.

Safety net: Certain groups are exempt from cost-sharing. Children under the age of 16 receive free physician treatment and access to essential drugs on the blue list, children under the age of 18 receive free psychological and dental care, pregnant women receive free medical examinations during and after pregnancy, and residents eligible for minimum retirement pensions or disability pensions, which amount to about NOK176,000 (USD19,450) per year, receive free essential drugs and nursing care. Individuals suffering from specified communicable diseases, including HIV/AIDS, and patients with work-related injuries receive free medical treatment and medication. Taxpayers with high expenses as a result of permanent illness receive a tax deduction.



How is the health system financed?

Norway has the second-highest per-capita spending on health care among OECD countries (NOK55,560, or USD6,140). As a percentage of GDP, Norway spends close to the OECD median (9.3% in 2012) (OECD, 2012).

Publicly financed health care: Public spending on health is financed through general taxation, and accounted for 85.5 percent of total health expenditure in 2013. The central government, counties, and municipalities all collect taxes. The central government proposes an annual health budget in October, which the Parliament debates and passes in December. After the budget is passed, the General Purpose Grant Scheme allocates funds to each municipality as a block grant, according to population size and other characteristics, among which population age is the predominant factor. Funding is not adjusted according to actual utilization. Funds for hospital care are allocated to regional health care authorities through a combination of block grants (50%) and activity-based funding (50%).

Privately financed health care: In 2013, out-of-pocket payments accounted for approximately 15 percent of total health care expenditure, reflecting cost-sharing arrangements. Private funds are spent on medicines and general practitioner (GP) services, but also on outpatient specialist services and transportation. Voluntary health insurance, operated by for-profit companies, does not play a significant role in health care funding. Of the 7 percent of the population with some coverage, 88 percent receive coverage through their employer (employees are taxed for these benefits). Voluntary insurance plays a supplementary role, primarily offering shorter waiting times for publicly covered elective services (Ringard et al., 2013).



How is the delivery system organized and financed?

Primary care: Although the number of physicians has increased in both the general practitioner and the hospital sector, the proportion of physicians working as GPs has fallen dramatically in the past 10 years, indicating faster growth in specialist services and secondary care. According to the health personnel registry, there are 2.09 specialists in hospitals or ambulatory care for every practicing primary care physician (with or

^{*} Please note that throughout this profile, all figures in USD were converted from NOK at a rate of about NOK9.05 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for Sweden.

without specialty in primary care medicine). Financial incentives have, however, been put in place both to encourage specialized GP certification and for GPs to see more patients per day.

Patients are encouraged to register with a GP, and virtually all residents are now registered. Those not registered pay an additional NOK110 (USD12) for GP consultations. Patients have a legal right to seek a second medical opinion, and may choose a new GP twice a year. In many areas, there are too few GPs with availability on their patient list, so choice is limited. GPs function as gatekeepers; all patients need a referral by a GP in order to receive coverage for specialist treatment.

Municipalities contract with GPs, who in turn receive a combination of capitation from the municipalities (approximately 35% of income), fee-for-service from the Norwegian Health Economics Administration (35% of income, for services such as blood tests or preventive and mental health consultations), and out-of-pocket payments from patients (30% of income). GP financing is determined nationally. There are particular fees for taking part in coordination of care and individual planning, but they are relatively low. Most GPs are self-employed and a few are salaried municipal employees. GP practices typically comprise two to six physicians, nurses, lab technicians, and secretaries. They are organized either as individual practitioners with joint offices or in joint enterprises or corporations, but each GP has an individual contract with the municipality. Nurses, lab technicians, and secretaries are employees. Some practices have nurse practitioners taking care of certain patient groups, such as diabetics and people with chronic obstructive lung disease. Many municipalities have multidisciplinary outreach teams for mental health, and those health care workers are employed by the municipalities. Physicians and ambulance services are the main referrers of patients to emergency hospital consultation or admittance to hospitals for specialty care.

Outpatient specialist care: Hospital-based specialists are salaried. Privately practicing specialists are self-employed and are paid an annual lump sum based on their contract with an RHA, in addition to fee-for-service payments (about 35%) and patients' copayments (about 30%). The fee-for-service payment scheme is negotiated between central government and the Norwegian Medical Association. Some services, such as smoking cessation and secondary prevention for cardiovascular diseases, are reimbursed at a higher fee as an incentive for providing them. In principle, patients have choice of specialist, although in practice specialist availability varies by geographic location. In more densely populated areas, clinics with multidisciplinary specialists have emerged during the last few years and seem to have increased. Hospital-based specialists cannot see private patients at the hospital, but they may practice privately after hours, on their own time, in offices outside of the hospital. Privately practicing specialists with a public contract may charge patients only the specified out-of-pocket fee. If they do not have a public contract, they are not entitled to any public financing; these payments are not publicly regulated.

Administrative mechanisms for paying primary care doctors and specialists: Providers are paid directly for the publicly reimbursed part of their fees, according to the terms of the contract. Patients make copayments directly to providers at the time of service (see above for further detail). There is no reimbursement process for patients. When patients reach the ceiling for out-of-pocket payments, which is automatically registered, they no longer make any direct payments to providers. Instead, the full amount is paid directly by the third-party payer.

After-hours care: After-hours emergency services are the responsibility of the municipalities. For general practitioners, the contract with the municipality includes after-hours emergency services, unless the GP is above a certain age or is exempt for other reasons. The municipalities provide offices, equipment, and assistance, and pay the GPs a small fee. The rest of the salary is provided by the national fee-for-service system and out-of-pocket payments from patients. In many places, after-hours emergency services are available at or near a hospital, providing easy access to X-rays and laboratory services and convenient referral to hospital care.

The organization of the after-hours services varies according to the size of the municipality, and in rural areas it is common that two or more municipalities have joint after-hours services. More densely populated municipalities organize after-hours emergency services as a walk-in service, where nurses triage patients and answer their calls, and several doctors see patients all through the day and night. Smaller municipalities have a service where patients call an after-hours hotline and speak with a nurse, who calls the GP if the patient needs to be seen.

Information from emergency visits may or may not be shared with a patient's regular GP. There is an emergency phone number patients can call for urgent ambulance services, but there is no national medical advice telephone service for patients. Patients can always get in touch with health care personnel at their local after-hours care facility. Patient cost-sharing and provider fees are slightly higher for after-hours emergency services.

Hospitals: All hospital trusts are state-owned but are formally registered as legal entities with an executive board, and are governed as publicly owned corporations. A few hospitals are privately owned, mostly by nonprofit humanitarian organizations, and most of these are publicly funded by the regional health care authorities and are part of the plan for providing acute care. All hospitals offer ambulatory services, and virtually all ambulatory care consultations take place in hospitals or through private specialists with contractual agreements with RHAs. Patients are free to choose the hospital they want to go to for elective services, but not for emergency care. Unless the emergency warrants transportation only to the nearest hospital, the patient's home address determines which hospital provides the emergency services.

Public hospitals are financed annually through RHAs. A block grant covers 50 percent of the cost of expected patient volume, with the remainder paid according to actual patient volume, based on somatic diagnosis-related groups. Thus, the ratio between fixed and variable funding is 50:50 if actual patient volume equals expected volume, but that ratio changes if actual volume differs. All health personnel are salaried, including doctors. The Coordination Reform introduced cofinancing for municipalities of approximately 20 percent of the cost of a hospital stay for their residents (Helsedepartementet 2012).

Mental health care: In municipalities, mental health care is provided by general practitioners and by other providers (psychologists, psychiatric nurses, social care workers). For specialized care, GPs refer patients to a private practitioner, psychologist, or psychiatrist, or to a low-threshold outpatient hospital (district psychiatric center), some of which also have inpatient wards. These hospitals are dispersed geographically throughout the country to facilitate further treatment and follow-up by community health and social care workers. They often have psychiatric outreach teams, which treat patients in their homes as often as possible. More-advanced specialized services are organized in the inpatient psychiatric wards of mental health and general hospitals. Hospital treatment is provided free of charge, and outpatient services are subject to the same cost-sharing as described above. The role of private mental hospital care is very small, and includes services for eating disorders, nursing homes for older psychiatric patients, and some psychiatrist and psychologist outpatient practices, mostly contracted by regional health care authorities. The diagnosis-related group system does not apply to psychiatric care.

Long-term care and social supports: The municipalities are responsible for providing long-term care. Cost-sharing for institutionalized care is income-based, and is set between 75 and 85 percent, means-adjusted. Patients' assets are not subject to assessment in setting cost-sharing requirements and do not need to be liquidated to cover cost-sharing (it is based on income only). Institutions include nursing homes, long-term psychiatric homes, and sheltered homes for severely disabled children and youth. Home nursing is provided, if feasible and needed, and is free of cost-sharing. After a home visit and discussions with the patient and family, the municipality makes a determination of the level of care that will be provided, which most often takes into account an evaluation by the patient's GP or by a hospital upon discharge; decisions about providing care in a nursing home are not excluded. A few nursing homes are privately run, but their services are provided under contract with the municipalities. Very few patients pay individually for full-time nursing home care. Municipalities may also provide for end-of-life care for terminal patients, within nursing homes, but many nursing homes do not have palliative units.

Patients may pay for their own care, but only with private funds. There is also a system in place for informal carers to apply for financial support from the municipalities.



What are the key entities for health system governance?

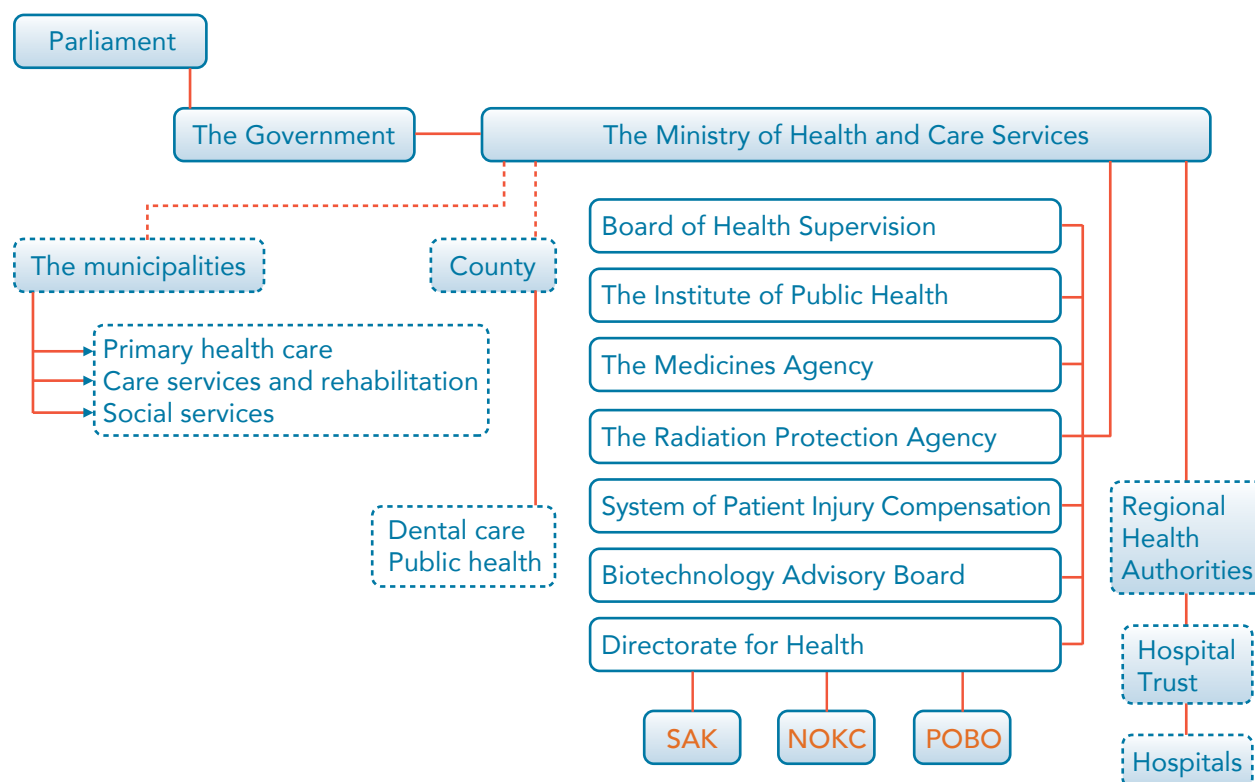
The Ministry of Health and Care Services is politically led by the Minister of Health. The chief executive of the ministry and his staff translate political decisions into practice by working out proposals for legislation and budgets as well as by developing documents instructing the regional health authorities and the Directorate for Health and other underlying agencies regarding activities and priorities. The directives are given in yearly board meetings between the Minister of Health and the Regional Health Authorities.

The Norwegian Medicines Agency determines which medications to reimburse. For new drugs, the agency determines whether a prescription drug should be covered (i.e., be on the blue list) by evaluating its cost-effectiveness in comparison with existing treatments. The agency also decides on the maximum price of the specific drugs.

The Directorate for Health is an executive agency and authority subordinate to the Ministry of Health and Care Services, subject to resolutions of government per the instructions in the annual letter of allocation from the Ministry of Health, as well as to the political values conveyed by the annual national budget and those of Parliament. The Directorate for Health issues clinical guidelines, and has in place a system for introducing new treatment methodologies in hospitals, including drugs, which is based on health technology assessments provided mainly by the Norwegian Knowledge Center for the Health Services (see below). The Directorate for Health also coordinates a system of patient ombudsmen, which has an office in each county.

The Norwegian Knowledge Center for Health Services, financed by the central government, focuses on comparative effectiveness, patient safety, and quality indicators, and on national patient experience surveys. It often includes economic analyses in its systematic reviews and health technology assessments, which are

Organization of the Health System in Norway



SAK: Norwegian registration authority for health personnel
 NOKC: Norwegian Knowledge Centre for the Health Services
 POBO: Health and care services ombudsmen

Source: A. K. Lindahl, Norwegian Knowledge Centre for Health Services, 2014.

actively used by the Norwegian Council for Priority-Setting in Health Care and by policymakers. The Center also includes the National Agency for Patient Safety, which runs the national reporting and learning system for adverse events.

The Norwegian Board of Health Supervision is organized under and operates within a framework set by the Ministry of Health and Care Services. The Board carries out national audits, including incident-related audits. There is an alert system through which hospitals must inform the Board of serious adverse events like unexpected and sudden deaths (according to Section 3-3a in the Specialized Health Care Act). The Board can issue fines for institutions and warnings to health personnel, and can revoke certification for health care personnel who engage in misconduct.

The Norwegian Institute of Public Health (NIPH), organized under the Ministry of Health and Care Services, is a center for research on and surveillance of the health status of the population. It advises the ministry regarding public health issues. It is the main authority on infection control and infectious disease surveillance in Norway. It holds several of the large health registries, including the prescription registry. The NIPH assists the prosecuting authorities and the judiciary in resolving criminal and civil cases.



What are the major strategies to ensure quality of care?

The 2012 MoH white paper on quality and patient safety is guiding the strategies to ensure quality of care (Ministry of Health and Care Services, 2012). The Directorate for Health is in charge of the national program for health care quality indicators and for disseminating information about health and health care for the public. The national quality improvement strategy focuses on efficacy, safety, efficiency, patient-centered care, coordination and continuity, and equality in access to health care (Helsedirektoratet, 2005). In support of those efforts, the Knowledge Center and the Directorate for Health gather and disseminate information on the effectiveness and quality of health services, including patient experiences, and make it available to the public through a Web site (www.helsenorge.no). To further improve quality, national evidence-based guidelines are being developed for a number of diseases. A disease management program for cancer is also in development. To improve patient safety in particular, there is a five-year national program for patient safety (2014–2018), as well as a national reporting and learning system for adverse events.

The Norwegian Registration Authority for Health Personnel licenses and authorizes all health care professionals and can grant full and permanent approval to those meeting educational and professional criteria. There is no system for reevaluation or reauthorization. The authority also issues certificates of specialization to medical doctors, according to specific and transparent requirements. Only general practitioners require recertification. Audits of all levels of the health system, including the health care workforce, are carried out by the Norwegian Board of Health.

Regional health care authorities, hospitals, municipal health care providers, and private practitioners are responsible for ensuring the quality of their services. Hospitals need an approval to provide services to patients, issued by the Directorate for Health. There is no requirement for accreditation or reaccreditation, although some hospitals are accredited (either the total organization or particular departments, often laboratories). Quality indicators, determined nationally by the Directorate for Health and including process indicators, patient experiences, and survival rates for specific conditions, are publicly available on a Web page (www.helsenorge.no). There is currently a five-year developmental period for pay-for-performance schemes on the part of RHAs based on some of these indicators (2013–2017).

There are about 15 national health registries (e.g., the Cancer Registry and the National Patient Registry) and about 47 national clinical quality registries, which are available online and supported by the National Center for Clinical Documentation and Evaluation. Most registries are based on data submitted by hospitals with patient consent, and hospitals are given feedback on their performance. Efforts to better integrate registries with electronic medical records are currently under way.

The Norwegian Institute of Public Health uses the Norwegian Prescription Database to produce annual reports on prescribing trends, giving national health authorities a statistical base for planning and monitoring the prescribing and use of prescription drugs.



