Attachment E

INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS, 2016

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

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The Australian Health Care System, 2016

Lucinda Glover

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 of 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 the regulation of food standards.[i]

Who is covered and how is insurance financed?

Publicly financed health insurance: Total health expenditures in 2013–2014 represented 9.8 percent of gross domestic product (GDP), an increase of 3.1 percent from 2012–2013. Two-thirds of these expenditures (67.8%) came from 2012–2013.[ii]

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.[iii] Restricted access is provided to citizens of certain other countries through formal agreements.[iv] Other visitors to Australia do not have access to Medicare. Medicare is funded in part by a government levy collected through the tax system, which raised an estimated AUD10.3 billion (USD6.7 billion[v]) in 2013–2014.[vi] (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).[vii] The Lifetime Health Coverage program provides a lower premium for life if

participants sign up before age 31. For people who do not sign up, there is a 2 percent increase in the base premium for each year after age 30. Consequently, take-up is highest among those 30 and under but rapidly drops off as age increases, with a trend to opt out starting at age 50.

Nearly half of the Australian population (47%) had private hospital coverage and nearly 56 percent had general treatment coverage in 2016.[viii]

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.[ix]

Private health insurance can include coverage for hospital care, 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 by number of services.

Private health insurance coverage varies by socioeconomic status. PHI covers just one in five (22.1%) of the most disadvantaged 20 percent of the population, a proportion that rises to more than 57.2 percent for the most advantaged population quintile. This disparity is due in part to the Medicare Levy surcharge applied to higher-income earners.[x]

What is covered?

Services: The federal government defines and funds 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. To be listed, pharmaceuticals need to be approved for cost-effectiveness by the independent Pharmaceutical Benefits Advisory Committee (PBAC). War veterans, the widowed, and their dependents may be eligible for the Repatriation PBS.[xi]

Nearly half (49%) of federal support for mental health is for payments to people with a disability; the remaining support goes toward payments to states, payments and allowances for caregivers, and subsidies provided through the MBS and PBS.[xii] 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.[xiii]

There are no deductibles or out-of-pocket costs for public patients receiving public hospital services. General practitioner (GP) visits are subsidized at 100 percent of the MBS fee, and specialist visits at 85 percent. GPs and specialists can choose whether to charge above the MBS fee. About 83 percent of GP visits were provided without charge to the patient in 2014–2015. Patients who were charged paid an average of AUD31 (USD20).[xiv]

Out-of-pocket pharmaceutical expenditures are capped. In 2016, the maximum cost per prescription for low-income earners was set at AUD6.20 (USD4.00), with an annual cap of AUD372.00 (USD242.00). For the general population, the cap per prescription is AUD38.30 (USD25.00), which reverts to the low-income cost cap if a patient incurs more than AUD1,476.00 (USD958.00) in out-of-pocket expenditure within a year.[xv] Consumers pay the full price of medicines not listed on the PBS. Pharmaceuticals provided to inpatients in public hospitals are generally free.

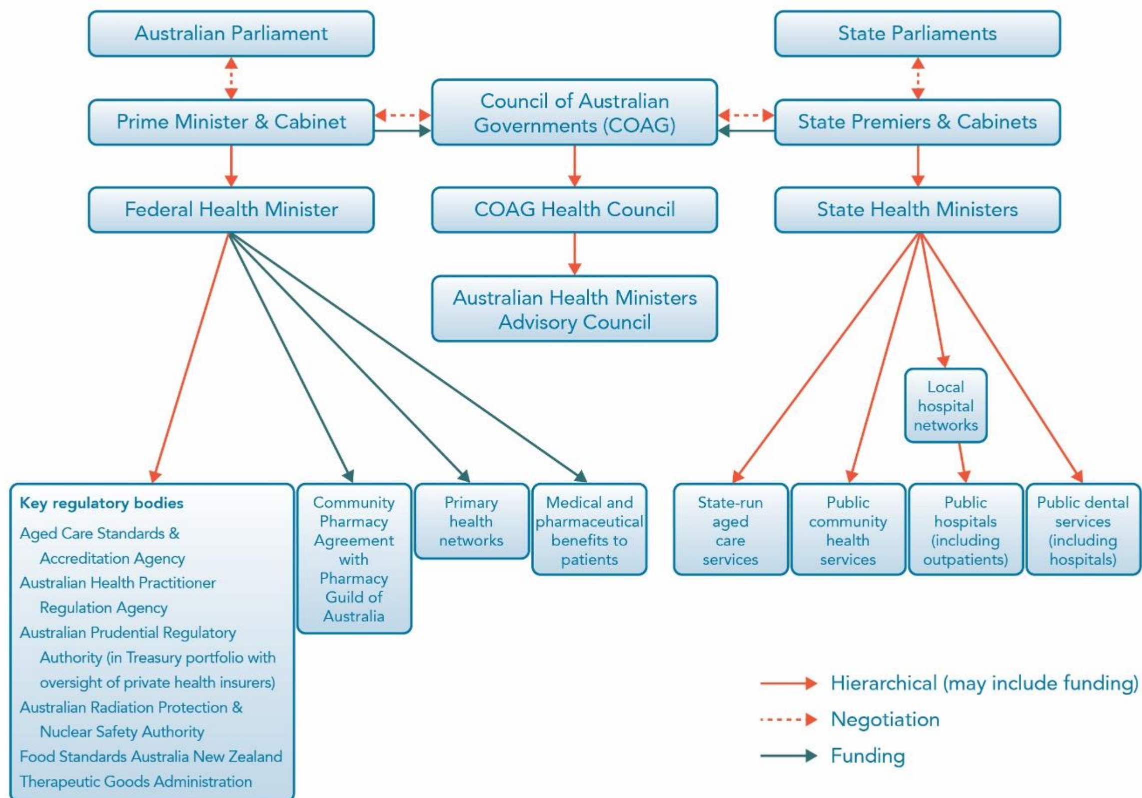
Safety nets: There are three safety nets. The Original Medicare Safety Net covers the cost of all Medicare services out of hospital above an annual out-of-pocket threshold of AUD447 (USD290). The Extended Medicare Safety Net covers 80 percent of out-of-pocket costs over an annual threshold of AUD648 (USD420) for those with government-issued concession cards (e.g., low-income, seniors, caregivers) and AUD2,030 (USD1,318) for others. The "Greatest Permissible Gap" sets the maximum out-of-pocket fee per out-of-hospital service at AUD79.50 (USD52.00). The government is seeking to replace these with a single Medicare Safety Net that would reimburse 80 percent of out-of-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: AUD638 (USD414) for

concessional patients (including low-income adults, children under 16, and certain veterans); AUD648 (USD420) for parents of school children; and AUD2,030 (USD1,318) for singles and all other families.

How is the delivery system organized and financed?

Primary care: In 2015, there were 34,367 GPs, 49,060 practitioners registered as generalists and specialists, and 8,386 specialists.[xvi] GPs are typically self-employed, with about four per practice on average.[xvii] In 2012, those in nonmanagerial positions earned an average of AUD2,862 (USD1,858) 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.[xviii]



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

In 2015, there were 11,040 nurses or midwives working in a general practice setting.[xix] Their role has been expanding with the support of the PIP practice nurse payment. Nurses are also 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.[xx]

Outpatient specialist care: Specialists deliver outpatient care in private practice (8,001 specialists in 2015) or in a public hospital (3,745).[xxi] 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 also may 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' support for and coordination of after-hours services, and there is an after-hours advice and support line.

Hospitals: In 2014–2015, there were 698 public hospitals (678 acute, 20 psychiatric), with a total of nearly 60,300 beds, an increase of 1,700 beds over the previous year, despite there being 20 fewer hospitals. In the same period, there were 624 private hospitals (342 day hospitals and 282 others) with 32,000 beds.[xxii] Private hospitals are a mix of for-profit and nonprofit.

Public hospitals receive a majority of funding (91%) from the federal government and state governments, with the remainder coming from private patients and their insurers. Most of the funding (62% of the total recurrent expenditure) is for public-physician salaries. Private physicians providing public services are paid on a per-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%).[xxiii]

Public hospitals are organized into Local Hospital Networks (LHNs), of which there were 136 in 2014–2015. 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 funding for growth set at 45 percent of the "efficient price of services," determined by the Independent Hospital Pricing Authority (IHPA). From July 2017, the Commonwealth will fund 45 percent of the efficient growth in these services, capped at 6.5 percent of total growth.[xxiv] 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.[xxv]

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 outpatient, 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.[xxvi]

As part of the federal government's response to a recent review by the National Mental Health Commission, funding through Primary Health Networks will be redirected to commission mental health services that meet local needs. The focus will be on suicide prevention and coordinated care.[xxvii]

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 percent 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). Federal government also provides an annual Carer Supplement of AUD480 million (USD312 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 (USD649). There are also a number of respite programs providing further support for caregivers.[xxviii]

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, and nursing. 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.[xxix] The Western Australian Government administers and delivers its Home and Community Care Program with funding support from federal government.

Aged-care, or nursing, homes may be private nonprofit or for-profit, or run by state or local governments. Federally subsidized residential aged-care positions are available to 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.[xxx]

In 2013, the federal government, in partnership with states, implemented the pilot phase of the National Disability Insurance Scheme, with full implementation planned for 2019–2020. 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 from the 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 (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 the quality and safety of care (see below). The Australian Institute of Health and Welfare (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.

The state governments operate their own departments of health and have devolved the 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 the state level.

What are the major strategies to ensure quality of care?

The overarching strategy for ensuring 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 that of 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. These include standards for conducting patient surveys, which must be met by hospitals and day surgery centers to ensure 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 to facilitate 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. The 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, agreed to by the COAG, includes measures of equity, effectiveness, and efficiency.

The federal government has regulatory oversight of quarantine, blood supply, pharmaceuticals, and therapeutic goods and appliances.[xxxi] In addition, there are a number of national bodies that 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 set a target of closing the gap in life expectancy by 2031. Progress toward this target is not on track, with the gap currently at 10.6 years for males and 9.5 for females. From 2005–2007 to 2010–2012 there was a very small reduction of 0.8 years for males and 0.1 years for females.[xxxii]

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.phidu.torrens.edu.au) for the purpose of publishing small-

area data showing disparities in access to health services and in 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 also may be coordinated by Aboriginal health and community health services.

What is the status of electronic health records?

The Australian Digital Health Agency, established in July 2016, has national responsibility for digital health strategy. An interoperable national e-health program based on personally controlled unique identifiers is now in operation. Around 4 million patients and more than 8,900 providers, two-thirds of whom are in primary care, are registered.[xxxiii] The record supports prescription information, medical notes, referrals, and diagnostic imaging reports. Patients are also able to add information about allergies, adverse reactions, and their wishes for their health care in the event that they are too unwell to communicate.

How are costs contained?

The major drivers of cost growth are the MBS and PBS. The federal 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 to report by the end of 2016.

The government influences the cost of the PBS by making determinations about which pharmaceuticals to list on the scheme and by negotiating the price with suppliers. It also provides funds to pharmacies to dispense medicines subsidized through the PBS and to support professional programs and the wholesale supply of medicines. This arrangement is implemented 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 (USD4.29 billion) in savings through supply chain efficiencies.[xxxiv]

Hospital funding is set through policy decisions by the federal government, with states required to manage funding within their budgets. 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 2016, the federal government announced that it will implement "health care homes" for the 20 percent of patients with multiple chronic conditions who are most in need of support. Patients will enroll with a GP, who will be paid a bundled payment for their care. The first of these patients are due to begin treatment in a health care home by July 2017.

The federal government has committed to doubling its investment in the public dental program to around AUD5.0 billion (USD3.25). It is estimated that the Child and Adult Public Dental Scheme, implemented by states and territories, will help more than 10 million Australians, providing coverage for the 5.3 million children under age 18 and some 5 million low-income adults.

Notes

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The Canadian Health Care System, 2016

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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. The federal government cofinances provincial and territorial programs, which must adhere to the Canada Health Act (1985),[i] which in turn sets standards for "medically necessary" hospital, diagnostic, and physician services. The act states that to be eligible to receive full federal cash contributions for health care, each provincial health care insurance plan needs to be: publicly administered, comprehensive in coverage, universal, portable across provinces, and accessible (e.g., 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, members of the Canadian Armed Forces, some veterans, resettled refugees and some refugee claimants, and inmates in federal penitentiaries; and administers several public health functions.

Who is covered and how is insurance financed?

***Publicly financed health care*:** Total and publicly funded 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.[ii] The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents in accordance with their own residency requirements.[iii] Temporary legal visitors, undocumented immigrants, 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.[iv] The federal government contributes cash funding to the provinces and territories on a per capita basis through the Canada Health Transfer, which will total an estimated CAD36 billion (USD28.8 billion) in 2016–2017, accounting for an estimated 23 percent of total provincial and territorial health expenditures.[v]

Private health insurance: 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 2014, approximately 94 percent of premiums for private health plans were paid through employers, unions, or other organizations under a group contract or uninsured contract (by which a plan sponsor provides

benefits to a group outside of an insurance contract).[vi] In 2015, private insurance accounted for approximately 12 percent of total health spending.[vii] The majority of insurers are for-profit.

What is covered under the mandated benefit package?

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 benefit package; most public coverage decisions are made by provincial and territorial governments in conjunction with the medical profession. Provincial and territorial governments' insurance plans provide varying levels of additional benefits, such as outpatient prescription drugs, nonphysician mental health care, vision care, dental care, home care, and hospice care. They also provide public health and prevention services (including immunizations) as part of their public programs.

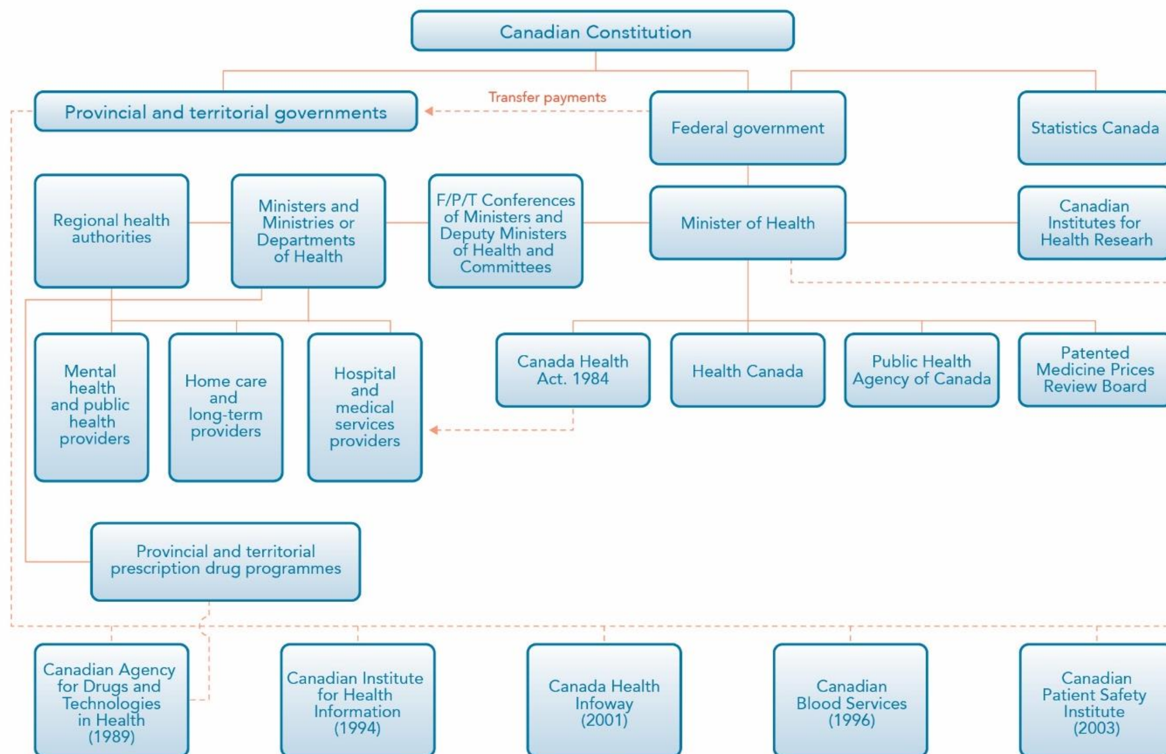
Cost-sharing and out-of-pocket spending: There is no cost-sharing for publicly insured physician, diagnostic, and hospital services. User fees for ambulance services vary considerably across provinces.[viii] All prescription drugs provided in hospitals are covered publicly, with outpatient coverage varying by province or territory. Physicians are not allowed to charge patients prices above the negotiated fee schedule. In 2015, out-of-pocket payments represented about 14 percent of total health spending, going mainly toward prescription drugs (21%), nonhospital institutions (mainly long-term care homes) (22%), dental care (16%), vision care (9%), and over-the-counter medications (10%).[ix]

Safety nets: 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, Ontario administers a universal prescription drug program for seniors and social assistance recipients[x] that includes copayments and deductibles.[xi] 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.[xii,xiii]

How is the delivery system organized and financed?

Primary care: In 2015, there were 2.28 practicing physicians per 1,000 population, about half of whom were general practitioners, or GPs (1.15 per 1,000 population), and the rest specialists (1.13 per 1,000 population).[xiv] Primary care physicians act largely as gatekeepers, and many provinces pay lower fees to specialists for non-referred 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 2014–2015, fee-for-service payments made up 45 percent of payments to GPs in Ontario, compared with 68 percent in Quebec and 84 percent in British Columbia.[xv] 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.[xvi]



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

Patients have free choice of primary care doctor. The requirement for patient registration varies.[xvii] Clinical fee-for-service payments to primary care physicians in Canada averaged CAD271,417 (USD217,134) in 2014–2015.[xviii] In several provinces, networks of GPs work together and share resources, with variations across provinces in the composition and size of teams.

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.[xix]

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, although there is variation across provinces.[xx] Specialists in

Canada received an average of CAD370,091 (USD296,073) annually in clinical fee-for-service payments in 2014–2015.[xxi] 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, compared with 24 percent in a private office or clinic.[xxii] 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.

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.[xxiii]

After-hours care: After-hours care is provided generally by physician-led (and mainly privately owned) walk-in clinics and by 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.[xxiv] In 2015, 48 percent of primary care physicians in Canada (67% in Ontario) reported having arrangements for patients to see a doctor or nurse after hours.[xxv]

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,[xxvi] whereas in other provinces, such as Ontario, they are predominantly private nonprofit corporations.[xxvii] There are no data on the number of private for-profit clinics (which are mostly diagnostic and surgical).[xxviii]

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, including Ontario, Alberta, and British Columbia, have considered introducing activity-based funding for hospitals.[xxix] 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, along with a fragmented system of allied services. Hospital mental health care is provided in

specialty psychiatric hospitals and in general hospitals with mental health beds. The provinces and territories all provide a range of community mental health and addiction services including case management, help for families and caregivers, community-based crisis services, and supportive housing.[xxx,xxxi] 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 with primary care is unique to its particular practice. In Ontario, an inter-sectoral mental health strategy has been in place since 2011,[xxxii] and was expanded in 2014[xxxiii] to better integrate mental health care into primary care.

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.[xxxiv] 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.[xxxv] 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.[xxxvi]

Eligibility criteria for home and institutional long-term care services 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 under 11 percent of total health expenditure in 2015, with financing mostly from public sources (70%).[xxxvii]

A mix of private for-profit (44%), private not-for-profit (30%), and public facilities (27%) provide facility-based long-term care.[xxxviii] Public funding of home care is provided either through provincial or territorial government contracts with agencies that deliver services, or through government stipends to patients to purchase their own services.[xxxix]

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.[xl] 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.[xli]

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 the following: promoting overall health; funding and delivery of certain health services for First Nations and Inuit; 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?

Many 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 the territorial level.[xlii] The use of financial incentives to improve quality is

limited. At the physician level, these have had little demonstrable effect on quality to date.[xliii] Professional revalidation for physicians, including requirements for continuing education and peer review, varies across provinces.

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 public reports on health system performance, including indicators of hospital and long-term care performance. To date, there is no information available on doctors' performance. The federally funded Canadian Foundation for Healthcare Improvement works with the provinces and territories to implement performance improvement initiatives, recently, for example, to reduce inappropriate prescribing for seniors in long-term care facilities.[xliv] Accreditation Canada—a not-for-profit organization—provides accreditation services to about 1,200 health care organizations across Canada, including regional health authorities, hospitals, long-term care facilities, and community organizations.

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). The provinces' and territories' premiers established the Health Care Innovation Work Group in 2012 to improve quality, for example to promote guidelines for treating heart disease and diabetes and to reduce costs.[xlv]

What is being done to reduce disparities?

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, with a focus on lower-income Canadians.[xlvi] No formal and periodic process exists to measure disparities; however, 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. The 2016 federal budget[xlvii] included CAD8.4 billion (USD6.7 billion) over a five-year period earmarked for services for indigenous people, including education, environment (e.g., water quality), and health and social services. In Ontario, a new strategy to improve the health of indigenous people was launched in 2016, with emphasis on investments in primary care, cultural competency training for health providers, access to fresh fruit and vegetables, and mental health

services for youth for First Nations.[xlviii] In 2008, the Truth and Reconciliation Commission was established to collect stories regarding the events and effects of the Indian Residential School legacy. In 2015, the commission ended its mandate, releasing a series of calls to action including several to address health disparities affecting aboriginal communities.[xlix]

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),[l] the Regulated Health Professions Network (Nova Scotia), and Health Links (Ontario). Also, Ontario has long-standing alternative community-based and multidisciplinary primary care models including 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.[li][lii]

Each province determines its own structure for the coordination of health and social care services.[liii] In Ontario and Quebec, there is a single ministry responsible for health care that includes long-term and social 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 own 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.[liv] However, interoperability is limited.[lv] 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.[lvi] 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 for 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. The board regulates "ex-factory" prices but does not have jurisdiction over wholesale or pharmacy prices, or over pharmacists' professional fees. Since 2010, the Pan-Canadian Pharmaceutical Alliance[lvii] has negotiated lower prices for 95 brand-name medications and has set price limits at 18 percent of equivalent brand-name drugs for the 15 most common generics.[lviii] Notwithstanding this pan-Canadian collaboration, jurisdiction over prices of generics and control over pricing and purchasing under public drug plans (and, in some cases, pricing under private plans) are held by provinces, leading to some interprovincial variation. "Choosing Wisely Canada" provides recommendations to governments, providers, and the public on reducing low-value care.[lix]

What major innovations and reforms have been introduced?

In June 2016, the federal government introduced new legislation that amended the criminal code to allow eligible adults to request medical assistance in dying from a physician or nurse practitioner.[lx]

Provincial health system governance: Provinces and territories continue to implement structural reforms to improve efficiency. For example, in August 2016 the new Northwest Territories Health and Social Services Authority became operational, consolidating eight former regional authorities in order to improve care coordination across health and social services.[lxi] In June 2016, Ontario announced a proposal to transfer responsibility for the contracting and coordination of home and community care from Community Care Access Centres to the Local Health Integration Networks. The provincial government also announced it will increase the integration of primary care and public health within health regions.[lxii]

Notes

[i] Canada Health Act, RSC 1985, c. C-6

[ii] Canadian Institute for Health Information (CIHI). *National Expenditure Trends 1975–2015*. (Ottawa: Canadian Institute for Health Information, 2015).

[iii] Health Canada. *Canada Health Act Annual Report 2012–2013*. Ottawa: Minister of Health of Canada, 2013). http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2013-cha-lcs-ar-ra/index-eng.php.

[iv] CIHI. *National Expenditure Trends*.

[v] CIHI, *National Expenditure Trends*. Government of Canada, "Federal Support to Provinces and Territories," www.fin.gc.ca/fedprov/mtp-end.asp, 2015. Please note that, throughout this profile, all figures in USD were converted from CAD at a rate of about CAD1.25 per USD, the purchasing power parity conversion rate for GDP in 2015 reported by OECD (2016) for Canada.

[vi] Canadian Life and Health Insurance Association Inc. "Canadian Life and Health Insurance Facts." clhia.uberflip.com/i/563156-canadian-life-and-health-insurance-facts, 2015.

[vii] CIHI. *National Expenditure Trends*. [date?]

[viii] CBC. MAP: Ambulance fees. www.cbc.ca/marketplace/blog/map-ambulance-fees. Accessed Aug 26, 2016.

[ix] CIHI. *National Expenditure Trends*. [date?]

[x] Ontario Ministry of Health and Long-Term Care (MOHLTC). "Ontario's drug plans: How much do I pay?" www.health.gov.on.ca/en/public/programs/drugs/programs/odb/opdp_pay.aspx, 2016. Accessed Aug 23, 2016.

[xi] Seniors pay a CAD6.11 (USD5.00) copayment per prescription and CAD100 (USD80) annual deductible, but low-income seniors and social assistance recipients are exempt from all cost-sharing except for a CAD2.00 (USD1.60) copayment, which is often waived by pharmacies. In August 2016, the low-income threshold for seniors was increased for the first time since cost-sharing was introduced in Ontario in 1996. The threshold is set at an annual income of less than or equal to CAD19,300 (USD15,440) for single people and less than or equal to CAD32,300 (USD25,840) for couples.

[xii] Canada Revenue Agency. Lines 330 and 331 – "Eligible medical expenses you can claim on your return." www.cra-arc.gc.ca/medical. Accessed Aug 26, 2016.

[xiii] Above 3 percent of income or over $2,208 (USD1,766), whichever is less.

[xiv] Canadian Institute for Health Information (CIHI). *Supply, Distribution and Migration of Canadian Physicians.* (Ottawa: Canadian Institute for Health Information, 2016).

[xv] Canadian Institute for Health Information (CIHI). *National Physician Database, 2014–2015*. (Ottawa: Canadian Institute for Health Information, 2016).

[xvi] The College of Family Physicians of Canada, the Canadian Medical Association, and the Royal College of Physicians and Surgeons of Canada, National Physician Survey, 2014. http://nationalphysiciansurvey.ca/. Accessed Aug 26, 2016.

[xvii] In 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.

[xviii] CIHI. *National Physician Database*.

