THE COMMONWEALTH FUND
2007 INTERNATIONAL SYMPOSIUM ON HEALTH CARE POLICY

DESCRIPTIONS OF HEALTH CARE SYSTEMS:
AUSTRALIA, CANADA, GERMANY, THE NETHERLANDS,
NEW ZEALAND, THE UNITED KINGDOM, AND THE UNITED STATES

Multinational Comparisons of Health Systems Data
Selected Indicators for Seven Countries, 2005

		Australia	Canada	Germany	Netherlands	New Zealand	U.K.	U.S.
	Total Population (1000s of People)	20,329	32,271	82,466	16,320	4,099	60,227	296,410
Spending	Percentage GDP Spent on Health Care	9.5%[a]	9.8%	10.7%	9.2%[a]	9.0%	8.3%	15.3%
	Health Care Spending per Capita[c]	$3,128[a]	$3,326	$3,287	$3,094[a]	$2,343	$2,724	$6,401
	Average Annual Growth Rate of Real Health Care Spending per Capita, 1995-2005	4.5%[b]	3.2%	1.8%	3.3%[b]	4.3%	4.2%	3.6%
	Spending on Physician Services per Capita[c]	$512[a]	$336	$386	na	$397	na	$1,421
	Out-of-Pocket Health Care Spending per Capita[c,d]	$627[a]	$482	$431	$250	$392	$0	$842
	Spending on Pharmaceuticals per Capita[c]	$415[a]	$589	$498	$318[e]	$290	na	$792
	Spending on Long-Term Institutional Care per Capita[c]	$220[a]	$392	$247	$218[e]	$155	na	$411
Physicians	Number of Practicing Physicians per 1,000 Population	2.7[a]	2.2	3.4	3.7	2.2[a]	2.4	3.0[f]
	Average Annual Number of Physician Visits per Capita	6.1	6.0[a]	7.0[a]	5.4	3.2[g]	5.1	3.8[a]
Hospital Spending, Capacity and Utilization	Inpatient Hospital Spending per Capita[c,i]	$1,201[a]	$945	$1,144	$1,043[e]	$680	na	$1,695
	Hospital Spending per Inpatient Acute Care Day	$1,201[a]	$1,004[a]	$636	$1,304[e]	$520[a,h]	na	$2,421
	Number of Acute Care Hospital Beds per 1,000 Population	3.6[a]	2.9[a]	6.4	3.1	na	3.1	2.7
	Average Length of Stay for Acute Care	6.1[a]	7.3[a]	8.6	6.8	5.6[a,h]	6.1	5.6
Elderly and Long-Term Care	Number of Long-Term Care Beds per 1,000 Population over Age 65	37.5[a]	97.4[d,g]	47.8	27.4[g]	na	19.1[a]	43.9[a]
	Percentage of Population over Age 65 with Influenza Immunization	79.1%[a]	66.5%	63.0%	77.0%	60.6%	75.0%	64.6%
IT	Physicians' Use of EMRs, 2001[i](% of Primary Care Physicians)	25%[j]	14%[j]	48%	88%	52%[j]	58%	17%[j]
Avoidable Deaths	Mortality Amenable to Health Care[i] (Deaths per 100,000 Population)	88	92	106	97	109	130	115
Non-Medical Determinants of Health	Percentage of Adults Who Reported Being Daily Smokers	17.4%[a,k]	17.3%	24.3%[g]	31.0%	22.5%	24.0%	16.9%
	Obesity (BMI>30) Prevalence	na	18.0%	13.6%	10.7%	20.9%[g]	23.0%	32.2%[a]

Source: OECD Health Data 2007 (October 2007)

[a]2004

[b]1995-2004

[c]Adjusted for differences in the cost of living

[d]Source: OECD Health Data 2007 (July 2007)

[e]2002

[f]Source: American Medical Association

[g]2003

[h]Source: New Zealand Ministry of Health

[i]Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

[j]2000

[k]Australian Government Department of Health & Ageing

The Australian Health Care System

Who is covered?

- Australia's national public health insurance scheme, Medicare, provides universal health coverage for citizens, permanent residents and visitors from countries which have reciprocal arrangements with Australia.

What is covered?

