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The COMMONWEALTH FUND

INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS, 2015

AUSTRALIA, CANADA, DENMARK, ENGLAND, FRANCE, GERMANY, ISRAEL, JAPAN, THE NETHERLANDS, NEW ZEALAND, NORWAY, SINGAPORE, SWEDEN, SWITZERLAND, AND THE UNITED STATES

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Contents

The Australian Health Care System, 2015

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What is the role of government?

Three levels of government are collectively responsible for providing universal health care: federal; state and territory; and local. The federal government mainly provides funding and indirect support to the states and health professions, subsidizing primary care providers through the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and providing funds for state services. It has only a limited role in direct service delivery.

States have the majority responsibility for public hospitals, ambulance services, public dental care, community health services, and mental health care. They contribute their own funding in addition to that provided by federal government. Local governments play a role in the delivery of community health and preventive health programs, such as immunization and regulation of food standards (Department of the Prime Minister and Cabinet, 2015).

Who is covered and how is insurance financed?

Publicly financed health insurance: Total health expenditure in 2013–2014 represented 9.8 percent of gross domestic product (GDP), with 67.8 percent coming from government. These figures reflect an increase of 3.1 percent from 2012–2013 (Australian Institute of Health and Welfare [AIHW], 2015).

The federal government funds Medicare, a universal public health insurance program providing free or subsidized access to care for Australian citizens, residents with a permanent visa, and New Zealand citizens following their enrollment in the program and confirmation of identity (AIHW, 2014). Restricted access is provided to citizens of certain other countries through formal agreements (Department of Human Services [DHS], 2015). Other visitors to Australia do not have access to Medicare. Government funding is raised through general federal taxes and through the Medicare Levy, which raised AUD10.5 billion (USD6.8 billion) in 2013–2014. (In July 2014, the levy was expanded to raise funds for disability care.)

Private health insurance: Private health insurance (PHI) is readily available and offers more choice of providers (particularly in hospitals), faster access for nonemergency services, and rebates for selected services. Government policies encourage enrollment in PHI through a tax rebate and, above a certain income, a penalty payment for not having PHI (the Medicare Levy surcharge) (PHIO, 2015). The Lifetime Health Coverage program provides a lower premium for life if participants sign up before age 31. There is a 2 percent increase in the base premium for every year after age 30 for people who do not sign up. Consequently, take-up is highest for this age group but rapidly drops off as age increases, with a trend to opt out at age 50 and up.

Nearly half of the Australian population (47%) had private hospital coverage and nearly 56 per cent general treatment coverage in 2015 (Private Health Insurance Administration Council, 2015).

Insurers are a mix of for-profit and nonprofit providers. In 2013–2014, private health insurance expenditures represented 8.3 percent of all health spending (AIHW, 2015).

Private health insurance can include coverage for hospital, general treatment, or ambulance services. When accessing hospital services, patients can opt to be treated as a public patient (with full fee coverage) or as a private patient (with 75% fee coverage). For private patients, insurance covers the MBS fee. If a provider charges above the MBS fee, the consumer will bear the gap cost unless they have gap coverage. The patient may also be charged for costs such as hospital accommodation, surgery fees (implants and theater fees), and diagnostic tests.

General coverage provides insurance for dental, physiotherapy, chiropractic, podiatry, home nursing, and optometry services. Coverage may be capped by dollar amount or number of services.

Private health insurance coverage varies by socioeconomic status. PHI covers just one-third of the most disadvantaged 20 percent of the population, a proportion that rises to more than 79 percent for the most advantaged population quintile. This disparity is due in part to the Medicare Levy surcharge applied to higher-income earners (Australian Bureau of Statistics [ABS], 2013).

What is covered?

Services: The federal government defines Medicare benefits, which include hospital care, medical services, and pharmaceuticals, to name a few. States provide further funding and are responsible for the delivery of free public hospital services, including subsidies and incentive payments in the areas of prevention, chronic disease management, and mental health care. The MBS provides for limited optometry and children's dental care.

Pharmaceutical subsidies are provided through the PBS. Pharmaceuticals need to be approved for cost-effectiveness by the independent Pharmaceutical Benefits Advisory Committee (PBAC) to be listed. War veterans, the widowed, and their dependents may be eligible for the Repatriation PBS (DHS, 2015).

Nearly half (48%) of federal support for mental health is for payments to people with a disability; remaining support goes to payments to states, payments and allowances for caregivers, and subsidies provided through the MBS and PBS (National Mental Health Commission, 2014). State governments are responsible for specialist and acute mental care services.

Home care for the elderly and hospice care coverage are described below in the section "How Is the Delivery System Organized and Financed?"

Cost-sharing and out-of-pocket spending: Out-of-pocket payments accounted for 18 percent of total health expenditures in 2013–2014. The largest share (38%) was for medications, followed by dental care (20%), medical services (e.g., referred and unreferred private health insurance), medical aids and equipment, and other health practitioner services (AIHW, 2015).

There are no deductibles or out-of-pocket costs for public hospital services. GP visits are subsidized at 100 percent of the MBS fee, and specialist visits 85 percent. GPs and specialists can choose whether to charge above the MBS fee. About 83 percent of GP visits were provided without charge in 2014–2015. Patients who were charged paid an average of AUD30 (USD20) (DH, 2015).

Out-of-pocket pharmaceutical expenditures are capped. In 2015, the maximum cost was set at AUD38 (USD25), or AUD6 (USD4) for those on a low income (DHS, 2015).[1] Consumers pay the full price of medicines not listed on the PBS. Pharmaceuticals provided in public hospitals are generally free.

Safety nets: Beginning in January 2016, a new Medicare Safety Net will replace the previous Original Medicare Safety Net, the Extended Medicare Safety Net, and the Greatest Permissible Gap arrangements. Medicare will reimburse 80 percent of out-of-

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[1] Please note that, throughout this profile, all figures in USD were converted from AUD at a rate of about AUD1.54 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Australia.

pocket costs (up to a cap of 150 percent of the MBS fee) for the remainder of the calendar year once annual thresholds are met: AUD400 (USD260) for concessional patients (including low-income adults, children under 16, and certain veterans); AUD700 (USD456) for singles; and AUD1,000 (USD651) for families.

In addition, patients with out-of-pocket expenses for disability aids, attendant care, or aged care can claim the income-tested Net Medical Expenses Tax Offset. This arrangement had applied more broadly to out-of-pocket expenses but is being phased out. The remaining offset will be eliminated in July 2019 (Australian Taxation Office, 2014).

How is the delivery system organized and financed?

Primary care: In 2013, there were 25,702 GPs, and a slightly higher number of specialists (27,279) (AIHW, 2015a). GPs are typically self-employed, with about four per practice on average (DH, 2015, and DHS, 2015). In 2012 those in nonmanagerial positions earned an average of AUD2,862 (USD1,864) per week. The schedule of service fees is set by the federal health minister through the MBS.

Registration with a GP is not required, and patients choose their primary care doctor. GPs operate as gatekeepers, in that a referral to a specialist is needed for a patient to receive the MBS subsidy for specialist services. The fee-for-service MBS model accounts for the majority of federal expenditures on GPs, while the Practice Incentives Program (PIP) accounts for 5.5 percent (ANAO, 2010).

State community health centers usually employ a multidisciplinary provider team. The federal government provides financial incentives for the accreditation of GPs, multidisciplinary care approaches, and care coordination through PIP and through funding of GP Super Clinics and Primary Health Networks (PHNs). PHNs (which replace Medicare Locals) are being implemented in 2015–2016 to support more efficient, effective, and coordinated primary care.

The number of nurses working in primary care has been increasing, from 8,649 registered or enrolled nurses primarily working in a general practice setting in 2011 to 11,370 in 2014. Their role has been expanding with the support of the PIP practice nurse payment. Beyond this, nurses are funded through practice earnings. Nurses in general practice settings provide chronic disease management and care coordination, preventive health education, and oversight of patient follow-up and reminder systems (Health Workforce Australia [HWA], 2015).

Outpatient specialist care: Specialists delivering outpatient care are either self-employed in a solo private practice (6,745 specialists in 2013) or employed in a group practice (5,257) (HWA, 2015). Patients are able to choose which specialist they see, but must be referred by their GP to receive MBS subsidies. Specialists are paid on a fee-for-service basis. They receive a subsidy through the MBS of 85 percent of the schedule fee and set their patients' out-of-pocket fees independently. Many specialists split their time between private and public practice.

Administrative mechanisms for direct patient payments to providers: Many practices have the technology to process claims electronically so that reimbursements from public and private payers are instantaneous, and patients pay only their copayment (if the provider charges above the MBS fee). If the technology is not in place, patients pay the full fee and seek reimbursement from Medicare and/or their private insurer.

After-hours care: GPs are required to ensure that after-hours care is available to patients, but are not required to provide care directly. They must demonstrate that processes are in place for patients to obtain information about after-hours care, and that patients can contact them in an emergency. After-hours walk-in services are available, and may be provided in a primary care setting or within hospitals. As there is free access to emergency departments, these may also be utilized for after-hours primary care.

The federal government provides varying levels of practice incentives for after-hours care, depending on whether access is direct or provided indirectly through arrangements with other practitioners in the area. Government also funds PHNs to support and coordinate after-hours services, and there is an after-hours advice and support line.

Hospitals: In 2013–2014 there were 747 public hospitals (728 acute, 19 psychiatric) with a total of 58,600 beds and 612 private hospitals (326 day hospitals and 286 other) with 31,000 beds (AIHW, 2014a; AIHW, 2014b). Private hospitals are a mix of for-profit and nonprofit.

Public hospitals receive a majority of funding (91%) from federal and state governments, with the remainder coming from private patients and their insurers. Most of the funding (62% of the total) is for public physician salaries. Private physicians providing public services are paid on a session or fee-for-service basis. Private hospitals receive most of their funding from insurers (47%), federal government's rebate on health insurance premiums (21%), and private patients (12%) (AIHW, 2014b).

Public hospitals are organized into Local Hospital Networks (LHNs), of which there were 138 in 2013–2014. These vary in size, depending on the population they serve and the extent to which linking services and specialties on a regional basis is beneficial. In major urban areas, a number of LHNs comprise just one hospital.

State governments fund their public hospitals largely on an activity basis using diagnosis-related groups. Federal funding for public hospitals includes a base level of funding, with growth funding set at 45 percent of the "efficient price of services" of activities, determined by the Independent Hospital Pricing Authority (IHPA [http://www.ihpa.gov.au]). States are required to cover the remaining cost of services, providing an incentive to keep costs at the efficient price or lower. Small rural hospitals are funded through block grants (IHPA, 2015). Starting in July 2017, the federal government will return to block-grant funding for all hospitals.

Mental health care: Mental health services are provided in many different ways, including by GPs and specialists, in community-based care, in hospitals (both in- and out-patient, public and private), and in residential care. GPs provide general care, and may devise treatment plans of their own or refer patients to specialists. Specialist care and pharmaceuticals are subsidized through the MBS and PBS.

State governments fund and deliver acute mental health and psychiatric care in hospitals, community-based services, and specialized residential care. Public hospital-based care is free to public patients (AIHW, 2015b).

The federal government has commissioned the National Mental Health Commission to undertake a review of all existing services (NMHC, 2015).

Long-term care and social supports: The majority of people living in their own homes with severe or profound limitations in core activities receive informal care (92%). Thirty-eight percent receive only informal assistance and 54 percent receive a combination of informal and formal assistance. In 2009, 12 percent of Australians were informal caregivers and around 30 per cent of those were the primary caregiver (carer). In 2011–2012, federal government provided AUD3.18 billion (USD2.07 billion) under the income-tested Carer Payment program, and AUD1.75 billion (USD1.14 billion) through the Carer Allowance (not income-tested, and offered as a supplement for daily care). Government also provides an annual Carer Supplement of AUD480 million (USD313 million) to help with the cost of caring. Recipients of the Carer Allowance who care for a child under the age of 16 receive an annual Child Disability Assistance Payment of AUD1,000 (USD651). There are also a number of respite programs providing further support for caregivers (AIHW, 2013).

Home care for the elderly is provided through the Commonwealth Home Support Program in all states except Western Australia. Subsidies are income-tested and may require copayments from recipients. Services can include assistance with housework, basic care, physical activity, nursing, and allied health. The program began in July 2015 as a consolidation of home and community care, planned respite for caregivers, day therapy, and assistance with care and housing (Department of Social Services, 2015). The Western Australian Government administers and delivers its Home and Community Care Program with funding support from federal government.

Aged care homes may be private nonprofit or for-profit, or run by state or local governments. Federally subsidized residential aged care positions are available for those who are approved by an Aged Care Assessment Team. Hospice care is provided by states through complementary programs funded by the Commonwealth. The Australian Government supports both permanent and respite residential aged care. Eligibility is determined through a needs assessment, and permanent care is means-tested (AIHW, 2015c).

In 2013, federal government, in partnership with states, implemented the pilot phase of the National Disability Insurance Scheme. The scheme provides more-flexible funding support (not means-tested), allowing greater tailoring of services.

What are the key entities for health system governance?

Intergovernmental collaboration and decision-making at the federal level occur through the Council of Australian Governments (COAG), with representation from the Prime Minister and first ministers of each state. The COAG focuses on the highest-priority issues, such as major funding discussions and the interchange of roles and responsibilities between governments. The COAG Health Council is responsible for more detailed policy issues and is supported by the Australian Health Ministers Advisory Council (http://www.coaghealthcouncil.gov.au/).

The federal Department of Health (DH) oversees national policies and programs such as the MBS and PBS. Payments through these schemes are administered by the Department of Human Services. The PBAC provides advice to the Minister for Health on the cost-effectiveness of new pharmaceuticals (but not routinely on delisting).

Several national agencies and the state governments are responsible for quality and safety of care (see below). The AIHW and the Australian Bureau of Statistics (ABS) are the major providers of health data.

Regulatory oversight is provided by a number of agencies, such as the Therapeutic Goods Administration, which oversees supply, imports, exports, manufacturing, and advertisement; the Australian Health Practitioner Regulation Agency, which ensures registration and accreditation of the workforce in partnership with National Boards; and the Australian Prudential Regulation Authority, for private health insurance. The Australian Competition and Consumer Commission promotes competition among private health insurers. Beginning in July 2016, the Australian eHealth Commission will take over responsibility from the National eHealth Transition Authority for matters relating to electronic health data.

State governments operate their own departments of health, and have devolved management of hospitals to the LHNs. The LHNs are responsible for working collaboratively with PHNs. There are patient consumer organizations and groups operating at the national and state level.

What are the major strategies to ensure quality of care?

The overarching strategy to ensure quality of care is captured in the National Healthcare Agreement of the COAG (2012). The agreement sets out the common objective of Australian governments in providing health care—improving outcomes for all and the sustainability of the system—and the performance indicators and benchmarks on which progress is assessed. It also sets out national-priority policy directions, programs, and areas for reform, such as major chronic diseases and their risk factors. Indicators and benchmarks in the agreement address issues of quality from primary to tertiary care and include disease-specific targets of high priority, as well as general benchmarks.

The Australian Commission on Safety and Quality in Health Care (ACSQH) is the main body responsible for safety and quality improvement in health care. The ACSQH has developed service standards that have been endorsed by health ministers (DH, Portfolio Budget Statement 2015–16). These include standards for conducting patient surveys, which must be met by hospitals and day surgery centers for accreditation. The ABS, the national government statistical body, also undertakes an annual patient experience survey.

The Australian Council on Healthcare Standards is the (nongovernment) agency authorized to accredit provider institutions. States license and register private hospitals and the health workforce, legislate on the operation of public hospitals, and work collaboratively through a National Registration and Accreditation Scheme facilitating workforce mobility across jurisdictions while maintaining patient protections.

The Royal Australian College of General Practitioners has responsibility for accrediting GPs. The MBS includes financial incentives such as the PIP, and approximately 85 percent of GPs are accredited. To be eligible for government subsidies, aged care services must be accredited by the government-owned Aged Care Standards and Accreditation Agency.

There are a number of disease and device registries. Government-funded registries are housed in universities and nongovernmental organizations, as well as within state governments. ACSQH has developed a national framework to support consistent registries.

The National Health Performance Authority reports on the comparable performance of LHNs, public and private hospitals, and other key health service providers. The reporting framework was agreed to by the COAG, and includes measures of equity, effectiveness, and efficiency.

The federal government has regulatory oversight of quarantine, blood supply, pharmaceuticals, and therapeutic goods and appliances (AIHW, 2014). In addition, there are a number of national bodies who promote quality and safety of care through evidence-based clinical guidelines and best-practice advice. They include the National Health and Medical Research Council and Cancer Australia.

What is being done to reduce disparities?

The most prominent disparities in health outcomes are between the Aboriginal and Torres Strait Islander population and the rest of Australia's population; these are widely acknowledged as unacceptable. In 2008, the COAG agreed to a target date of 2031 for closing the gap in life expectancy. Its strategy goes beyond health care, seeking to address disparities in other areas such as education and housing. The Prime Minister makes an annual statement to Parliament on progress toward closing the gap.

Disparities between major urban centers and rural and remote regions and across socioeconomic groups are also major challenges. The federal government provides incentives to encourage GPs and other health workers to work in rural and remote areas, where it can be very difficult to attract a sufficient number of practitioners. This challenge is also addressed to an extent through the use of telemedicine. Since 1999, the Australian Government has funded the Public Health Information Development Unit (www.publichealth.gov.au) for the purpose of publishing small-area data showing disparities in access to health services and health outcomes on a geographic and socioeconomic basis.

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

Approaches to improving integration and care coordination include the PIP, which provides a financial incentive to providers for the development of care plans for patients with certain conditions, such as asthma, diabetes, and mental health needs. The PHNs were established in July 2015 with the objective of improving coordinated care, as well as the efficiency and effectiveness of care for those at risk of poor health outcomes. These networks are funded through grants from the federal government and will work directly with primary care providers, health care specialists, and LHNs. Care may also be coordinated by Aboriginal health and community health services.

What is the status of electronic health records?

The National eHealth Transition Authority has been working to establish interoperable infrastructure to support communication across the health care system. A national e-health program based on personally controlled unique identifiers has commenced operation in Australia, and 2.5 million patients and nearly 8,000 providers have registered (DH, 2015a). The record supports prescription information, medical notes, referrals, and diagnostic imaging reports. Following a review, government is taking a number of steps to increase uptake by both patients and providers, which has been poor to date, by improving usability, clinical utility, governance, and operations. In addition, an opt-out approach will be tested to replace the current opt-in approach. The new Australian Commission for eHealth will begin oversight in July 2016, taking on the e-health roles of the Department of Health and the National eHealth Transition Authority. The current PIP eHealth Incentive, which aims to encourage GPs to participate, will also be reviewed for potential improvements.

How are costs contained?

The major drivers of cost growth are the MBS and PBS. Government regularly considers opportunities to reduce spending growth in the MBS through its annual budget process and has established an expert panel to undertake a review of the entire schedule and report by the end of 2016.

Government influences the cost of the PBS in making determinations about what pharmaceuticals to list on the scheme and in negotiating the price with suppliers. Government provides funds to pharmacies for dispensing medicines subsidized through the PBS and to support professional programs and the wholesale supply of medicines. This arrangement is through the current Community Pharmacy Agreement (the

Community Pharmacy Agreements were instituted in 1991 and are subject to renegotiation every five years). The Sixth Community Pharmacy Agreement, which began in July 2015, supports AUD6.6 billion (USD4.3 billion) in savings through supply chain efficiencies (Ley, 2015).

Hospital funding is set through policy decisions by the federal government, with states required to manage funding within their budgets.

Through the 2015-2016 budget, the federal government also consolidated the back-office functions of a number of its health agencies to generate AUD106 million (USD69 million) in savings. Beyond these measures, the major control is through the capacity constraints of the health system, such as workforce supply.

What major innovations and reforms have been introduced?

In 2015, the federal government announced a number of reforms to primary care, including implementation of the aforementioned PHNs and the MBS Review. In addition, the government has established the Primary Health Care Advisory Group to consider innovations to funding and service delivery for people with complex and chronic illness, including mental health. Together, these three reforms seek to ensure that primary care is being delivered efficiently and effectively and that Medicare is put on a sustainable funding trajectory. The group’s advice, which will be submitted to the government by the end of 2015, will consider how to best utilize the PHNs. The primary care reforms come on the heels of the 2014 announcement of a new copayment for GP visits (AUD5.00, or USD3.26), to serve as a price signal to patients and a source of revenue.

The government is also reforming care for the aging. In addition to the implementation of the Commonwealth Home Support program outlined above, a new funding model is pursued whereby allocations will be made directly to consumers based on their care needs instead of directly to service providers, affording them greater choice in providers and stimulating provider competition. This reform will take effect in February 2017.

References

Australian Bureau of Statistics, Australian Government (2013). “Cat no: 4364.0.55.002 - Australian Health Survey: Health Service Usage and Health Related Actions, 2011-12.” ABS: Canberra.

Australian National Audit Office (2010). Audit Report No. 5 2010–11. Performance Audit: Practice Incentives Program. Canberra: ANAO.

Australian Taxation Office, Australian Government. https://www.ato.gov.au/General/New-legislation/In-detail/Direct-taxes/Income-tax-for-individuals/Net-medical-expenses-tax-offset-phase-out/. Retrieved November 16, 2015.

Australia’s Institute of Health and Welfare (AIHW), Australian Government (2015). “Health Expenditure Australia 2013-14.” Canberra: AIHW.

AIHW, Australian Government (2015a). “Medical Workforce 2013 Detailed Tables, Table 4.” Retrieved August 12, 2015. Canberra: AIHW.

AIHW, Australian Government (2015b). “Mental Health Services in Australia.” https://mhsa.aihw.gov.au/home/. Retrieved November 18, 2015.

AIHW, Australian Government (2015c). http://www.aihw.gov.au/aged-care/residential-and-community-2011-12/aged-care-in-australia/. Retrieved November 18, 2015.

AIHW, Australian Government (2014). “Australia's Health 2014.” Canberra: AIHW.

AIHW, Australian Government (2014a). “Australia’s Hospitals 2013-14 at a glance.” Canberra: AIHW.

AIHW, Australian Government (2014b). “Hospital resources 2013-14: Australian hospital statistics.” Canberra: AIHW.

AIHW, Australian Government (2013). “Australia’s Welfare.” Canberra: AIHW.

Department of the Prime Minister and Cabinet, Australian Government (2015). “Reform of the Federation White Paper: Roles and Responsibilities in Health. Issues Paper 3.” Canberra, DPMC.

Department of Health, Australian Government (2015). General Practice Workforce Statistics. http://www.health.gov.au/internet/main/publishing.nsf/content/F210D973E08C0193CA257BF0001B5F1F/$File/GP%20Workforce%20Statistics%202013-14%20PUBLIC%20Web%20version.pdf. Retrieved August 12, 2015.

Department of Health, Australian Government (2015a). http://www.ehealth.gov.au/internet/ehealth/publishing.nsf/Content/pcehr-statistics. Retrieved November 16, 2015.

Department of Human Services, Australian Government (2015). http://www.humanservices.gov.au/. Retrieved November 16, 2015.

Department of Human Services, Australian Government (2015). http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?_PROGRAM=%2Fstatistics%2Fdgp_report_selector&statisticF=count&reportTypeFH=report&variableF=&drillTypeFH=on&DIVISIONS=&DGPSORT=divgp&groupF=999&schemeF=PIP&reportNameFH=piprrma&reportFormatF=by+time+period&reportPeriodF=quarter&startDateF=201310&endDateF=201312. Retrieved August 12, 2015.

Health Workforce Australia, Australian Government. http://data.hwa.gov.au/webapi/jsf/tableView/tableView.xhtml. Retrieved September 6, 2015.

Department of Social Services (2015). https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform/commonwealth-home-support-programme#03. Retrieved September 6, 2015.

Independent Hospital Pricing Authority (2015). “National Efficient Price Determination 2015-16.” IHPA: Sydney.

Ley, Susan (2015). Media release by Susan Ley (Minister for Health): “Pharmaceutical Benefits Scheme to be reformed.” Retrieved September 6 from: https://www.health.gov.au/internet/ministers/publishing.nsf/Content/FDA6A9682797EDD7CA257E52001F423C/$File/SL063.pdf.

National Mental Health Commission, Australian Government (2014). “Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services.” NMHC: Canberra.

Private Health Insurance Administration Council, Australian Government (2015). “Statistics:
Private Health Insurance Membership and Coverage, September 2015.” PHIAC: Sydney.

Private Health Insurance Ombudsman, Australian Government. http://www.privatehealth.gov.au/healthinsurance/whatiscovered/privatehealth.htm. Retrieved November 16, 2015.

The Canadian Health Care System, 2015

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What is the role of government?

Provinces and territories in Canada have primary responsibility for organizing and delivering health services and supervising providers. Many have established regional health authorities that plan and deliver publicly funded services locally. Generally, those authorities are responsible for the funding and delivery of hospital, community, and long-term care, as well as mental and public health services. Nearly all health care providers are private. The federal government cofinances provincial and territorial programs, which must adhere to the five underlying principles of the Canada Health Act—the law that sets standards for medically necessary hospital, diagnostic, and physician services. These principles state that each provincial health care insurance plan needs to be: 1) publicly administered; 2) comprehensive in coverage; 3) universal; 4) portable across provinces; and 5) accessible (i.e., without user fees).

The federal government also regulates the safety and efficacy of medical devices, pharmaceuticals, and natural health products; funds health research; administers a range of services for certain populations, including First Nations, Inuit, Métis, and inmates in federal penitentiaries; and administers several public health functions.

Who is covered and how is health insurance financed?

Publicly financed health care: Total and public health expenditures were forecast to account for an estimated 10.9 percent and 8.0 percent of GDP, respectively, in 2015; by that measure, 70.7 percent of total health spending comes from public sources (Canadian Institute for Health Information, 2015a). 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). Temporary legal visitors, 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 by any federal or provincial program, although provinces and territories provide some limited services.

The main funding sources are general provincial and territorial spending, which was forecast to constitute 93 percent of public health spending in 2015 (Canadian Institute for Health Information, 2015a). The federal government contributes cash funding to the provinces and territories on a per capita basis through the Canada Health Transfer, which totaled CAD34 billion (USD27 billion) in 2015–2016, accounting for an estimated 24 percent of total provincial and territorial health expenditures (Canadian Institute for Health Information, 2015a; Government of Canada, 2015a).[2]

Privately financed health care: Private insurance, held by about two-thirds of Canadians, covers services excluded from public reimbursement, such as vision and dental care, prescription drugs, rehabilitation services, home care, and private rooms in hospitals. In 2013, approximately 90 percent of premiums for private health plans were paid through group contracts with employers, unions, or other organizations (Canadian Life and Health Insurance Association, 2014). In 2015, private health insurance accounted for approximately 12 percent of total health spending (Canadian Institute for Health Information, 2015a). The majority of insurers are for-profit.

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 care, home health care, and hospice care. They also provide public health and prevention services (including immunizations) as part of their public programs.

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 14.2 percent of total health spending (Canadian Institute for Health Information, 2015a), going mainly toward prescription

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[2] Please note that, throughout this profile, all figures in USD were converted from CAD at a rate of about CAD1.26 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Canada.

drugs (21%), nonhospital institutions (mainly long-term care homes) (22%), dental care (16%), vision care (9%), and over-the-counter medications (10%) (Canadian Institute for Health Information, 2015a).

Safety net: Cost-sharing exemptions for noninsured services such as prescription drugs vary among provinces and territories, and there are no caps on out-of-pocket spending. For example, the prescription drug program in Ontario exempts low-income seniors and social assistance recipients from all cost-sharing except a CAD2.00 (USD1.60) copayment, which is often waived by pharmacies. Low income is defined as annual household income of less than CAD16,018 (about USD12,700) for single people and less than CAD24,175 (USD19,168) 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 delivery system organized and financed?

Primary care: In 2014, about half of all practicing physicians (2.24 per 1,000 population) were general practitioners, or GPs (1.14 per 1,000 population) and half were specialists (1.10 per 1,000 population) (Canadian Institute for Health Information, 2015b). 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 there has been a movement toward group practice and alternative forms of payment, such as capitation. In 2013–2014, fee-for-service payments made up 45 percent of payments to GPs in Ontario, compared with 67 percent in Quebec and 84 percent in British Columbia (Canadian Institute for Health Information, 2015c). In 2014, 46 percent of GPs reported to work in a group practice, 19 percent in an interprofessional practice, and 15 percent in a solo practice (National Physician Survey, 2014).

In some provinces, such as Ontario, some new primary care teams paid partly by capitation must require patients to register to receive those partial payments; otherwise, registration is not required. Clinical fee-for-service payments to primary care physicians in Canada averaged CAD249,154 (USD197,550) in 2013–2014 (Canadian Institute for Health Information, 2015c); these do not account for alternative payments and nonclinical payments. It has been estimated that the average payment, including alternative payments, for primary care physicians in Ontario is 21 percent higher than for fee-for-service alone (Henry, et al., 2012).

In several provinces, networks of GPs work together and share resources. For instance, Primary Care Networks in Alberta, My Health Teams in Manitoba, and Family Health Teams in Ontario support interdisciplinary health professionals (e.g., nurses, pharmacists, and dietitians). In Ontario, the minimum size of practice for physicians in alternative payment models (not fee-for-service) is three (Sweetman and Buckley, 2014). In Family Health Teams, the average practice size is approximately 10 physicians, and ranges from seven to 14 physicians in other models (Rudoler, et al., 2015). In Ontario, team composition varies among practices, and interdisciplinary providers are generally salaried employees of the practice.

Patients have free choice of primary care doctor, although in some areas choices are restricted owing to limited supply.

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 are also used 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, and registering complex or vulnerable patients.

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 mostly self-employed and paid fee-for-service. Specialists in Canada received an average of CAD379,051 (USD300,545) annually in clinical fee-for-service payments in 2013–14 (Canadian Institute for Health Information, 2015c). In most provinces, specialists have the same fee schedule as primary care physicians. In 2014, 65 percent of specialists reported to work in a hospital, as compared to 24 percent in a private office or clinic (National Physician Survey, 2014). Patients can choose, and have direct access to, a specialist, but it is common for GPs to refer patients to specialty care. 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, 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 services that are not medically necessary—for example, physician letters sent to employers when employees are ill.

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, physicians practicing in non-fee-for-service models have to provide sessions during some evenings and weekends. In some models, this amounts to a single three-hour session per week per physician in the group, up to five sessions per week (MOHLTC, 2009). These physicians are paid a 30 percent bonus for primary care services provided during evenings, weekends, and holidays (MOHLTC, 2011). Manitoba has implemented QuickCare clinics, staffed by nurses and nurse practitioners, to meet health care needs after hours (Government of Manitoba, 2015).

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 only 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 (which are mostly diagnostic and surgical). In Ontario, as of May 2014, the government was providing funding to 145 not-for-profit hospital corporations (with 224 different facilities and 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 (Sutherland, et al., 2013, 2013a). Hospital-based physicians generally are not hospital employees and are paid fee-for-service directly.

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 provinces and territories all provide a range of community mental health and addiction services including 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 its particular practice. In Ontario, the government introduced an intersectoral mental health strategy in 2011 that aims to better integrate mental health care into primary care (Government of Ontario, 2011).

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. All provinces and territories fund services, 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, but there is considerable variation when it comes to other services, including medical equipment, supplies, and home support, 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. Some provinces have established minimum residency periods as an eligibility condition for facility admission. Spending on nonhospital institutions, of which the majority are long-term care facilities, accounted for just over 10 percent of total health expenditure in 2013, with financing mostly from public sources (71%) (Canadian Institute for Health Information, 2015a).

A mix of private for-profit (41%), private not-for-profit (43%), and public facilities (13%) provide long-term care (Statistics Canada, 2011). Public funding of home care is provided either through provincial or territorial government contracts with agencies that 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, where the majority of such costs occur. But many provide some coverage for services outside those settings, such as doctors, nurses, and drug coverage in hospices, in nursing facilities, and at home.

Support for informal caregivers (estimated to provide 66% to 84% of care to the elderly) varies by province and territory (Grignon and Bernier, 2012). In Ontario, for example, the Family Caregiver Leave Bill offers job protection to caregivers. There are also some federal programs, including the Family Caregiver Tax Credit 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. The federal ministry of health, Health Canada, plays a role in promoting overall health, disease surveillance and control, food and drug safety, and medical device and technology review. 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 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. The Agency's Common Drug Review reviews the clinical effectiveness and cost-effectiveness of drugs and provides common, nonbinding formulary recommendations to the publicly funded provincial drug plans (except in Quebec) to support greater consistency in access and evidence-based resource allocation.

Nongovernmental organizations with important roles in system governance include professional organizations such as the Canadian Medical Association, provincial regulatory colleges, which are responsible for licensing professions and developing and enforcing standards of practice, and Accreditation Canada (see below). 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 are also responsible for negotiating fee schedules with the provincial ministries of health. Most provinces have an ombudsperson providing patient advocacy.

What are the major strategies to ensure quality of care?

Since 2014, there have been no new national strategies initiated to ensure quality of care, although in the previous decade the Canada Health Accord provided for dedicated federal funding to provinces to achieve common goals in wait times, primary care, and home care. Some provinces 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 use of financial incentives to improve quality is limited. For example, since 2010, Ontario hospitals have been required to develop and report quality improvement plans, and executive compensation has been linked to the achievement of targets set out in these plans (Government of Ontario, 2010).

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 undergo peer review. There is no information available on doctors' performance. 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 tracks cancer incidence.

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. Each province has its own strategies and programs to address chronic disease (see below).

What is being done to reduce disparities?

By signing the *Rio Political Declaration on Social Determinants of Health*, Canada committed to reducing inequalities in health (Public Health Agency of Canada, 2011). Although no single body is responsible for addressing health disparities, several provincial or territorial governments have departments and agencies devoted to addressing population health and health inequities.

Aboriginal health is a concern for federal as well as 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. The Public Health Agency of Canada includes in its mandate reporting on health disparities, and the Canadian Institute for Health Information also reports on disparities in health care and health outcomes (Canadian Institute for Health Information, 2015d). However, no formal and periodic process exists to measure disparities.

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. These include Divisions of Family Practice (British Columbia) (Divisions of Family Practice, 2014), the Regulated Health Professions Network (Nova Scotia), and Health Links (Ontario). Also, Ontario has alternative community-based and multidisciplinary primary care models that are funded by the province and serve primarily vulnerable populations; these models include Community Health Centres and Aboriginal Health Access Centres. Also in Ontario, a pilot program that bundles payments across different providers is being expanded (from one to six communities) to improve coordination of care for patients as they transition from hospital to the community (Government of Ontario, 2015). As discussed above, some provinces have also implemented incentives to encourage physicians to provide guideline-based care for chronic disease. In Ontario, for example, Diabetes Education Programs (employing teams of diabetes education nurses and registered dieticians) support individuals and primary care physicians in providing guideline-based diabetes care (Government of Ontario, 2015a).

Each province determines its own structure for the coordination of health and social care services. In Ontario, for instance, Community Care Access Centres are also responsible for coordinating services for vulnerable populations, particularly the elderly and individuals with disabilities, including health and social care services (e.g., supportive housing and meal delivery programs). In Ontario, there is a single ministry responsible for health and long-term care, with funding devolving to the regional level.

What is the status of electronic health records?