[xix] Ontario Ministry of Health and Long-Term Care (MOHLTC). "Billing & Payment Guide for Family Health Organization (FHO) Physicians." http://www.health.gov.on.ca/en/pro/programs/ohip/publications/docs/fho_billing_payment_guide_nov2014_en.pdf, (2014). M.R. Lavergne, M.R. Law, S. Peterson, et al., "A population-based analysis of incentive payments to primary care physicians for the care of patients with complex disease." *Canadian Medical Association Journal* 2016.

[xx] For example, in Quebec and Ontario, alternative payments made up about 15 percent of total payments to specialists in 2014–2015, compared to 20 percent in British Columbia and 33 percent in Saskatchewan.

[xxi] CIHI, *National Physician Database*.

[xxii] National Physician Survey, 2014.

[xxiii] For example, physician letters sent to employers when employees are ill.

[xxiv] 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. These physicians are paid a 30 percent bonus for primary care services provided during evenings, weekends, and holidays. Manitoba has implemented QuickCare clinics, staffed by registered nurses and nurse practitioners, to meet health care needs after hours.

[xxv] Canadian Institute for Health Information (CIHI). *How Canada Compares: Results for the Commonwealth Fund 2015 International Survey of Primary Care Physicians.* (Ottawa: Canadian Institute for Health Information, 2016).

[xxvi] G.P. Marchildon, *Canada: Health System Review*. (Copenhagen: WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Policies, 2013).

[xxvii] Ontario Ministry of Health and Long-Term Care (MOHLTC). "Hospitals: Questions and Answers." www.health.gov.on.ca/en/common/system/services/hosp/faq.aspx, 2014.

[xxviii] 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.

[xxix] J.M. Sutherland, R.T. Crump, N. Repin, et al. *Paying for Hospital Services: A Hard Look at the Options*. (Toronto: C.D. Howe Institute, 2013). J.M. Sutherland, R.T. Crump, and N. Repin. *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, 2013).

[xxx] P. Goering, D. Wasylenki, and J. Durbin, "Canada's Mental Health System." *International Journal of Law and Psychiatry*, 2000 23(3-4): 345-359.

[xxxi] Other common community mental health services include Assertive Community Treatment programs and Early Intervention for Psychosis programs. Some of these teams are multidisciplinary, and may include nurses and physicians, but generally include social workers and case managers.

[xxxii] Government of Ontario. "Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy." www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf, 2011.

[xxxiii] Government of Ontario. "Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy." www.health.gov.on.ca/en/public/programs/mentalhealth/docs/open_minds_healthy_minds.pdf, 2014.

[xxxiv] Canada Health Act, RSC 1985, c. C-6.

[xxxv] Organisation of Economic Co-operation and Development (OECD). *Long-Term Care.* (Paris: OECD, 2011).

[xxxvi] A. Blomquist and C. Busby, *Long-Term Care for the Elderly: Challenges and Policy Options*. (Toronto: C.D. Howe Institute, 2012).

[xxxvii] CIHI, *National Expenditure Trends*.

[xxxviii] Canadian Institute for Health Information (CIHI). "Residential Long-Term Care Financial Data Tables," 2012. https://www.cihi.ca/web/resource/en/data_tables_ltc_en.xlsx, 2012.

[xxxix] For example, the "Choice in Support for Independent Living" program in British Columbia.

[xl] M. Grignon and N.F. Bernier, *Financing Long-Term Care in Canada*. (Canada: Institute for Research on Public Policy, 2012).

[xli] Canada Revenue Agency. "Family Caregiver Amount (FCA)." www.cra-arc.gc.ca/familycaregiver/, 2014. Government of Canada. "EI Compassionate Care Benefit – Overview." www.esdc.gc.ca/en/ei/compassionate/index.page, 2016.

[xlii] Examples include the Saskatchewan Health Quality Council, Health Quality Ontario, the British Columbia Patient Safety & Quality Council, and the New Brunswick Health Council.

[xliii] M.R. Lavergne, M. R. Law, S. Peterson, et al., "A population-based analysis of incentive payments to primary care physicians for the care of patients with complex disease," 2016. R. Carter, B. Riverin, J-F. Levesque, et al, "The impact of primary care reform on health system performance in Canada: a systematic review." *BMC Health Services Research* 2016 16:324. J. Li, J. Hurley, P. DeCicca, et al. "Physician response to pay-for-performance: evidence from a natural experiment." *Health Economics* 2014 23(8):962–978.

[xliv] Canadian Foundation for Healthcare Improvement New National Results. "Taking seniors off antipsychotics shows dramatic improvement in care." http://www.cfhi-fcass.ca/NewsAndEvents/NewsReleases/NewsItem/2016/05/16/new-national-results-taking-seniors-off-antipsychotics-shows-dramatic-improvement-in-care. Accessed August 26, 2016.

[xlv] The Council of the Federation. Health Care Innovation Working Group. http://www.pmprovincesterritoires.ca/en/initiatives/128-health-care-innovation-working-group. Accessed August 26, 2016.

[xlvi] Canadian Institute for Health Information (CIHI). *Trends in Income-Related Health Inequalities in Canada*. (Ottawa: Canadian Institute for Health Information, 2015: 2.)

[xlvii] Government of Canada. "Budget 2016." www.budget.gc.ca/2016/home-accueil-en.html, 2016.

[xlviii] Government of Ontario. "Ontario Launches $222 Million First Nations Health Action Plan." https://news.ontario.ca/mohltc/en/2016/05/ontario-launches-222-million-first-nations-health-action-plan.html. Accessed August 26, 2016.

[xlix] Truth and Reconciliation Commission of Canada. *Calls to Action*. (Winnipeg: Truth and Reconciliation Commission, 2015).

[l] Divisions of Family Practice. "Welcome to the Divisions of Family Practice." https://www.divisionsbc.ca/provincial/ home, 2014.

[li] Government of Ontario. "Ontario Funds Bundled Care Teams to Improve Patient Experience." news.ontario.ca/mohltc/en/2015/09/ontario-funds-bundled-care-teams-to-improve-patient-experience.html, 2015.

[lii] As discussed above, some provinces also have 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.

[liii] In Ontario, for instance, Community Care Access Centres are also responsible for coordinating services for vulnerable populations, particularly seniors and individuals with disabilities, including health and social care services (e.g., supportive housing and meal delivery programs), although this responsibility may be transferred to the Local Health Integration Networks (see "innovation and reforms," below).

[liv] Canada Health Infoway. *Annual Report, 2013–2014*. (Ottawa: Canada Health Infoway, 2014). www.infoway-inforoute. ca/index.php/resources/infoway-corporate/annual-reports.

[lv] K.K. Ogilvie and A. Eggleton, *Time for Transformative Change: A Review of the 2004 Health Accord*. (Ottawa: The Standing Senate Committee on Social Affairs, Science and Technology, 2012.)

[lvi] The College of Family Physicians of Canada, et al. "National Physician Survey, 2014."

[lvii] This is a collaboration between provinces' and territories' premiers, as well as the Federal government as of 2016.

[lviii] The Council of the Federation. The pan-Canadian Pharmaceutical Alliance. http://www.pmprovincesterritoires.ca/en/initiatives/358-pan-canadian-pharmaceutical-alliance. Accessed August 26, 2016.

[lix] Choosing Wisely Canada. "What is CWC?" http://www.choosingwiselycanada.org/about/what-is-cwc/, 2015.

[lx] Government of Canada. "An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)." S.C. 2016, c. 3. http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html. Accessed August 26, 2016.

[lxi] Northwest Territories Health and Social Services. "Establishment of the Northwest Territories Health and Social Services Authority." http://www.hss.gov.nt.ca/news/establishment-northwest-territories-health-and-social-services-authority. Accessed August 26, 2016.

[lxii] Government of Ontario. “Patients First. Reporting Back on the Proposal to Strengthen Patient-Centred Health Care in Ontario.” http://health.gov.on.ca/en/news/bulletin/2016/docs/patients_first_report_back_20160602.pdf. Accessed August 26, 2016.

The Danish Health Care System, 2016

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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 ensuring a high quality of care; 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 finance the majority of services delivered by private 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. The 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 2015 accounted for 84.2 percent of total health spending, representing 10.6 percent of GDP in 2015.[i] It should be noted, however, that Danish cost reporting with regard to the "gray zone" of long-term care tends to include more activities (services) than reporting requirements do in many other member countries of the Organisation for Economic Co-operation and Development (OECD).[ii]

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 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 services is activity-based or tied to specific priority areas, usually defined in the annual economic agreements between the national government and the municipalities or regions. The remaining 20 percent of financing for regional services 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.[iii]

In addition, nearly 1.5 million people hold supplementary insurance to gain expanded access to private providers.[iv] 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.[v]

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 age 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 benefit 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,[vi] covering mostly outpatient drugs, corrective lenses,

hearing aids, and doctor and dental care. Patients with outpatient drug expenses of more than DKK3,045 (USD406) per year receive the highest reimbursement rate—85 percent.[vii] Private specialists, hospitals, and dentists are free to set their own fees for patients not covered by public funding.

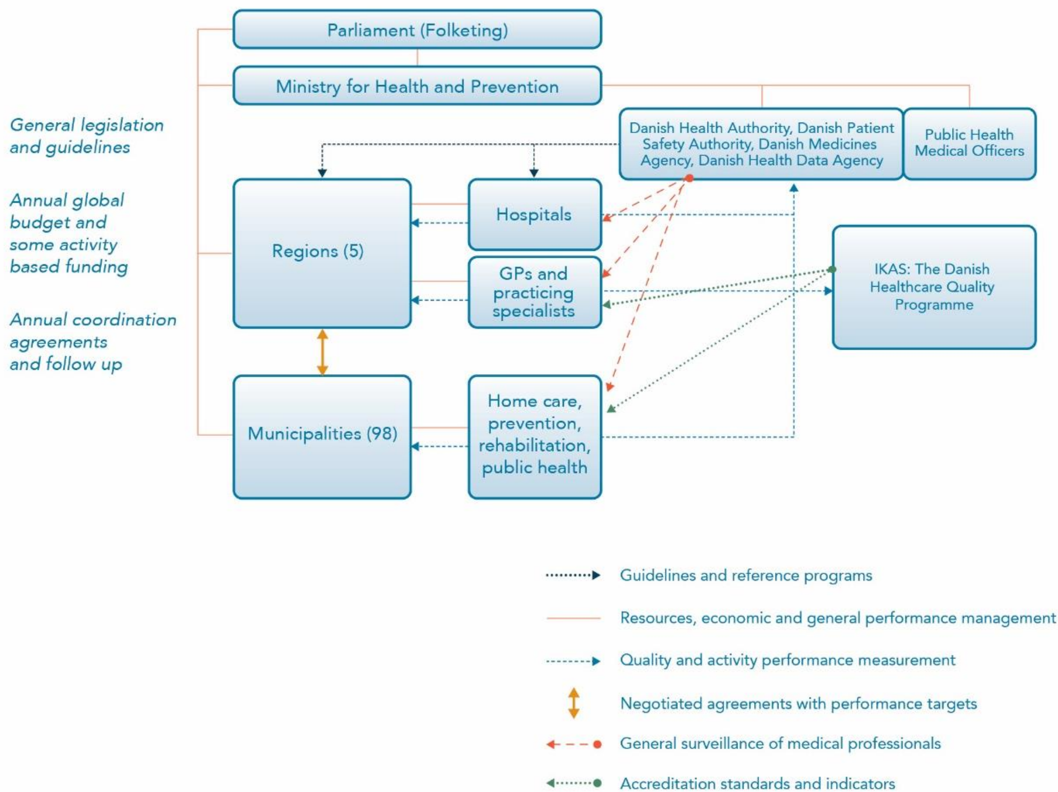
Safety net: There are cost-sharing caps of DKK22,115 (USD2,949)[viii] for children and DKK17,975 (USD2,397) for adults, and the municipalities provide means-tested social assistance to older people. If personal assets are DKK77,500 (USD10,333) or less, 85 percent of all prescription drug costs are covered. Chronically ill people with high drug usage and costs can apply for full reimbursement above an annual out-of-pocket ceiling of DKK3,775 (USD503). The terminally ill also can 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. Almost all general practitioners (GPs) are self-employed and are paid by the regions via capitation (about 30% of income) and fee-for-service (70% of income). Rates are set through national agreements with 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 DKK1.1 million (USD146,000) in 2011. The average salary for senior hospital doctors was DKK1 million (USD133,000).[ix]

The practice structure is gradually shifting from solo to group practices, typically consisting of two to four GPs and two to three nurses.[x] 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 and hospitals also receive patients paying out-of-pocket or covered by voluntary insurance. Fees for patients without referral are set by the specialists. As a result of legislation initially introduced in 2013 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.[xi]

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), with the fixed budget making 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 of payment 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.[xii] Bundled payments are not yet used extensively, but experiments are being carried out in all five regions. 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 one month of referral was introduced in 2014. Treatment must be commenced 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 enable 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.[xiii] Municipalities are obliged to organize markets with open access for both public and private providers of home care (personal and practical care such as cleaning and shopping), and patients may choose between public or private providers. While this system 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 also have contracted with private institutions for institutional care of older people, but more than 90 percent of residential care institutions (nursing homes) remain public.

Providers are paid directly by the 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 percent of income above DKK188,700, or USD24,880), as well as heating and electricity charges.[xiv]

Relatives of seriously ill individuals are allowed to 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 the 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 Parliament, the Ministry of Health, the Danish Health Authority, the Danish Medicines Agency, and the Danish Patient Safety Authority. The national authorities are responsible for the 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 negotiating 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.[xv]

The 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 provides information about quality and waiting times to support patient choice (see below).[xvi] 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.[xvii]

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 through 2015.[xviii] It is currently being replaced in hospitals with a new program featuring fewer standards and more emphasis on clinical and local dimensions (due in part 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 made available online for institutions but not for individual health providers at the hospital level.[xix] General quality and efficiency data are published regularly in national-level reports as a follow-up to national budget agreements between the state and the regions.[xx] Patient experiences are collected through 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 with which patients are diagnosed and treated. DDKM standards enforce the use of pathway programs and national clinical guidelines for all major disease types. The regions develop more specific practice guidelines for hospitals and other organizations, based on general national recommendations. There are no explicit national economic incentives tied to quality, but all five regions are experimenting with such schemes. In general, regions are obliged to take action in the event of poor results. The Danish Health Authority can step in if 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.[xxi] 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 hospital)

- 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 the 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 a patient's journey within 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 degree to which the regions and municipalities succeed in reaching the goals is measured by national indicators published online.[xxii]

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; the 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 place a special emphasis on people with chronic care needs, multimorbidity, or frailty resulting from aging or mental health conditions.[xxiii] The municipalities are in charge of a range of services, including social care, elder care, and employment services; most are currently working on models for better integration of these services, such as through joint administration with shared budgets and formalized communication procedures.

Practices increasingly employ specialized nurses, and several municipalities and regions have set up joint 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 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.[xxiv] All citizens in Denmark have a unique electronic personal identifier, which is used in all public registries, including health databases. The government has implemented an electronic medical card containing encoded information about each patient's prescriptions and medication use; this information is accessible by all relevant health professionals. 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.[xxv] 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 among regions, municipalities, and government to coordinate policy initiatives aimed at limiting spending, including direct controls of supply.

Block grants to the regions are conditional on annual increases in productivity of 2 percent on the basis of diagnosis-related groups and are withheld if productivity falls short of targets. Even though the activity-based portion is small, it makes up regions' marginal income and presents a strong incentive.[xxvi] Furthermore, regions are under pressure to deliver good performance, as they can be reformed 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. The purchase of medicine takes place through tendering by the joint regional organization AMGROS. A new regional “medicines council” will be established in 2017 to provide information to AMGROS and other decision-makers on the cost-effectiveness of new pharmaceuticals.

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, provides input to decision-making on new treatments and guidelines.

Regions may enter into contracts with private providers to deliver diagnostic and curative procedures. Prices for those services are negotiated between regions and private providers and can be lower than rates in the public sector.

Together, the above 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 standardized hospital mortality rates.[xxvii]

What major innovations and reforms have been introduced?

A plan for reorganization of the central governance structure was implemented by the incoming government in the fall of 2015. The reorganization created four separate agencies, dealing with health, medicines, patient safety, and IT, to replace the previous Health and Medicines Agency. The intent is to provide a clearer division of labor and more transparency and to improve the overall surveillance and accountability structure.

A new regional "Medicines Council" will be established in 2017 to evaluate the cost-effectiveness of new pharmaceuticals. The new council will replace the existing assessment structure, which does not include economic evaluation. The council will provide guidance for regional decision-making and the administration of tenders within AMGROS, the joint regional purchasing organization.

The Danish government and the regions have agreed to implement a new quality management scheme for hospitals in 2017 to replace the existing accreditation-based model. The new scheme includes a set of national indicators to be published annually, but will also allow more freedom for the regions and hospitals in designing their internal quality procedures and standards. The new model accommodates input from health professionals and hospitals that considered the accreditation-based scheme too burdensome and inflexible. The new scheme is based on the ideas of "permanent improvement culture" and "value-based health care." The existing accreditation-based scheme will continue to operate for primary care and municipalities.

Notes

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The English Health Care System, 2016

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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.[i] Under the Health Act (2006), the Secretary of State has a legal duty to promote a comprehensive health system providing services that are free of charge, apart from those with charges already in place. Rights for those eligible for National Health Service (NHS) care are summarized in the NHS Constitution; they include the right to access to care without discrimination and within certain time limits for some categories, such as emergency and planned hospital care.[ii] The Department of Health provides stewardship for the overall health system, but day-to-day responsibility for running the NHS rests with 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 host "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 2014, the U.K. spent 9.9 percent of GDP on health care, of which public expenditure, mainly on the NHS, accounted for 79.5 percent.[iii] 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 undocumented immigrants, only treatment in an emergency department and for certain infectious diseases is free.[iv]

Private health insurance: In 2015, an estimated 10.5 percent of the U.K. population had private voluntary health insurance, with 3.94 million policies held at the beginning of 2015.[v] 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.[vi] 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.[vii]

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. For drugs or treatments that have not been appraised by NICE, the NHS Constitution states that CCGs shall make rational, evidence-based decisions.[viii,ix]

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 some services, such as examinations for employment or insurance purposes and the provision of certificates for travel or insurance.

Outpatient prescription drugs are subject to a copayment (currently GBP8.40, or USD12.14, per prescription item in England); drugs prescribed in NHS hospitals are free. NHS dentistry services are subject to copayments of up to GBP233.70 (USD338.00) per course of treatment.[x] These charges are set nationally by the Department of Health. Out-of-pocket expenditure on health by households accounted for 14.8 percent of total expenditures in the U.K. in 2014. Also in 2014, the largest portion of out-of-pocket spending (42.4%) was for medical goods (including pharmaceuticals), followed by 35.9 percent on long-term care services, including residential care.[xi,xii]

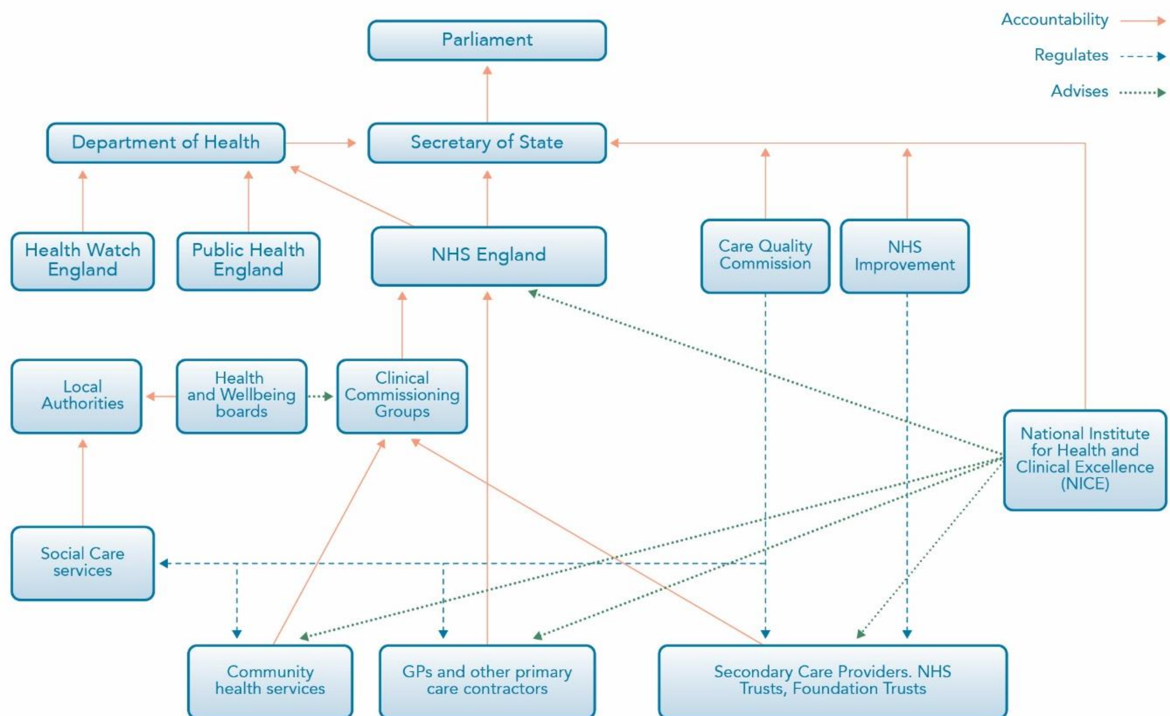
Safety net: People who are exempt from prescription drug copayments include children age 15 and younger those 16 to 18 in school full-time; people age 60 or older; people with low income; pregnant women and those who have given birth in the past 12 months; and people with cancer,

certain other long-term conditions, or certain disabilities. Patients who need large amounts of prescription drugs can buy prepayment certificates costing GBP29.10 (USD42.00) for a period of three months and GBP104.00 (USD150.00) for 12 months. Users incur no further charges for the duration of the certificate, regardless of how many prescriptions they need. In 2015, 89.7 percent of prescriptions in England were dispensed free of charge.[xiii] 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 2015, there were 34,592 general practitioners (full-time equivalents) in 7,674 practices, with an average of 7,450 patients per practice and 1,530 patients per GP.[xiv] There were 41,300 hospital specialists and a further 53,000 hospital doctors in training.[xv] The number of solo practices was 843 in 2014, while there were 3,589 practices with five or more GPs. 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%).[xvi] 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 are based mainly on evidence-based clinical interventions and care coordination for chronic illnesses. The proportion of income from these bonuses will fall when the new 2014–2015 contract is fully 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, whose duties include monitoring patients for blood pressure and providing minor treatments. General practice is undergoing a structural change, from single-handed "corner shops" to networked practices, including larger multipractice organizations using multidisciplinary teams of specialists, pharmacists, and social workers.[xvii] The average income for combined GPs (contracted and salaried) was GBP92,200 (USD133,237) before tax in 2013–2014.[xviii]

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 (in 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.[xix] 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" that 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 both 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 72) directly accountable to the Department of Health or as foundation trusts (currently 150)[xx] regulated by NHS Improvement, whose functions include the economic regulation 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.

Both NHS trust 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.[xxi] Responsibility for setting those rates is shared between NHS England and NHS Improvement. 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.[xxii] Private providers must be registered with the Care Quality Commission and with NHS Improvement, 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.[xxiii]

Mental health care: Mental health care is an integral part of the NHS, and 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, although there can still be long waiting times. Policies to improve the 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 treatment of mental health, by comparison with that of physical illnesses, has been underfunded.[xxiv]

Long-term care and social supports: The NHS pays for some long-term care, such as care 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 (USD20,592) in assets who are also assessed as having high levels of need, with a sliding scale applied up to GBP23,250 (USD33,600). 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.[xxv] Plans to impose a cap on total out-of-pocket spending on long-term care have been postponed until 2020.

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 GBP82.30 (USD119.00) a week.

In 2009, the private sector provided 78 percent of residential care places for older people and the physically disabled in the U.K.[xxvi] 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 (now NHS Improvement), responsibility for setting DRG rates for the 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.

NHS Improvement licenses all providers of NHS-funded care and may investigate potential breaches of NHS cooperation and competition rules, as well as 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–

2013.[xxvii]

What are the major strategies to ensure quality of care?

The CQC regulates all health and adult social care in England. All providers, including institutions, individual partnerships, and solo 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.[xxviii] 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 (which determine a portion 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 also must 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 actions needs to be taken. NHS England publishes an annual report on the actions taken and progress being made in reducing disparities in access and outcomes, by gender, disability, age,

socioeconomic status, and ethnicity.[xxix] 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 (2014–2015) 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, i.e., 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.

Practical initiatives include the Better Care Fund (GBP3.9 billion, or USD5.6 billion), pooled from existing health and social care budgets, for integration projects by local health and social care commissioners starting in 2015–2016. These funds are being used to improve the discharge process for hospital patients, reduce reliance on long-term care, and improve access to out-of-hospital care.

What is the status of electronic health records?

The NHS number assigned to every registered patient serves as a unique identifier. All general-practice patient records are computerized. Since April 2015, GP practices have been contractually obliged to offer patients the choice of booking appointments and ordering prescriptions online. As of March 31, 2016, practices are required to offer patients access to their detailed coded record—including information about diagnoses; medications and treatments; immunizations; and test results. Practices are not required to allow patients access to information that clinicians enter in free-text fields. Where electronic records are not available to patients, such as in dentistry, they can request a paper copy. Records are not routinely linked between providers.

The NHS had aimed to make primary, urgent, and emergency care services paperless by 2018, and all other parts of the NHS by 2020. However, this time line has already slipped, and a recent independent review of digital use in the NHS suggests that 2023 is a more reasonable target for trusts to reach digital maturity.[xxx]

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.[xxxi]

How are costs contained?