- Services: Medicare provides free or subsidized access to most medical and optometry services; hospital care for public patients; prescription pharmaceuticals; and some allied health and dental services for the chronically ill. The Australian Government also funds a wide range of other health services including population health, mental health, rural health, Indigenous health, health services for war veterans. Private insurance complements the public system and offers consumers broader choice of doctor, hospital (including private hospital accommodation) and timing of procedures, as well as services such as physiotherapy, dental, and podiatry services.
- Cost sharing: Medicare reimburses 75% of the schedule fee for private inpatient services and 85-100% of the schedule fee for ambulatory services. Doctors are free to charge above the schedule fee, or they can treat patients for the cost of the subsidy and bill the federal government directly with no patient charge (referred to as bulk-billing). There is a bulk-billing incentive scheme and almost 75% of all medical services, and almost 80% of general practitioner attendances, are bulk-billed.
- Safety nets: A Medicare safety net for non-inpatient services protects against high out-of-pocket medical costs over a year.

How is the health system financed?

- National Health Insurance (Medicare): Compulsory national health insurance administered by the Australian Government. Medicare is funded by a 1.5% levy on taxable income (except where an individual is exempt or pays a reduced levy because of low income). Individuals and families on higher incomes who do not have an appropriate level of private hospital coverage may also have to pay a Medicare levy surcharge which is an additional 1% of taxable income. In 2005-06, the revenue raised from the Medicare levy funded 26% of total Medicare expenditure and 18% of total federal government health expenditure.
- Other federal, state and territory government health expenditure is funded from general tax revenue, including the Goods and Services Tax (GST), with some revenue raised from patient fees and other non-government sources. Government funds 68% of total health expenditures, with 43% funded by the Australian Government and 25% funded by state and territory governments.
- Private Insurance: Private insurance covers 50.3% of the population and accounts for around 7% of total health expenditure. Through a rebate, 30% of private health insurance premiums are paid by the Australian Government. The Government's Lifetime Health Cover initiative encourages people to take out private hospital coverage early in life and maintain their coverage by offering people who join a health fund before they turn 31 years old a relatively lower premium throughout their lives, regardless of their health status. Private health insurance is community-rated. Out-of-pocket expenditures by individuals accounts for 17% of total health expenditure.

How is the delivery system organized?

- Physicians: Most medical and allied health practitioners are in private practice and charge a fee for service. The Australian Government establishes fee schedules for medical services.
- Hospitals: A mix of public (run by the states) and private facilities. The public hospital system provides free access under Medicare to hospital care for public patients. Public hospitals are jointly funded by the Australian Government and state/territory governments through five-yearly agreements. Public hospitals also receive some revenue from services to private patients. Physicians in public hospitals are either salaried (but may have private practices and fee-for-service income) or paid on a per-session basis. Many salaried specialist doctors in public hospitals are able to treat some private patients in hospital. Private hospitals (including free-standing ambulatory day centers) can be either for-profit or not-for-profit. Their income is chiefly derived from patients with private health insurance. The majority of physicians working in private hospitals are in private practice and do not concurrently hold salaried positions in public hospitals. Private hospitals provide a third of all hospital beds, almost 40% of total

hospital separations, and over half of all surgical episodes requiring the use of an operating room.

- Pharmaceuticals: Most prescribed pharmaceuticals are dispensed by private sector pharmacies. Prescription pharmaceuticals have a patient co-payment, set by the federal government. A safety net protects against high out-of-pocket pharmaceutical costs over a year.
- Government: The federal government regulates private health insurance, pharmaceuticals, and medical services and has the primary funding and regulation responsibility for aged care homes that attract government assistance. States are charged with operating public hospitals and regulating all hospitals and community-based general services.

How are costs controlled?

- The Australian Government controls its health costs through a combination of price signals for consumers (gap fees and co-payments); setting fee schedules for government subsidies; using its purchasing power to negotiate pharmaceutical prices; assessing the cost-effectiveness of proposed new pharmaceuticals and medical treatments; limiting the diffusion of technology; controlling the growth in cost of some large volume services through industry agreements with the relevant medical specialty; and restricting the number of medical students and Medicare-licensed providers. Electronic health technologies offer further scope for efficiency improvements by reducing duplicate testing and the risk of inappropriate treatment.