Uptake of health information technologies has been slowly increasing in recent years. Provinces and territories are responsible for developing their electronic information systems, with support from Canada Health Infoway; however, there is no national strategy for implementing electronic health records and no national patient identifier. According to Canada Health Infoway, provinces have systems for collecting data electronically for the majority of their populations (Canada Health Infoway, 2014). Interoperability, however, is limited (Ogilvie and Eggleton, 2012). In 2014, 42 percent of GPs reported using exclusively electronic records to enter and retrieve patient clinical notes, and 38 percent used a combination of paper and electronic charts (National Physician Survey, 2014). In the same survey, 87 percent of GPs report that their patients are not able to access their personal health record for any function, and only 6 percent reported that patients can request appointments online.

How are costs contained?

Costs are controlled principally through single-payer purchasing, and increases in real spending mainly reflect government investment decisions 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 (e.g., provincial quotas of students admitted annually) as well as restrictions on new investment in capital and technology. The national health technology assessment process is one of the mechanisms for containing the costs of new technologies (see above).

The federal Patented Medicine Prices Review Board, an independent, quasi-judicial body, regulates the introductory prices of new patented medications. This measure ensures that prices are not “excessive,” on the basis of their “degree of innovation” and by comparison with prices of existing medicines in Canada and in seven other countries, including the United States and the United Kingdom. The board regulates “ex-factory” 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. “Choosing Wisely Canada” is a new publicly funded campaign that provides recommendations to governments, providers, and the public on reducing low-value care (Choosing Wisely Canada, 2015).

What major innovations and reforms have been introduced?

At the annual meeting of Canada's provincial premiers in July 2015, national health care priorities included pharmaceuticals, appropriateness of care, senior care, and dementia. There has not been a meeting between the first ministers of the federal and provincial governments on health care since 2009. In its 2015 election platform, the Liberal Party committed to a CAD3 billion (USD2.4 billion) investment in home care services and proposed a pan-Canadian collaboration to improve access to prescription medication (Liberal Party of Canada, 2015).

In 2015, the Canadian government expanded the National Anti-Drug Strategy to include prescription drug abuse. This strategy focuses on reducing the supply of and demand for illicit drugs (Government of Canada, 2015b). Also introduced in 2015 was the Protecting Canadians from Unsafe Drugs Act (Vanessa’s Law), which strengthens regulation on therapeutic products to promote reporting of adverse reactions by health care institutions (Government of Canada 2014).

Provincial health system governance: Several provinces have reformed or are in the process of reforming their health system governance structures, mostly in an attempt to achieve efficiencies and reduce costs. Quebec is merging 182 Health and Social Centres, which include hospitals, clinics, and long-term care facilities, into just 28 (Assemblée Nationale Québec 2015). In April 2015, Nova Scotia passed legislation to consolidate 10 district health authorities into two: the Nova Scotia Health Authority and the IWK Health Centre. The two merged authorities will work together to plan and deliver primary care, community health services, and acute care across the province (Government of Nova Scotia, 2015). The 2015 Newfoundland and Labrador provincial budget announced the consolidation of administrative service for the health care system into one shared services organization. The regional health authorities will remain in place, while the shared services organization will provide them with support for human resources, information technology, telecommunications, marketing, communications, finance, and payroll (Government of Newfoundland Labrador, 2015). The government appointed an implementation team in August 2015.

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References

Assemblee Nationale Quebec (2015). “Bill No. 10: An Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies” http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-10-41-1.html. Accessed Aug 24, 2015.

Canada Health Infoway (2014). Annual report, 2013–2014. Ottawa: Canada Health Infoway, https://www.infoway-inforoute. ca/index.php/resources/infoway-corporate/annual-reports. Accessed Oct. 1, 2014.

Canada Revenue Agency (2014). “Family Caregiver Amount (FCA),” http://www.cra-arc.gc.ca/familycaregiver/. Accessed Oct. 1, 2014.

Canadian Institute for Health Information (2015a). “National Health Expenditure Trends 1975–2015.” Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information (2015b). “Supply, Distribution and Migration of Canadian Physicians.” Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information (2015c). “National Physician Database, 2010–2011.” Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information (2015d) “Trends in Income-Related Health Inequalities in Canada.” Ottawa: Canadian Institute for Health Information.

Canadian Life and Health Insurance Association Inc. (2014). Canadian Life And Health Insurance Facts. http://clhia.uberflip.com/i/369328-canadian-life-and-health-insurance-facts-2014-edition. Accessed August. 27, 2015.

Choosing Wisely Canada (2015). “What is CWC?” http://www.choosingwiselycanada.org/about/what-is-cwc/ Accessed Nov 1, 2015.

Divisions of Family Practice (2014). “Welcome to the Divisions of Family Practice,” https://www.divisionsbc.ca/provincial/ home. Accessed Sept. 1, 2014.

Goering, P., Wasylenki, D., and Durbin, J. (2000). “Canada’s mental health system.” International Journal of Law and Psychiatry 23(3–4):345–59.

Government of Canada (2014). “Protecting Canadians from Unsafe Drugs Act (Vanessa’s Law): Questions/Answers,” http://www.hc-sc.gc.ca/dhp-mps/legislation/unsafedrugs-droguesdangereuses-faq-eng.php. Accessed Aug 24, 2015.

Government of Canada (2015a). “Federal Support to Provinces and Territories.” Ottawa: Department of Finance, http://www. fin.gc.ca/fedprov/mtp-eng.asp. Accessed Nov. 1, 2015.

Government of Canada (2015b). “National Anti-Drug Strategy,” http://healthycanadians.gc.ca/anti-drug-antidrogue/index-eng.php. Accessed Aug 24, 2015.

Government of Ontario (2010) “Excellent Care for All Act, 2010, S.O. 2010, c. 14.” http://www.ontario.ca/laws/statute/10e14. Accessed August 1, 2015.

Government of Ontario (2011). “Open Minds, Healthy Minds. Ontario’s Comprehensive Mental Health and Addictions Strategy,” http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011. pdf. Accessed Oct. 1, 2014.

Government of Ontario (2014). “Health Force Ontario. Family Practice Models,” http://www.healthforceontario.ca/en/Home/ Physicians/Training_%7C_Practising_Outside_Ontario/Physician_Roles/Family_Practice_Models. Accessed Oct. 9, 2014.

Government of Ontario (2015) “Ontario Funds Bundled Care Teams to Improve Patient Experience” http://news.ontario.ca/mohltc/en/2015/09/ontario-funds-bundled-care-teams-to-improve-patient-experience.html Accessed on Sept 1, 2015

Government of Ontario. (2015a). “Diabetes Education Program.” https://www.ontario.ca/page/diabetes-education-program?_ga=1.120298504.125010404.1446227826 . Accessed on October 30, 2015.

Government of Manitoba (2015). “QuickCare Clinic,” http://www.gov.mb.ca/health/primarycare/public/access/quickcare.html Accessed Aug. 25, 2015.

Government of Newfoundland Labrador (2015). “Innovative Approaches to Effective Health Care Delivery: Minister Announced Implementation Team for New Health Shared Services Organization,” http://www.releases.gov.nl.ca/releases/2015/health/0806n02.aspx. Accessed Aug 24, 2015.

Government of Nova Scotia (2015). “District Health Authority Consolidation,” http://novascotia.ca/dhw/peoplecentredhealthcare/. Accessed Aug 24, 2015.

Grignon, M., and Bernier, N. F. (2012). “Financing Long-Term Care in Canada.” Canada: Institute for Research on Public Policy (IRPP).

Health Canada (2013a). “Canada Health Act Annual Report 2012-2013.” Ottawa: Minister of Health of Canada, http://www. hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2013-cha-lcs-ar-ra/index-eng.php. Accessed Oct. 1, 2014.

Health Canada (2013b). “Provincial and Territorial Home Care Programs: A Synthesis for Canada,” http://www.hc-sc.gc.ca/ hcs-sss/pubs/home-domicile/1999-pt-synthes/index-eng.php. Accessed Oct. 9, 2014.

Health Council of Canada (2013). “How Do Canadian Primary Care Physicians Rate the Health System? Survey Results from the 2012 Commonwealth Fund International Survey of Primary Care Doctors.” Toronto: Health Council of Canada.

Henry, D. A., Schultz, S. E., Glazier, R. H., Bhatia, R. S., Dhalla, I. A., and Laupacis, A. (2012). “Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources 1992/93 to 2009/10.” Toronto: Institute for Clinical Evaluative Sciences.

Liberal Party of Canada. (2015). “A New Plan for a Strong Middle Class.” https://www.liberal.ca/realchange/. Accessed on October 30, 2015.

Marchildon, G. P. (2013). Canada: Health system review. Copenhagen: WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Policies.

National Physician Survey, 2014. The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada. http://nationalphysiciansurvey.ca/wp-content/uploads/2014/11/2014-National-EN.pdf (Accessed Aug 1, 2015).

Ogilvie, K. K., and Eggleton, A. (2012). “Time for transformative change: A review of the 2004 health accord.” Ottawa, Ontario: The Standing Senate Committee on Social Affairs, Science and Technology.

Ontario Ministry of Health and Long-Term Care (MOHLTC) (2011). Info Bulletin. http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul11020.pdfhttp://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul11020.pdf. Access October 30, 2015.

Ontario Ministry of Health and Long-Term Care (MOHLTC) (2014). “Hospitals. Questions and Answers,” http://www.health.gov.on.ca/ en/common/system/services/hosp/faq.aspx. Accessed Oct. 1, 2014.

Ontario Ministry of Health and Long-Term Care (MOHLTC) (2009). “Guide to Physician Compensation,” http://www.health.gov.on.ca/en/pro/programs/fht/docs/fht_compensation.pdf (Accessed Aug 30, 2015).

Organization for Economic Cooperation and Development (2015). OECD.Stat. DOI: 10.1787/data-00285-en. Accessed 2 July 2015.

Organization for Economic Cooperation and Development (2014). Health Data, 2014. Paris: OECD.

Organization for Economic Cooperation and Development (2011). “Long-Term Care.” Paris: OECD.

Public Health Agency of Canada (2011). “Reducing Health Inequalities: A Challenge for Our Times” Ottawa: Public Health Agency of Canada.

Rudoler, D., Laporte, A., Barnsely, J., Glazier, R. H., and Deber, R. B. (2014). “Paying for Primary Care: A Cross-Sectional Analysis of Cost and Morbidity Distributions Across Primary Care Payment Models in Ontario, Canada.” Unpublished Manuscript, Institute of Health Policy, Management and Evaluation, University of Toronto.

Statistics Canada. (2011). Residential Care Facilities: 2009/10. Ottawa: Statistics Canada Catalogue, no.83-237-X. http://www.statcan.gc.ca/pub/83-237-x/83-237-x2012001-eng.pdf (Accessed August 29, 2015).

Stukel, T., Glazier, R. H., Schultz, S. E., Guan, J., Zagorski, B. M., Gozdyra, P., and Henry, D. A. (2013). “Multispecialty physician networks in Ontario.” Open Medicine 7:2.

Sutherland, J. M., Crump, R. T., Repin, N., and Hellsten, E. (2013). “Paying for Hospital Services: A Hard Look at the Options.” Toronto: C. D. Howe Institute.

Sutherland, J. M., Repin, N., and Crump, R. T. (2013b). “The Alberta Health Services Patient/Care–Based Funding Model for Long-Term Care: A Review and Analysis.” British Columbia: Centre for Health Services and Policy Research.

Sweetman, A., and Buckley, G. (2014). “Ontario’s Experiment with Primary Care Reform.” The University of Calgary School of Public Policy Research Papers 7(11):1–37, http://www.policyschool.ucalgary.ca/sites/default/files/research/ontario-health-care-reform.pdf. Accessed Oct. 10, 2014.

The Danish Health System, 2015

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What is the role of government?

Universal access to health care is the underlying principle inscribed in Denmark's Health Law, which sets out the government's obligation to promote population health and prevent and treat illness, suffering, and functional limitations. Other core principles include high quality; easy and equal access to care; service integration; choice; transparency; access to information; and short waiting times for care. The law also assigns responsibility to regions and municipalities for delivering health services.

The national government sets the regulatory framework for health services and is in charge of general planning and supervision. Five administrative regions governed by democratically elected councils are responsible for the planning and delivery of specialized services, but also have tasks related to specialized social care and coordination. The regions own, manage, and finance hospitals and the majority of services delivered by general practitioners (GPs), office-based specialists, physiotherapists, dentists, and pharmacists. Municipalities are responsible for financing and delivering nursing home care, home nurses, health visitors, some dental services, school health services, home help, and treatment for drug and alcohol abuse. Municipalities are also responsible for general prevention and rehabilitation tasks; the regions are responsible for specialized rehabilitation.

Who is covered and how is insurance financed?

Publicly financed health care: Public expenditures in 2013 accounted for 84 percent of total health spending, representing 10.4 percent of GDP in 2013 (OECD, 2015a). It should be noted, however, that Danish cost reporting with regard to the "gray zone" of long-term care tends to include more activities than does reporting in many other member countries of the Organisation for Economic Co-operation and Development (OECD) (Søgaard 2014).

All registered Danish residents are automatically entitled to publicly financed health care, which is largely free at the point of use. In principle, undocumented immigrants and visitors (estimated at fewer than 2,000) are not covered, but a voluntary, privately funded initiative by Danish doctors, supported by the Danish Red Cross and Danish Refugee Aid, provides this population with access to care.

Health care is financed mainly through a national health tax, set at 8 percent of taxable income. Revenues are allocated to regions and municipalities, mostly as block grants, with amounts adjusted for demographic and social differences; these grants finance 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, usually defined in the annual economic agreements between national government and the municipalities or regions. The remaining 20 percent of financing for regional activities comes from municipal activity-based payments, which are financed through a combination of local taxes and block grants.

Private health insurance: Complementary voluntary insurance, purchased on an individual basis, covers statutory copayments—mainly for pharmaceuticals and dental care—and services not fully covered by the state (e.g., physiotherapy). Some 2.2 million Danes have such coverage, which is provided almost exclusively by the not-for-profit organization Danmark (Sygeforsikringen "Danmark," 2014).

In addition, nearly 1.5 million people hold supplementary insurance to gain expanded access to private providers (CEPOS, 2014). Policies are purchased mostly from among seven for-profit insurers and are provided mainly through private employers as a fringe benefit, although some public-sector employees are also covered. Students, pensioners, the unemployed, and others outside the job market are generally not covered by supplementary insurance.

Private expenditures accounted for nearly 16 percent of health care spending in 2013, and private insurance accounted for about 12 percent of total private expenditures (OECD, 2015a).

What is covered?

Services: Publicly financed health care covers all primary, specialist, hospital, and preventive care, as well as mental health and long-term care services. Dental services are fully covered for children under 18. Outpatient prescription drugs, adult dental care, physiotherapy, and optometry services are subsidized. Home care and hospice care are organized and financed by the regions as described below.

Decisions about levels of service and new medical treatments are made by the regions, within a framework of national laws, agreements, guidelines, and standards.

Municipalities decide on the service level for most other welfare services. There is no defined benefits package, but very few restrictions exist for treatments that are evidence-based and clinically proven.

Cost-sharing: 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 in 2013, covering mostly outpatient drugs, corrective lenses, hearing aids, and doctor and dental care. Patients with outpatient drug expenses of more than 3,045 DKK (USD394) per year receive the highest reimbursement rate—85 percent. Private specialists, hospitals, and dentists are free to set their own fees for patients not covered by public funding.

Safety net: There are cost-sharing caps for children, and municipalities provide means-tested social assistance to older people. If personal assets are DKK77,500 (USD10,217) or less, 85 percent of all prescription drug costs are covered. Chronically ill people with high drug usage and costs can apply for full reimbursement above an annual out-of-pocket ceiling of DKK3,775 (USD498). The terminally ill can also apply for full coverage of prescriptions. Municipalities may grant financial assistance to individuals certified as otherwise unable to pay for needed medicine.

How is the delivery system organized and financed?

Primary care: Around 22 percent of all doctors work in general practice. All general practitioners (GPs) are self-employed and paid by the regions via capitation (about 30% of income) and fee-for-service (70% of income). Rates are set through national agreements with the doctors' associations. Service-based fees are used as financial incentives to prioritize services. National fees are paid per consultation, whether for office visits, e-consults, or home visits. The average income for a GP was DKK1.1M (USD145,000) in 2011. The average salary for senior hospital doctors was DKK1M (USD132,000) (Danske Regioner, 2012).

The practice structure is gradually shifting from solo to group practices, typically consisting of two to four GPs and two to three nurses (Danske Regioner, 2007). The number of nurses employed has increased in the past decade; they are paid by the practice and have gradually assumed responsibility for such tasks as blood sampling and vaccination. Colocation of various clinicians is also on the rise, with GPs, physiotherapists, and office-based specialists operating out of the same facilities but under separate management.

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

Outpatient specialist care: Outpatient specialist care is delivered through hospital-based ambulatory clinics (fully integrated and funded, as are other public hospital services) or by self-employed specialists in privately owned facilities. Private self-employed specialists can be full-time or part-time; full-timers may not have other full-time jobs. Part-timers may also work in the hospital sector, subject to codes of conduct, with their activity level monitored and their incomes limited by the regions. 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 covered by voluntary insurance. As a result of legislation guaranteeing patients the right to diagnostic assessment within 30 days of referral, private practitioners may also receive patients referred from public-sector providers; they are paid for these services through specific agreements with the regions.

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

Administrative mechanisms for direct patient payments to providers: There is no out-of-pocket payment for medical services for patients in group 1. Primary care doctors and specialists are paid directly by the regions when registering provision of services electronically. Group 2 patients make a copayment to supplement the automatic payment (Strandberg-Larsen, et al., 2007).

After-hours care: After-hours care is organized by the regions, mainly by agreement with GPs on a collective basis. The Copenhagen region employs 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 to after-hours care. The first line of contact is a regional telephone 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 a hospital emergency department. Information on patient visits is sent routinely to GPs. There are walk-in emergency units in larger hospitals.

Hospitals: Approximately 97 percent of hospital beds are publicly owned. Regions decide on budgeting mechanisms, generally using a combination of fixed-budget and activity-based funding based on diagnosis-related groups (DRGs), where the fixed budget makes up the bulk of the funding (although significant fluctuations occur among specialties and hospitals). DRG rates are calculated by the Ministry of Health at the national level based on average costs. Activity-based funding is usually combined with target levels of activity and declining rates to control expenditure. This strategy succeeded in increasing activity and productivity by an average of 5 percent annually from 2009 to 2011 and by 1.4 percent from 2011 to 2012 (Danske Regioner, 2015). Bundled payments are not yet used extensively. Hospital physicians are salaried and employed by regional hospitals, which bear the attendant costs, as are other health care professionals in hospitals and in most municipal health services. Patients can choose among public hospitals upon referral, and payment follows the patient to the receiving hospital if it is located in another region. 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, 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 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 providers are public and salaried. A right to diagnostic assessment for psychiatry within two months of referral was introduced in 2014 (shortened to one month as of September 2015). Assessment is followed by a right to treatment within two months for less serious conditions and one month for more serious conditions. There are walk-in units for acute psychiatric care in all regions.

Long-term care: Responsibility for chronic care is shared between regional hospitals, general practitioners, and providers of 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 needs-based, and is organized and funded by municipalities. Most municipal long-term care is provided at home, in line with a policy initiative to allow people to remain at home as long as possible. Home nursing is fully funded after medical referral. Permanent home care is free of charge, while temporary home care can be subject to cost-sharing if the recipient's income is above DKK143,300 (USD18,890) for single individuals and DKK215,300 (USD28,380) for couples (Frederiksberg Kommune, 2015). Municipalities are obliged to organize markets with open access for both public and private providers of home care, and patients may choose between public or private providers. While this functions relatively well in most municipalities, it has been difficult to attract private providers to remote areas. A considerable number of the elderly choose private providers. Some municipalities have also 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 by municipalities, and no cash benefits are paid to patients. Public providers are employed by the municipalities. For staying in residential care institutions, patients pay according to the facility's costs plus 10 percent of their income (20% of income above DKK188,700, or USD24,880), as well as heating and electricity charges (Rudersdal Kommune, 2015).

Relatives of seriously ill individuals may take paid leaves of absence from their jobs for up to nine months. These can be incremental and may be divided among several relatives. A similar scheme exists for relatives of terminally ill patients who no longer receive treatment.

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

What are the key entities for health system governance?

The general regulation, planning, and supervision of health services, including cost control mechanisms, take place at the national level through the Ministry of Health and the Danish Health Authority, Danish Medicines Agency, and Danish Patient Safety Authority. The national authorities are responsible for general supervision of health personnel and for development of quality management in line with national clinical guidelines and standards, usually in close collaboration with representatives from medical societies. These authorities also have 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. Health technology assessments are developed at the regional level, while the national authorities do comparative effectiveness (productivity) studies that are published on a regular basis, allowing regions and hospital managers to benchmark performance of individual hospital departments (Danske Regioner, 2015).

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

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

Aspects of care that are affected by regional benchmarking results, which are published online, include expenditures for administration; expenditures for support functions (washing and cleaning); organization and handling of free choice (of private provider); and psychiatry, obesity operations, selected medical treatments, knee operations, shoulder operations, heat treatment, and back operations (Danske Regioner, 2014c).

What are the major strategies to ensure quality of care?

The Danish Healthcare Quality Programme (DDKM), based on accreditation and a set of accreditation standards, was in operation at the hospital level until 2015. It is currently being replaced in hospitals with a new program featuring fewer standards and more emphasis on clinical and local dimensions (due partially to pressure from the medical profession). The DDKM continues to be rolled out in primary and municipal health care.

Quality data for a number of treatment areas are captured in clinical registries and published online for institutions, but not for individual health providers at the hospital level (sundhedskvalitet.dk). General quality and efficiency data are also published regularly in national level reports as a follow-up to national budget agreements between the state and the regions (Ministry of Health, 2013). Patient experiences are collected though biannual national, regional, and local surveys.

The Danish Health Authority has laid out standard treatment pathways, with priorities including chronic disease prevention and follow-up interventions. Pathways for 34 cancers have been in place since 2008, covering nearly all cancer patients. The authority monitors pathways and the speed at which patients are diagnosed and treated. DDKM standards enforce the use of pathway programs and national clinical guidelines for all major disease types. Regions develop more specific practice guidelines for hospitals and other organizations, based on general national recommendations. There are no explicit national economic incentives tied to quality, but several regions are experimenting with such schemes. In general, regions are obliged to take action in case of poor results, and may fire hospital managers or introduce other measures to support quality improvement. The Danish Health Authority can step in if entire regions fail to live up to standards.

The Danish Patient Safety Authority was created in 2015 when the former Danish Health and Medicines Authority was split into separate agencies. It receives anonymized reports of accidents and near-accidents that health care professionals at all levels are obliged to submit to regional authorities, which evaluate the incidents. The information is published in an annually updated database, with the intention of fostering learning rather than sanctioning.

What is being done to reduce disparities?
Regular reports are published on variations in health and health care access (Sundhedsstyrelsen, 2015). These have prompted the formulation of action plans, 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, thus creating economic incentives for municipalities to keep citizens healthy and out of hospitals)
- improved psychiatric care
- 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 address a number of topics related to admission and discharge from hospitals, rehabilitation, prevention, psychiatric care, IT support systems, and formal progress targets. Agreements are formalized for municipal and regional councils at least once per four-year election term, generally take the form of shared standards for action in different phases of the patient journey in the system, and must be approved by the Danish Health Authority. The agreements are partially supported by IT systems with information that is shared between different caregivers. The performance of regions and municipalities in reaching the goals is measured by national indicators published online (www.esundhed.dk).

Regions and municipalities have implemented various measures to promote care integration. Examples include the use of outreach teams from hospitals doing follow-up home visits; training programs for nursing and care staff; establishment of municipal units located within hospitals to facilitate communication, particularly in regard to discharge; and the use of “general practitioner practice coordinators.” Many coordination initiatives have a special emphasis on citizens with chronic care needs, multi-morbidity, or frailty due to aging or mental health conditions (Økonomi- og Indenrigsministeriet, 2013). Municipalities are in charge of a range of services, including social care, elder care, and employment services; most are currently working on models for integrating these services better, such as through joint administration with shared budgets and formalized communication procedures.

Practices increasingly 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 GPs, practicing specialists, and physiotherapists, among 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 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 use electronic information systems as a conduit for discharge letters, electronic referrals, and prescriptions.

What is the status of electronic health records?

Information technology (IT) is used at all levels of the health system as part of a national strategy supported by the National Agency for Health IT. Each region uses its own electronic patient record system for hospitals, with adherence to national standards for compatibility. Danish general practitioners were ranked first in an assessment of overall implementation of electronic health records in 2014 (HimSS Europe, 2014). All citizens in Denmark have a unique electronic personal identifier, which is used in all public registries, including health databases. A shared medical card with encoded information on a person’s prescriptions and use of drugs has been implemented. General practitioners also have access to an online medical handbook with updated information on diagnosis and treatment recommendations. Attempts to develop national clinical databases to monitor quality in primary care (DataFangst) were aborted in 2015, as they were found to violate privacy rights and to endanger the trust between GPs and their patients.

Sundhed.dk is a national IT portal with differentiated access for health staff and the wider public. It 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, treatments offered, and patients' laboratory test results. The portal also provides access to available quality-of-care 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. The budget law is supplemented by annual agreements between regions, municipalities, and government that coordinate policy initiatives to control expenditures. These include direct controls of supply.

Block grants to regions 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 presents a strong incentive (Danske Regioner, 2014). Furthermore, regions are under pressure to deliver good performance, as they can be shut down if they do not deliver.

At the regional level, hospital cost control includes a combination of global budgets and activity-related incentives (see above).

Inpatient pharmaceutical expenditure 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—the Council for the Use of Expensive Hospital Medicines (RADS) and the Coordinating Council for the First Use of Hospital Medicines (KRIS).

Policies to control outpatient pharmaceutical expenditure include generic substitution, prescribing guidelines, and assessment by the regions of deviations in prescribing behavior. Pharmaceutical companies report a monthly price list to the Danish Health Authority, 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 they 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 into contracts with private providers to deliver diagnostic and curative procedures. Prices for these services are negotiated between regions and private providers and can be lower than rates in the public sector.

These measures have been relatively successful in controlling expenditures and driving up activity levels. General productivity in the hospital sector increased almost 20 percent from 2008 to 2012, while maintaining high patient satisfaction and also reducing hospital standardized mortality rates (Danske Regioner, 2014b and 2014c).

What major innovations and reforms have been introduced?

A reorganization of the hospital infrastructure is currently under way. All five regions are in the process of closing or amalgamating small hospitals and building new hospitals, at a total cost of DKK40.0 billion (USD5.3 bilion). A central part of this process is the reorganization of acute care, with stronger pre-hospital services and larger specialized emergency departments with senior medical specialists at the front end.

The third generation of mandatory “health agreements” for coordination between municipalities and regions came into force in 2014. These agreements cover 2015–2018, and are based on a slightly revised format that resulted from a formal evaluation published in 2011.

Upscaling of municipal health services with “temporary care units” and various types of health centers is occurring, 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 services for population health (Rigsrevisionen, 2013).

A plan for reorganization of the central governance structure was decided on by the incoming government in August 2015, and was implemented in the fall of 2015. The reorganization will split the existing Health and Medicines Agency into four separate agencies, dealing with health, medicines, patient safety, and IT/data, to provide more clarity and improve the overall surveillance and accountability structure.

References

CEPOS (2014). Halvdelen af danskerne har nu en privat sundhedsforsikring. http://www.cepos.dk/sites/default/files/analyse_publication/Notat_Halvdelen_af_danskerne_har_nu_en_privat_sundhedsforsikring_apr14.pdf.

Danske Regioner (2007). Organisering af almen praksis. Delrapport. http://www.regioner.dk/Sundhed/Praksissektoren/Almen+praksis/~/media/73D4270B3EDD4EAA9450599581F4E7E3.ashx.

Danske Regioner (2012). Fakta om økonomi og aktivitet i almen praksis. Notat. http://www.regioner.dk/~/media/Mediebibliotek_2011/Nyheder/Fakta%20om%20%C3%B8onomi%20og%20aktivitet%20i%20almen%20praksis_2012.ashx.

Danske Regioner (2014). Økonomisk Vejledning 2013. http://www.regioner.dk/~/media/Filer/Økonomi/Budgetvejledning/Budgetvejledning%20for%202013/Økonomisk%20vejledning%20aktivitetspuljen%20og%20baseline%202014.ashx.

Danske Regioner (2014b). Styr på regionernes økonomi. http://www.regioner.dk/~/media/Filer/Økonomi/Analyser/Styr%20på%20regionernes%20økonomi/Styr%20på%20regionernes%20økonomi.ashx.

Danske Regioner (2014c). Høj produktivitet, øget kvalitet og tilfredse patienter. http://www.regioner.dk/~/media/Subsites/GF14/Regionernes%20resultater/Effektive%20regioner/høj%20prod%205.ashx.

Danske Regioner (2015). LØBENDE OFFENTLIGGØRELSE AF PRODUKTIVITET I SYGEHUSSEKTOREN. 10. delrapport. http://www.regioner.dk/aktuelt/nyheder/2015/januar/~/media/64631EF66EEC42E6AAC59A420C566124.ashx.

Frederiksberg Kommune (2015). http://www.frederiksberg.dk/Borger/Aeldre/Hjemmehjaelp-og-sygepleje/Hjemmehjaelp.aspx.

HimSS Europe (2014). Electronic Medical Record Adoption in Denmark. http://www.regioner.dk/~/media/Mediebibliotek_2011/SUNDHED/Sundheds-it/HIMMS_Denmark_2014.ashx.

Ministry of Health, 2013. Øget fokus på gode resultater på sygehusene. http://www.sum.dk/Aktuelt/Nyheder/Tal_og_analyser/2013/Maj/~/media/Filer%20-%20Publikationer_i_pdf/2013/Oeget-fokus/oeget-fokus-paa-gode-resultater-paa-sygehusene-maj-2013.ashx.

Økonomi- og Indenrigsministeriet (2013). Evaluering af Strukturreformen. http://www.regioner.dk/~/media/Mediebibliotek_2011/Om%20regionerne/Evaluering%20af%20kommunalreformen%20040313.ashx.

Organisation for Economic Co-operation and Development (2014), OECD.Stat, (database). DOI: 10.1787/data-00285-en. Accessed on October 6, 2014.

Organisation for Economic Co-operation and Development Health Data, 2015a.

Organisation for Economic Co-operation and Development (2015b). OECD.Stat. DOI: 10.1787/data-00285-en. Accessed July 2, 2015.

Rigsrevisionen (2013). "Beretning om borgerrettet forebyggelse på sundhedsområdet." http://www.rigsrevisionen.dk/publikationer/2013/102012/. Accessed June 20, 2013.

Rudersdal Kommune (2015). http://www.rudersdal.dk/Borgerservice_selvbetjening/Aeldre/Boliger_for_aeldre/Plejecentre/Udgifter_plejebolig.aspx.

Sundhedsstyrelsen (2014). Den nationale sundhedsprofil. http://sundhedsstyrelsen.dk/da/nyheder/2014/den-nationale-sundhedsprofil

Sygeforsikring "danmark" (2014). Årsrapport 2014. http://www.sygeforsikring.dk/Default.aspx?ID=23.

Søgaard, J. (2014). *Hvor høje er sundhedsudgifterne i Danmark?* (*How high are health expenditures in Denmark?*). Report for Danish Regions. Copenhagen. http://www.regioner.dk/~/media/Mediebibliotek_2011/Nyheder/REGIO/Rapport_hvor%20h%C3%B8je%20er%20sundhedsudgifterne%20i%20Danmark_2014.ashx. Accessed Oct. 3, 2014.

Strandberg-Larsen, M., Nielsen, M.B., Vallgårda, S., Krasnik, A., Vrangbæk, K., and Mossialos, E. (2007). "Denmark: Health System Review," *Health Systems in Transition* 9(6):1–164.

www.esundhed.dk: National website with interactive quality information. http://www.esundhed.dk/sundhedsaktivitet/sundhedsaftaler/Sider/Sundhedsaftaler.aspx

www.ikas.dk**:** The Danish Healthcare Quality Programme (website: http://www.ikas.dk). Copenhagen.

www.Sundhed.dk: National portal for patients and providers (website: https://www.sundhed.dk). Copenhagen.

Forsikring og Pension (2014). Sundhedsforsikringer – hovedtal 2003–2014. http://www.forsikringogpension.dk/presse/Statistik_og_Analyse/statistik/forsikring/antalpolicer/Documents/Sundhedsforsikringer.pdf.

The English Health Care System, 2015

RUTH THORLBY AND SANDEEPA ARORA, NUFFIELD TRUST

What is the role of government?

Responsibility for health legislation and general policy in England rests with Parliament, the Secretary of State for Health, and the Department of Health.[3] Under 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 those with charges already in place. Rights for those eligible for National Health Service (NHS) care are summarized in the NHS Constitution; they include access to care without discrimination and within certain timeframes for some categories, such as emergency and planned hospital care (Department of Health, 2013b). The Department of Health provides stewardship for the overall health system, but day-to-day responsibility for running the NHS belongs to a separate public body, NHS England.

NHS England manages the NHS budget, oversees 209 local Clinical Commissioning Groups (CCGs), and ensures that the objectives set out in an annual mandate by the Secretary of State for Health are met, including both efficiency and health goals. Budgets for public health are held by local government authorities, which are required to establish "health and well-being boards" to improve coordination of local services and reduce health disparities.

Who is covered and how is insurance financed?

Publicly financed health care: In 2013, the U.K. spent 8.8 percent of GDP on health care, of which public expenditure, mainly on the NHS, accounted for 83.3 percent (Office of National Statistics, 2015). The majority of funding for the NHS comes from general taxation, and a smaller proportion from national insurance (a payroll tax). The NHS also receives income from copayments, people using NHS services as private patients, and some other minor sources.

Coverage is universal. All those "ordinarily resident" in England are automatically entitled to NHS care, largely free at the point of use, as are nonresidents with a European Health Insurance Card. For other people, such as non-European visitors or illegal

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

immigrants, only treatment in an emergency department and for certain infectious diseases is free (Department of Health, 2013a).

Private health insurance: In 2012, 10.9 percent of the UK population had private voluntary health insurance (Nuffield Trust, 2013). The bulk of it was provided through employers (3.97 million policies) versus individual policies (0.97 million). Private insurance offers more rapid and convenient access to care, especially for elective hospital procedures, but most policies exclude mental health, maternity services, emergency care, and general practice (King's Fund, 2014). Data on private insurers are not freely available, but according to the Competition and Markets Authority (2014), four insurers account for 87.5 percent of the market, with small providers making up the rest.

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 ensure comprehensive coverage. 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), if recommended by their clinician (Department of Health, 2013b). For drugs or treatments that have not been appraised by NICE, the NHS Constitution states that CCGs shall make rational, evidence-based decisions (Department of Health, 2013b).[4] There is no routine reporting of how individual clinical commissioning groups make decisions, but a study of predecessor organizations found considerable variation (Nuffield Trust, 2011). There is also evidence of wide variations in access to some treatments, 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. Out-of-pocket payments for general practice are limited to services that fall outside the purview of the NHS, including examinations for

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[4] A total of 533 appraisals were carried out between March 2000 and August 2014.

employment or insurance purposes and the provision of certificates for travel or insurance.