Costs in the NHS are constrained by a global budget that cannot be exceeded, rather than through patient cost-sharing or direct constraints on supply. 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 seen between 1996–1997 and 2009–2010.[xxxii] Although the government has allocated more money for the NHS in England (GBP4.5 billion, or USD6.5 billion, in real terms) over the next Parliament, the amount equates to an average of 0.85 percent per year between 2015–2016 and 2020–2021.[xxxiii] The mismatch between funding, demand, and the cost of providing services has led to NHS hospitals and other providers recording a deficit of GBP3.7 billion (USD5.3 billion) for 2015–2016, and a projected gap of GBP6.0 billion (USD8.7 billion) by 2020–2021, even if hospitals can continue to create efficiencies of 2 percent a year.[xxxiv]

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 the quality of care—notably waiting time targets.[xxxv]

Cost-containment strategies to date include freezing staff pay increases, supporting the increased use of generic drugs, reducing DRG payments for hospital activity, managing demand, and reducing administration costs. In 2016, NHS Improvement launched a program to help hospital providers generate savings through more efficient use of staff, more cost-effective purchasing of drugs and medical equipment, and better management of estates and facilities, which, if implemented, could save GBP5.0 billion (USD7.2 billion) by 2020.[xxxvi] There are a number of tools whereby local purchasers can 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.

The costs of prescription (branded) drugs are contained by the Pharmaceutical Price Regulation Scheme (PPRS). The latest scheme, lasting five years through 2018, regulates the profits that drug companies can make selling drugs to the NHS. It is a voluntary scheme, negotiated between the U.K. government and the pharmaceutical industry, with new medicines to be introduced to the NHS at prices set by the manufacturer as long as they remain within the profit cap.[xxxvii] This scheme runs parallel with the cost-effectiveness appraisals by NICE, which tends not to recommend new drugs as cost-effective if they exceed GBP20,000–GBP30,000 (USD28,900–USD43,350) per Quality Adjusted Life Year (QALY).

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 strategies to address them.[xxxviii] These include pilot programs across England to test new models of care known as "vanguards." To date, there are 50 vanguard sites testing such innovations as 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 these will lead to better tools for identifying those at risk of becoming high-need, high-cost patients, and to the development of capitated contracts to encourage 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.[xxxix] All NHS areas are also expected to implement full seven-day working weeks in hospitals and general practice by 2020, as pledged in an election manifesto in 2015.

To accelerate the process of reform, in December 2015 the government announced a new approach that involves all local purchasers and providers coming together across 44 local "footprints" to create multiyear plans to transform services, based on a conglomerated budget for their local populations.[xl] Although the legal responsibility of individual NHS organizations to break even remains unchanged, this approach calls for organizations to collaborate, and represents an important break with the previous policy of competition.

The authors would like to acknowledge Anthony Harrison, the author of earlier versions of this profile.

Notes

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

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[vii] Competition and Markets Authority, Private Healthcare Market Investigation, 2014.

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

[x] Please note that, throughout this profile, all figures in USD were converted from GBP at a rate of GBP0.692 per USD, the purchasing power parity conversion rate for GDP in 2015 reported by OECD (2016) for England.

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The French Health Care System, 2016

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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. Over the past two decades, the state has been increasingly involved in controlling health expenditures funded by statutory health insurance (SHI).[i]

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 Ministry of Health and Social Affairs is represented in the regions by the 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 Councils, which are the governing bodies at the local level.

Who is covered and how is insurance financed?

Publicly financed health insurance: Total health expenditures constituted 12 percent of GDP (EUR257 billion [USD310 billion]) in 2014, of which 76.6 percent was publicly financed.

SHI is financed by employer and employee payroll taxes (50%); a national earmarked income tax (35%); taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies (13%); and state subsidies (2%).

Coverage is universal and compulsory, provided to all residents by noncompetitive SHI. As of January 2016, SHI eligibility is universally granted under the "PUMA law" (*protection universelle maladie*, or universal healthcare coverage).[ii] Citizens can opt out of SHI only in rare cases (e.g., individuals working for foreign companies).

The state 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 13.5 percent of total health expenditure.[iii] 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.

In 2013, standards for employer-sponsored VHI were established by law in order to reduce inequities in coverage stemming from variations in access and quality. By 2017, all employees will benefit from employer-sponsored insurance (for which they pay 50% of the cost), which will cover at least 125 percent of SHI fees for dental care and EUR100 (USD121) for vision care per year.[iv] The population of beneficiaries without supplementary insurance is estimated at 4 million. Choice among insurance plans is determined by the industry in which the employer operates.

What is covered?

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

SHI covers hospital care and treatment in public or private rehabilitation or physiotherapy institutions; outpatient care provided by general practitioners, specialists, dentists, and midwives; diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals; prescription drugs, medical appliances, and prostheses that have been approved for reimbursement; and prescribed health care–related 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, such as immunization, mammography, and colorectal cancer screening, as well targeted populations. A measure of the “Touraine law,” adopted on April 14, 2015, mandated the legalization of drug-use centers over a subsequent six-year period. These centers will be used exclusively for treatment of especially vulnerable drug addicts, under the supervision of health professionals.[v]

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 2014, total out-of-pocket spending made up 8.5 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 balance billing In exchange for its voluntary capping at twice the official fee. This contract offers patients partial reimbursement of balance billing by SHI and reduced social charges for physicians.

Most out-of-pocket spending is for dental and vision 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.

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%)
- the effectiveness of prescription drugs (highly effective drugs, like insulin, carry no coinsurance; rates for all other drugs are 15% to 100%, depending 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	18.00	22.00
Doctor visit	1.00	1.20
Prescription drug	0.50	0.60
Ambulance	2.00	2.40
Hospital	18.00	22.00

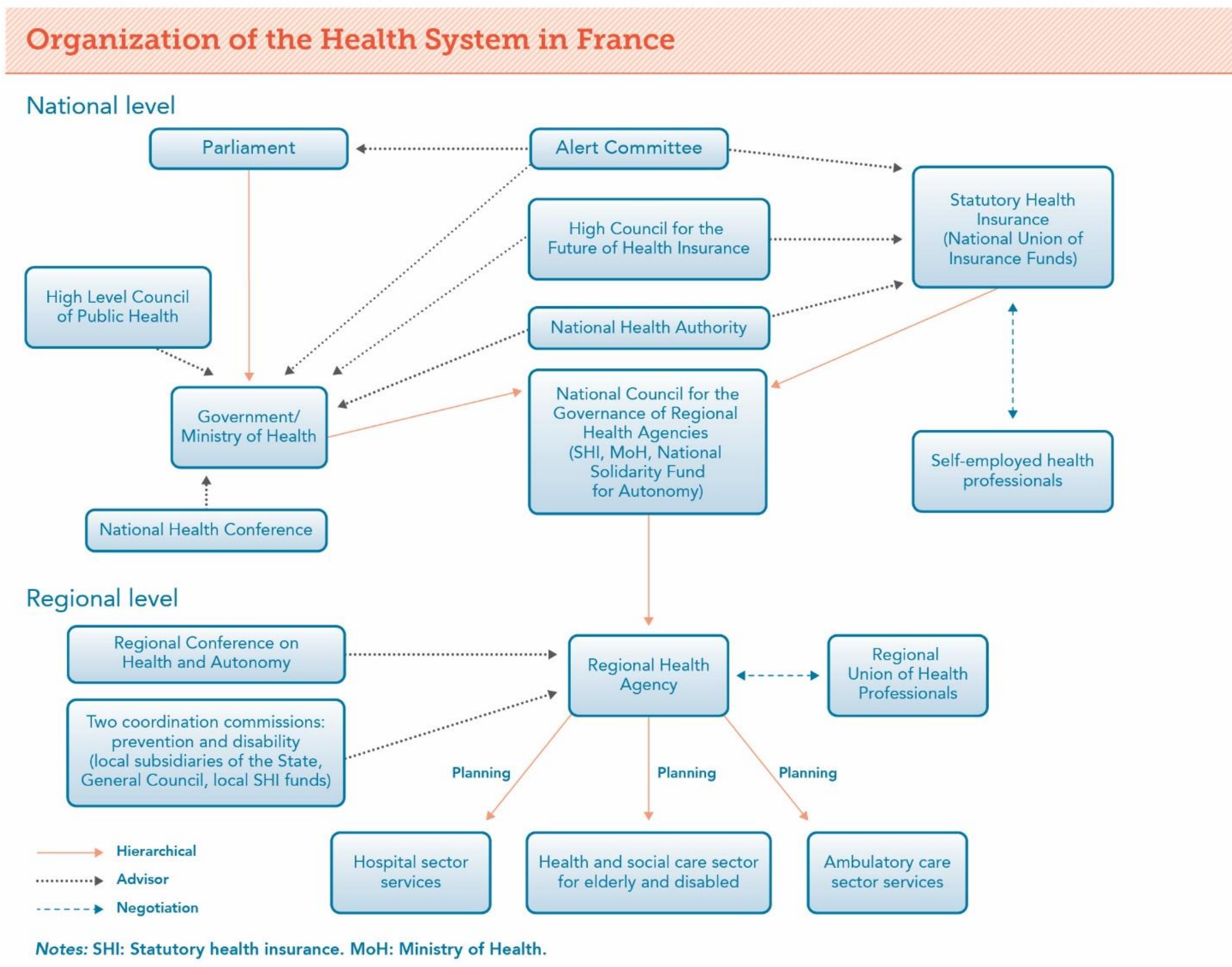
Safety net: People with low incomes are entitled to free or state-sponsored VHI, free vision care, and free dental care, with the total number of such beneficiaries estimated at around 10 percent of the population.[vi] Exemptions from coinsurance apply to individuals with any of 32 specified chronic illnesses (13% of the population, with exemption limited to treatment 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. 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. These agreements set the fee schedule as well as coordination and quality incentives.

Primary care: There are roughly 221,000 general practitioners (GPs) and 119,000 specialists in France (a ratio of 1:1.17). About 59 percent of physicians are fully or partly self-employed (67% of GPs, 51% of specialists).[vii] Over 50 percent of GPs, predominantly 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.



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

There is a voluntary gatekeeping system for adults age 16 and older, with financial incentives offered for registering with a GP or specialist.

Self-employed GPs are paid mostly fee-for-service (currently EUR23 [USD28], to be increased to EUR25 [USD30] in 2017) and can receive a yearly capitated per-person payment of EUR40 (USD48) to coordinate care for patients with a chronic condition. In addition, up to EUR5,000 (USD6,024) 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 also can enter into a contractual agreement under which they are guaranteed a monthly income of EUR6,900 (USD8,313) if they set up their practice in a region with insufficient physician supply. For those who elect to work full-time in medical centers, the guaranteed salary is around EUR50,000 (USD60,240).

The average income of primary care doctors in 2011 was EUR82,020 (USD98,820), 94 percent of which came from fees[viii] and the remainder from financial incentives and salary. Fees, set by the Ministry of Health and SHI, have been frozen since 2011, but revenues from other sources have increased.

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. In addition, over 1,000 medical homes, providing multiprofessional services (usually with three to five physicians and roughly a dozen other health professionals) and after-hours care, will be in operation by the end of 2016.

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; specialists must meet disease-specific quality targets in addition to those targets that apply to GPs. The average annual income derived from pay-for-performance is EUR5,480 (USD6,602) per physician; 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 gynecologists, ophthalmologists, psychiatrists, and stomatologists. Bypassing referral results in reduced SHI coverage.

The specialist fee set by SHI is EUR28 (USD34), but specialists can balance-bill. The average yearly income of self employed specialists is EUR133,460 (USD160,795).[ix] 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.

Specialists working in public hospitals may see private-pay patients on either an outpatient or an inpatient 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 claims by private clinics of unfair competition, has prompted several public inquiries—the latest of which resulted in recommendations to increase public control over this activity.

Administrative mechanisms for direct patient payments to providers: 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 EUR50.00 (USD60.00) per patient per year. A very controversial article in the 2015 Touraine law was the third-party payment management system (*système du tiers-payant*) as a safety net for the poorest populations. Third-party payment makes physicians' consultations totally free at the point of care: practitioners will be paid directly by social security and supplementary health insurance.[x]

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 medical homes financed by SHI and staffed by health professionals on a voluntary basis. Primary care physicians are not mandated to provide after-hours care.

Emergency services can be accessed via the national emergency phone number, which is staffed by trained professionals who determine the type of response needed. The feasibility of telephone or telemedicine advice is undergoing experimentation; 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.

Hospitals: Public institutions account for about 65 percent 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. As of 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 in public and not-for-profit hospitals. 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) and from the provision of emergency services, organ harvesting, and organ 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). 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 both the public and the private health care sector, 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. Statutory health insurance covers the medical costs of long-term care, while families are responsible for the housing costs in hospices and other long-term facilities—on average, EUR1,500 (USD1,809) per month. 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 with a total of 720,000 beds. Of these institutions, 54 percent are public, 28 percent private nonprofit, and 18 percent for-profit, although the percentage of for-profit institutions is increasing.

In addition, temporary care for dependent patients and respite services for their caregivers are available without restrictions from the states or regions.

Means-tested monetary allowances are provided for the frail elderly. The allowances are 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.

A law enacted in December 28, 2015, relating to societal adaptation to aging has established local conferences to define priorities and list existing services in order to propose and fund programs to prevent autonomy loss.[xi]

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 roughly 75 percent 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 DRG fees and copayments), and pricing drugs.

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, particularly 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.

The Public Health Agency (Santé publique France, loi n° 2016-41) was created In 2016 to protect population health.

What are the major strategies to ensure quality of care?

National plans have been developed for treatment of rare diseases and a number of chronic conditions, including cancer and Alzheimer's, as well as for prevention and healthy aging. 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 HAS publishes an evidence-based basic benefit package for 32 chronic conditions. Further

guidance on recommended care pathways 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 practices, 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 HAS. For hospital physicians, both can be performed as part of the hospital accreditation process.

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 HAS 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,[xii] and poorer self-reported health among those with state-sponsored insurance and those with no complementary insurance. 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. In 2009, launching its Second Cancer Plan, France placed inequalities at the heart of its public health policy. In 2012, the French president reaffirmed this priority with the Third Cancer Plan and later the 2015 Touraine law.[xiii] 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 care are reported by

the Ministry of Health.

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

Inadequate coordination in the health care system remains a problem. Various quality-related initiatives piloted by the Ministry of Health or by regional agencies aim to improve the coordination of hospital, out-of-hospital, and social care (see above). They target the elderly and fragile populations and attempt to streamline the health care pathway, integrating providers of health and social care via a shared portal and case managers.

What is the status of electronic health records?

The initiative to fully integrate electronic health records has faced multiple delays, and the integration of information systems between health care professionals and hospitals remains limited.[xiv] The electronic health record (EHR) project covers 587,443 patients as of 2016, or 0.8 percent of the population, and an estimated 731 hospitals.[xv] 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. 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.

The government has created a national agency for health information systems for expanding the uptake and interoperability of existing systems.

How are costs contained?

SHI has faced large deficits over the past 20 years, but they have fallen from an annual EUR10.0 billion –EUR12.0 billion (USD12.1 billion – USD14.5 billion) in 2003 to EUR4.6 billion (USD5.5 billion) in 2015.[xvi] This trend is the result of 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[xvii]; and a reduction of the official fees for self-employed radiologists and biology labs. Other measures include central purchasing to better negotiate costs, increasing the share of outpatient surgery, instituting earlier post-surgery and post-delivery discharge, and reducing duplicate testing. Competition is not used as a cost-control mechanism. Global budgets are used only in price–volume agreements for drugs or devices. Patient cost-sharing mechanisms include increased copayments for patients who refuse generics or do not use the gatekeeping system. The increasing price of drugs is addressed (1) by using earmarked funds for hepatitis C drugs and capping the total cost of treatments at EUR700 million (USD843 million) in 2015, thus providing treatment to successive waves of patients by decreasing severity, and (2) by negotiating price-volume agreements and undisclosed rebates with manufacturers.

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 benefit of prostate cancer screening; using DRG payments to incentivize shifts to outpatient surgery; establishing guidelines for the number of allowable 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 of other less costly biosimilar drugs; and testing the use of taxi vouchers, instead of ambulances, for chronically ill patients.

What major innovations and reforms have been introduced?

The two major reforms of 2016 have been the universal access to statutory health insurance (effective January 2016) and the deployment of third-party payment for physicians' consultations (to go into effect in 2017). Both reforms have a clear Beveridgian inspiration and are part of the policy to reduce social inequities in access to care; the latter has also been denounced by physicians' unions as the "nail in the coffin" for private providers. Reducing health inequities was part of the 2012 presidential campaign platform and has been a recurrent theme for the past several years. While universal insurance access was implemented at once and without political difficulty, third-party payment has a phased entitlement. Starting in July 2016, patients with chronic conditions and pregnant women can obtain it, and by January 2017 all patients will be able to do so, with use becoming mandatory in November 2017. The impact on health inequities will be assessed by monitoring the uptake and patients' use of medical resources.

Notes

[i] Nay O, Béjean S, Benamouzig D, Bergeron H, Castel P, Ventelou B. Achieving universal health coverage in France: policy reforms and the challenge of inequalities.Lancet. 2016 May 28;387:2236–49.

[ii]PUMa 2016 : http://www.ameli.fr/assures/droits-et-demarches/la-protection-universelle-maladie.php.

[iii] DREES 2015. Ministère de la Santé. "Les dépenses de santé en 2014", études et résultats n°935, 15 septembre 2015.

[iv] 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 France.

[v] Nay O, Béjean S, Benamouzig D, Bergeron H, Castel P, Ventelou B. Achieving universal health coverage in France: policy reforms and the challenge of inequalities.Lancet. 2016 May 28;387:2236–49.

[vi] DREES 2015. Ministère de la Santé. "Les dépenses de santé en 2014", études et résultats n°935, 15 septembre 2015.

[vii] DREES . Ministère de la Santé. DREES 2016 Portrait des professionnels de santé.SÉRIE ETUDES ET RECHERCHE N° 134 ● FEVRIER 2016.

[viii] Ibid.

[ix] Ibid.

[x] Nay O, Béjean S, Benamouzig D, Bergeron H, Castel P, Ventelou B. Achieving universal health coverage in France: policy reforms and the challenge of inequalities.Lancet. 2016 May 28;387:2236–49.

[xi] Cour des Comptes Le maintien à domicile des personnes âgées en perte d'autonomie - juillet 2016 Cour des comptes - www.ccomptes.fr -.

[xii] DREES 2015. Ministère de la Santé. "Les dépenses de santé en 2014", études et résultats n°935, 15 septembre 2015. AND Nay O, Béjean S, Benamouzig D, Bergeron H, Castel P, Ventelou B. Achieving universal health coverage in France: policy reforms and the challenge of inequalities.Lancet. 2016 May 28;387:2236–49.

[xiii] Nay O, Béjean S, Benamouzig D, Bergeron H, Castel P, Ventelou B. Achieving universal health coverage in France: policy reforms and the challenge of inequalities.Lancet. 2016 May 28;387:2236–49.

[xiv] Nay O, Béjean S, Benamouzig D, Bergeron H, Castel P, Ventelou B. Achieving universal health coverage in France: policy reforms and the challenge of inequalities.Lancet. 2016 May 28;387:2236–49.

[xv] DMP 2016. http://www.dmp.gouv.fr/web/dmp/.

[xvi] CNAM TS: Direction Déléguée des Finances et de la Comptabilité. Comptes CNAM TS exercice 2105.

[xvii] IRDES. Historique de la politique du médicament en France. http://www.irdes.fr/documentation/syntheses/historique-de-la-politique-du-medicament-en-france.pdf.

The German Health Care System, 2016

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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 two systems, namely: 1) competing, not-for-profit, nongovernmental health insurance funds ("sickness funds"—there were 118 as of January 2016[i]) in the statutory health insurance (SHI) system; and 2) substitutive private health insurance (PHI). States own most university hospitals, while municipalities play a role in public health activities, and own about half of all hospital beds. However, the various levels of government have virtually no role in the direct financing or delivery of health care. To a large degree, regulation is delegated to self-governing associations within sickness funds and provider organizations, which are together represented by the most important body, the Federal Joint Committee.

Who is covered and how is insurance financed?

Publicly financed health insurance: In 2014, total health expenditure was 11.2 percent of GDP, of which 74 percent was public, mainly SHI spending (58% of total). General tax-financed federal spending on "insurance-extraneous" benefits provided by SHI, such as coverage for children, amounted to about 4.5 percent of total expenditure in 2014.[ii] Sickness funds are financed 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 EUR56,250 (USD71,564) per year as of 2016 are mandatorily covered by SHI, and their nonearning dependents are covered free of charge.[iii] 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 (as 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. Military members, police, and other public employees are covered under special programs. Visitors are not covered through German SHI. Refugees and undocumented immigrants are covered by social security in case of acute illness and pain, as well as pregnancy and childbirth.

As of 2016, the legally set uniform contribution rate is 14.6 percent of gross wages, shared equally by the employer and employees. A previous legally fixed additional contribution rate for employees (0.9%) and supplementary per capita premiums set by sickness funds have been

abolished and replaced by a supplementary income-dependent contribution rate determined individually by each sickness fund.[iv] In 2015, the supplementary contribution rate was, on average, 0.83 percent—that is, most of the SHI-insured paid less than previously, with rates ranging between 0 and 1.3 percent. For 2016, the average supplementary contribution rate is estimated at 1.1 percent.[v]

This contribution also covers dependents (nonearning spouses and children). Earnings above EUR50,850 (USD64,994) per year (as of 2016) are exempt from contribution. The 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 2015, 8.8 million people were covered through substitutive private health insurance.[vi] 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 April 2016 (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)[vii] 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). The federal government determines provider fees under substitutive, complementary, and supplementary PHI through a specific fee schedule. There are no government subsidies for complementary and supplementary PHI. In 2014, all forms of PHI accounted for 8.9 percent of total health expenditure.[viii]

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). Preventive services under SHI include regular dental checkups, child checkups, basic immunizations, checkups for chronic diseases, and cancer screening at certain ages. All prescription drugs are covered except for those explicitly excluded

by law (mainly so-called lifestyle drugs) and those excluded following benefits assessment. While the broader framework of the benefit package is legally defined, specifics are determined 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 13.2 percent of total health spending in 2014, mostly on nursing homes, pharmaceuticals, and medical aids.[ix]

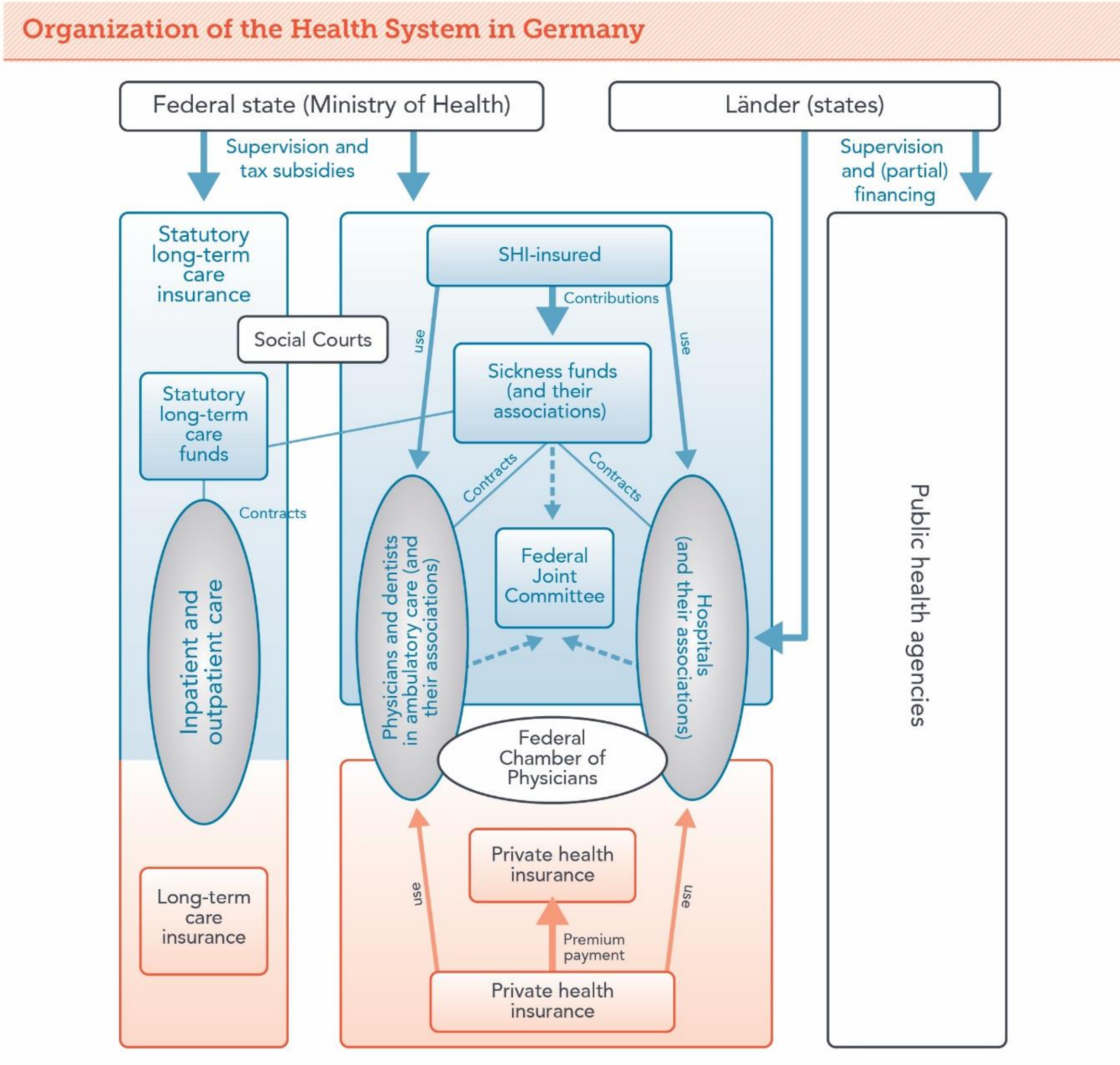
Copayments include EUR5.00 to EUR10.00 (USD6.36 to USD12.72) per outpatient prescription, EUR10.00 per inpatient day for hospital and rehabilitation stays (for the first 28 days per year), and EUR5.00 to EUR10.00 for prescribed medical devices. Sickness funds offer selectable tariffs with a range of 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 0.3 million of those insured under SHI exceeded the 2 percent cap in 2014 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 6.3 million people, or around 9 percent of all the SHI-insured, benefited from this regulation in 2014.[x] 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 between 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 2015, of the roughly 108,500 self-employed SHI-accredited physicians in ambulatory care, 51,900 (48%) were practicing as family physicians

(including GPs, internists, and pediatricians) and 56,600 (52%) as specialists. There were about 2,000 multispecialty clinics, with more than 13,000 physicians (10% of ambulatory care physicians), in 2015. 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 and psychotherapists is more than 140,000.[xi] 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.