The Canadian Health Care System

Who is covered?

- Coverage is universal for eligible residents of Canada.

What is covered?

- Services: Through the *Canada Health Act*, the federal government requires that provincial and territorial health insurance plans cover all medically necessary physician and hospital services to qualify for full federal transfers. The federal government provides specific health care services for certain groups, including the Royal Canadian Mounted Police, serving members of the armed forces, eligible veterans, First Nations people living on reserves, the Inuit, inmates in federal penitentiaries and refugee protection claimants.
- Provincial and territorial governments also provide varying levels of supplementary benefits for certain groups such as children, senior citizens and social assistance recipients. Benefits include services such as prescription drug coverage, vision care, dental care, home care, aids to independent living, and ambulance services.
- Cost-sharing: No cost-sharing for insured physician and hospital services. However, there are charges for supplementary benefits and for non-insured services.

How is the health system financed?

- Publicly Funded Health Care: Public health insurance plans are administered by the provinces/territories and generally funded by general taxation. Three provinces charge additional health care premiums. Federal transfers to provinces/territories are tied to population and other factors and are conditional on meeting the principles of the *Canada Health Act.* Public funding accounts for approximately 70% of total health expenditures.
- Privately Funded Health Care: Many Canadians have supplemental private insurance coverage through group plans, which cover services such as vision and dental care, prescription drugs, rehabilitation services, private care nursing, and private rooms in hospitals. Private health expenditures represent approximately 30% of total health expenditures.

How is the delivery system organized?

- Physicians: Most physicians are in group or private practice and are remunerated on a fee-for-service basis. However, some Canadian physicians receive payment for clinical care through alternative public payment plans, such as salaries. In 2004-05, 20.5% of total clinical payments to physicians were made through these types of arrangements. Provincial/territorial medical associations generally negotiate the fee schedule for insured services with provincial/territorial health ministries. Physicians must opt out of the public system of payment to have the right to charge their own rates for medically necessary services.
- Nurses: Most nurses are primarily employed either in hospitals or by community health care organizations, including home care and public health services. Nurses are generally paid salaries negotiated between their unions and their employers. With an increasing emphasis on primary care, the majority of provinces are changing their laws to allow nurse practitioners to deliver a greater range of primary care services.
- Other health professionals such as dentists, optometrists, therapists, psychologists, pharmacists, public health inspectors may be employed or self-employed.
- Hospitals: Mix of public and private non-profit hospitals that operate under annual, global budgets, negotiated with the provincial/territorial ministries of health or regional health authority, with some fee-for-service payment.
- Government: Provincial/territorial governments have the authority to regulate health providers. However, they typically delegate control over physicians and other providers to professional “colleges” whose duty is to license providers and set standards for practice.

How are costs controlled?

- Cost control measures include mandatory annual global budgets for hospitals/health regions, negotiated fee schedules for health care providers, formularies for public drug plans and limits on the diffusion of technology.

The German Health Care System

Who is covered?

- Up to the determined income level, every employee has to enroll with any of the Sickness Funds (SFs) offering the same comprehensive health care coverage. Individuals above that income level have the right to opt out to obtain private coverage instead.

What is covered?

- Services: The statutory benefit package includes preventive services; inpatient and outpatient hospital care; physician services; mental health care; dental care; prescription drugs; rehabilitation; and sick leave compensation. Long-term care is covered by a separate insurance scheme, mandatory since 1995. There is free choice of ambulatory care physicians and hospitals, as well as any medical service which is covered by statutory insurance.
- Cost-sharing: Traditionally few cost-sharing provisions. However co-payments, especially for dental care but also for physician services and inpatient care, were increased over the last years. In addition, there are now co-payments for GP visits and medications. Out-of-pocket payments (glasses, OTC drugs, others) accounted for 10.4 % of health care expenditures.

How is the health system financed?