Outpatient prescription drugs are subject to a copayment (currently GBP8.20, or USD11.60, per prescription item in England); drugs prescribed in NHS hospitals are free. NHS dentistry services are subject to copayments of up to GBP222.50 (USD314.00) per course of treatment.[5] These charges are set nationally by the Department of Health. Out-of-pocket expenditure on health by households accounted for 11.9 percent of total expenditures in the U.K. in 2013 (Office for National Statistics, 2015). In 2013, the largest portion of out-of- pocket spending (34%) was for pharmaceuticals, followed by about 20 percent on medical appliances and equipment (Office for National Statistics, 2015).[6]

Safety net: People who are exempt from prescription drug copayments include children under age 16 and those 16 to 18 in school full time; 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, or certain disabilities. Patients who need large amounts of prescription drugs can buy prepayment certificates costing GBP29.10 (USD41.10) for a period of three months and GBP104 (USD147) 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. Vision tests are free for young people, those over 60, and people with low incomes, and financial support to meet the cost of corrective lenses is available to young people and those with low incomes. Transportation costs to and from provider sites also are covered for people who qualify for the NHS Low Income Scheme.

How is the delivery system organized and financed?

Primary care: Primary care is delivered mainly through general practitioners (GPs), who act as gatekeepers for secondary care. In 2014, there were 36,920 general practitioners (full-time equivalents) in 7,875 practices, with an average of 7,171 patients per practice and 1,530 patients per GP. There were 40,443 hospital specialists and a further 53,786 hospital doctors in training (Health and Social Care Information Service, 2015a, 2015b).

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[5] Throughout this profile, all figures in USD were converted from GBP at a rate of GBP0.71 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015).

[6] 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.

The number of solo practices is currently 843, while there are 3,589 practices with five or more GPs (Health and Social Care Information Service, 2015a). General practices are normally patients' first point of contact, and people are required to register with a local practice of their choice; however, choice is effectively limited because many practices are full and do not accept new patients. In some areas, walk-in centers offer primary care services, for which registration is not required.

Most GPs (66%) are private contractors, and approximately 56 percent of practices operate under the national General Medical Services contracts, negotiated between the British Medical Association (representing doctors) and government. These provide payment using a mixture of capitation to cover essential services (representing about 60% of income), optional fee-for-service payments for additional services (e.g., vaccines for at-risk populations, about 15%), and an optional performance-related scheme (about 10%) (Health and Social Care Information Centre, 2015d). Capitation is 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. Performance bonuses mainly relate to evidence-based clinical interventions and care coordination for chronic illnesses. The proportion of income from these bonuses will fall when the new 2014–15 contract is implemented, as the number of bonus-related services is reduced and funding rerouted into capitation.

The proportion of GPs employed in practices or on a salaried basis as locums (e.g., standing in when other GPs are unavailable) is increasing (currently around 20%). Most general practices employ other professionals such as nurses, who monitor patients for such things as blood pressure and provide minor treatments such as dressing wounds. The structure of general practice is changing, away from the single-handed "corner shops" and toward networked practices, including larger multipractice organizations using multidisciplinary teams of specialists, pharmacists, and social workers (King's Fund and Nuffield Trust, 2013). The average income for combined GPs (contracted and salaried) was GBP92,200 (USD130,200) before tax in 2013–2014 (Health and Social Care Information Service, 2015c).

Outpatient specialist care: Nearly all specialists are salaried employees of NHS hospitals, and CCGs pay hospitals for outpatient consultations at nationally determined rates. Specialists 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 private work, a proportion that is declining as the earnings gap between public and private practice narrows (GHK Consulting and Office of Fair Trading, 2011). Patients are able to choose which hospital to visit, and the 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 GPs "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: GPs are no longer required personally to provide after-hours care to their patients (a small minority still do), but must ensure that adequate arrangements for its provision are in place. In practice, this means that CCGs contract mainly with GP cooperatives and private companies, both of which usually pay GPs 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 GP-led centers. Telephone advice is available on a 24-hour basis through NHS 111 for those with an urgent but not life-threatening condition.

Hospitals: Publicly owned hospitals are organized either as NHS trusts (currently 98) directly accountable to the Department of Health 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 CCGs to provide services. They are reimbursed mainly at nationally determined diagnosis-related group (DRG) rates, which include medical staff costs and account for about 60 percent of income, with the remainder coming from activities not covered by DRGs, such as mental health, education, and research and training funds (Department of Health, 2013c). Responsibility for setting those rates is shared between NHS England and Monitor. In some areas, rates are not applied and payments are made for an overall 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 as yet are not in widespread use. There is no cap on hospital incomes.

An estimated 548 private hospitals and between 500 and 600 private clinics in the U.K. offer a range of services, including treatments either unavailable in the NHS or subject to long waiting times, such as bariatric surgery and fertility treatment, but generally do not have emergency, trauma, or intensive-care facilities (Competition and Markets Authority, 2014). 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. Although the volume of care purchased from private providers by the NHS has increased recently in areas outside of mental health, NHS use of private hospitals remains low—3.6 percent of overall spending by commissioners on hospital services in 2012–2013 (Nuffield Trust, 2014a).

Mental health care: Mental health care is an integral part of the NHS, which covers a full range of services. Less serious illnesses—mild depressive and anxiety disorders, for example—are usually treated by GPs. 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, though there can still be long waiting times. Policies to improve care of more severe conditions in the community have focused on outreach and early intervention, and there is an overarching aim to ensure “parity of esteem” between mental health and other kinds of health services. A review conducted in 2012 suggested that mental health services have been underfunded compared with treatment of physical illnesses (Centre for Economic Performance, 2012).

Long-term care and social supports: The NHS pays for some long-term care, such as for people with continuing medical or skilled-nursing needs, but payments in recent years 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 (USD20,123) in assets who also have high levels of need, with a sliding scale applied up to GBP23,250 (USD32,832). There is a national framework for assessing need, but local authorities are free to set eligibility thresholds for access to funds, which has become progressively more restricted (Nuffield Trust, 2014b).

Those eligible are liable for some copayments, with some people contributing almost all of their "assessed income," including pensions. Beneficiaries can receive personal budgets to purchase their own care but can also opt to have the local authority arrange it. Some additional allowances paid to users and carers are exempt from means testing, such as "attendance allowance," worth a maximum of GBP81.30 (USD115) a week.

The 2014 Care Act aims to limit individuals' risk of catastrophic long-term care costs by imposing a cap on total out-of-pocket expenditure; however, this provision has been postponed until 2020 over cost concerns.

In 2009, the private sector provided 78 percent of residential care places for older people and the physically disabled in the U.K. (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.

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 health system as a whole. The Health and Social Care Act 2012 transferred important functions to NHS England, including overall budgetary control, supervision of CCGs, and, along with Monitor (described below), responsibility for setting DRG rates for provision of NHS services. NHS England also commissions some specialized low-volume services, national immunization and screening programs, and primary care. It is also 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 IT infrastructure of the NHS.

The National Institute for Health and Clinical Excellence (NICE) sets guidelines for clinically effective treatments and appraises new health technologies for their efficacy and cost-effectiveness. The CQC 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.

The 2012 Act extended Monitor's role to being the economic regulator of public and private providers, with powers to intervene if performance deteriorates significantly.

Monitor licenses all providers of NHS-funded care and may investigate potential breaches of NHS cooperation and competition rules and mergers involving NHS foundation trusts. Where such mergers are found to be *prima facie* undesirable, they are referred to the Office of Fair Trading and the Competition Commission.

Healthwatch England promotes patient interests nationally. In each community, local Healthwatches support people who make complaints about services; quality concerns may be reported to Healthwatch England, which can then recommend that the Care Quality Commission (CQC) take action. In addition, local NHS bodies, including general practices, hospital trusts, and CCGs, 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 health conditions, the location and quality of health services, and other information. The website, which also offers a platform for user feedback, received 27 million visits a month in 2012–13 (NHS Choices, 2013).

What are the major strategies to ensure quality of care?

The CQC has responsibility for the regulation of all health and adult social care in England. All providers, including institutions, individual partnerships, and sole practitioners, must be registered with the CQC, which monitors performance using nationally set quality standards and investigates individual providers when concerns have been raised (e.g., by patients). It rates hospitals' inspection results and can close down poorly performing services. New "fundamental standards" for all health and social care came into force in 2015 (Department of Health, 2014a). The monitoring process includes results of national patient experience surveys.

NICE 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, from cancer to trauma. There are national registries for key disease groups and procedures. Maximum waiting times have been set for cancer treatment, elective treatments, and emergency 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 at the organization, department, and (for some procedures) physician levels is published on NHS Choices. Results of inspections by the CQC 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 registry of patients with certain diseases or conditions and their management and treatment. For hospitals, 2.5 percent of contract value is linked to the achievement of a limited number of quality goals through the Commissioning for Quality and Innovation initiative. In addition, DRG rates for some procedures are linked to best practice.

All doctors 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. Providers of hospital services must also be registered with the CQC.

What is being done to reduce disparities?

The Secretary of State, NHS England, and CCGs have a legal duty to "have regard" for the need to reduce health disparities, although the applicable legislation does not specify what action needs to be taken. NHS England publishes an annual report on the actions and progress being made in reducing disparities in access and outcomes, by gender, disability, age, socioeconomic status, and ethnicity (NHS England, 2015b). Strategies include ensuring that local areas receive adequate resources to tackle inequalities and that the outcomes for at-risk groups are routinely monitored.

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

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 have some of the features of a medical home—that is, they direct patients to specialists in hospitals or to community-based professionals, like dieticians 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 (2014–15) requires practices to have a "named accountable GP" for all patients over age 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 CCGs with promoting integrated care—closer links between hospital- and community-based health services, including primary and social care. The health and well-being boards within local authorities are intended to promote integration between NHS and local authority services, particularly at the intersection of hospital and social care.

The government announced in 2013 the selection of 14 "Pioneer" integration pilot programs, aimed at improving coordination of health and care services for patients most at risk of having to undergo unplanned or emergency treatment. The Better Care Fund provides GBP3.8 billion (USD5.4 billion), pooled from existing health and social care budgets, for integration projects by local health and social care commissioners starting in 2015–16. Health and well-being 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?

The NHS number assigned to every registered patient serves 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 GP, but there is no requirement for practices to have that capability. Records are not routinely linked between providers.

A move to make primary, urgent, and emergency care services paperless by 2018, and all other parts of the NHS by 2020, is being enforced by requirements that NHS organizations show progress toward that end in the intervening years; they risk having funding removed if universal digital care records are not implemented by 2020.
NHS Choices will serve as a single point of access for patients to register with a GP, book appointments and order prescriptions, access apps and digital tools, speak to their doctor online or via video link, and view their full health record (Department of Health 2014c). All NHS patients have the right of access to their own health records (in some cases it is possible electronically) and can apply in writing to have a copy of their records held by their general practice, hospital, or dentist. By 2016, all patients will be able to have access to their GP electronic record in full, and by 2018 it is hoped that access will extend to data from all health and health care interactions.

Electronic transfers are widely used by GPs to send prescriptions to pharmacies, and for the storage and distribution of digital scans, X-rays, and other images.
NHS England has been developing a program for collecting data and for linking electronic records from general practice with those from hospitals and other care settings, for purposes of research and planning in health and social care services (NHS England, 2014b). Full implementation has been delayed because of concerns about confidentiality, but piloting in 265 general practices started in 2014.

How are costs contained?

Rather than using patient cost-sharing or imposing direct constraints on supply, costs in the NHS are constrained by a global budget that cannot be exceeded. NHS budgets are set at the national level, usually on a three-year cycle. CCGs are allocated funds by NHS

England, which closely monitors their financial performance to prevent overspending. They are expected to achieve a balanced budget each year.

The current economic situation has resulted in a largely flat NHS budget against a backdrop of rising demand. Between March 2010 and March 2015, the NHS budget rose by between 0.6 percent and 0.9 percent (in real terms), versus the 5.6 percent growth between 1996–97 and 2009–10 (King's Fund, 2015b). NHS England (2014a) estimated that the gap between rising demand and a continuation of this minimal increase in funding would be equivalent to GBP30 billion (USD42.4 billion) per year by 2020–21, assuming no additional efficiencies, but also that efficiencies equivalent to 2–3 percent of the annual budget are possible, versus a historic rate of 0.8 percent.

Although some of the savings targets have been met in the past five years, the financial pressure on the NHS is being associated with some deterioration in quality of care—notably waiting time targets (Nuffield Trust and Health Foundation, 2015).

Cost-containment strategies to date include freezing staff pay increases, supporting increased use of generic drugs, reducing DRG payments for hospital activity, managing demand, and reducing administration costs (King's Fund, 2015a). There are a number of tools for local purchasers to maximize value by addressing unwarranted variations in utilization and clinical practice, provided by the government-funded "Rightcare" program. Local purchasers can also run competitive tenders for certain services.

What major innovations and reforms have been introduced?

In October 2014, NHS bodies, led by NHS England, published the *Five Year Forward View*, which sets out the challenges facing the NHS and a series of strategies to address them (NHS England, 2014a). These included setting up a number of pilot programs across England to test new models of care known as "vanguards." To date there are 37 vanguard sites, which focus on scaled-up primary care, enhanced health care in long-term care homes, vertically integrated hospital and community care, and networks to improve emergency care. NHS England hopes that, among other benefits, evaluations of the program will lead to better tools for identifying those at risk of becoming high-cost, high-need patients, and to the development of capitated contracts to incentivize providers to collaborate in the care of complex patients. The *Five Year Forward View* also sets out strategies to improve health and well-being, including a diabetes prevention initiative (NHS England, 2015a).

The primary challenge facing the NHS is finding a way to redesign services and invest in prevention while at the same time generating efficiencies without compromising service quality or access. In November 2014, the National Audit Office reviewed the financial health of hospital providers in the NHS and warned that the trend of increasing financial distress was unsustainable (National Audit Office, 2014). The new Conservative government elected in May 2015 endorsed the *Five Year Forward View* and committed an additional GBP8 billion (USD11 billion) per year. But measured against the GBP30 billion (USD42 billion) gap identified by NHS England, this additional funding equates to an annual savings target of GBP22 billion (USD31 billion). Moreover, this funding will need to cover the implementation of new pledges, made in the election manifesto, to implement full seven-day working weeks in hospitals and general practice by 2020.

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References

Centre for Economic Performance and London School of Economics (2012). “How mental health loses out in the NHS: a report by the Centre of Economic Performance’s mental health policy group.”

Competition and Markets Authority (2014). Private healthcare market investigation.

Department of Health (2013a). *Guidance on implementing the overseas visitors hospital charging regulations*.

Department of Health (2013b). *The NHS Constitution for England*.

Department of Health (2013c). *A Simple Guide to Payment by Results*.

Department of Health (2014a). *Hard Truths — The Journey to Putting Patients First: Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry*.

Department of Health (2014c). Personalised Health and Care 2020 — Using Data and Technology to Transform Outcomes for Patients and Citizens: A Framework for Action. November 2014. [see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384650/NIB_Report.pdf]

GHK Consulting Ltd and Office of Fair Trading (2011). Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants: Population Overview Report for the Office of Fair Trading.

Health and Social Care Information Centre, (2015a). General and Personal Medical Services, England-2004-2014

Health and Social Care Information Centre, (2015b). NHS Hospital & Community Health Service and General Practice workforce.

Heath and Social Care Information Centre (2015c). GP earnings and expenses.

Health and Social Care Information Centre (2015d). Investment in General Practice, 2010/11 to 2014/15 England, Wales, Northern Ireland and Scotland

Health & Social Care Information Centre (2014a). Prescriptions dispensed in the community, Statistics for England, 2003-2013.

The King's Fund (2015a) The NHS under the coalition government. Part two: NHS performance. March 2015.

The King's Fund (2015b) How is the NHS performing? Quarterly monitoring report, July 2015.

The King's Fund (2014) The UK private healthcare market. Appendix to the Commission on the future of health and social care in England: final report.

The King's Fund and Nuffield Trust (2013). Securing the future of general practice: new models of primary care.

Laing and Buisson (2013). Laing's Healthcare Market Review.

Local Government Association (2013). Better Care Fund: support and resources pack for integrated care.

NHS Choices (2013). Annual Report 2012/13.

National Audit Office (2014) The financial sustainability of NHS bodies. November 2014.

NHS England (2015a) Five Year Forward View. Time to deliver. June 2015.

NHS England (2015b) NHS England Annual Report. July 2015.

NHS England (2014a) Five Year Forward View, October 2014.

NHS England (2014b). Care.data: http://www.england.nhs.uk/ourwork/tsd/care-data/.

Nuffield Trust (2011). Setting priorities in health: a study of primary care trusts.

Nuffield Trust (2013). Public payment and private provision: The changing landscape of health care in the 2000s.

Nuffield Trust (2014a). Into the Red? The State of the NHS' Finances.

Nuffield Trust (2014b). Focus on: social care for older people.

Nuffield Trust and Health Foundation (2015) Closer to critical? Quality Watch Annual Statement 2015

Organisation for Economic Cooperation and Development (2015). OECD.Stat. DOI: 10.1787/data-00285-en. Accessed 2 July 2015.

Office of National Statistics (ONS), 2015. Expenditure on Healthcare in the UK, 2013.

Royal College of Surgeons in England (2014). Is access to surgery a postcode lottery?

The French Health Care System, 2015

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What is the role of government?

The provision of health care in France is a national responsibility. The Ministry of Social Affairs, Health, and Women's Rights is responsible for defining national strategy (Touraine, M., 2014). The French system has evolved from a labor-based Bismarckian system to a mixed public–private system. Over the past two decades, however, the state has been increasingly involved in controlling expenditures related to statutory health insurance (SHI).

Planning and regulation within health care involve negotiations among provider representatives, the state, and SHI. Outcomes of these negotiations are translated into laws passed by parliament.

In addition to setting national strategy, the responsibilities of the central government include allocating budgeted expenditures among different sectors (hospitals, ambulatory care, mental health, and services for disabled residents) and, with respect to hospitals, among regions.

The Administration of Health and Social Affairs is represented by Regional Health Agencies, which are responsible for population health and health care, including prevention and care delivery, public health, and social care. Health and social care 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 and how is insurance financed?

Publicly financed health insurance: Total health expenditures constituted 11 percent of GDP in 2013, of which 76 percent was publicly financed (DREES, Ministère de la Santé 2015).

SHI is financed by employer and employee payroll taxes (64%); a national earmarked income tax (16%); 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%) (Assurance Maladie 2015).

Coverage is universal and compulsory, provided to all residents by noncompetitive SHI. SHI eligibility is either gained through employment or granted, as a benefit, to students, to retired persons, and to unemployed adults who were formerly employed (and their families). Citizens can opt out of SHI only in rare cases (e.g., individuals working for foreign companies).

The state covers the insurance costs of residents who are not eligible for SHI, such as the long-term unemployed, and finances health services for undocumented immigrants who have applied for residence. Visitors from elsewhere in the European Union (EU) are covered by an EU insurance card. Non-EU visitors are covered for emergency care only.

Private health insurance: Most voluntary health insurance (VHI) is complementary, covering mainly the copayments for usual care, balance billing, and vision and dental care (minimally covered by SHI). Complementary insurance is provided mainly by not-for-profit, employment-based mutual associations or provident institutions, which are allowed to cover only copayments for care provided under SHI; 95 percent of the population is covered either through employers or via means-tested vouchers. Private for-profit companies offer both supplementary and complementary health insurance, but only for a limited list of services.

VHI finances 13.8 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 according to the official fee schedule. Coverage of balance billing is also commonly offered, and most contracts cover the balance for services billed at up to 300 percent of the official fee.

To reduce inequities in coverage stemming from variations in access and quality, standards for employer-sponsored VHI were established by law in 2013. By 2016, all employees will benefit from employer-sponsored insurance (for which they pay 50% of the cost), which would cover at least 125 percent of SHI fees for dental care and EUR100 (USD121) for vision care per year.[7] The population of additional beneficiaries is estimated at 4 million. Choice among insurance plans is determined by the industry in which the employer operates (DREES, Ministère de la Santé 2015).

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[7] All figures in USD were converted from EUR at a rate of about 0.83 EUR per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for France.

What is covered?

Services: Lists of covered procedures, drugs, and medical devices are defined at the national level and apply to all regions of the country. The Ministry of Health, a pricing committee, and SHI funds all play roles in setting these lists, rates of coverage, and prices.

SHI covers the following: 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 transportation and home care. It also partially covers long-term hospice and mental health care, and provides only minimal coverage of outpatient vision and dental care.

While preventive services in general receive limited coverage, there is full reimbursement for targeted services and populations, e.g., immunization, mammography, and colorectal cancer screening.

Cost-sharing and out-of-pocket spending: Cost-sharing takes three forms: coinsurance; copayments (the portion of fees not covered by SHI); and balance billing in primary and specialist care. In 2013, total out-of-pocket spending made up 8.8 percent of total health expenditures (excluding the portion covered by supplementary insurance), a lower percentage than in previous years, possibly because of the agreement signed between physicians' unions and government to limit extra billing (DREES, Ministère de la Santé 2015). In exchange for a voluntary restriction on extra billing to no more than twice the official fee, this contract offers patients partial reimbursement of extra billing by SHI and reduced social charges for physicians.

Most out-of-pocket spending is for dental and optical services, for which official fees are very low, not more than a few euros for glasses or hearing aids and a maximum of EUR200 (USD241) for dentures, but all of these are commonly balance-billed at amounts over 10 times the official fee. The share of out-of-pocket spending on dental and optical services is decreasing, however, while that on drugs is increasing, owing to increased VHI coverage of dental and optical care and increasing numbers of delisted drugs, as well as a rise in self-medication (DREES, Ministère de la Santé 2015).

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

- type of care (inpatient, 20%; doctor visits, 30%; and dental, 30%)
- effectiveness of prescription drugs (highly effective drugs, like insulin, carry no coinsurance; rates for all other drugs are 40%–100%, based on therapeutic value)
- compliance with the recently implemented gatekeeping system

The table below lists nonreimbursable copayments for various services. These apply up to an annual ceiling of EUR50 (USD60). There are no deductibles.

Service	**Copayment**	
	Euros	*U.S. Dollars*
Inpatient hospital day	18	22
Doctor visit	1.00	1.20
Prescription drug	0.50	0.60
Ambulance	2.00	2.40
Hospital treatment above EUR120	18	22

Safety net: People with low incomes are entitled to free or state-sponsored VHI, free vision care, and free dental care, with the total number of such beneficiaries estimated at around 10 percent of the population (DREES, Ministère de la Santé 2015). Exemptions from coinsurance apply to individuals with any of 32 specified chronic illnesses (13% of the population, with exemption 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 (6% of the population); and individuals receiving invalidity and work-injury benefits (Fonds CMU 2014). 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.

How is the delivery system organized and financed?

Collective agreements between representatives of the health professions and SHI, signed at the national level, apply to all but those professionals who expressly opt out.

Primary care: There are roughly 102,000 primary care physicians (GPs) and 118,000 specialists in France. About 46 percent of physicians are self-employed, more GPs (59%) than specialists (36%) (INSEE 2015; CISS 2014). Forty-two percent of GPs, mostly younger doctors, are in group practices. An average practice is made up of two to three physicians. Seventy-five percent of practices are made up exclusively of physicians; the remaining practices comprise a range of allied health professionals, typically paid fee-for-service.

There is a voluntary gatekeeping system for adults age 16 and over, with financial incentives offered for registering with a GP or specialist (Cour des Comptes 2013).

Self-employed GPs are paid mostly fee-for-service and can receive a yearly capitated per-person payment of EUR40 (USD48) to coordinate care for patients with a chronic condition (Assurance Maladie 2012). In addition, up to EUR5,000 (USD 6,031) annually is provided for achieving targets related to the use of computerized medical charts, electronic claims transmission, delivery of preventive services such as immunization, compliance with guidelines for diabetic and hypertensive patients, generic prescribing, and limited use of psychoactive drugs for elderly patients.

Since 2013, GPs can also enter into a contractual agreement under which they are guaranteed a monthly income of EUR6,900 (USD8,322) if they set up their practice in a region with insufficient physician supply (Ministry of Health 2014). Moreover, they can work part-time in multidisciplinary medical centers and receive a salary or capitated payment. For those who elect to work full-time in medical centers, the guaranteed salary is around EUR50,000 (USD60,300) (Quotidien du Médecin 2015).

The average income of primary care doctors in 2011 was EUR82,020 (USD98,925), 94 percent of which came from fees (INSEE 2015) and the remainder from financial incentives and salary. Fees, set by the Ministry of Health and SHI, have been frozen since 2011 (Cour des Comptes 2013).

Experimental GP networks providing chronic care coordination, psychological services, dietician services, and other care not covered by SHI are financed by earmarked funds from the Regional Health Agencies (Nolte, E., 2008).

Outpatient specialist care: About 36 percent of outpatient specialist care providers are exclusively self-employed and paid on a fee-for-service basis; the rest are either fully salaried by hospitals or have a mix of income. In October 2014, participation in pay-for-performance programs was extended to all self-employed physicians, including specialists, who must meet disease-specific quality targets in addition to those targets that apply to GPs. The average income derived from pay-for-performance is EUR5,480 (USD6,609) per physician (Cour des Comptes 2014); such income constitutes less than 2 percent of total funding for outpatient services.

Patients can choose among specialists upon referral by a GP, with the exception of gynecology, ophthalmology, psychiatry, and stomatology (Assurance Maladie 2014). Bypassing referral results in reduced SHI coverage.

The specialist fee, set by SHI, is EUR28 (USD34), but specialists can balance-bill. Half of specialists are in group practices, which are increasing among specialties that require major investments, such as nuclear medicine, radiotherapy, pathology, and digestive surgery (Sénat 2014).

Specialist doctors working in public hospitals may see private-pay patients, on an out-patient or an in-patient basis, but they must pay a percentage of their fees to the hospital. A 2013 report to the Ministry of Health estimated that 10 percent of the 46,000 hospital specialists in surgery, radiology, cardiology, and obstetrics had treated private patients. The mounting discontent over excessive balance billing revealed in the press, together with the claim of unfair competition made by private clinics, has prompted several public inquiries—the latest of which resulted in recommendations to increase public control over this activity (Ministère de la Santé 2013).

Administrative mechanisms for paying primary care doctors and specialists: Patients pay the full fee (reimbursable portion and balance billing, if any) and claim reimbursement covering the full sum or less, depending on coverage, minus EUR1.00 (USD1.20), capped at a maximum of EUR50 (USD60) per patient per year. The 2015 Health Law included a contentious item stipulating that by 2017 patients will pay directly only for balance billing, and the reimbursable fee will be paid directly by SHI.

After-hours care: After-hours care is delivered by the emergency departments of public hospitals, private hospitals that have signed an agreement with their Regional Health Agency, self-employed physicians who work for emergency services, and, more recently, public facilities financed by SHI and staffed by health professionals on a voluntary basis. Primary care physicians are not mandated to provide after-hours care.

Physicians are paid an hourly rate, regardless of the number of patients seen. Emergency services can be accessed via the national emergency phone number, which is staffed by trained professionals who determine the type of response needed. Feasibility of telephone or telemedicine advice is currently under assessment; it would include sharing information from the patient’s electronic medical record with the patient’s primary care doctor. Publicly funded multidisciplinary health centers with self-employed health professionals (physicians and nonphysicians) allow 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 institutions account for about two-thirds of hospital capacity and activity, private for-profit facilities account for another 25 percent, and private nonprofit facilities, the main providers of cancer treatment, make up the remainder (DREES Ministère de la Santé 2015). Since 2008, all hospitals and clinics are reimbursed via the diagnosis-related group (DRG) system, which applies to all inpatient and outpatient admissions and covers physicians' salaries. Bundled payment by episode of care does not exist.

Public hospitals are funded mainly by statutory health insurance (80%), with voluntary insurance and direct patient payment accounting for their remaining income. Public and private nonprofit hospitals also benefit from grants that compensate research and teaching (up to an additional 13% of the budget) as well as the provision of emergency services and 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 share of respective payers differs. Doctors' fees are billed in addition to the DRG in private clinics, and DRG payment rates are lower there than they are in public or nonprofit hospitals. This disparity is justified by differences in the size of facilities, the DRG mix, and the patients' characteristics (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 public and private health care sectors, with an emphasis on community-based provision. Public care is provided within geographically determined areas and includes a wide range of preventive, diagnostic, and therapeutic inpatient and outpatient services. Ambulatory centers provide primary ambulatory mental health care, including home visits.
Mental health care is not formally integrated with primary care, but a large number of disorders are also treated on an outpatient basis by GPs or private psychiatrists or psychologists, some of them practicing psychotherapy and, occasionally, psychoanalysis. Statutory health insurance covers care provided by GPs and psychiatrists in private practice, public mental health care dispensaries, and private psychiatric hospitals. Copayments do not apply to persons with a diagnosed long-term mental illness. Care provided by psychotherapists or psychoanalysts is fully financed by patients or covered by VHI. Copayments and the flat-rate fee for accommodation can also be fully covered by VHI.
Long-term care and social supports: Total expenditure for long-term care in 2013 was estimated to be EUR39 billion (USD47 billion), or 17 percent of total health expenditures (DREES 2014 Ministère de la Santé). Statutory health insurance covers the medical costs

of long-term care, while families are reponsible for the housing costs in hospices and other long-term facilities—on average, EUR1,500 (USD1,809) per month (Ministère de la Santé 2013, 2). End-of-life care in hospitals is fully covered. Some funding of care for the elderly and disabled comes from the National Solidarity Fund for Autonomy, which is in turn financed by SHI and the revenues from an unpaid working "solidarity" day. Local authorities, the general councils, and households also participate in financing these categories of care.

Home care for the elderly is provided mainly by self-employed physicians and nurses and, to a lesser extent, by community nursing services. 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 private nonprofit, and 18 percent for-profit, although the percentage of for-profit institutions is increasing (DREES Ministère de la Santé 2014).

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

Means-tested monetary allowances are provided for the frail elderly. The allowance is adjusted in relation to the 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.

What are the key entities for health system governance?

The Ministry of Health sets and implements 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 regulates a large part of health care expenditure on the basis of the overall framework established by parliament, which includes a shared responsibility with statutory health insurers for defining the benefit package, setting prices and provider fees (including diagnosis-related group fees and copayments), and pricing drugs. The parliamentary "Alert" Committee provides a midyear assessment of health care expenditures and proposes corrective measures in case expenditures exceed the target by more than 0.75 percent.

The French Health Products Safety Agency oversees the safety of health products, from manufacturing to marketing. The agency also coordinates vigilance activities relating to all relevant products.

The Agency for Information on Hospital Care manages the information systematically collected from all hospital admissions and used for hospital planning and financing. The remit of the National Agency for the Quality Assessment of Health and Social Care Organizations encompasses the promotion of patient rights and the development of preventive measures to avoid mistreatment, in particular in vulnerable populations such as the elderly and disabled, children, adolescents, and socially marginalized people. It produces practice guidelines for the health and social care sector and evaluates organizations and services.

The National Health Authority (HAS) is the main health technology assessment body, with in-house expertise as well as the authority to commission assessments from external groups. The HAS remit is diverse, ranging from the assessment of drugs, medical devices, and procedures to publication of guidelines, accreditation of health care organizations, and certification of doctors.

Competition is limited to VHI, whose providers are supervised by the Mutual Insurance Funds Control Authority.

What are the major strategies to ensure quality of care?

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

The National Health Authority publishes an evidence-based basic benefit package for 32 chronic conditions. Further guidance on recommended care pathways (Assurance Maladie 2014, 2) covers chronic obstructive pulmonary disease, heart failure, Parkinson's, and end-stage renal disease.

SHI and the Ministry of Health fund "provider networks" in which participating professionals share guidelines and protocols, agree on best practice, and have access to a common patient record. Regional authorities fund telemedicine pilot programs to improve care coordination and access to care for specific conditions (e.g., stroke) or populations (e.g., newborns, the elderly, prisoners). The PAERPA (Personnes Agées en Risque de Perte d'Autonomie) program, established in 2014 in nine pilot regions, is a nationwide endeavor to improve the quality of life and coordination of interventions for the frail elderly.

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

To ensure the lifelong quality of their practice, doctors, midwives, nurses, and other professionals must undergo continuous learning activities, which are audited every fourth or fifth year. Optional accreditation exists for a number of high-risk medical specialties (e.g., obstetrics and gynecology, surgery, cardiology). Accredited physicians can claim a deduction on their professional insurance premiums.

Hospitals must be accredited every four years; criteria and accreditation reports are publicly available on the National Health Authority website (www.has-sante.fr). CompaqH, a national program of performance indicators, 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. Currently, financial rewards or penalties are not linked to public reporting, although they remain a contested issue. Information on individual physicians is not available.

What is being done to reduce disparities?

There is a 6.3-year gap in life expectancy between males in the highest and males in the lowest social categories (DREES Ministère de la Santé 2015) and poorer self-reported health among those with state-sponsored or without any complementary insurance. The reduction of health inequities is a major national target, and the 2004 Public Health Act set targets for reducing inequities in access to care related to geographic availability of services (so far, only nurses have agreed to limit new practices in overserved areas), financial barriers (out-of-pocket payments will be limited by state-sponsored complementary insurance), and inequities in prevention related to obesity, screening, and immunization. A contractual agreement allows for the use of incentives for physicians practicing in underserved areas, the extension of third-party payment, and enforced limitations on denial of care.

National surveys showing regional variations in health and access to health are reported by the Ministry of Health (DREES Ministère de la Santé 2015).

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

Various quality-related initiatives aim to improve coordination of hospital, out-of-hospital, and social care (see above). At the regional level, telemedicine pilot programs are under way to coordinate health and social care services for target populations identified by the Regional Health Agencies, such as infants, prisoners, and persons with disabilities. Funding streams are pooled and earmarked for these pilots, and assessment is planned for 2016.

What is the status of electronic health records?

A high-level electronic health record (EHR) project is currently being implemented across the entire country. Approximately 551,000 patients, or 0.8 percent of the population, have an EHR, and an estimated 600 hospitals and 6,000 health professionals use them. Hospital-based and office-based professionals and patients have a unique electronic identifier, and any health professional can access the record and enter information subject to patient authorization. Interoperability is ensured via a chip on patients' health cards. By law, patients have full access to the information in their own records, either directly or through their GP. All "structured information" included in EHRs must be communicated, but handwritten notes are excluded. The sharing of information between health and social care professionals is not currently permitted, but will be tested as part of the PAERPA program for hospice residents.

A national agency for health information systems was created for the purpose of expanding uptake and interoperability of existing systems (ASIP 2014), and the health records are available on a government website.

How are costs contained?

SHI has faced large deficits over the past 20 years, but it fell from an annual EUR10–12 billion (USD12.1–14.5 billion) in 2003 to EUR6.2 billion (USD7.5 billion) in 2014. This trend is due to a range of initiatives, including a reduction in the number of acute-care hospital beds; the removal of 600 drugs from public reimbursement; an increase in generic prescribing and the use of over-the-counter drugs; a reduction in the price of generic drugs; and a reduction of the official fees for self-employed radiologists and biology labs.**Error! Bookmark not defined.** Other cost-containment measures include central purchasing to better negotiate costs, increasing the share of outpatient surgery, and reducing duplicate testing.**Error! Bookmark not defined.** Competition is not used as a cost-control mechanism. Global budgets are used only in price–volume agreements for drugs or devices. As described above, patient cost-sharing mechanisms include increased copayments for patients who refuse generics or do not use the gatekeeping system (Sénat 2013).

A number of initiatives to reduce “low-value” care, launched by SHI and HAS, include pay-for-performance to reduce prescription of benzodiazepines for elderly persons; reductions in avoidable hospital admissions for patients with heart failure; early discharge after orthopedic surgery and normal childbirth; information on the absence of the benefit of prostate cancer screening; using DRG payments to incentivize shifts to outpatient surgery; establishing guidelines for the number of off-work days according to disease or procedure; strengthening controls for the prescription of expensive statins and new anticoagulants; encouraging the use of Avastin over Lucentis, and other less costly biosimilar drugs; and testing the use of taxi vouchers, instead of ambulances, for chronically ill patients (Assurance Maladie 2015).