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

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 also often 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 covering a predefined maximum number of patients per practice and reimbursement points per patient, setting thresholds on the number of patients and of 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 (USD254,452) per year, covering costs for personnel, etc., but excluding income from private patients, which varies substantially.[xii]

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 USD153, in 2016) 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 across 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 receive the money from the sickness funds in the form of annual capitations. 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 by 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 2015, there were a total of 35,368 office-based psychiatrists, neurologists, and psychotherapists working in the ambulatory care sector (paid FFS).[xiii] 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), intended 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 is 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 by 0.2 percent 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 only 50 percent of institutional care costs, people are advised to buy supplementary private LTCI. Family caregivers get financial support through continuing payment of up to 50 percent of care costs.

Hospice care is partly covered by LTCI if the SHI Medical Review Board has determined 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 past 15 years, to 235 hospices and 304 palliative care wards nationwide in spring 2016.[xiv] The Act to Improve Hospice and Palliative Care passed in 2015, 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 those in many other countries.

Within the legal framework set by the Federal 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 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 Institute for Quality and Transparency (IQTiG), which is responsible for intersectoral quality assurance. The committee has 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. Representatives of patient organizations have the right to participate in different decision-making bodies—for example, 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. As of 2016, the IQTiG is responsible for developing instruments for interfacility and intersectoral quality assurance on behalf of the Federal Joint Committee. In addition, the institute develops criteria for evaluating certificates and quality targets, and ensures that the published results are comprehensible to the public.

All hospitals are required to publish findings on selected indicators, as defined by the IQTiG, to enable hospital comparisons. Volume thresholds have been introduced for a number of complex procedures (e.g., transplants), requiring that hospitals perform a minimum number of such procedures in order to be reimbursed for them. Process and, in part, 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 introduces a focus on quality-related hospital accreditation and payment, beginning in 2016.

Structural quality is further 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. For instance, all new diagnostic and therapeutic procedures applied in ambulatory care must receive a positive evaluation for benefit and efficiency before they can be reimbursed by sickness funds.

Although there is no revalidation requirement for physicians, 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.

The Robert Koch Institute, an agency subordinate to the Federal Ministry of Health and responsible for the control of infectious diseases and for 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.

Disease management programs (DMPs), implemented in 2002, ensure quality of care for people with chronic illness. DMPs 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 other professional societies.

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 more than 120 health-related institutions (e.g., sickness funds and their associations) promotes the health of the socially deprived.[xv] Primary preventive care 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.[xvi] With the Act to Strengthen Health Promotion and Prevention, these programs have recently been further developed and financially supported.

The Health Monitor (*Gesundheitsmonitor*) was a national association of nonprofit organizations and sickness funds. To assess the accessibility of health care, it regularly conducted studies from the patient perspective—for example, on the availability of information, experiences with health care, and progress of health system reforms. The Health Monitor, last conducted in 2016, ceased to exist after 15 years. A comparable survey on health access has not been provided.

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

Many efforts to improve care coordination have been implemented; for example, sickness funds offer integrated-care contracts and DMPs for chronic illnesses to improve care for chronically ill patients and to improve coordination among providers in the ambulatory sector. In December 2015, 9,966 registered DMPs for six indications had enrolled about 6.6 million patients (more than 8% of all the SHI-insured).[xvii] There is no pooling of funding streams by the health and social care sectors.

As of 2016, the Innovation Fund promotes new forms of cross-sectoral and integrated care (also for vulnerable groups) supported by annual funding of EUR300 million, or USD382 million (including EUR75 million, or USD95 million, for evaluation and health services research). Funds are awarded through an application process overseen by the Innovation Committee, based at the Federal Joint Committee.[xviii]

What is the status of electronic health records?

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.[xix] In 2015, the Federal Cabinet passed 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 (2016–2017), 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 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.[xx]

How are costs contained?

Recently, there has been a shift away from reliance on overall budgets for ambulatory physicians and hospitals and on collective regional prescription caps for physicians toward 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 for "low-value" services.

To enhance competition, some purchasing power has been handed over to the sickness funds. For example, the funds can now selectively negotiate integrated care contracts with providers and negotiate rebates with pharmaceutical companies.

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. For drugs with added benefit (evaluated by IQWiG but decided on by the Federal Joint Committee), 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.

What major innovations and reforms have been introduced?

Since 2012, the German health care system has been undergoing a period of active reform in several areas. The most influential reform in the past year was the Second Act to Strengthen Long-Term Care, which went into effect in January 2016; this followed the First Act, which significantly expanded support for individuals in need of long-term care and for their families. The Second Act, set to start in 2017, will broaden eligibility for long-term care services, which previously have been granted only to people with considerably restricted daily functions. The

new act aims to provide services more equitably, by expanding eligibility to people with physical, mental, and psychological impairments. The new benefits are being integrated into the standard legislation on benefits.[xxi]

To finance these reforms, the contribution rate for LTCI will increase by 0.2 percentage points, up to 2.55 percent of income for people with children and 2.80 percent for people without children. According to the government, the increase in contribution rates will generate about EUR6.0 billion (USD7.6 billion) in additional revenue, which should cover the additional spending on long-term care by 2022.[xxii]

The authors would like to acknowledge Stephanie Stock as a contributing author to earlier versions of this profile.

Notes

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The Israeli Health Care System, 2016

Bruce Rosen and Ruth Waitzberg, Myers-JDC-Brookdale Institute

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 (including the regulation of health care insurers and providers). 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.[i]

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

Who is covered and how is insurance financed?

In 2015, national health expenditures accounted for 7.5 percent of GDP, a figure that has remained stable during the last two decades. In 2015, 62 percent of health expenditures were publicly financed, a share that is one of the lowest among OECD countries. (The Israeli figure is down from 63.5% in 2010 and 68% in 1995.)

Publicly financed health insurance: Israel's NHI system automatically covers all citizens and permanent residents (aside from soldiers, who receive health care directly from the army). It is funded primarily through a special income-related health tax in combination with 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 benefit 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.[ii] HP-VHI premiums are age-related and cross-subsidized, and health plans cannot reject applicants. C-VHI premiums are risk-related, and coverage is tailored to consumers. C-VHI packages tend to be more comprehensive and more expensive than HP-VHI packages. While C-VHI coverage is found among all population groups, coverage rates are highly correlated with income.

Together, these two types of private VHI financed 14 percent of national health expenditures in 2014. 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, usually with secondary attention to consumer protection; in HP-VHI regulation, there is more attention to equity considerations and potential impacts on the health care system.[iii]

Israelis purchase VHI to secure coverage of services not covered by NHI (e.g., dental care, certain lifesaving 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 time). VHI is also supplementary to NHI, as it extends coverage of services in the health basket such as more physiotherapy or psychotherapy sessions. However, it does not cover user charges. 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 illness.

What is covered?

The mandated benefit 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 benefit package as well.[iv]

Israel has a well-developed system for prioritizing coverage of new technologies within an annual overall budget set by the Cabinet (which includes Parliament members from the ruling parties).[v] Proposals for additions are solicited and received from pharmaceutical companies, medical specialty societies, and others. The Ministry of Health then assesses the 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 Ministry and subsequently by the Cabinet.

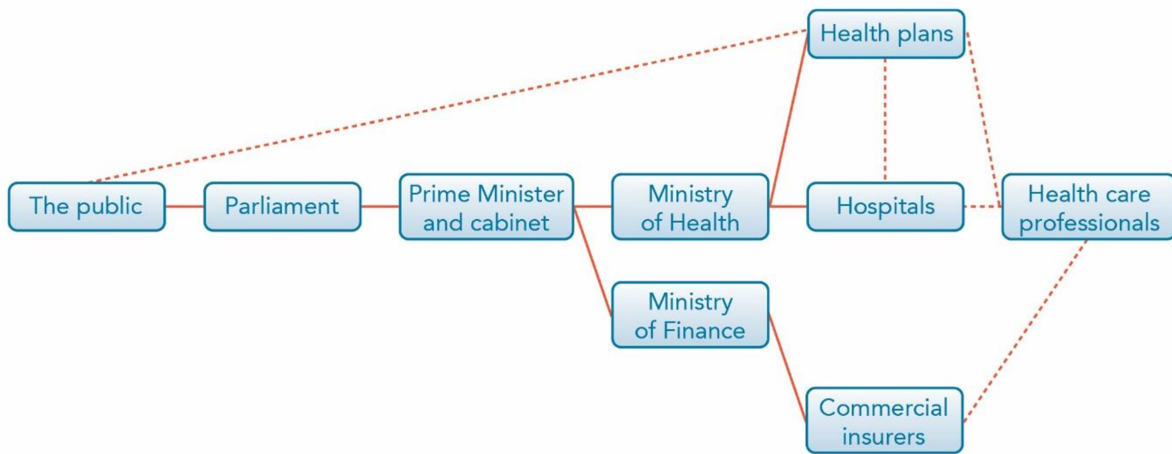
Cost-sharing and out-of-pocket spending: In 2014, out-of-pocket spending accounted for 23 percent of national health expenditures. Some of this was for services not provided in the NHI benefit package, including dental care for adults, optical care, institutional long-term care (for those not eligible for means-tested assistance), certain medications, and medical equipment. The other major component was copayments (user charges) 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 per household on total copayments for these visits, 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 financed?

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.



Source: B. Rosen, Myers-JDC-Brookdale Institute, 2015.

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 and 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 non-physicians, they have access to various administrative and nursing services at Clalit district clinics.

The other three health plans also use a mix of clinics and independent physician practices, 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; in Leumit, the clinic model predominates.

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 who acts as a gatekeeper to secondary care, with the exception of five common specialties. In Leumit, patients are registered with a clinic rather than with a GP, and in the other two plans there is no registration. However, in all plans there is a movement underway to associate each member with a physician for purposes of quality assurance and accountability. Clalit is the only plan that requires referral 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.[vi] 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.

In 2012–2014, Israel had an average of approximately 27,700 employed physicians. As of 2011, approximately 7,000 of them worked with or for the health plans as GPs.

Outpatient specialty care: Outpatient specialty care is provided predominantly in community settings, either in health plan clinics (the dominant mode in Clalit) or in physicians' offices (the predominant 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, staffed by nurses 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.[vii] However, the for-profits account for a much larger share of admissions and an even larger share of surgical operations.[viii]

Hospital outpatient care is reimbursed on a fee-for-service basis, and inpatient care is reimbursed using a mix of per-diem and activity-based DRG arrangements, with approximately two-thirds of revenue coming from per-diem payments.[ix] 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, hospital 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 benefit package is broad and includes psychotherapy, medications, and inpatient and outpatient care. Integration with primary care is currently limited, but is expected to improve because of the transfer of responsibility to the health plans.

Long-term care and social supports: The 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 range 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 be used 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 elderly) via home care teams and telemedicine.

The National Insurance Institute finances personal care and housekeeping services for the community-dwelling disabled elderly.[x] Additional supports include an extensive network of daycare centers and a growing network of supportive neighborhoods.

For nursing homes, home medical care, and home aids, eligibility is based on the degree of 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 benefit 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 pertaining 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 operations of the MoH.
- A large number of departments, including those responsible for quality and safety, assessment of 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 benefit 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 the 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's 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.[xi] While the published data relate to the health plans as a whole, the plans also maintain internal data on regions, clinics, and individual physicians. The plans and their clinicians have made intensive use of these data to bring about substantial improvements in quality.[xii,xiii]

The MoH publishes comparative data on the quality of hospital care. This data system is much newer than the system for primary care quality, and is currently limited to a relatively small number of indicators. However, it is expected to develop rapidly over the coming years. In addition, a new effort is underway to develop and implement quality indicators for continuity of care between hospital and community settings.

The MoH is in the process of launching a national initiative to reduce waiting times for surgical procedures, and there are several other initiatives focused on the care of particular diseases, such

as dementia. The Ministry also collects and publishes data on individual hospitals' waiting times for elective procedures. 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 as long as basic quality standards are met. Hospitals are also increasingly seeking, and securing, accreditation from Joint Commission International.

An independent research institute carries out biannual surveys of the general population regarding the service level provided by the health plans and the level of satisfaction with the health system. The MoH recently launched an annual survey of hospitalized patients; the ministry publishes hospital-level results.

There are currently no explicit financial incentives for hospitals and health plans to improve quality. However, owing to the competitive environment, public dissemination of quality data may be providing an indirect incentive. Consideration is being given to introducing a limited number of 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 training in an accredited specialty program and passing an exam. 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.[xiv] Key initiatives include:

- Reducing financial barriers to care, particularly for those with low incomes and other vulnerable populations. Most prominently, mental health care and dental care for children have been added to the NHI benefit package, thereby reducing the substantial financial barriers that existed when these services were provided privately.[xv]
- Enhancing the availability of services and professionals in peripheral regions, by increasing the supply of beds and advanced equipment in those regions and providing financial incentives for physicians to work there. In addition, in 2010, a new risk

adjustment related to place of residence in the peripheral regions was added to the capitation formula.

- Addressing the unique needs of cultural and linguistic minorities, through the 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.
- Designating particular professionals within the hospitals and the health plans to be the leaders in their institutions for promoting equity and cultural responsiveness, along with government-sponsored training programs for them and for additional professionals.
- Promoting greater poverty awareness at all levels of the health system.
- Implementing intersectoral efforts to address the social determinants of health and promote healthy lifestyles.
- Compiling, analysing, and publicly disseminating information about health care disparities, including periodic reporting of variations in health and health care access, and instituting an annual conference showcasing initiatives to reduce disparities.

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 a foundation for the provision of relatively 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. These systems are increasingly providing 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.[xvi]

Generally speaking, there is still only limited integration among the various components of the long-term care system, and between long-term care and other components of the health care system. However, integration may be expanded 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 the health plan EHRs. The MoH is leading a major national health information exchange project to create a system for sharing relevant information across all hospitals and health plans.

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

How are costs contained?

Among high-income countries, Israel is one of the most successful at 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, to reduce 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 global revenue caps for hospitals.
- Explicitly prioritizing public funding for new technologies included in the NHI benefit package.
- Aligning organizational and financial incentives between clinicians and the hospitals or health plans for which 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 for discouraging care that provides poor value.

Of 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.

Other growing concerns are the rapid increase in expenditures on pharmaceuticals, particularly those related to cancer care,[xvii] and the future cost impact of the expanding field of biologic therapies and personalized medicines.[xviii]

What major innovations and reforms have been introduced?

Voluntary health insurance: In 2016, the government introduced several changes to the regulation of voluntary health insurance (VHI), with an eye toward restraining growth in this coverage and providing consumers with greater value for the premiums they pay. Key components include the standardization of commercial insurance coverage for surgical operations and the requirement that VHI payments to surgeons be channeled through the hospitals in which they work.

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. 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.[xix]

Comparative data on hospital performance: In 2015, the MoH began publishing comparative data on hospital quality, and the indicator set is rapidly being expanded. In 2014, the Ministry published the results of nationwide surveys of hospitalized patients regarding their care experience, and a similar survey has been carried out in 2016. The Ministry has also assembled a database of waiting times for surgical operations, with the intention of publishing updated comparative data in the near future. The objectives of all these efforts are to provide hospitals with information to help identify problem areas, to enhance consumer choice of hospitals, and to 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 and to improve quality of care, the MoH is planning a major initiative to reduce surgical waiting times. This will involve additional funding to expand the 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 staffing of physicians and nurses, the introduction of physician assistants into the EDs, and the engagement of operations management experts to improve workflow.

Long-term care insurance: Israel's long-term care (LTC) 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 LTC to the set of NHI benefits for which the health plans are responsible, with the plans also serving as the LTC budget holders.

Full-timer program: In mid-2016, the MoH launched an initiative in which voluntarily selected physicians in public (i.e., government and nonprofit) hospitals will receive significantly enhanced pay in return for (a) working additional hours in a public hospital and (b) agreeing not to work in the private sector. The overall objective of the full-timer initiative is to strengthen Israel's publicly financed health care system by improving its availability, quality, and safety.

This profile draws on Health Systems in Transition—Israel, *by Bruce Rosen, Ruth Waitzberg, and Sherry Merkur, 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.*

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The Dutch Health Care System, 2016

Joost Wammes, Patrick Jeurissen, Gert Westert, and Marit Tanke, Radboud University Medical Center

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 (a comprehensive system with universal coverage) for the basic benefit package (through subsidies from general taxation and reallocation of payroll levies among insurers via 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. Municipalities and health insurers are responsible for most outpatient long-term services and all youth care under a provision-based approach (with a high level of freedom at the local level).

Who is covered and how is insurance financed?

Publicly financed health insurance: In 2015, the Netherlands spent 10.8 percent of GDP on health care, and 77 percent (2014 estimate) 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. At the end of 2014, 30,000 people (less than 0.2% of the population) were uninsured. 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 three 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 insurance 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, eyeglasses 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 2014, voluntary insurance accounted for 7.9 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; home nursing care; basic ambulatory mental health care for mild-to-moderate mental disorders; 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.

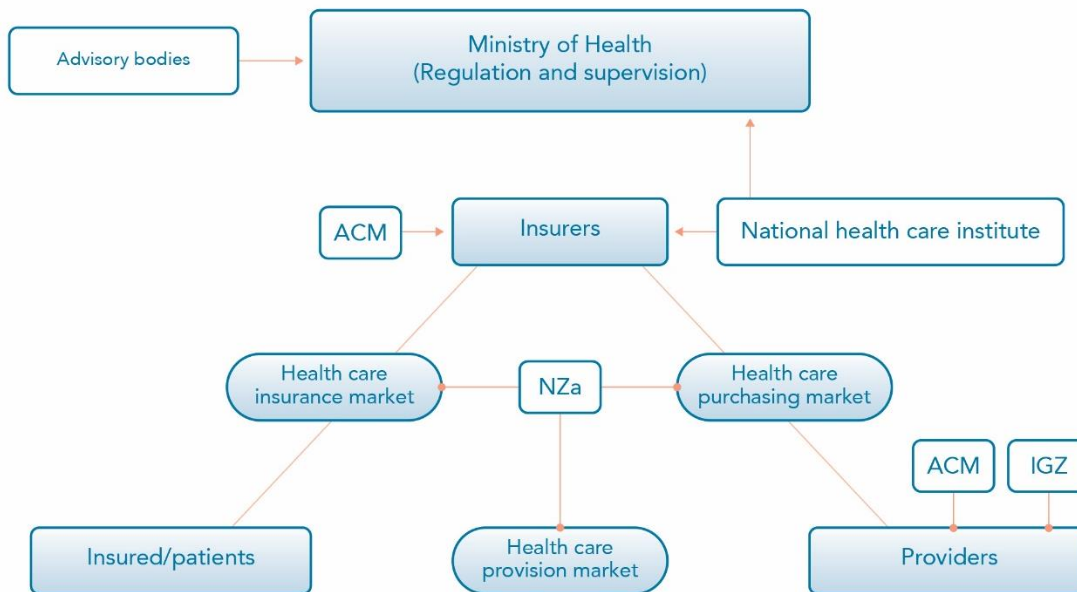
Cost-sharing and out-of-pocket spending: As of 2016, every insured person over age 18 must pay an annual deductible of EUR385 (USD465)[i] for health care costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits. Apart from the overall deductible, patients are required to share some of the costs of selected services, such as medical transportation 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 14.7 percent of health care spending in 2014 (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 less than EUR27,012 [USD32,662] and households with income less than EUR33,765 [USD40,828]). Approximately 4.42 million people (about a quarter of the total population) receive allowances set on a sliding scale, ranging from EUR2.00 (USD2.40) to EUR83.00 (USD 100.00) per month for singles and from EUR10.00 (USD 12.00) to EUR 158.00 (USD191.00) for households, depending on income.

How is the delivery system organized and financed?

Primary care: There were more than 11,600 practicing primary care doctors (GPs) in 2015, and more than 22,585 specialists in 2013. Thirty-nine percent of practicing GPs worked in group practices of three to seven, 40 percent worked in two-person practices, and 22 percent worked solo (2015). Most GPs work independently or in a self-employed partnership; only 16 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]).

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 (USD117,900) in 2012, while salaried GPs earned €80,000 (USD97,000).

Outpatient specialist care: Nearly all specialists are hospital-based and either in group practice (in 2015, 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 part-time in ambulatory centers. 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.[ii]

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. Almost all GPs work for a GP post. Specially trained assistants answer the phone and perform triage; GPs decide whether patients need to be referred to a hospital. Doctors are compensated at hourly rates for after-hours care and must provide at least 50 hours of after-hours care annually to maintain their registration as general practitioner. The GP post sends the information regarding a patient's visit to the patient's regular GP. There is no national medical telephone hotline.

Hospitals: In 2015, there were 89 hospital organizations, including eight university medical centers. Practically all organizations were private and nonprofit. In 2015, there were 231 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 (through which doctors are paid) 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 basic mental health care (e.g., a psychologist, an independent psychotherapist) or to 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, as reflected in the steady increase in the number of GPs who 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. 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 2015, copayments covered 8.7 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).

Long-term care 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 the Health Insurance Act, 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. Under the Health Insurance Act and the Social Support Act, health insurers and municipalities are free to set “sufficient” budget rates (typically, about 70% of in-kind rates), whereas under the Long-Term Care Act budget rates are set nationally. Municipalities have a great deal of freedom in how to support caregivers, for example through respite care or a small allowance.

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 in 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., it sets the prices for 30 percent of diagnosis treatment combinations and determines the design, construction, and maintenance of the diagnosis treatment combination system). Meanwhile, the Dutch Competition Authority (*Autoriteit Consument en Markt*) enforces antitrust laws among both insurers and providers. The Health Care Inspectorate (IGZ) supervises the quality, safety, and accessibility of care. Self-regulation by medical doctors is also an important aspect of the Dutch system.[iii] 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 the 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 population management pilot programs (initiatives that aim to rearrange health services and promote intersectoral collaboration at the regional level, in order to improve population health and quality of care and to control health care costs) featuring quality targets were initiated but, as yet, specifics about the programs' effects are unknown. Pay-for-performance constitutes a small portion of GP funding. Patient experiences are also systematically assessed and, since 2007, a national center has been working with approved 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.

What is being done to reduce disparities?

Health disparities are considerable in the Netherlands, with up to seven years' difference in life expectancy between the highest and lowest socioeconomic groups. Smoking is still a leading cause of 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, variations in health accessibility 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, and another in which care groups contract services from individual providers, each with freely negotiable fees.[iv] 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 0.8 percent as of 2015.

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.

Health technology assessment is gaining in importance and is used mainly for decisions concerning the benefit package and the appropriate use of medical devices. The Dutch health minister has formulated an ambitious policy proposal aiming in part to limit the pharmaceutical industry's power over drug pricing. During the Dutch EU presidency, the topic was successfully put on the EU agenda but the effectiveness of the proposed policies remains to be seen.

The annual deductible, which accounts for the majority of patient cost-sharing, more than doubled between 2008 and 2016, from EUR170 (USD206) to EUR385 (USD465). There are some worries that this increase has led to greater numbers of people abstaining from or postponing needed medical care.

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 2015–2017, provided they demonstrate that their services are a substitute for hospital care. These agreements will expire at the end of 2017, and it is unclear what future cost containment policies will replace them.

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%).

The Federation of University Medical Centres has recently started a program aimed at reducing lower-value services. In addition, the Dutch Federation of Medical Specialists launched the "Dutch Choosing Wisely" campaign, which is also aimed at reducing lower-value services.

What major innovations and reforms have been introduced?

After years of rapid spending growth, in January 2015 long-term care was 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 are as yet unknown. In 2015–2016, some mitigating policies have been adopted, and future amendments are expected to alleviate fiscal stress in nursing homes.[v]

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. Financial accessibility and the accessibility of expensive drugs have rapidly become prominent issues.[vi]

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.

Notes

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[i] Organisation for Economic Co-operation and Development (OECD), OECD.Stat. https://stats.oecd.org/Index.aspx?DataSetCode=SNA_TABLE4. Accessed September 6, 2016.

Please note that, throughout this profile, all figures in USD were converted from euros at a rate of about 0.827 euros per USD, the purchasing power parity conversion rate for GDP in 2015 reported by OECD (2016) for the Netherlands.

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

[iii] P.C. Smith, A. Anell, R. Busse, et al., "Leadership and Governance in Seven Developed Health Systems," *Health Policy, June 2011* 106(1):37–49.

[iv] J.N. Struijs and C.A. Baan, "Integrating Care Through Bundled Payments—Lessons from the Netherlands," *New England Journal of Medicine,* March 2011 364(11):990–991.

[v] J.A. Maarse and P.P. Jeurissen, "The policy and politics of the 2015 long-term care reform in the Netherlands," *Health Policy,* 2016 120(3): 241–245.

[vi] H. Maarse, P.P. Jeurissen, D. Ruwaard, "Results of the market-oriented reform in the Netherlands: a review," *Health Economics, Policy and Law,* 2016 11(2): 161–178.

The New Zealand Health Care System, 2016

Robin Gauld, University of Otago, New Zealand

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. Through the New Zealand Health Strategy, government plays a central role in setting the policy agenda and service requirements for the health system, and in determining the publicly funded annual health budget.

Responsibility for planning, purchasing, and providing health services, as well as 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.[i] 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, 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 9.4 percent of GDP in 2015.[ii] 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 can provide 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 benefit package, based largely on political priorities and health need. 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,[iii] 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 set by GPs vary significantly, as they have no limits. 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.[iv] 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.

For drugs prescribed by GPs and private specialists, copayments are required for the first 20 prescriptions per family per year (NZD5.00, or USD3.40, per item), after which there are none. There are no charges for residents for treatment 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.