- Sickness Funds (SFs): There are approximately 240 SFs, autonomous, not-for-profit, nongovernmental bodies (although regulated by the government). They are currently funded by compulsory payroll contributions averaging 14.8% of wages, shared by employers (46%) and employees (54%). In 2009, the varying contributions will be replaced by a single contribution rate set by the government. The Health Fund will distribute finances to the funds based on a risk-adjusted formula. SFs cover approximately 88% of the population. Dependents are covered through the primary SF enrollee. While the unemployed continue to contribute to the SF proportionate to their unemployment entitlements, health care costs incurred by welfare recipients, asylum seekers, and the homeless, are financed through general revenues. In 2000, SFs accounted for 56.9% of health care expenditures.
- Private Insurance: Private insurance, which provides health insurance based on voluntary, risk-adjusted individual premiums, covers 10% of the population (the affluent, the self-employed, and civil servants). Private insurance accounted for 8.2% of health care expenditures in 2000.

How is the delivery system organized?

- Physicians: GPs have no formal gatekeeper function. However, in 2004 SFs were required to offer insurees the option to enroll in a "family physician care model" which provides a bonus for complying with gatekeeping rules. Ambulatory care is mainly delivered by private for-profit providers working in single practice, and all physicians in the outpatient sector are paid per medical procedure. There is a strong sector of ambulatory specialized care in Germany. Therefore, Germany has two branches of specialized care: one in the hospital and the other in the ambulatory sector. Representatives of the sickness funds annually negotiate with the regional associations of physicians to determine aggregate payments.
- Hospitals: Hospitals are mainly non-profit, both private and public. They are staffed with salaried doctors. Senior doctors may also treat privately insured patients on a fee-for-service basis. Doctors in hospitals are typically not allowed to treat outpatients. Exceptions are made when necessary care cannot be provided on an outpatient basis by specialists in private practices. A new payment system based on diagnosis-related group (DRG) per-admission payments was introduced in 2004.
- Care Coordination: Legislation in 2002 created Disease Management Programs (DMPs) for six major chronic conditions in order to give the SFs an incentive to promote coordinated and high quality care for chronically ill members. SFs' compensation is adjusted for income, age, sex and incapacity to work; the introduction of DMPs added high-risk pools to this list, so that SFs with higher shares of DMP patients receive higher compensation. As of September 2007, over 3.5 million patients were enrolled in DMPs, with about two-thirds in diabetes II programs. In 2004 (renewed in 2007), lawmakers put in place financial incentives to encourage integrated care contracts outside the regionally negotiated health care budgets. Integrated

care agreements range from contracts between two providers, to selected contracting between SF and providers to the establishment of new types of group practice, called medical care centers.

- Government: The German government delegates regulation to the self-governing corporatist bodies of both the sickness funds and the medical providers' associations. However, given lack of efficacy and compliance, the Government is increasingly willing to replace the self-regulating system and delegate more purchasing powers to the sickness funds.

How are costs controlled?

- Annual budget growth is linked directly to GDP growth. The self-governance bodies negotiate regional health care budgets for GP, specialist, and hospital services. In early 2001 the drug budget ceilings for collective liability of physicians on a regional basis was lifted, leading to an unprecedented increase of expenditures for pharmaceuticals increasing financial strain on the SFs. This lift was recently replaced by a drug budget ceiling with individual liability. Health care reforms in the 1990s included increased competition among sickness funds; the introduction of a per-admission DRG hospital payment system; the control of physician supply; and moderate cost-sharing provisions.

The Dutch Health Care System

Who is covered?

- As of January 1, 2006, everyone who resides or pays income tax in The Netherlands (except those with conscientious objections or members of the armed forces on active service) is required to purchase private health insurance coverage.

What is covered?

- Beginning January 1, 2006, under the Health Insurance Act (Zorgverzekeringswet) all citizens are covered by private health insurance. Private health insurance companies must accept every resident in their coverage area and everyone that chooses the same insurance policy of an insurer pays the same premium. A system of risk equalization prevents direct or indirect risk selection.
- The new health insurance system legally mandates that insurers provide a standard package of essential health care. The package includes: medical care, including care by GPs, hospitals and midwives; hospitalization; dental care (up to age 18; coverage from age 18 on will be confined to specialized dental care and dentures); medical aids; medicines; maternity care; ambulance and patient transport services; paramedical care (limited physiotherapy/remedial therapy, speech therapy, occupational therapy and dietary advice). Insurers may decide by whom and how this essential care is delivered and in that way several health insurance policies are possible – citizens have a choice of policies based on quality and premiums.
- Citizens may also purchase supplemental insurance for services not covered by the basic package. However, insurers are not legally bound to accept applications for supplemental insurance.
- Cost-sharing: Insured pay a nominal premium to the health insurer. Low income citizens can qualify for a "Healthcare Allowance" (Zorgtoeslag) to go towards the cost of their premiums.
- The 2006-07 Health Insurance included a no-claim scheme, under which an insured person is eligible for a refund of €255 if that person incurs no health care costs. If an insured person incurs less than €255 in health care costs, then that person receives the difference at the end of the insurance year. Visits to GPs, natal care and maternity care do not count towards the no-claim scheme. The refund scheme does not apply to children under 18. The no-claim scheme is to be abolished on January 1, 2008 and will be replaced by a compulsory excess of €150 per year, which will be collected by the health insurer. People with unavoidable long-term health expenses will be compensated financially.

How is the health system financed?

- The new health insurance system is 50% funded by premiums paid by the insured. The average premium is estimated to be about €1,146 in 2007. The government provides the funds to pay for the premiums of children up to age 18.
- The Health Insurance Act also requires an income-related contribution. Everyone with an income must pay a contribution equal to 6.5% of their income (with a maximum contribution of 6.5% of income of €30,000). Employers must reimburse their employees for this contribution, and employees must pay taxes on this reimbursement. For those who do not have an employer and do not receive unemployment benefits, the income-related contribution is 4.4%. The contribution by self-employed people is individually assessed by the Tax Department. The income-related contributions are divided among the insurers by the risk equalization fund.
- The government provides Healthcare Allowances for low income citizens who qualify. A citizen qualifies if the average nominal premium exceeds 5% of his/her household income.

How is the delivery system organized?

- Health insurance companies must be registered with the Supervisory Board for Health Insurance (CTZ) to allow supervision of the services they provide under the Health Insurance Act and to qualify for payments from the equalization fund.
- Physicians: Physicians practice under contracts negotiated with private health insurers. GPs receive a capitation payment for each patient on the practice list and a fee per consultation. Additional budgets can be negotiated for extra services, practice nurses, complex location, etc. Experiments with pay-for-performance for quality are underway. Specialists working in hospitals are self-employed and are paid capitated amounts based on negotiations with insurers. Some specialists are paid a fix income/salary and have a contract with the hospital. Future payment will be gradually be related to Diagnose-Treatment-Combination (see below).
- Hospitals: The majority of hospitals are private non-profit. Hospital budgets are developed based on a formula that pays a fixed amount per bed, patient volume, and number of licensed specialists, in addition to other considerations. Additional funds are provided for capital purchases. As of 2000, payments to hospitals are rated according to performance on a number of accessibility indicators. Hospitals that produce fewer inpatient days than agreed with health insurers are paid less, a measure designed to reduce waiting lists. A new system of payment (Diagnose-Treatment Combinations - DBCs) was introduced in recent years: 10% (growing to 20% next year) of all medical interventions are now reimbursed on the basis of these DBCs. In some experimental hospitals 100% of all interventions are based on DBCs. It is expected that most of the care will be defined in these new entities in the future, although there is an ongoing debate about the feasibility of this new system.

How are costs controlled?

- The goal of the new Health Insurance Act is to increase competition between private health insurers and providers to control costs and increase quality. Costs are expected to be increasingly controlled by the new DBC system in which hospitals have to compete on price for specific medical interventions.

The New Zealand Health Care System

Who is covered?

- All New Zealand residents have access to a broad range of health services with substantive government funding.

What is covered?

- Services: Public health preventive and promotional services; inpatient and outpatient hospital care; primary health care services; inpatient and outpatient prescription drugs; mental health care; dental care for school children; and disability support services. Free choice of GP.

- Cost-sharing: Co-payments are required for GP and general practice nurse primary health care services, and non-hospital prescription drugs. Health care is substantially free for children under age 6 and is subsidized to a significant degree for all people enrolled with Primary Health Organisations (PHOs) which includes 95% of the public. Patient co-payments (out-of-pocket payments) account for 17% of health care expenditures (2004).

How is the health system financed?

- General taxation: Public funding is derived from taxation. It accounts for about 78% of health care expenditures (2005).

- The government sets a global budget annually for publicly funded health services. This is distributed to District Health Boards (DHBs). DHBs provide services at government-owned facilities (about one-half, by value, of all health services) and purchase other services from privately owned providers, such as GPs (most of whom are grouped as PHOs), disability support services, and community care.

- Patient Co-payments: People pay fee-for-service co-payments to GPs and for pharmaceuticals, some private hospital or specialist care and adult dental care. In addition, complementary and alternative medicines and therapies are paid for out-of-pocket.

- Private Insurance: Not-for-profit insurers generally cover private medical care. Private insurance is most commonly used to cover cost-sharing requirements, elective surgery in private hospitals, and specialist outpatient consultations. About one-third of New Zealanders have private health insurance, which accounts for approximately 5.7% of total health care expenditures.

How is the delivery system organized?

- Physicians: GPs act as gatekeepers and are independent, self-employed providers paid through fee-for-service with partial government subsidy and capitation through PHOs. Consultants (specialists) working for DHBs are salaried but may supplement their salaries through treatment of patients in private (noncrown) hospitals.

- Primary Health Organisations (PHOs): The Government has injected substantial additional funding into subsidizing primary health care to improve access to services. Since July 2002, 82 PHOs have formed to reduce health disparities and take a population approach to primary health care. 95% of New Zealanders are now enrolled with a PHO. PHOs have clinical and non-clinical health practitioners on staff and are funded by capitation and FFS. Since July 2007, all New Zealanders receive low cost access to primary health services provided by PHOs.

- District Health Boards (DHBs): DHBs (21 in the country) are partly elected by the people of a geographic area and partly appointed by the Minister of Health. DHBs determine the health and disability support service needs of the population in their districts, and planning, providing, and purchasing those services. A DHB's organization has a funding arm and a service provision arm, operating government-owned hospitals, health centers, and community services.

- Government: New Zealand's government has responsibility for legislation, regulation, and general policy matters, funds 78% of health care expenditures, and owns DHB assets.

How are costs controlled?

- The government sets an annual publicly funded health budget. New Zealand is shifting from open-ended, fee-for-service arrangements to contracting and funding mechanisms such as capitation. "Booking systems" in lieu of waiting lists ensure that elective surgery services are targeted to those people best able to benefit. Early intervention, health promotion, disease prevention, and chronic care management are being

emphasized in primary care and by DHBs. Drug purchasing for the country occurs through a government agency (Pharmac) for publicly subsidized drugs dispensed through community pharmacies and hospital.

The British Health Care System

Who is covered?

- Coverage is universal.

What is covered?

- Services: Publicly funded coverage – the National Health Service – includes preventive services; community care, inpatient and outpatient hospital care; physician services; inpatient and outpatient drugs; dental care; mental health care; and rehabilitation. Free choice of GP.
- Cost-sharing: There are relatively few cost-sharing arrangements for covered services, with physician and hospital services free at the point of service. Drugs prescribed by family doctors are subject to a prescription charge, although in England, 88% of items prescribed are exempt from these charges, and there are no charges in Wales. In England and Wales, ophthalmology and dentistry services are also subject to co-payments. Out-of-pocket payments account for 8% of health expenditures.

How is the health system financed?

- National Health Service (NHS): The NHS is administered by the NHS Executive, DH, and Health Authorities. The NHS is funded by a mixture of general taxation and national insurance contributions, which account for 88 % of total health expenditures.
- Private Insurance: Mix of for-profit and not-for-profit insurers covers private medical care, which plays a complementary role to the NHS. Private insurance offers choice of specialists and avoidance of queues for elective surgery. Uptake is primarily related to employer perks in a buoyant labor market, with individual uptake leveling off. Private insurance covers 12% of the population and accounts for 4% of health expenditures.

How is the delivery system organized?

Primary care: GPs act as gatekeepers and are commissioned by Primary Care Trusts (PCTs), which have budgets for most of the care of their enrolled population and responsibility for the service, but some are employed locally. The 2004 GP contract introduced greater use of local contracting and provided substantial financial incentives tied to achievement of clinical and other performance targets. Private GPs set their own fee-for-service rates and are not generally reimbursed by the public system. Recent policy developments include an expansion of patient choice of provider and GP.

- Hospitals: Mainly semiautonomous, self-governing public trusts that contract with PCTs. In England some routine elective surgery has been procured for NHS patients from purpose-built Treatment Centres, which may be owned and staffed by private sector health care providers. Consultants (specialist physicians) work mainly in NHS Trust hospitals but may supplement their salary by treating private patients. Recent policy developments include a move to case-mix reimbursement of hospitals, and strengthening of commissioning within the context of a more devolved system.
- Government: Responsibility for health legislation and general policy matters rests with Parliament at Westminster and in Scotland and with the Assemblies in Wales and Northern Ireland. There are important differences between these health systems.

How are costs controlled?

- The government sets the global budget for the NHS on a 3 year cycle. To control utilization and costs, the U.K. has controlled physician training, capital expenditure, pay, and PCT revenue budgets. There are also waiting lists, although these have fallen substantially, especially in England. A centralized administrative system results in lower overhead costs. Other mechanisms which contribute to improved value for money include arrangements for the systematic appraisal of new technologies (the National Institute for Health and Clinical Excellence) and for monitoring the quality of care delivered (the Healthcare Commission).

The United States Health Care System

Who is covered?

- Public and private health insurance covers 84% of the population. 47 million were uninsured in 2006.

What is covered?

- Services: Benefit packages vary according to type of insurance, but often include inpatient and outpatient hospital care and physician services. Many also include preventive services, dental care, and prescription drug coverage.
- Cost-sharing: Cost-sharing provisions vary by type of insurance. Out-of-pocket payments account for 12.6% of health expenditures.

How is the health system financed?

- Medicare: Social insurance program for the elderly, some of the disabled under age 65, and those with end-stage renal disease. Administered by the federal government, Medicare covers 15% of the population. The program is financed through a combination of payroll taxes, general federal revenues, and premiums. It accounts for 17% of total health expenditures. Beginning January 2006, Medicare was expanded to cover outpatient prescription drugs.
- Medicaid: Joint federal-state health insurance program covering certain groups of the poor. Medicaid also covers nursing home and home health care and is a critical source of coverage for frail elderly and the disabled. Medicaid is administered by the states, which operate within broad federal guidelines. It covers 13% of the population and accounts for 16% of total health expenditures.
- Private Insurance: Provided by more than 1,200 not-for-profit and for-profit health insurance companies regulated by state insurance commissioners. Private health insurance can be purchased by individuals, or it can be funded by voluntary premium contributions shared by employers and employees on a negotiable basis. Employer coverage is the predominant form of health insurance coverage. Private insurance covers 60% of the population, including individuals covered by both public and private insurance. It accounts for 35% of total health expenditures.
- Other: Out-of-pocket payments, other private funds, and other public funds account for 32% of total national health expenditures.

How is the delivery system organized?

- Physicians: General practitioners have no formal gatekeeper function, except within some managed care plans. The majority of physicians are in private practice. They are paid through a combination of methods: charges, discounted fees paid by private health plans, capitation rate contracts with private plans, public programs, and direct patient fees.
- Hospitals: For-profit, non-profit, and public hospitals. Hospitals are paid through a combination of methods: charges, per admission, and capitation.
- Government: The federal government is the largest health care insurer and purchaser.

How are costs controlled?

- Total national health expenditures have been increasing at rates well above increases in national income, with total expenditures reaching 15.3% of GDP as of 2005 (OECD adjusted). Annual rates of increases since 2000 have averaged 8 to 9% per year.
- Payers have attempted to control cost growth through a combination of selective provider contracting, discount price negotiations, utilization control practices, risk-sharing payment methods, and managed care.
- Recently, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included new provisions for tax credits for Health Savings Accounts (HSAs) when coupled with high deductible ($1,000+) health insurance plans. HSAs allow individuals to save money tax-free to use on out-of-pocket medical expenses. Tax incentives plus double digit increases in premiums have led to a shift in benefit design toward higher patient payments.
- Medicare demonstrations and various private purchasers, including employer groups, are also experimenting with new payment incentives that reward performance. Private purchasing strategies include “value based” strategies that profile care systems or providers that appear to provide higher quality care with more efficient use of resources.