What major innovations and reforms have been introduced?

The new Health Law, based on the 2012 pledge by the newly elected government to reduce health inequities and on the 2014 health strategy (Touraine 2014), was passed in April 2015 to replace the previous law, dating back to 2004. It has 57 articles, the most prominent being the deployment of direct SHI payments to self-employed GPs and a strong commitment to public health and prevention. The direct GP payments have been strongly opposed by physicians’ unions on the grounds that such payments might be delayed by software dysfunction (versus immediate payment at the end of the consultation) and that physicians would become SHI “employees,” and could be pressured into giving cheap care instead of appropriate care. The timetable is to have a full deployment by 2017 (the year of the presidential election).

Prevention and public health measures aim to reduce addictions, eating disorders, and obesity, and include measures to fight binge drinking and anorexia. They support the mandatory neutral cigarette pack, the ban on soda fountains, experimentation with medically supervised IV drug injecting facilities, and mandatory nutrition information on packaged foods (Parlement 2015).

References

ASIP 2014.
http://www.interopsante.org/offres/doc_inline_src/412/4_FranE7ois%2BMacary_ASIP%2BSantE9_Les%2Btests%2Bd5C27interopE9rabilitE9%2Bpour%2Bla%2Be-santE9%2Ben%2BFrance.pdf?bcsi_scan_43167910db6ab4d9=0&bcsi_scan_filename=4_FranE7ois%2BMacary_ASIP%2BSantE9_Les%2Btests%2Bd5C27interopE9rabilitE9%2Bpour%2Bla%2Be-santE9%2Ben%2BFrance.pdf

Assurance Maladie 2105. Rapport charges et produits pour l'année 2016.
http://www.ameli.fr/fileadmin/user_upload/documents/cnamts_rapport_charges_produits_2016.pdf

CISS 2014. Exercice libéral des médecins.
http://www.leciss.org/sites/default/files/44-Exercice%20liberal%20medecine-fiche-CISS.pdf

Cour des Comptes 2013. Le médecin traitant et le parcours de soins coordonnés : une réforme inaboutie.
https://www.google.fr/url?url=https://www.ccomptes.fr/content/download/53083/1415030/version/2/file/2_1_3_medecin_traitant_parcours_soins_coordonnes.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CD0QFjAHahUKEwit3JHY4qXHAhXpK9sKHV1eByc&usg=AFQjCNHnPSaxT0EnmwuvCpwR37kbWQJlIw

Cour des Comptes 2014. Les relations conventionnelles entre l'assurance maladie et les professions libérales de santé.
http://www.ccomptes.fr/Actualites/Archives/Les-relations-conventionnelles-entre-l-assurance-maladie-et-les-professions-liberales-de-sante

DREES 2014 Ministère de la Santé. Comptes nationaux de la santé 2013.
http://www.drees.sante.gouv.fr/IMG/pdf/comptes_sante_2013_edition_2014.pdf

DREES Ministère de la Santé 2015. Les dépenses de santé en 2014.
http://www.drees.sante.gouv.fr/IMG/pdf/rapport_cns_2015_commission.pdf

Fonds CMU 2014. SIXIEME RAPPORT D'EVALUATION DE LA LOI DU 27 JUILLET 1999 PORTANT CREATION D'UNE COUVERTURE MALADIE UNIVERSELLE.
http://www.cmu.fr/fichier-utilisateur/fichiers/Rapport_Evaluation_VI.pdf

INSEE 2015. Médecins suivant le statut et la spécialité en 2015.
http://www.insee.fr/fr/themes/tableau.asp?reg_id=0&ref_id=NATTEF06102

INSEE 2015;2. Les revenus d’activité des médecins libéraux récemment installés : évolutions récentes et contrastes avec leurs aînés.
http://www.insee.fr/fr/ffc/docs_ffc/REVAIND15_c_D2_sante.pdf

Ministère de la Santé 2013 (1).
http://www.social-sante.gouv.fr/IMG/pdf/01_Rapport_activite_liberale_EPS-2.pdf

Ministère de la Santé 2013 (2)
http://www.social-sante.gouv.fr/IMG/pdf/rapport_final_annexes.pdf “employees,”

Organisation for Economic Co-operation and Development (2015). OECD.Stat. DOI: 10.1787/data-00285-en. Accessed July 2, 2015.

Parlement 2011. **Arrêté du 22 septembre 2011 portant approbation de la convention nationale des médecins généralistes et spécialistes.**
http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000024803740

Parlement 2015. La loi de santé. http://www.gouvernement.fr/action/la-loi-de-sante

Quotidien du Médecin 2015. Rémunération des maisons de santé.
http://www.lequotidiendumedecin.fr/actualites/article/2015/02/27/la-remuneration-des-maisons-centres-et-poles-de-sante-au-journal-officiel-_741936

Senat 2014. L'EXERCICE REGROUPÉ, UN NOUVEAU MODE D'ORGANISATION DE L'OFFRE DE SOINS.
http://www.senat.fr/rap/r07-014/r07-0142.html

Touraine, M. Health inequalities and France’s national health strategy. Lancet, 2014:1101 – 1102.

The German Health Care System, 2015

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What is the role of government?

Health insurance is mandatory for all citizens and permanent residents of Germany. It is provided by competing, not-for-profit, nongovernmental health insurance funds ("sickness funds"; there were 124 as of January 2015) in the statutory health insurance (SHI) system, or by substitutive private health insurance (PHI). States own most university hospitals, while municipalities play a role in public health activities, and own about half of hospital beds. However, 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, which together constitute the most important body, the Federal Joint Committee.

Who is covered and how is insurance financed?

Publicly financed health insurance: In 2013, total health expenditure was nearly 12 percent of GDP, of which 73 percent was public and 58 percent was SHI spending (Federal Statistical Office, 2015). General tax–financed federal spending on "insurance-extraneous" benefits provided by SHI (e.g., coverage for children) amounted to about 4.4 percent of total expenditure in 2014 and 2015. Sickness funds are funded by compulsory contributions levied as a percentage of gross wages up to a ceiling. Coverage is universal for all legal residents. All employed citizens (and other groups such as pensioners) earning less than EUR54,900 (USD69,760) per year as of 2015 are mandatorily covered by SHI, and their nonearning dependents are covered free of charge.[8] Individuals whose gross wages exceed the threshold and the previously SHI-insured self-employed can remain in the publicly financed scheme on a voluntary basis (and 75% do) or purchase substitutive PHI, which also covers civil servants. About 86 percent of the population receive their primary coverage through SHI and 11 percent through substitutive PHI. The remainder (e.g., soldiers and policemen) are covered under special programs. Visitors are

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[8] Please note that, throughout this profile, all figures in USD were converted from EUR at a rate of about EUR0.79 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Germany.

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.

As of 2015, the legally set uniform contribution rate is 14.6 percent of gross wages. Both the legal contribution rate for employees (0.9%) and the supplementary premiums set by sickness funds have been abolished and replaced by a supplementary income-dependent contribution rate determined by each sickness fund individually (Busse and Blümel, 2014). As of 2015, the supplementary contribution rate is, on average, 0.9 percent—that is, most of the SHI-insured pay the same as previously, but rates range between 0 percent and 1.3 percent (Federal Association of Sickness Funds, 2015).f

This contribution also covers dependents (nonearning spouses and children). Earnings above EUR49,500 (USD63,360) per year (as of 2015) are exempt from contribution. Sickness funds' contributions are centrally pooled and then reallocated to individual sickness funds using a risk-adjusted capitation formula, taking into account age, sex, and morbidity from 80 chronic and/or serious illnesses.

Private health insurance: In 2014, 8.8 million people were covered through substitutive private health insurance (Association of Private Health Insurance Companies, 2015). PHI is especially attractive for young people with a good income, as insurers may offer them contracts with more extensive ranges of services and lower premiums.

There were 42 substitutive PHI companies in June 2015 (of which 24 were for-profit) covering the two groups 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 of the PHI-insured pay a risk-related premium, with separate premiums for dependents; risk is assessed only upon entry, and contracts are based on lifetime underwriting. Government regulates PHI to ensure that the insured do not face large premium increases as they age and are not overburdened by premiums if their income decreases.

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). Federal government determines provider fees in substitutive, complementary, and supplementary PHI through a specific fee schedule. There are no government subsidies for complementary and supplementary PHI. In 2013, all forms of PHI accounted for 9.2 percent of total health expenditure (Federal Statistical Office, 2015).

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. Home care is covered by long-term care insurance (LTCI). SHI preventive services include regular dental checkups, child checkups, basic immunizations, checkups for chronic diseases, and cancer screening at certain ages. All prescription drugs are covered unless explicitly excluded by law (mainly so-called lifestyle drugs) or disallowed following evaluation. While the broader framework of the benefits package is legally defined, specifics are decided upon by the Federal Joint Committee (see below). Long-term care services are covered separately by the LTCI scheme (see below).

Cost-sharing and out-of-pocket spending: Out-of-pocket (OOP) spending accounted for 13.6 percent of total health spending in 2013, mostly on nursing homes, pharmaceuticals, and medical aids (Federal Statistical Office, 2015).

Copayments include EUR5.00 (USD6.40) to EUR10.00 (USD12.70) per outpatient prescription, EUR10.00 per inpatient day for hospital and rehabilitation stays (for the first 28 days per year), and EUR5.00 to EUR10.00 for prescribed medical devices. Sickness funds offer selectable tariffs 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 OOP.

Safety nets: Children under 18 years of age are exempt from cost-sharing. 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 0.4 million SHI insureds exceeded the 2 percent cap in 2013 and were exempted from further cost-sharing. The cap is lowered to 1 percent of annual gross income for qualifying chronically ill people; to qualify, those people have to demonstrate that they attended recommended counseling or screening procedures prior to becoming ill. Nearly 6.5 million people, or around 9 percent of all the SHI-insured, have benefited from this regulation in 2013 (Federal Statistical Office, 2015). Unemployed people contribute to SHI in proportion to their unemployment entitlements. For the long-term unemployed, government contributes on their behalf.

How is the delivery system organized and financed?

Physicians: General practitioners (GPs) and specialists in ambulatory care who get reimbursed by SHI are by law mandatory members of regional associations that negotiate contracts with 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 the physicians in ambulatory care. However, ambulatory physicians typically work in their own private practices—around 60 percent in solo practice and 25 percent in dual practices. Most physicians employ doctors' assistants, while other nonphysicians (e.g., physiotherapists) have their own premises. In 2014, of the roughly 109,600 self-employed SHI-accredited physicians in ambulatory care, 52,800 (48%) were practicing as family physicians (including GPs, internists, and pediatricians) and 56,800 (52%) as specialists. There were about 2,000 multispecialty clinics with more than 13,000 physicians (10% of ambulatory care physicians) in 2014. Around 11,000 physicians working in multispecialty clinics are salaried employees, while 12,000 are employed in practices of self-employed physicians. The total number of ambulatory care physicians is more than 130,000 (Federal Association of SHI Physicians, 2015). Some specialized outpatient care is provided by hospital specialists, including treatment of rare diseases and of severe progressive forms of disease, as well as highly specialized procedures.

Individuals have free choice among GPs, specialists, and, if referred to inpatient care, hospitals. Registration with a family physician is not required, and GPs 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 (GPs and specialists) are generally reimbursed on a fee-for-service (FFS) basis according to a uniform fee schedule negotiated between sickness funds and physicians (see below). Payments are limited to predefined maximum numbers 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. For the treatment of private patients, GPs and specialists also get an FFS, but the private tariffs are usually higher than the tariffs in the SHI uniform fee schedule. Pay-for-performance has not been established yet. The average reimbursement of a family physician is above EUR200,000 (USD254,000) per year, covering costs for personnel, etc., but excluding income from private patients, which varies substantially (Federal Association of SHI Physicians, 2015).

Financial incentives for care coordination can be part of integrated care contracts, but are not routinely implemented. The only regular financial incentive that GPs receive is a fixed annual bonus (EUR120, or USD152, in 2015) for patients enrolled in a Disease Management Program (DMP), in which physicians provide patient training and document patient data. Bundled payments are not common in primary care, but a regional initiative, “Healthy Kinzigtal” (Kinzigtal is a valley in southeast Germany), provides an example of a shared savings model offering primary care doctors and other providers financial incentives for integrating care among providers and services.

Administrative mechanisms for direct patient payments to providers: SHI physicians in ambulatory care bill their regional associations according to a uniform fee schedule; the associations are in turn reimbursed by sickness funds. Copayments or payments for services not included in the benefit catalogue are paid directly to the provider. In cases of private health insurance, patients pay up front and submit 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 in their practice, with differing regional regulations. In some areas (e.g., Berlin), after-hours care has been delegated to hospitals. The patient is given a report of the visit afterwards to hand to his or her GP. There is also a tight network of emergency care providers (the responsibility of the municipalities). After-hours care assistance is also available via a nationwide telephone hotline (*116 117-Ärztlicher Bereitschaftsdienst*). Payment for 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 (now around one-sixth of all beds). All hospitals are staffed principally by salaried doctors. Doctors in hospitals are typically not allowed to treat outpatients (similar to hospitalists in the U.S.), but exceptions are made if necessary care cannot be provided by office-based specialists. Senior doctors can treat privately insured patients on an FFS basis. Hospitals can also 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) revised annually, currently based on around 1,200 DRG categories. DRGs also cover all physician costs. Other payment systems like pay-for-performance or bundled payments have yet to be implemented in hospitals.

Mental health care: Acute psychiatric inpatient care is largely provided by psychiatric wards in general (acute) hospitals, while the number of hospitals providing care only for patients with psychiatric and/or neurological illness is low. In 2014, there were a total of 32,872 office-based psychiatrists, neurologists, and psychotherapists working in the ambulatory care sector (paid FFS) (Federal Association of SHI Physicians, 2015). Qualified GPs can provide basic psychosomatic services. Ambulatory psychiatrists are also coordinators of a set of SHI-financed benefits called “sociotherapeutic care” (which requires referral by a GP), 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.

Long-term care and social supports: LTCI is mandatory and usually provided by the same insurer as health insurance, and therefore comprises a similar public–private insurance mix. The contribution rate of 2.35 percent of gross salary is shared between employers and employees; people without children pay an additional 0.25 percent. The contribution rate will increase further by 0.2 percentage points in early 2017. Everybody with a physical or mental illness or disability (who has contributed for at least two years) can apply for benefits, which are: 1) dependent on an evaluation of individual care needs by the SHI Medical Review Board (leading either to a denial or to a grouping into currently 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 these 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. Since 2013, family caregivers get financial support through continuing payment of up to 50 percent of care payments if they provide care.

Hospice care is partly covered by LTCI if the SHI Medical Review Board has evaluated a care level. Medical services or palliative care in a hospice are covered by SHI. The number of inpatient facilities in hospice care has grown significantly over the last 15 years, to 200 hospices and 250 palliative care wards nationwide in 2014 (German Hospice and Palliative Association, 2015). Legislation has recently been discussed to improve hospice and palliative care with the aim of guaranteeing care in underserved rural areas and linking long-term care facilities more strongly to ambulatory palliative and hospice care.

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, federal government, and self-regulated organizations of payers and providers; and 2) the separation of SHI (including the social LTCI) and PHI (including the private LTCI). SHI and PHI (as well as the two long-term care insurance systems) use the same providers—that is, hospitals and physicians treat both statutorily and privately insured patients, unlike 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 (IQWiG), a foundation legally charged with evaluating the cost-effectiveness of drugs with added therapeutic benefits, and the newly formed Institute for Quality and Transparency (IQTiG). 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 in the committee. Representatives of patient organizations have the right to participate in different decision-making bodies, e.g., the subcommittees of the Federal Joint Committee.

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 DRG catalogue, which are then adopted by bilateral joint committees.

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. Structural quality is assured by the requirement that providers have a quality management system, by the stipulation that all physicians continue their medical education, and by health technology assessments for drugs and procedures. However, there is no revalidation requirement for physicians. Hospital accreditation is voluntary.

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. 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 are addressed through the mandatory quality reporting system for the roughly 2,000 acute-care hospitals. The recently passed Hospital Care Structure Reform Act will provide a focus on quality-related hospital accreditation and payment, beginning in 2016 (see section on reforms).

Disease management programs are modeled on evidence-based treatment recommendations, with mandatory documentation and quality assurance. Nonbinding clinical guidelines are produced by the Physicians’ Agency for Quality in Medicine and by professional societies.

All hospitals are required to publish results on selected indicators defined by the Federal Office for Quality Assurance and, until 2015, the AQUA Institute, allowing for hospital comparisons.

Many institutions and health service providers include complaint management systems as part of their quality management programs; in 2013, such systems 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.

To strengthen quality by law, in addition to the above, government commissioned the Federal Joint Committee in 2015 to establish the Institute for Quality and Transparency in Health Care, replacing the AQUA Institute. The institute will be operational from January 2016, with the task of developing further indicators for quality assurance, which might provide an additional criterion for decisions on 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, has conducted national patient surveys and published epidemiological, public health, and health care data. Disease registries for specific diseases, such as certain cancers, are usually organized regionally. In August 2013, as part of the National Cancer Plan, the federal government passed a bill that proposes the implementation of a nationwide standardized cancer registry in 2018 to improve the quality of cancer care.

What is being done to reduce disparities?

Strategies to reduce health disparities are delegated mainly to public health services, and the levels at which they are carried out differ between states. Health disparities are implicitly mentioned in the national health targets. A network of 53 health-related institutions (e.g., sickness funds and their associations) promotes the health of the socially deprived (Cooperative Alliance National Health Targets, 2015). 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 procedure and methods. Sickness funds support 22,000 health-related programs, e.g., in nurseries and schools (Federal Association of Sickness Funds, 2015). With the Act to Strengthen Health Promotion and Prevention, these programs will be further developed and financially supported (see below).

The Health Monitor (*Gesundheitsmonitor*) is a national association of nonprofit organizations and sickness funds. To assess access to health care, it regularly conducts studies from the patient perspective, for example, on the level of information, experiences with health care, or evaluation of health system reforms.

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

Many efforts to improve care coordination have been implemented, e.g., sickness funds offer integrated-care contracts and disease management programs for chronic illnesses to improve care for chronically ill patients and to improve coordination among providers in the ambulatory sector. In December 2014, 9,917 registered disease management programs for six indications had enrolled about 6.5 million patients (more than 8% of all the SHI-insured). There is no pooling of funding streams between the health and social care sectors.

From 2016, the Innovation Fund will promote new forms of cross-sectoral and integrated care (also for vulnerable groups) supported by annual funding of EUR300 million, or USD381 million (including EUR75 million, or USD95 million, for evaluation and health services research). Funds will be awarded through an application process overseen by an Innovation Committee based at the Federal Joint Committee.

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. The use of online services to transmit billing information and documentation from disease management programs is obligatory. Hospitals have implemented EHRs to varying degrees. Unique patient identifiers do not exist and interoperability is limited, as data safety concerns represent a significant obstacle.

As of 2015, electronic medical chip cards are used nationwide by all the SHI-insured; they encode information as to the person’s name, address, date of birth, and sickness fund, along with details of insurance coverage and the person's status regarding supplementary charges (Company for Telematics Applications for the Electronic Health Card, 2015). In 2015, the Federal Cabinet proposed a bill for secure digital communication and health care applications (E-Health Act), which provides concrete deadlines for implementing infrastructure and electronic applications, and introduces incentives and sanctions if schedules are not adhered to. SHI physicians will receive additional fees for transmitting electronic medical reports (2016–17), collecting and documenting emergency records (from 2018), and managing and reviewing basic insurance claims data online. From July 2018, SHI physicians who do not participate in the online review of the basic insurance claims data will receive reduced remuneration. Furthermore, in order to ensure greater safety in drug therapy, patients who use at least three prescribed drugs simultaneously will receive an individualized medication plan, starting in October 2016. In the medium term, this medication plan will be included in the electronic medical record (Federal Ministry of Health, 2015).

How are costs contained?

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. Drug companies are required to produce scientific dossiers for all new drugs demonstrating added medical benefit, which is then evaluated by IQWiG, followed by a Federal Joint Committee decision within a six-month period. For drugs with added benefit, the Federal Association of Sickness Funds negotiates a rebate on the manufacturer’s price that 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 on collective regional prescription caps for physicians has been replaced by an emphasis on quality and efficiency. The Hospital Care Structure Reform Act aims not only to link hospital payments to good service quality, but also to reduce payments in the case of “low value.”

To extend competition, some purchasing powers have been handed over to the sickness funds, e.g., to contract providers selectively within an integrated care contract or to negotiate rebates with pharmaceutical companies.

What major innovations and reforms have been introduced?

In June 2015, parliament passed the Act to Strengthen SHI Health Care Provision. This act is based on the 2011 SHI Care Structures Act, and takes measures to further strengthen service provision structures for SHI patients, particularly in underserved rural areas. These measures include a right for municipalities to establish medical treatment centers, a ban on transferring SHI-accredited practices to successors in overserved areas, the establishment of appointment service centers that would guarantee a specialist appointment within four weeks, and the promotion of innovative forms of care, especially through the establishment of an Innovation Fund at the Federal Joint Committee endowed with EUR300 million (USD381 million) annually from 2016 to 2019 (Health Systems and Policy Monitor, 2015).

The Act to Strengthen Health Promotion and Prevention passed parliament in July 2015. In an upcoming National Prevention Conference, the social security schemes, in collaboration with federal, state, and local governments, as well as the Federal Employment Agency, will agree on common goals and approaches. Furthermore, the act aims to improve prevention and health promotion by regulating vaccination policy and by expanding health checkups. Sickness funds and long-term care funds invest EUR500 million (USD635 million) annually, of which about EUR300 million is earmarked for health promotion in children’s day-care facilities, schools, the work environment, and long-term care facilities (Federal Ministry of Health, 2015).

The Hospital Care Structure Reform Act comes into force in January 2016. The law provides for the introduction of quality aspects in hospital planning (legally defined minimum volumes) and payment (quality-related supplements and reductions), as well as a more patient-friendly design for hospital reports. In order to strengthen nursing care of patients and to create new nursing jobs, a subsidy program will provide up to EUR660 million (USD839 million) in 2016–2018, and, starting in 2019, EUR330 million (USD419 million) per year. Hospital financing will be developed further and the reallocation pool will earmark EUR500 million to support measures to improve hospital care structures (Federal Ministry of Health, 2015).

Several other bills are pending in the legislative process, e.g., the E-Health Act (see section on EHR) and the Hospice and Palliative Care Act (see section on long-term care and social supports).

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References

Association of Private Health Insurance Companies (Verband der privaten Krankenversicherung) (2015). Zahlen und Fakten, https://www.pkv.de/service/zahlen-und-fakten/ (accessed Nov. 5, 2015).

Busse, R., Blümel, M. (2014). Germany: "Health system review." *Health Systems in Transition*, 2014, 16(2):1–296, http://www.euro.who.int/__data/assets/pdf_file/0008/255932/HiT-Germany.pdf?ua=1 (accessed July 22, 2015).

Company for Telematics Applications for the Electronic Health Card (Gesellschaft für Telematikanwendungen der Gesundheitskarte) (2015). Elektronische Gesundheitskarte, https://www.gematik.de (accessed Nov. 5, 2015).

Cooperative Alliance National Health Targets (Kooperationsverbund zur Weiterentwicklung nationaler Gesundheitszieleprozesse) (2015). gesundheitsziele.de, http://www.gesundheitsziele.de/ (accessed Nov. 5, 2015).

Federal Ministry of Health (Bundesministerium für Gesundheit) (2015). Gesetze und Verordnungen, http://bmg.bund.de/ (accessed July 22, 2015).

German Hospice and Palliative Association (Deutscher Hospiz und Palliativverband) (2015). Entwicklung stationärer Hospiz- und Palliativeinrichtungen, http://www.dhpv.de/service_zahlen-fakten.html (accessed Nov. 5, 2015).

Organisation for Economic Co-operation and Development (2015). OECD.Stat. DOI: 10.1787/data-00285-en (accessed July 2, 2015).

Federal Association of Sickness Funds (GKV Spitzenverband) (2015). Kennzahlen der gesetzlichen Krankenversicherung, http://www.gkv-spitzenverband.de (accessed July 22, 2015).

Federal Association of SHI Physicians (Kassenärztliche Bundesvereinigung) (2015). Statistische Informationen aus dem Bundesarztregister 2014, http://www.kbv.de (accessed July 22, 2015).

Federal Statistical Office (Statistisches Bundesamt) (2015). Gesundheitsberichterstattung des Bundes, http://www.gbe-bund.de (accessed July 22, 2015).

Health Systems and Policy Monitor (2015). Country page Germany, http://www.hspm.org/countries/germany28082014/countrypage.aspx (accessed July 22, 2015).

The Israeli Health Care System, 2015

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What is the role of government?

Government, through the Ministry of Health, is responsible for population health and the overall functioning of the health care system. It also owns and operates a large network of maternal and child health centers, about half of the nation’s acute care bed capacity, and about 80 percent of its psychiatric bed capacity (Rosen, Waitzberg and Merkur, forthcoming).

In 1995, Israel passed a national health insurance (NHI) law, which provides for universal coverage. In addition to financing insurance, government also provides financing for the public health service, active in areas such as control of communicable diseases, screening, health promotion and education, and environmental health, as well as various other services provided directly by the government. It is also actively involved in financial and quality regulation of key health system actors, including health plans, hospitals, health care professionals, and others.

Who is covered and how is the insurance financed?

In 2013, national health expenditures accounted for 7.6 percent of GDP, of which about 60 percent are publicly financed.

Publicly financed health insurance: Israel’s NHI system automatically covers all citizens and permanent residents. It is funded primarily through a combination of a special income-related health tax and general government revenues, which in turn are funded primarily through progressive income-related sources such as income tax.

Employers are required to enroll any foreign workers (whether documented or undocumented) in private insurance programs, whose range of benefits is similar to that of NHI. Private insurance is also available, on an optional basis, for tourists and business travelers.

Nevertheless, there are people living in Israel who do not have health insurance, including undocumented migrants who are not working. Several services are made available to all individuals irrespective of their legal or insured status. These include emergency care, preventive mother and child health services, and treatment of tuberculosis, HIV/AIDS, and other sexually transmitted infections.

Within the NHI framework, residents can choose among four competing, nonprofit health plans. Government distributes the NHI budget among the plans primarily through a capitation formula that takes into account sex, age, and geographic distribution. The health plans are then responsible for ensuring that their members have access to the NHI benefits package, as determined by government.

Private health insurance: Private voluntary health insurance (VHI) includes health plan VHI (HP-VHI), offered by each health plan to its members, and commercial VHI (C-VHI), offered by for-profit insurance companies to individuals or groups. In 2014, 87 percent of Israel's adult population had HP-VHI, and 53 percent had C-VHI (Brammli-Greenberg and Medina-Artom). C-VHI packages tend to be more comprehensive and more expensive than the HP-VHI packages. While C-VHI coverage is found among all population groups, coverage rates clearly are highly correlated with income.

Together, these two types of private VHI financed 14 percent of national health expenditures in 2012, a figure has been increasing steadily. The Ministry of Health regulates HP-VHI programs, while the Commissioner of Insurance, who is part of the Ministry of Finance, regulates C-VHI programs. The focus of C-VHI regulation is actuarial solvency, with secondary attention to consumer protection more generally; in HP-VHI regulation, there is more attention to equity considerations and potential impacts on the health care system (Brammli-Greenberg, Waitzberg and Gross, 2015).

Reasons for purchasing VHI include securing coverage of services not covered by NHI (e.g. dental care, certain life-saving medications, institutional long-term care, and treatments abroad), care in private hospitals, or a premium level of service for services covered by NHI (e.g., choice of surgeon and reduction of waiting times). VHI coverage is also purchased as a result of a general lack of confidence in the NHI system's capacity to fully fund and deliver all services needed in cases of severe illnesses.

What is covered?

The mandated benefits package includes hospital, primary, and specialty care, prescription drugs, certain preventive services, mental health care, dental care for children, and other services. Dental care for adults, optometry, and home care are generally excluded, although the National Insurance Institute does provide some funding for home care, dependent on need. Limited palliative and hospice services are included in the NHI benefits package as well (Bentur et al., 2012).

Israel has a well-developed system for prioritizing coverage of new technologies within an annual overall budget set by the Cabinet (Parliament members from the ruling parties) (Greenberg et al., 2009). Proposals for additions are solicited and received from pharmaceutical companies, medical specialty societies, and others. The Ministry of Health then assesses costs and benefits of the proposed additions, and a public commission combines the technical input with broader considerations to prepare a set of recommendations. These are usually adopted by the Minister of Health and subsequently by the Cabinet.

Cost-sharing and out-of-pocket spending: In 2012, out-of-pocket spending accounted for 26 percent of national health expenditures. Some of this was for services not included in the NHI benefits package, including dental care for adults, optical care, institutional long-term care (for those not eligible for means-tested assistance), certain medications, and medical equipment. The other major component was copayments for NHI services, such as pharmaceuticals, visits to specialists, and certain diagnostic tests. Dental care and pharmaceuticals are the two largest out-of-pocket components.

There are no copayments for primary care visits or for hospital admissions. There are also no quarterly or annual deductibles with NHI coverage. Within the NHI system, physicians are not allowed to balance-bill.

Safety net: There are a variety of safety-net mechanisms in place. For pharmaceuticals there is a quarterly ceiling for the chronically ill, and discounts for the elderly based on age, income, and health status. Holocaust survivors are exempt from copayments for pharmaceuticals. With regard to specialist visits, there are exemptions for elderly welfare recipients, children receiving disability payments, and people afflicted with certain severe diseases. There is a quarterly ceiling on total copayments for these visits at the household level, which is 50 percent lower for elderly people. In addition, people earning less than 60 percent of average wages pay a reduced health tax of 3 percent of income, instead of 5 percent.

How is the delivery system organized and how are providers paid?

Primary care: Nearly all Israeli primary care physicians (referred to as general practitioners (GPs) in this profile, although they also include board-certified family physicians) provide care through only one of the four competing nonprofit health plans, which vary markedly in how they organize care.

In Clalit, the largest health plan, most primary care is provided in clinics owned and operated by the plan, and GPs are salaried employees. The typical clinic has three to six GPs, several nurses, pharmacists, and other professionals. Clalit also contracts with independent physicians; although these doctors tend to work in solo practices with limited on-site support from nonphysicians, they have access to various administrative and nursing services at Clalit district clinics.

The other three health plans also use of a mix of clinics and independent physicians in primary care, with the mix varying across plans. In Maccabi (the second-largest plan) and Meuhedet, almost all of the primary care is provided by independent physicians, while in Leumit the clinic model predominates (though not to the same extent as in Clalit).

Members of all plans can generally choose their GP from among those on the plan's list and can switch freely. In practice, nearly all patients remain with the same GP for extended periods.

In Clalit, each patient is registered with a GP who has responsibility for coordinating care and acts as gatekeeper, except for access to five common specialties. In Leumit, patients are registered with a clinic rather than a GP, while there is no registration in the other two plans. However, in all plans there is movement under way to associate each member with a physician for purposes of quality assurance and accountability. Clalit is the only plan with referral requirements to secondary care.

Independent physicians in all plans are paid on a capitation basis, with Clalit and Leumit using "passive capitation" (a quarterly, per member payment made irrespective of whether the member visited the GP in the relevant quarter) and Maccabi and Meuhedet using "active capitation" (where the payment is made only for members who visited their GP at least once during the quarter). Independent physicians also receive limited fee-for-service payments for certain procedures.

Plans monitor the care provided by their GPs and work closely with them to improve quality (Rosen et al., 2011). However, quality-related financial incentives are generally not used.

The salaries of Clalit clinic physicians are set via a collective bargaining agreement with the Israel Medical Association. The capitation rates of independent physicians, in all the health plans, are set by the plans in consultation with their physicians' associations.

It is estimated that of Israel's 24,000 physicians employed in 2011, approximately 7,000 worked with or for the health plans as GPs.

Outpatient specialty care: Outpatient specialty care is provided predominantly in community settings, either health plan clinics (the dominant mode in Clalit) or physician's offices (the dominant mode in the other health plans). The former tend to be integrated multispecialty clinics, while the latter tend to be single-specialty. Most specialists are paid on an active capitation basis, plus fee-for-service for certain procedures. Rates are set by the health plans and, within the NHI system, specialists may not balance-bill; patients pay the quarterly copayment only. Patients can choose from a list of specialists provided by their health plans. Specialists who work for the plans may also see private patients.

Administrative mechanisms for direct patient payments to providers: As noted above, the only direct payments to NHI providers are copayments. Patients can usually use their health plan membership cards instead of making cash payments; the provider receives the full fee from the health plans, which then collect the copayments from enrollees.

After-hours care: After-hours care is available via hospital emergency departments (EDs), freestanding walk-in "emergi-centers," and companies that provide physician home visits. Physicians providing care in EDs and emergi-centers come from a range of disciplines, including primary care, internal medicine, general surgery, orthopedics and, increasingly, emergency medicine. Nurses play a significant role in triage. They are typically salaried, while physicians working for home-visit companies are typically paid per visit.

Primary care physicians are not required to provide after-hours care. They receive reports from the after-hours providers, and increasingly this information is conveyed electronically.

All the health plans operate national telephone advice lines for their members, which are nurse-staffed with physician backup.

Hospitals: Acute-care bed capacity is divided approximately as follows: government, 50 percent; Clalit, 30 percent; other nonprofits, 15 percent; for-profits, 5 percent (Haklai, et al., 2014). However, the for-profits account for a much larger share of admissions and an even large share of surgical operations (Brammli-Greenberg and Artom, 2015).

Hospital outpatient care is reimbursed on a fee-for-service basis, and inpatient care is reimbursed using a mix of per diem and DRG arrangements, with approximately two-thirds of revenue coming from per diem payments (Brammli-Greenberg et al., forthcoming). Maximum rates are set by government, but health plans negotiate discounts. There are also revenue caps set by government, which limit the extent to which each hospital’s total revenues can grow from year to year. Generally speaking, hospitals payments include the cost of the physicians working for the hospitals.

In government and nonprofit hospitals, physicians are predominantly salaried employees, with limited arrangements for supplemental fee-for-service in some hospitals. Fee-for-service is the predominant payment mode in private hospitals.

Mental health care: Responsibility for the provision of mental health care was transferred in mid-2015 from the Ministry of Health to the health plans, which provide care through a mix of salaried professionals, contracted independent professionals, and services purchased from organizations (including the Ministry’s mental health clinics). The benefits package is broad and includes psychotherapy, medications, and inpatient and outpatient care. Integration with primary care is currently limited, but this is expected to improve because of the transfer of responsibility to the health plans.

Long-term care and social supports: Financing of institutional long-term care is considered a responsibility of patients and their families, to the extent that they can afford it. An extensive system of needs-based, graduated subsidies is available from the Ministry of Health. These are generally paid directly to providers, although recently a change was made to the law to make it easier for families to receive cash subsides to use in paying providers.

The health plans are responsible for medical care of the disabled elderly living in the community. In recent years, they have increased access to clinicians (particularly for the homebound) via home-care teams and telemedicine.

The National Insurance Institute finances personal care and housekeeping services for community-dwelling disabled elderly (Asiskovitch, 2013). Additional supports include an extensive network of day-care centers and a growing network of supportive neighborhoods.

For nursing homes, home medical care, and home aids, eligibility is based on inability to carry out activities of daily living. In addition, there are means tests for government assistance for nursing home and home aids, but not for medical home care provided by the health plans, or for any services provided through private insurance.