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, that accounts for about half their income; patient copayments, set by individual GPs, provide the rest. An average of 3.48 GPs work

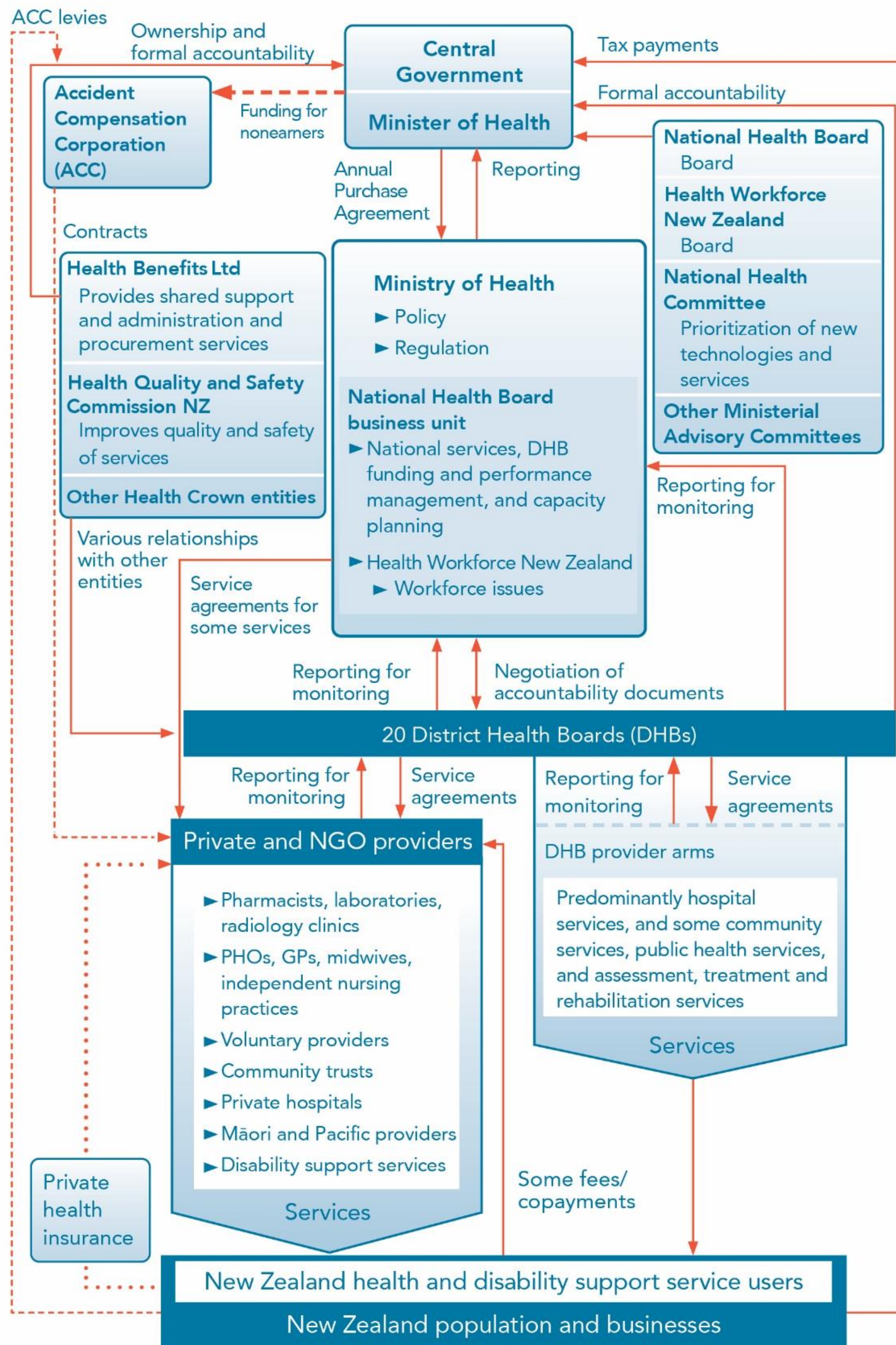
together in each practice, assisted by practice nurses. Nurses are salaried and paid by GPs, and have a significant role in the management of long-term conditions (e.g., diabetes), incentivized by specific government funding for chronic care management. Patient registration is not mandatory, but GPs 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 those 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. 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 for vaccinations. Most GPs belong to an organized network that provides management and other clinical support services. The larger networks represent several hundred GPs each.

Outpatient specialist care: 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.[v] 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 a specialist.

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 copayments from patients. Some patients subscribing to private insurance may be eligible to claim for a 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.

Organization of the Health System in New Zealand



Source: New Zealand Ministry of Health, 2015.

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 after-hours GP 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 nongovernmental 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. 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.

Disability support services for those under age 65 are purchased directly by the Ministry of Health. Some disabled people opt for individualized funding, which enables disabled people to directly manage their disability supports.

End-of-life care in New Zealand is provided in a range of settings, including hospitals, a network of hospices, aged residential care, and the individual's home. DHBs either fully fund or contribute to these settings according to the needs of their population. Hospices also rely on fundraising for support.

Long-term care subsidies for older people are means-tested. Individuals with assets over a given national threshold pay the cost of their care up to a maximum contribution. Those with assets under the allowable threshold contribute all their income, except for a small personal allowance. DHBs cover the difference between a person'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), operate at arm's length from the central government. Others are "crown agents," with their own boards, and are required to follow government policy. Key national arrangements are:

- The Ministry of Health, which has overall responsibility for the health and disability system, acts as the Minister of Health's principal adviser 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 patients' copayments.
- The ministry has two subcommittees: the Capital Investment Committee, which advises on matters relating to capital investment in the public health sector, in line with the government's service plans; and the National Health IT Board, which advises on the implementation and use of IT systems.
- Health Workforce New Zealand leads and supports health and disability workforce training and development.

- NZ Health Partnerships, supported and owned by New Zealand's 20 DHBs, is tasked with enabling those DHBs to collectively maximize shared services opportunities.
- The Pharmaceutical Management Agency of New Zealand, PHARMAC, 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.[vi] Since late 2015, a new set of "factors for consideration" has been used to underpin decisions: need; health benefit; costs and savings; and suitability.
- The Health Quality and Safety Commission is 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 Health Promotion Agency develops and enables health-promoting policy, initiatives, and environments.
- The Health Research Council invests in a broad range of research on issues important to New Zealand.

What are the major strategies to ensure quality of care?

The aforementioned health and disability commissioner investigates patients' 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. 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 "Patient Experience" surveys of randomly selected patients. The Health Quality and Safety Commission publishes the findings.

Certification by the Ministry of Health is mandatory for hospitals, nursing homes, and assisted-living facilities. 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 Ministry of Health is also working on quality improvement in DHBs. "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.[vii]

The Health Quality and Safety Commission aims to increase the focus on quality and coordinate DHB activities, such as those aimed at improving the patient journey, 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. These Quality Accounts report on how a DHB approaches 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 harm associated with falls, surgery, health care–associated infections, and medications. Since 2015, it has collated routine data in an annual report aimed at providing a "window" on the quality of New Zealand health care.[viii]

What is being done to reduce disparities?

Health disparities are a concern in New Zealand. Maori and Pacific Island people have shorter life expectancies than other New Zealanders (by seven and five years, respectively) and experience greater difficulty in gaining access to health services. Reducing disparities is a policy priority, with data describing disparities routinely collected and publicly reported.[ix]

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 "Whānau Ora," a policy designed to integrate health and social services. The aim has been to develop coordinated, multiagency approaches to service provision and to foster joint responsibility for outcomes.

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

District-level alliances (partnerships between DHBs and PHOs) are driving stronger system integration by changing service models. While alliance performance varies, the leaders have multiple members, including, but not limited to, DHB, PHO, pharmacy, ambulance, district nursing, allied health, local government, and Māori providers. District alliances are developing

services based on locality-specific needs. Some alliances have begun to form partnerships with local social agencies.

The primary care sector has begun exploring for the most appropriate model of general practice and enhanced primary care that will meet future demand. The “health care home” model is being implemented in several districts, with support and resourcing shared between DHBs and PHOs.

While DHBs are held accountable for driving integration through their annual plans, variability still exists. There is an ongoing effort to drive improvement through other means, including funding models and contracting for outcomes.

Four “System Level Measures” have been implemented in 2016. These measure performance at a system level, and success is dependent on the contributions of individual providers and/or organizations. This reliance on multiple contributions drives the integration of services and providers and requires an effective alliance.

What is the status of electronic health records?

The ability to access and share accurate clinical information is central to the New Zealand Health Strategy, with increasing emphasis on investing in regional hospital systems that support and enable integrated care.

In 2015, the Ministry of Health announced the Digital Health Work Programme 2020. The program aims to ensure appropriate access to health and wellness information facilitated by a single electronic health record (SEHR). The SEHR will collect and present existing core health information in a single view, accessible by consumers and clinicians. Data will also be able to be shared with social-sector professionals.

Current levels of interoperability between health information systems are limited. However, the ability to provide services such as structured electronic transfer of information is increasing. Primary care providers can transfer patients’ records securely between practices, send electronic referrals, and receive electronic hospital discharge summaries.

Well over one-third of all primary care practices have implemented a patient portal, and over 140,000 patients have registered to access their information through the portal. This advancement supports the Health Strategy’s goal of enabling health care consumers to have an active role in managing their own health, to engage more conveniently with the system, and to move services closer to home.

A recent survey found that 359 of 992 general practices have implemented provider portals, giving after-hours facilities and some hospital emergency departments access to primary care

information.[x] Providers in community, hospital, and specialist settings in one of New Zealand's four regions can now access a shared view of clinical information; the other three regions are reviewing their information systems to enable information-sharing. Implementation of electronic prescribing is underway in primary care and in hospitals. The use of telehealth to deliver services remotely is also increasing.

The Health Information Standards Organisation promotes the development and use of standards to ensure interoperability between systems, and the SNOMED CT (short for Systematized Nomenclature of Medicine – Clinical Terms) has been endorsed as a national standard for clinical terminology in New Zealand. 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 six years, from NZD154.8 million (USD105.3 million) in 2008–2009 to NZD65.8 million (USD44.8 million) in 2014–2015.[xi] 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.

The Ministry of Health has recently taken on the functions of the former National Health Committee. To assist with implementing the New Zealand Health Strategy, it is developing an integrated approach to prioritizing health technologies.

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.[xii] If patients prefer a medicine for which a subsidy is unavailable, 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.[xiii]

What major innovations and reforms have been introduced?

The updated New Zealand Health Strategy, launched in 2016, consists of two parts: the Future Direction, and the Roadmap of Actions 2016.[xiv] The Future Direction lays out some of the challenges and opportunities the system faces and describes the desired future, including the

underpinning culture and values. In addition, it identifies five strategic themes for driving change: (1) improving patient literacy and empowerment; (2) emphasizing prevention, early intervention, and community care; (3) improving system performance; (4) integrated and collaborative health care delivery; and (5) technological innovation.

The Roadmap of Actions 2016 identifies 27 areas for action over five years to implement the Health Strategy. These actions, organized under the five themes listed above, will ultimately contribute to the stated goal that "all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team."[xv]

The author would like to acknowledge the New Zealand Ministry of Health for its comments and for providing updated information for this profile.

Notes

[i] The government replaced the governing board in one DHB with an appointed commissioner in mid-2015 owing to ongoing concerns about its financial situation.

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

[iii] Ibid.

[iv] Please note that, throughout this profile, all figures in USD were converted from NZD at a rate of about NZD1.47 per USD, the purchasing power parity conversion rate for GDP in 2015 reported by OECD (2016) for New Zealand.

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

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

[vii] R. Gauld, S. Horsburgh, *Clinical Governance Assessment Project: Final Report on a National Health Professional Survey and Site Visits to 19 New Zealand DHBs*. Dunedin: Centre for Health Systems, University of Otago, 2012.

[viii] Health Quality and Safety Commission, *A Window on the Quality of New Zealand's Health Care 2016*. Wellington: Health Quality and Safety Commission, 2016.

[ix] Ministry of Health, *Annual Report for the Year Ended 30 June 2015*. Wellington: Ministry of Health, 2016.

[x] Personal communication, Ministry of Health.

[xi] Personal communication, Ministry of Health.

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

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

[xiv] Minister of Health, *New Zealand Health Strategy: Future Direction*. Wellington: Ministry of Health, 2016.

[xv] Minister of Health, *New Zealand Health Strategy: Roadmap of Actions 2016*. Wellington: Ministry of Health, 2016.

The Norwegian Health Care System, 2016

Anne Karin Lindahl, Norwegian Knowledge Center for Health Services

What is the role of government?

Government is responsible for providing health care to the population, in accordance with the stated goal of equal access to health care regardless of age, race, gender, income, or area of residence. Primary health and social care is the responsibility of the municipalities, with Norway's ministry of health playing an indirect role through legislation and funding mechanisms. In specialist care, the ministry also plays a direct role through its ownership of hospitals and its provision of directives to the boards of regional health care authorities (RHAs).

Who is covered and how is insurance financed?

Publicly financed health care: Health expenditure represented 9.9 percent of GDP in 2015, slightly above the average of 8.9 percent for countries in the Organisation for Economic Co-operation and Development (OECD). Norway ranks among the highest in the OECD in terms of absolute expenditure per capita (NOK60 000, or USD6,122,[i] in 2015). Public financing accounts for 85 percent of this spending.

Coverage is universal and automatic for all residents. It is financed through national and municipal taxes. Social security contributions finance public retirement funds, sick leave payment, and, for some patient groups, reimbursement of extra health care costs.

For acute hospitalization, there is no private alternative.

Through common agreements, European Union residents have the same access to health services as in their home country. 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.

Private health insurance: Private health insurance is provided by for-profit insurers and purchased for quicker access and greater choice among private providers. It accounts for less than 5 percent of planned services. About 9 percent of the population (or nearly 15 percent of the workforce) have some kind of private insurance. About 91 percent of policies are paid for by an employer.[ii]

What is covered?

Services: Parliament determines what is covered, although there is no defined benefit package other than 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 some chronic diseases, patients with chronic mental disabilities, and patients in nursing homes. Dental care for 19-to-20-year-olds and dental orthopedics (braces) for children are partially covered. Regular glasses and contact lenses are not covered unless the vision is very limited. Cosmetic surgery is 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 healthy lifestyles 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 (NOK152 [USD15.5] and NOK345 [USD35] per visit in 2015, respectively), as do physiotherapy visits (in varying amounts), covered prescription drugs (up to NOK520 [USD53] per prescription), and radiology and laboratory tests (NOK245 [USD25] and NOK50 [USD5], respectively). Public providers cannot charge patients more than these amounts, other than for bandages and other supplies. Consultations for children under 16 years, for antenatal and postnatal follow-up of mother and child, for prevention and treatment of some transmittable diseases, and for 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 care and institutional care for older or disabled people require means-tested, high cost-sharing (up to 85 percent of personal income).

Safety net: The major safety net mechanisms are annual caps, set by Parliament, for out-of-pocket expenditure, above which fees are waived. For 2016, the cost-sharing ceiling for most services is NOK2,185 (USD223). A second ceiling, for services such as physiotherapy and certain dental services, is set at NOK2,670 (USD272). Long-term care and prescription drugs outside the blue list do not apply toward these ceilings.

Residents eligible for the minimum retirement or disability pensions, which amount to about NOK162,000 (USD16,530) 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 NOK9180, or USD937) as a result of permanent illness receive a tax deduction. “Basic benefits” (NOK670–NOK3,346, or USD68–USD341 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?

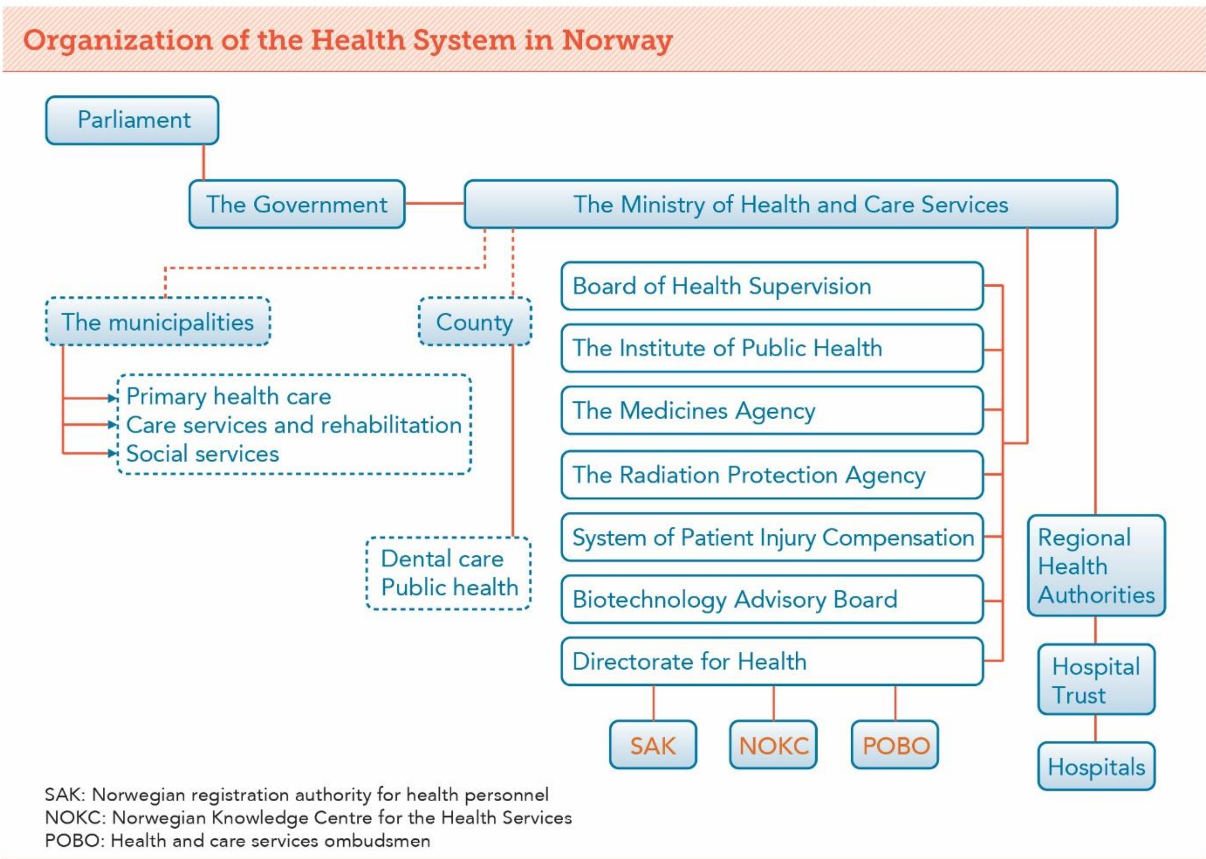
Primary care: The municipalities provide primary care in accordance with current legislation, government directives, and quality requirements set by the Directorate for Health.

The “regular GP scheme,” whereby people register with one general practitioner (GP), covers 99.6 percent of the population. There were an average of 1,127 patients per GP in 2015.[iii] 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.[iv] 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 medication reconciliation, for taking part in coordination of care, and for individual planning, but they are relatively low. Most GPs are self-employed; only 5 percent are salaried municipal employees.[v] The average salary is estimated to be NOK750,000 (USD76,530), but can be substantially higher for full-time practitioners. GP practices typically comprise one to six physicians and employ nurses, lab

technicians, and secretaries, but networks for shared resources are not common. Many municipalities have multidisciplinary mental health outreach teams.



Source: A. K. Lindahl, Norwegian Knowledge Centre for Health Services, 2015.

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 the 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 (35%); fee-for-service payments (35%); and patients' copayments (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. 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.

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.

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.

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 more densely populated municipalities have walk-in centers where nurses triage patients and answer calls, with several doctors seeing 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. There is a common national phone number for primary care after-hours services (*legevakt*), through which calls are directed to the caller's local service. In larger cities, there are also 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 out-of-pocket fees are higher for after-hours emergency services (about NOK100 [USD10] higher per consultation).

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

Hospitals: Public hospital trusts are state-owned, formally registered legal entities with an executive board and are governed as publicly owned corporations. A few hospitals are privately owned, and those owned by nonprofit humanitarian organizations provide publicly funded services as part of RHAs' plans for providing acute care. The for-profit hospital sector is small,

providing less than 0.2 percent of somatic hospital stays and 7 percent of daytime stays, mostly outpatient surgery.[vi] For-profit hospitals do not provide a full range of services and do not offer acute care. Some of their services may be publicly funded, but the proportion varies, from almost none to 85 percent.

Patients are free to choose a hospital for elective services, but not for emergency care. Public hospitals are financed through RHAs. 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 DRGs. 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 and 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. Psychiatric services in the larger hospitals as well as in the district psychiatric centers are funded by government block grants through RHAs. Private mental hospitals account for about 12 percent of mental health care, including 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 (38%) and funded mostly through contracts with RHAs.[vii]

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. 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. Patients may purchase home nursing care and other services from private providers as a supplement to services by public home care. In some densely populated areas, patients themselves have a choice of home care provider or nursing home. People under 67 with permanently reduced functioning who live at home have a right to an on-demand personal assistant. Very few patients pay individually for full-time private nursing home care. End-of-life care for terminal patients is often provided in specific wards within dedicated nursing homes. There is a system in place for informal caregivers 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 translates political decisions into practice 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 an 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 is responsible for the national quality indicator system. From 2014 to 2018, the directorate is in charge of the secretariat for the National Patient Safety Program, and from 2016 also administers a reporting and learning system for adverse events in hospitals. The Directorate for Health is responsible for fee-setting in the DRG system, and also for a five-year project on quality-based financing (see "Strategies to ensure quality of care," below). There is no single authority overseeing fee-setting for providers other than hospitals.

The new Directorate of eHealth, established January 1, 2016, is responsible for the overall setting of standards and for leading the development and application of health information technology in health care. It provides public information on health and health care through the website www.helsenorge.no.

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. The agency decides the maximum price of drugs.

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 and 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 registries, including the prescription registry. The institute also assists the prosecuting authorities and the judiciary regarding forensic medicine. As of the beginning of January 2016, the Norwegian Knowledge Center for Health Services is included in the Norwegian Institute of Public Health. It produces comparative-effectiveness studies, systematic

reviews, and health technology assessments (HTAs) and performs comparative health services and systems analyses, including 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 National Board of Health Supervision audits the different areas of the health care system, either systematically on a national level or individually. An alert system ensures that hospitals inform the board of 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. Local audits are performed by the county governors.

Patient advocacy is ensured through statutory "user boards" at all hospital trusts and regional health authorities, but also through the offices of the patient ombudsmen in all counties.

Public information on the performance of the health services is made available partly through the website www.helsenorge.no, where national quality indicators are published, along with information on patients' rights, economic support, and ability to change their regular GP. There is secure entry via this website to patients' core medical records, as well as to a separate website for all patients' prescriptions.

For public and stakeholder engagement, there is a tradition of public hearing of white papers before their discussion and approval in Parliament, as was the case with the National Health and Hospital Plan (2016–2019).[viii]

What are the major strategies to ensure quality of care?

The National Strategy for Quality Improvement in Health and Social Services (2005–2015) focused on efficacy, safety, efficiency, patient-centered care, care coordination, and continuity and equality in access to health care.[ix] 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, and a project to implement similar service packages is underway also for mental health and addiction treatment. There is a five-year (2014–2018) national program to improve patient safety, as well as a national reporting and learning system for adverse events in hospitals. There are 54 national clinical registries for specific diseases, as well as 15 national health registries. There is no registry for technical devices.

The Directorate for Health is in charge of a national program for health care quality indicators. The program includes results from national patient experience surveys, as well as quality indicators for criteria such as survival rates, infection rates, and waiting times, as well as indicators specific to the different medical areas. No information is gathered or disseminated regarding results or quality of individual health care professionals' performance.

The Registration Authority for Health Personnel, in the Directorate for Health, 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 of 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 themselves responsible for ensuring the quality of their services. There is no requirement for accreditation or reaccreditation, although some hospitals or hospital departments are accredited.

A five-year developmental program (2013–2017) is under way for quality-based financing of RHAs, based on performance and improvement as measured by a set of indicators—29 indicators in 2014, 33 indicators in 2015, and 32 in 2016—with patient experiences constituting about 30 percent of the reporting. Quality-based financing amounts to only about 0.5 percent of the total of the RHAs' budgets. An evaluation in 2015 did not identify particular downsides to this quality-based financing, but did identify improvement areas.[x]

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 prescription 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.[xi] There have been some initiatives for children, including vaccination programs; 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 diet; and specific programs for populations considered at risk.

There is increasing focus on immigrants' health and their underutilization of health care. Research on pregnancy among immigrants has been informative, as there are significantly more complications for newborns and mothers among immigrants than among native Norwegians.[xii] There has been a resulting emphasis on the need for adequate information to be provided in immigrants' native languages.

Health outcomes vary by geography, 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?

The care 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. Hospitals and municipalities must now establish formal agreements on the care of patients with complex needs.[xiii]

For hospitals, incentives for care coordination are provided by mandatory agreements with municipalities. Financing remains unaligned between the hospitals, which are state-funded, and primary care, which is municipality-funded. The municipalities are fined per day for patients who stay in hospital after they are ready for discharge.

What is the status of electronic health records?

A national strategy for health information technology (HIT) was initiated in 2016 and is the responsibility of the Directorate of eHealth. Every resident is allotted a unique personal identification number, which is used in primary care and for hospitals' medical records. GPs use secure messaging to request prescriptions or to address patients' questions. 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 as yet no electronic method for doing so. An ongoing project on patient access currently gives 3.1 million inhabitants access to their core medical record.

The National Health Network, a state enterprise, 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, for communication with laboratories and radiology services, and for sick leave. Most GPs receive electronic discharge letters from hospitals. Where after-hours emergency care is organized within the same patient record network as primary care, patient histories remain available and primary care providers are able to access information regarding emergency visits. All hospitals use electronic records.