What is being done to reduce disparities?

Eliminating socioeconomic inequalities is a priority focus area of the Norwegian Directorate for Health. A national strategy for addressing inequalities in health and health care was issued in 2007 (Ministry of Health and Care Services, 2007). Efforts to reduce disparities include promoting equal access to high-quality child care, kindergarten, and education; initiatives to improve the working environment and opportunities for people with physical or mental disabilities to be included in the workplace; price and tax policies; initiatives for integration; general information campaigns regarding smoking cessation, alcohol, and diets; and specific initiatives for populations at risk. Systems for continuous mapping of socioeconomic health disparities are in development.

There is an ever increasing awareness of health disparities regarding immigrants, who on average have poorer health. The need for adequate information to be disseminated in immigrants' native languages has also been emphasized.

Geography also plays a significant role in differences in health outcomes. Recruitment of health personnel, notably doctors and specialized nurses, is more difficult in rural areas. There have been no accurate measures to determine whether access goals have been achieved.



What is being done to promote delivery system integration and care coordination?

In 2012, the Coordination Reform was implemented (Ministry of Health and Care Services, 2009). For hospitals, incentives for care coordination are provided by mandatory agreements between hospitals and the municipalities and through the recently introduced requirement for municipalities to finance 20 percent of diagnosis-related group costs in hospitals. The incentives are aimed at better treatment and coordination of care, particularly for elderly patients with chronic diseases. After both planned and emergency hospitalizations, a discharge letter is sent to a patient's GP. If the patient need home-based nursing care after discharge, there are structured routines for alerting the municipality, and in most instances the municipality performs an evaluation before the patient leaves the hospital.

New models for integrated care are currently being tested, with joint wards (financed jointly by hospitals and municipalities) for patients with intermediate needs for institutionalized care. In some instances, these include wards for palliative end-of-life care (mostly cancer patients); in other areas, hospice-type wards are run by nursing homes with more specialized staff than those in average nursing home wards. The municipalities are currently expanding their capacity to care for patients who do not need hospital treatment but need 24-hour acute care, since all municipalities must have this in place by 2015, in accordance with the integrated health care reform. All patients with chronic diseases, including patients with mental health diagnoses, have a right to an individual plan for their care and treatment.



What is the status of electronic health records?

The National Health Network, a state-owned enterprise, is currently establishing a single information exchange platform for health providers and authorities. The platform will facilitate communication among GPs, hospitals, nursing homes, pharmacists, and others. A national strategy for health information technology (HIT) is the responsibility of the Directorate for Health. Every legal resident in Norway is allotted a unique personal identification number for this purpose.

HIT in primary care is fragmented, and some areas of service lack the resources and equipment for its implementation. Currently, virtually all GPs use electronic patient records, and some communication (e.g., hospital discharge letters, drug prescriptions, patient referrals, and exchange of X-rays and results from

specialist services and laboratories) is electronic. However, there is no direct electronic exchange of medical information between GPs and hospitals. Because of strict confidentiality laws, the exchange of medical records between hospitals is also restricted.

Uptake of electronic records by municipality home care and nursing homes has been slow, and there is little availability of electronic communication between the GP and home care services in most municipalities.

There are some projects that explore how patients can best have access to their own medical record, but they are not yet an option for the majority.

All hospitals use electronic health records. The lack of structured and standardized patient records in both primary and secondary care precludes automatic data extraction; hence, there is still insufficient data for quality improvement or national activity registration at both the local and the national level. After-hours emergency care is often (but not everywhere) organized within the same patient record network, so that patient histories remain available after hours, and primary care providers are able to access information regarding emergency visits.



How are costs contained?

A balanced national budget gives Norway flexibility in addressing rising health costs. The central government sets an overall health budget in December every year, although Parliament typically approves additional funds throughout the year. The municipalities and RHAs are then given responsibility for maintaining their budgets.

The Norwegian Medicines Agency uses cost-effectiveness evaluations to determine which drugs will be reimbursed. Drug prices are linked to reference prices set at the average of the three lowest market prices for the drug in a group comparison of prices in Scandinavian and Western European countries. The drug pricing scheme aims to encourage use of generic drugs by setting the generic price as a gradually decreasing percentage of the branded price.

Costs are contained partly by the mandatory referral system for specialized services, with the general practitioner as a gatekeeper. The fee-for-service rates are negotiated each year between the central government and the Norwegian Medical Association, and GPs or privately practicing specialists cannot themselves set the fees if they want to access public financing. The RHAs contract some private providers, and those contracts are negotiated.



What major innovations and reforms have been introduced?

There have been a series of major changes in Norwegian health care, with relatively recent reforms in primary care (regular GP reform, 2001), in hospital care (2002), and at the national authority level (2002). In 2009, the Minister of Health proposed the Coordination Reform, focusing on prevention, care integration, and the strengthening of municipal health care. There has been growth in annual health expenditure in the past 10 years, most of it experienced by hospitals. Consequently, the Coordination Reform, which came into effect in January 2012, also aims to curb the growth of hospital costs and direct more investment toward primary care. It has introduced an economic incentive for municipalities to work toward less hospitalization of their patients. Now, after a transfer of funding from the hospital sector, municipalities must pay 20 percent of the costs of hospitalization for nonsurgical treatments of their citizens. In addition, between 2012 and 2015, the municipalities must incrementally establish primary emergency 24-hour care for patients who do not need specialized hospitalization but require some kind of health care attention that cannot be provided in the home. The Coordination Reform will also strengthen information systems: The Norwegian Health Network will develop further and operate information technology infrastructure for the health care sector. There are several ongoing evaluations of the effects of the reform, and numerous other ongoing innovative projects to improve coordination of care.

In recent years, there has been a greater focus on quality and priority-setting, including increased use of health technology assessment. The Norwegian Council for Priority-Setting in Health Care advises the Minister for Health and Care Services on specific issues (refer to section on key agencies), and a set of priority-setting

guidelines has been created to guide referrals to secondary care. In 2013, a system for regulating the introduction of new and costly treatments in hospitals, including pharmaceuticals, began to be implemented, mainly to evaluate their effectiveness.

In July 2012, the national reporting system for adverse events in hospitals was replaced by the nonpunitive, electronic Reporting and Learning System. Whereas the previous reporting system could be the basis for punitive actions regarding health personnel's authorization to practice, or for litigation, the new system is geared only toward preventing future harm to patients, and therefore focuses only on learning from the incidents. The Norwegian Board of Health Supervision has an investigating group for serious adverse events, with a focus on whether the patient received proper care. The government has decided to establish an investigation commission for serious adverse events, probably in addition to these systems, but it is not yet in place.

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The Singaporean Health Care System, 2014

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What is the role of government?

The government of Singapore planned, built, and continues to develop and maintain the nation's public health care system. It also regulates both public and private health insurance in the country. The health care system is administered by the Ministry of Health, which has responsibility for assessing health needs and for planning and delivering services through networks of health and hospital facilities, day care centers, and nursing homes. The ministry manages, plans for, and maintains staffing throughout the system and is also responsible for financing policies and governance of the entire public health care system. Because Singapore is a very small nation-state, there is little regional- or local-level funding or regulation; the national government takes on full responsibility for the health system. Singapore offers universal health care coverage to citizens, with a financing system anchored in the twin philosophies of individual responsibility and affordable health care for all.



Who is covered?

Singapore offers its citizens universal health care coverage, funded through a combination of government subsidies, multilayered financing schemes, and private individual savings, all administered at the national level. Capital expenditures are determined at the national level in the government's annual budget. The first tier of protection is provided by government subsidies of up to 80 percent of the total bill in public hospitals and primary care polyclinics. There are also subsidies of up to 80 percent in the government-funded intermediate and long-term care institutions. This is supported by a system of savings and insurance programs to help individuals and families pay for their care—known as the “3Ms,” for the Medisave, MediShield, and Medifund programs. Together, these play a critical role in maintaining Singaporeans' health and welfare.

Medisave is a mandatory medical savings program that requires workers to contribute a percentage of their wages to a personal account, with a matching contribution from employers. Individual contributions to and withdrawals from the accounts are tax-exempt. Account funds are used, under strict guidelines, to pay for health services such as hospitalization, day surgery, and certain outpatient expenses, as well as health insurance for the account holder and family members.

MediShield is a low-cost catastrophic health insurance scheme to help policyholders meet medical expenses for major or prolonged illnesses that their Medisave balance would not be sufficient to cover. All permanent residents are automatically enrolled in the program; undocumented immigrants and visitors are not covered. MediShield operates on a copayment and deductible system, with premiums payable by the insured through Medisave. A universal health insurance scheme will replace MediShield at the end of 2015 (see below).

Medifund is the government endowment fund set up to aid the indigent. The fund covers Singapore citizens who have received treatment from a Medifund-approved institution and have difficulties paying their medical bills despite government subsidies, Medisave, and MediShield coverage.

A range of private insurance plans are available, including Medisave-approved Integrated Shield Plans, which supplement MediShield coverage. Private plans are approved by the government and must have copayment and deductible elements. Policies are kept affordable through competition. Individuals can use funds from their Medisave accounts to pay the premiums for Integrated Shield Plans. Singaporeans also have the option of purchasing other types of private insurance, although this coverage cannot be paid for with Medisave funds. Employers may also provide insurance to employees as a benefit. (Data on the percentage of the population covered by private insurance are not readily available.)



What is covered?

Services: Subsidies are available for care provided by public hospitals and polyclinics, as well as by government-funded intermediate and long-term care providers. MediShield, the second of the “3Ms,” provides low-cost insurance coverage for treatments in the subsidized wards of public hospitals and outpatient care for certain conditions, including kidney dialysis and cancer treatments. As a catastrophic insurance program, MediShield generally does not cover primary care, prescription drugs, preventive services, mental health care, dental care, or optometry. MediShield is operated by the Central Provident Fund Board.

Cost-sharing and out-of-pocket spending: The government of Singapore contributes to building and maintaining the system and subsidizing a portion of the cost of patient care, based on the individual’s ability to pay. Copayments after subsidy can be covered by MediShield insurance or paid for through Medisave savings. For MediShield, an annual deductible against claims must be met before coverage can begin. Coinsurance for inpatient bills ranges from 20 percent to 10 percent as the bill increases. Therefore, after government subsidies, MediShield pays between 80 percent and 90 percent of the claimable amount that exceeds the deductible for selected outpatient treatment charges claimable under MediShield (e.g., kidney dialysis, chemotherapy for cancer, and erythropoietin for chronic kidney failure). Other outpatient services are fully paid from private funds or, in some cases, employer benefits. Deductibles do not apply to outpatient treatments. Instead, a 20 percent coinsurance is imposed. There is no annual cap on out-of-pocket spending.

The health care system requires individuals to be ultimately responsible for their own health and to share in the cost of the services they use. Consequently, patients approach their health care choices knowing that they will pay a portion of the bill. In the Singapore system, patients are responsible for copayments and deductibles that are often higher than in other nations. According to the World Health Organization (2013), private spending amounts to 69 percent of total health care expenditure, of which 88 percent is out-of-pocket, including costs that are covered and reimbursed by employer medical benefits.

Safety net: Medifund, the third of the Singapore system’s “3Ms,” is an endowment program funded by the government as a health care safety net. It was established in 1993, and its mission is to help the poor pay for their care. Money from the fund is disbursed each year to approved institutions, and a committee at each institution evaluates and approves financial assistance to patients. Government-funded providers (whether public or private institutions, or voluntary welfare organizations) are able to tap Medifund assistance for their patients.

Medifund generally covers necessary medical treatment, including drugs, services, and tests. Medical social workers are in place to assist patients with the application process required before aid is granted. The amount of aid granted is determined by the patient’s and the family’s income, the social circumstances of the patient, the medical condition, and treatment costs. More than 90 percent of patients whose applications are approved receive assistance amounting to 100 percent of the outstanding portion of subsidized bills that they are unable to pay.

The ElderCare Fund is another government-established endowment fund established by the government. The endowment, which stands at SGD3 billion (USD3.4 billion), provides grants to intermediate and long-term care facilities to subsidize the care of low- and middle-income patients (Ministry of Health, 2013).¹



How is the health system financed?

Publicly financed health care: The Singapore health care system is funded directly by the national government through its Ministry of Health. The ministry’s budget for fiscal year 2013 was SGD5.9 billion (USD6.7 billion), or 1.6 percent of GDP. The funds come from general revenue, and they are used for subsidies, campaigns to promote good health practices, manpower development and training, and infrastructure expenses. Most of the budget is devoted to subsidies for patients receiving medical care at public hospitals, polyclinics, community hospitals, and certain institutions providing intermediate and long-term care. Other budget allocations include

¹ Please note that throughout this profile, all figures in USD were converted from SGD at a rate of about SGD0.88 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by the World Bank (2014) for Singapore.

initiatives addressing obesity prevention, tobacco control, childhood preventive health services, chronic disease management, and public education, as well as Medisave grants to newborn Singapore citizens (Ministry of Health, 2013).

Privately financed health care: The other major source of funding for the health system is private financing and expenditure. According to the World Health Organization (2013), in 2010, private expenditure amounted to 69 percent of the nation's total expenditure on care, 10.1 percent coming from private prepaid plans.

Private insurance is available from a number of for-profit companies, usually in the form of Medisave-approved Integrated Shield Plans. These plans serve as a supplement to MediShield, providing, for example, additional benefits and coverage when a patient opts for Class A and Class B1 wards in public hospitals or private hospitalization. Employers may also offer private insurance to their employees as a staff benefit. Typically, employer-sponsored insurance cover primary care and other outpatient visits, in addition to hospitalization.



How is the delivery system organized and financed?

Primary care: Primary care is mostly administered by the 1,400 private clinics offering such care (Ministry of Health, 2013). In addition, there are 18 public, multi-doctor polyclinics that provide subsidized outpatient care, immunization, health screening, and pharmacy services, with some offering dental care as well. These clinics, however, generally serve lower-income populations; the bulk of primary care is delivered by private general practitioner clinics.

Patients can choose their primary care doctor, and registration is not required. Private primary care doctors make referrals but generally do not function as gatekeepers. They are usually paid on a fee-for-service basis.

The Singapore system is strengthening its ties to private general practitioner networks. The Community Health Assist Scheme was introduced in 2012 to provide portable subsidies to Singaporeans from lower- to middle-income households. The scheme subsidizes visits to a participating private clinic for acute conditions, specified chronic illnesses, specified dental procedures, and recommended health screening. There are about 720 participating medical clinics and about 460 dental clinics.

Outpatient specialist care: A number of centers focus on medical specialties, including cancer, oral care, cardiovascular disease, diseases of the nervous system, and skin diseases. The National Heart Centre, for example, offers a full range of treatment, from prevention to rehabilitation and is the national and regional referral center for any cardiovascular complications. Research, teaching, and training are also conducted there. Specialists who work in the public system are salaried; they may also see nonsubsidized patients.

Administrative mechanisms for paying primary care doctors and specialists: The government pays subsidies directly to provider institutions, reimbursing them for a portion of treatment costs. Patients receive the subsidy benefits for outpatient care in both public clinics and public hospitals; for emergency care at public hospitals; for intermediate- and long-term care at facilities managed by voluntary welfare organizations; and, through means-testing, for care in private nursing homes. Eligible lower- to middle-income patients may also receive subsidies for outpatient treatment for chronic or acute conditions, and also certain dental procedures, at private primary care providers.

After-hours care: Numerous public and private hospitals offer 24-hour emergency care. There are approximately 30 24-hour clinics throughout the country, and many other clinics have late-night hours; lists of those clinics are available online. There is also a 24-hour emergency hotline that can be used for contacting ambulances operated by the Singapore Civil Defence Force. A mobile 24-hour house-call medical service is also available. Information on patient visits is not sent routinely to primary care doctors.

Hospitals: General care is delivered at regional hospitals. General hospitals offer acute inpatient services and specialist outpatient services, and have 24-hour emergency departments. In 2010, there were more than 11,000 beds (public and private sector) in 30 hospitals (15 public and 15 private, including specialty centers, community

hospitals, and chronic care hospitals). In that same year, there were 4 million outpatient visits at public hospitals, two-thirds of them subsidized (Affordable Excellence, 2013).

Public hospital funding is derived from a block budget. Part of the budget is based on Casemix, which classifies medical conditions based on diagnosis-related groups. Hospitals can reallocate savings from the block budget to develop other aspects of public health care services. The block budgets are reviewed every three to five years to ensure that subvention models keep up with changes in models of care and hospital operations. In addition to the block grants, government funds are available for manpower training and research.

Wards in Singapore's public hospitals are tiered in four main classes, according to level of amenities. Patients in the highest-class wards are treated as private patients and therefore not subsidized. Patients in the other classes receive varying subsidies depending on the choice of ward and means-testing levels.

The private sector provides about 20 percent of secondary and tertiary care services. Raffles Medical Group and Parkway Health are two of the main private hospital groups; they generally offer faster service and more amenities, and are also more involved in medical tourism, than public facilities do. The public sector has begun renting private hospitals' spare capacity to treat subsidized patients, as private hospitals currently have more beds available.