Private, for-profit) providers deliver about two-thirds of nursing home care, virtually no medical home care (which is delivered by the private, nonprofit health plans), and nearly all home aids.

Although the government maintains that hospice care is included in the NHI benefits package that the health plans are supposed to provide, the plans dispute this. Some hospice care is available (particularly home hospice), though much less than is needed Approximately half of the adult population has private long-term care insurance. There is no direct financial support for informal or family caregivers.

What are the key entities for health system governance?

Parliament (the Knesset) adopts and amends legislation related to the health system. The Cabinet, comprising a selection of Knesset members from the ruling parties, has executive responsibility for the government as a whole, including the Ministry of Health (MoH). The MoH has overall responsibility for population health and the effective functioning of the health care system. It includes:

- The Minister, an elected member of the Knesset and typically also a member of the Cabinet. The Minister has full authority and responsibility for the functioning of the MoH.
- The Director-General, the MoH's top professional, who is appointed by the Minister to run the operationas of the MoH.
- A large number of departments, including those responsible for quality and safety, assessing cost-effectiveness, fee-setting, public information, and health IT.
- Various advisory bodies, including the National Health Council, a public advisory; the benefits package committee, which advises on prioritization of new technologies for inclusion in the NHI benefits package; and national councils in such areas as trauma care, mental health, and women's health.

The Ministry of Health has an ombudsman's office to help citizens realize their rights under the NHI law. In addition, there are various nongovernmental patient advocacy organizations, many of which focus on particular diseases.

The Budget Division of the Ministry of Finance prepares budgets of all ministries, including the MoH, for consideration by the Cabinet and then the Knesset. It also plays a major role in promoting and shaping major structural reforms to the health system and partners with the MoH on interministerial committees, such as those that set maximum hospital prices and the capitation formula. The Ministry of Finance Insurance and Capital Markets Division regulates commercial health insurers. The government also has an antitrust unit responsible for promoting competition, but it is not very active in the health area.

The Scientific Council of the Israel Medical Association is responsible for the specialty certification programs and examinations, in coordination with the MoH. The Council for Higher Education is responsible for the authorization, certification, and funding of all university degree programs, including those for training health care professionals.

What are the major strategies to ensure quality of care?

For over a decade, Israel has had a well-developed system for monitoring the quality of primary care. Comparative quality data for individual health plans has been made public since 2014 (Jaffe, 2012). While the published data relate to the health plans as a whole, the plans have internal data by region, clinic, and individual physician. The plans and their clinicians have made intensive use of this data to bring about substantial improvements in quality (Rosen et al., 2011; Balicer et al., 2015).

The MoH publishes comparative data on the quality of hospital care. This system is much newer than the system for primary care quality and is currently limited to a handful of indicators. However, it is expected to develop rapidly over the coming years.

The MoH is in the process of launching a national initiative to reduce waiting times for surgical procedures, and there are several initiatives focused on particular diseases, such as dementia. The health plans are increasingly active in implementing programs for the chronically ill, including disease management.

Hospitals and clinics require a license from the MoH, granted only when basic quality standards are met. Hospitals are also increasingly seeking, and securing, accreditation from Joint Commission International.

There are biannual surveys of the general population regarding the service level provided by the health plans. The MoH recently launched an annual survey of hospitalized patients. Results are published by institution.

There are currently no explicit financial incentives for hospitals and health plans to improve quality. However, due to the competitive environment, public dissemination of quality data may be providing an indirect incentive. Consideration is being given to introducing pay-for-performance incentives in the years ahead.

National registries are maintained by the MoH for certain expensive medical devices and for a broad range of diseases and conditions, including: cancer, low birth weight, trauma, and occupational diseases.

To receive a medical license from the MoH, persons who studied in an Israeli medical school must also successfully complete a one-year internship. Those who studied abroad are usually also required to pass an examination. Specialty recognition requires specialty training in an accredited program and passing an exam. The there are no re-licensure exams for physicians.

What is being done to reduce disparities?

The MoH is leading a major national effort to reduce disparities, in cooperation with the health plans and hospitals. Key initiatives include:

- Reducing financial barriers to care, particularly for low-income persons and other vulnerable populations: mental health care and dental care for children has been added to the NHI benefits package, thereby reducing the substantial financial barriers that existed when these services were provided privately (Rosen, 2012).
- Enhancing the availability of services and professionals in peripheral regions, by increasing the supply of beds and advanced equipment in the periphery and providing financial incentives for physicians to work in the periphery.
- Addressing the unique needs of cultural and linguistic minorities, through adoption of cultural responsiveness requirements for all providers, establishment of a national translation call center, and targeted interventions for the Bedouin and other high-risk groups.
- Intersectoral efforts to address the social determinants of health and promote healthy lifestyles.
- Creation, analysis, and public dissemination of information about health care disparities, including periodic reporting of variations in health and health care access.

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

The health plans, which are both insurers and providers, are essentially the sole source of primary care and the main source of specialty care. This structural integration of services provides the foundation for provision of seamless care for all the insured, including complex and chronically ill patients. The plans’ health information systems link primary and specialty care providers, and a new national health information exchange is linking the health plans and the hospitals. Increasingly these provide access to electronic medical information at the point of care.

In addition, the health plans have put forth several targeted management programs that aim to provide comprehensive integrated care for complex patients with chronic conditions. These make extensive use of the plans' sophisticated information systems, videoconferencing, and other innovative techniques (Intel, 2015).

Generally speaking, integration is still limited among the various components of the long-term care system and between long-term care and other components of the health care system. However, this may change in the future if long-term care becomes a responsibility of the health plans (see below).

What is the status of electronic health records?

All health plans have electronic health record (EHR) systems that link all community-based providers—primary care physicians, specialists, laboratories, and pharmacies. All GPs work with an EHR. Hospitals are also computerized but are not fully integrated with health plan EHRs. The MoH leads a major national health information exchange project to create a system for sharing relevant information across all hospitals and health plans.

Each citizen has a unique identification number, which functions as a unique patient ID. Patients have the right to get copies of their medical records from hospitals and health plans can access some components of their EHR online, but the full records are not generally available. Efforts are under way to set up secure messaging systems linking patients and their GPs.

How are costs contained?

Israel is one of the most successful high-income countries in containing costs, with health expenditures remaining below 8 percent of GDP. Strategies include:

- Channeling the bulk of funding through a single, tightly controlled, government source
- Maintaining tight controls on key supply factors, such as hospital beds and expensive medical equipment
- Requiring the health plans—which function as the building blocks of the health system—to provide care competitively, within budgets that are largely determined prospectively
- Maintaining a well-developed system of community-based services, which reduces reliance on high-cost hospital care
- Using electronic health records effectively, particularly in the community
- Purchasing pharmaceuticals in bulk and relying heavily on generics

- Setting maximum hospital reimbursement rates (government), negotiating discounts (health plans), and instituting hospital global revenue caps
- Explicitly prioritizing public funding for new technologies included in the NHI benefits package
- Aligning organizational and financial incentives between clinicians and the hospitals or health plans for whom they work (see below).

Although clinicians are rarely given explicit financial incentives to contain costs, reliance on salary and capitation (rather than fee-for-service) may reduce incentives to over-treat. Moreover, the health plans have various internal processes to discourage care that provides poor value.

Of recent concern to some experts, however, is the recent growth of private medical care and private financing, which is seen as potentially jeopardizing Israel's success in containing cost growth.

What major innovations and reforms have been introduced?

Mental health: In July 2015, mental health care was added to the set of services that the health plans must provide within the NHI framework, making access a legally guaranteed right rather than a government-supplied service whose availability is subject to budget constraints. Because of this new mandatory package of mental health services, government funding for health plans has been increased substantially to cover the additional costs. The main objectives of the reform are to improve the linkage between physical and mental care, increase the availability of mental health services, and increase efficiency. An external evaluation will ascertain the extent to which the objectives are achieved and whether various concerns are realized (Rosen et al., 2008).

Comparative data on hospital performance: In 2015, the MoH began publishing comparative data on hospital quality, and there are plans to rapidly expand the indicator set in the years ahead. In 2014, the Ministry published the results of a nationwide survey of hospitalized patients regarding their care experience. It is also assembling a database of waiting times for surgical operations, with the intention of publishing comparative data in 2016. The objectives of all these efforts are to provide hospitals with information to help identify problem areas, enhance consumer choice of hospitals, and provide hospitals with incentives to improve performance.

Reducing surgical waiting times: Long waiting times are perceived as one of the major causes of the recent growth in private financing and care provision. Motivated by a desire to improve public confidence in the publicly financed health care system as well as quality of care, the MoH is planning a major initiative to reduce surgical waiting times. This will involve additional funding to expand hours of operation for surgical theaters as well as a series of organizational changes to improve efficiency.

Improving service levels in hospital EDs: As part of a broader effort to improve patient-centered care and service levels, the MoH is launching a major effort to reduce waiting times between patient arrival and the first contact with a health care professional. Strategies are to include enhanced physician, nurse, and physician assistant staffing, as well as engaging operations management experts to improve workflow.

Long-term care insurance: Israel's long-term care system is seriously fragmented, with service gaps, duplication of care, inefficient incentives, and inadequate investment in prevention and rehabilitation. The government is working on a plan to add institutional long-term care to the set of NHI benefits for which the health plans are responsible, with the plans also serving as the budget holders for institutional LTC.

This profile draws heavily on the forthcoming Healthcare in Transition—Israel, *by Bruce Rosen, Ruth Waitzberg and Sherry Merkur, which is due to be published in early 2016 by the European Observatory on Health Systems and Policies. The profile also benefited from valuable input from Martin Wenzl of the London School of Economics and Political Science.*

References

Asiskovitch S. The Long-Term Care Insurance Program in Israel: solidarity with the elderly in a changing society. Israel Journal of Health Policy Research 2013, 2:3 (23 January 2013)

Balicer RD et al. (2015). Sustained reduction in health disparities achieved through targeted quality improvement: one-year follow-up on a three-year intervention. Health Services Research.

Bentur N, Emanuel LL, Cherney N. Progress in palliative care in Israel: comparative mapping and next steps. Israel Journal of Health Policy Research 2012, 1:9 (20 February 2012)

Brammli-Greenberg S, Medina-Artom T (2015). Public opinion on the level of service and performance of the healthcare system in 2014. Jerusalem, Myers-JDC-Brookdale Institute. (Hebrew).

Brammli-Greenberg S, Waitzberg R, Perman V, Gamzu, R. (forthcoming). How Israel reimburses hospitals based on activity: the procedure-related group (PRG) incremental reform. OECD Publishing.

Brammli-Greenberg S, Waitzberg R, Gross R (2015). Integrating private insurance into the Israeli health system: an attempt to reconcile conflicting values". In: Thomson S, E Mossialos E, eds. Private health insurance and medical savings accounts: history, politics, performance. Cambridge, Cambridge University Press.

Greenberg D, Siebzehner MI, Pliskin JS: The process of updating the National List of Health Services in Israel: Is it legitimate? Is it fair? Int J Technol Assess 2009, 25:255-261.

Haklai Z (2014). Inpatient institutions and day care units in Israel – 2013. Jerusalem, Ministry of Health. (Hebrew)

Intel (2015). Improving Health Outcomes and Reducing Costs with Video Conferencing Technology.

Jaffe DH et al. (2012). Community healthcare in Israel: quality indicators 2007–2009. Israel Journal of Health Policy Research 1(1):3.

Rosen B et al. (2008) The Israeli Mental Health Insurance Reform. J Ment Health Policy Econ 11, 201-208.

Rosen B et al. (2011). What the United States could learn from Israel about improving the quality of health care. Health Affairs 30(4):764–772.

Rosen B, Waitzbeg R, Merkur S (forthcoming). Israel: Health system review. Health Systems in Transition.

Rosen B (2012). Inclusion of dental care for children in NHI. Health Systems and Policies Platform. http://www.hspm.org/countries/israel25062012/country5page.aspx

The Japanese Health Care System, 2015

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What is the role of government?

Government regulates nearly all aspects of the universal public health insurance system (PHIS). The national and local governments are required by law to ensure a system that efficiently provides good-quality and well-suited medical care to the nation. National government sets the fee schedule and gives subsidies to local governments, insurers, and providers. It also establishes and enforces detailed regulations for insurers and providers. Japan's 47 prefectures (regions) implement those regulations and develop regional health care delivery with funds allocated by the national government. More than 1,700 municipalities operate components of the PHIS and long-term care insurance and organize health promotion activities for their residents (Tatara and Okamoto, 2009).

Who is covered and how is insurance financed?

Publicly financed health insurance: The PHIS, comprising more than 3,400 insurers, provides universal primary coverage (National Institute of Population and Social Security Research, 2014). In 2013, estimated total health expenditure amounted to approximately 10 percent of GDP, 83 percent of which was publicly financed, mainly through the PHIS (OECD, 2015). Within the PHIS, premiums, tax-financed subsidies, and user charges accounted for about 49 percent, 38 percent, and 12 percent of the sum of health expenditures, respectively (MHLW, 2014b).

Citizens are mandated to enroll in one of the PHIS plans based on employment status and/or place of residence, as are resident noncitizens; undocumented immigrants and visitors are not covered. Insurance premiums and the basis upon which they are charged vary between types of insurance funds and municipalities. Government employees are covered by their own insurers (known as Mutual Aid Societies), as are some groups of professionals (e.g., doctors in private practice). Those who fail to keep up their enrollment must pay up to two years' worth of premiums when they reenter the system. Means-tested public assistance covers health care for its recipients. Citizens and resident noncitizens enrolled in the PHIS age 40 and over are mandatorily enrolled in long-term care insurance.

Private health insurance: Private health insurance developed historically as a supplement to life insurance and generally has minor supplementary and complementary roles only. It provides additional income in case of sickness, mainly in the form of lump-sum payments when insured persons are hospitalized or diagnosed with cancer or another specified chronic disease, or through payment of daily amounts during hospitalization over a defined period (Japan Institute of Life Insurance, 2013; Life Insurance Association of Japan, 2014). Part of an individual's life insurance premium (up to JPY40,000, or USD380) can be deducted from taxable income. Small discounts can be applied to those employees whose employers have collective contracts with insurance companies. Both for-profit and nonprofit organizations operate private health insurance.

Since the early 2000s, insurance companies have been permitted to sell more diverse policies, which has increased the number of complementary policies sold separately from life insurance. Today, the majority of the population holds some form of medical insurance policy (Life Insurance Association of Japan, 2014).

The provision of privately funded health care has been limited to services such as dental orthodontics, expensive artificial teeth, and treatment of traffic accident injuries (although treatment of these injuries is usually paid for by compulsory or voluntary automobile insurance.)

What is covered?

Services: All PHIS plans provide the same benefits package, which is determined by the national government, usually following a decision by the Central Social Insurance Medical Council, a governmental body. The package covers hospital, primary, and specialist ambulatory and mental health care, approved prescription drugs, home care services by medical institutions, hospice care, physiotherapy, and most dental care. It does not cover corrective lenses unless recommended by physicians for children under age 9, or optometry services provided by nonphysicians. Home care services by nonmedical institutions are covered by long-term care insurance. Preventive measures, including screening, health education, and counseling, are covered by health insurance plans, while cancer screenings are delivered by municipalities.

Cost-sharing and out-of-pocket spending: All enrollees have to pay a 30 percent coinsurance rate for services and goods received, except for children under age 3 (20%), adults between 70 and 74 with lower incomes (20%), and those 75 and over with lower incomes (10%). There are no deductibles. Annual expenditures on health services and goods, including copayments and payments for balance billing and over-the-counter drugs, between JPY100,000 (USD 950) and JPY2 million (USD19,000) can be deducted from taxable income.[9] In 2012, out-of-pocket payments for cost-sharing accounted for 14 percent of total health expenditures (OECD, 2015). 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—for example, JPY80,100 (USD761) for people under age 70 with an average income; above this threshold, 1 percent coinsurance applies. There is a ceiling for low-income people, who do not pay more than JPY35,400 (USD336) 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 household health and long-term care out-of-pocket payments ceiling, which varies between JPY340,000 (USD3,230) and JPY1.26 million (USD11,970) per enrollee according to income and age, above which such payments can be reimbursed. Enrollees with employer-based insurance who are on parental leave are exempt from payment of premiums. Enrollees in Citizens Health Insurance (for the unemployed, self-employed, and retired, and those others under 75) with low income and those with moderate income who face sharp, unexpected income reductions are eligible for reduced premium payments. Reduced coinsurance rates apply to patients with 306 designated long-term diseases, varying by income, when using designated health care providers.

How is the delivery system organized and financed?

Primary care: Primary care is provided at most clinics and some hospital outpatient departments. Primary care and specialist care are not regarded as distinct disciplines, although it has been argued that they should be. 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, that own hospitals as well as clinics), but sometimes by local governments or public agencies.

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.[10] Clinics can dispense medication (which doctors

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[9] All figures in USD were converted from JPY at a rate of about JPY105 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015b).

[10] The figures are calculated from statistics of the Ministry of Health, Labor and Welfare (2012a).

can provide directly to patients). Use of pharmacists, however, has been growing; 67 percent of prescriptions were filled at pharmacies in 2013 (Japan Pharmaceutical Association, 2014). Patients are not required to register with a practice, and there is no strict gatekeeping, although government encourages patients to choose their family doctors, and there are patient disincentives for self-referral including extra charges for initial consultations at some large hospitals with many specialties. Patients can choose and drop in at any clinic, except those requiring reservations. An entity managing many clinics can share their resources, but there is no cross-entity resource sharing.

Payments for primary care are based principally 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. The schedule, set by the government (explained below), includes both primary and specialist services, which have common prices for defined services such as consultations, examinations, laboratory tests, imaging tests, and defined chronic disease management. Per-case payments can be chosen by providers in select cases, such as daily payments for pediatrics care and monthly payments for treating patients with diabetes. Bundled payments are not used. Balance billing is prohibited in principle.

Outpatient specialist care: Most outpatient specialist care is provided in hospital outpatient departments, but some is also available at clinics, where patients can visit without referral. Fees are determined by the same schedule that applies to primary care, as they do not usually vary by provider type, although some services must be provided by specialists in order to be covered by the PHIS. There are no collective regulations on payments for specialists. At hospitals, specialists are usually salaried, with additional payments such as night duty allowance. Those working at public hospitals can work at other health care institutions and privately with the approval of their hospitals, but in such cases they usually provide services covered by the public system. The employment status of specialists at clinics varies similarly to that of primary care physicians.

Administrative mechanisms for paying primary care doctors and specialists: There are no direct payments to primary care doctors and specialists in the PHIS. Although in principle patients are liable for copayments at point of service, practically all fee transactions are mediated by statutory bodies. Self-employed clinic-based primary care physicians and specialists receive all payments for services through the fee schedule, pay for employees and other inputs, allocate funds for investments, and retain surpluses. Legal entities managing clinics and hospitals send insurance claims, mostly online, to insurers in the PHIS.

After-hours care: After-hours care is provided by hospital outpatient departments, where on-call physicians are available, and by some regular clinics and after-hours care clinics owned by local governments and staffed by physicians and nurses that local medical societies provide. Hospitals and clinics are paid "top-up" fees for after-hours care, including fees for telephone consultations. There is no strict formal requirement for clinics to provide such services, although physicians have a general obligation to consult with patients when requested. Patients can walk in at hospitals and clinics. National government grants subsidies to local governments for these clinics. Patient information from after-hours clinics is provided to family physicians if necessary (necessary information is often handed to patients to show to family physicians). There is a national pediatric medical advice telephone line available after hours.

Hospitals: As of 2013, 14 percent of hospitals are owned by national or local governments or closely related agencies (MHLW, 2014c); most of the rest are private and not-for-profit, some of which receive subsidies because they are designated as having partly public roles. More than 20 percent of beds are in public hospitals; the rest are in not-for-profit hospitals. The entry of private for-profit companies in the hospital sector is now prohibited, while existing hospitals established by for-profit companies for their employees (e.g., Toyota) are allowed to continue. Payments to hospitals from the PHIS include costs for physicians' salaries.

Consultation fees for large hospitals and academic medical centers are lower than those for small hospitals and clinics. More than half of all acute-care hospital beds are paid for by the Diagnosis Procedure Combination (DPC) modification, a case-mix classification similar to diagnosis-related groups (DRGs) (Matsuda, et. al., 2008), and the rest are paid for solely on a fee-for-service basis. Hospitals choose whether to receive the DPC payments or to remain under fee-for-service. The DPC payment consists of a fee-for-service and a DPC component in the form of a per diem payment determined by the DPC grouping, 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). DPC rates are multiplied by a hospital-specific coefficient that keeps them relatively in line with fee-for-service payments; it may also limit incentives for providers to contain cost, although the correlation has not yet been formally evaluated. Episode-based payments are not used.

Mental health care: Mental health care is provided in outpatient, inpatient, and home care settings, with patients charged the standard 30 percent coinsurance (although there is reduced cost-sharing and other financial protections for those recently discharged from psychiatric institutions). Covered services include psychological tests and therapies, pharmaceuticals, and rehabilitative activities. Specialized mental clinics and hospitals exist, but services for depression, dementia, and other common conditions are integrated with primary care. Most psychiatric beds are in private hospitals owned by medical corporations (MHLW, 2014c).

Long-term care and social supports: National compulsory long-term care insurance (LTCI), administered by the municipalities, covers those age 65 and older and some disabled people ages 40 to 64. It covers home care, respite care, domiciliary care, disability equipment, assistive devices, and home modification. Medical services are covered by the PHIS, as are palliative care and hospice care in hospitals and medical services provided in home palliative care, while nursing services are covered by LTCI. Long-term home care services can be considered a part of home hospice services as dying patients become eligible.

Roughly half of long-term care financing comes through taxation and half through premiums. Citizens age 40 and over pay income-related premiums along with PHIS premiums. Employers pay the same premium as that of their employees. Premiums for those age 65 and older, also income-based (including pensions), and set by municipalities based on estimated expenditures, are paid only by the beneficiaries. A 10 percent coinsurance rate applies to all covered services, up to an income-related ceiling. There is 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).

Eligible people are entitled to use long-term services up to needs-based ceilings (called "care levels") set by local LTCI boards, according to assessment of physical and mental conditions. People are not allowed to buy unlisted services or services from non-LTCI providers with the budget provided, but they can purchase such services with their own money. Care management—covered by LTCI and offered by public, not-for-profit, and for-profit providers—is available to help people arrange long-term care services.

The majority of home care providers are private; 64 percent were for-profit, 35 percent not-for-profit, and 0.4 percent public in 2013 (MHLW, 2014a). While for-profits are not allowed to provide institutional care under LTCI, there are private nursing homes for which residents pay full costs (MHLW, 2013).

Family care leave benefits (part of employment insurance) are paid for up to three months when employees take leave to care for their families. Additionally, more than half of the municipalities have established marginal financial supports, mostly limited to those with lower incomes, with their own financial capacities and legislations (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, safety, and cost control, and sets guidelines for determining provider fees. Within the Ministry, the Central Social Insurance Medical Council defines the benefit package and fee schedule. National government and prefectures devise cost-control plans (described below).

The Japan Council for Quality Health Care, a nonprofit organization, works to improve quality throughout the health system and develops 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 governmental regulatory agency. It also sets the Public Health Insurance Drug Price List, which is a list of pharmaceuticals and their prices covered by the PHIS (English Regulatory Information Task Force: Japan Pharmaceutical Manufacturers Association 2012). The criteria for coverage include clinical effectiveness but not economic appraisal. Since 2012, the agency has been discussing the possible application of comparative cost-effectiveness studies in its decision-making (described below).

Nonprofit organizations work toward 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, an independent governmental administrative commission, promotes fair competition in health care as well as other sectors.

What are the major strategies to ensure quality of care?

By law, prefectures are responsible for making health care delivery “visions,” which include detailed plans on cancer, stroke, acute myocardial infarction, diabetes mellitus, psychiatric disease, pediatric, and home care, as well as emergency, prenatal, rural, and disaster medicine. These plans 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 as financial incentives.

Waiting times are generally not monitored by government, although there is cause for concern in some clinical areas, such as palliative care. Although there are structural health care delivery regulations, relatively few apply to process and outcomes.

Prefectures are in charge of the annual inspection of hospitals. Sanctions include 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. However, there is no disclosure of names of hospitals that fail the accreditation process. The Ministry of Health, Labor and Welfare organizes and financially supports a voluntary benchmarking project, in which hospitals report quality indicators on their websites.

In order to practice, physicians are required to obtain a license by passing a national exam, but they are not subject to revalidation. However, specialist societies have introduced revalidation for qualified specialists. Clinical audits are voluntary. Public reporting on performance has been discussed but is not yet implemented.

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.

Disease and medical device registries have been developed on a voluntary basis, possibly to be used for quality improvement in the future. Surveys of hospital patients' experiences are conducted every three years.

What is being done to reduce disparities?

Reducing health disparities between population groups has been a general goal since 2012. The two explicit targets are a reduction of disparities in healthy life expectancies between prefectures and an increase in the number of local government entities that make efforts to solve health disparity issues (MHLW, 2012b). There is another plan to reduce disparities among prefectures in cancer treatment delivery, with each prefecture setting treatment targets. Health variations between regions are regularly reported by government. Health variations between socioeconomic groups and variations in health care access are occasionally measured and reported by researchers, some of them funded by the Ministry of Health, Labor and Welfare.

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

The national government prioritizes the general coordination of care, including coordination in mental health care, and has introduced financial incentives for hospitals and clinics, particularly in cancer, stroke, cardiac, and palliative care. Hospitals admitting stroke victims or patients with hip fractures can receive additional fees if they use post-discharge protocols and have contracts with clinic physicians to provide effective follow-up after discharge, for which those physicians also receive additional fees. The government also provides subsidies to leading providers in the community to facilitate care coordination.

There are more than 4,000 “community comprehensive support centers” to coordinate services, particularly for those with long-term conditions. Funded by LTCI, they employ care managers, social workers, and long-term care support specialists. No pooled funding of the PHIS and LTCI exists.

Regional and large-city governments are required to establish councils to promote integration of care and support for patients with 306 designated long-term diseases.

What is the status of electronic health records?

Electronic health record networks have been developed only as experiments in selected areas. Interoperability between providers has not been generally established. Currently, experiments are under way to make personal health information available to patients and providers via cloud computing. The Social Security and Tax Number System (SSTNS), a system of unique identifiers, will begin in 2016. It will be used for social security from its inception, and for health services, possibly including medical records, starting in 2018.

How are costs contained?

Price regulation for all services under the PHIS is a critical cost-containment mechanism (Ikegami and Anderson, 2012). The fee schedule is revised every two years by the government, following informal stakeholder negotiations, and is based on the estimated overall rate of change in public health care expenditures and expenditures in different health care sectors.

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. The revisions of prices of pharmaceuticals and devices are determined based on a market survey of actual current prices (which are often less than the listed prices). 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 also considered in the revision.

Negotiations between stakeholders take place only for the purpose of revising the fee schedule and the rule for deciding pharmaceutical prices. Whether cost-sharing and the existing competition between providers contain costs is unclear.

The number of hospital beds is regulated by prefectures in accordance with national guidelines. The national medical student capacity, which is increasing since 2007 owing to physician shortages, is also regulated by the government.

The government's Cost-Containment Plan for Health Care is intended to promote healthy behavior, shorten hospital stays through care coordination and home care development, and increase generic substitution. Each prefecture makes cost-control plans in accordance with the plan. Both financial incentives in the fee schedule and other incentives, including education and training, are used. Peer review committees in each prefecture also monitor claims and may deny payment for services deemed inappropriate.

Currently, some pharmaceuticals whose medical effectiveness is considered uncertain are not covered by the PHIS. A trial cost-effectiveness evaluation for coverage of pharmaceuticals and medical devices is planned for 2016.

What major innovations and reforms have been introduced?

Community-based health insurance plans in the PHIS, operated by municipalities, usually insure residents who are sicker and less well-off than those covered by employment-based insurance plans. The plans vary significantly in the number they insure, from fewer than 100 to more than half a million. To mitigate financial risk in small plans, the national government has gradually expanded cross-subsidies between community-based plans while keeping its and local governments' subsidies. With increasing financial pressures and the development of region-based governance, plans are being restructured under the 2015 Health Care Reform Act: from 2018, regions will take overall administrative responsibility for community-based plans and work together with municipalities, which will still be insurers of their residents, to set premium rates and to collect premiums. Meanwhile, subsidies from the national government to the regions are to be slightly increased to help plans, and those with low incomes, with excessive financial burdens.

A plan to strengthen the financial incentive for patients to use family physicians is intended to decrease demand on hospital outpatient departments. Although hospitals with

200 beds or more are currently allowed to charge additional fees to patients who have no referral for outpatient consultations, fewer than half of such hospitals have opted for this extra charge. Under the Health Care Reform Act of 2015, highly specialized large-scale hospitals with 500 beds or more will have an obligation to promote care coordination between providers in the community, as well as to charge additional fees to such patients.

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References

English Regulatory Information Task Force: Japan Pharmaceutical Manufacturers Association (2012). Pharmaceutical Administration and Regulations in Japan (http://www.jpma.or.jp/english/parj/pdf/2012.pdf, accessed Aug. 20, 2013).

Life Insurance Association of Japan (2014). *Life Insurance Fact Book 2014,* http://www.seiho.or.jp/english/statistics/trend/pdf/2014.pdf.

Ikegami, N., and Anderson, G. F. (2012). “In Japan, All-Payer Rate Setting Under Tight Government Control Has Proved to Be an Effective Approach to Containing Costs.” *Health Affairs* 31(5):1049–1056.

Japan Institute of Life Insurance (2013). *FY2013 Survey on Life Protection.*

(Quick Report Version) (http://www.jili.or.jp/research/report/pdf/FY2013_Survey_on_Life_Protection_(Quick_Report_Version).pdf).

Japan Pharmaceutical Association (2014). *Annual report of JPA* (http://www.nichiyaku.or.jp/e/data/anuual_report2014e.pdf).

Kwon, S. (2014). *Research on income security of in-home caregivers*. Unpublished thesis (in Japanese).

Matsuda, S., Ishikawa, K. B., Kuwabara, K., Fujimori, K., Fushimi, K., and Hashimoto, H. (2008). “Development and use of the Japanese case-mix system.” *Eurohealth* 14(3):25–30.

Ministry of Health, Labor and Welfare (MHLW) (2012a). *Survey of Medical Institutions, 2012*.

Ministry of Health, Labor and Welfare (2012b). “A basic direction for comprehensive implementation of national health promotion” (Ministerial notification no. 430 of the Ministry of Health, Labor and Welfare) (tentative English translation) (http://www.mhlw.go.jp/file/06-Seisakujouhou-10900000-Kenkoukyoku/0000047330.pdf, accessed Oct. 15, 2014).

Ministry of Health, Labor and Welfare (2013). “The current situation and future direction of the Long-Term Care Insurance System in Japan, with a focus on housing for the elderly,” (http://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ri_130311-01.pdf, accessed Aug. 20, 2014).

Ministry of Health, Labor and Welfare (2014a). *2012 Survey of Long-Term Care Providers, 2012*.

Ministry of Health, Labor and Welfare (2014b). *Estimates of National Medical Care Expenditure, Summary of Results for FY2012*.

Ministry of Health, Labor and Welfare (2014c). *Survey of Medical Institutions, 2013 Summary*.

National Institute of Population and Social Security Research (2014). *Social Security in Japan* 2014 (http://www.ipss.go.jp/s-info/e/ssj2014/index.asp, accessed Aug. 20, 2014).

National Insurance Claims Review & Reimbursement Services (2013). *Utilization of Electronic Billing as of May, 2013* (in Japanese) (http://www.ssk.or.jp/rezept/files/hukyu02.pdf, accessed June 20, 2013).

OECD (2009). *Health-care reform in Japan: Controlling costs, improving quality and ensuring equity*. OECD Economic Surveys: Japan 2009. OECD Publishing.

OECD (2015). OECD Health Data 2015.

Organisation for Economic Co-operation and Development (2015b). OECD.Stat (database). DOI: 10.1787/data-00285-en, accessed July 2, 2015.

Tatara, K., and Okamoto, E. (2009). “Japan: Health system review.” *Health systems in Transition* 11(5).

The Dutch Health Care System, 2015

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What is the role of government?

In the Netherlands, the national government has overall responsibility for setting health care priorities, introducing legislative changes when necessary, and monitoring access, quality, and costs. It also partly finances social health insurance for the basic benefit package (through subsidies from general taxation and reallocation of payroll levies among insurers through a risk adjustment system) and the compulsory social health insurance system for long-term care. Prevention and social support are not part of social health insurance but are financed through general taxation. The 2015 national reforms to long-term care made municipalities and health insurers responsible for most outpatient long-term services and all youth care under a provision-based approach (with a great level of freedom at the local level).

Who is covered and how is insurance financed?

Publicly financed health insurance: In 2013, the Netherlands spent 12 percent of GDP on health care, and 78 percent of curative health care services were publicly financed. 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, as well as 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 their insurer each year.

Apart from acute care, long-term care, and obstetric care, undocumented immigrants have to pay for most health care themselves (they cannot take out health insurance). However, some mechanisms are in place to reimburse costs that undocumented immigrants are unable to pay. For asylum seekers, a separate set of policies has been developed. Permanent residents (for more than 3 months) are obliged to purchase private insurance coverage. Visitors are required to purchase insurance for the duration of their visit if they are not covered through their home country.

Statutory health insurance 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). Contributions are collected centrally and issued among insurers in accordance with a risk-adjusted capitation formula that considers age, gender, labor force status, region, and health risk (based mostly on past drug and hospital utilization).

Insurers are expected to engage in strategic purchasing, and contracted providers are expected to compete on both quality and cost. The insurance market is dominated by the four largest insurer conglomerates, which account for 90 percent of all enrollees. Currently, there is a ban on the distribution of profits to shareholders.

Private (voluntary) health insurance: In addition to statutory coverage, most of the population (84%) purchases a mixture of complementary voluntary insurance covering 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—an incentive for using generics). Premiums for voluntary insurance are not regulated; insurers are allowed to screen applicants based on risk factors and offer both statutory and voluntary benefits. Nearly all of the insured purchase their voluntary benefits from the same (mostly nonprofit) insurer that provides their statutory health insurance. People with voluntary coverage do not receive faster access to any type of care, nor do they have increased choice of specialist or hospital. In 2013, voluntary insurance accounted for 7.6 percent of total health spending.

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 including, among other things, care provided by general practitioners (GPs), hospitals, and specialists; dental care through age 18 (coverage after that age is confined to specialist dental care and dentures); prescription drugs; physiotherapy through age 18; 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. In case the duration exceeds three years, the last of these is financed under the Long-term Care Act (see below).

Some treatments, such as general physiotherapy and pelvic physiotherapy for urinary incontinence, are only partially covered for some people with specific chronic conditions, as are the first three attempts at in vitro fertilization. Some elective procedures, such as cosmetic plastic surgery without a medical indication, dental care above age 18, and optometry, are excluded. 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.

As of 2015, home care is a shared responsibility of the national government, municipalities (day care, household services), and insurers (nursing care at home), and is financed through the Health Insurance Act. Hospice care is financed through the Long-term Care Act. Prevention is not covered by social health insurance, but falls under the responsibility of municipalities.