The lack of standardized, 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 the use of generic drugs. Cost-effectiveness is a criterion for getting 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 has been effective in negotiating drug purchases and delivery jointly for the four RHAs.

GP gatekeeping for specialized services helps contain costs. There is very little competition regarding pricing within the health services. A small proportion of specialized care is privately proivded 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, makes decisions on whether to approve new, costly drugs or treatments, mainly on the basis of health technology assessments that address cost-effectiveness.

Norway's number of hospital beds—four per 1,000 inhabitants in 2012—is low by comparison with the OECD-Europe mean of five.[xiv] The low number can be attributed to a policy of driving services toward outpatient and daycare settings and of making municipalities accountable for patients not needing specialized hospital care. There is an ongoing debate about overdiagnosing and the 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, about levels of end-of-life care and the 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.

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

The restructuring of the governmental health bureaucracy in 2016, with the integration of smaller agencies into the Institute for Public Health and the Directorate for Health, as well as the development of the new Directorate of eHealth, will continue in 2017 with the establishing of common IT services for the governmental health bureaucracy through the National Health Network.

The author would like to acknowledge David Squires and Ånen Ringard as contributing authors to earlier versions of this profile.

Notes

[i] Please note that, throughout this profile, all figures in USD were converted from NOK at a rate of about NOK9.8 per USD, the purchasing power parity conversion rate for GDP in 2015 reported by OECD (2016) for Norway.

[ii] "Norske kunder kjøper helseforsikring for 300 millioner mer enn I 2013." *Dagens medisin* 24.02.16. http://www.dagensmedisin.no/artikler/2016/02/24/norske-kunder-kjoper-helseforsikring-for-270-millioner-kroner-mer-enn-i-2013/.

[iii] Helsedirektoratet (2016). Fastlegestatistikken. https://helsedirektoratet.no/statistikk-og-analyse/fastlegestatistikk#fastlegestatistikk-2015.

[iv] Den norske legeforening (2015). Legestatistikk. http://legeforeningen.no/Emner/Andre-emner/Legestatistikk/. Accessed Nov. 19, 2015.

[v] Helsedirektoratet (2016). Fastlegestatistikken.

https://helsedirektoratet.no/Documents/Statistikk%20og%20analyse/Fastlegestatistikk/Fastlegedata%202015/Oppsummering%20av%20hovedtallene%20for%20landet%20med%20kommentar%202015_4.pdf.

[vi] Helsedirektoratet (2016). Private aktører I spesialisthelsetjenesten. https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/1159/Private%20aktører%20i%20spesialisthelsetjenesten.%20Omfang%20og%20utvikling%202010-2014.%20IS-2450.pdf.

[vii] Helsedirektoratet (2016). Private aktører I spesialisthelsetjenesten. https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/1159/Private%20aktører%20i%20spesialisthelsetjenesten.%20Omfang%20og%20utvikling%202010-2014.%20IS-2450.pdf.

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[ix] "Og bedre skal det bli – Nasjonal strategi for kvalitetsforbedring i sosial-og helsetjenesten 2005–2015." https://helsedirektoratet.no/publikasjoner/og-bedre-skal-det-bli-nasjonal-strategi-for-kvalitetsforbedring-i-sosial-og-helsetjenesten-20052015.

[x] Sirona health solutions (2015). Evaluering av kvalitetsbasert finansiering (KBF). https://helsedirektoratet.no/Documents/Finansieringsordninger/KBF/Evaluering%20av%20KBF_Sirona.pdf.

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[xiii] 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).

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The Swedish Health Care System, 2016

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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 are responsible for financing and delivering health services to citizens. At the local level, 290 municipalities are responsible for 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 relation 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 2014. About 83 percent of this spending was publicly financed, with county councils' expenditures amounting to almost 57 percent, municipalities' to 25 percent, and the central government's to almost 2 percent.[i] The county councils and the municipalities levy proportional income taxes on their populations to help cover health care services. In 2015, 69 percent of the county councils' total revenues came from local taxes and 17 percent from subsidies and national government grants financed by national income taxes and indirect taxes.[ii] 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 2015, 89 percent of county councils' total spending was on health care.[iii]

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 2016, 635,000 individuals had private insurance, representing roughly 10 percent of all employed individuals aged 15 to 74 years.[iv]

What is covered?

Services: There is no defined benefit 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 2014, about 16 percent of all expenditures on health were private, and of these 97 percent were out-of-pocket.[v] The majority of out-of-pocket spending is for drugs.

The county councils set copayment rates, leading to variation across the country (see table below). Providers cannot charge above the scheduled fee.

Service	**Fee Range (2016)[vi]**	
	Swedish Kroner	U.S. Dollars
Primary care physician visit	150–300	17–33
Hospital physician consultation	200–350	22–38
Hospitalization per day	50–100	5.5–11

Source: SALAR, 2016.

Nationally, annual out-of-pocket payments for health care visits are capped at SEK1,100 (USD120) per individual.[vii] In all county councils, people under age 18—and in most county councils, people under 20—are exempt from user charges for visits.

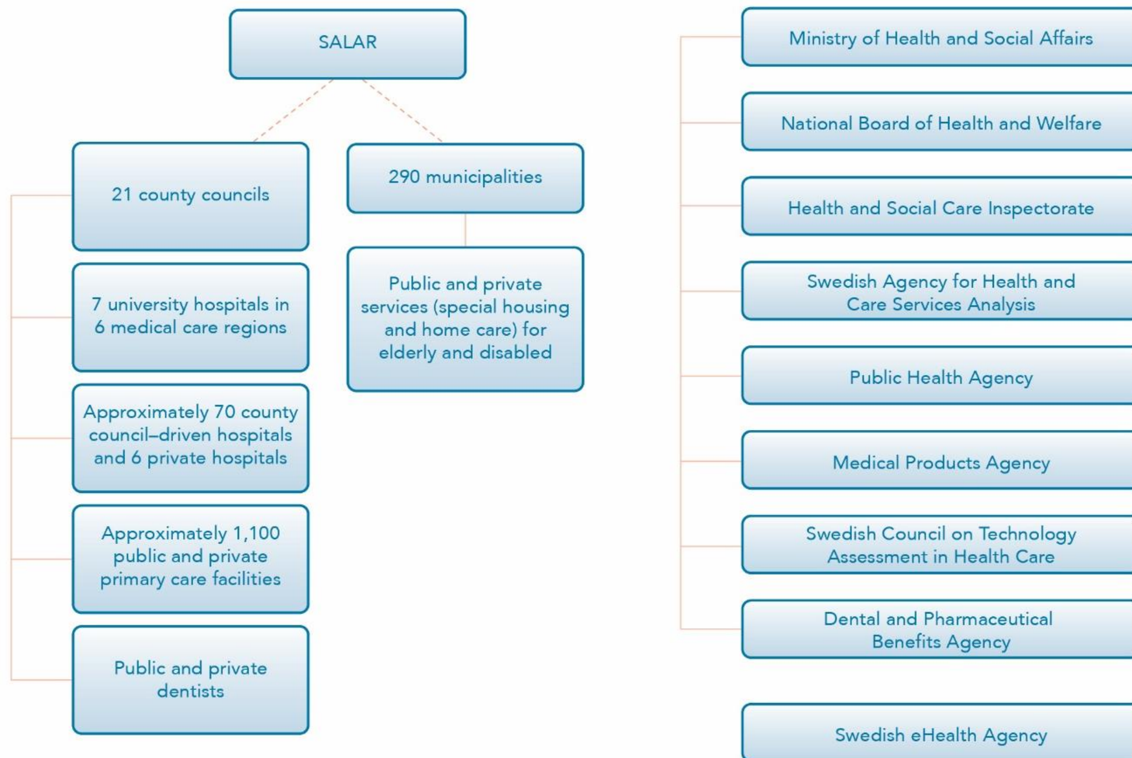
Dental care: Dental and pharmaceutical benefits are determined at the national level. People under 20 have free access to all dental care. People 20 or older receive a fixed annual subsidy of SEK150–SEK300 (USD17–USD34), depending on age, for preventive dental care. For other dental services, within a 12-month period patients 20 or older pay the full cost of services up to SEK3,000 (USD330), 50 percent of the cost for services between SEK3,000 and SEK15,000 (USD330 and USD1,643), and 15 percent of costs above SEK15,000 (USD1,643). There is no cap on user charges for dental care.

Prescription drugs: Individuals pay the full cost of prescribed medications up to SEK1,100 (USD120) annually, after which the subsidy gradually increases to 100 percent. The annual ceiling for out-of-pocket payments for prescriptions is SEK2,200 (USD240) for adults. A separate annual out-of-pocket maximum of SEK2,200 (USD 240) 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: 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?

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 SEK63,000 (USD6,900) in 2015.[viii] 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.



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

Primary care: Primary care accounts for about 20 percent of all expenditures on health,[ix] and about 16 percent of all physicians work in this setting.[x] Primary care has no formal gatekeeping function. Team-based primary care, comprising 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; most individuals register with a practice instead of with a physician. Registration is not required to visit a practice. There are about 1,200 primary care practices, of which 40 percent are privately owned. Providers (public and private) are paid a combination of fixed capitation for their registered individuals (80%–95% of total payment), fee-for-service (5%–18%), and often performance-related payment (0%–3%) for achieving quality targets in such areas as patient satisfaction, care coordination, continuity, enrollment in national registers, and compliance with guidelines based on evidence-based medicine.

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. 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 and nurses. There is no special arrangement for provider payment, and the same copayments apply as those during regular hours. 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 (1177), with medical staff available all day to give treatment advice. Moreover, all county councils and their regional counterparts collaborate to provide information online (at 1177.se) about pharmaceuticals, medical conditions, and pathways for seeking care.

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. 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, including 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 (SEK1,772 [USD194] per month in 2016). The Social Services Act specifies that adults at all later stages of life have the right to receive public services and assistance, 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 30 percent of all nursing home and home care was privately provided in 2014,[xi] 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?[xii]

The county councils are responsible for the funding and organization of health care, while the municipalities are responsible for meeting the routine care and housing needs of the elderly 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 opening hours, clinical competencies, and other organizational aspects and by regulating financial conditions for accreditation and payment. 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 board is the licensing authority for health care staff. (Health care personnel are not required to reapply for their license.) The agency also maintains health data registries and official statistics.

The Swedish eHealth Agency focuses on promoting public involvement and providing support for professionals and decision-makers. It stores and transfers electronic prescriptions issued in Sweden and is responsible for transferring electronic prescriptions abroad. The agency is also responsible for statistics on drugs and pharmaceutical sales.

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

The Swedish Agency for Health and Care Services Analysis analyzes and evaluates health policy and 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 evidence-based knowledge in the area of infectious disease control and public health, including health technology assessment. The Swedish Council on Technology Assessment in Health Care promotes the use of cost-effective health care technologies. The council reviews and evaluates new treatments from medical, economic, ethical, and social points of view. Information from the reviews is disseminated to central and local governments and medical staff 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 ensuring that health care providers deliver services of high quality. Their governance of providers includes assessing whether quality targets—those associated with a pay-for-performance scheme or tied to requirements for accreditation and its continuance—have been achieved. Providers are evaluated on the basis of information from patient registries and national quality registries, surveys related to patient satisfaction, and dialogue meetings.

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 complications.[xiii]

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 trend toward developing 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 more than 100 national quality registries are used for monitoring and evaluating quality among providers and for assessing treatment options and clinical practice. Registries store individualized data on diagnosis, treatment, and treatment outcomes. They are funded by the central government and by county councils, managed by specialist organizations, and monitored annually by an executive committee.

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 2015 publication included 350 indicators, organized into various categories such as prevention, patient satisfaction, waiting times, trust, access, surgical treatment, and drug treatment. Some 100 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. The 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 and accessible services are supported by targeted government grants. In 2005, the "0–7–90–90 rule" was introduced to improve and ensure the equality of access across the country, namely: 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. Between 2008 and 2014, county councils where 70 percent of all patients received care within the stipulated times were eligible for the grant targeted at accessibility. Since 2015, the targeted grants have focused more on care coordination; they support action plans for improving coordination and collaboration at the county council level. At the provider level, performance-related payment is commonly linked to quality targets related to care coordination and compliance with evidence-based clinical guidelines, particularly for care provided to elderly patients with multiple diagnoses.

What is the status of electronic health records?

Both the quality of IT systems and their level of use are high in hospitals and in primary care, although the type of systems used vary by care setting and by county council. Nearly all Swedish prescriptions are e-prescriptions. Patients increasingly have access to their electronic medical records for the purpose of scheduling appointments or viewing their personal health data, but there is variation in this regard between county councils.

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 central government's 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 of the variables used to evaluate different providers. The funding of health services through global budgets, volume caps, capitation formulas, and contracts 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, patients' rights, and investment in e-health.

Studies following Sweden's 2010 market reform in primary care show that objectives related to accessibility have been achieved. The reform's 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 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) detailing 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, those patients' right to a second opinion, and their 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.

Finally, in 2016, the government set out a vision of Sweden as world leader in e-health by 2025. The strategy involves (1) coordination and communication between different health care stakeholders; (2) development of common concepts in the field; (3) implementation of standards for health information exchange; and (4) creation of national drug lists that assist health care professionals in efforts to improve patient safety.

Notes

[i] Statistics Sweden, *Systems of Health Accounts (SHA) 2001–2014*, www.scb.se, accessed July 12, 2016.

[ii] SALAR, *Statistik inom hälso- och sjukvård samt regional utveckling: Verksamhet och ekonomi i landsting och regioner 2015*. Stockholm: Swedish Association of Local Authorities and Regions, 2016.

[iii] SALAR, *Statistik inom hälso- och sjukvård samt regional utveckling: Verksamhet och ekonomi i landsting och regioner 2015*. Stockholm: Swedish Association of Local Authorities and Regions, 2016.

[iv] Swedish Insurance Federation, http://www.svenskforsakring.se, accessed July 13, 2016.

[v] Statistics Sweden, *Systems of Health Accounts (SHA) 2001–2014*, www.scb.se, accessed July 12, 2016.

[vi] SALAR, *Patientavgifter i hälso- och sjukvården 2016*. Stockholm: Swedish Association of Local Authorities and Regions.

[vii] Please note that, throughout this profile, all figures in USD were converted from SEK at a rate of about SEK9.13 per USD, the purchasing power parity conversion rate for GDP in 2015 reported by OECD (2015) for Sweden.

[viii] Statistics Sweden, *Lönedatabasen*, www.scb.se, accessed July 13, 2016.

[ix] Statistics Sweden, *Systems of Health Accounts (SHA) 2001–2014*, www.scb.se, accessed July 12, 2016.

[x] Swedish Medical Association, *Läkarförbundets undersökning av primärvårdens läkarbemanning*. Stockholm: Sveriges läkarförbund.

[xi] National Board of Health and Welfare, *Äldre och personer med funktionsnedsättning – regiform år 2014*. Stockholm: National Board of Health and Welfare.

[xii] A. Anell, A. H. Glenngård, S. Merkur, "Sweden: Health System Review," *Health Systems in Transition 2012* 14(5):1–161.

[xiii] SALAR, *National Initiative for Improved Patient Safety*. Stockholm: Swedish Association of Local Authorities and Regions, 2011.

The Swiss Health Care System, 2016

Isabelle Sturny, Swiss Health Observatory

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 play a critical role. Each of the 26 cantons (including six half-cantons) has its own constitution and is responsible for licensing providers, coordinating hospital services, and subsidizing institutions and individual premiums. The federal government plays an important role in regulating the financing of the system, which is effected through mandatory health insurance (MHI) and other social insurance; the quality and safety of pharmaceuticals and medical devices; public health; and research and training. The municipalities, in turn, are responsible mainly for long-term care (nursing homes and home care services) and other social support services for vulnerable groups.

The introduction of the new Federal Health Insurance Law in 1996 had three main objectives: (1) to strengthen solidarity by introducing universal coverage and subsidies for low-income households; (2) to expand the benefit basket and ensure high standards of health services; and (3) to contain the growing costs of the health system.[i]

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 health insurance (MHI) premiums.
3. Social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance, and military insurance.

All government expenditures on health are financed by general taxation. In 2014, direct spending by government accounted for 20.1 percent of total health expenditures (CHF71.2 billion, or USD55.8 billion), while income-based MHI subsidies accounted for an additional 5.6 percent.[ii] Publicly financed health care accounted for 67.4 percent of all spending, including MHI premiums (31.0% of total health expenditure, excluding statutory subsidies), other social insurance schemes (6.3%), and old age and disability benefits (4.4%).[iii]

Mandatory MHI coverage is universal. Residents are legally required to purchase MHI within three months of arrival in Switzerland, and it then applies retroactively to the arrival date. Insurance 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. The absence of MHI for undocumented immigrants remains an unsolved problem acknowledged by the Swiss Federal Council (SFC), the highest governing and executive authority.

MHI is offered by competing nonprofit insurers supervised by the Federal Office of Public Health (FOPH), which sets floors for premiums calculated to cover past, current, and estimated future costs for insured individuals in a given region. Cantonal average annual premiums in 2016 for adults with the minimum deductible (CHF300 [USD235]), the standard insurance model, and accident coverage range from CHF3,920 (USD3,074), for Appenzell Innerrhoden, to CHF6,547 (USD5,134), for Basel-Stadt.[iv] 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 consecutive 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 cost of 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 2014, 63.0 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.[v]

Private health insurance: Private expenditure accounted for 32.6 percent of total health expenditure in 2014, which is high by comparison with other OECD countries.[vi] There is complementary voluntary health insurance (VHI, 7.2% of total expenditure) for services not covered in the basic basket of MHI, 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 by these plans.

VHI is regulated by the Swiss Financial Market Supervisory Authority (FINMA). 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 MHI 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 MHI benefit 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.

MHI covers most general practitioner (GP) and specialist services, as well as an extensive list of pharmaceuticals and medical devices; home care services (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 MHI, but are highly subsidized by the cantons. 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. MHI covers only "medically necessary" services in long-term care. The FOPH and Swiss Conference of Cantonal Health Ministers aim to eliminate gaps that exist in the financing of hospice care. Dental care is largely excluded from MHI, as are glasses and contact lenses for adults (unless medically necessary), but these are covered for children.

Cost-sharing and out-of-pocket spending: Under MHI, insurers are required to offer a minimum annual deductible of CHF300 (USD235) for adults and a zero deductible for children, although insured persons may opt for a higher deductible (up to CHF2,500 [USD1,960] for adults and CHF600 [USD470] for children) and a lower premium. In 2014, 22.3 percent of all insured persons opted for the standard CHF300/0 deductible, 14.7 percent had a higher deductible, and 63.0 percent chose another model with a gatekeeping element.

Insured persons pay 10 percent coinsurance above deductibles for all services (including GP consultations), but it is capped at CHF700 (USD549) for adults and CHF350 (USD274) for minors (under 19) in a given year. For brand-name drugs with a generic alternative, 20 percent instead of 10 percent coinsurance is charged. For hospital stays, there is an additional charge of

CHF15 (USD12) per inpatient day. Cost-sharing in MHI and VHI accounted for 5.6 percent and 0.1 percent of total health expenditure in 2014.

Out-of-pocket payments for services not covered by insurance (and in addition to cost-sharing) accounted for 18.6 percent of total health expenditure. Most of these direct out-of-pocket payments were spent on dentistry and long-term care. Providers under MHI are not allowed to charge above the fee schedule.

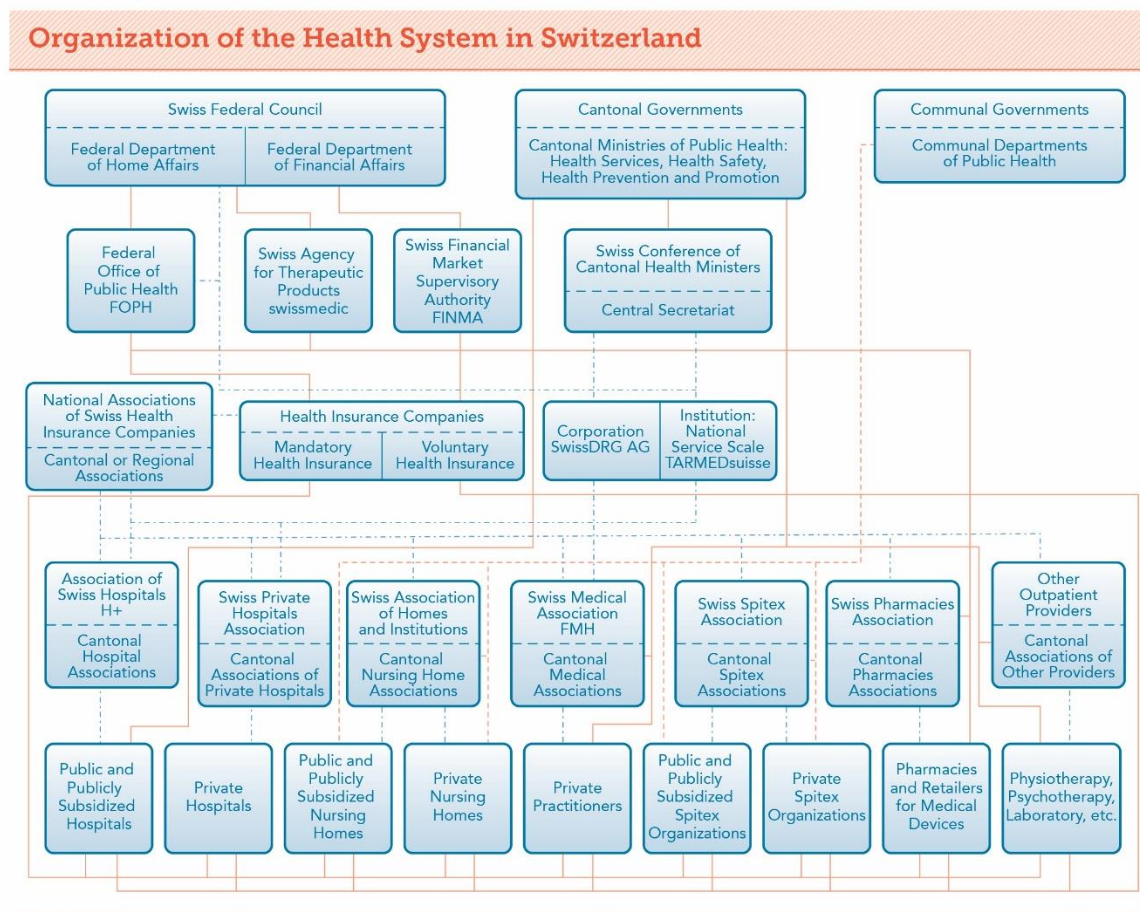
Safety net: Maternity care and some preventive services are fully covered and thus exempt from deductibles, coinsurance, and copayments. Minors or young adults in training (up to the age of 25) do not pay copayments for inpatient care. Federal government and the cantons provide income-based subsidies to individuals or households to cover MHI premiums; income thresholds vary widely by canton.[vii] Overall, 26.9 percent of residents in 2014 benefited from individual premium subsidies.[viii] 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 2015, 38.2 percent of doctors in the outpatient sector were classified as GPs. Apart from scale-of-charge measures, 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 2015, 56.1 percent of physicians were in solo practice.[ix]

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 providing 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 CHF190,150 (USD149,109) in 2009.[x]

Outpatient specialist care: In the outpatient sector, 61.8 percent of doctors were classified as specialists in 2015.[xi] 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. The public health system allows specialists to see MHI patients as well as private patients.



Source: P. Camenzind, Swiss Health Observatory, 2015.

Administrative mechanisms for direct patient payments to providers: MHI 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: The cantons are responsible for after-hours care. They delegate those services (with fees set by TARMED) to cantonal doctors' associations, which organize urgent-care networks in collaboration with their affiliated doctors. The networks can include ambulance and

rescue services, hospital emergency services, 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: In 2014, there were 289 hospitals (108 general and 181 specialized hospitals), with a total of 37,540 beds.[xii] Hospital care represented one-third (36.4%) of total health expenditures in 2014. For services covered by MHI and billed through a national diagnosis-related group (DRG) payment system, hospitals[xiii] receive around half (45%–55%) of their funding from insurers.[xiv] The other half is covered by cantons and municipalities, or, in case of additional services, by private health insurance.

The cantons are responsible for hospital planning and funding, and are legally bound to coordinate plans with other cantons. In 2012, in parallel to the introduction of the DRG system, free movement of patients between cantons was allowed, reducing cantonal fragmentation. Remuneration mechanisms depend on insurance contracts; consequently, fee-for-service for inpatient services not covered under MHI is still possible. Hospital-based physicians are normally paid a salary, and public-hospital physicians can receive extra payments for seeing privately insured patients.

Mental health care: Psychiatric practices are generally private, and psychiatric clinics and hospital departments are a mix of public, private with state subsidies, and fully private. There is also a wide range of socio-psychiatric facilities and daycare institutions that are mainly state-run and -funded.

Psychiatric hospitals or clinics normally provide a full range of medical services such as 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 mental health practices is psychotherapy; psychiatrists are allowed to prescribe medication. 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 MHI, 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 MHI, but are highly subsidized by the cantons. For services in nursing homes and institutions for disabled and chronically ill persons, MHI 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 municipality. Long-term inpatient care costs totaled CHF12.3 billion (USD9.7 billion) in 2014, representing 17.3 percent of total health expenditures. Around one-third of these costs (31.3%) were paid by private households, one-quarter (24.1%) by old age and disability benefits, one-fifth (19.1%) by MHI and other social insurances, and the rest by government subsidies (25.4%). Of the 1,575 nursing homes in operation in 2014, 29.2 percent were state-operated and -funded, 30.5 percent were privately operated with public subsidies, and 40.3 percent were exclusively private.[xv]

Almost half (47.1%) of the total Spitex expenditure of CHF2.0 billion (USD1.6 billion), as of 2014, is financed by government subsidies. MHI and the other social insurances covering the cost of medically necessary health care at home made up roughly one-third (34.9%). The rest (18.0 percent), devoted mainly to support and household services, was paid out-of-pocket, by old age and disability benefits, by VHI, or by other private funds.[xvi] In 2014, one-third of Spitex organizations were subsidized nonprofit organizations (36.6%), 13.6 percent were nonsubsidized for-profit companies, and almost half (49.8%) of Spitex organizations were individual health care workers.[xvii] At the national level, there is no legal basis for financial support for informal help or family caregivers.