Mental health care: Health care and social service agencies involved in mental health care are guided by the National Mental Health Blueprint of 2007, and provide integrated services such as education and prevention, early detection, and treatment for at-risk individuals or people facing emotional difficulties. The blueprint laid the groundwork for a network of care and support systems that will enable integrated community living. The Institute of Mental Health is Singapore's only acute tertiary psychiatric hospital. It provides psychiatric, rehabilitative, and counseling services for children, adolescents, adults, and the elderly, as well as long-term care and forensic services. Patients with addictions can be treated in the Institute's National Addictions Management Services unit. General and specialized treatment services for eating, sleep, and addictions disorders, and for geriatric psychiatry, are also offered at a number of public hospitals.

To cope with projected increase in demand for mental health care and to improve accessibility, the National Mental Health Blueprint calls for more community-based mental health services, led mainly by tertiary facilities. Components of the program include multidisciplinary shared-care teams operating in service networks in the community; support for caregivers; community safety networks for people with dementia and depression and their caregivers; and general practitioner training and support for the care and management of people with mental illnesses. There are also community-based mental health programs targeting youth, adults, and the elderly. Most cases requiring residential care or a transition period, with close supervision provided by the Institute of Mental Health and by two voluntary welfare organizations (Singapore Association for Mental Health and Singapore Anglican Community Services).

Long-term care and social supports: Management of long-term care services for the elderly is provided by voluntary welfare organizations and private operators. Services are financed in a number of ways, including direct payment by individuals and families, direct government subsidy to patients through providers, and capital and recurrent funding for intermediate and long-term care providers to provide means-tested, subsidized care. ElderShield, a long-term care insurance program regulated by the government but run through designated private insurers, is also available. ElderShield makes monthly direct cash payouts to those who can no longer take care of themselves. These payouts are intended to be setting-neutral, so that families and seniors can choose the type of care that best suits their needs. Eligible care includes nursing home, facility-based, and home-based health care, including hospice care.

Financial support is available for informal and family caregivers. The Agency for Integrated Care administers the Caregivers Training Grant that provides an annual SGD200 (USD228) subsidy to attend approved training courses in caring for elderly or persons with disability. The grant is allocated per care recipient, not per caregiver. Care recipients must be Singaporeans or permanent residents age 65 or older or with disability. The Foreign Domestic Worker Grant, a monthly grant of SGD120 (USD137) for hiring a foreign domestic worker to

care for the frail elderly or for an individual with at least moderate disability, is also available through the Agency for Integrated Care. Eligibility requires a maximum household monthly income of SGD2,600 (USD2,965) (Ministry of Health, 2013).



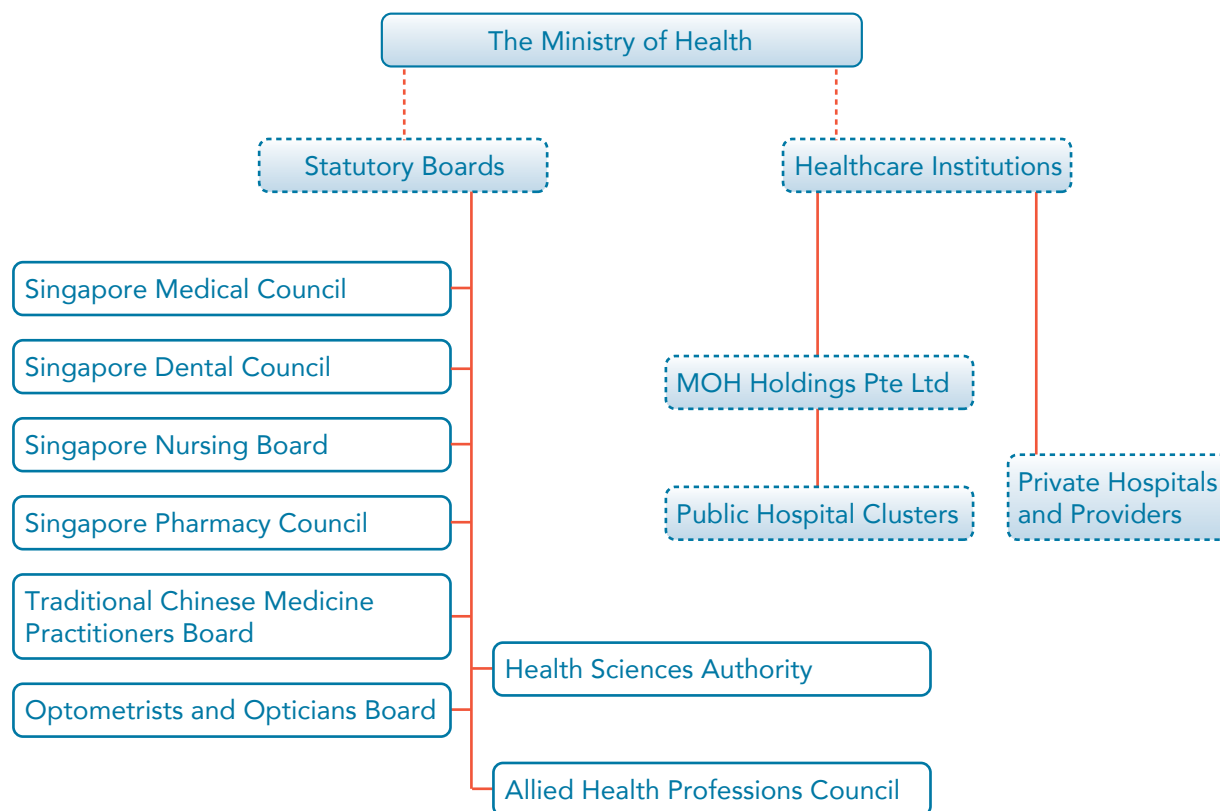
What are the key entities for health system governance?

Organization and planning: Singapore's Ministry of Health has overall responsibility for health care, setting policy direction and managing the public health care system. Its responsibilities include needs assessment, services planning, manpower planning, system governance and financing, provider fee-setting, cost control, and health information technology, with an overall goal of ensuring quality of care and responsiveness to Singaporeans' needs.

Regulation: The Ministry of Health regulates the health system through legislation and enforcement. Among its core regulatory functions are licensing health care institutions under the Private Hospitals and Medical Clinics Act and conducting regular inspections and audits. Advertising is subject to monitoring and analysis to identify potential problems, which can lead to compliance audits and prosecutions in some cases. Marketing by licensed facilities is also regulated in order to safeguard the public against false or unsubstantiated claims and to prevent inducements to using nonessential services, such as aesthetic medicine.

Professional bodies, including the Singapore Medical Council, Singapore Dental Council, Singapore Nursing Board, and Singapore Pharmacy Board, regulate professionals through practice guidelines and codes of ethics and conduct. The Ministry of Health also engages these bodies to explain policy rationale and to garner support for various initiatives. The Health Sciences Authority regulates the manufacture, import, supply,

Organization of the Health System in Singapore



Source: Adapted from Singapore Ministry of Health website.

presentation, and advertisement of health products, including conventional medicines, complementary medicines (traditional medicine and health supplements), cosmetic products, medical devices, tobacco products, and medicinal therapies for clinical trials. Its mission is to ensure that all these products meet internationally benchmarked standards of safety, quality, and efficacy. The insurance industry is regulated by the Monetary Authority of Singapore as part of its financial regulatory role.

Public consultation: The government takes the views of patients and other stakeholders into account through various means, including the “Our Singapore Conversation” sessions and an online survey. Public consultation occurs before policies are enacted to ensure that public sentiment, concerns, and feedback are added to the discussion; that diverse views are heard and ideas are tested and refined; and that public understanding and support are cultivated to facilitate implementation. As an example, after public consultation, Medisave was expanded to include a variety of preventive and treatment services, such as mammograms and colonoscopies, treatment of some mental health disorders and chronic diseases, and palliative care.



What are the major strategies to ensure quality of care?

Singapore’s Ministry of Health conducts an annual survey to gauge patient satisfaction and expectations regarding public health care institutions. The survey measures satisfaction with waiting times, facilities, and care coordination, among other health system attributes. Results of the 2012 survey show that 77 percent of respondents were satisfied, and that 78 percent of patients would “strongly recommend” or “likely recommend” institutions to others based on their own experience (Ministry of Health, 2013).

Public and private hospitals, clinics, laboratories, and nursing homes are required to submit applications to the health ministry for operating licenses. Physicians wishing to practice in Singapore must secure a position with a health care institution and register with the Singapore Medical Council, which maintains the official Register of Medical Practitioners. Physicians are required to fulfill continuing medical education requirements administered by the Medical Council. For institutions, preclicensing inspections are conducted to ensure standards.

Singapore uses a performance measurement and management process to help health care providers assess and benchmark their performance against peers. The National Health System Scorecard uses internationally established performance indicators to compare performance. The Public Acute Hospital Scorecard is used to measure institution-level performance. Its indicators cover clinical quality and patient perspectives. Similar scorecards for providers are being rolled out in primary care facilities and in community hospitals.

The scorecards define standards of service and key deliverables required of public health care institutions, and institutions are monitored to ensure compliance. The scorecards incorporate internationally accepted indicators and definitions where possible, such as the U.S. Center for Medicare and Medicaid Services’ Joint Commission–aligned measures for acute myocardial infarction and stroke.

In 2008, Singapore introduced national standards for health care to set priorities for improvement efforts and alignment with planning initiatives. These standards focus on key areas of concern and are intended to promote a culture of continuous quality improvement. The national standards are implemented through the network of Healthcare Performance Offices, each chaired by a senior clinical leader who reports directly to the institution’s chief executive officer or medical board chairman. Resulting quality improvement outputs can then be incorporated into the National Health System Scorecard and the Public Acute Hospital Scorecard for performance analysis and monitoring.



What is being done to reduce disparities?

Community Health Assist Scheme: The Community Health Assist Scheme subsidizes treatment for lower- and middle-income Singaporeans at private primary care sites. The subsidies cover acute conditions, 15 chronic conditions, and a range of dental procedures. Subsidies are also available for recommended screenings for obesity, diabetes, hypertension, lipid disorders, colorectal cancer, and cervical cancer.

Revised Central Provident Fund contribution rates: The Central Provident Fund is the umbrella account under which Singaporeans save for retirement, housing costs, and medical care (through the “3Ms”). There have been periodic increases in both employee and employer matching contribution rates in recent years, with another increase in the employer contribution rate to Medisave slated for January 2015. These increases are intended to encourage low-wage workers to save more for their retirement and medical needs and to have better access to care.



What is being done to promote delivery system integration and care coordination?

Singapore’s Agency for Integrated Care was created in 2009 to bring about a patient-focused integration of primary and intermediate- and long-term care. The agency, which operates at the patient, provider, and system levels, works to encourage health care providers to coordinate their efforts on behalf of the patient. The agency also advises patients and families about appropriate health care services and helps them navigate the system. A primary example of the issues it addresses is follow-up treatment for chronic-disease patients discharged from the hospital. Another major initiative seeks to expand and improve health care capabilities at the community level. To achieve better integration of all care services, all six public hospital clusters in Singapore are undergoing a systemwide transformation to a regional health care system model. Hospitals will work in close partnership with other providers in their region, such as community hospitals, nursing homes, general practitioners, and home care providers.

Another significant role for the agency is to ensure integration of health and social care services for elderly and disabled populations. The agency coordinates and facilitates the placement of sick elderly people with nursing homes, community providers, day rehabilitation centers, and long-term care facilities, and manages referrals to home care services. The agency also actively helps the elderly and people with disability apply for available financial assistance.



What is the status of electronic health records?

Singapore is building a sophisticated national electronic health record system. The system collects, reports, and analyzes information to aid in formulating policy, monitoring implementation, and sharing patient records. The long-term goal is to allow medical professionals to access clinical data on patient treatment and safety. System capabilities include: a master index that matches patient records from a variety of sources and includes a unique identifier as well as other patient identity information; a summary care record for each patient that offers an overview of recent medical activity; access to overviews of specific events, such as hospital admissions; and access to health data in Singapore’s registries for immunization, medical alerts, and allergies.

When fully developed, the system will allow data to be accessed and viewed in appropriate formats by medical professionals, patients, and researchers. Data sources will include the electronic medical record systems of public hospitals and polyclinics. There are plans to enable patients to view and possibly contribute to their personal health records.



How are costs contained?

Singapore spends just 4.7 percent of its GDP on health care (World Bank Health Data, 2014). Cost is controlled in a number of ways, perhaps foremost by the manner in which the government both fosters and controls competition—intervening when the market fails to keep costs down. Public and private hospitals exist side by side, with the public sector having the advantage of patient incentives and subsidies. Because it regulates prices for public hospital services and regulates the number of public hospitals and beds, the government is able to shape the marketplace. Within this environment, the private sector must be careful not to price itself out of the market.

At the same time, the government sets subsidy and cost-recovery targets for each hospital ward class, thereby indirectly keeping public sector hospitals from producing excess profits. Hospitals are also given annual budgets for patient subsidies, so they know in advance the levels of reimbursement they will receive for patient care. Within their budgets, hospitals are required to break even.

To keep demand for services in check, the government possesses numerous tools, including copayments, deductibles, and restrictions on the use of Medisave and MediShield for consultations, treatments, and procedures. These controls discourage unnecessary doctor visits, tests, and treatments, resulting in more careful use of health system resources.

Price transparency: Another factor in controlling costs is price and outcome transparency. On its website, the Ministry of Health makes available hospital bills for common illnesses, treatments, and ward classes. Patients can look up costs for specific surgeries and tests, the number of cases treated in each hospital, and more. Data for public sector hospitals are complete; since private hospitals supply data voluntarily, the information may not offer the same level of detail. Armed with pricing information, consumers are able to shop better for the services they require.

Pooling of funds and purchasing: The Group Purchasing Office consolidates drug purchases at the national level. One goal of this system is to keep drug prices affordable by containing the costs of pharmaceutical-related expenditure. The Group Purchasing Office also purchases medical supplies, equipment, and IT services for the health care system.



What major innovations and reforms have been introduced?

Government spending: Since 2012, Singapore has been conducting a major review of the health care financing framework. In the 2012 health care budget, the Minister of Finance announced the government would increase its annual share of expenditure on health care from SGD4 billion (USD4.6 billion) to SGD8 billion (USD9.1 billion) over four years (Ministry of Health, 2012). The contribution by the government will soon rise from one-third to approximately 40 percent of the total, with the prospect of future increases.

Outpatient subsidies: To maintain affordability of health care, subsidies to lower- and middle-income patients at Specialised Outpatient Clinics in public hospitals were increased starting in September 2014. Subsidies for standard drugs will also be increased these patients beginning in January 2015. Increases are means-tested.

Medisave: Medisave use has been expanded gradually to cover chronic conditions and health screening and vaccinations for selected groups. In early 2015, Medisave will also cover outpatient scans needed for diagnosis and treatment.

MediShield Life: Changes to MediShield are being implemented to address the growing need for chronic disease care and long-term care. Coverage has become universal and compulsory, and now includes individuals with preexisting conditions. Previously ending at age 90, coverage is now for life. The lifetime cap on benefits has been removed, and the annual limit increased to SGD100,000 (USD114,000). Another recent change provides better protection from large hospital bills by reducing coinsurance payments below 10 percent, for the portion of the bill exceeding SGD5,000 (USD5,702) (Ministry of Health, 2014).

Medifund: In 2013, the government added SGD1 billion (USD1.1 billion) to Medifund's capital fund, which now totals SGD4 billion (USD4.6 billion). This increase will support the implementation of Medifund Junior, which will target assistance to needy children. It also allows for the extension of Medifund coverage in 2013 to primary care, dental services, prenatal care, and delivery. In the same year, annual assistance increased by almost 30 percent, to SGD130 million (USD148 million) (Ministry of Health, 2013).

Community Health Assist Scheme: Previously set at 40 years, the minimum age qualification for the program was removed in 2014. The household income ceiling for eligibility increased from SGD1,500 (USD1,711) to SGD1,800 (USD2,053) per capita per month. More chronic diseases were added, and subsidies for

recommended health screening were introduced. These enhancements have enabled more lower- and middle income Singaporeans to benefit from the portable subsidies available at more than 1,000 medical and dental clinics (Ministry of Health, 2014).

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The Swedish Health Care System, 2014

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What is the role of government?

The three independent levels of Swedish government are all involved in the health system. At the state level, the Ministry of Health and Social Affairs is responsible for overall health and health care policy, working in concert with seven national government agencies directly involved in the areas of health, health care, and public health. Sweden has had a long history of strong local self-government. Responsibility for the organization and provision of health care services lies mainly with the 21 county councils (including four regional bodies), which are also responsible for operating regional transportation and cultural activities. At the local level, 290 municipalities are responsible for matters relating to the immediate environment of their citizens, including care of older people and disabled people. The local and regional authorities are represented by the Swedish Association of Local Authorities and Regions.

Three basic principles apply to all health care in Sweden:

1. *Human dignity*: all human beings have an equal entitlement to dignity and have the same rights regardless of their status in the community.
2. *Need and solidarity*: those in greatest need take precedence in being treated.
3. *Cost-effectiveness*: when a choice has to be made, there should be a reasonable relationship between health care costs and benefits measured in terms of improved health and quality of life.