Cost-sharing and out-of-pocket spending: As of 2015, every insured person over age 18 must pay an annual deductible of EUR375 (USD455) for health care costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits.[11] Apart from the overall deductible, patients are required to share some of the costs of selected services, such as medical transportation or medical devices, via copayments, coinsurance, or direct payments for goods or services that are reimbursed up to a limit, such as drugs in equivalent-drug groups. Providers are not allowed to balance-bill above the fee schedule. Patients with an in-kind insurance policy may be required to share costs of care from a provider that is not contracted by the insurance company. Out-of-pocket expenses represented 13.8 percent (45% through deductible) of health care spending in 2013 (author's calculation).

Safety net: GP care and children's health care are exempt from cost-sharing. Government also pays for children's coverage up to the age of 18 and provides subsidies (health care allowances), subject to asset testing and income ceilings, to cover community-rated premiums for low-income families (singles with annual income of less than EUR26,316 [USD31,896] and households with income less than EUR32,655 [USD39,580]). Approximately 5.4 million people receive allowances set on a sliding scale, ranging from EUR5.00 (USD6.10) to EUR78.00 (USD95.00) per month for singles and from EUR9.00 (USD11.00) to EUR 149.00 (USD181.00) for households, depending on income.

How is the delivery system organized and financed?

Primary care: There were more than 11,300 practicing primary care doctors (GPs) in 2014 and more than 20,400 specialists in 2013. Nearly 33 percent of practicing GPs

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[11] Please note that, throughout this profile, all figures in USD were converted from EUR at a rate of about EUR0.83 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for the Netherlands.

worked in group practices of three to seven, 39 percent worked in two-person practices, and just over 28 percent worked solo. Most GPs work independently or in a self-employed partnership; only 11 percent are employed in a practice owned by another GP.

The GP is the central figure in Dutch primary care. Although registration with a GP is not formally required, most citizens are registered with one they have chosen, and patients can switch GPs without formal restriction. Referrals from a GP are required for hospital and specialist care.

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. Care groups are legal entities (mostly GP networks) that assume clinical and financial responsibility for the chronic disease patients who are enrolled; the groups purchase services from multiple providers. To incentivize care coordination, bundled payments are provided for certain chronic diseases—diabetes, cardiovascular conditions, and chronic obstructive pulmonary disease (COPD)—and efforts are under way to implement them for chronic heart failure and depression.

In 2015, the government introduced a new GP funding model comprising three segments. Segment 1 (representing 75% of spending) funds core primary care services and consists of a capitation fee per registered patient, a consultation fee for GPs (including phone consultation), and consultation fees 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 (15% of spending) consists of funding for programmatic multidisciplinary care for diabetes, asthma, and COPD, as well as for cardiovascular risk management; prices are negotiated with insurers. Segment 3 (10% of spending) provides GPs and insurers with the opportunity to negotiate additional contracts—including prices and volumes—for pay-for-performance and innovation. Self-employed GPs earned average gross annual income of €97,500 (USD117,000) in 2012, while salaried GPs earned €80,000 (USD96,000).

Outpatient specialist care: Nearly all specialists are hospital-based and either in group practice (in 2012, 54% of full-time-equivalent specialists, paid under fee-for-service) or on salary (46%, mostly in university clinics). As of 2015, specialist fees are freely negotiable as a part of hospital payment. This so-called “integral funding” dramatically changed the relationship between medical specialists and hospitals. Hospitals now have the responsibility of allocating their financial resources among their specialists.

There is a nascent trend toward working outside of hospitals—for example, in growing numbers of (mostly multidisciplinary) ambulatory centers—but this shift is marginal, and most ambulatory centers remain tied to hospitals. Specialists in ambulatory centers tend to work most of the time in academic or general hospitals. Only a small minority of doctors working in hospitals choose to work in ambulatory centers for part of their time. Ambulatory care center specialists are paid fee-for-service, and the fee schedule is negotiated with insurers. Medical specialists are not allowed to charge above the fee schedule. Patients are free to choose their provider (following referral), but insurers may set different conditions (e.g., cost-sharing) for different choices within their policies (Schäfer, et al., 2010).

Administrative mechanisms for paying primary care doctors and specialists: The annual deductible (see above) is paid to the insurer. The insured have the option of paying the deductible before or after receiving health care and may choose to pay all at once or in installments. Other copayments—those for drugs or transportation, for example—have to be paid directly to the provider.

After-hours care: After-hours care is organized at the municipal level in GP "posts," which are centers, 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 hospital. The GP post sends the information regarding a patient's visit to his or her regular GP. There is no national medical telephone hotline.

Hospitals: In July 2014, there were 131 hospitals and 112 outpatient specialty clinics spread among 85 organizations, including eight university medical centers. Practically all organizations were private and nonprofit. In 2013, there were also more than 260 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.

Hospital payment rates (including doctor fees) are determined through negotiations between each insurer and each hospital over price, quality, and volume. 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; the remaining 30 percent are set nationally. The number of diagnosis treatment combinations was reduced from 30,000 to 4,400 in 2012. Diagnosis treatment combinations cover both outpatient and inpatient as well as specialist costs, strengthening the integration of specialist care within the hospital organization.

Mental health care: Mental health care is provided in basic ambulatory care settings, such as GP offices, for mild to moderate mental disorders. In cases of complicated and severe mental disorders, GPs will often refer patients to a psychologist, an independent psychotherapist, or a specialized mental health care institution. The delivery of preventive mental health care is the responsibility of municipalities and is governed by the Social Support Act.

A policy of further integration of general practice and mental health was agreed on in 2012, with the goals of ensuring that patients receive timely care from the right source and reducing the need for specialized care. For several years, policymakers have been aiming to substitute outpatient care for inpatient care, reflected in the steady increase in the number of GPs that employ primary care psychologists.

Long-term care and social supports: A substantial proportion of long-term care is financed through the Long-term Care Act (*Wet langdurige zorg*), a statutory social insurance scheme for long-term care and uninsurable medical risks and cost that cannot be reasonably borne by individuals. It operates nationally, and taxpayers pay a contribution based on taxable income. The remainder of services are financed through the Social Support Act, from general sources. Long-term care encompasses residential care; personal care, supervision, and nursing; medical aids; medical treatment; and transport services. Cost-sharing depends on size of household, annual income, indication, assets, age, and duration of care. In 2014, copayments covered 7 percent of total spending in the compulsory long-term care (LTC) scheme.

With funding provided through a block grant from the national government, municipalities are responsible for household services, medical aids, home modifications, services for informal caregivers, preventive mental health care, transport facilities, and other assistance, in accordance with the Social Support Act (*Wet Maatschappelijke Ondersteuning*). Municipalities have a great deal of freedom in how they organize services, including needs assessments, and in how they support caregivers (e.g., through the provision of respite care or a small allowance).

LTC is mostly provided by private, nonprofit organizations, including home care organizations, residential homes, and nursing homes. Most palliative care is integrated into the health system and delivered by general practitioners, home care providers, nursing homes, specialists, and volunteer workers.

Under both the Social Support Act and the Long-term Care Act, personal budgets are provided for patients to buy and organize their own long-term care, and under the Long-term Care Act are set at 66 percent of rates paid for in-kind services.

What are the key entities for health system governance?

Since 2006, the Ministry of Health's role has been to safeguard health care from a distance rather than managing it directly. It is responsible for the preconditions pertaining to access, quality, and cost of the health system, has overall responsibility for setting priorities, 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 National Health Care 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 (e.g., risk adjustment). The Medicines Evaluation Board oversees the efficacy, safety, and quality of medicines. Decisions about the benefits package rest with the health minister. The Dutch Health Care Authority (*Nederlandse Zorgautoriteit*) has primary responsibility for ensuring that the health insurance, health care purchasing, and care delivery markets all function appropriately (e.g., by setting the prices for 30 percent of diagnosis treatment combinations). Meanwhile, the Dutch Competition Authority (*Autoriteit Consument en Markt*) enforces antitrust laws among both insurers and providers. The Health Care Inspectorate (IGZ) supervises quality, safety, and accessibility of care. Self-regulation by medical doctors is also an important aspect of the Dutch system (Smith, et al., 2012). Private insurers are tasked with increasing health system efficiency and cost control through prudent purchasing of health services.

The patient movement consists of a wide range of organizations, some for specific diseases and some functioning as umbrella organizations. The patient umbrella organization *Nederlandse Patiënten Consumenten Federatie* conducts a range of activities to promote transparency. Health Information Technology is not centralized in one body. The Union of Providers for Health Care Communication (*De Vereniging van Zorgaanbieders voor Zorgcommunicatie*) is responsible for exchange of data via an IT infrastructure.

What are the major strategies to ensure quality of care?

At the system level, quality is ensured through legislation governing professional performance, quality in health care institutions, patient rights, and health technologies. In 2014, the National Health Care Institute was established to further accelerate the process of quality improvement and evidence-based practice**.** The Dutch Health Care Inspectorate 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. There are ongoing experiments with disease management and integrated care programs for the chronically ill.

In the past few years, many parties have been working on quality registries. Most prominent among these are several cancer registries and surgical and orthopedic (implant) registries. Mechanisms to ensure the quality of care provided by individual professionals include reregistration of specialists contingent upon compulsory continuous medical education; regular on-site peer assessments by professional bodies; and professional 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. Furthermore, quality of care is supposed to be enhanced by selective contracting (e.g., volume standards for breast cancer treatment).

In 2014, a few pay-for-performance pilot programs featuring quality targets were initiated but, as yet, specifics about the programs and effects are unknown. Moreover, in the new GP funding model, part of the old budget is preserved for pay-for-performance projects. Patient experiences are also 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. Although progress has been made, public reporting on quality of care and provider performance is still in its infancy in the Netherlands. To stimulate the transparency movement, the Ministry of Health called 2015 the “year of transparency.”

What is being done to reduce disparities?

Health disparities are considerable in the Netherlands, with up to seven years of difference in life expectancy between the highest and lowest socioeconomic groups. Smoking is still a leading cause of untimely death. The current government does not have a specific policy to overcome health disparities. In 2013, government decided to include diet advice and smoking cessation programs in the statutory benefits package. Every four years, health access variations are measured and published in the *Dutch Health Care Performance Reports.*

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, COPD, and cardiovascular risk management. Under this system, insurers pay a single fee to a principal contracting entity—the care group (see above)—to cover a full range of chronic disease services for a fixed period. 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, each with freely negotiable fees (Struijs & Baan, 2011). To head off potential additional coordination problems and better reach vulnerable populations, the role of district nurses is currently being strengthened.

What is the status of electronic health records?

Authorities are working to establish a central health information technology network to enable providers to exchange information. 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. 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; access to their own files is granted by providers upon request.

How are costs contained?

The main approach to controlling costs relies on market forces while regulating competition and improving efficiency of care. In addition, provider payment reforms, including a shift from a budget-oriented reimbursement system to a performance- and outcome-driven approach, have been implemented.

Cost containment was one of the most significant subjects of public debate surrounding the 2012 elections. The most recent figures indicate that expenditure growth has fallen significantly, to 1.8 percent in 2014.

The pharmaceutical sector is generally considered to have contributed significantly to the decrease in spending growth. Average prices for prescription drugs declined in 2014, although less than in previous years. Reimbursement caps for the lowest-price generic have contributed to the decrease in average price. Reimbursement for expensive drugs has to be negotiated between hospital and insurer. There is some concern that this and other factors may limit access to expensive drugs in the near future.

The annual deductible, which accounts for the majority of patient cost-sharing, more than doubled between 2008 and 2015, from EUR170 (USD206) to EUR375 (USD454).[Error! Bookmark not defined.] 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 concerning the benefit package and the appropriate use of medical devices.

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 spending on hospital and mental care. When overall costs exceed that limit, the government has the ability to control spending via generic budget cuts. The agreement included an extra 1 percent spending growth allowance for primary care practices in 2014 and 1.5 percent in 2015–17, provided they demonstrate that their services are a substitute for hospital care.

Cost containment is most severe in long-term care. People with lower care needs are no longer entitled to residential care. In addition, the devolution of services to the municipalities was accompanied by substantial cuts to the available budgets (on average almost 10%).

What major innovations and reforms have been introduced?

After years of rapid spending growth, long-term care as of January 2015 is fundamentally reformed. The reform program’s main goals were to guarantee fiscal sustainability and universal access in the future and to stimulate greater individual and social responsibility. The new structure seems to be up and running, but its effects as yet are unknown, and future amendments may be needed.

In curative health care, market reform and regulated competition remain somewhat controversial. The government, determined to continue stimulating competition between insurers and providers, undertook some measures to that effect, such as requiring insurers and providers to assume greater financial risk. In December 2014, however, the Dutch Senate rejected a new policy proposal restricting free provider choice in specific insurance policies. The accessibility of expensive drugs has rapidly become a prominent issue in 2015.

As of the date of this report, the Health Insurance Act has undergone two evaluations. The latest evaluation pointed to an imbalance of power, with providers having an advantage over insurers.

References

Organisation for Economic Co-operation and Development (2015). OECD.Stat. DOI: 10.1787/data-00285-en. Accessed July 2, 2015.

Schäfer, W., Kroneman, M., Boerma, W., et al. (2010). “The Netherlands: Health System Review,” *Health Systems in Transition* 12(1):1–229.

Smith, P.C., Anell, A., Busse, R., Crivelli, L., Healy, J., Lindahl, A.K., Kene, T. (2012). “Leadership and governance in seven developed health systems” (Research Support, Non-U.S. Gov’t Review), *Health Policy* 106(1):37–49. DOI: 10.1016/j.healthpol.2011.12.009.

Struijs, J.N., and Baan, C.A. “Integrating Care through Bundled Payments—Lessons from the Netherlands,” *N Engl J Med* 2011 364:990–991, March 17, 2011.

The New Zealand Health Care System, 2015

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What is the role of government?

Beginning with passage of the Social Security Act in 1938, a consensus has developed in New Zealand that government has a fundamental role in providing for the population's health care needs. At the same time, there is continued public support for a private sector role as well. Government plays a central role in setting the 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 for those over age 65 lies with 20 geographically defined district health boards (DHBs), each of which comprises seven locally elected members and up to four members appointed by the Minister of Health. These boards 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 and how is insurance financed?

Publicly financed health care: All permanent residents have access to a broad range of services, which are largely publicly financed through general taxes. Nonresidents, such as tourists and illegal immigrants, are charged the full cost of services by public health care providers, unless treatment is related to an accident, in which case they are covered by a no-fault accident compensation scheme.

Total health spending was 9.5 percent of GDP in 2013 (OECD, 2015). Public spending, generated through general taxes, accounted for 79.8 percent of total spending.

Privately financed health care: Private health insurance is offered by a variety of organizations, from nonprofits and "Friendly Societies" to for-profit companies, and accounts for about 5 percent of total health expenditure. It is used mostly to cover cost-sharing requirements, elective surgery in private hospitals, and private outpatient specialist consultations; private coverage also often affords faster access to nonurgent treatment. About one-third of the population has some form of private insurance, purchased predominantly by individuals.

What is covered?

Services: The publicly funded system covers preventive care; inpatient and outpatient hospital services; primary care via private providers (excluding services such as optometry, adult dental services, orthodontics, and physiotherapy); inpatient and outpatient prescription drugs included in the national formulary (see below); mental health care; dental care for schoolchildren; long-term care; home help; hospice care; and disability support services. Government sets an annual overall budget and benefits package, based largely on political priorities. It also sets national requirements for publicly funded 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: Out-of-pocket payments, including both cost-sharing and other costs paid directly by private households, accounted for approximately 12.6 percent of total health expenditures in 2014 (OECD, 2015), with the largest portion going to outpatient services. There are no deductibles in the public sector, although copayments are required for general practitioner (GP) services and many nursing services provided in GP clinics. The average copayment for a GP consultation for an adult ranges from NZD15 to NZD45 (USD10–USD31), but copayments vary significantly, as there are no limits to these set by GPs. An exception applies to the one-third of New Zealanders residing in low-income areas, where a higher annual per-patient capitation rate is paid and, in return, patient copayments are capped at NZD17.50 (USD12.00) per visit.[12] GP copayments fell during the period 2002–2008, when there were significant increases in government funding for primary care, but copayments have been increasing since then.

Copayments are also required for drugs prescribed by GPs and private specialists (NZD5.00 [USD3.40] per item); after copayments are made for 20 prescriptions per family per year, they are free. There are no charges for residents treated in public hospitals, although there are some user charges, such as those for crutches and other aids supplied upon discharge. There are various means-tested subsidies, resulting in some copayments for long-term care, as discussed in the relevant section below.

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[12] Please note that, throughout this profile, all figures in USD were converted from NZD at a rate of about
1.47 NZD per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015b) for New Zealand.

Safety net: Primary care is mostly free for children age 13 and under, 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 greater health needs. 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 for those patients are set at a higher level to reflect this high-utilization pattern, although patients continue to make copayments.

How is the delivery system organized and financed?

Primary care: The ratio of GPs to specialists is about 2:3. GPs act as gatekeepers to specialist care. They are usually independent, self-employed providers compensated by a capitated government-determined subsidy, paid through PHOs and accounting for about half their income; patient copayments, set by individual GPs, provide the rest. An average of 3.48 GPs work together in each practice, assisted by practice nurses. Nurses are salaried and paid by GPs, and have a significant role in the management of long-term conditions (e.g., diabetes), incentivized by specific government funding for chronic care 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.

PHOs receive additional per-capita funding to improve access, especially for people who can least afford primary care, and to aid in promoting health, coordinating care, and providing additional services for people with chronic conditions. In some cases, this support has led to the development of multidisciplinary care teams that may include specialists, such as nutritionists or podiatrists; this trend is being further driven by new alliance arrangements (outlined below). PHOs also receive up to 3 percent additional funding that is handed on to GPs if they reach targets for cancer, diabetes, and cardiovascular disease screening and follow-up, and also goes toward 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: Most specialists are employed by DHBs and salaried for working in a public hospital. However, they are also able to work privately in their own clinics or treat patients in private hospitals, where they are paid on a fee-for-service basis. The impact of this "dual practice" on the public sector remains under-researched and under-debated (Gauld, 2013). Many specialists are based in multispecialty clinics but work independently, renting their office from the clinic. Private specialists are concentrated 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 specialists.

Administrative mechanisms for paying primary care doctors and specialists: As noted above, GPs' income is derived from government subsidies, which include payments from the Accident Compensation Corporation (ACC), and from patient copayments. Some patients subscribing to private insurance may be eligible to claim for the copayment. Patients pay the full cost of private specialist visits up front, unless the service is funded by ACC or by private insurance. In the latter case, patients may seek reimbursement from their insurer, or there may be no direct patient charge if a specialist or private hospital holds a contract with the insurer.

After-hours care: GPs are required in their funding contracts to provide after-hours care or to arrange for its provision, and receive a separate government subsidy for doing so, which is higher per patient than the general capitation rate. In rural areas and small towns, GPs work on call; in some of these areas, 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 usually see a GP in the first instance. Patient charges at these clinics are higher than those for services during the day (although 95% of children under age 13 can have access to free GP after-hours services). Consequently, some patients will visit a 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 in response to 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 constitute the majority, providing all emergency and intensive care. Public hospitals receive a budget from their owners, the DHBs, based on historic utilization patterns, population needs projections, and government goals in areas such as elective surgery. The 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 DHB 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"—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. Public-hospital services are provided largely by consultant specialists, specialist registrars, and house surgeons.

Mental health care: Most people get access to 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, acute inpatient, and community-based services, and provide support to primary care providers; they also fund nongovernment providers of community-based services. Private provision is limited.

Long-term care and social supports: DHBs fund long-term care for patients on the basis of needs assessment, age, and a means test. They fund 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). Those eligible receive comprehensive services including medical care; many older or disabled people receive home care. Some younger disabled recipients opt for individual budgets to arrange their own home care. Respite care is available to relieve informal or family caregivers, 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 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 the resident's payments and the contract price 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. Home care services are all provided by nongovernment agencies.

What are the key entities for health system governance?

As the health system is primarily public, 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 the central government. Others are "crown entities," with their own boards, and are required to follow government policy through letters of expectation. Key national arrangements, all of which have a role in providing information to, and engaging with, the public, are:

- the Ministry of Health, which has overall responsibility for the health and disability system. The ministry acts as the Minister of Health’s principal advisor on health policy and maintains a role as funder, monitor, purchaser, and regulator of health and disability services. While it sets capitation rates paid to GPs, it has no role in regulating patient copayments.
- the National Health Board (NHB), which aims to improve the quality, safety, and sustainability of health care by actively engaging with clinicians and the wider health sector. The NHB provides advice to the health minister and the director-general of health on all of the aforementioned matters. It 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.
- NZ Health Partnerships, established in July 2015 to support DHBs in delivering shared services and reduce costs by identifying opportunities for savings in administrative, support, and procurement.
- the Pharmaceutical Management Agency of New Zealand, which assesses the effectiveness of drugs, distributes prescribing guidelines, and determines inclusion of drugs on the national formulary (with relative cost-effectiveness being one of nine criteria for inclusion). In addition, certain medical devices have been added to its schedule (Gauld, 2014). As of late 2015, a new set of “factors for consideration” will be used to underpin decisions: need; health benefit; costs and savings; and suitability.
- the Health Quality and Safety Commission, which ensures that New Zealanders receive the best health and disability care possible given available resources. 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), which advises 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 no longer provide value for money.

What are the major strategies to ensure quality of care?

The aforementioned health and disability commissioner investigates patient complaints, reports directly to Parliament, and has been active in promoting quality and patient safety.

DHBs are held formally accountable to 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, that aim to stimulate competition among DHBs and are enforced by financial sanctions if not met. In addition, DHB performance with regard to waiting times, access to primary care, and mental health outcomes is publicly disclosed. Also publicly reported are data comparing the performance of PHOs, including such information as screening rates for chronic diseases. Data on individual doctors' performance, however, are not routinely made available. As noted above, PHOs and GPs receive performance payments for achieving various targets.

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. Since 2014, public hospitals have been required to conduct a nationally standardized survey of a random sample of patients and to submit data to the Health Quality and Safety Commission, which publicizes the findings.

Certification 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. 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 supervise 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–associated infection, and standardizing national incident reporting. Other initiatives include the 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, Quality Accounts 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.

The National Health Board is also working on quality improvement in DHBs, with particular emphasis 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?

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 (by seven and six years, respectively), and reducing disparities is a policy priority (Ministry of Health, 2013). Maori and Pacific people are also known to experience greater difficulty in gaining access to health services, and data describing disparities are routinely collected and publicly reported.

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 focused on specific initiatives such as Whanau Ora, a policy designed to integrate health and social services for disadvantaged Maori. The aim has been to develop coordinated, multiagency approaches to service provision and foster joint responsibility for outcomes.

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

Larger Integrated Family Health Centers (IFHCs) are developed in line with the “Better, Sooner, More Convenient” government 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 by emphasizing chronic disease management (Ryall, 2008; Ministerial Review Group, 2009). These centers provide comprehensive primary care and care coordination, after-hours services, and some minor elective procedures for an enrolled population. 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 size, performance, and activities. The highest-performing among them 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 would remain.

The New Zealand 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. These directions have been propelled by a new PHO contract in place since mid-2013 that requires PHO–DHB alliances modeled after Integrated Family Health Center pilot programs. There is considerable scope for these alliances to integrate health and social services (see below), and there is a gradual move toward pooled funding streams. Some specialized providers contracted by the government that focus on vulnerable populations, such as Maori and Pacific people, work to coordinate health and social services (e.g., Whanau Ora, described above).

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 almost 100 percent uptake (Schoen, et al., 2012). The government's goal is universal electronic access to a core set of residents' personal health information by 2014. However, despite some progress, that goal is unlikely to be met, owing to the complexity of implementing a national patient portal. Clinicians and vendors are working together on numerous projects: there is a larger emphasis 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 structured electronic transfer of patient records, electronic referrals, decision support tools with patient safety features, and patient access to health information in a secure environment.
In the near future, there will be more emphasis on facilitating secure sharing of patient information among 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, current levels of interoperability are limited.

The National Health IT Board works with a number of sector groups and receives advice from, among others, clinicians, consumers, and vendors. The Health Information

Standards Organisation supports and promotes the development and use of standards to ensure interoperability between systems. Every person who uses health and disability support services has a unique national health number, facilitating the process of building interoperable systems.

How are costs contained?

The financial sustainability of publicly funded health care is a top government priority. To support this goal, government has implemented a range of measures, 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 demonstrate their fit with the strategic direction of the health sector.

Cost control in DHBs has been closely monitored by the Ministry of Health, with a significant reduction in deficits over the last five years, from NZD154.8 million (USD105.4 million) in 2008–2009 to NZD7.4 million (USD5.0 million) in 2013–2014 (personal communication, Ministry of Health). These reductions are achieved largely through efficiency gains and cuts in spending on staff, services, and equipment. As 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.

The National Health Committee prioritizes health technologies and provides advice as to which technologies no longer offer value for money, increasingly using comparative-effectiveness research in evaluation.

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

What major innovations and reforms have been introduced?

Reforms over the past two years have been mostly adjustments to existing arrangements, with one standout. In mid-2013, a new national Primary Health Organisation contract was issued, with new minimum PHO standards and a requirement that DHBs and PHOs enter into alliances. The rationale for the requirement was to link together the parts of the health system—GPs and public hospitals in particular—that operate largely separately but with common populations in a region. The impetus for forming these alliances is the government's increasing concern over chronic disease and care for complex patients, and its desire to better support patients and their providers in primary care settings.

These alliances reflect an important shift in the governance model and structures for designing and delivering health services in New Zealand. Each alliance must take a whole-system approach, bringing together clinical leaders, managers, and community representatives from across the local health system to consider health services from a patient perspective. An alliance's focus is primarily integration, with the alliance setting service priorities, generating consensus on how those priorities will be met, and then sharing financial and other resources to facilitate implementation. Many alliances are creating further clinically led "service level alliances" targeting different areas of care design; many also govern health pathway development, which is rapidly expanding across New Zealand (Gauld, 2014b).

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References

Gauld, R. (2013). "Questions About New Zealand's Health System in 2013, Its 75th Anniversary Year," *New Zealand Medical Journal* 126(1380):1–7.

Gauld, R. (2014). "Ahead of Its Time? Reflecting on New Zealand's PHARMAC Following Its 20th Anniversary," *Pharmacoeconomics* 32:937–942.

Gauld, R. (2014b). "What Should Governance for Integrated Care Look Like? New Zealand's Alliances Provide Some Pointers," *Medical Journal of Australia* 201(3):s67–68.

Ministerial Review Group (2009). "Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand" (Wellington: Ministry of Health).

Ministry of Health (2013). *Annual Report for the Year Ended 30 June 2013, Including the Director-General of Health's Annual Report on the State of Public Health*

(Wellington: Ministry of Health).

Organisation for Economic Co-operation and Development (2015), OECD Health Statistics 2015.

Organisation for Economic Co-operation and Development (2015b). OECD.Stat. DOI: 10.1787/data-00285-en. Accessed July 2, 2015.

Organisation for Economic Co-operation and Development (2014), OECD Health Statistics 2014.

Ryall, T. (2008). “Better, Sooner, More Convenient: Health Discussion Paper by Hon. Tony Ryall MP” (Wellington: National Party).

Schoen, C., et al. (2012). “A survey of primary care doctors in ten countries shows progress in use of health information technology, less in other areas.” *Health Affairs* 31(12):2805–2816.

The Norwegian Health Care System, 2015

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What is the role of government?

Government is responsible for providing health care to the population. Norway's 428 municipalities are responsible for providing primary health and social care, with the Ministry of Health playing an indirect role, mainly through legislation and funding mechanisms. The ministry plays a direct role, however, in specialist care, through its ownership of hospitals and provision of directives to the boards of regional health care authorities (RHAs), as well as through legislation and funding.

Who is covered and how is insurance financed?

Publicly financed health care: Total health expenditure represented 9.2 percent of GDP in 2014, which is about the average for countries in the Organisation for Economic Co-operation and Development (OECD). But Norway ranks among the highest in the OECD in terms of absolute expenditure per capita (NOK56,400, or USD5,965) in 2014) (Statistics Norway 2015).[13]

The nationally managed and financed health system, providing more than 95 percent of all health care, is built on universal coverage and on the principle of equal access for all regardless of socioeconomic status, ethnicity, and area of residence. It is financed through national and municipal taxes. Social security contributions finance public retirement funds, sick leave payment, and reimbursement of extra health care costs for some patient groups.

For acute hospitalization, there is no private alternative.

Through common agreements, European Union residents and other legal residents have the same access to health services as Norwegians. Other visitors are charged in full. Undocumented adult immigrants have access only to emergency acute care, while undocumented children receive the same care as citizens.

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[13] Please note that, throughout this profile, all figures in NOK were converted to USD at a rate of about NOK9.45 per USD, the 2014 purchasing power parity for GDP published for Norway by OECD (2015).

Private health insurance: Private health insurance is provided by for-profit insurers and purchased for quicker access to examinations and care but also for choice among private providers. Private health insurance accounts for less than 5 percent of planned services. About 8 percent of the population (or nearly 15 % of the workforce) have some kind of private insurance. About 92 percent of policies are paid for by an employer (Finans Norge 2014)

What is covered?

Services: Parliament determines what is covered, although there is no defined benefits package except for new and costly treatments and technologies (see below). In practice, national health care covers planned and acute primary, hospital, and ambulatory care, rehabilitation, and outpatient prescription drugs on the formulary (the "blue list"). It also covers dental care services for children up to 18 years of age and other prioritized groups, such as people with rare diseases or chronic diseases that increase the risk of dental problems, patients with chronic mental disabilities, and patients in permanent nursing homes. Dental care for 19–20-year-olds and dental orthopedics (braces) for children are partially covered. Nonmedical eye care, aesthetic surgery, and complementary medicine are not covered.

Primary, preventive, and nursing care are organized at the local level by municipalities. The municipality, often in cooperation with the county, 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. Psychological care for children under the age of 18 is fully covered. Primary care for mental health is provided by general practitioners (GPs) and municipal psychologists. Long-term care, including palliative end-of-life care, is provided on the basis of need, either at home or in nursing homes. There are few designated hospice facilities. The substantial government funding for municipalities is generally not earmarked, and budgets are set locally, but provision of some services is statutory, particularly those related to pediatric and long-term care.

Cost-sharing: GP and specialist visits, including outpatient hospital care and same-day surgery, require copayments (NOK141 [USD15] and NOK320 [USD34] per visit in 2015, respectively), as do physiotherapy visits (in varying amounts), covered prescription drugs (up to NOK520 [USD55] per prescription), and radiology and laboratory tests (NOK227 [USD24] and NOK50 [USD5]). Public providers cannot charge patients more than these amounts, except for bandages and other supplies. Consultations for antenatal and postnatal follow-up, for prevention and treatment of transmittable diseases for particularly vulnerable individuals, and treatment of sexually transmitted diseases are also exempt from copayments. Hospital admissions and inpatient treatment are free. Out-of-pocket payments finance about 14 percent of total expenditure.

Home-based and institutional care for older or disabled people require high cost-sharing (up to 85% of personal income), but are means-tested.

Safety net: The major safety net mechanisms are annual caps for out-of-pocket expenditure set by Parliament, above which fees are waived. For 2015, the cost-sharing ceiling for most services is NOK2,105 (USD223). A second ceiling is set at NOK2,675 (USD283) for services such as physiotherapy and certain dental services. Long-term care and prescription drugs outside the "blue list" do not apply toward these ceilings.

Children under the age of 16 receive free treatment and access to essential drugs on the blue list. Pregnant women receive free medical examinations during and after pregnancy. Residents eligible for minimum retirement pension or disability pensions, which amount to about NOK162,000 (USD17,134) per year, receive free essential drugs and nursing care. Individuals with specified communicable diseases, including HIV/AIDS, and patients with work-related injuries receive free medical treatment and medication. Taxpayers with high expenses (above NOK5,880, or USD622) as a result of permanent illness receive a tax deduction. "Basic benefits" (NOK653–NOK2,264, or USD69–USD239 per month) may be provided, upon application, to patients who regularly incur additional expenses due to permanent illness, injury, or disability.

How is the delivery system organized and financed?

Primary care: Municipalities provide primary care in accordance with current legislation, government directives, and quality requirements set by the Directorate for Health.

The "regular GP scheme," whereby people register with one general practitioner (GP), covers 99.4 percent of the population. There were an average of 1,132 patients per GP in 2014. Patients may change their GP twice a year. GPs function as gatekeepers, as referral to specialist treatment by a GP is required for coverage.

There are 2.4 specialists in hospitals or ambulatory care for every practicing primary care physician (Den norske legeforening, 2015). Financial incentives encourage physicians to certify as a specialized GP and to see many patients per day.

Municipalities contract with individual GPs, who receive a combination of capitation from the municipalities (35% of income), fee-for-service from the Norwegian Health

Economics Administration (Helfo) (35%), and out-of-pocket payments from patients (30%). GP financing is determined nationally by negotiation between the Ministry of Health and the Norwegian Medical Association. In the fee-for-service scheme, there are fees provided for taking part in coordination of care and individual planning, but they are relatively low. There is also a financial incentive for medication reconciliation. Most GPs are self-employed, and 10 percent are salaried municipal employees (Helsedirektoratet 2014). The average salary is estimated to be NOK750,000 (USD79,325), but may be substantially higher for full-time practitioners. GP practices typically comprise two to six physicians and employ nurses, lab technicians, and secretaries. Many municipalities have multidisciplinary outreach teams for mental health, staffed by health care workers employed by the municipalities.

Specialist care: The four RHAs, which are state-owned corporations that report to the Ministry of Health, are responsible for supervising specialist inpatient somatic and psychiatric care, as well as treatment for alcohol and substance abuse. The ministry provides RHAs' budgets, and issues an annual document instructing the RHAs as to aims and priorities.

Outpatient specialist care is provided both by hospitals and by self-employed specialists. Hospital-based specialists are salaried. Privately practicing specialists contracted by an RHA are paid a combination of annual lump sums, based on the type of practice and number of patients on the list (about 35%); fee-for-service payments (about 35%); and patients' copayments (about 30%). The annual lump sum and the out-of-pocket fees are set by government, and the fee-for-service payment scheme is negotiated between government and the Norwegian Medical Association. In principle, patients have a choice of specialist, although in practice specialist availability varies by geographic location. In the more densely populated areas, clinics with multidisciplinary specialists have emerged during the last few years and seem to be increasing in number. Hospital-employed specialists cannot see private patients at the hospital, but may practice privately after hours, on their own time. Specialists with an RHA contract can charge patients only the specified out-of-pocket fee. Those who do not receive public financing are neither regulated nor subject to the out-of-pocket expenditure caps.

Patient out-of-pocket payments: Patients pay their out-of-pocket fee directly to the provider. If they reach the first safety net ceiling, it is automatically registered and copayments are made directly to the provider by Helfo. For the second ceiling, patients need to submit an application with proof of payment of the out-of-pocket costs. Once it is approved, patients receive a certificate and are not charged further copayments.

After-hours care: After-hours emergency primary care services are the responsibility of the municipalities, whose contracts with GPs include after-hours emergency services on rotation. The municipalities provide offices, equipment, and assistance, and pay the GPs a small fee. Other payments are provided by the national fee-for-service system and out-of-pocket payments from patients. The organization of after-hours services varies according to the size of the municipality. The more densely populated municipalities have walk-in centers where nurses triage patients and answer calls, and several doctors see patients all through the day and night. In smaller municipalities, patients call an after-hours phone number and speak with a nurse, who calls the GP if the patient needs to be seen. As of September 2015, a common national phone number (116117) was launched for all of these public primary care after-hours services (*legevakt*). In larger cities, as a supplement to the public services, there are a few privately owned and run after-hours clinics where patients pay in full.