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, the 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 Cantonal Health Ministers, 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.[xviii]

The main national player is the FOPH, which, among other tasks, supervises the legal application of mandatory MHI, 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 MHI benefit basket. Professional self-regulation has been the traditional approach to quality improvement.

Prices for outpatient services are set using the fee-for-service scale TARMED, which defines the relative cost weights of all services covered by MHI at the national level and is authorized by the Swiss Federal Council. TARMED values can vary among cantons and service groups (e.g., 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 is in use as of 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 MHI, is legally charged with disease prevention and health promotion programs, and provides public information on health. The Association of Swiss Patients and a national ombudsman for health insurance 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.

Increasing the quality of care is a priority of the federal strategy Health2020. The strategy includes the implementation of a national network for quality and of national quality programs in fields like medication safety and hospital infections.[xix] In 2008, the Swiss Inpatient Quality Indicators were introduced to monitor and evaluate the quality of care provided by acute-care hospitals. In addition, the National Association for Quality Improvement in Hospitals and Clinics (ANQ) publishes quality indicators for hospital inpatient care based on registries or patient surveys. Registries are often organized by private initiatives or cantons, such as the cantonal cancer registries.

What is being done to reduce disparities?

The Swiss Federal Council's national Health2020 strategy[xx] 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 every five years.[xxi]

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 health professionals 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 strategy includes a comprehensive projection of the priorities of health care policy until the year 2020. The strategy also addresses care coordination, stating that integrated health care models need to be supported in all areas. The FOPH works on implementing 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 at the conceptual level and design pilot projects, aiming at the practical level to encourage different types of health professionals to work together. The *National Health Report 2015* discusses the growing number of case management programs for chronically ill patients, but pooled funding streams do not yet exist.[xxii] It is also worth noting the efforts in the area of e-health, which should considerably improve care coordination.

What is the status of electronic health records?

In June 2015, a law addressing the national electronic patient record was adopted; it will come into effect in 2017 and should increase care coordination, quality of treatment, patient safety, and efficiency in the health care system. Insured persons are free to opt into such a record and to decide who is allowed to have access to specific details of their treatment-related information. The records are being stored in decentralized databases. Providers will have to take part in certified communities (organizational units of health specialists and their institutions) in order to be able to read the records. Whereas ambulatory providers are not obliged to join such communities, hospitals and long-term care institutions are legally bound to join and to offer their services using an electronic patient record.

For some years, a national e-health coordination service called eHealth Suisse (an administrative unit of the FOPH) has been in place under the joint responsibility of the federal and cantonal

governments. The confederation will provide partial funding for the development of networks constituting the infrastructure for the electronic patient record.

GP e-health is still at an early stage,[xxiii] and there are ongoing discussions about incentives for physicians to adopt new technologies. Hospitals are generally more technologically 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.

How are costs contained?

Switzerland's health care costs are among the highest in the world. In 2014, total health expenditure represented 11.1 percent of gross domestic product.[xxiv] "Regulated competition"[xxv] among nonprofit health insurers and among service providers is aimed at containing costs and guaranteeing high-quality health care, and at establishing solidarity among the insured. Such were the objectives of MHI introduced in 1996. While most of its objectives are considered to have been achieved, academic analyses[xxvi] 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.[xxvii] In 2013, the FDAH postulated that the costs of providing mandatory benefits in the health system could be reduced by up to 20 percent.[xxviii]

An overview of possible cost-reducing measures is part of the Health2020 strategy. The strategy outlines a need for further flat-rate remuneration mechanisms and revision of existing fee schedules to limit incentives for service providers. Also mentioned is the need to concentrate highly specialized medicine in fewer sites to eliminate inefficiency and duplicated infrastructure and to increase the quality of treatments through more-experienced teams of providers. 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."

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 the prices of one-third of existing drugs every year. 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 strategy outlines important national topics, objectives, and measures for improving the quality of life, promoting equal opportunity and self-responsibility, ensuring and enhancing the quality of care, and creating more transparency, better governance, and closer coordination. In concrete terms, the SFC is pursuing the following 10 priorities in 2016:[xxix]

1. Adoption of the revised radiation protection regulations
2. A decision on how to proceed in the total revision of the Federal Act on the Genetic Testing of Human Beings (HGTA)
3. Adoption of the national strategy for the prevention of noncommunicable diseases
4. Adoption of the revised regulation of risk adjustment in health insurance
5. Consultation on the modification of the federal law on health insurance for the introduction of a reference price system
6. Adoption of resources to create an HTA unit
7. Consultation on the revision of the obligation of complementary medical services in the mandatory health insurance
8. A decision on the introduction of the federal law on electronic patient records
9. Adoption of the Suicide Prevention Action Plan
10. Adoption of the dispatch on the approval and implementation of the MEDICRIME Convention of the Council of Europe

The author would like to acknowledge Paul Camenzind and David Squires as contributing authors to earlier versions of this profile.[xxx]

Notes

[i] Swiss Federal Council (SFC), "Botschaft über die Revision der Krankenversicherung," Bern: SFC, 1991.

[ii] Please note that, throughout this profile, all figures in USD were converted from CHF at a rate of CHF1.28 per USD, the purchasing power parity conversion rate for GDP in 2015 reported by OECD for Switzerland: Organisation for Economic Co-operation and Development, "OECD Health Statistics 2016," http://www.oecd.org/els/health-systems/health-data.htm, accessed Aug. 17, 2016.

[iii] Swiss Federal Statistical Office (FSO), "Costs and Financing of the Health Care System 2014," Neuchâtel: FSO, 2016.

[iv] Swiss Federal Office of Public Health (FOPH), "Statistik der obligatorischen Krankenversicherung 2014," Bern: FOPH, 2016.

[v] Ibid.

[vi] FSO, "Costs and Financing of the Health Care System 2014," 2016, and Organisation for Economic Co-operation and Development (OECD), "Reviews of Health Systems: Switzerland," Paris: OECD, 2011.

[vii] Swiss Conference of Cantonal Health Ministers, http://www.gdk-cds.ch/fileadmin/docs/public/gdk/themen/krankenversicherung/praemienverbilligung/ipv_2016_df_def.pdf, accessed Aug. 17, 2016.

[viii] FOPH, "Statistik der obligatorischen Krankenversicherung 2014," 2016.

[ix] S. Hostettler and E. Kraft, "FMH-Ärztestatistik 2015: Zuwanderung grundlegend für Versorgungssystem," *Schweizerische Ärztezeitung 2016* 93(38):1371–75.

[x] K. Künzi and S. Strub, "Einkommen der Ärzteschaft in freier Praxis: Auswertung der Medisuisse-Daten 2009," *Schweizerische Ärztezeitung 2012* 97(12–13):448–453.

[xi] Hostettler and Kraft, "FMH-Ärztestatistik 2015: Zuwanderung grundlegend für Versorgungssystem," 2016.

[xii] Swiss Federal Statistical Office (FSO), "Krankenhausstatistik – Standardtabellen 2014," Neuchâtel: FSO, 2016.

[xiii] These include private hospitals that receive public subsidies if the cantonal governments have need of their services to guarantee a sufficient supply for the population.

[xiv] Swiss Conference of Cantonal Health Ministers, http://www.gdk-cds.ch/index.php?id=942, accessed Aug. 17, 2016.

[xv] Swiss Federal Statistical Office (FSO), "Statistik der sozialmedizinischen Institutionen – Standardtabellen 2014," Neuchâtel: FSO, 2016.

[xvi] FSO, "Costs and Financing of the Health Care System 2014," 2016.

[xvii] Swiss Federal Statistical Office (FSO), "Statistik der Hilfe und Pflege zu Hause – Spitex-Statistik 2014," Neuchâtel: FSO, 2016.

[xviii] OECD, "Reviews of Health Systems: Switzerland," 2011.

[xix] Swiss Federal Council (SFC), "Mehr Patientensicherheit dank nationalen Qualitätsprogrammen," press release, Dec. 7, 2015.

[xx] Swiss Federal Department of Home Affairs (FDHA), "The Federal Council's Health-Policy Priorities," http://www.bag.admin.ch/gesundheit2020/index.html?lang=en, accessed Aug. 17, 2016.

[xxi] Swiss Federal Statistical Office (FSO), "Schweizerische Gesundheitsbefragung – Standardtabellen 2012," Neuchâtel: FSO, 2014.

[xxii] Swiss Health Observatory (Obsan), "National Health Report 2015," Bern: Hogrefe, 2015.

[xxiii] C. Merçay, "Médecins de premier recours – Situation en Suisse, tendances récentes et comparaison internationale. Analyse de l'International Health Policy Survey 2015 du Commonwealth Fund sur mandat de l'Office fédéral de la santé publique (OFSP)," Neuchâtel: Observatoire suisse de la santé, 2015.

[xxiv] FSO, "Costs and Financing of the Health Care System 2014," 2016.

[xxv] A. C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs 1993* 12(1):24–48.

[xxvi] OECD, "Reviews of Health Systems: Switzerland," 2011.

[xxvii] Ibid.

[xxviii] FDHA, "The Federal Council's Health-Policy Priorities," 2013.

[xxix] Swiss Federal Council (SFC), "Gesundheit2020: zehn Prioritäten für 2016," press release, May 18, 2016.

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The Taiwan Health Care System

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What is the role of government?

Article 157 of the constitution of Taiwan, Republic of China, calls for the national government to promote health maintenance and implement the public provision of health care for all citizens. That article is the constitutional platform for the National Health Insurance (NHI) Act, passed by Taiwan's legislature in 1994.

The act stipulates that NHI is compulsory and that the government is to provide health care and medical services to the insured in case of illness, injury, and childbirth. It further stipulates that the government and contracted providers should regularly make public information on the quality of health care.

The NHI system is administered by the National Health Insurance Administration (NHIA) under the Ministry of Health and Welfare (MOHW) through six regional offices supported by a health information infrastructure. Municipal and district governments may offer additional benefits for residents within their jurisdiction, such as subsidies for out-of-pocket costs for poor residents.

Who is covered and how is insurance financed?

Publicly financed health insurance: Enrollment in NHI is mandatory for all citizens and for foreigners residing in Taiwan for longer than six months. As of 2016, 99.9 percent of the population is enrolled.
NHI is a predominantly premium-based social health insurance system. Sixty-eight percent of revenue is derived from payroll-based premiums; 27 percent from supplementary premiums levied on nonpayroll income (large bonuses, professional fees, wages from second and third jobs, and incomes from dividends, interests, rents); and 5 percent from tobacco tax and lottery gains.[i] Government accounts for 23.3 percent of payroll-based premiums; households, 38.2 percent; and employers, 38.6 percent.[ii] In 2016, rates for payroll-based and supplementary premiums are 4.69 percent and 1.91 percent, respectively.[iii]

During most of the period 1998 to 2010, NHI expenditures nearly always exceeded revenues. However, by raising the premium rate from 4.55 percent to 5.17 percent of payroll income in 2010[iv]—the second increase in its then 15-year history—NHIA began to accumulate surpluses starting in 2012.

Premium contributions are calculated on a per capita basis but are limited to a maximum of four members per household (the insured plus three dependents). Any additional members are covered for free. Premiums are paid monthly, with nearly all Taiwanese paying their premiums on time.[v]

Private health insurance: Private health insurance consists of disease-specific cash indemnity policies. Patients can use the cash for private hospital rooms or products, such as drug-eluting

stents, not covered by the NHI. Private policies do not cover medical services covered by NHI, nor do they buy faster access to specialists, diagnostic tests, or choice of specialists. As a component of total health expenditures, however, private coverage is growing, although the exact extent is unknown.

What is covered?

Services: NHI benefits are uniform and comprehensive. They include inpatient and outpatient care (both primary and specialist care), prescription drugs, dental care (excluding orthodontics and prosthodontics), traditional Chinese medicine, child birth care, physical rehabilitation, home care, chronic mental health care, and end-of-life care.

The NHIA determines which services are covered in consultation with a broad spectrum of stakeholders. Coverage decisions are subject to considerations of their budget impact (see below).

Cost-sharing and out-of-pocket spending: The NHI mandates copayment for physician visits and prescription drugs, and coinsurance for inpatient care. Ceilings and exemptions (latter to be discussed further on) for both apply. Once the ceilings are reached, NHI covers all remaining expenses. Copayments for accessing care without referral are higher than if the patient had referral.

Coinsurance for inpatient care varies by length of stay. Ceilings apply. In 2015, ceiling per inpatient stay for the same disease was US$1,031 (NT$33,000), and that for calendar year US$1,750 (NT$56,000).[vi]

The officially reported 2014 out-of-pocket (OOP) of 34.7 percent of total NHE[vii] in Taiwan overstates what OECD (and U.S.) counts as OOP, because Taiwan includes spending on items not included in OECD data, such as infant formula, baby diapers, dietary supplements, health foods, Chinese herbal medicine, private hospital rooms, cosmetic surgery, high-tech surgical procedures such as Davinci for prostate surgery (NHI covers traditional prostatectomy), etc. Thus OOP in Taiwan and OECD countries are not comparable. According to a former NHIA administrator, OOP spending in Taiwan associated with necessary health care such as medical and dental care, and drugs amounted to only 12.1 percent of Taiwan's NHE in 2012,[viii] which is more in line with OECD norm.

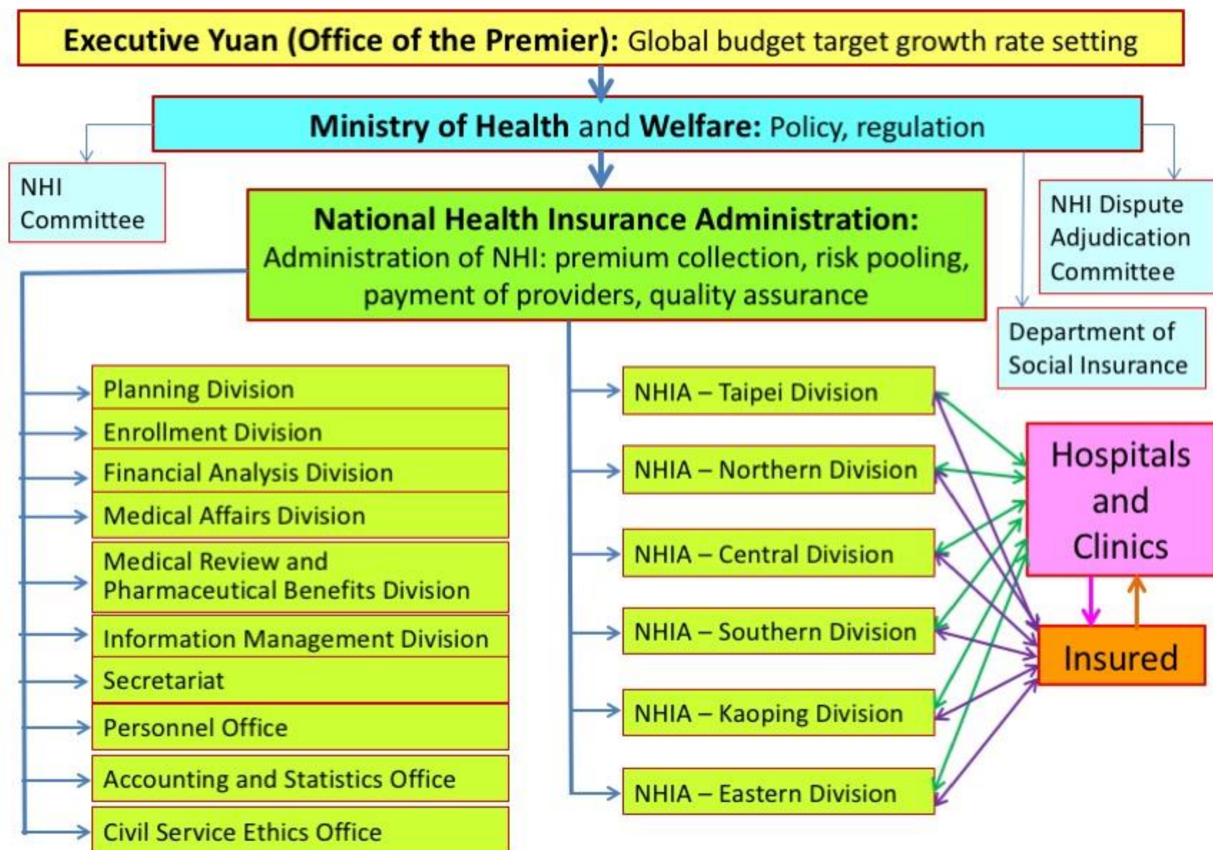
Safety nets: The NHI has a generous safety net that protects access to needed services for disadvantaged populations in Taiwan, including the very sick. Copayment exemptions apply to those with any of 30 catastrophic diseases and conditions, baby delivery, residents of remote, mountainous areas and off-shore islands (approximately 0.45 percent of the population), veterans, families of diseased veterans, low-income households, children under 3, tuberculosis patients, etc.[ix] In addition, copayments for residents living in under-resourced areas copayments are reduced by 20 percent, and for those receiving home care copayment has now been reduced from 10 percent to 5 percent.[x]
For those living in remote, mountainous areas and off-shore islands, the NHI provides access to needed services through an Integrated Delivery System (IDS). Satisfaction with the IDS is extremely high (over 90%).

The NHIA also provides premium subsides to insure access to care for all (more on this further on). In recent years, the government has tried to lower the income threshold to allow more people to become eligible for government subsidies.

How is the delivery system organized and financed?

Primary care: Approximately 40 percent of Taiwan's physicians are self-employed and own and practice in their private clinics. 80 percent to 90 percent of the clinics are solo-practices, the remaining 10 percent to 20 percent group practices.[xi] 98 percent of all private clinics contract with the NHIA to deliver services.

Only approximately 5 percent of all clinic doctors have received formal family medicine training,[xii] the rest are specialists delivering specialty care (general internal medicine, pediatrics, ear-nose-throat, obstetrics-gynecology, orthopedic surgery, ophthalmology, optometry, dental care, traditional Chinese medicine, etc.) In recent years there has been a trend towards multi-specialty group practices.



As of 2016, there is no gate-keeper system. Patients have complete free choice of doctors. Registration with a primary care physician thus is not applicable and care coordination difficult to achieve. Utilization of physician services has been high. The average number of visits per

person per year is 12.6 in 2012, significantly higher than the OECD median of 6.3; and higher than Germany (9.9), Canada (7.4), France (6.6), Denmark (4.7), Norway (4.4), US (4.0), New Zealand (3.7), Sweden (2.9), and Finland (2.7); but lower than Korea (14.3), and Japan (12.9).[xiii]

Physicians are paid predominantly fee-for-service according to national, uniform fee schedules set by the NHIA with stakeholder inputs under the primary care global budget. Under FFS payment, physicians compete fiercely for patients to maximize revenue, although of course not on price. Other forms of physician payment are pay-for-performance and capitation, both are on a pilot basis.

Other sources of income for physicians include patient registration fees paid at time of visit, services and goods not covered by NHI, and copayments.

No balance billing is permitted for physician (or hospital) services as NHI values equity above other considerations. In recent years, however, NHI has made exceptions for six medical devices (intraocular lens implants, drug-eluting and bioactive stents, and artificial ceramic knee joints, metal-on-metal artificial hip joints, bioprosthetic heart valves, and programmable ventriculoperitonneal shunt) which the patients may opt for, paying the difference between the NHI fees and the actual price charged for the more expensive devices.[xiv]

Outpatient specialist care: Patients in Taiwan also have complete free choice of hospital-based specialists on an outpatient basis with or without referrals. This has led to overcrowding in outpatient departments in hospitals, especially those at large hospitals and major medical centers. To discourage doctor- and hospital-shopping or accessing tertiary care without referral, the NHIA in recent years established graduated patient registration fee and copayment schedules whereby patients without referrals pay higher registration fees and copayments.

Hospital-based physicians, including outpatient specialists, are employees of the hospital and are paid salaries plus bonuses pegged on their "productivity", i.e., volume of services delivered, other activities such as publications and public lectures given, etc.

After-hours care: There are as yet no formal after-hours care provisions such as After-Hours Care centers. At present the hospital association and NHIA has an agreement to provide telephone consultation after hours. But future prospects for this arrangement are uncertain– physician associations mandate that doctors must "rest" on weekends.[xv] It is unclear how this will shake out going forward.

24-hour designated telephone consultation however, is available for those enrolled in the Family Physicians Integrated Care Plan (2.48 million, or approximately 10.6% of the population).[xvi] Physicians in Taiwan work long hours. Many clinics are open in the evening till 9 PM and on Saturdays. Outside of these hours, patients go directly to hospital emergency rooms. ER use in recent years has been increasing. However, Taiwan has over 400 hospitals all of which have ERs so access at all times is convenient and affordable, thus after-hours care is not viewed a serious problem.[xvii]

Hospitals: Hospitals in Taiwan have a closed-staff structure. There are 454 accredited hospitals for western medicine in 2014, representing 93.4 percent of all hospitals for western medicine in Taiwan; of these, 78 of 80 public hospitals (97.5%) and 376 of 406 private hospitals (92.6%) were accredited.[xviii] All accredited hospitals contract with the NHIA to deliver services. Contracts are renewed on three-year intervals upon passing evaluation. By law hospitals are not-for-profit, at least in name.

Hospitals in Taiwan provide both inpatient- and out-patient services, and derive revenues from a nationwide global budget set by the NHIA for all of Taiwan's hospitals combined. This arrangement is unlike hospital global budget systems in other countries where each hospital receives its hospital-specific global budget for its operations. The Taiwan Hospital Association lobbied for one single global budget for all hospitals in Taiwan. That overall national budget is divided into six regional global budgets, which are administered by the NHIA's six regional offices. Under this arrangement, all hospitals within a region compete fiercely for revenues derived from the one single regional global budget.

Under Taiwan's hospital global budget system, hospitals are paid by a combination of DRG and FFS according to uniform, national fee schedules set by the NHIA with stakeholder inputs. As of October 2016, there are 401 DRGs, which account for 22 percent of all hospital payments. When fully implemented, the battery of 1,062 DRGs will account for 60 percent of the total hospital expenditure.[xix]

Hospitals also derive revenues from non-NHI-covered services and goods, patient copayment for outpatient visits and coinsurance for inpatient services, and registration fees paid by patients at time of service.

Mental health care: The NHI provides mental health services as a covered benefit. As of 2014, Taiwan has 0.32 acute mental health beds, and 0.59 chronic mental health beds per 1,000 population, respectively.[xx] These represent a 21 percent increase in mental health beds in the period 2003-2013.[xxi] In 2003 Taiwan had an acute shortage of mental health beds.[xxii]

NHI also covers mental health services on an ambulatory basis at either private clinics or hospital outpatient mental health departments, and day care for the mentally ill.

Long-term care and social support: Taiwan does not yet have a formal long term care (LTC) program as of 2016, but needs one urgently to meet the growing needs of a rapidly ageing population. As of 2015, 12.5 percent of Taiwan's population is aged 65 and over. This percentage will increase to 24.1 percent by 2030, and to 36.9 percent by 2050.[xxiii] Starting in 2016 or 2017 Taiwan will have more people 65 years old or older than those aged between 0-14 years old. Rapid ageing aside, as of 2016 the number of disabled has reached 3.45 percent of the population, and is growing.

LTC in Taiwan has been a work in progress for many years. The previous government had hoped to implement LTC by 2016 or 2017 which did not happen.

With the change in government in May 2016, unresolved issues include LTC financing, benefits, eligibility, staffing and workforce. For example, the current government abandoned the previous administration's decision to finance LTC via the premium route and opted for tax-financing of LTC. On September 29, 2016 the premier's office passed the "Long Term Care Ten Year Plan 2.0" to promote capacity building and widespread distribution of LTC resources, with the principle objective of establishing an integrated and comprehensive community based LTC system. The government plans to begin pilot testing the feasibility of this ageing-in-place LTC model in early November 2016.

Meanwhile, through its new integrated home care program the NHI provides home care for the elderly and disabled including home visits by physicians and nurses, community services, and end-of-life care. The Quality of Death rankings performed every five years by the Economist Intelligence Unit ranked Taiwan 6th place among 80 countries, and 1st place in Asia, that participated in the survey.[xxiv] The top ten countries in 2015 were, in order of ranking from 1st to 10th: UK, Australia, New Zealand, Ireland, Belgium, Taiwan, Germany, Netherlands, US, and France.[xxv]

What are the key entities for health system governance?

As Taiwan's is a single payer system, governance of the NHI is a fairly straightforward affair. In a nutshell, the MOHW is responsible for policy, and the NHIA for the administration of the NHI. NHIA's tasks include premium collection, risk pooling, and paying providers. The NHIA also oversees utilization, delivery, and quality of NHI services through its powerful IT system.

One of the MOHW's most important tasks is to decide by how much the NHI global budget should grow each year. The process of global budget setting is as follows: each January-April, MOHW performs due diligence to come up with a proposed global budget growth rate for the next year; in April-May MOHW sends to the Office of the Premier (the highest administrative office in Taiwan) a proposed lower- and upper ceiling for the next year's growth; in May-June the National Development Council of the Office of the Premier reviews the MOHW's proposal and determines a range for the next year's growth rate and sends it back to the MOHW; and finally, in September-December, the MOHW's 35-member multi-stakeholder National Health Insurance Committee meets to negotiate the specific growth rate for each of the five sectoral global budgets – primary care, hospital, dental, traditional Chinese medicine, and renal dialysis. Once the NHI Committee reaches consensus, the minister approves a fixed value of growth rate and sends it to the NHIA for implementation.

Two other MOHW agencies also play a role in the NHI's operations. First, the National Health Insurance Mediation Committee oversees individual cases of disputes brought by providers regarding claims and premium collection disputes brought by individuals and employers. Second, the Department of Social Insurance also monitors the NHIA's operations and may make recommendations to the minister on cases referred to the ministry from the NHIA.