Who is covered?

Coverage is universal. The 1982 Health and Medical Services Act states that the health system must cover all legal residents. Emergency coverage is provided to all patients from European Union/European Economic Area countries. It is also provided to patients from nine other countries with which Sweden has bilateral agreements. Asylum-seeking and undocumented children have the right to health care services, as do children who are permanent residents, and adult asylum seekers have the right to receive care that cannot be deferred (e.g., maternity care). Undocumented adults have the right to receive nonsubsidized immediate care. About 5 percent of the population has supplementary private health insurance. Almost all private health insurance is paid for by employers and is linked to occupational health care services.



What is covered?

Services: There is no defined benefits package. The publicly financed health system covers public health and preventive services; primary care; inpatient and outpatient specialized care; emergency care; inpatient and outpatient prescription drugs; mental health care; rehabilitation services; disability support services; patient transport support services; home care and long-term care, including nursing home care; dental care and optometry for children and young people; and, with limited subsidies, adult dental care. As responsibility for the organization and financing of health care rests with the 21 county councils, and responsibility for the care of older people and the disabled rests with the 290 municipalities, services may vary throughout the country.

Cost-sharing and out-of-pocket spending: About 19 percent of all health care expenditure in 2012 was on private care, and 88 percent of that was out-of-pocket spending. The majority of all out-of-pocket spending is for drugs.

Cost-sharing per health care visit and per bed-day is determined by individual county councils. In 2014, consultation with a physician in primary care cost between SEK120 (about USD14) and SEK300 (USD34).^{*} The fee for consulting a specialist at a hospital was between SEK200 (USD23) and SEK350 (USD40), and patients were charged SEK80–SEK100 (USD10–USD11) per day for hospitalization (Swedish Association of Local Authorities and Regions, 2014). Providers cannot charge above the scheduled fee. There is a national ceiling for out-of-pocket payments that caps an individual’s spending on health care visits at SEK1,100 (USD126) per year. In all county councils, people under 18 years of age, and in most county councils people under 20, are exempt from user charges for health care visits.

Dental and pharmaceutical benefits are determined at the national level. People under 20 have free access to all dental care. People 20 or older receive a fixed annual subsidy of between SEK150 (USD17) and SEK300 (USD34), depending on age, for preventive dental care. The aim is to maintain good dental health by encouraging individuals to utilize basic and preventive services and thereby decrease the need for future treatment.

For other dental services, within a 12-month period, patients 20 or older pay the full cost of services up to SEK3,000 (USD344), 50 percent of the cost for services between SEK3,000 and SEK15,000 (USD1,720), and 85 percent of costs above SEK15,000. Individuals pay the full cost of prescribed drugs up to SEK1,100 (USD126) annually, after which the subsidy gradually increases to 100 percent. The annual ceiling for prescribed drugs is SEK2,200 (USD252) for adults. A separate annual maximum of SEK2,200 for pharmaceuticals applies collectively to all children belonging to the same family. Some over-the-counter and prescription drugs are not on the National Drug Benefits Scheme and not subject to reimbursement; patients must pay the full price. There is no cap on user charges for dental care.

Safety net: The Swedish health care system is designed to be a socially responsible, equity-driven system. All social groups are entitled to the same benefits within the health system. The ceilings on out-of-pocket spending for visits and for prescribed drugs apply to everyone, and the overall cap on user charges is not adjusted for income. Children, adolescents, pregnant women, and the elderly are generally targeted groups, exempted from user charges or granted subsidies for certain services, for example, maternity care or vaccination programs for children and the elderly.



How is the health system financed?

Publicly financed health care: Health expenditure as a share of GDP was 9.6 percent in 2012. About 81 percent of that expenditure was publicly financed, with county councils’ expenditures amounting to nearly 72 percent, municipalities’ to nearly 8 percent, and the central government’s to about 2 percent (Statistics Sweden, 2014). The county councils and the municipalities levy proportional income taxes, set by the local authorities, on the population to help cover health care services. In 2011, 69 percent of county councils’ total revenues were derived from local taxes and 20 percent from subsidies and state grants financed by national income taxes and indirect taxes (Swedish Association of Local Authorities and Regions, 2013). General state grants are based on a capitation formula that reallocates some resources among municipalities and county councils. Targeted state grants must be used to finance specific initiatives—for instance, reducing waiting times—sometimes over a specific period. In 2011, about 93 percent of county councils’ total spending was on health care (Swedish Association of Local Authorities and Regions, 2013).

Privately financed health care: In 2012, about 19 percent of all expenditures on health were private, mainly in the form of out-of-pocket spending (Statistics Sweden, 2014). The primary reasons for having private individual

¹ Please note that throughout this profile, all figures in USD were converted from SEK at a rate of about SEK8.72 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for Sweden.

insurance are to get quick access to a specialist in ambulatory care, and to avoid waiting lists for elective treatment. Insurers are for-profit. Voluntary health insurance in Sweden is mainly linked to occupational health services. Some 580,000 individuals had private health care insurance in 2014, including about 12 percent of all employed individuals (Swedish Insurance Federation, 2014).



How is the delivery system organized and financed?

The health system is highly integrated. An important policy initiative driving structural changes since the 1990s has been the shift from inpatient care to outpatient or community-based care. Structural changes in specialized care during the past two decades have focused on a shift away from hospital inpatient care toward hospital outpatient care and day care, and on concentrating highly specialized care in university hospitals and/or regional centers on specific diseases, such as cancer. Guidelines for payment of providers as well as for patient fees at all levels of care are set by the county councils, leading to variation across the country.

Primary care: Primary care accounts for about 20 percent of all expenditures on health, and about 16 percent of all physicians work in the primary care setting (Swedish Medical Association, 2013, 2014). Primary care has no formal gatekeeping function. Team-based primary care is the main form of practice, in which general practitioners, nurses, midwives, physiotherapists, psychologists, and gynecologists provide treatment, advice, and prevention. There are, on average, four general practitioners in a primary care practice. The general practitioner is often the first point of contact for adults, including the elderly. For children, this function is shared between general practitioners, outpatient pediatricians, and district nurses. District nurses employed by municipalities participate in home care and regularly make home visits, especially to the elderly; they have limited prescribing authority.

Since 2010, citizens may register with any public or private provider accredited by the local county council. Individuals register with a practice, as opposed to a physician, in most county councils. In all county councils except Stockholm, registration with a practice is required. Individuals may also, however, make visits to practices where they are not registered. “Freedom of establishment”—the right to practice medicine—applies to all providers fulfilling the conditions for accreditation determined by the county councils. Those conditions focus primarily on opening hours and on the minimum number of clinical competencies available at the practice. There are more than 1,100 primary care practices throughout the country, of which about 40 percent are privately owned. The same requirements for accreditation apply to both public and private providers. Both public and private practices are paid a combination of fixed payment for their registered individuals (capitation, about 80% of total payment), fee-for-service (about 17%–18%), and performance-related pay for achieving targets (e.g., patient satisfaction, enrollment in national registers, care coordination, and compliance with recommendations from county council drug formulary committees). Performance-based payment constitutes about 2–3 percent of total payment. Public and private physicians (including specialists), nurses, and other categories of health care staff at all levels of care are predominantly salaried employees. The county councils set provider fees and copayment rates.

Outpatient specialist care: Outpatient specialist care is provided at university and county council hospitals as well as in private clinics specializing in certain areas, such as cataract surgeries. Patients have a choice of specialist in outpatient care. The same fixed, prospective, per-case payments (based on diagnosis-related groups), complemented by price or volume ceilings and quality components, are used to pay public and private providers. Public and private providers (including primary care physicians and specialists) who have a contract with a county council for reimbursement cannot bill above the fee schedule. There is no regulation prohibiting physicians (including specialists) and other staff working in public hospitals or primary care practices from also seeing private patients outside the public hospital or primary care practice. Employers, however, may establish such rules for their employees.

Administrative mechanisms for paying primary care doctors and specialists: County councils allocate funds to hospitals and primary care practices. Patients normally pay the patient fee up front for primary care and other outpatient visits. In most cases it is also possible for patients to get a bill and pay later.

After-hours care: Primary care practices in proximity to each other (normally three to five practices) collaborate regarding after-hours arrangements. Patients registered with the providers in question can get information about where to go after hours through the practices' Web sites and by phone. With regard to staffing, after-hours primary care services normally include general practitioners and nurses. There is no special arrangement for payment to providers of after-hours care, and the same copayments apply as those during regular hours, including the higher copayments for seeing hospital-based specialists rather than general practitioners (see above, "Cost-sharing and out-of-pocket spending").

In addition to after-hours care at the primary care level, there are seven university hospitals and about 50 county council hospitals that provide full emergency services 24 hours a day. The national emergency phone line (inclusive of ambulance service) is 112.

All county councils and regions provide information on how and where to seek care through their Web sites and a national phone line, 1177, with medical staff available to give advice about treatment 24 hours a day. Additionally, there is a collaborative initiative between all county councils and regions to provide online information about pharmaceuticals, medical conditions, and pathways for seeking care, known as 1177.se. There is a similar private initiative called omvard.se.

Hospitals: There are seven university hospitals, and about 70 hospitals at the county council level. Counties are grouped into six health care regions to facilitate cooperation and to maintain a high level of advanced medical care. Highly specialized care, requiring the most advanced technical equipment, is concentrated at university hospitals to achieve higher quality and greater efficiency, and to create opportunities for development and research. Acute care hospitals (seven university hospitals and two-thirds of the 70 county council hospitals) provide full emergency services. Most hospitals are public, but county councils also contract with private hospitals. There are six private hospitals in the country, of which three are not for profit. Global budgets or a mix of global budgets, diagnosis-related groups, and performance-based methods are commonly used to determine payment to hospitals. About two-thirds or more of total payment is usually in the form of budgets. Performance-based payment constitutes less than 5 percent of total payment. The payments are traditionally based on historical (full) costs. All staff are composed predominantly of salaried employees. The county councils set patient fees and provider payment rates.

Mental health care: Mental health care is an integrated part of the health care system and is subject to the same legislation and user fees as other health care services. People with minor mental health problems are usually attended to in primary care either by a general practitioner or by a psychologist or psychotherapist; patients with severe mental health problems are referred to specialized psychiatric care in hospitals. Specialized psychiatric care includes both inpatient and outpatient services, and is available to adults, children, and adolescents with psychiatric disorders. It also includes treatment of illness related to substance use disorders.

Long-term care and social supports: Responsibility for the financing and organization of long-term care for the elderly and for the support of people with disabilities lies with the municipalities (financed through general taxes), but the county councils are responsible for these patients' routine health care. Older and/or disabled people incur a separate maximum copayment for services commissioned by the municipalities (SEK1,780 [USD204] per month in 2014). The Social Services Act of 1980, revised in 2001, specifies that older people have the right to receive public services and help at all later stages of life. These services include, for example, home care aids, home assistance, and meal deliveries. They also include end-of-life care, either in the individual's home or in a nursing home or hospice. The Health and Medical Services Act and the Social Services Act regulate how the county councils and the municipalities manage palliative care. The organization and quality of palliative care vary widely both between and within county councils. Palliative-care units are located in hospitals and hospices. An alternative to palliative care in a hospital or hospice is advanced palliative home care.

There are both public and private nursing homes and home care providers. The number of private nursing homes has increased gradually, but varies significantly among municipalities. About 14 percent of all nursing home and home care was privately provided in 2012 (Statistics Sweden, 2014). Payment to private providers is usually contract-based, following a public tendering process. Eligibility for both public and private nursing home

care is based on need and determined by each municipality. Need is determined at meetings in which the elderly person, staff from the municipality, and often a relative participate. Since the 1980s, there has been an established national policy to promote home assistance and home care over institutionalized care. Also per national policy, older people are entitled to live in their homes for as long as possible. Municipalities can also reimburse informal carers (relatives or others caring for an elderly or disabled person) either directly (“relative-care benefits”) or by employing the informal carer (“relative-care employment”).



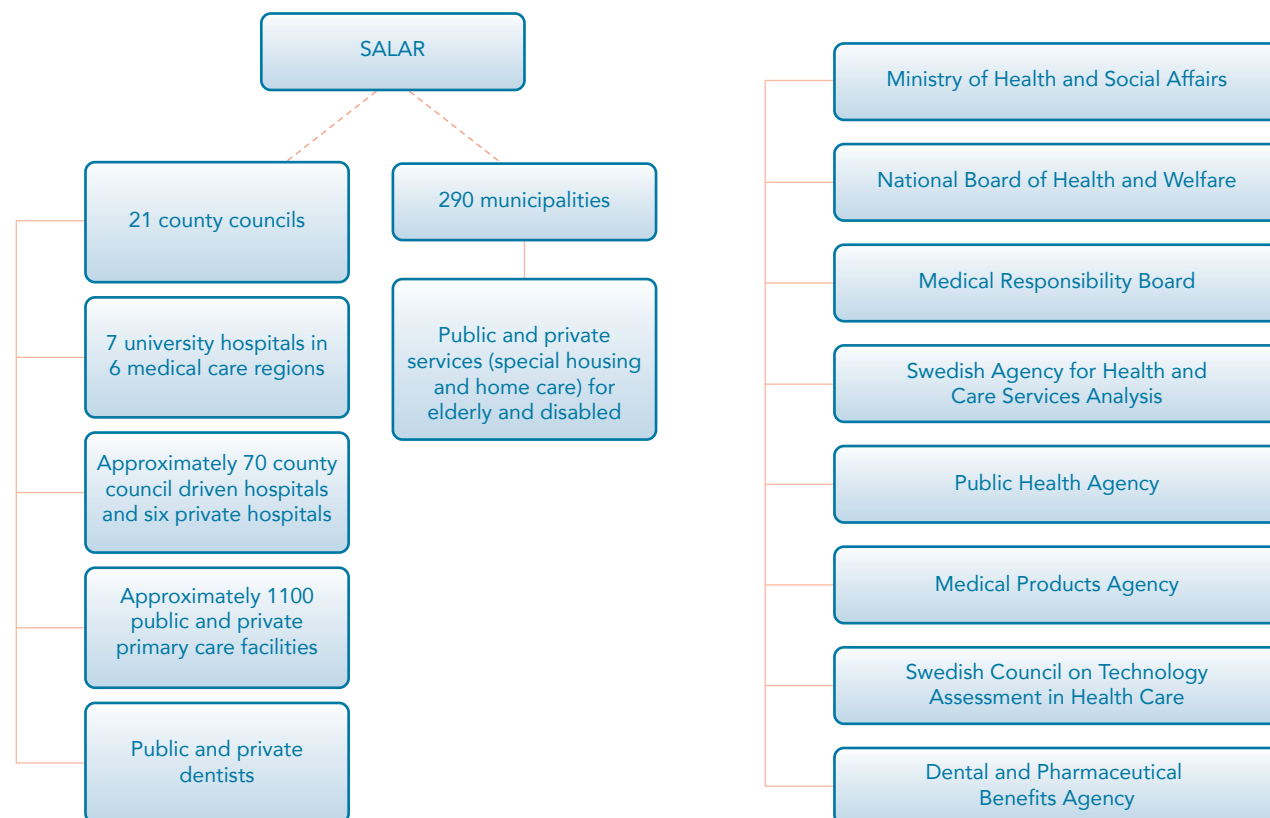
What are the key entities for health system governance?

The Health and Medical Services Act specifies that the responsibility for ensuring that everyone living in Sweden has access to quality health care lies with the county councils and municipalities. The county councils are responsible for the funding and provision of health care services. The municipalities are responsible for meeting the care and housing needs of older people and people with disabilities. The county councils and municipalities control establishment of providers and guidelines for payment of providers, and set patient fees.

The state, through the Ministry of Health and Social Affairs, is responsible for overall health care policies. There are seven government agencies directly involved in the areas of medical care and public health.

The National Board of Health and Welfare, a large government agency, supervises all health care personnel, disseminates information, develops norms and standards for medical care, and, through data collection and analysis, ensures that these norms and standards are met. The National Board of Health and Welfare is the licensing authority for health care staff. Health care personnel do not have to reapply periodically in order to keep their license. The National Board of Health and Welfare also maintains health data registries and official

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Source: Adapted from A. Anell, A. H. Glenngård, and S. Merkur, “Sweden: Health System Review,” *Health Systems in Transition*, vol. 14, no. 5, 2012, p. 19.

statistics. The Medical Responsibility Board decides on disciplinary measures in the event of complaints or possible malpractice. The Swedish Agency for Health and Care Services Analysis, established in 2011, analyzes and evaluates health policy, as well as the availability of health care information to citizens and patients, from the perspective of individuals and patients; the results of such analyses are published.

The Public Health Agency provides the national government, government agencies, municipalities, and county councils with new knowledge in the area of infectious disease control and public health based on scientific evidence, including health technology assessment. There are two health technology assessment bodies. The Swedish Council on Technology Assessment in Health Care has the primary objective of promoting the use of cost-effective health care technologies; it has a mandate to review and evaluate health care technology from medical, economic, ethical, and social points of view. Information from reviews of evidence is disseminated to central and local government officials and medical staff to provide basic data for decision-making purposes.

The main health technology assessment body for pharmaceuticals is the Dental and Pharmaceutical Benefits Agency (TLV), which assesses the cost-effectiveness of prescription drugs. Since 2002, the Dental and Pharmaceutical Benefits Agency has been mandated to decide whether particular drugs should be included in the National Drug Benefit Scheme; prescription drugs are priced in part on the basis of their value. The agency's mandate also includes dental care. The Medical Products Agency, meanwhile, is the Swedish national authority responsible for the regulation and surveillance of the development, manufacture, and sale of drugs and other medicinal products.

In primary care, since 2010 there has been competition among providers (public and private) to register patients, although they cannot compete through pricing since fees are set by county councils. County councils control the establishment of new private practices by regulating requirements for accreditation. Private providers must have agreements with the local county council in order to be publicly reimbursed.



What are the major strategies to ensure quality of care?

Concern for patient safety has increased during the past decade, and patient safety indicators are compared regionally (see below). Eight priority target areas for preventing adverse events have been specified: health care-associated urinary tract infections; central line infections; surgical site infections; falls and fall injuries; pressure ulcers; malnutrition; medication errors in health care transitions; and drug-related problems (Swedish Association of Local Authorities and Regions, 2011).

The National Board of Health and Social Welfare, together with the National Institute for Public Health and the Dental and Pharmaceutical Benefits Agency, conducts systematic reviews of evidence and develops guidance for priority-setting, which supports disease management programs developed at the county council level; international guidelines and specialists are also central to the development of these local programs. There is a tendency to develop regional rather than local guidelines to inform priority-setting in order to avoid unnecessary variation in clinical practice. For example, a national cancer plan was established in 2009, and regional cancer centers were formed in 2011 following a national decision to develop cancer prevention plans as well as treatment and care plans for all stages of the disease. There are six centers—one in each health care region—all with the common purpose of coordinating and developing the processes of prevention and care in the area of cancer from a patient perspective.

County councils control the establishment of provider institutions through conditions for accreditation, and follow up on such conditions to control the quality of services provided. County councils evaluate providers by examining a variety of data, including information obtained from patient registries, national quality registries, and surveys related to patient satisfaction, and, in dialogue with providers, by clinical auditing activities. The National Board of Health and Welfare supervises health care professionals (see above).

The 90 or so national quality registries are increasingly important for monitoring and evaluating quality among providers and for assessing treatment options and clinical practice. Registries contain individualized data on

diagnosis, treatment, and treatment outcomes. They are monitored annually by an executive committee, and are funded by the state and county councils and managed by specialist organizations.

Since 2006, annual performance comparisons and rankings of the county councils' health care services using data from the national quality registers, the National Health Care Barometer Survey, and the National Patient Surveys have been made available to the public through a collaborative project undertaken by the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions. The 2012 publication included 169 indicators, organized into various categories—prevention, patient satisfaction, waiting times and trust, access, surgical treatment, and drug treatment, among others. Some 50 indicators are shown also for hospitals, but without rankings. Other projects aim to collect information about availability and waiting times for specific patient groups. Since 2009, statistics on patient experiences in primary care have been collected separately through a standardized biannual national patient survey and made available through the Internet (npe.ske.se) in order to help guide people in their choice of primary care provider.



What is being done to reduce disparities?

International comparisons indicate that health disparities are relatively low in Sweden. Approaches to reducing disparities include preventive programs to support behavioral changes, and outpatient services to reach vulnerable groups in order to prevent diseases at an early stage. Most county councils allocate funds to primary care providers based on a formula that takes into account both overall illness (based on diagnoses) and the overall socioeconomic conditions among registered individuals in order to prevent providers from avoiding patients with great needs.



What is being done to promote delivery system integration and care coordination?

The division of responsibilities between county councils (for medical treatment) and the municipalities (for nursing and rehabilitation) requires coordination. Efforts to improve collaboration and develop more-integrated services include the development of national action plans supported by targeted state grants. Such grants are often awarded to county councils and/or providers according to their degree of fulfillment of goals related to the targeted area. Since 2005, for example, there has been a new guarantee to improve access to care and to ensure the equality of that access across the country. The guarantee is based on the 0–7–90–90 rule: instant contact (zero delay) with the health system for advice; seeing a general practitioner within seven days; seeing a specialist within 90 days; and waiting no more than 90 days to receive treatment after being diagnosed. In order for county councils to be eligible for the grant targeted at accessibility, 70 percent of all patients must receive care according to the stipulated time frames. At the county council level, providers are eligible for grants linked partly to the fulfillment of goals related to coordination and collaboration in care provided to elderly adults with multiple diagnoses.



What is the status of electronic health records?

Every hospital selects and procures its own preferred IT system. There are several ongoing efforts, at the county council level and at the national level, aimed at integrating the various systems and making them compatible in order to increase their security and effectiveness as a whole. Generally, both the quality of IT systems and the level of use are high in hospitals and in primary care; more than 90 percent of primary care providers used electronic patient records for diagnostic data in 2009 (Health Consumer Powerhouse, 2009). About 90 percent of all Swedish prescriptions are e-prescriptions, meaning that they are sent electronically to pharmacies (*Dagens Medicin*, 2012). Generally, patients do not have access to their electronic medical record for the purposes of scheduling appointments or viewing their personal health data, but there is some variation in this regard between county councils. There is also a trend toward giving patients access to such services and information electronically.



How are costs contained?

County councils and municipalities are required by law to set and balance annual budgets for their activities. For prescription drugs, the county councils and the central government form agreements, lasting a period of years, on subsidy levels paid to the county councils. The Dental and Pharmaceutical Benefits Agency also engages in the value-based pricing of prescription drugs, determining reimbursement based on an assessment of health needs and cost-effectiveness.

At the local level, there is de facto cost control because most health care providers are owned and/or financed by the county councils and municipalities. Most private providers work under contract with county councils. The financing of health services through global budgets, capitation formulas, and contracts, as well as salary-based pay for staff, also contributes to cost control as providers retain responsibility for meeting costs with funds received through these prospective payment mechanisms. Although several hospitals are paid on a diagnosis-related-group basis, payments are usually formulated to diminish once a specified volume of activity has been reached, limiting hospitals' incentives to increase activity beyond a certain level. Primary care services are reimbursed mainly via capitation, with minimal reliance on fee-for-service arrangements. In several county councils, primary care providers are financially responsible for prescription costs, and therefore have an incentive to control pharmaceutical expenditure.



What major innovations and reforms have been introduced?

There are some important policy areas that have been under scrutiny at both the local and the national level during the last two years. These areas concern the reporting and monitoring of quality in care, coordination of care, and patients' rights.

Recent reforms initiated by individual county councils have focused on strengthening primary care and developing coordinated care for older people. Choice of primary care provider, combined with freedom of establishment for accredited private providers, has been gradually introduced throughout the country during 2007–2010, and has been regulated by law since 2010. Studies show that objectives related to accessibility have been achieved following the reform. Other consequences of the reform are unclear, since there is a lack of data regarding the distribution, content, and outcome of visits. The reporting and monitoring of quality therefore remain as important challenges in Swedish primary care and as a concern for policymakers.

Efforts toward improved continuity and coordination of care, especially for older people, continue to be an important policy area. In 2014, the government launched a four-year national strategy for the care of people with chronic diseases. There are three areas of focus for improvement: patient-centered care, evidence-based care, and prevention and early detection. The strategy sets out 19 initiatives to be implemented during 2014.

Two government agencies were formed in January 2014. The Public Health Agency was established as a merger of the Swedish National Institute of Public Health and the Swedish Institute for Communicable Disease Control. The new authority will be able to integrate communicable disease control with other public health work by coordinating these activities. The merger also provides better opportunities to work effectively within the European Union and in other international arenas. The actual outcome of this merger has not been evaluated yet. The Swedish eHealth Agency (eHälsomyndigheten) was also formed to further develop the national e-health infrastructure. Its activities focus on promoting public involvement and providing support for professionals and decision-makers. The Agency stores and transfers electronic prescriptions issued in Sweden and is responsible for transferring e-prescription details to other countries. The Agency is also responsible for Sweden's national drug statistics, and for compiling, processing, and publishing statistics on pharmaceutical sales in the country. The Agency has not been evaluated yet.

Finally, there are two recent changes in national law pertaining to patients' rights. A new act addressing patients' rights will come into effect in 2015. The purpose of the act is to strengthen the position of patients and enhance patient integrity, influence, and shared decision-making. Emphasis is placed on patients' consent to treatment and patients' rights to information, to a second opinion, and to choice of provider in outpatient

care. Moreover, the government proposed legislation to incorporate the so-called Directive on Patient Mobility (Directive 2011/24/EU) into Swedish law in 2013. According to the new legislation, Swedish patients will not be required to seek prior authorization before seeking care in another EU member state.

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The Swiss Health Care System, 2014

Paul Camenzind
Swiss Health Observer



What is the role of government?

Duties and responsibilities in the Swiss health system are divided among the federal, cantonal, and communal levels of government. The system can be considered highly decentralized, as the cantons are given a critical role. The 26 cantons (including six half-cantons) are responsible for licensing providers, hospital planning, and the subsidizing of institutions and organizations. Cantons are like states, in that they are sovereign in all matters, including health care, that are not specifically designated as the responsibility of the Swiss Confederation by the federal constitution. Each canton and half-canton has its own constitution articulating a comprehensive body of legislation.



Who is covered?

Coverage is universal; residents are required, under the 1996 Federal Health Insurance Act, to purchase statutory health insurance from competing insurers. There are virtually no uninsured residents. Every individual intending to reside in Switzerland is required, within three months of arrival, to take out an insurance policy, which is then applied retroactively to the arrival date. Temporary visitors with no residence pay for care up front and claim expenses from any coverage they may hold in their home country. The unsolved problem of missing statutory health insurance for undocumented immigrants is acknowledged by the Swiss Federal Council, the highest governing and executive authority of the Confederation. Statutory health insurance typically applies to the individual. It is not sponsored by employers, and individuals must purchase separate policies for dependents.

People also purchase complementary and supplementary voluntary health insurance, but no data is available on the number of people covered.



What is covered?

Services: The Federal Department of Home Affairs (the Ministry of Health) defines the statutory health insurance benefits basket by evaluating whether services are effective, appropriate, and cost-effective. It is supported in this task by the Federal Office of Public Health and by Swissmedic, the Swiss agency for the authorization and supervision of therapeutic products.

Statutory health insurance covers most general practitioner and specialist services, as well as an extensive list of pharmaceuticals, medical devices, home health care (called Spitex), physiotherapy (if prescribed), and some preventive measures, including the costs of selected vaccinations, selected general health examinations, and screenings for early detection of disease among certain risk groups and diseases (e.g., one mammogram a year if a woman has a family history of breast cancer).

Hospital services are covered by statutory health insurance, but are highly subsidized by cantons (further described below). Care for mental illness is covered if provided by certified physicians. The services of nonmedical professionals (e.g., psychotherapy by psychologists) are covered only if prescribed by a qualified medical doctor and provided to patients in the doctors' practice. Statutory health insurance covers only "medically necessary" services in long-term care. Dental care is largely excluded from statutory health insurance, as are glasses and contact lenses for adults (unless medically necessary). From mid-2012, however, optometry (including glasses and contact lenses) for children has been covered, along with some complementary medicine.

Cost-sharing and out-of-pocket spending: Insurers are required to offer a minimum annual deductible of CHF300 (about USD216) for adults in statutory health insurance, though insured persons may opt for a higher deductible (up to CHF2,500 [USD1,800]) and a lower premium. In 2012, 25.6 percent of all insured persons opted for the standard CHF300 (USD216) deductible; the other 74.4 percent chose a higher deductible or another model with a gatekeeping element. Insured persons pay 10 percent coinsurance above deductibles for all services, although there is a 20 percent charge for brand-name drugs with a generic alternative, unless specifically prescribed. For treatment in acute-care hospitals, there is a CHF15 (USD11) copayment per inpatient day. Cost-sharing on covered services (10% coinsurance) is capped at CHF700 (USD504) for adults and at CHF350 (USD252) for minors under age 19 in a given year.*

Overall, cost-sharing in statutory and voluntary health insurance accounted for 5.4 percent and 0.1 percent, respectively, of total health expenditure in 2012. Moreover, out-of-pocket payments for services not covered by insurance (in addition to cost-sharing in statutory and voluntary health insurance) accounted for 19.7 percent of total health expenditure. Most of these direct out-of-pocket payments were spent on dentistry and long-term care. Of all expenditure on dental treatment, 91 percent is paid by private households (Weber, 2010). Providers are not allowed to charge higher prices than statutory health insurance will reimburse.

Safety net: Maternity care and a few preventive services are fully covered and are thus exempt from deductibles, coinsurance, and copayments. Minors do not have to pay deductibles or copayments for inpatient care. The federal government and the cantons provide income-based subsidies to individuals or households to help cover statutory health insurance premiums; income thresholds vary widely by canton (see Swiss Conference of Cantonal Health Ministers, 2014a for details). Overall, 29 percent of residents (2012) benefit from individual premium subsidies. Municipalities or cantons cover the health insurance expenses of social assistance beneficiaries and recipients of supplementary old age and disability benefits.



How is the health system financed?

Publicly financed health care: There are three streams of public funding: first, mandatory statutory health insurance premiums; second, direct financing by government for health care providers (tax-financed budgets spent by the Confederation, cantons, and municipalities; the largest portion of this spending is given as cantonal subsidies to hospitals providing inpatient acute care); and third, social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance, and military insurance.

Mandatory statutory health insurance, regulated by law and supervised by the Federal Office of Public Health, is purchased by individuals from a number of competing nonprofit insurers. Cantonal average annual premiums in 2014 for adults (for ages 26 and above, with a deductible of CHF300 (USD216) and including coverage for accident) range from CHF3,701 (USD2,663) (Appenzell Innerhoden) to CHF6,145 (USD4,421) (Basel-Stadt). Funds are redistributed among insurers by a central fund, in accordance with a risk equalization scheme adjusted for canton, age, and gender and, since 2012, hospital or nursing home stays of more than three days in the previous year.

Insurers offer premiums for defined geographical regions. The number of such “premium regions” is limited to three per canton. Within every premium region, the basis for variation in premiums is limited to age category (children up to age 18, young adults ages 19 to 25, and adults over age 25), level of deductible, and alternative insurance plans (so-called managed care plans, the main characteristic of which is giving up free choice of first medical contact for patients). In 2012, 57.6 percent of residents opted for basic coverage with a managed care insurer: a health maintenance organization, an independent practice association, or a fee-for-service plan with gatekeeping provisions (see FOPH, 2013).

Within a given region, premium variations between insurers can be significant. This variation may be caused by risk selection (by insurers and policy holders). All premiums for the subsequent year are controlled and

* Please note that throughout this profile, all figures in USD were converted from CHF at a rate of about CHF1.39 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for Switzerland.

authorized by the Federal Office of Public Health, which puts a floor on the premiums offered to cover past, current, and estimated future costs for the insured persons in a given premium region. Otherwise, the insurer has to propose a new (higher) premium that satisfies the Federal Office of Public Health's criteria.

All expenditures by government are financed by general taxation. In 2012, direct spending by government accounted for 20.2 percent of the total health expenditure (CHF68.0B [USD48.9B], 11.5% of GDP), while income-based statutory health insurance subsidies accounted for an additional 5.8 percent. Including statutory health insurance premiums (30.0% of total health expenditure, statutory health insurance subsidies subtracted), other social insurance schemes (6.2%), and old age and disability benefits (4.5%), publicly financed health care accounted for 66.7 percent of all health care spending (see SFOS, 2014).

Privately financed health care: Private expenditure accounted for 33.3 percent of total health expenditure in 2012, of which 7.2 percent was from voluntary health insurance, 25.3 percent from out-of-pocket payments as described above, and 1 percent from unknown private sources (SFOS, 2014). This number is regarded as relatively high in international comparison (OECD, 2011). There is complementary voluntary health insurance for services not covered under the basic basket statutory health insurance, and supplementary coverage for free choice of hospital doctor, or for improved hospital accommodation (e.g., an individual or twin room instead of a shared room).

Voluntary health insurance is regulated by the Swiss Financial Market Supervisory Authority; health insurers offering voluntary coverage can vary benefit baskets and premiums and refuse subscription to applicants based on medical history. Service prices are usually negotiated directly between insurers and providers. Unlike statutory health insurers, voluntary insurers are for-profit; often an insurer will have a nonprofit branch offering statutory health insurance and a for-profit branch offering voluntary health insurance. It is illegal for voluntary insurers to base voluntary insurance subscription decisions on health information obtained via basic health coverage, but this rule is not easily enforced.



How is the delivery system organized and financed?

Primary care: Residents are not required to register with a general practitioner (GP), and generally have free choice among self-employed GPs, unless enrolled in managed care plans. In 2012, 38.5 percent of doctors in the outpatient sector were classified as GPs. Apart from scale of charge measures (see below) there are no specific financial incentives for general practitioners for taking care of chronically ill patients, and no reforming efforts are underway on the national level to engage general practitioners in “bundled payments” to coordinate care for such types of patients (e.g., diabetics). Primary (and specialist) care tends to be physician-centered, with nurses and other health professionals playing a relatively small role. In 2012, about 58.6 percent of physicians were in solo practice (Hostettler and Kraft, 2014).

Outpatient specialist care: In the outpatient sector, 61.5 percent of doctors were classified as specialists in 2012 (Hostettler and Kraft, 2014). Residents have free access (without referral) to specialists unless enrolled in a gatekeeping managed care plan. Specialist practices tend to be concentrated in urban areas and in the proximity of acute-care hospitals. Specialists can hold appointments in public hospitals and private practice in parallel and they can see patients with statutory health insurance as well as private patients.

Administrative mechanisms for paying primary care doctors and specialists: Apart from some managed care plans, in which physician groups are paid on a capitation basis, ambulatory physicians (including GPs) are paid according to a national fee-for-service scale (called TARMED). TARMED point values are set as described in the section on key entities for system governance. TARMED offers some incentives for less resource-intensive forms of care, but is criticized by GPs as insufficient to render attractive services like coordinating and communicating with chronically ill patients, home visits, and after-hours care.

In response, the Swiss Federal Council made use of its exceptional authority and decided to increase slightly remuneration for consultations in primary care (with general practitioners and pediatricians in particular) from October 2014 onward. Remuneration for some other, more technical services (such as computer tomography) has been slightly reduced.

Statutory health insurance allows different methods of payment among insurers, patients, and providers. Providers can invoice the patient, who pays upfront and claims reimbursement by the insurer, or the patient can forward the invoice to the insurer for payment. The other option is that the provider directly bills the insurer, who pays and informs the patient about payment and possible cost-sharing.

After-hours care: The cantons guarantee the reliability of care provision and are responsible for after-hours care. They delegate those services (paid according to fees set by the national fee-for-service scale, TARMED) to the cantonal doctors' associations, which organize appropriate care networks in collaboration with their affiliated doctors. Theoretically, every affiliated doctor must participate in the network. The networks can include public and private ambulance and rescue services, hospital emergency services, and, increasingly in recent years, walk-in clinics and several telephone advice lines run or mandated by insurers. There is no institutionalized exchange of information between these services and general practitioners' offices (as people are not required to register with a general practitioner). The amount of additional payment included in TARMED for after-hours care is heavily criticized by general practitioners.

Hospitals: About 70 percent of acute inpatient hospitals are public or publicly subsidized private hospitals. These hospitals receive around half (55% to 45%, see Swiss Conference of Cantonal Health Ministers, 2014b) of their funding from insurers. Private hospitals also receive public subsidies if the cantonal governments have need of their services to guarantee a sufficient supply within that canton.

In 2012, a national diagnosis-related group payment system was introduced for acute inpatient care. Base rates are negotiated between hospitals and health insurers and must be approved by the cantonal government. The remaining cost of public and subsidized hospitals is covered by the cantons and communes, and subsidies vary extensively between cantons (see Swiss Conference of Cantonal Health Ministers, 2014b for details on funding mechanisms). Arrangements for bundled payments to include entire episodes of care (e.g., from diagnosis through rehabilitation) are not used.

Cantons are responsible for hospital planning. Cantonal planning and funding of hospitals is one of the main reasons why the Swiss system is fragmented along cantonal lines. However, since 2009, cantons have been legally bound to coordinate their planning with other cantons. The introduction of free movement of patients between cantons under the diagnosis-related group system since 2012 also redresses cantonal fragmentation. The precise remuneration scheme depends on the insurance contracts; as a consequence, fee-for-service remuneration is still possible for patients with voluntary health insurance for inpatient services not covered under statutory health insurance. Hospital-based physicians are normally paid a salary, and public-hospital physicians can receive extra payments for seeing privately insured patients.

Mental health care: Psychiatric practices are generally private, and psychiatric clinics and hospital departments are a mix of public, private with state subsidies, and fully private. There is also a wide range of socio-psychiatric services and day-care institutions that are mainly state run and funded. Psychiatric hospitals or clinics normally provide a full range of medical services like psychiatric diagnostics and treatment, psychotherapy, pharmaceutical treatment, or forensic services. Often, the socio-psychiatric services and day-care institutions offer a wide range of the same medical services as the clinics, but normally treat patients with less acute illnesses or symptoms. The main field of activity of psychiatric practices is psychotherapy that can be supplemented by pharmaceutical treatment. The provision of psychiatric care is not systematically integrated into primary care as in other countries. Outpatient psychiatric prices are calculated using the national fee-for-service scale, TARMED, while psychiatric inpatient care prices are usually calculated as a daily rate.

Long-term care and social supports: Long-term health care is covered by statutory health insurance. Services are provided for inpatient health care (in nursing homes and institutions for disabled and chronically ill persons) and for outpatient health care through Spitex. Admission is sometimes only possible by a hospital or must be approved by an admission authority. Palliative care provided in hospitals, nursing homes, hospices, or at home is not regulated separately in statutory health insurance, so coverage of services is similar to acute services in the respective provider setting. Individual or personal budgets allowing patients to organize their own services are not used.

Inpatient hospital (long-term) somatic and mental services are covered by statutory health insurance, but are highly subsidized by cantons (further described above). For services in nursing homes and institutions for disabled and chronically ill persons, statutory health insurance pays a fixed contribution to cover direct-care-related (i.e., medically necessary) inpatient long-term care costs; the patient pays at most 20 percent of uncovered care-related costs, and the remaining care-related costs are financed by the canton or commune.

Long-term inpatient care costs a total of CHF11.8B (USD8.5B) in 2012, representing 17.3 percent of total health expenditures. More than one-third of these costs (35%) were paid by private households, one-quarter (24.4%) by old age and disability benefits, 18.8 percent by statutory health insurance and other social insurances, and the rest by government subsidies (21.7%). Of the 1,582 nursing homes in Switzerland (2012), 29.7 percent are state operated and funded, 29.5 percent are privately operated but with public subsidies, and 40.7 percent are funded exclusively by private means (SFSO, 2014).

Many of the organizations providing paid professional help through Spitex are nonprofit (80% of services) and publicly subsidized, while the remaining 20 percent are nonsubsidized for-profit organizations. For long-term outpatient care covered under Spitex, state subsidies and old age and disability benefits cover almost half (48.1%) of total expenditure on Spitex of CHF1.8B (USD1.3B) in 2012 (see SFSO, 2014). While state subsidies normally go to institutions, patients pay directly for professional health care and/or help at home and get their expenditure reimbursed afterwards by old age and disability benefits. Statutory health insurance and the other social insurances cover the cost of (medically necessary) health care at home, which made up roughly one-third (29.7%) of total Spitex expenditure. The rest (22.2%), devoted mainly to support and household services, is paid for by customers (out-of-pocket), voluntary health insurance, and other private funds. There is no legal basis for financial support for informal help or family caregivers (see SFSO, 2014).



What are the key entities for health system governance?

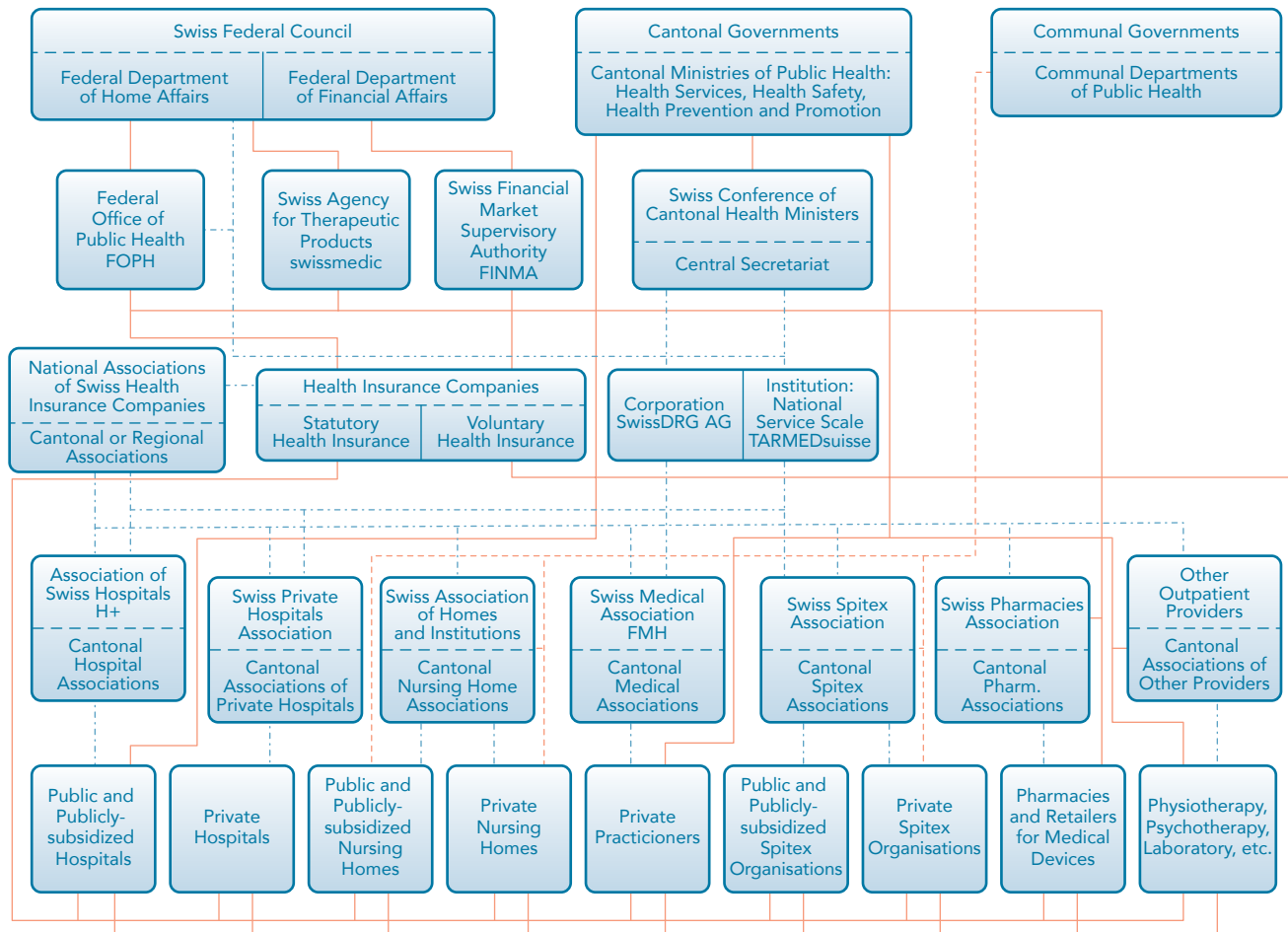
Since health care is largely decentralized, the key entities for health system governance exist mainly at the cantonal level. All 26 cantons (including six half-cantons) have their own elected minister of public health. The cantonal ministers, supported by cantonal offices of public health, are responsible for licensing providers, hospital planning, subsidizing institutions, and health promotion and prevention. Their common political body, the Swiss Conference of the Cantonal Ministers of Public Health, plays an important coordinating role. The Swiss Health Observatory supports coordination between cantons and the national political authorities by improving the transfer of health information.

The main national player is the Federal Office of Public Health, which, among other tasks, supervises the legal application of mandatory statutory health insurance, authorizes insurance premiums offered by statutory insurers, and governs statutory coverage and prices of pharmaceuticals. Other cost control measures are shared with cantonal and communal governments as described below. As also described above, the Federal Department of Home Affairs legally defines the statutory health insurance benefits basket.

Prices for outpatient health care services are first set in the fee-for-service scale TARMED, which defines the relative cost weights of all services covered by statutory health insurance on the national level and is authorized by the Swiss Federal Council, but TARMED point values can then vary among cantons and service groups (physicians, outpatient hospital services) as negotiated annually between the health insurers' associations and cantonal medical associations or hospitals, or are decided by the cantonal government if the other parties cannot agree. For inpatient hospital care, the national diagnosis-related group payment system Swiss DRG has been in use since 2012. The nonprofit corporation Swiss DRG AG is responsible for defining, developing, and adapting the national system of the relative cost weights of rates per case.

In addition to responsibilities of the Federal Office of Public Health and cantonal governments, Health Promotion Switzerland (see <http://www.gesundheitsfoerderung.ch>), a nonprofit organization financed by mandatory health insurance, is legally charged with prevention and health promotion programs and provides

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Source: P. Camenzind, Swiss Health Observatory, 2014.

public information on health. A national ombudsman for health insurance and the Association of Swiss Patients engage in patient advocacy.



What are the major strategies to ensure quality of care?

Professional self-regulation has been the traditional approach to quality improvement. Providers must be licensed in order to practice medicine, and are required to meet educational and regulatory standards. Since 2007, postgraduate training is compulsory. Many local quality initiatives have been undertaken, often at the provider level, including the development of clinical pathways and consensus guidelines.

At the end of 2009, the Swiss Federal Council approved the Quality Strategy of the Swiss Health System. This is a broad conceptual approach with different fields of action, including the publication of quality indicators for acute care hospitals; the implementation of a national pilot program on medication safety in acute care hospitals by the Swiss Foundation for Patient Security (www.patientensicherheit.ch); and another pilot program that aims to reduce hospital infections.

As part of the Quality Strategy, the Federal Council has also decided to create a suitable national body (a Quality Institute) and put in place sustainable financing. This institute would coordinate and reinforce existing quality assurance activities and support the Confederation, the cantons, and service providers with scientific

principles as well as work on actual projects. A corresponding preliminary bill was sent for consultation and this procedure will be concluded in autumn 2014.

Quality control mechanisms do usually not involve information from registries or patient surveys. Registries are organized by private initiatives or cantons, such as the cantonal cancer registries.



What is being done to reduce disparities?

There are several reasons why health disparities have not received as much political and professional interest at the national level as elsewhere. First, health inequalities are not considered to be significant in comparison to other Organization for Economic Cooperation and Development countries; second, it remains difficult to obtain detailed statistical information about the epidemiology of health outcomes of the Swiss population as a whole, and for its different regional and socioeconomic subgroups in particular; and third, health inequalities are seen more as the responsibility of regional authorities (cantons or communes) than of the federal government, making them much less visible at the national level.

The Swiss Federal Council's national Health2020 agenda contains an explicit objective to improve the health opportunities of the most vulnerable population groups, such as children and the young, those on low incomes or with a poor educational background, and the elderly and immigrants. The aim is to avoid situations in the future where vulnerable population groups are unable to make sufficient or appropriate use of the necessary health care services.



What is being done to promote delivery system integration and care coordination?

Care coordination is an issue, particularly in light of a projected lack of providers in the future and the need to improve efficiency to increase capacity. A task force led by the cantons and the Confederation (Dialogue on National Health Policy) discusses existing and new approaches to care. Care coordination will also be the number one topic of the coming national conference in January 2015 on the Health2020 agenda, which contains a comprehensive overview of the priorities of Swiss health care policy until the year 2020 (FDHA, 2013).

The agenda also addresses care coordination under the objective of "promoting modern forms of health care delivery," stating that integrated health care models need to be supported in all areas, from acute through long-term to palliative care. The Federal Office of Public Health works on concrete measures or programs to confront these challenges.

Moreover, strategies and networks tackling emerging areas of importance, like palliative care, dementia, or mental health have been built to find new ways to coordinate. They start on a conceptual level, aiming at the practical level to encourage different types of health professionals to work together. It is also worth noting the efforts in the area of e-health (see below), which should considerably improve coordination among all the stakeholders in the treatment process.



What is the status of electronic health records?

A national e-health service called eHealth Suisse (an administrative unit of the Federal Office of Public Health) is coordinated and funded by the federal and cantonal governments and has three sets of responsibilities. First, all providers in Switzerland should be able to electronically collect and store information on their patients' treatment. Second, health-related websites and online services will be required to undergo quality certification and a national health website will be constructed. Third, necessary legal changes will be made to realize these measures. The Swiss Federal Council made a formal statement in May 2013 and sent it for further discussions to the national parliament.

A key element of eHealth Suisse is the statutory health insurance subscription card, introduced in 2010, which encodes a personal identification number and allows all insured persons to record information about allergies, illnesses, and medication. General practitioner eHealth is still at an early stage, and there are ongoing discussions about forthcoming incentives for physicians to adopt new technologies.

Hospitals are generally more advanced: some have merged their internal clinic systems in recent years and hold interdisciplinary patient files. However, the extent of this varies greatly among hospitals and across cantons, in spite of efforts by eHealth Suisse to convince providers of the benefits of electronic health records for medical practice. An interoperable national patient record is not a priority for eHealth Suisse, since the principles of decentralization, privacy, and data protection are regarded as very important in Swiss health care.



How are costs contained?

Switzerland's health costs are among the highest in the world. Regulated competition among nonprofit health insurers and among service providers aims at containing costs and guaranteeing high-quality, comprehensive health care, and to establish greater solidarity among the insured. While most of these objectives are considered successfully achieved, scientific analyses and public perception have been particularly critical of competition's ability to cut or control health care costs. Many argue (FDHA, 2013) that the costs of providing mandatory benefits in the health insurance system could be reduced by 20 percent.

The failure of regulated competition to contain costs is largely ascribed to inadequate risk equalization (see section on innovations and reforms), the dual funding of hospitals by cantons and insurers, and pressure on insurers to contract with all certified providers (OECD, 2011).

An overview of possible cost-reducing (nonconcrete) measures—in coordination of care, compensation systems, or in highly specialized medicine—is part of the Health2020 agenda. The agenda outlines a need for increasing the flat-rate remuneration mechanism and revising existing fee schedules to limit incentives for service providers. Also mentioned in the agenda is the need for the concentration of highly specialized medicine in order to eliminate inefficiency and duplication in infrastructure systems and, at the same time, to increase the quality of health care provision.

To contain hospital care costs, the national diagnosis-related groups payment system Swiss DRG was introduced for acute inpatient care and a “necessity clause for outpatient providers” in outpatient care, as described in the section on reforms.

To control pharmaceutical costs, all new medicines are evaluated before a coverage decision is made, and both effectiveness (by Swissmedic) and cost (by the Federal Office of Public Health) are considered. Efforts are also being made to reassess more frequently the price of older drugs. Generics must be sold for at least 20 percent to 50 percent less than the original brand (depending on the national market volume). Patients pay 20 percent instead of 10 percent coinsurance for brand-name drugs that have a generic equivalent. Pharmacists are paid a flat amount for filling prescriptions, so they have no financial incentive to dispense more expensive drugs.



What major innovations and reforms have been introduced?

Since 2000, two reform packages have been debated in parliament. The first was mainly concerned with reform of risk equalization between insurers, financing of long-term care, monitoring of insurers, statutory health insurance enrollee cards, selective contracting, premium reduction, and cost-sharing. The second involved reform of hospital funding and managed care.

To contain cost and improve quality and transparency, new financial arrangements for long-term care came into effect in 2011, and hospital payment for acute inpatient care was fully converted to the diagnosis-related groups system, Swiss DRG, in 2012. Whether this system of reimbursement by rates per case reduces costs is about to be evaluated. Other evaluations of the reforms in nursing home and hospital care are under way and will be available in 2015.

Moreover, to bolster insurers' incentives to improve efficiency, the risk equalization formula was first improved in 2012 to also account for hospital or nursing home stays of more than three days in the previous year. In 2014, an ex-post adjustment based on actual cost in the period has been removed so that the allocation of funds is now based solely on cost forecasts (in turn based on historic utilization and cost). Further improvements are planned by introducing new morbidity indicators based on pharmaceutical information in the outpatient sector. Greater use of managed care plans employing gatekeeping and capitation-based physician payment may also help to reduce expenditure in the future.

As mentioned, the "necessity clause" in outpatient care was introduced in 2002 for all new outpatient service providers. The aim here was to regulate and limit the establishment of all new outpatient service providers through 2009, and for specialist physicians and pharmacists until 2011. After a short period (2012 and the first half of 2013) without regulation, the clause was reintroduced for specialists and pharmacists in mid-2013 for another three years. The main objective is the containment of costs in the outpatient sector, particularly in urban regions, where most specialists are active.

This abundance of specialists is contrasted by a looming shortage of general practitioners, especially in rural and remote areas. To address the problem, the Swiss Federal Council launched an initiative (*Masterplan Hausarztmedizin und medizinische Grundversorgung*) featuring concrete measures in the areas of training, further education, research, new care models, and after-hours care. A complete revision of the national fee-for-service scale includes a specific section of charges for general practitioners.

As discussed throughout this profile, the Health2020 agenda outlines important national topics, objectives, and measures ensuring quality of life, improving equal opportunities and self-responsibility, ensuring and improving quality of care, and creating more transparency, better governance, and more coordination. Concrete measures for realizing these goals have been planned incrementally up to 2020 in collaboration with all the relevant partners in the Swiss health care system.

Lastly, the National Dementia Strategy for 2014–2017 and the National Strategy Against Cancer for 2014–2017, both created in 2013, aim to improve long-term care so that nursing structures are appropriate for meeting the needs of patients and nursing staffing levels are sufficient.

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The U.S. Health Care System, 2014

The Commonwealth Fund



What is the role of government?

The Patient Protection and Affordable Care Act (ACA) of 2010 established “shared responsibility” between the government, employers, and individuals for ensuring that all Americans have access to affordable and quality health insurance. However, health insurance coverage remains fragmented, with numerous private and public sources as well as wide gaps in coverage rates across the U.S. population. The Centers for Medicare and Medicaid Services (CMS) administers the Medicare program (a federal program for those age 65 and older and the disabled, including those with end-stage renal disease) and works in partnership with state governments to administer Medicaid and the Children’s Health Insurance Program (a conglomeration of joint federal–state programs for certain low-income populations). Private insurance is regulated mostly at the state level. In 2014, state- and federally administered health insurance marketplaces were established to provide additional access to private insurance coverage, with income-based premium subsidies for low- and middle-income families, and federally subsidized expansion of Medicaid eligibility was made available in states choosing to participate.



Who is covered?

In 2013, about 64 percent of U.S. residents received health insurance coverage from private voluntary health insurance (VHI): 54 percent received employer-provided insurance, and 11 percent acquired coverage directly. Public programs covered roughly 34 percent of residents: Medicare covered 16 percent, Medicaid 17 percent, and military health care insurance 5 percent (U.S. Census Bureau, 2014).¹ In 2013, there were 42 million uninsured individuals in the United States (U.S. Census Bureau, 2014). However, the implementation of many ACA provisions in January 2014—such as the requirement of most Americans that they have health insurance, the opening of the health insurance marketplaces, or exchanges, which offer premium subsidies to lower- and middle-income families, and the expansion of Medicaid in many states, which increased coverage for low-income families—has increased the percentage of the population that has health insurance. According to one survey, there were 9.5 million fewer uninsured adults ages 19 to 64 in April–June 2014 than there were in July–September 2013 (Collins, Rasmussen, and Doty, 2014). It is projected that the implementation of the ACA will have reduced the number of the uninsured by 26 million by 2017 (CBO, 2014).

Public programs provide coverage to various and often overlapping populations. In 2010, about 9.6 million Americans were eligible for both Medicare and Medicaid (the “dual eligibles”) (Henry J. Kaiser Family Foundation, 2014a). The federal–state Children’s Health Insurance Program (CHIP), which offers coverage to children in low-income families—in some states as an extension of Medicaid and in others as a separate program—covered more than 5.7 million children in 2013. Undocumented immigrants are generally ineligible for public coverage, and nearly two-thirds are uninsured. Hospitals that accept Medicare funds (which are the vast majority) must provide care to stabilize any patient with an emergency medical condition, and several states allow undocumented immigrants to qualify for emergency Medicaid coverage beyond “stabilization” care. Some state and local governments provide additional coverage such as coverage for undocumented children or pregnant women.

¹ Some 9 million individuals are eligible for both Medicare and Medicaid (see below). Note: people may have multiple insurance plan types at once or may switch coverage throughout the year.



What is covered?

Services: The ACA requires all health plans offered in the individual and small-group (employers with 50 or fewer employees) markets to cover services within the following 10 essential health benefit categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health services and substance use disorder treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including dental and vision care. Each state determines the range and extent of specific services covered under each essential health benefit category by selecting a benchmark plan that covers all 10 categories, with most states choosing one of the largest small-group plans as a benchmark. Specific services covered vary somewhat by state. Private insurance plans sometimes use narrow networks of providers, with limited or no coverage if patients receive out-of-network care. Private coverage for dental care and optometry is also available—sometimes through separate policies—as is long-term care insurance. Private health insurance is required to cover certain preventive services (with no cost-sharing if provided in-network).

Medicare provides coverage for hospitalization, physician services, and—through a supplementary program with voluntary participation—prescription drug coverage, and has eliminated cost-sharing for a number of preventive services. Medicare offers a choice between “traditional” Medicare, which is open-network and pays predominately on a fee-for-service basis, and Medicare Advantage, under which the federal government pays a private insurer for a network-based plan. Medicare covers postacute care but not long-term care, while Medicaid offers more extensive long-term care coverage (see below). In addition, Medicaid covers a broad range of core services, including hospitalization and physician services, with some optional benefits varying by state.

Cost-sharing and out-of-pocket spending: Cost-sharing provisions in private health insurance plans vary widely, with most requiring copayments for physician visits, hospital services, and prescription drugs. High-deductible health plans—those with a minimum annual deductible of \$1,250 per individual or \$2,500 per family—can be paired with tax-advantaged Health Savings Accounts. The ACA includes cost-sharing subsidies for people purchasing plans through the marketplaces, with the largest subsidies aimed at people with incomes below 250 percent of the federal poverty level (FPL) (the FPL is \$19,790 for a family of three, as of 2014). The ACA also limits deductibles in the small-group market to \$2,000 for individuals and \$4,000 for families. Medicare requires deductibles for hospital stays and ambulatory care, and copayments for physician visits and other services, while Medicaid requires minimal cost-sharing. Most public and private insurers prohibit providers from “balance-billing”—that is, charging patients more than the copayment called for under their insurance plan—if they have an agreement with the payer to accept their set or negotiated payment amounts. Out-of-pocket spending accounts for 12 percent of total expenditure on health in the U.S. (OECD, 2014). The ACA caps cost-sharing for most private insurance plans at \$6,350 for individuals and \$12,700 for families per year in 2014.

Safety net: A variable and patchwork mix of organizations and programs deliver care for uninsured, low-income, and vulnerable patients in the United States, including public hospitals, local health departments, free clinics, Medicaid, and the Children’s Health Insurance Program. Under the ACA, about half of the states have expanded Medicaid coverage to cover individuals with incomes up to 133 percent of the FPL, and premium and cost-sharing subsidies are now available to low- and middle-income families on the insurance exchanges (premium subsidies for income of 133%–400% of FPL; cost-sharing subsidies for income of 100%–250% of FPL). Hospitals that provide care to a high percentage of low-income and uninsured patients receive Disproportionate Share Hospital (DSH) payments from Medicare and Medicaid to partially offset their uncompensated care; however, these payments are being substantially reduced as the ACA reduces the number of the uninsured. The federal government also funds community health centers, which provide a major source of primary care for underserved and uninsured populations. Private providers are also a significant source of charity and uncompensated care.



How is the health system financed?

Publicly financed health care: In 2012, public spending accounted for 47.6 percent of total health care spending, although this figure is expected to increase with the insurance expansion under the Affordable Care Act. Medicare is financed through a combination of payroll taxes, premiums, and federal general revenues. Medicaid is a tax-funded, joint federal–state health insurance program—administered by the states—that operates within broad federal guidelines. States receive matching funds from the federal government at rates that vary based on their per-capita income—in 2014, federal matching ranged from 50 percent to 73 percent of states’ Medicaid expenditures (ASPE, 2014). The expansion of Medicaid (see below) under the ACA will initially be fully funded by the federal government for the three years starting in 2014, after which the government’s funding share will be phased down to 90 percent by 2020. Federal premium subsidies on the exchanges are offered as tax credits.

Privately financed health care: In 2012, private health insurance spending accounted for about 33 percent of total health care spending (CMS, 2014a). Private insurers can be for-profit or nonprofit, and are regulated by state insurance commissioners and subject to varying state (and federal) regulations. Private health insurance can be purchased by individuals, but is usually funded by voluntary, tax-exempt premium contributions shared by employers and employees on an employer-specific basis, sometimes varying by type of employee. The employer tax exemption is the government’s third-largest health care expenditure (after Medicare and Medicaid), reducing tax revenues by \$260 billion per year (NBER, 2014).

Some individuals are covered by both public and private health insurance—for example, many Medicare beneficiaries purchase private supplemental “Medigap” policies to cover additional services and cost-sharing. Private insurers, in general, pay rates to providers that are higher than the rates paid under public programs, particularly Medicaid, leading to wide variations in payment rates among payment sources and in revenues among providers, depending on their payer mix and market power.



How is the delivery system organized and financed?

Payment rates under the Medicare program are typically determined according to a fee schedule, with various adjustments (based on cost of living and other local and provider characteristics). How rates are determined under the Medicaid program varies by state. Private health insurers typically negotiate payment rates with providers.

Primary care: Primary care doctors account for roughly one-third of all U.S. doctors. The majority of primary care doctors operate in small self- or group-owned practices with fewer than five full-time-equivalent physicians, although larger practices are becoming increasingly common. Practices—particularly large ones—often include nurses and other clinical staff, who are usually paid a salary by the practice. Patients generally have free choice of doctor, at least among in-network providers, and are usually not required to register with a primary care practice, depending on their insurance plan. Primary care doctors have no formal gatekeeping function, except within some managed-care plans.

Physicians are paid through a combination of methods, including negotiated fees (private insurance), capitation (private insurance), and administratively set fees (public insurance). Physicians can also receive financial incentives based on various performance criteria. Accountable care organizations and patient-centered medical homes (see below) are being implemented and tested as a means of improving care coordination and quality, and starting in 2015 Medicare will pay monthly fees to primary care doctors who coordinate the care of patients with multiple chronic conditions. Insured patients are generally directly responsible for some portion of physician payment, and uninsured patients are nominally responsible for all or part of physicians’ charges, although those charges can be reduced or waived (with the extent of charity care varying substantially among providers).

Outpatient specialist care: Specialists can work in both private practice and hospitals. Some insurance plans (such as HMOs) require a referral by a primary care doctor to see a specialist and limit patients’ choice of specialist, while other plans (such as PPOs) allow patients broader and direct access. Access to specialists can be especially difficult for Medicaid beneficiaries and the uninsured, as some specialists refuse to accept

Medicaid patients owing to low reimbursement rates, and because safety-net programs for specialist care are limited. Like primary care physicians, specialists are paid through negotiated fees, capitation, and administratively set fees, and are typically not allowed to bill above the fee schedule for services offered in-network. Multispecialty and single-specialty groups are increasingly common. Specialists can see patients with both public and private insurance.

Administrative mechanisms for paying primary care doctors and specialists: Copayments for doctor visits are typically paid at the time of service or are billed to the patient afterward. Some insurance plans and products (including Health Savings Accounts) require patients to submit claims to receive reimbursement. Providers bill insurers by coding the services rendered; this process can be very time-consuming, as there are thousands of codes.

After-hours care: After-hours access to primary care is limited (only 34% of primary care doctors reported having after-hours care arrangements in 2012), and such care is often provided by emergency rooms. As of 2007, there were between 12,000 and 20,000 urgent-care centers in the U.S. providing walk-in after-hours care. Most urgent-care centers are independently owned by physicians, while about 25 percent are owned by hospitals (Rice et al., 2013). Some insurance companies make after-hours telephone advice lines available.

Hospitals: Hospitals can be nonprofit (approximately 70% of beds nationally), for-profit (15% of beds), or public (15% of beds). Public hospitals can serve private patients. Hospitals are paid through a combination of methods, including per-service or per-diem charges, per-case payments, and bundled payment, in which case the hospital may be financially accountable for readmissions and services rendered by other providers. Some hospital-based physicians are salaried hospital employees, but most are paid on some form of fee-for-service basis—physician payment is not included in Medicare’s diagnosis-related group (DRG) payments. Hospitalists are becoming increasingly common, and are present in a majority of hospitals.

Mental health care: Mental health care is provided by a mix of for-profit and nonprofit providers and professionals—including psychiatrists, psychologists, social workers, and nurses—and paid for through a variety of methods that vary by provider type and payer. Most insurance plans cover inpatient hospitalization, outpatient treatment, emergency care, and prescription drugs; other benefits may include case management and peer support services.

Historically, insurance coverage of mental health care has been less extensive than care for physical health conditions, with different prior authorization requirements, higher cost-sharing structures, and limits on inpatient and outpatient visits (Goodell, 2014). The ACA aims to improve mental health parity by establishing mental health care as an essential health benefit (see above), applying federal parity rules to ensure that coverage is comparable, and increasing access to health insurance more generally.

Integrated mental and primary health care is limited, as many insurance plans “carve out” mental health services to capitated managed behavioral health care organizations (MBHOs). However, there are some promising models being implemented with support from the ACA, such as Medicaid health homes and the colocation of physical and behavioral health care in some community health centers.

Long-term care and social supports: Long-term care is provided by a mix of for-profit and nonprofit providers, and paid for through a variety of methods that vary by provider type and payer. Medicaid, but not Medicare, offers the most extensive coverage of long-term care, although it varies from state to state (within federal eligibility and coverage requirements). Since Medicaid is a means-tested program, patients must often “spend down” their assets to qualify for long-term care assistance. However, hospice care is included as a Medicare benefit, as are skilled short-term nursing services and nursing home stays for up to 100 days. Long-term care insurance that offers comprehensive care is available but rare. Most certified nursing facilities are for-profit (68%), while 25 percent are nonprofit and 6 percent are government-owned (the Henry J. Kaiser Family Foundation, 2014b). Caregiver support programs and personal health budgets—such as cash and counseling programs in Medicaid—are available in some states to support caregivers and recipients of home-based care.

Some of these programs allow recipients to employ family members. However, most informal and family caregivers do not receive payment or benefits for their work.

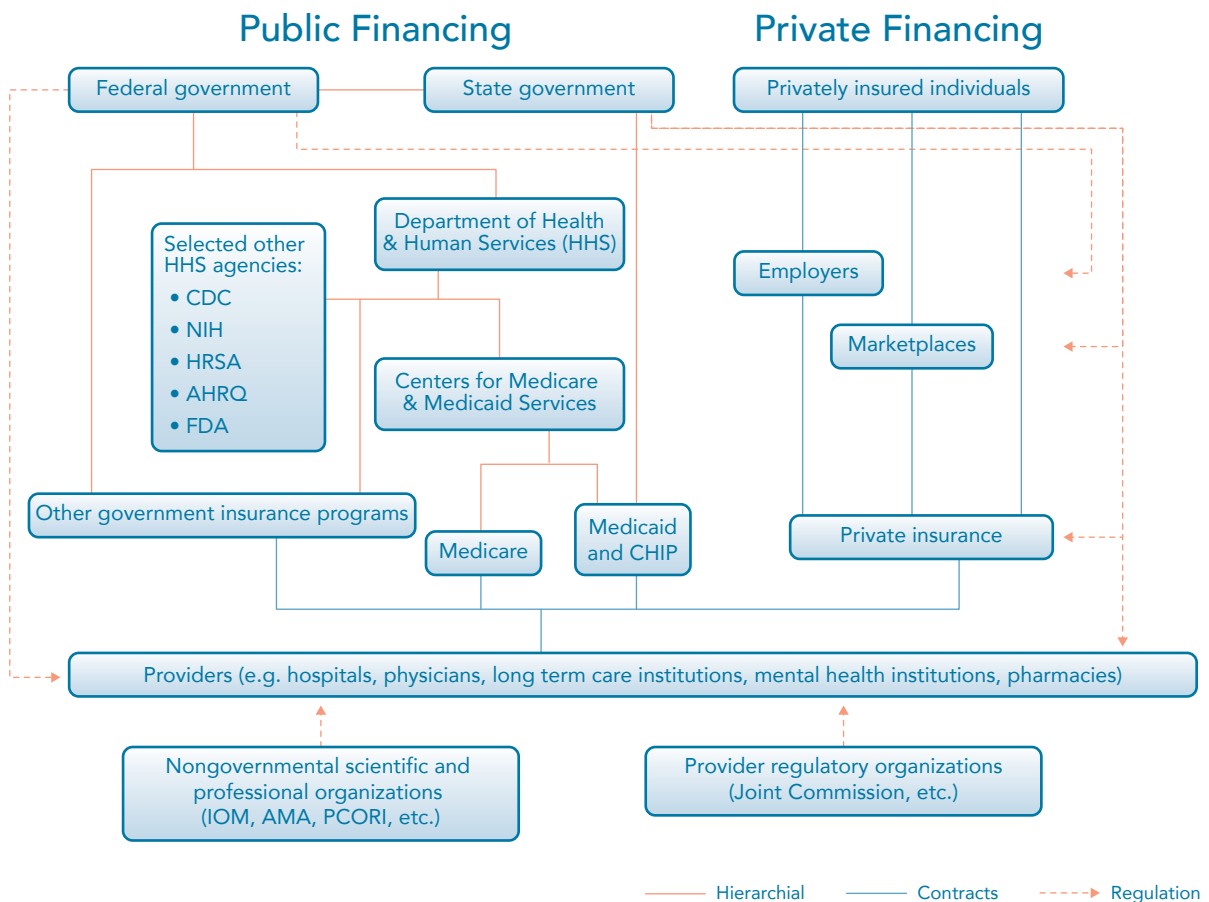


What are the key entities for health system governance?

The Department of Health and Human Services (HHS) is the federal government’s principal agency involved with health care services. Organizations that fall within HHS include the Centers for Medicare and Medicaid Services (CMS); the Centers for Disease Control and Prevention (CDC), which conducts research and programs to protect public health and safety; the National Institutes of Health (NIH), which is responsible for biomedical and health-related research; the Health Resources and Services Administration (HRSA), which supports efforts to improve health care access for people who are uninsured, isolated, or medically vulnerable; the Agency for Healthcare Research and Quality (AHRQ), which sponsors, conducts, and disseminates research to improve health care quality and safety; and the Food and Drug Administration (FDA), which is responsible for promoting public health through the regulation of food, tobacco products, pharmaceutical drugs, medical devices, and vaccines, among other products.

The Institute of Medicine (IOM), an independent nonprofit organization that works outside of government, acts as an adviser to policymakers and the private sector on improving the nation’s health. Stakeholder associations (e.g., the American Medical Association) comment on and lobby for policies affecting the health system.

Organization of the Health System in the United States



Source: Adapted from T. Rice, P. Rosenau, L. Y. Unruh et al., "United States of America: Health System Review," *Health Systems in Transition*, vol. 15, no. 3, 2013, p. 27.

The Joint Commission—an independent, nonprofit organization—accredits more than 20,000 health care organizations across the country, primarily hospitals, long-term care facilities, and laboratories, using criteria that include patient treatment, governance, culture, performance, and quality improvement. The National Committee for Quality Assurance is the primary accreditor of private health plans, and is responsible for accrediting the plans participating in the newly created health insurance marketplaces. The American Board of Medical Specialties and the American Board of Internal Medicine provide certification to physicians who meet specified standards of quality.

These agencies, as well as other major components of the health system (see above for further details), are presented in the chart below.



What are the major strategies to ensure quality of care?

In 2011, the U.S. Department of Health and Human Services released the National Quality Strategy; called for under the Affordable Care Act, it lays out national aims and priorities to guide local, state, and national quality improvement efforts. It is supported by an array of partnerships with public and private stakeholders, including the National Quality Forum—a nonprofit organization that builds consensus on national performance priorities and on standards for performance measurement and public reporting.

The ACA also created, within CMS, the Center for Medicare and Medicaid Innovation (CMMI), which is charged with testing and spreading innovative payment and service delivery models that reduce spending while preserving or improving quality. Current initiatives include efforts to reduce hospital-acquired infections and preventable readmissions through the Partnership for Patients—a public-private partnership with stakeholders at the federal, state, and local levels.

AHRQ, funded by the federal government, conducts evidence-based research on practices, outcomes, effectiveness, clinical guidelines, safety, patient experience, health information technology (HIT), and health disparities. The Affordable Care Act created the Patient-Centered Outcomes Research Institute (PCORI), tasked with setting national clinical comparative-effectiveness research priorities and managing the funding and conducting of research on a broad array of topics related to illness and injury. The institute is not permitted to present comparative-effectiveness research findings as practice guidelines, coverage recommendations, or payment or policy recommendations, and federal insurance programs are not allowed to use its findings as the sole basis for denying coverage.

CMS has moved toward increased public reporting to improve quality. One such initiative is Hospital Compare, a service that reports on process of care, outcome of care, and patient experience measures at over 4,000 hospitals. Additionally, with help from the ACA and other movements such as the Open Government Partnership, which aims to improve government transparency, CMS is making many other data sources publicly available. These initiatives include making Medicare data available to “Qualified Entities” (e.g., health improvement institutions and organizations) so that they can report publicly on performance, releasing data on payments made by Medicare to individual physicians, and publishing data on the amounts paid to physicians and hospitals by pharmaceutical and device companies. Releasing this data is expected to increase transparency and quality.

States have developed additional public reporting systems and measures, including some that address ambulatory care. Consumer-led groups, such as Consumers Union, which publishes *Consumer Reports*, and the Leapfrog Group, also report on quality and safety. Finally, Medicare and the majority of private insurance providers implement a variety of pay-for-performance programs.



What is being done to reduce disparities?

There are wide disparities in the accessibility and quality of health care in the United States. Since 2003, AHRQ has been releasing an annual report—the *National Healthcare Disparities Report*—that documents disparities among racial, ethnic, income, and other demographic groups, and highlights priority areas requiring action. Federally Qualified Health Centers (FQHCs), which are eligible for certain types of public reimbursement, provide comprehensive primary and preventive care regardless of their patients' ability to pay. Initially created to provide health care to underserved and vulnerable populations, FQHCs largely provide safety-net services to the uninsured. Medicaid and CHIP provide public health insurance coverage for certain low-income populations. The ACA contains a number of provisions aimed at reducing disparities, including providing subsidies for low-income Americans to purchase insurance in the exchanges, improving parity for mental health care and substance abuse services, and providing additional funding to community health centers located in underserved communities. Additionally, a multitude of public initiatives and policies at the local, state, and federal levels target disparities, as do a wide range of private initiatives.



What is being done to promote delivery system integration and care coordination?

The government and private insurance companies are funding many initiatives aimed at shifting from a specialist-focused health system to one that is primary care-focused. The “patient-centered medical home” model—in which a patient receives targeted, accessible, continuous, coordinated, and family-centered care from a personal physician—has aroused particular interest among U.S. experts and policymakers as a means to strengthen primary care and better link medical care to community services and supports.

Another movement gathering considerable momentum in the U.S. among both public and private payers is the creation of accountable care organizations (ACOs). ACOs are networks of providers, including hospitals and physicians, that agree to take responsibility for providing a defined population with care that meets quality targets; in exchange, they can share in the savings that constitute the difference between forecasted and actual health care spending for their population. Two Medicare-driven ACO programs have been rolled out—the Medicare Shared-Savings Program and the Pioneer ACO Program. Other ACO-like models, such as Blue Cross Blue Shield's “Alternative Quality Contract,” already exist among private insurers. There are currently over 600 ACOs, which cover more than 20 million Americans (Petersen et al., 2014).

Medicare, Medicaid, and various private purchasers, including employer groups, are also experimenting with new payment incentives that reward higher-quality and more efficient care. In addition to pay-for-performance, strategies being implemented include “bundled” payments, under which a single payment is made for services from a number of providers related to a single episode of care.

CMS has supported the development of local programs that aim to better integrate health and social services, such as Massachusetts General Hospital's Care Management Program, in which a nurse case manager works closely with Medicare patients who have serious chronic conditions, and with their caregivers, to help coordinate their medical and social care. Medicaid ACOs are also implementing programs to integrate primary care and behavioral health. ACOs are not only trying to integrate clinical and social services, but also exploring innovative financing models, such as cross-sectoral shared-savings models. Yet although there are some promising initiatives, and integration is a goal of many policymakers, poor coordination of health care and social services is still widespread.



What is the status of electronic health records?

In 2013, 78 percent of office-based physicians used some form of electronic medical record system (Furukawa et al., 2014). Interorganizational operability of electronic health records is less common, although the Veterans' Health Administration and Kaiser Permanente (a large nonprofit health insurance provider) have successfully implemented such systems. Some large health insurance providers and systems, such as the Veterans Health

Administration, Kaiser Permanente, and Cambridge Health Alliance, offer personal health records that allow patients to access their electronic record for appointments, prescription requests, and other services (Rice et al., 2013). Additionally, the Blue Button Initiative—run by CMS—will allow Medicare beneficiaries to obtain access to their own medical data in electronic form. There is no universal patient identifier in the United States.

The 2009 American Recovery and Reinvestment Act led to significant investment in HIT by establishing financial incentives for physicians and hospitals; by creating Regional HIT Extension Centers to provide technical assistance, guidance, and information on best practices to support providers' use of HIT; by giving additional funding to "beacon communities" with already high rates of HIT adoption to demonstrate how HIT can be leveraged to improve quality, cost-efficiency, and population health; and by providing support for clinical registries and health outcomes research networks. Currently, one of the priorities of the Office of the National Coordinator is to improve interoperability of electronic records, with strategies that include developing policies and standards as well as setting goals and measures of success.



How are costs contained?

Annual per-capita health expenditure in the United States is the highest in the world (\$8,745 in 2012), despite a recent slowdown in spending (OECD, 2014). Payers have attempted to control cost growth through a combination of selective provider contracting, price negotiations and controls, utilization control practices, risk-sharing payment methods, and managed care. Recently, both public and private payers have focused more attention on value-based purchasing and other models that reward effective and efficient health care delivery. Tax advantages are granted for Health Savings Accounts (see above). Tax incentives plus double-digit increases in premiums have led to a shift in benefit design toward higher patient payments. In addition, a movement toward favoring generic drugs over brand-name drugs has led to a slowdown in pharmaceutical spending in recent years.

Using tools that facilitate choice in the insurance marketplaces—including smart-default search settings and "true cost" calculators that yield estimated costs for premiums and out-of-pocket expenses—consumers are able to make more cost-efficient plan selections. Meanwhile, innovations that improve efficiency—such as telemedicine, e-visits with primary care physicians, and e-consultations—allow people to get care when and where they prefer, steering care away from more expensive "brick and mortar" settings.

The ACA called for the creation of an Independent Payment Advisory Board—yet to be implemented—tasked with finding ways to keep Medicare costs down without compromising quality; its recommendations would only be put into effect if spending exceeds a certain threshold (which has not occurred because of the recent particularly sharp slowdown in Medicare spending).



What major innovations and reforms have been introduced?

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act, ushering in a sweeping series of insurance and health system reforms. The key aims of the reform are to:

1. Achieve near-universal coverage.
2. Improve the affordability of coverage.
3. Improve quality and efficiency while reducing unnecessary costs.
4. Strengthen primary care.
5. Invest in public health by increasing preventive care and community resources (Rosenbaum, 2011).

To attain these goals, the legislation includes provisions—many of which went into effect in 2014—that:

- Expand Medicaid to include everyone with incomes below 133 percent of the federal poverty level. (In 2012, the Supreme Court issued a ruling that made the expansion of Medicaid optional for states, and only about half of them have pursued it as of this writing.)
- Establish state-based insurance marketplaces for individuals and small businesses.
- Provide insurance subsidies for low- and middle-income individuals and tax credits for small businesses.
- Institute a series of insurance regulations that include guaranteed issue and community rating.
- Eliminate copayments for recommended preventive services and immunizations.
- Establish a mandate for most individuals to have health insurance or pay a fee.
- Create the Patient-Centered Outcomes Research Institute to conduct comparative-effectiveness research.
- Create the Center for Medicaid and Medicare Innovation to develop and test payment models for improving quality and lowering costs.
- Establish the Independent Payment Advisory Board, with a mandate to reduce the growth of Medicare expenditures through payment reforms.
- Create a shared savings program in Medicare for accountable care organizations that take responsibility for efficiently providing care to a defined population and meeting quality targets.
- Temporarily increase Medicare and Medicaid payments for primary care.
- Expand federal funding for federally qualified health centers that provide care for low-income and uninsured individuals.

While it is too early to measure the impact of all of the various components of the ACA, studies already have found evidence that the number of uninsured adults has declined by about 9.5 million from July–September 2013 to April–June 2014 (Collins, Rasmussen, and Doty, 2014). Early evaluations of Medicare ACOs have also found promising results with regard to quality improvement and savings (CMS, 2014b).

As of January 2015, Medicare will pay for doctors to coordinate the care of patients with chronic conditions. To be eligible for an extra \$42 per patient, doctors will have to draft and help carry out a comprehensive plan of care for each patient who signs up for one. Under federal rules, those patients will have access to doctors or other health care providers on a doctor's staff 24 hours a day and seven days a week to deal with "urgent chronic care needs."

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Abbreviations and Acronyms

Australia

ACSQHC Australian Commission on Safety and Quality in Healthcare

DoH Department of Health

EHR electronic health record

GP general practitioner

HACC Home and Community Care

NDIS National Disability Insurance Scheme

NMHC National Mental Health Commission

PBS Pharmaceutical Benefits Scheme

Denmark

DDKM Danish Healthcare Quality Program

GP general practitioner

IKAS Danish Institute for Quality and Accreditation in Healthcare

IT information technology

England

GP general practitioner

NHS National Health Service

NICE National Institute for Health and Clinical Excellence

France

SHI statutory health insurance

Germany

DRG diagnosis-related group

EHR electronic health record

LTCI long-term care insurance

PHI private health insurance

SGB V Social Code Book V

SHI statutory health insurance

Italy

GP general practitioner

Japan

FFS fee-for-service

Netherlands

GP general practitioner

New Zealand

DHB district health board

IFHC Integrated Family Health Center

IT information technology

PHO Primary Health Organization

Norway

EU European Union

GP general practitioner

HIT health information technology

NIPH Norwegian Institute for Public Health

RHA regional health care authorities

Sweden

TLV Dental and Pharmaceutical Benefits Agency

Switzerland

GP general practitioner

TARMED national fee-for-service scale

United States

ACA Patient Protection and Affordable Care Act

ACO accountable care organization

AHRQ Agency for Healthcare Research and Quality

CDC Centers for Disease Control and Prevention

CMMI Center for Medicare and Medicaid Innovation

CMS Centers for Medicare and Medicaid Services

DSH disproportionate share hospital (payment)

FDA Food and Drug Administration

FPL federal poverty level

HRSA Health Resources and Services Administration

IOM Institute of Medicine

MBHO managed behavioral health care organization

NIH National Institutes of Health

PCORI Patient-Centered Outcomes Research Institute

VHI voluntary health insurance



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