There is variation as to whether information from emergency visits is shared with patients' regular GPs. There is an emergency phone number patients can call for urgent ambulance services, but no national medical advice line. Patient cost-sharing and provider fees are slightly higher for after-hours emergency services.

Acute-care hospital services are the responsibility of RHAs. Patients need an acute-care referral to these services by a primary care physician or may, in particular cases (accidents, suspected heart attack, stroke, etc.) have access directly via ambulance.

Hospitals: Public hospital trusts are state-owned, formally registered as legal entities with an executive board (approved and partly appointed by the Ministry of Health), and governed as publicly owned corporations. A few are privately owned, mostly by nonprofit humanitarian organizations, and mostly provide publicly funded services as part of RHA plans for providing acute care. The for-profit hospital sector is small, providing less than 1 percent of specialist services in 2013 (Samdata 2013). For-profit hospitals do not provide the full range of services, and do not offer acute services. A part of their services may be publicly funded, but the proportion varies, from almost none to 85 percent in 2013.

Patients are free to choose a hospital for elective services but not for emergency care. Public hospitals are financed through RHAs—for somatic services with a block grant (50%), and with an activity-based portion (50%, based on diagnosis-related group, or DRG). The RHAs are free to decide how the hospitals are paid, but all four have chosen the same funding mechanism for somatic services; 50 percent as block grant and 50 percent based on DRG. All health personnel are salaried, including doctors, and all payments, public and private, include all services.

Mental health: Mental health care is provided by GPs and by other providers (psychologists, psychiatric nurses, social care workers) in municipalities. For specialized care, GPs refer patients to private psychologists or psychiatrists, or to a low-threshold hospital (district psychiatric center). These hospitals are dispersed throughout the country. They often include psychiatric outreach teams. More advanced specialized services are organized in the inpatient psychiatric wards of general hospitals or in mental health hospitals. Hospital treatment is provided free of charge, and outpatient services are subject to the same cost-sharing as described above. Hospitals and district psychiatric centers are funded by government block grants through RHAs. The role of private mental hospital care is very small, and includes services for eating disorders, nursing home care for older psychiatric patients, and some psychiatrist and psychologist outpatient practices, mostly contracted by RHAs. The role of private treatment centers for addiction (mainly drugs and alcohol) is more prominent, and funded mostly through contracts with RHAs.

Long-term care: The municipalities are responsible for providing long-term care, and contract also to some extent with private providers. Cost-sharing for institutionalized care is income-based, and is set at 75–85 percent of patients' income, depending on means tests. Home nursing is also provided, if needed. The levels of care at home or in a nursing home are determined by the municipality. Only about 3 percent of nursing homes are private, and for home nursing care, the proportion is even lower. There are a few private providers of home nursing care and other services, which are purchased by patients most often as a supplement to services by public home care. In some densely populated areas, patients can have a choice of home care provider or nursing home, but rarely arrange for services themselves. Very few patients pay individually for full-time private nursing home care. End-of-life care for terminal patients is often provided in particular wards within dedicated nursing homes. There is 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, who ensures that political decisions are translated into practice. This is done through legislation, economic measures, and documents instructing the RHAs and the Directorate for Health and other underlying agencies regarding activities and priorities. The political values conveyed by the annual national budget and the instructions in the annual letter of allocation from the ministry are determinative, and specify provider fees, out-of-pocket payments, and ceilings.

The Directorate for Health is an executive agency and authority subordinate to the ministry. It issues clinical guidelines, maintains the National System for the Introduction of New Health Technologies, coordinates 18 patient ombudsmen, and provides public information on health and health care through the website www.helsenorge.no. The Directorate for Health is not responsible for producing systematic reviews or health technology assessments (HTAs) but rather applies them to decision-making pertaining to the system for new technologies, to guidelines, and to policymaking. From 2014 to 2018, the directorate is also in charge of the secretariat for the National Patient Safety Program. It is responsible overall for setting standards and leading the development and application of health information technology in health care. The Directorate for Health is responsible for fee-setting in the DRG system, and also for the five-year project on quality-based financing. There is no single authority overseeing fee-setting for providers other than hospitals.

The Medicines Agency determines which medications to reimburse. For new drugs, the agency determines whether a prescription drug should be covered (on the blue list) by evaluating its cost-effectiveness in comparison with that of existing treatments; a “green” scheme encourages providers to prescribe lifestyle and nutrition programs as a first alternative to more expensive preventive medicine. The agency also decides on the maximum price of specific drugs.

The Norwegian Knowledge Center for Health Services, financed by government, produces comparative effectiveness studies (systematic reviews and HTAs) and works with quality and patient safety, quality indicators, and national patient experience surveys. Its HTAs are used by the Norwegian Council for Priority Setting in Health Care and the National System for the Introduction of New Health Technologies. The center also runs the national Reporting and Learning System for adverse events in hospitals.

The Board of Health Supervision is a national public institution organized under the Ministry of Health. The board audits the different areas of the health care system, either systematically on a national basis or individually. An alert system ensures that hospitals alert the board to serious adverse events, and the board may then decide to investigate particular incidents. The board can issue fines to institutions and warnings to health personnel, and can revoke authorization for health care personnel who engage in misconduct.

The Norwegian Institute of Public Health is a center for research on and surveillance of the health status of the population. It provides the Ministry of Health with advice on public health. It is the main authority regarding infection control and infectious disease surveillance. It provides community health profiles regarding prevalence of disease and holds several of the large health registers, including the prescription registry. The institute also assists the prosecuting authorities and the judiciary regarding forensic medicine.

What are the major strategies to ensure quality of care?

The national strategy for quality improvement (2005–15) focuses on efficacy, safety, efficiency, patient-centered care, care coordination, and continuity and equality in access to health care (Directorate for Health 2005). National evidence-based guidelines are being developed for a number of diseases. For cancer, there is a disease management program, introducing defined “packages” to be delivered to patients. To improve patient safety, there is a five-year national program (2014–18), as well as a national reporting and learning system for adverse events. There are 47 national clinical registries for specific diseases, as well as 15 national health registries. There is no registry for technical devices, but a statutory duty for hospitals to report adverse events, including those involving technical equipment.

The Directorate for Health is in charge of the national program for health care quality indicators. The program includes results from national patient experience surveys. No information is gathered or disseminated regarding results or quality of individual health care professionals’ performance.

The 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 issues certificates of specialization to medical doctors, in accordance with specific and transparent requirements. Only the specialization for GPs requires recertification. The Norwegian Board of Health carries out audits of all levels of the health system, including the health care workforce.

RHAs, hospitals, municipal providers and private practitioners are responsible for ensuring the quality of their services. There is no requirement for accreditation or re-accreditation, although some hospitals or hospital departments are accredited.

A five-year developmental period (2013–17) is under way for quality-based financing of RHAs, based on performance and improvement on a set of indicators—29 indicators in 2014, increased to 33 indicators in 2015—of which patient experiences constitute about 30 percent of the reporting. Quality-based financing constitutes only about 0.5 percent of the total of the RHAs’ budgets.

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 drugs. Personal information held by the registry is anonymized.

What is being done to reduce disparities?

Eliminating socioeconomic inequalities in health is a priority of the Directorate for Health. A national strategy for addressing inequalities in health and health care includes various ways of increasing knowledge and awareness (Ministry of Health and Care Services 2007). There have been some initiatives for children, including vaccination programs, kindergarten and education; initiatives for people with disabilities to be included in the workplace; price and tax policies; initiatives for care integration; general information campaigns regarding smoking cessation, alcohol and diets; and specific initiatives for populations at risk.

There is increasing focus on immigrants' health and underutilization of health care. Research on pregnancy has been informative, as there are significantly more complications for newborns and mothers among immigrants than among Norwegians (Ahlberg and Vangen 2005). The need for adequate information to be provided in immigrants' native languages has been emphasized.

Health outcomes vary geographically, not only because of differences in the prevalence of diseases but also as a result of variations in the availability and quality of health care. Recruitment of health personnel, notably doctors and specialized nurses, is more difficult in rural areas.

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

Care coordination has been pointed out as a weakness in the health care system. The coordination reform of 2012 put more emphasis on municipalities' responsibility for 24-hour and post-discharge care, including individual treatment plans for patients with chronic diseases, but not for hospital treatment. Hospitals and municipalities must establish formal agreements on the care of patients with complex needs (Ministry of Health and Care Services 2009 and 2011). The number of integrated primary care practices is experiencing moderate growth, with GPs establishing common practices with physiotherapists and specialists in orthopedics, gynecology, ophthalmology, dentistry, and pediatrics.

For hospitals, incentives for care coordination are provided by mandatory agreements with municipalities. Financing is still fragmented between the hospitals (state-funded) and primary care (municipality-funded), but the municipalities pay substantial fines per day to hospitals if they are not able to accommodate patients ready for discharge.

What is the status of electronic health records?

A national strategy for health information technology (HIT) is the responsibility of the Directorate for Health, with implementation by a departmental steering committee. Every resident is allotted a unique personal identification number, which is used in primary care and for hospitals' medical records. Secure messaging is not a part of that system, but several GPs use such messaging systems, for instance to request prescriptions. Some GP and specialist outpatient offices have electronic booking, while most hospitals do not. All patients have the right to see or get a copy of their complete record, including doctors' notes, but there is not yet an electronic solution for doing so. An ongoing project on patient access currently gives 2.3 million inhabitants access to their core medical record, also allowing for correction of personal information.

The National Health Network is charged with providing efficient and secure electronic exchange of patient information between all relevant parties within the health and social services sector. It provides secure telecommunication for GPs, hospitals, nursing homes, pharmacists, dentists, and others.

HIT in primary care is fragmented, and some areas of service lack resources and equipment for its implementation. Still, virtually all GPs use electronic patient records and transmit prescriptions electronically to pharmacies. HIT is also used for referrals, communication with laboratories and radiology services, and sick leave. Most GPs receive electronic discharge letters from hospitals. Where after-hours emergency care is organized within the same patient record network, patient histories remain available and primary care providers are able to access information regarding emergency visits. All hospitals use electronic records.

The lack of structured electronic records in primary and secondary care precludes automatic data extraction; hence, there is still insufficient data for quality improvement at local and national levels.

How are costs contained?

Central government sets an overall health budget annually, and municipalities and RHAs are responsible for maintaining their budgets. The drug pricing scheme aims to encourage use of generic drugs. Cost-effectiveness is a criterion to get on the “blue list” of drugs eligible for reimbursement, and there is a defined maximum price for drugs, linked to reference prices set at the average of the three lowest market prices for the drug in a defined group of Scandinavian and Western European countries. The Drug Procurement Cooperation (LIS) has been effective in negotiating drug purchases and delivery jointly for the four RHAs.

Costs are contained through GP gatekeeping for specialized services. There is very little competition regarding pricing within the health services. A minute proportion of specialized care is offered to the private sector by RHAs and contracted through tenders, for which price is one of several criteria.

The National System for the Introduction of New Health Technologies, established in 2014, bases its decisions on whether to approve new, costly drugs or treatment mainly on Health Technology Assessments, which address cost-effectiveness.

Norway has a low number of hospital beds (four per 1,000 inhabitants in 2012) compared with the OECD-Europe mean of five (OECD 2014). The low number is part of a policy to drive services toward outpatient and daycare settings, and to make municipalities accountable for patients not needing specialized hospital care. There is an ongoing debate about overdiagnosing and use of procedures that are not evidence-based. Clinical guidelines and a published atlas of variation in frequency of some daytime surgical procedures (www.helseatlas.no) are the only measures taken to date to reduce “low value” care. Although the Council on Priorities in Health Care has debated, for instance, levels of end-of-life care and use of intensive care beds, no focused initiatives have resulted from the debates.

What major innovations and reforms have been introduced?

Municipality cofinancing of hospital care was abolished in 2015, as it was concluded that it did not have the intended effect of keeping patients out of the hospital.

Availability of single occupancy for patients in nursing homes for those preferring it has been a goal for many years. The realization that the goal had not been met led the government to introduce reduced payments by patients for occupancy in double rooms as a financial incentive (or penalty) for the municipalities effective from January 2015. No plan is in place for evaluation of the effect.

A new Agency for Hospital Construction (Sykehusbygg HF) was established in November 2014. Owned by the RHAs, the agency will serve as a national center of competence for hospital planning and construction for all hospital trusts. There is no plan for evaluation.

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References

Ahlberg, N., and Vangen, S. (2005). "Pregnancy and Birth in Multicultural Norway," *Tidskr Nor Legefor* 125(5):586–88.

Den norske legeforening 2015. Legestatistikk, http://legeforeningen.no/Emner/Andre-emner/Legestatistikk/. Accessed Nov 19th 2015

Directorate for Health 2005. National Strategy for Quality Improvement for the Health and Care Services, 2005–2015. IS 1162 https://helsedirektoratet.no/publikasjoner/og-bedre-skal-det-bli-nasjonal-strategi-for-kvalitetsforbedring-i-sosial-og-helsetjenesten-20052015 (accessed November 19th 2015)

Finans Norge 2014. https://www.fno.no/statistikk/skadeforsikring/Arlige-publikasjoner/Behandlingsforsikring---kritisk-sykdom-og-barneforsikring/. Acessed Nov 19th 2015

Helsedirektoratet 2014, Fastlegestatistikk. https://helsedirektoratet.no/statistikk-og-analyse/fastlegestatistikk. Accessed Nov 19th 2015

Ministry of Health and Care Services (2007). National Strategy to Reduce Social Inequalities in Health, Report No. 20 (Oslo: Ministry of Health and Care Services).

Ministry of Health and Care Services (2009). *The Coordination Reform: Proper Treatment at the Right Place and Time*, Report No. 47 (Oslo: Ministry of Health and Care Services). [

Ministry of Health and Care Services (2011); Helse-og omsorgstjenesteloven (The new law for health and care services), OECD 2014. *Health at a Glance Europe 2014.* http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2014_health_glance_eur-2014-en. Accessed November 19th 2015

Organisation for Economic Co-operation and Development (2015). OECDStat. DOI: 10.1787/data-00285-en. Accessed July 2, 2015.

Samdata 2013. Spesialisthelsetjenesten Helsedirektoratet 2014 https://helsedirektoratet.no/publikasjoner/samdata-spesialisthelsetjenesten. Accessed Nov 19th 2015

Statistics Norway 2015, Health Accounts. http://www.ssb.no/en/nasjonalregnskap-og-konjunkturer/statistikker/helsesat. Accessed Nov 19th, 2015.

Ringard, Å., Sagan, A., Saunes, I.S., Lindahl, A.K. Norway: “Health system review,” *Health Systems in Transition 2013*:15(8): 1–162.

The Singaporean Health Care System, 2014

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 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 the 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, 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, prelicensing 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).

References

Accenture. “Singapore’s Journey to Build a National Electronic Health Record System.” http://www.accenture.com/SiteCollectionDocuments/PDF/Accenture-Singapore-Journey-to-Build-National-Electronic-Health-Record-System.pdf#zoom=50

Department of Statistics, Singapore (2013).

Haseltine, W. A. (2013). *Affordable Excellence: The Singapore Healthcare Story*.

Ministry of Health, Singapore (2013). “Expenditure Overview.”

World Bank (2014). World DataBank. http://databank.worldbank.org. Accessed Oct. 14, 2014.

World Health Organization (2013). *World Health Statistics 2013*, Part III, “Global Health Indicators,” 138–39. http://www.who.int/gho/publications/world_health_statistics/2013/en/.

The Swedish Health Care System, 2015

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What is the role of government?

All three levels of Swedish government are involved in the health care system. At the national level, the Ministry of Health and Social Affairs is responsible for overall health and health care policy, working in concert with eight national government agencies. At the regional level, 12 county councils and nine regional bodies (regions) are responsible for financing and delivering health services to their citizens. At the local level, 290 municipalities are responsible care of the elderly and the disabled. The local and regional authorities are represented by the Swedish Association of Local Authorities and Regions (SALAR).

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 balance between the costs and the benefits of health care, measuring cost in relationship to improved health and quality of life.

Who is covered and how is insurance financed?

Publicly financed health care: Health expenditures represented 11 percent of GDP in 2013. About 84 percent of this spending was publicly financed, with county councils' expenditures amounting to 57 percent, municipalities' to 25 percent, and the central government's to almost 2 percent (Statistics Sweden, 2015a). The county councils and the municipalities levy proportional income taxes on their populations to help cover health care services. In 2013, 68 percent of county councils' total revenues came from local taxes and 18 percent from subsidies and national government grants financed by national income taxes and indirect taxes (SALAR, 2014). General government grants are designed to reallocate some resources among municipalities and county councils. Targeted government grants finance specific initiatives, such as reducing waiting times.

In 2013, about 90 percent of county councils' total spending was on health care (SALAR, 2014).

Coverage is universal and automatic. 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 and 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. 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.

Private health insurance: Private health insurance, in the form of supplementary coverage, accounts for less than 1 percent of expenditures. Associated mainly with occupational health services, it is purchased primarily to ensure quick access to an ambulatory care specialist and to avoid waiting lists for elective treatment. Insurers are for-profit. In 2015, 614,000 individuals had private insurance, accounting for roughly 10 percent of all employed individuals aged 15 to 74 years (Swedish Insurance Federation, 2015).

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 and hospice care; dental care and optometry for children and young people; and, with limited subsidies, adult dental care. As the responsibility for organizing and financing health care rests with the county councils and municipalities, services vary throughout the country.

Cost-sharing and out-of-pocket spending: In 2013, about 16 percent of all expenditures on health were private, and of these 93 percent were out-of-pocket (Statistics Sweden, 2015a). The majority of out-of-pocket spending is for drugs.

The county councils set copayment rates per health care visit and per bed-day, leading to variation across the country. Providers cannot charge above the scheduled fee. The table below shows fee ranges for 2014.

Service	**Fee Range (2014)**[14]	
	Swedish Kroner	*U.S. Dollars*
Primary care physician visit	100–300	11–34
Hospital physician consultation	200–350	22–39
Hospitalization per day	80–100	9–11

Source: SALAR, 2015.

Nationally, annual out-of-pocket payments for health care visits are capped at SEK1,100 (USD123) per individual. In all county councils, people under age 18—and in most county councils, people under 20—are exempt from user charges for visits.

Dental care: 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 SEK150–SEK300 (USD17–USD34), depending on age, for preventive dental care. For other dental services, within a 12-month period patients 20 or older pay the full cost of services up to SEK3,000 (USD335), 50 percent of the cost for services between SEK3,000 and SEK15,000 (USD1,676), and 15 percent of costs above SEK15,000. There is no cap on user charges for dental care.

Prescription drugs: Individuals pay the full cost of prescribed medications up to SEK1,100 (USD123) annually, after which the subsidy gradually increases to 100 percent. The annual ceiling for out-of-pocket payments for prescriptions is SEK2,200 (USD246) for adults. A separate annual out-of-pocket maximum of SEK2,200 applies collectively to all children belonging to the same family. For certain prescription drugs not on the National Drug Benefits Scheme and not subject to reimbursement, patients must pay the full price.

Safety net: Because the Swedish health care system is designed to be socially responsible and equity-driven, all social groups are entitled to the same benefits. The ceilings on out-of-pocket spending 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 such as maternity care or vaccination programs.

How is the delivery system organized and financed?

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[14] Please note that, throughout this profile, all figures in USD were converted from SEK at a rate of about SEK8.95 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Sweden.

The health system is highly integrated. An important policy initiative driving structural changes since the 1990s has been the shifting of inpatient care to outpatient and primary care, and the concentration of highly specialized care in academic medical centers. All provider fees are set by county councils, leading to variation across the country. Public and private physicians (including hospital specialists), nurses, and other categories of health care staff at all levels of care are predominantly salaried employees. The average monthly salary for a physician with a specialist degree (including specialists in general medicine) was SEK73,000 (USD8,157) in 2014 (Statistics Sweden, 2015b). There is no regulation prohibiting physicians (including specialists) and other staff who work in public hospitals or primary care practices from also seeing private patients outside the public hospital or primary care practice. Employers of health care professionals, however, may establish such rules for their employees.

Primary care: Primary care accounts for about 20 percent of all expenditures on health, and about 16 percent of all physicians work in this setting (Swedish Medical Association, 2013, 2014). Primary care has no formal gatekeeping function. Team-based primary care, with general practitioners, nurses, midwives, physiotherapists, psychologists, and gynecologists, is the main form of practice. There are, on average, four general practitioners in a primary care practice. General practitioners or district nurses are usually the first point of contact for patients. District nurses employed by municipalities also participate in home care and regularly make home visits, especially to the elderly; they have limited prescribing authority.

People may register with any public or private provider accredited by the local county council, with most individuals registering with a practice instead of a physician. Registration is not required to visit a practice. There are more than 1,100 primary care practices, of which 40 percent are privately owned. Providers (public and private) are paid a combination of fixed payment for their registered individuals (about 80% of total capitated payment), fee-for-service (17%–18%), and performance-related payment (2%–3%) for achieving quality targets in such areas as patient satisfaction, enrollment in national registers, compliance with guidelines based on evidence-based medicine, and recommendations from county council drug formulary committees.

Outpatient specialist care: Outpatient specialist care is provided at university and county council hospitals and in private clinics. Patients have a choice of specialist. Public and private providers are paid through the same fixed, prospective, per-case payments (based on diagnosis-related groups), complemented by price or volume ceilings and quality components.

Administrative mechanisms for direct patient payments to providers: Patients normally pay the provider fee up front for primary care and other outpatient visits. In most cases, it is also possible for patients to pay later.

After-hours care: Primary care providers are required to provide after-hours care in accordance with the conditions for accreditation in each county council. Practices in proximity to each other (normally three to five practices) collaborate on after-hours arrangements. Through their websites and phone services, providers advise their registered patients where to go for care. Staff providing after-hours primary care services normally include general practitioners as well as nurses. There is no special arrangement for provider payment, and the same copayments apply as those during regular hours (see above, "Cost-sharing and out-of-pocket spending"). Information regarding after-hours patient visits is routinely sent to the practice where the patient is registered.

In addition, seven university hospitals and about 50 county council hospitals provide full emergency services 24 hours a day.

All county councils and regional bodies provide information on how and where to seek care through their websites and a national phone line, with medical staff available all day to give treatment advice. Moreover, all county councils and their regional counterparts collaborate to provide online information about pharmaceuticals, medical conditions, and pathways for seeking care. A similar private colloboration exists as well.

Hospitals: There are seven university hospitals, and about 70 hospitals at the county council level. Six of them are private, and three of those are not-for-profit. The rest are public. Counties are grouped into six health care regions to facilitate cooperation and to maintain a high level of advanced medical care. Highly specialized care, often requiring the most advanced technical equipment, is concentrated in 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. Global budgets or a mix of global budgets, diagnosis-related groups, and performance-based methods are used to reimburse hospitals. Two-thirds or more of total payment is usually in the form of budgets, and about 30 percent is based on DRGs. Performance-based payment related to attainment of quality targets constitutes less than 5 percent of total payment. The payments are traditionally based on historical (full) costs.

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 settings, 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 inpatient and outpatient psychiatric care, include that related to substance use disorders, is available to adults, children, and adolescents.

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, but the county councils are responsible for those patients' routine health care. Older adults and disabled people incur a separate maximum copayment for services commissioned by the municipalities (SEK1,780 [USD199] per month in 2015). The Social Services Act specifies that older adults have the right to receive public services and assistance at all later stages of life, e.g., home care aids, home help, and meal deliveries. Also included is 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. About 14 percent of all nursing home and home care was privately provided in 2012 (Statistics Sweden, 2015a), although the percentage varies significantly among municipalities. Payment to private providers is usually contract-based, following a public tendering process. Eligibility for nursing home care is based on need, which is determined collaboratively by the client and staff from the municipality; often a relative participates as well. There is a national policy to promote home assistance and home care over institutionalized care, and that policy entitles older people to live in their homes for as long as possible. Municipalities can also reimburse informal caregivers either directly ("relative-care benefits") or by employing the informal caregiver ("relative-care employment").

What are the key entities for health system governance?

The Health and Medical Services Act specifies that 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 services, while the municipalities are responsible for meeting the care and housing needs of older adults and people with disabilities. In primary care, there is competition among providers (public and private) to register patients, although they cannot compete through pricing, since the county councils set fees.

County councils control the establishment of new private practices by regulating conditions for accreditation and payment. Those conditions pertain primarily to opening hours and to the minimum number of clinical competencies at the practice. The right to establish a practice and be publicly reimbursed applies to all public and private providers fulfilling the conditions for accreditation.

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

The National Board of Health and Welfare supervises all health care personnel, disseminates information, develops norms and standards for medical care, and, through data collection and analysis, ensures that those norms and standards are met. The agency is the licensing authority for health care staff. (Health care personnel are not required to reapply for their license.) The National Board of Health and Welfare also maintains health data registries and official statistics.

The Swedish eHealth Agency, established in 2014, focuses 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 electronic prescriptions abroad. The agency is also responsible for Sweden’s national drug statistics and for statistics on pharmaceutical sales.

The Health and Social Care Inspectorate is responsible for supervising health care, social services, and activities concerning support and services for persons with certain functional impairments. It is also responsible for issuing permits in those areas.

The Swedish Agency for Health and Care Services Analysis analyzes and evaluates health policy, as well as the availability of health care information to citizens 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, based on scientific evidence, in the area of infectious disease control and public health, including health technology assessment. The Swedish Council on Technology Assessment in Health Care, which promotes use of cost-effective health care technologies, has a mandate to review and evaluate new treatments from medical, economic, ethical, and social points of view. Information from the council’s reviews is disseminated to central and local government officials and medical staff to provide basic data for decision-making purposes.

The principal agency for assessing pharmaceuticals is the Dental and Pharmaceutical Benefits Agency. Since 2002, it has had a mandate 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.

What are the major strategies to ensure quality of care?

County councils are responsible for accrediting health care providers and following up on conditions for accreditation. These activities include assessing whether quality targets—those associated with a pay-for-performance scheme or tied to requirements for continued accreditation—have been achieved. Providers are evaluated based on information from patient registries and national quality registries, surveys related to patient satisfaction, and clinical audits.

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 (SALAR, 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 establishing priorities in support of 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 guidelines to inform the setting of priorities in order to avoid unnecessary variation in clinical practice. For example, the National Cancer Strategy was established in 2009, and six Regional Cancer Centers (RCCs) were formed in 2011. The RCCs' role is to contribute to more equitable, safe, and effective cancer care through regional and national collaboration.

The 90 or so national quality registries are used 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, funded by the central government and by county councils, and managed by specialist organizations.

Since 2006, the government has published 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, the National Waiting Time Survey, and the National Patient Surveys. The 2012 publication included 169 indicators, organized into various categories such as prevention, patient satisfaction, waiting times, trust, access, surgical treatment, and drug treatment. Some 50 indicators are shown also for hospitals, but without rankings. Statistics on patient experiences and waiting times in primary care are also made available through the Internet (www.skl.se) to help guide people in their choice of provider.

What is being done to reduce disparities?

The 1982 Health and Medical Services Act emphasizes equal access to services on the basis of need, and a vision of equal health for all. International comparisons indicate that health disparities are relatively low in Sweden. The National Board of Health and Welfare and the Public Health Agency compile and disseminate comparative information about indicators on public health. Approaches to reducing disparities include programs to support behavioral changes, and the targeting of outpatient services to vulnerable groups in order to prevent diseases at an early stage. To prevent providers from avoiding patients with extensive needs, most county councils allocate funds to primary care providers based on a formula that takes into account both overall illness (based on diagnoses) and registered individuals' socioeconomic conditions.

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

The division of responsibilities between county councils (for medical treatment) and 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 government grants. In 2005, Sweden introduced a "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. For county councils to be eligible for the grant targeted at accessibility, 70 percent of all patients must receive care within 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 the elderly with multiple diagnoses.

What is the status of electronic health records?

Generally, both the quality of IT systems and their 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). Nearly all Swedish prescriptions are e-prescriptions. Patients increasingly have access to their electronic medical record for the purposes of scheduling appointments or viewing their personal health data, but there is variation in this regard between county councils. The Swedish eHealth Agency (*eHälsomyndigheten*) was formed in 2014 to strengthen the national e-health infrastructure. Its activities focus on promoting public involvement and providing support for professionals and decision makers (see governance section, above).

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 central government and the county councils form agreements, lasting a period of years, on the levels of subsidy paid by the government to the councils. The Dental and Pharmaceutical Benefits Agency also employs value-based pricing for prescription drugs, determining reimbursement based on an assessment of health needs and cost-effectiveness. In some county councils, there are also local models for value-based pricing for specialized care such as knee replacements.

Because county councils and municipalities own or finance most health care providers, they are able to undertake a variety of cost-control measures. For example, contracts between county councils and private specialists are usually based on a tendering process in which costs constitute one variable used to evaluate different providers. The financing of health services through global budgets, volume caps, 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 those prospective payment mechanisms. In several counties, providers are also financially responsible for prescription costs.

What major innovations and reforms have been introduced?

Important policy areas that have been under scrutiny at both the local and the national level during the last two years include the quality and equity of care, coordination of care, and patients’ rights.

Studies following Sweden’s 2010 market reform in primary care show that objectives related to accessibility have been achieved. Its effects on quality, equity, and efficiency, however, are unclear. Accurate reporting and monitoring to measure these criteria remain important challenges in Swedish primary care and are a concern for policymakers.

In the area of specialized care**,** there have been recent efforts to foster greater equity. The government has committed to providing SEK500 million (USD55.87 million) per year from 2015 to 2018 to reduce waiting times in cancer care and to reduce regional disparities. This effort is to be built on work previously undertaken within the framework of the National Cancer Strategy and the six Regional Cancer Centers (RCCs). In addition, a commission on equitable health, established in 2015, is to submit a report (due by the end of May 2017) containing proposals for reducing health inequalities in society.

To improve continuity and coordination of care, in 2014 the government launched a four-year national initiative for people with chronic diseases. Its three areas of focus are patient-centered care, evidence-based care, and prevention and early detection of disease.

In 2015, a new law addressing patients’ rights went into effect, with the purpose of strengthening the rights of patients and enhancing patient integrity, influence, and shared decision-making. The law clarifies and expands providers’ responsibility in conveying information to their patients, patients’ right to a second opinion, and patients’ choice of provider in outpatient specialist care throughout the country. The government has commissioned the Swedish Agency for Health and Care Services Analysis to monitor and follow up on implementation of the new law until 2017.

References

Anell, A., Glenngård, A.H., Merkur, S. (2012). “Sweden: Health System Review,” *Health Systems in Transition* 14(5):1–161.

Health Consumer Powerhouse (2009). *Euro Health Consumer Index 2009 Report* (Danderyd: Health Consumer Powerhouse).

Organisation for Economic Co-operation and Development (2015), OECD.Stat (database). DOI: 10.1787/data-00285-en, accessed Jul. 2, 2015.

Statistics Sweden (2015a). Systems of Health Accounts (SHA) 2001–2013.

Statistics Swecen (2015b). Lönestrukturstatistik, landstingskommunal sector 2014.

SALAR (2011). *National Initiative for Improved Patient Safety* (Stockholm: Swedish Association of Local Authorities and Regions).

SALAR (2014). *Statistik inom hälso- och sjukvård samt regional utveckling. Verksamhet och ekonomi i landsting och regioner 2013* (Stockholm: Swedish Association of Local Authorities and Regions).

SALAR (2015). *Patientavgifter i hälso- och sjukvården 2015* (Stockholm: Swedish Association of Local Authorities and Regions).

Swedish Insurance Federation (2015). Web site: http://www.svenskforsakring.se, accessed June 18, 2015.

Swedish Medical Association (2013). Läkarförbundets undersökning av primärvårdens läkarbemanning (Stockholm: Sveriges läkarförbund).

Swedish Medical Association (2014). Kostnader och produktion i primärvårdens vårdval (Stockholm: Sveriges läkarförbund).

The Swiss Health Care System, 2015

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What is the role of government?

Duties and responsibilities in the Swiss health care 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, coordinating hospital services, and subsidizing institutions and organizations. Cantons are like U.S. 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 and how is insurance financed?

Publicly financed health insurance: There are three streams of public funding:

1. Direct financing for health care providers through tax-financed budgets for the Swiss Confederation, cantons, and municipalities. The largest portion of this spending is given as cantonal subsidies to hospitals providing inpatient acute care.
2. Mandatory statutory health insurance (SHI) premiums.
3. Social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance, and military insurance.

All government expenditures are financed by general taxation. In 2013, direct spending by government accounted for 20.2 percent of total health expenditures (CHF69.2 billion, or USD50.5 billion), while income-based SHI subsidies accounted for an additional 5.8 percent.[15] Including SHI premiums (30.9% of total health expenditure, excluding statutory subsidies), other social insurance schemes (6.5%), and old age and disability benefits (4.4%), publicly financed health care accounted for 67.9 percent of all spending (SFOS, 2015a).

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[15] Please note that, throughout this profile, all figures in USD were converted from CHF at a rate of about CHF1.37 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Switzerland.

Mandatory SHI coverage is universal. Residents are legally required to purchase SHI within three months of arrival in Switzerland, which then applies retroactively to the arrival date. Policies typically apply to the individual, are not sponsored by employers, and must be purchased separately for dependents.

There are virtually no uninsured residents. Temporary nonresident visitors pay for care up front, and must claim expenses from any coverage they may hold in their home country. Missing SHI for undocumented immigrants remains an unsolved problem acknowledged by the Swiss Federal Council (SFC), the highest governing and executive authority.

SHI is offered by competing nonprofit insurers supervised by the Federal Office of Public Health (FOPH), which sets floors for premiums offered to cover past, current, and estimated future costs for insured individuals in a given region. Cantonal average annual premiums in 2015 for adults range from CHF3,836 (USD2,800) to CHF6,398 (USD4,670) (Appenzell Innerrhoden; Basel-Stadt). Funds are redistributed among insurers by a central fund, in accordance with a risk equalization scheme adjusted for canton, age, gender, and hospital or nursing home stays of more than three days in the previous year.

Insurers offer premiums for defined geographical “premium regions” limited to three per canton. Within every region, the criteria for variation in premiums are limited to age group, level of deductible, and alternative insurance plans (so-called managed care plans with the main characteristic of giving up free choice of first medical contact), but variations in premiums among insurers can be significant. In 2013, 60.6 percent of residents opted for basic coverage with a health maintenance organization, an independent practice association, or a fee-for-service plan with gatekeeping provisions (FOPH, 2014).

Private health insurance: Private expenditure accounted for 32.1 percent of total health expenditure in 2013 (SFOS, 2015a), which is high by comparison with other OECD countries (OECD, 2011). There is complementary voluntary health insurance (VHI, 7.3% of total expenditure) for services not covered in the basic basket of SHI, and supplementary coverage for free choice of hospital doctor or for a higher level of hospital accommodation. No data are available on the number of people covered.

VHI is regulated by the Swiss Financial Market Supervisory Authority. Insurers can vary benefit baskets and premiums and can refuse applicants based on medical history. Service prices are usually negotiated directly between insurers and providers. Unlike statutory insurers, voluntary insurers are for-profit; an insurer will often have a nonprofit branch offering SHI and a for-profit branch offering VHI. 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.

What is covered?

Services: The Federal Department of Home Affairs (FDHA) defines the SHI benefits basket by evaluating whether services are effective, appropriate, and cost-effective. It is supported in this task by the FOPH and by Swissmedic, the agency for authorization and supervision of therapeutic products.

SHI covers most general practitioner (GP) 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 (e.g., one mammogram per year for women with a family history of breast cancer).