In addition to debating and negotiating with the government on new health legislations or their amendment, Parliament plays an important watchdog role regarding the NHI. For any premium rate increases beyond 6 percent, Parliament must pass an amendment to the NHI Act.

What are the major strategies to ensure quality of care?

Major MOHW quality monitoring systems and offices in charge include:

a) Hospital accreditation and patient safety - Department of Medical Affairs

b) NHI program administration - National Health Insurance Administration

c) Communicable disease control - Centers for Disease Control and Prevention

d) Cancer prevention and control - Health Promotion Administration

Major NHIA strategies to ensure quality of care fall into three broad categories:

a) Payment incentives -- a number of plans have specific funding to improve quality, such as extra bonus for service delivery for residents in remote and mountainous areas and off-shore islands (IDS plans), P4P schemes for management of chronic conditions (asthma, diabetes, breast cancer, hypertension, schizophrenia, hepatitis B and C carriers, early renal disease).

b) Claims management and reviews -- Because of the massive volume of claims submitted each day, the review process follows two tracks: a fully automated procedural review utilizing profile analysis based on specific medical criteria (for example, a claim for hysterectomy performed on a male patient will be identified by the system), and a peer review of randomly selected claims.

c) Information sharing and transparency -- public reporting of hospital quality, PharmaCloud, etc., to improve quality and reduce waste.

The NHIA has developed several hundred quality indicators for different purposes, e.g., some are used for pay-for-performance schemes, others for calculating global budgets, for making public disclosures, and still others for claims review, etc.[xxvi] Many of these programs serve the dual purpose of improving quality and reducing costs. Important national programs for quality assurance and improvement include:

- Integrated Delivery System (IDS) with 48 IDS plans (discussed earlier)
- Pay-for-performance (P4P) disease management programs (discussed above)
- Family Physicians Integrated Care Plan
- Hospital Patient Centered Integrated Care Project (outpatient basis) for patients aged ≥ 65 with two or more chronic conditions
- Capitation Pilot Project

- NHI PharmaCloud (more further on)
- My Health Bank (more further on)
- Post-acute Care Pilot Project for stroke patients
- Integrated Post-Acute Care program for Burns
- Artificial Joints Registry System to improve patient safety, reduce amenable mortality from unsafe artificial joints, and quality of care, began in January 2016.

The five sectoral global budgets themselves receive reviews for quality and possible inappropriate use of resources. In July each year, as part of the preparation to propose next year's global budget, the NHI Committee meets with scholars and experts to review and grade the previous year's performance of each of the sectoral global budgets by service delivery, quality indicators, public satisfaction, etc. There are five grades: Exceptional, Excellent, Good, Fair, and Bad (the last has never been assigned). Based on the grade of each of the sectoral global budget, it receives an increase in its global budget funding allocation for the next year as a reward. Performance bonuses may range from +0.5 percent for "Exceptional,", +0.3 percent for "Excellent", and so on.[xxvii]

Access to care has been convenient. 85 percent of patients reach a hospital or clinic in less than 30 minutes, and 83 percent of patients wait 30 minutes or less before being seen by a doctor. There are essentially no waiting lines.

What is being done to reduce disparities?

The government guarantees right to care for all. Everyone in Taiwan receives the same care based on the national uniform benefit package, regardless of their ability to pay. Over 3 million (12.8% of the population) economically disadvantaged Taiwanese have unhampered access to NHI services because of NHIA's various financial and access assistance measures.

Government provides varying amounts of premium subsidies to different population groups considered disadvantaged. For example, government pays 100 percent of premium for low income households, military personnel, veterans, civil servants including public school teachers, and convicts; 70 percent for dependents of veterans and members of farmers, fishermen's and irrigation associations; 35 percent for private school teachers, and 0 percent for employers, self-employed professional, and so on.

Outpatient copayment for the physically and mentally handicapped is limited to NT$50 (USD1.67) regardless of the level of hospitals. Copayments for the general public ranges from NTD 80-360 (USD2.67) to NTD 360 (USD12) depending on the level of the hospital visited. Copayments are also reduced for those elderly with chronic diseases enrolled in the government's Hospital Patient-Centered Integrated Care Plan.

The copayment exemption applies to patients with any of 30 designated catastrophic diseases, delivery, low-income households, residents of remote mountainous areas and offshore islands, veterans, head of household of surviving dependents of diseased veterans, children under 3 years

old, registered tuberculosis patients, and patients under labor insurance suffering occupational disease or injury. Drug copayment is waived for certain groups of the insured.

To protect the right to care of those with MOHW-recognized rare diseases, NHIA waives all copayments for all the drugs necessary to keep them alive. Today there are nine such patients whose annual drug costs exceed USD1 million each.[xxviii]

NHIA also makes interest-free loans and installment payment plans to those who cannot pay the premiums on time due to temporary circumstances such as being unemployed or in between jobs.

Other access and financial protection schemes, such as the IDS Plans, have been discussed elsewhere in this report. The bottom line is that everyone is guaranteed access to needed care regardless of their premium payment status.

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

Delivery system integration and care coordination have been on the agenda of NHIA for many years. Many such initiatives have been mentioned in earlier sections of this report.

What is the status of electronic health records?

Everyone in Taiwan carries a credit-card size electronic NHI-Card with a unique personal health identifier. The NHI-card makes accessing care convenient and is patient friendly. The card contains the cardholder's personal information, insurance data, six most recent medical visits, diagnosis, drug prescriptions, drug allergies, major illnesses, organ donation consent, palliative care directives, and public health records (immunizations, etc.). The NHI-Card also allows the NHIA to track both individual and national aggregate utilization of services almost in real time as providers are required to report to the NHIA every 24 hours every patient visit and services delivered.

The NHI-card also helps the government identify and track public health threats and infectious disease outbreaks such as the 2003 SARS epidemic, and identify and manage heavy users of NHI services as it allows the NHIA to know utilization and spending almost in real time.

The NHI-card makes administration of the NHI simple and efficient. NHIA administrative cost was approximately a mere 1 percent of total NHI expenditure (1.07% in 2014).

Two recent IT-driven personal health information innovations are worthy of note:

1. NHI PharmaCloud, a cloud based and patient-centered drug information system the NHIA introduced in 2013, using Big Data analytics and the vast data base the NHIA has accumulated since inception. It enables doctors (during clinic and outpatient visits, house calls, and ER care) and pharmacists to know in real time a patient's medication history for the past three months. PharamaCloud also provides prescribers clinical and safe-use information on the drugs, which help prevent drug adverse reactions and also reduce overuse and waste.

2. My Health Bank, introduced in 2014, is another cloud-based innovation that provides comprehensive health and medical records about any insured upon request. Records can be updated anytime. This initiative not only strengthen the public's "right to know" and the transparency of important information about the patient, but also enables the insured to better manage their own health, lessening the information asymmetry that typically exists between doctors and patients.

All hospitals and clinics use electronic patient medical records. However, NHI system-wide interoperability does not yet exist. Inter-hospital exchange of patient medical records is "still very limited and not yet very good because the government did not make the investment in the infrastructure needed."[xxix]

How are costs contained?

Health spending in Taiwan as a percent of GDP or per-capita has been consistently low compared to OECD countries, even though Taiwan's per capita GDP (in PPP$) is higher than that of many OECD countries. Taiwan's total national health expenditure (NHE) in 2013 was 5.9 percent of GDP (and 6.2% in 2014), low compared to the OECD median of 8.8 percent (2013) and average of 9.3 percent (2012).[xxx] Per capita health spending and per capita GDP (PPP$) in Taiwan in 2013 was 2,595 and 43,813 compared to 3,385 and 36,953 in OECD countries, and 8,713 and 53,042 in the U.S, respectively.[xxxi]

Cost containment had been a stated major policy goal of Taiwan's government as early as the late 1980s during the NHI's planning stage. Annual health spending then was growing in double digits, which the government deemed unsustainable.

Since inception of NHI in 1995, the NHIA has introduced a number of cost containment strategies on both the supply- and demand sides.
On the supply side, NHI's global budget system may be said to be the most powerful tool for cost containment. NHI expenditure growth rates in the earlier years following the NHI's implementation had been between 6 percent - 9 percent, significantly higher than NHI revenues growth rates. Beginning in 1998 through 2003, the government phased in five sectoral global budgets: dental (1998), Chinese medicine (2000), primary care-clinics (2001), hospitals (2002), and dialysis (2003).

Global budgets have had a significant impact on the growth of health spending. In the period 2004-2015, when the growth in NHE in Taiwan was between 2.9 percent - 4.4 percent, or an average of 3.87 percent annual growth, while GDP growth had ranged between (-1.4%) and 8.9 percent, or average of 3.61 percent per year in the same period.[xxxii]

Other supply constraints included DRG payment for hospitals and annual drug price adjustments. The latter are based on comparing the actual transaction prices of drugs procured by providers, which providers must report to the NHIA in the 4th quarter of the year, to the NHI fee for the drug. Fee adjustments are made in the first quarter of the following year according to a formula bringing the NHIA fee closer to the actual transaction prices of drugs.[xxxiii]

Capacity constraints in the delivery system also play a role in cost containment in Taiwan. The physician-population ratio in Taiwan was 1.8 per 1,000 population in 2012, lower than the OECD median of 3.1 per 1,000 population.[xxxiv] The ratio of CT per million population in Taiwan is lower than that in many OECD countries; comparable to Canada and France; and higher than that in the Netherlands. Taiwan has fewer, and in many cases far fewer, MRI machines than Australia, Canada, France, Germany, the Netherlands, US, Japan, and Korea. On the other hand, the bed (acute)-population ratio in Taiwan, at 3.2 beds per 1,000 population, was higher than the OECD median of 3.0; and U.S. 2.5, UK 2.3, Canada 1.7 per 1,000 population.[xxxv]

The NHIA's pharmaceutical benefit management initiative considers both clinical- and cost-effectiveness and the budget impact of the drugs and devices in coverage decisions. It is in the process of building capacity for health technology assessment to evaluate medical services to help the NHIA make coverage decisions and improve quality.

The NHIA's automated IT-supported claims review checks for the overall appropriateness of claims. In addition, it also randomly selects a small percentage of claims for individual professional review by clinical experts. These measures help the NHIA monitor utilization and costs on a real time basis (providers are required to report to NHIA all services delivered daily, by patient), detect fraud and abuse, and safeguard quality.

Demand-side constraints are fewer in Taiwan's NHI. Graduated copayment and coinsurance schemes whereby patients who access tertiary care without referral pay higher copayment and coinsurance, and utilization monitoring help contain costs. Ceilings and exemptions from copayments and coinsurance, however, protect access to care. Overall, government provisions to safeguard access to care for all, especially for the disadvantaged including the sick, has rendered patient cost sharing not a significant factor in cost containment in Taiwan.

In the long run, however, one may legitimately ask, "Is NHI too nice?"-- NHI's generous copayment policy, among other things, may prove to be unsustainable; going forward, eligibility for copayment exemption should be reviewed through means-testing as a cost-containment measure and "to prevent reverse income distribution from the middle class to the rich."[xxxvi] Administrative costs in Taiwan are very low. Unlike the U.S. health system that is burdened by huge (15% - 25%) administrative costs, Taiwan's NHI IT-driven single payer system has consistently enjoyed administrative simplicity and thus low administrative costs: from 1.5 percent in 2005 to 1.07 percent in 2014.[xxxvii]

Eliminating services that are of low value from the benefit package (delisting), however, has been very difficult due to political considerations.

Taiwan achieves good cost containment without waiting lines, and public satisfaction (for medical services covered, quality improvements, and extensive use of information technology) has been high -- in the 80 percent range in recent years.

What major innovations and reforms have been introduced?

Important innovations and reforms in Taiwan's single payer NHI have been discussed in earlier sections. To recap a few: global budget system, DRG payment for hospitals, P4P, NHI-Card,

PharmaCloud, My Health Bank, and various quality improvement and cost containment strategies and program.

The one major reform that merits special attention is the second-generation NHI Reform, which imposed a supplementary premium on six non-payroll sources of income (rents, interests, dividends, large bonuses, professional incomes, and income from second and third jobs.) Implemented in January 2013 at a rate of 2 percent initially and reduced to 1.91 percent as of January 2016, the supplementary premium not only broadened the premium base for the NHI and put the NHI's financial status on a sound footing (NHI now has a large surplus), but it also improved equity in financing of the NHI as previously the payroll based premium scheme placed the bulk of the premium burden on the salaried class and favored the well-off in Taiwan.

Notes

[i] National Health Insurance Administration, Ministry of Health and Welfare, Taiwan's National Health Insurance 2015–2016.

[ii] Author's personal communication with official at the Planning Division, National Health Insurance Administration, Ministry of Health and Welfare, Nov. 1, 2016.

[iii] National Health Insurance Administration, Ministry of Health and Welfare, *2015–2016 National Health Insurance Annual Report.*

[iv] Ibid.

[v] Ibid.

[vi] Ibid.

[vii] Ministry of Health and Welfare, The Statistics and Trends in Health and Welfare 2014.

[viii] Tsung-Mei Cheng, "Reflections on the 20th Anniversary of Taiwan's Single-Payer National Health Insurance System," *Health Affairs,* 2015 34(3).

[ix] National Health Insurance Administration, Ministry of Health and Welfare, 2015–2016 National Health Insurance Annual Report.

[x] Ibid.

[xi] Author's personal communication with Cheng-hua Lee, Deputy Director-General, National Health Insurance Administration, Ministry of Health and Welfare, Oct. 22, 2016.

[xii] Ibid.

[xiii] Ministry of Health and Welfare, *The Statistics and Trends in Health and Welfare 2014.*

[xiv] National Health Insurance Administration, Ministry of Health and Welfare, *2015–2016 National Health Insurance Annual Report.*

[xv] Author's personal communication with Cheng-Hua Lee, Deputy Director-General, National Health Insurance Administration, Ministry of Health and Welfare, Oct. 22, 2016.

[xvi] National Health Insurance Administration, Ministry of Health and Welfare, *2015–2016 National Health Insurance Annual Report.*

[xvii] Author's personal communication with Cheng-Hua Lee, Deputy Director-General, National Health Insurance Administration, Ministry of Health and Welfare, Oct. 22, 2016.

[xviii] Ministry of Health and Welfare, *The Statistics and Trends in Health and Welfare 2014.*

[xix] Author's personal communication with Cheng-hua Lee, Deputy Director-General, National Health Insurance Administration, Ministry of Health and Welfare, Oct. 23, 2016.

[xx] Ministry of Health and Welfare, *The Statistics and Trends in Health and Welfare 2014.*

[xxi] Ibid.

[xxii] Tsung-Mei Cheng, "Taiwan's New National Health Insurance Program: Genesis and Experience So Far," *Health Affairs,* 22(3).

[xxiii] National Development Council, *Republic of China Population Estimates 2014–2061.*

[xxiv] Data from The Economist Intelligence Unit 2015 Quality of Death Survey. Cited in Ruey-Yun Long in consultation with Sheng-jian Huang, Superintendent, Taipei Municipal Hospitals System; and Zheng-hui Chen, Medical Affairs Division, National Health Insurance Administration, Ministry of Health and Welfare, "Palliative Care in Taiwan: An International Perspective," *National Health Insurance Quarterly,* Oct. 2016.

[xxv] Ibid.

[xxvi] Author's personal communication with Pen-Jen Wang, Senior Executive Officer, Medical Review and Pharmaceutical Benefits Division. National Health Insurance Administration, Ministry of Health and Welfare, Oct. 26, 2016.

[xxvii] Ibid.

[xxviii] Author's personal communication with Cheng-hua Lee, Deputy Director-General, National Health Insurance Administration, Ministry of Health and Welfare, Oct. 22, 2016.

[xxix] Ibid.

[xxx] Ministry of Health and Welfare, *The Statistics and Trends in Health and Welfare 2014.*

[xxxi] Ibid.

[xxxii] Author's calculation based on data from *2016 National Health Insurance Global Budget Payment Consultation Reference Index,* National Health Insurance Committee, Ministry of Health and Welfare.

[xxxiii] Author's personal communication with Cheng-Hua Lee, Deputy Director-General, National Health Insurance Administration, Ministry of Health and Welfare, Oct. 27, 2016.

[xxxiv] Ministry of Health and Welfare, *The Statistics and Trends in Health and Welfare 2014.* OECD data based on OECD Health Data 2015.

[xxxv] Ministry of Health and Welfare, *The Statistics and Trends in Health and Welfare 2014.*

[xxxvi] Cheng, Tsung-Mei, *Taiwan's Health Care System: The Next 20 Years* (Brookings Institution, 2015), https://www.brookings.edu/opinions/taiwans-health-care-system-the-next-20-years/; accessed Oct. 31, 2016.

[xxxvii] Cheng, Tsung-Mei, "Reflections on the 20th Anniversary of Taiwan's Single-Payer National Health Insurance System," *Health Affairs,* 34, No. 3 (2015).

The U.S. Health Care System, 2016

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 2015, about 67.2 percent of U.S. residents received health insurance coverage from private voluntary health insurance (VHI): 55.7 percent received employer-provided insurance, and 14.6 percent acquired coverage directly.[i] Public programs covered roughly 37.1 percent of residents: Medicare covered 16.3 percent, Medicaid 19.6 percent, direct-purchase 16.3 percent, and military coverage 4.7 percent.[ii]

In the first quarter of 2016, 27.3 million individuals were uninsured, representing 8.6 percent of the population, down from 9.1 percent in 2015.[iii] 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. Between 2014 and the start of 2016, the overall rate of health insurance coverage increased for most racial and ethnic groups. Hispanics had the largest increase (6.6 percentage points), followed by Asian Americans (4.8 points), non-Hispanic blacks (3.1 points), and non-Hispanic whites (2.4 points).[iv] It is projected that the ACA will reduce the overall number of uninsured by 24 million by 2018.[v]

Public programs provide coverage to various, often overlapping, populations. In 2015, more than 10 million Americans were both entitled to Medicare and eligible for Medicaid services ("dual eligibles").[vi] 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 2015.[vii]

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 in 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 drugs. 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 post-acute 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 between 100 percent and 250 percent of the federal poverty level (FPL) (the FPL is $20,090 for a family of three, as of 2015).[viii] In the last open-enrollment season, 57 percent of people who selected plans in the federally facilitated marketplaces had cost-sharing subsidies.[ix]

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 11 percent of total health expenditures in the U.S.[x] Cost-sharing for most private insurance plans is capped at $6,850 for individuals and $13,700 for families per year for 2016 and $7,150 for individuals and $14,300 for families for 2017.[xi]

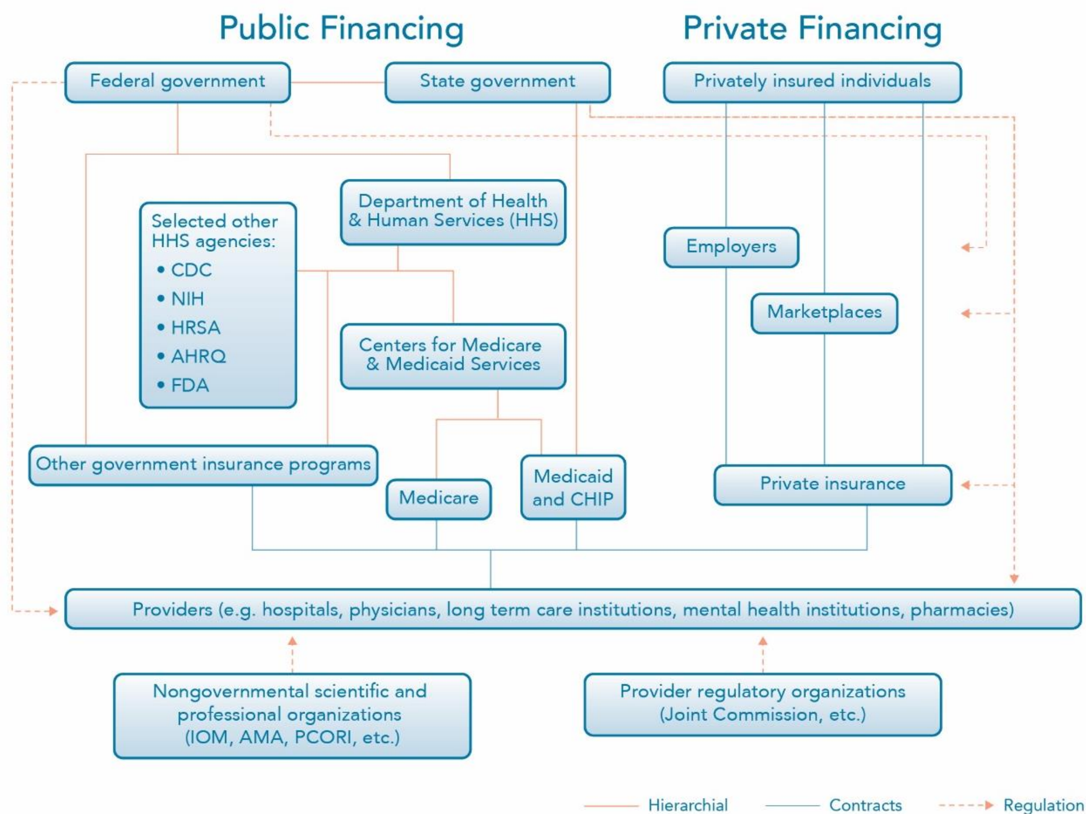
Safety nets: A variable and patchwork mix of organizations and programs deliver care for uninsured, low-income, and vulnerable patients in the United States, including public hospitals, local health departments, free clinics, Medicaid, and CHIP. Under the ACA, 32 states and the District of Columbia have expanded Medicaid coverage to cover individuals with incomes up to 138 percent of the FPL,[xii] 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 the FPL, and cost-sharing subsidies for incomes of 100%–250% of the 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. The federal government also funds community health centers, which are 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 financed?

Publicly financed health care: In 2014, public spending accounted for about 49 percent of total health care spending.[x]**Error! Bookmark not defined.** 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 fiscal year 2016, federal matching ranged from 50 percent to 74 percent of states' Medicaid expenditures.[xiii] 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

in the form of tax credits.

Privately financed health care: In 2014, private health insurance spending accounted for about 39 percent of total health care spending.[x] Private insurers, which can be for-profit or nonprofit, are answerable to 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.[xiv]



Source: Adapted from T. Rice, P. Rosenau, L. Y. Unruh et al., "United States of America: Health System Review," *Health Systems in Transition*, vol. 15, no. 3, 2013, p. 27.

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?

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 be given 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

2015 reported having after-hours care arrangements),[xv] 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.[xvi] 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 following discharge. 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 are 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 primary care physicians, psychiatrists, psychologists, social workers, and nurses—and paid for through a range 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 and substance abuse 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. As a result of the law, most health plans now cover preventive services and cannot deny coverage because of mental illness. Several ACA mechanisms, such as accountable care organizations and bundled payment (see below), promote the integration of behavioral and primary care.

Long-term care and social supports: Long-term care is provided by a mix of for-profit and nonprofit providers and paid for through 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.[xvii] 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 the 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
- 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 National Academy of Medicine (formerly the Institute of Medicine), 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. The 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, 30-day readmission rates nationally for conditions subject to penalties have declined from 21 percent to less than 18 percent.[xviii] 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, with a 17 percent decline over the first three years.[xix]

HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through these programs and others, such as Hospital Value Based Purchasing.[xx]

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 has 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 in underserved communities. There are also a multitude of public and private initiatives at the local and the state level.

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

Government agencies and private insurance companies are leading efforts to move away from the current 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 800 ACOs have been launched by public programs and private insurers, and more than 28 million Americans are enrolled in one.[xxi] 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 470 ACOs servicing 17 percent of the Medicare population, or 8.9 million Americans.[xxii] Patients have reported better care experiences, quality measures have generally improved for the tracked indicators, and modest savings have been achieved.[xxiii] CMS has unveiled the new Next Generation ACO program for experienced, high-performing ACOs.

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," whereby 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.[xxiii]**Error! Bookmark not defined.**

In addition, CMS has supported the development of local programs that aim to better integrate health and social services. 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 EHR Incentive Program. As of 2015, 84 percent of physicians used some form of EHR system, and three out of four hospitals (76%) had adopted at least a basic EHR system, representing an eightfold increase since 2008.[xxiv]

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 ($9,364 in 2014), despite a recent slowdown in spending from 2008 to the present.[x] 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. Patent expirations and a movement toward favoring generic drugs over brand-name drugs, meanwhile, have led to a slowdown in pharmaceutical spending in recent years, although growth rebounded in 2014 with the market entry of expensive biologics for conditions such as hepatitis C. 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 July 2016, showed that spending had grown 4.9 percent over the previous year.[xxv]

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, greater affordability, higher quality, more efficiency, lower costs, more robust primary and preventive care, and a broader array of community resources, has survived. There have been modifications to the law, however, as a result of several Supreme Court decisions since 2010. Perhaps the 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) had pursued expansion as of late 2015.

Still, since implementation of the ACA in 2013, the number of uninsured adults has declined by historic proportions.[ii] Groups that have long been at greatest risk of being uninsured—young adults, Hispanics, blacks, and those with low income—have made the greatest coverage gains, yet inequalities remain.[xxvi]

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. As of early 2016, HHS had already reached an interim goal of 30 percent.[xxvii] 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 care plan 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."

In 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed by Congress to align financial incentives for providers with high-value care. The law overhauls how hundreds of thousands of clinicians are paid by Medicare, through two value-based provider payment pathways under Medicare Part B: Advanced Alternative Payment Models (APMs) and the Merit-Based Incentive Payment System (MIPS).[xxviii] The Advanced APM path aims to promote participation in existing APMs such as ACOs, medical homes, and bundled payments for joint replacement and cardiac care. MIPS adjusts traditional fee-for-service provider payment according to several factors: quality, cost, provider efforts to utilize health information technology, and practice improvement. The reforms under MACRA are meant to support the transition of the U.S. health care system from fee-for-service payment to payments based on the value and quality of care delivered; they are intended to generally promote approaches to care delivery focused on better care, efficient spending, and healthier patients.

Notes

[i] Estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

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