Hospital services are also covered by SHI, but highly subsidized by cantons (see 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 in his or her practice. SHI covers only “medically necessary” services in long-term care. The FOPH and Swiss Conference of Cantonal Health Ministers aim to eliminate the gaps in financing of hospice care. Dental care is largely excluded from SHI, as are glasses and contact lenses for adults (unless medically necessary), but these are covered for children.

Cost-sharing and out-of-pocket spending: Insurers are required to offer minimum annual deductibles of CHF300 (about USD219) for adults under SHI, although insured persons may opt for a higher deductible (up to CHF2,500 [USD1,825]) and a lower premium. In 2013, 23.5 percent of all insured persons opted for the standard CHF300 deductible; the other 76.5 percent chose a higher deductible or another model with a gatekeeping element.

Insured persons pay 10 percent coinsurance above deductibles for all services (including GP consultations), but is capped at CHF700 (USD511) for adults and at CHF350 (USD255) for minors (under age 19) in a given year. There is also a 20 percent charge for brand-name drugs with a generic alternative. For treatment in acute-care hospitals, there is a CHF15 (USD11) copayment per inpatient day. Cost-sharing in SHI and VHI accounted for 5.6 percent and 0.1 percent of total health expenditure in 2013.

Moreover, out-of-pocket payments for services not covered by insurance (and in addition to cost-sharing) accounted for 18.1 percent of total health expenditure. Most of these direct out-of-pocket payments were spent on dentistry and long-term care. Providers are not allowed to charge prices higher than SHI will reimburse.

Safety net: Maternity care and some preventive services are fully covered and thus exempt from deductibles, coinsurance, and copayments. Minors do not pay deductibles or copayments for inpatient care. Federal government and cantons provide income-based subsidies to individuals or households to cover SHI premiums; income thresholds vary widely by canton (Swiss Conference of Cantonal Health Ministers, 2015a). Overall, 28 percent of residents (in 2013) 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 delivery system organized and financed?

Primary care: As registering with a GP is not required, people not enrolled in managed care plans generally have free choice among self-employed GPs. In 2014, 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 GPs to take care of chronically ill patients, and no concrete reforming efforts are underway to engage GPs in "bundled payments" for chronic 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 2014, 57.2 percent of physicians were in solo practice (Hostettler and Kraft, 2015).

Apart from some managed care plans in which physician groups are paid through capitation, ambulatory physicians (including GPs and specialists) are paid according to a national fee-for-service scale (TARMED). While billing above the fee schedule is not permitted, TARMED offers some incentives for less resource-intensive forms of care. These incentives, however, are criticized by GPs as insufficient to render attractive such services as home visits, after-hours care, and coordinating and communicating with chronically ill patients. In response, the SFC decided to slightly increase remuneration for consultations in primary care as of October 2014, while remuneration for some more technical services (such as computer tomography) has been slightly reduced. The median income of primary care doctors was CHF197,500 (USD144,151) in 2009 (Künzi and Strub, 2012).

Outpatient specialist care: In the outpatient sector, 61.5 percent of doctors were classified as specialists in 2014 (Hostettler and Kraft, 2015). 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 within proximity of acute-care hospitals. Mostly self-employed specialists can schedule appointments in public hospitals with both SHI and private patients.

Administrative mechanisms for direct patient payments to providers: SHI allows different methods of payment among insurers, patients, and providers. Providers can invoice the patient, who pays up front and claims reimbursement from the insurer, or the patient can forward the invoice to the insurer for payment. Alternatively, providers can directly bill the insurer, who makes payment and bills any balance to the patient.

After-hours care: Cantons are responsible for after-hours care. They delegate those services (fees set by TARMED) to cantonal doctors' associations, which organize care networks in collaboration with their affiliated doctors. The networks can include ambulance and rescue services, hospital emergency services, and walk-in clinics and telephone advice lines run or contracted by insurers. There is no institutionalized exchange of information between these services and GPs' offices (as people are not required to register).

Hospitals: About 70 percent of the 293 acute inpatient hospitals (in 2013) are public or publicly subsidized private hospitals (SFOS, 2015b). For services covered by SHI and billed through a national diagnosis-related group (DRG) payment system, hospitals[16] receive around half (45%–55%) of their funding from insurers (Swiss Conference of Cantonal Health Ministers, 2015b). The other half is covered by cantons and communes, or, in case of additional services, by private health insurance. There are no arrangements for bundled payments to include entire episodes of care are not used.

Cantons are responsible for hospital planning and funding, and are legally bound to coordinate plans with other cantons. The introduction in 2012 of free movement of patients between cantons under the DRG system has reduced cantonal fragmentation. Remuneration mechanisms depend on insurance contracts; as a consequence, fee-for-service is still possible for inpatient services not covered under SHI. Hospital-based physicians are normally paid a salary, and public-hospital physicians can receive extra payments for seeing privately insured patients.

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[16] This includes private hospitals that receive public subsidies if the cantonal governments have need of their services to guarantee a sufficient supply

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 facilities and daycare 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, and forensic services. Often, the socio-psychiatric facilities and daycare institutions offer 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. Prices for outpatient psychiatric services are calculated using TARMED, while psychiatric inpatient care prices are usually calculated as a daily rate.

Long-term care and social supports: Services are provided for inpatient care (in nursing homes and institutions for disabled and chronically ill persons) and for outpatient care through Spitex. In some cases admission is possible only through a hospital or by approval from an admission authority. Palliative care provided in hospitals, in nursing homes, in hospices, or at home is not regulated separately in SHI, so coverage of services is similar to acute services in the respective provider setting. There is no provision of individual or personal budgets for patients to organize their own services.
Inpatient long-term somatic and mental services are covered by SHI, but are highly subsidized by cantons. For services in nursing homes and institutions for disabled and chronically ill persons, SHI pays a fixed contribution to cover care-related inpatient long-term care costs; the patient pays at most 20 percent of care-related costs that are not covered, and the remaining care-related costs are financed by the canton or the commune. Long-term inpatient care costs totaled CHF12.0 billion (USD8.8 billion) in 2013, representing 17.4 percent of total health expenditures. Around one-third of these costs (32.0%) were paid by private households, one-quarter (24.1%) by old age and disability benefits, 18.4 percent by SHI and other social insurances, and the rest by government subsidies (25.5%). Of the 1,580 nursing homes (as of 2013), 29.6 percent are state-operated and -funded, 29.6 percent are privately operated with public subsidies, and 40.8 percent are exclusively private (SFOS, 2015c).

Almost half of total Spitex expenditure of CHF2.0 billion (USD1.4 billion), as of 2013 (SFOS, 2015d), is financed by government subsidies (47.5%). SHI and the other social insurances covering the cost of medically necessary health care at home made up roughly one-third (30.0%). The rest (22.6%), devoted mainly to support and household services, was paid out-of-pocket, by old age and disability benefits, by VHI, and by other private funds (SFOS, 2015a). There is no legal basis for financial support for informal help or family caregivers. Most Spitex organizations are subsidized nonprofit organizations (85% of personnel), while the remaining 15 percent are nonsubsidized for-profit organizations (SFOS, 2015d).

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. Each of the 26 cantons has its own elected minister of public health. Supported by their respective cantonal offices of public health, ministers are responsible for licensing providers, coordinating hospital services, subsidizing institutions, and promoting health through disease prevention. Their common political body, the Swiss Conference of the Cantonal Ministers of Public Health, plays an important coordinating role. At the cantonal and the national level, market pressure, i.e., from competition, is felt most by hospitals and by health insurers (OECD, 2011).

The main national player is the FOPH, which, among other tasks, supervises the legal application of mandatory SHI, authorizes insurance premiums offered by statutory insurers, and governs statutory coverage (including health technology assessment) and the prices of pharmaceuticals. Other cost-control measures are shared with cantonal and communal governments. The FDHA legally defines the SHI benefits basket. Professional self-regulation has been the traditional approach to quality improvement.

Prices for outpatient services are set in the fee-for-service scale TARMED, which defines the relative cost weights of all services covered by SHI on the national level and is authorized by the Swiss Federal Council. TARMED values can vary among cantons and service groups (physicians, outpatient hospital services) as negotiated annually between the health insurers' associations and cantonal provider associations, or are set by cantonal government if the parties cannot agree. For inpatient care, the Swiss national DRG system has been in use since 2012. The nonprofit corporation SwissDRG AG is responsible for defining, developing, and adapting the national system of relative cost weights per case.

In addition to the responsibilities of the FOPH and cantonal governments, Health Promotion Switzerland, a nonprofit organization financed by SHI, is legally charged with disease prevention and health promotion programs and provides 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?

Providers must be licensed in order to practice medicine, and are required to meet educational and regulatory standards; continuing medical education for doctors is compulsory. Local quality initiatives, often at the provider level, include the development of clinical pathways, medical peer groups, and consensus guidelines. However, there are no explicit financial incentives for providers to meet quality targets.

The Quality Strategy, approved by the SFC at 2009, takes a broad conceptual approach with different fields of action, including the implementation of a national pilot program by the Swiss Foundation for Patient Security on medication safety in acute-care hospitals, a pilot program to reduce hospital infections, and the publication of quality indicators for acute-care hospitals. Quality-control mechanisms usually do not involve information from registries or patient surveys. Registries are organized by private initiatives or cantons, such as the cantonal cancer registries.

At the end of 2013, the SFC mandated a task force led by the cantons and the Swiss Confederation (the Dialogue on National Health Policy) to work out a national strategy for the prevention of noncommunicable diseases (NCDs) by 2016. The strategy aims to improve the health competence of the population and promote healthy living conditions. The *National Health Report* (Obsan, 2015) discusses the growing number of case management programs for chronic illnesses.

What is being done to reduce disparities?

There are several reasons why health disparities have not attracted as much political and professional interest at the national level as elsewhere: Health inequalities are not considered to be very significant in comparison to other OECD countries; it is difficult to obtain detailed statistical information about the epidemiology of health outcomes; and health inequalities are seen more as the responsibility of cantons, making them less visible at the national level.

The Swiss Federal Council’s national Health2020 agenda (FDHA, 2013) includes the explicit objective of improving 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, the elderly, and immigrants. The aim is to prevent vulnerable population groups from being unable to make appropriate use of necessary health care services. Health and health access variations are measured and reported publicly by the Swiss Health Survey (SFOS, 2014) every five years.

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. The task force Dialogue on National Health Policy discusses existing and new approaches to care. The national Health2020 agenda includes a comprehensive projection of the priorities of health care policy until the year 2020. The agenda also addresses care coordination, stating that integrated health care models need to be supported in all areas. The FOPH works on concrete measures to confront these challenges.

Strategies and networks tackling emerging areas of importance, like palliative care, dementia, and mental health, have been created to improve coordination. They start on a conceptual level, aiming at the practical level to encourage different types of health professionals to work together. A growing number of such programs are in the works, as shown in the National Health Report (Obsan, 2015), but pooled funding streams do not exist yet. It is also worth noting the efforts in the area of e-health (see below), which should considerably improve coordination as well.

What is the status of electronic health records?

A national e-health service called eHealth Suisse (an administrative unit of the FOPH) is coordinated by the federal and cantonal governments and has three sets of responsibilities. First, all providers in Switzerland should be able to collect and store information on their patients' treatment electronically. 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.

A key element of eHealth Suisse is the SHI subscription card, which encodes a personal identification number and all necessary administrative data. If allowed by the insured person, information about allergies, illnesses, and medication can be recorded on the card. The insured person also decides who is allowed access to this information (all, selected, or no providers). GP e-health is still at an early stage (Vilpert, 2012), and there are ongoing discussions about incentives for physicians to adopt new technologies.

Hospitals are generally more advanced; some have merged their internal clinical systems in recent years and hold interdisciplinary patient files. However, the extent of this integration varies greatly among hospitals and among cantons, despite 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.

How are costs contained?

Switzerland's health care costs are among the highest in the world. "Regulated competition" (Enthoven, 1993) among nonprofit health insurers and among service providers is aimed at containing costs and guaranteeing high-quality health care, and establishing solidarity among the insured. While most of its objectives are considered successfully achieved, academic analyses (OECD, 2011) and public perception have been critical of competition's ability to control health care costs. A global budget, however, has never been regarded as a possible remedy for this problem. Failures are ascribed largely to inadequate risk equalization, the dual funding of hospitals, and pressure on insurers to contract with all certified providers (OECD, 2011). The costs of providing mandatory benefits in the health system could be reduced by up to 20 percent (FDHA, 2013).

An overview of possible cost-reducing measures—in coordination of care, compensating systems, and highly specialized medicine—is part of the Health2020 agenda. The agenda outlines a need for increasing flat-rate remuneration mechanisms and revising existing fee schedules to limit incentives for service providers. Also mentioned is the need for greater concentration in sites of highly specialized medicine to eliminate inefficiency and duplication in infrastructure systems and to increase the quality of health care provision. SwissDRG AG was introduced to contain hospital costs. Inpatient capacity is subject to cantonal planning requirements, and there is a "necessity clause for outpatient providers." See also the section on cost-sharing for patient cost-sharing mechanisms.

To control pharmaceutical costs, coverage decisions on all new medicines are subject to evaluation of their effectiveness (by Swissmedic) and cost (by the FOPH). Efforts are being made to reassess more frequently the prices of older drugs. Depending on national market volume, generics must be sold for 20 to 50 percent less than the original brand. In addition to the aforementioned 20 percent coinsurance for brand-name drugs, pharmacists are paid flat amounts for prescriptions, so they have no financial incentive to dispense more expensive drugs.

What major innovations and reforms have been introduced?

As discussed throughout this profile, the Health2020 agenda outlines important national topics, objectives, and measures for improving quality of life, promoting equal opportunity and self-responsibility, ensuring and enhancing quality of care, and creating more transparency, better governance, and more coordination. In concrete terms, the SFC realized the following nine priorities in 2014 (SFC, 2015):

- Adoption of the message (i.e., official explaining text of SFC) concerning the federal law of cancer registries (implementation date of law: not before 2018;
- Submission for public consultation of the preliminary draft of a federal law concerning a national health quality institute in SHI (new proposal made by the Swiss Federal Council, with open date for implementation);
- Submission for public consultation of a partial revision of the federal law on SHI concerning better control of the outpatient sector, more control of health care cost, and better assurance of health care quality (implementation date of law: mid-2016);
- Submission for public consultation of the preliminary draft of a federal law concerning non-ionizing radiation and sound waves (implementation date of law: open);
- Submission for public consultation of the preliminary draft of a federal law concerning tobacco products (implementation date of law: open);
- Adoption of regulation on the adjustments of tariff structures in SHI (regulation introduced: October 2014);
- Adoption of the results of a public consultation on the federal law concerning health professionals (implementation date of law: open);
- Adoption of the results of a report on the current state of and need for action to support caring relatives;
- Recognition of the results of the new constitutional article concerning primary health care and plans to enact it (implementation date: open).

The Swiss Health Observatory (Obsan) is currently creating an indicator system to evaluate the effects of all measures proposed by the Health2020 agenda.

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References

Enthoven, A.C. (1993). “The History and Principles of Managed Competition.” *Health Affairs*, 12, no.suppl 1 (1993):24–48. DOI: 10.1377/hlthaff.12.suppl_1.24.

Künzi, K., and Strub, S. (2012). “Einkommen der Ärzteschaft in freier Praxis: Auswertung der Medisuisse-Daten 2009.” *Schweizerische Ärztezeitung*, 93: 38:1371–1375.

Hostettler, S., and Kraft, E. (2015). FMH-Ärztestatistik 2014: “Frauen- und Ausländeranteil nehmen kontinuierlich zu.” *Schweizerische Ärztezeitung* 96: 13:462–469.

Organisation for Economic Co-operation and Development (2015). OECD.Stat. DOI: 10.1787/data-00285-en. Accessed July 2, 2015.

Organisation for Economic Co-operation and Development. OECD (2011). *Reviews of Health Systems: Switzerland*. Paris: OECD.

Swiss Conference of Cantonal Health Ministers (2015a). Online publication under: http://www.gdk-cds.ch/fileadmin/docs/public/gdk/themen/krankenversicherung/praemienverbilligung/ipv_2015_df_def.pdf.

Swiss Conference of Cantonal Health Ministers (2015b). Online publication under: http://www.gdk-cds.ch/index.php?id=942.

Swiss Federal Council. SFC (2015). “Gesundheit2020: zehn Prioritäten für 2015.” Pressemitteilung vom 25.03.2015, Bern.

Swiss Federal Department of Home Affairs FDHA (2013). *The Federal Council’s health-policy priorities*. Online publication: http://www.bag.admin.ch/gesundheit2020/index.html?lang=en.

Swiss Federal Office of Public Health. FOPH (2014). Statistik der obligatorischen Krankenversicherung 2013 (Bern: BAG, Sektion Datenmanagement und Statistik).

Swiss Federal Office of Statistics. SFOS (2014). Schweizerische Gesundheitsbefragung 2012 – Standardtabellen 2012.

Swiss Federal Office of Statistics. SFOS (2015a). Statistik der Kosten und Finanzierung des Gesundheitswesens 2013.

Swiss Federal Office of Statistics. SFOS (2015b). Krankenhausstatistik 2013 – Standardtabellen 2013.

Swiss Federal Office of Statistics. SFOS (2015c). Statistik der sozialmedizinischen Institutionen 2013 – Standardtabellen 2013.

Swiss Federal Office of Statistics. SFOS (2015d). Statistik der Hilfe und Pflege zu Hause 2013 – Spitex-Statistik 2013.

Swiss Health Observatory (Obsan) (Ed., 2015). *National Health Report 2015*, Hogrefe Verlag, Bern.

Vilpert, S. (2012). Médecins de premier recours – Situation en Suisse et comparaison internationale. Obsan Dossier 22, Schweizerisches Gesundheitsobservatorium, Neuchâtel.

The U.S. Health Care System, 2015

THE COMMONWEALTH FUND

What is the role of government?

The Affordable Care Act (ACA), enacted in 2010, established "shared responsibility" between the government, employers, and individuals for ensuring that all Americans have access to affordable and good-quality health insurance. However, health coverage remains fragmented, with numerous private and public sources as well as wide gaps in insured rates across the U.S. population. The Centers for Medicare and Medicaid Services (CMS) administers Medicare, a federal program for adults 65 and older and people with disabilities, and works in partnership with state governments to administer both Medicaid and the Children's Health Insurance Program, a conglomeration of 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 people. In addition, states were given the option of participating in a federally subsidized expansion of Medicaid eligibility.

Who is covered and how is insurance financed?

In 2014, about 66 percent of U.S. residents received health insurance coverage from private voluntary health insurance (VHI): 55.4 percent received employer-provided insurance, and 14.6 percent acquired coverage directly.[17] Public programs covered roughly 36.5 percent of residents: Medicare covered 16 percent, Medicaid 19.5 percent, and military health care insurance 4.5 percent.[17] (U.S. Census Bureau, 2014).

In 2014, 33 million individuals were uninsured, representing 10.4 percent of the population (U.S. Census Bureau, 2014). The implementation of the ACA's major coverage expansions in January 2014, however, has increased the share of the population with insurance. These reforms include: the requirement that most Americans procure health insurance; the opening of the health insurance marketplaces, or exchanges, which offer premium subsidies to lower- and middle-income individuals; and the expansion of Medicaid in many states, which increased coverage for low-income adults. According to one survey, the rate of uninsurance among working-age adults

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[17] The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

fell by 7 percentage points between March 2015 and September 2013 (Collins, 2015); another survey found that 17.6 million previously uninsured people have acquired health insurance coverage (ASPE, 2015a). It is projected that the ACA will reduce the number of uninsured by 24 million by 2018 (CBO, 2015).

Public programs provide coverage to various, often overlapping populations. In 2011, nearly 10 million Americans were eligible for both Medicare and Medicaid (the "dual eligibles") (Henry J. Kaiser Family Foundation, 2015a). The Children's Health Insurance Program (CHIP), which in some states is an extension of Medicaid and in others a separate program, covered more than 8.1 million children in low-income families in 2014 (Medicaid.gov, 2014).

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.

What is covered?

Services: The ACA requires all health plans offered in the individual insurance market and small-group market (for firms with 50 or fewer employees) to cover services in 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 category by selecting a benchmark plan that covers all 10 categories; most states choose one of the largest small-group plans as the benchmark. Specific covered services 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 voluntary supplementary program, prescription drug coverage. The program also 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 certain 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 (i.e., deposited funds are not subject to federal income tax). The ACA includes cost-sharing subsidies for the purchase of plans through the insurance exchanges, with the largest subsidies aimed at people with incomes below 250 percent of the federal poverty level (FPL) (the FPL is $20,090 for a family of three, as of 2015) (ASPE, 2015b).

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—charging patients more than the copayment required by 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 health expenditures in the U.S. (OECD, 2015). The ACA caps cost-sharing for most private insurance plans at $6,600 for individuals and $13,200 for families per year in 2015 (Healthcare.gov, 2015).

Safety nets: 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 CHIP. Under the ACA, 30 states and the District of Columbia have expanded Medicaid coverage to cover individuals with incomes up to 138 percent of FPL (Commonwealth Fund, 2015), and premium and cost-sharing subsidies are now available to low- and middle-income individuals through the insurance exchanges (plan premium subsidies for incomes of 133%–400% of FPL; cost-sharing subsidies for incomes 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. In addition, private providers are a significant source of charity and uncompensated care.

How is the delivery system organized and financed?

Publicly financed health care: In 2013, public spending accounted for about 48 percent of total health care spending, although this figure is expected to increase post-ACA. (8) Medicare is financed through a combination of payroll taxes, premiums, and federal general revenues. Medicaid is tax-funded and administered by the states, which operate the program within broad federal guidelines. States receive matching funds from the federal government for Medicaid 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 under the ACA is fully funded by the federal government through 2017, 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 2013, private health insurance spending accounted for about 33 percent of total health care spending (CMS, 2015a). Private insurers, which can be for-profit or nonprofit, 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 premiums, the cost of which is shared by employers and workers 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 providers at rates higher than those paid by public programs, particularly Medicaid. This disparity leads to wide variations in provider payment rates and revenues, which depend to a large extent on payer mix and market power.

Medicare's payment rates are typically determined according to a fee schedule, with various adjustments based on cost of living and other local and provider characteristics. Medicaid rates vary by state. Private health insurers typically negotiate payment rates with providers.

How is the delivery system organized and financed?

Primary care: Primary care physicians account for roughly one-third of all U.S. doctors. The majority 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, made available by some private insurers and public programs like Medicare, based on various quality and cost performance criteria. 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.

Outpatient specialist care: Specialists can work in both private practice and hospitals. Some insurance plans (such as health maintenance organizations, or HMOs) require a referral by a primary care doctor to see a specialist, and limit patients' choice of specialist, while other plans (such as preferred provider organizations, or PPOs) allow patients broader and direct access. Access to specialists can be particularly 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 either public or 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 (39% of primary care doctors in 2105 reported having after-hours care arrangements) (Osborn et al., 2015), with such care often being 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 increasingly common and now 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.

The Affordable Care Act aimed to improve access to mental health care by establishing it 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.

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 of up to 100 days. Long-term care insurance that offers comprehensive care is available but rare. Most certified nursing facilities are for-profit (69%), while 24 percent are nonprofit and 6 percent are government-owned (Henry J. Kaiser Family Foundation, 2015b). 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:
- Centers for Disease Control and Prevention, which conducts research and programs to protect public health and safety;
- National Institutes of Health, which is responsible for biomedical and health-related research;
- Health Resources and Services Administration, which supports efforts to improve health care access for people who are uninsured, isolated, or medically vulnerable;
- Agency for Healthcare Research and Quality, which conducts evidence-based research on practices, outcomes, effectiveness, clinical guidelines, safety, patient experience, health information technology, and health disparities;
- Food and Drug Administration, which is responsible for promoting public health through the regulation of food, tobacco products, pharmaceutical drugs, medical devices, and vaccines, among other products;
- Center for Medicare and Medicaid Innovation, an agency within CMS that was created

by the Affordable Care Act to test and disseminate promising payment and service delivery models designed to reduce spending while preserving or improving quality; and
- Patient-Centered Outcomes Research Institute, also created by the ACA, which is tasked with setting national clinical comparative-effectiveness research priorities and managing research on a broad array of topics related to illness and injury.

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.

The independent, nonprofit Joint Commission 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, the primary accreditor of private health plans, is responsible for accrediting the plans participating in the newly created health insurance marketplaces. The nonprofit National Quality Forum builds consensus on national performance priorities and on standards for performance measurement and public reporting. The American Board of Medical Specialties and the American Board of Internal Medicine provide certification to physicians who meet specified standards of quality.

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, a component of the ACA that lays out national aims and priorities to guide local, state, and national quality improvement efforts, supported by an array of partnerships with public and private stakeholders. Current initiatives include efforts to reduce hospital-acquired infections and preventable readmissions (see below).

CMS has moved toward increased public reporting of provider performance data in an effort to promote improvement. One such initiative is Hospital Compare, a service that reports on measures of care processes, care outcomes, and patient experience at more than 4,000 hospitals. In additionally, with support from the ACA and such groups as the Open Government Partnership, CMS is making Medicare data available to "qualified entities," such as health improvement organizations, which are beginning to release data on payments made by Medicare to individual physicians and amounts paid to physicians and hospitals by pharmaceutical and device companies. Release of such information is intended to both increase transparency and improve quality.

States have developed additional public reporting systems and measures, including some that address ambulatory care. Consumer-led groups, such as Consumers Union and the Leapfrog Group, also report on quality and safety.

Incentives to reduce avoidable hospital readmissions among Medicare patients were introduced in October 2012, by way of financial penalties. Since the program's initiation, 20-day readmission rates nationally have declined from 19 percent to less than 18 percent. (16) Incentives to reduce hospital-acquired conditions, by reducing Medicare payments to the lowest-performing hospitals by 1 percent, were also introduced. Recent data show the first-ever decline in rates of hospital-acquired conditions nationally (Edward and Landon, 2014).

Finally, Medicare, and the majority of private insurance providers, is implementing a variety of pay-for-value programs. Starting in 2013, 1 percent of Medicare payments are redistributed to the highest performers on a composite of cost and quality measures. The program was introduced to physicians in 2015 on a voluntary basis and is expected to become mandatory by 2017. As yet, results are too preliminary to draw conclusions (Edward and Landon, 2014).

What is being done to reduce disparities?

There are wide disparities in the accessibility and quality of health care in the U.S. Since 2003, the annual *National Healthcare Disparities Report,* released by the Agency for Healthcare Research and Quality, has documented disparities among racial, ethnic, income, and other demographic groups and highlighted 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. In addition, the ACA contains a number of provisions aimed at reducing disparities: subsidies to enable low-income Americans to purchase insurance through the exchanges; efforts to achieve parity for mental health care and substance abuse services; and additional funding to community health centers located in underserved communities. There are also a multitude of public and private initiatives at the local and state levels.

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

Both the government and private insurance companies are leading efforts to move away from the currently specialist-focused health system to a system founded on primary care. In particular, the "patient-centered medical home" model, with its emphasis on care continuity and coordination, has aroused interest among U.S. experts and policymakers as a means of strengthening primary care and linking medical services more closely to community services and supports.

Another trend is the proliferation of accountable care organizations (ACOs), networks of providers that assume contractual responsibility for providing a defined population with care that meets quality targets. Providers in ACOs share in the savings that constitute the difference between forecasted and actual health care spending. More than 700 ACOs have been launched by public programs and private insurers, and more than 23.5 million Americans are enrolled in one (Muhlestein, 2015). Two Medicare-driven ACO programs have been rolled out—the

Medicare Shared-Savings Program (MSSP) and the Pioneer ACO Program, which together encompass more than 420 ACOs servicing 14 percent of the Medicare population, or 7.8 million Americans (Muhlestein, 2015; CMS, 2015b). Patients have reported better care experiences, quality measures have generally improved for the tracked indicators, and modest savings have been achieved (Edwards and Landon, 2014).

Medicare, Medicaid, and private purchasers, including employer groups, are also experimenting with new payment incentives that reward higher-quality, more efficient care. One strategy is "bundled payments," where a single payment is made for all the services delivered by multiple providers for a single episode of care. About 7,000 hospitals, physician organizations, and postacute care providers participate in bundled payment initiatives (Edwards and Landon, 2014).

In addition, CMS has supported the development of local programs that aim to better integrate health and social services. Among these is Massachusetts General Hospital's Care Management Program, where nurse case managers work closely with Medicare patients who have serious chronic conditions to help coordinate their medical and social care. Medicaid ACOs are also implementing programs to integrate primary care and behavioral health services. Some ACOs are not only trying to integrate clinical and social services but also exploring innovative financing models, such as cross-sectoral shared-savings models.

What is the status of electronic health records?

The 2009 American Recovery and Reinvestment Act led to significant investment (more than $30 billion) in health information technology. The legislation established financial incentives for physicians and hospitals to adopt electronic health record (EHR) systems, under what is known as the Meaningful Use Incentive Program. As of 2014, 83 percent of physicians used some form of EHR system, and three of four (76%) hospitals had adopted at least a basic EHR system, representing an eightfold increase since 2008 (Heisey-Grove and Patel, 2015; Charles et al., 2015).

The Meaningful Use Incentive Program is designed to gradually raise the threshold for EHR functionality above which providers receive incentives and avoid penalties. The current focus is on information exchange.

How are costs contained?

Annual per capita health expenditures in the United States are the highest in the world ($9,086 in 2013), despite a recent slowdown in spending (OECD, 2015). 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. A movement toward favoring generic drugs over brand-name drugs, meanwhile, has led to a slowdown in pharmaceutical spending in recent years, although growth rebounded in 2014. Another growing trend is the increase in private insurance plans with high deductibles.

A number of reforms included in the ACA attempt to develop payment methods in the Medicare and Medicaid programs that reward high-quality, efficient care. Some of these use pay-for-performance mechanisms, whereas others rely on bundled payments, shared savings, or global budgets to incentivize integration and coordination among health care providers.

Despite a recent slowdown in health care spending, the latest data, through August 2015, show that spending grew 5.7 percent in the past year (Altarum Institute, 2015).

What major innovations and reforms have been introduced?

The Affordable Care Act, which ushered in a sweeping series of insurance and health system reforms aimed at achieving near-universal coverage, improved affordability, higher quality, greater efficiency, lower costs, strengthened primary and preventive care, and expanded community resources, has survived. There have been modifications to the law, however, as a result of several Supreme Court decisions since 2010. Perhaps most notable was the 2012 ruling that made the expansion of Medicaid optional for states: because of that decision, only 30 of 50 states (in addition to the District of Columbia) have pursued expansion as of late 2015.

Still, since implementation of the ACA in 2013, the number of uninsured adults has declined by historic proportions (Collins, 2015). Groups that have been long been at greatest risk of being uninsured—young adults, Hispanics, blacks, and those with low income—have made the greatest coverage gains (Edwards and Landon, 2014).

In 2015, the Department of Health and Human Services announced a goal to move 50 percent of Medicare payments to alternative payment models, including ACO-based arrangements, by 2018 (Edwards and Landon, 2014; Muhlestein, 2015). Medicare has also begun paying for doctors to coordinate the care of patients with chronic conditions. To be eligible for an extra $40 per patient, doctors must draft and help carry out a comprehensive plan of care for each patient who signs up for one. Under federal rules, those patients have access to doctors or other health care providers on a doctor’s staff 24 hours a day, seven days a week, to deal with “urgent chronic care needs” (Edwards and Landon, 2014).

In April 2015, the Senate passed the so-called Medicare “doc fix,” averting an imminent cut in Medicare physician fees that was scheduled to occur under the now-repealed sustainable growth rate formula (SGR). While the SGR was designed to counter the tendency toward spending growth inherent in the fee-for-service model, it was a flawed model. It was replaced by an approach focusing on rewarding high-performing providers and supporting alternative payment models (Guterman, 2015).

References

Altarum Institute (2015). "Health Sector Economic Indicators—Insights from Monthly National Health Spending Data Through August 2015," Oct. 2015. http://altarum.org/sites/default/files/uploaded-related-files/CSHS-Spending-Brief_October_2015_0.pdf.

Agency for Healthcare Research and Quality (AHRQ) (2014). National Healthcare Quality Report and National Healthcare Disparities Report, 2013.

Assistant Secretary for Planning and Evaluation (ASPE) (2015a). Health Insurance Coverage and the Affordable Care Act.

Assistant Secretary for Planning and Evaluation (ASPE) (2015b). U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs. http://aspe.hhs.gov/2015-poverty-guidelines.

Centers for Medicare and Medicaid Services (CMS) (2015a). National Health Expenditure Data, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.

Centers for Medicare and Medicaid Services (CMS) (2015b). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-25.html.

Charles, D., Gabriel, M., Searcy, T. "Adoption of Electronic Health Record Systems among U.S. NonFederal Acute Care Hospitals: 2008–2014," ONC Data Brief No. 23, April 2015, https://www.healthit.gov/sites/default/files/data-brief/2014HospitalAdoptionDataBrief.pdf

Collins, S. R., P. W. Rasmussen, M. M. Doty, S. Beutel (2015). Americans' Experiences with Marketplace and Medicaid Coverage—Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015. New York: The Commonwealth Fund.

Commonwealth Fund (2015). Medicaid Expansion Map. http://www.commonwealthfund.org/interactives-and-data/maps-and-data/medicaid-expansion-map.

Congressional Budget Office (CBO) (2015). Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline, https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

Edwards, S. T., B. E. Landon (2014). "Medicare's Chronic Care Management Payment—Payment Reform for Primary Care." *New England Journal of Medicine* 371(22):2049–51. http://www.nejm.org/doi/full/10.1056/NEJMp1410790.

Guterman, S. (2015). "With SGR Repeal, Now We Can Proceed with Medicare Payment Reform. *Commonwealth Fund Blog*, April 15, 2015. http://www.commonwealthfund.org/publications/blog/2015/apr/repealing-the-sgr.

Healthcare.gov (2015). Out-of-pocket maximum/limit. https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.

Heisey-Grove, D., Patel, V. "Any, Certified and Basic: Quantifying Physician HER Adoption Through 2014," ONC Data Brief No. 28, Sept. 2015. https://www.healthit.gov/sites/default/files/briefs/oncdatabrief28_certified_vs_basic.pdf.

Henry J. Kaiser Family Foundation (2015a). Number of Dual Eligible Beneficiaries, http://kff.org/medicare/state-indicator/dual-eligible-beneficiaries/.

Henry J. Kaiser Family Foundation (2015b). Distribution of Certified Nursing Facilities by Ownership Type, http://kff.org/other/state-indicator/nursing-facilities-by-ownership-type/.

Medicaid.gov (2014). FY 2014 Unduplicated Number of Children Ever Enrolled in Medicaid and CHIP. http://medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.

Muhlestein, D. (2015). “Growth and Dispersion of Accountable Care Organizations in 2015.” *Health Affairs Blog*, March 31, 2015. http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/

National Bureau of Economic Research (NBER) (2014). Tax Breaks for Employer-Sponsored Health Insurance.

Organisation for Economic Co-operation and Development (OECD) (2015). Health Data.

Osborn, R., D. Moulds, E. C. Schneider, M. M. Doty, D. Squires, D. O. Sarnak (2015). “Primary Care Physicians in Ten Countries Report Challenges Caring for Patients with Complex Health Needs.” *Health Affairs* 34(12):2104–2112.

Rice, T., P., Rosenau, L. Y., Unruh, et al. “United States of America: Health System Review,” *Health Systems in Transition*, 2013 15(3):1–431.

Rosenbaum, S. “The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice,” *Public Health Reports*, 2011 126(1):130–135.

U.S. Census Bureau (2014). Health Insurance Coverage in the United States: 2014 –Current Population Reports. http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf.