Health system snapshots: perspectives from six countries

Prospects for a new golden era in vaccines?
Access to research data
Supporting and using publicly orientated health research
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The health system in England

Seán Boyle

Who is covered?
Coverage is universal. All those ‘ordinarily resident’ anywhere in the United Kingdom\(^*\) are entitled to health care that is largely free at the point of use.

What is covered?
Services: the publicly-funded National Health Service (NHS) covers preventative services; inpatient and outpatient (ambulatory) hospital (specialist) care; physician (general practitioner) services; inpatient and outpatient drugs; dental care; mental health care; learning disabilities and rehabilitation.

Cost sharing: there are relatively few cost sharing arrangements for publicly-covered services. Drugs prescribed by general practitioners are subject to a co-payment (£7.10 (€8.85) per prescription), but about 88% of prescriptions are exempt from charges.\(^1\) Dentistry services are subject to co-payments of up to about £200 (£250) per year; in some areas there is difficulty in obtaining NHS dental services. Out-of-pocket payments accounted for 11.9% of total expenditure on health in the UK in 2005.\(^2\)

Safety nets: most costs are met from the public purse. There are measures in place to alleviate costs where these may have an undue impact on certain patient groups. The following are exempt from prescription drug co-payments: children under the age of sixteen years and those in full-time education up to age eighteen; people aged sixty years or over; people on low incomes; pregnant women and those having had a baby in the last twelve months; and people with certain medical conditions and disabilities. There are discounts through pre-payment certificates for those individuals who use a large amount of prescription drugs. Transport costs to and from provider sites are also covered for people on low incomes.

How are revenues generated?
National Health Service (NHS): the NHS accounts for 86% of total health expenditure. It is mainly funded by general taxation (76%), but also by national insurance contributions (19%) and user charges (3%).\(^3\) Apart from the income the NHS receives for the provision of prescription drugs and dentistry services to the general population, there is some income from other fees and charges, particularly to private patients who use NHS services.

Private health insurance: a mix of for-profit and not-for-profit insurers provide supplementary private health insurance. Private insurance offers choice of specialists, avoidance of queues for elective surgery and higher standards of comfort and privacy than the NHS. United Kingdom-wide it covered 12% of the population and accounted for 1% of total health expenditure in 2005.

Other: individuals also pay directly out of pocket for some services – for example, care in the private sector. Direct out-of-pocket payments account for over 90% of total private expenditure on health.

How is the delivery system organised?
Physicians: general practitioners (GPs) are usually the first point of contact for patients and act as gatekeepers for access to secondary care services. Most GPs are paid directly by primary care trusts (PCTs) through a combination of methods: salary, capitation and fee-for-service. The 2004 GP contract introduced a range of different local contracting possibilities, as well as providing substantial financial incentives tied to achievement of clinical and other performance targets. Private providers of GP services set their own fee-for-service rates but are not generally reimbursed by the public system.

Hospitals: these are organised as NHS trusts directly responsible to the Department of Health. More recently, foundation trusts have been established as semi-autonomous, self-governing public trusts. Both contract with PCTs for the provision of services to local populations. Public funds have always been used to purchase some care from the private sector, but since 2003 some routine elective surgery has been procured for NHS patients from purpose-built treatment centres owned and staffed by private sector providers. Consultants (specialists) work mainly in NHS hospitals but may supplement their salary by treating private patients.

Government: responsibility for health legislation and general policy matters rests with Parliament at Westminster. The NHS is administered by the NHS Executive and the Department of Health, and locally is provided through a series of contracts between commissioners of health care services (PCTs) and providers (hospital trusts, GPs, independent providers). PCTs control around 85% of the NHS budget (allocated to them based on a risk-adjusted capitation formula) and are responsible for ensuring the provision of primary and community services for their local populations. Recent policy developments include the introduction of patient choice of hospital and a move to the reimbursement of hospitals using a Diagnosis Related

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\(^*\) Although coverage is applicable across the whole of the United Kingdom, the structure of health systems in Northern Ireland, Scotland and Wales are a matter for local devolved administrations and differ significantly from the system in England. The situation in these countries is not discussed in this paper. However it should though be noted that data on expenditure obtained from the World Health Organization refer to the entire United Kingdom.
Private insurance funds and casemix of activity undertaken. (PbR). PbR relates payment to the quantity system known as Payment by Results Group (DRG) like activity-based funding

What is being done to ensure quality of care?

Quality of care is a key focus of the NHS. A Department of Health objective in 2007 was to enhance the quality and safety of health and social care services. Quality issues are addressed in a range of ways outlined below.

Regulatory bodies: a number of bodies monitor and assess the quality of health services provided by public and private providers. This involves regular assessment of all providers, investigation of individual providers where an issue has been drawn to the attention of a regulatory body and consideration of key areas of provision in order to recommend best practice. The three bodies primarily responsible for regulation in England (the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission) are due to be merged later in 2008.

Targets: targets have been set by the government for a range of variables that reflect the quality of care delivered. Some of these targets are monitored by the regulatory bodies mentioned above; others are monitored on a regular basis either by the Department of Health or its regional organisations (ten strategic health authorities).

National Service Frameworks (NSFs): since 1998 the Department of Health has developed a set of NSFs intended to improve particular areas of care (for example, coronary disease, cancer, mental health, diabetes). These set national standards and identify key interventions for defined services or care groups. They are one of a range of measures used to raise quality and decrease variations in service.

Quality and Outcome Framework: this is a new framework for measuring the quality of care delivered by GPs. It was introduced as part of the new GP contract in 2004, which provided incentives for improving quality, and has been operating since 2005. GP practices are awarded points related to payments for how well the practice is organised, how patients view their experience at the surgery, whether extra services are offered, such as child health and maternity, and how well common chronic diseases such as asthma and diabetes are managed.

What is being done to improve efficiency?

Efficiency has always been a key focus of the NHS. The NHS seeks to improve efficiency in a range of ways including:

High-level efficiency targets: the government is committed to a programme to achieve efficiency gains of £6.5 (€8.1) billion by March 2008 through a range of policies known as the Gershon Efficiency Programme. These include increasing front-line productivity, centralising procurement to obtain more cost-effective deals, reductions in the costs of both NHS provider and central administration and increasing the efficiency of social care provision. Local NHS organisations are also set targets for efficiency savings.

Benchmarking: NHS organisations are benchmarked against the performance of their peers on a number of activity measures including day case rates and lengths of stay for common operative procedures, readmission rates and NHS reference costs (costs of standard procedures known as Healthcare Resource Groups). The Healthcare Commission reviews the performance of NHS trusts against these measures in providing an overall assessment of NHS performance through the Annual NHS Health Check.

Institute for Innovation and Improvement: the Department of Health supports the development of better and more efficient ways of providing health care through the use of semi-autonomous bodies such as the Institute for Innovation and Improvement. The Institute helps the NHS to develop new ways of dealing with the introduction of new technology and changes to working practices, and helps to spread these throughout the NHS.

How are costs controlled?

The government sets the budget for the NHS on a three-year cycle. To control utilisation and costs, the government sets a capped overall budget for PCTs. NHS trusts and PCTs are expected to achieve financial balance each year. The centralised administrative system tends to result in lower overhead costs. Other mechanisms that contribute to improved value for money include arrangements for the systematic appraisal of both new and existing technologies through the National Institute for Health and Clinical Excellence (NICE).

REFERENCES


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WHO European Ministerial Conference

“Health Systems, Health and Wealth”


Organized by WHO/Europe and hosted by the Government of the Republic of Estonia, the Conference aims to place health systems high on the political agenda. Specifically it will:

• lead to better understanding of the impact of health systems on people’s health and therefore on economic growth in the WHO European Region;
• take stock of recent evidence on effective strategies to improve the performance of health systems, given the increasing pressure on them to ensure sustainability and solidarity.

www.euro.who.int/healthsystems2008
The health system in France

Isabelle Durand-Zaleski

Who is covered?
Coverage is universal. All residents are entitled to publicly financed health care. Following the introduction of Couverture Maladie Universelle (CMU) in 2000, the state finances coverage for residents not entitled to coverage by the public health insurance scheme (0.4% of the population). The state also finances health services for illegal residents (L'Aide Médicale d'Etat; AME).

What is covered?
Services: the public health insurance scheme covers hospital care, ambulatory care and prescription drugs. It provides minimal cover for outpatient eye and dental care.

Cost sharing: cost sharing is widely applied to publicly financed health services and drugs and takes three forms.

Co-insurance rates are applied to all health services and drugs listed in the publicly financed benefits package. Rates vary depending on:

- the type of care: hospital care (20% plus a daily co-payment of €16), doctor visits (30%), dental care (30%);
- the type of patient: patients with chronic conditions and poorer patients are exempt from cost sharing;
- the effectiveness of prescription drugs: 0% for highly effective drugs, 35%, 65% and 100% for drugs of limited therapeutic value; and
- whether or not patients comply with the recently-implemented gatekeeping system (médecin référent). Visits to the gatekeeping general practitioner (GP) are subject to a 30% co-insurance rate, while visits to other GPs are subject to a 50% co-insurance rate; the difference between the two rates cannot be reimbursed by complementary private health insurance (see below).

In addition to cost sharing through co-insurance, which can be fully reimbursed by complementary private health insurance, the following non-reimbursable co-payments apply from 2008, up to an annual ceiling of €50: €1 per doctor visit, €0.50 per prescription drug, €2 per ambulance journey and €18 for expensive treatments.

Reimbursement by the publicly financed health insurance scheme is based on a reference price. Doctors and dentists may charge above this reference price (extra billing) based on their level of professional experience. The difference between the reference price and the extra billed amount must be paid by the patient and may or may not be covered by complementary private health insurance.

Safety nets: exemptions from co-insurance apply to people receiving disability and work injury benefits, people with specific chronic illnesses and those on low incomes. Hospital co-insurance only applies to the first thirty-one days in hospital and some surgical interventions are exempt. Children and people on low incomes are exempt from making non-reimbursable co-payments.

Complementary private health insurance covers statutory cost sharing (the share of health care costs not reimbursed by the health insurance scheme). It only applies to health services and prescription drugs listed in the publicly financed benefits package. Most people obtain complementary private cover through their employment. Since 2000, individuals on low incomes are entitled to free complementary private cover (CMU-C) and free eye and dental care; in addition, they cannot be extra billed by doctors. Complementary private health insurance now covers over 92% of the population. In 2005, out-of-pocket payments and private health insurance accounted for 7.4% and 12.8% of total health expenditure respectively.

How are revenues generated?
Publicly financed health care: the public health insurance scheme is financed by employer and employee payroll taxes (43%); a national income tax (contribution sociale généralisée; 33%) created in 1990 to broaden the revenue base for social security; revenue from taxes levied on tobacco and alcohol (8%); state subsidies (2%); and transfers from other branches of social security (8%). CMU is mainly financed by the state through an earmarked tax on tobacco and a 2.5% tax on the revenue of complementary private health insurers. There is no ceiling on employer (12.8%) and employee (0.75%) contributions, which are collected by a national social security agency. Public expenditure accounted for 79.1% of total expenditure on health in 2005.

Government: the public health insurance funds are managed by a board of representatives, with equal representation from employers and employees (trades unions). Every year parliament sets a (soft) ceiling for the rate of expenditure growth in the public health insurance scheme for the following year (Objectif National de Dépenses d’Assurance Maladie, ONDAM). In 2004, a new law created two new associations, the National Union of Health Insurance Funds (Union Nationale des Caisses d’Assurance Maladie, UNCAM) and the National Union of voluntary health insurers (Union Nationale des Organismes Complémentaires d’Assurance Maladie, UNOCAM), incorporating all public health insurance funds and private health insurers respectively. The law also gave the public health insurance funds responsibility for defining the benefits package and setting price and cost sharing levels.

Private health insurance: complementary private health insurance reimburses statutory cost sharing. It is mainly provided by not-for-profit employment-
based mutual associations (mutuelles), which cover 87% to 90% of the population. It only covers those services that are already covered by the public health insurance scheme. There is some evidence to show that the quality of coverage purchased (in other words, the extent of reimbursement) varies by income group. Since 2000, people on low incomes (including the unemployed and those receiving single parent subsidies) and their dependants have been entitled to obtain complementary private cover at no or very low cost (CMU-C). CMU-C covers about two million people via a voucher which can be used to obtain cover from a variety of insurers, although most choose to obtain cover from the public health insurance scheme. More recently, for-profit commercial insurers have started to offer cover for services not included in the public benefits package. For example, the company AXA offered a plan offering cover for services not included in the insurance scheme. More recently, for-profit commercial insurers have started to offer cover for services not included in the public benefits package. For example, the company AXA offered a plan offering faster access to renowned specialists, but this was outlawed by the physicians' association and parliament.

How is the delivery system organised?

Health insurance funds: public health insurance funds are statutory entities and membership is based on occupation so there is no competition between them. There is limited competition among mutual associations providing complementary private health insurance, but as they are employment-based, most employees usually only have a choice of one or two mutuelles. There is no system of risk adjustment among mutuelles, even though there is inadvertent risk selection based on occupation.

Physicians (non-hospital based physicians): the 2004 health financing reform law introduced a voluntary gatekeeping system for adults (aged 16 years and over) known as médecin traitant. There are strong financial incentives to encourage gatekeeping. Physicians are self-employed and paid on a fee for service basis. The cost per visit is slightly higher for specialists (€23) than for GPs (€22) and is based on negotiation between the government, the public insurance scheme and the medical unions. Depending on the total duration of their medical studies, physicians may charge above this level. There is no limit to what physicians may charge, but medical associations recommend tact in determining fee levels.

Hospitals: two-thirds of hospital beds are in government-owned or not-for-profit hospitals. The remainder are in private for-profit clinics. All university hospitals are public. Hospital physicians in public or not-for-profit facilities are salaried. Since 1968, hospital physicians have been permitted to see private patients in public hospitals, an anachronism originally intended to attract the most prestigious doctors to public hospitals and one that has survived countless attempts to abolish it. From 2008, all hospitals and clinics will be reimbursed via a DRG (Diagnosis Related Group)-like prospective payment system (the original DRG scheme was only to be fully implemented by 2012). Public and not-for-profit hospitals benefit from additional non activity-based grants to compensate them for research and teaching (up to an additional 13% of the budget) and for providing emergency services and organ harvesting and transplantation (on average an additional 10-11% of a hospital's budget).

What is being done to ensure quality of care?

An accreditation system is used to monitor the quality of care in hospitals and clinics. The quality of ambulatory care rests on a system of professional practice appraisal. Both systems are mandatory, under the responsibility of the national health authority (Haute Autorité de Santé, HAS) created in 2004. Hospitals must be accredited every four years by a team of experts. The accreditation criteria and reports are publicly available via the HAS website (www.has-sante.fr). Every fifth year physicians are required by law to undergo an external assessment of their practice in the form of an audit. For hospital physicians, the practice audit can be performed as part of the accreditation process. For physicians in ambulatory practice, the audit is organised by an independent body approved by HAS (usually a medical society representing a particular specialty). Dentists and midwives will soon have to undergo a similar process.

What is being done to improve efficiency?

Improving efficiency is the major challenge facing the public health insurance funds, which are currently working on structural and procedural changes. Structural changes involve the creation of a national computerised system of medical records to limit duplication of tests, over prescribing and adverse drug side effects, and to facilitate the implementation of prospective payment for all hospitals and clinics from 2008.

Procedural changes on the supply side mainly focus on two issues: the reorganisation of inputs (for example, by transferring some physician tasks to nurses or other professionals) and improved coordination of care (particularly for patients with chronic illnesses). On the demand side, the main health insurance scheme is experimenting with patient education and hotlines. As of 2008 it will also transfer some drugs to over-the-counter status.

How are costs controlled?

Cost control is a key issue in the French health system as the health insurance scheme has faced large deficits for the last twenty years. More recently the deficit has fallen, from €10-12 billion per year in 2003 to an expected €6 billion in 2007. This may be attributed to the following changes, which have taken place in the last two years:

- a reduction in the number of acute hospital beds;
- limits on the number of drugs reimbursed; around six hundred drugs have been removed from public reimbursement in the last few years;
- an increase in generic prescribing and the use of over-the-counter drugs;
- the introduction of a voluntary gatekeeping system in primary care;
- protocols for the management of chronic conditions; and
- from 2008, new co-payments for prescription drugs, doctor visits and ambulance transport are not reimbursable by complementary private health insurance.

At the same time, there has been an increase in the number of medical students admitted to university due to an expected shortage of doctors in the coming decade. Public funding has also had to increase to accommodate a rise in the fee schedule, since GPs are now considered as specialists and their cost per visit has risen from €20 to €22.

References

The health system in Germany

Reinhard Busse

Who is covered?
Publicly-financed (‘social’) health insurance is compulsory for employees earning up to €48,000 per year and their dependants. Employees with earnings above this amount are currently not obliged to be covered. If they wish, they can remain in the publicly-financed scheme on a voluntary basis, they can purchase private health insurance or they can be uninsured. The publicly-financed scheme covers about 88% of the population. Around three quarters of those who are able to choose between public or private health insurance (less than 20% of the population) opt to remain in the publicly-financed scheme, which offers free cover of dependants. Most of the remainder purchase private health insurance. In total, 10% of the population are covered by private health insurance, mainly civil servants and self-employed people who generally do not fall under social health insurance. Less than 1% of the population has no insurance coverage at all. From 2009, health insurance will be compulsory for the whole population, depending on previous insurance and/or job status.

What is covered?
Services: the publicly-financed benefits package covers 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, which has been compulsory for the whole population since 1995.

Cost sharing: traditionally the publicly-financed scheme has imposed few cost sharing provisions (mainly for pharmaceuticals and dental care). However, in 2004 co-payments were introduced for adult visits to physicians and dentists (€10 each for the first visit per quarter or subsequent visits without referral), while other co-payments were made more uniform: €5 to €10 per pack of outpatient prescription drugs (except if the price is at least 30% below the reference price*, which is the case for more than 12,000 drugs), €10 per inpatient day (up to twenty-eight days per year) and €5 to €10 for prescribed medical aids. For dental prostheses, patients receive a lump sum which covers, on average, 50% of costs. In total, out-of-pocket payments accounted for 13.8% of total health expenditure in 2005.

Safety nets: children up to the age of eighteen are exempt from cost sharing. Cost sharing is generally limited to an annual maximum of 2% of household income (or 1% for chronically ill people). For additional family members, a proportion of household income is excluded from this calculation.

How are revenues generated?
The publicly-financed scheme: this is operated by over two hundred competing health insurance funds (known as sickness funds - SFs): autonomous, non-profit, non-governmental bodies regulated by the government. The scheme is funded by compulsory contributions on the first €43,000 earned in a year. On average, the employee contributes almost 8% of gross earnings, while the employer contributes a further 7%. Dependents are covered through the primary SF member. Unemployed people contribute in proportion to their unemployment entitlements, but since 2004 the government employment agency has paid a flat rate per capita contribution for long-term unemployed people. Currently, SFs are free to set their own contribution rates for all other members. However, from 2009, a uniform contribution rate will be set by the government and, although SFs will continue to collect contributions, all contributions will be centrally pooled by a new national fund, which will allocate resources to each SF based on an improved risk-adjusted capitation formula. In addition to this, SFs will be allowed to charge their members a flat-rate premium. In 2005 public sources of finance accounted for 77.2% of total health expenditure.

Private health insurance: private health insurance playing a substitutive role** covers groups excluded from publicly-financed health insurance (civil servants and self-employed people; the former have part of their health care costs directly reimbursed by their employers) and high earners who choose to opt out of the publicly-financed scheme. All pay a risk-rated premium, although contracts are based on life-time underwriting, so risk is assessed upon entry only. Substitutive private health insurance is regulated by the government to ensure that the insured do not face increasing premiums as they age (the old age reserves requirement) and that they are not overburdened by premiums if their income falls (access to a ‘standard tariff’ with benefits and premiums that match those of the publicly-financed scheme). From 2009, private insurers offering substitutive cover will be required to take part in a risk adjustment scheme to finance the costs of cover for people in ill health, who would otherwise not be able to afford a risk-rated premium. Private health insurance also plays a mixed complementary and supplementary role, providing SF members with cover for some health care costs and access to better amenities. In 2005, private health insurance accounted for 9.1% of total health expenditure.

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* The reference price is the maximum price reimbursed for a group of equal or similar drugs.
** Substitutive private health insurance covers people excluded from or allowed to opt out of the publicly-financed health insurance scheme.
How is the delivery system organised?

 Physicians: individuals have free choice of ambulatory physician. General practitioners have no formal gatekeeper function. However, in 2004 SFs were required to offer their members the option of enrolling in a ‘family physician care model’ which may provide a bonus for complying with gatekeeping rules. Ambulatory specialist care is mainly delivered by private for-profit providers working in single practice, although polyclinic-type ambulatory care centres with employed physicians have been permitted since 2004. Physicians in the ambulatory sector are paid a mixture of fees per time period and per medical procedure. These are agreed following annual negotiations between SFs and regional physician associations to determine aggregate payments.

 Hospitals: individuals have free choice of hospital (following referral). Hospitals are mainly non-profit, both public (about half of beds) and private (about a third of beds). The private, for-profit hospital sector has grown in recent years (about a sixth of beds), mainly through takeovers of public hospitals. Independent of ownership, hospitals are principally staffed by 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, although exceptions have been made when necessary care cannot be provided on an outpatient basis by specialists in private practice. Since 2004, hospitals may also provide certain highly specialised services on an outpatient basis. Inpatient care is reimbursed through a system of diagnosis-related groups (DRG) per admission, currently based on around 1,100 DRG categories. The DRG system was introduced in 2004 and is revised annually to take into account new technologies, changes in treatment patterns and associated costs into account.

 Disease Management Programmes (DMPs): legislation in 2002 created DMPs for chronic illnesses in order to give SFs an incentive to care for chronically ill patients. DMPs exist for diabetes type I and II, breast cancer, coronary heart disease, asthma and chronic obstructive pulmonary disease. DMP participants are accounted for separately in the risk-adjustment mechanism for SFs, resulting in higher per capita allocations. At the end of 2007 there were 14,000 regional DMPs with 3.8 million enrolled patients.

 How are costs controlled?

 In line with a greater emphasis on quality and efficiency, the cruder cost containment measures used in the past have been revised (notably, the use of sector-wide budgets for ambulatory physicians, hospital budgets and the collective regional drug prescription cap for physicians). The drug prescription cap, which complemented reference pricing for pharmaceuticals, was lifted in 2001, initially leading to an unprecedented increase in spending on pharmaceuticals by SFs. Following this, drug prescription caps with individual physician liabilities were introduced. More recently, contracts involving rebates and incentives to lower prices below the reference price are being used to control pharmaceutical spending. In 2009 hospital budgets will be fully replaced by the DRG system (using state-wide base rates). From 2009, budgets for ambulatory care will be replaced by a more sophisticated resource allocation mechanism that accounts for population morbidity.

 References


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 New policy brief on capacity planning

 This policy brief published by the European Observatory on Health Systems and Policies reviews approaches to capacity planning in Canada, Denmark, England, Finland, France, Germany, Italy, the Netherlands and New Zealand. It aims to show a range of approaches to health care financing and organisation, as they impact capacity planning.

The health system in Denmark

Karsten Vrangbæk

Who is covered?
Coverage is universal. All those registered as resident in Denmark are entitled to health care that is largely free at the point of use.

What is covered?
Services: the publicly-financed health system covers all primary and specialist (hospital) services based on medical assessment of need.

Cost sharing: there are relatively few cost sharing arrangements for publicly-covered services. Cost sharing applies to dental care for those aged eighteen and over (co-insurance of 35% to 60% of the cost of treatment), outpatient drugs and corrective lenses.

An individual’s annual outpatient drug expenditure is reimbursed at the following levels: below DKK520 (no reimbursement); DKK520-1,260 (50% reimbursement for children); DKK1,260 - 2,950 (75% reimbursement); above DKK2,950 (85% reimbursement).1 In 2005, out-of-pocket payments, including cost sharing, accounted for about 14% of total health expenditure.2 Safety nets: chronically ill patients with a permanently high use of drugs can apply for full reimbursement of drug expenditure above an annual ceiling of DKK3,805. People with very low income and those who are dying can also apply for financial assistance, and the reimbursement rate may be increased for some very expensive drugs. Complementary private health insurance provided by a not-for-profit organisation reimburses cost sharing for pharmaceuticals, dental care, physiotherapy and corrective lenses. In 1999 it covered about 36% of the population. Coverage is relatively evenly distributed across social classes.

How are revenues generated?
Publicly-financed health care: a major administrative reform in 2007 gave the central government responsibility for financing health care. Health care is now mainly financed through a centrally-collected ‘health-contribution’ tax set at 8% of taxable income. The new proportionate earmarked tax replaces a mixture of progressive central income taxes and proportionate regional income and property taxes. The central government allocates this revenue to five regions (80%) and ninety-eight municipalities (20%) using a risk-adjusted capitation formula and some activity-based payment. Public expenditure accounted for around 82% of total health expenditure in 2005.2 Private health insurance: around 36% of the population purchase complementary private health insurance covering statutory cost sharing from the not-for-profit organisation ‘Danmark’. Supplementary private health insurance provided by for-profit companies offers access to care in private hospitals in Denmark and abroad. It covers around 13.5% of the population and is mainly purchased by employers as a fringe benefit for employees. Some individuals have both types of cover. In 2005, private health insurance accounted for 1.6% of total health expenditure.2

How is the delivery system organised?
Government: The five regions are responsible for providing hospital care. They own and run hospitals. The regions also finance general practitioners, specialists, physiotherapists, dentists and pharmaceuticals. The ninety-eight municipalities are responsible for nursing homes, home nurses, health visitors, municipal dentists (children’s dentists and home dental services for physically and/or intellectually disabled people), school health services, home help and the treatment of alcoholics and drug addicts. Professionals involved in delivering these services are paid a salary. Physicians: self-employed general practitioners act as gatekeepers to secondary care and are paid via a combination of a capital (30%) and fee for service. Hospital physicians are employed by the regions and paid a salary. Non-hospital based specialists are paid on a fee for service basis. Hospitals: Almost all hospitals are publicly owned (99% of hospital beds are public). They are paid partly via fixed budgets determined through soft contracts with the regions and partly on a fee for service basis.

What is being done to ensure quality of care?
A comprehensive standards-based programme for assessing quality is currently being implemented. The programme is systemic in scope, aiming to incorporate all health care delivery organisations and including both organisational and clinical standards. Organisations are assessed on their ability to improve performance measured against standards for standards processes and outcomes. The core of the assessment programme is a system of regular accreditation based on annual self assessment and external evaluation (every third year) by a professional accreditation body. The self assessment involves reporting of performance against national input, process and outcome standards, which allows comparison over time and between organisations. The external evaluation begins with self assessment and goes on to assess status for quality development. Some quality data is already being published on the internet (www.sundhedsvalitet.dk) to facilitate patient choice of hospital and encourage hospitals to raise standards.

What is being done to improve efficiency?
In the last few years, many national and regional initiatives have aimed to improve efficiency, with a particular focus on hospitals. For example, Denmark has been at the forefront of efforts to reduce average lengths of stay and to shift care from inpatient to outpatient settings. The adminis-
The health system in the Netherlands

Niek Klazinga

Who is covered?
Since the beginning of 2006, everyone resident or paying income tax in the Netherlands is required to purchase health insurance coverage. Coverage is statutory under the Health Insurance Act (Zorgverzekeringwet; ZVW), but provided by private health insurers and regulated under private law. The uninsured proportion of the population is estimated to be 1.5%, a figure that is likely to rise further. Asylum seekers are covered by the government and several mechanisms are in place to reimburse the health care costs of illegal immigrants unable to pay for care. New legislation regarding the health care costs of illegal immigrants is being debated in parliament.

Prior to 2006, people with earnings above €30,000 per year and their dependants (around 35% of the population) were excluded from statutory coverage provided by public sickness funds. If they required health insurance they could purchase cover from private health insurers. This form of substitutive private health insurance was regulated by the government to ensure that older people and people in poor health had adequate access to health care and to compensate the publicly-financed health insurance scheme for covering a disproportionate amount of high risk individuals. Over time, growing dissatisfaction with the dual system of public and private coverage led to the reforms of 2006.

What is covered?
Services: insurers are legally required to provide a standard benefits package covering the following: medical care, including care by general practitioners (GPS), hospitals and midwives; hospitalisation; dental care (up to the age of eighteen; from eighteen cover is confined to specialist dental care and dentures); medical aids; medicines; maternity care; ambulance and patient transport services; and paramedical care (limited physio-

referenced reforms of 2007 aimed to enhance the coordination of service delivery and to benefit from economies of scale by centralising some functions and enabling the closure of small hospitals. The reforms lowered the number of regions from fourteen to five, and the number of municipalities from two hundred and seventy five to ninety-eight.

The introduction of a Danish DRG (diagnosis-related groups) system in the late 1990s has facilitated various partially-activity-based payment schemes (for example, for patients crossing county borders) and benchmarking exercises. The national Ministry of Health also publishes regular hospital productivity rankings. These show that productivity in public hospitals increased by 1.9% in 2005-06 and by 2.4% in 2003–04. The total number of treatments increased by 5.5% in 2007–08.

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therapy/remedial therapy, speech therapy, occupational therapy and dietary advice).

Insurers may decide by whom and how this care is delivered, which gives the insured a choice of policies based on quality and cost. In addition to the standard benefits package, all citizens are covered by the statutory AWBZ (Exceptional Medical Expenses Act) scheme for a wide range of chronic and mental health care services such as home care and care in nursing homes. Most people also purchase complementary private health insurance for services not covered by the standard benefits package. Insurers are not required to accept applications for private health insurance.

Cost sharing: the insured pay a flat-rate premium (set by insurers) to their private health insurer. Everyone with the same policy pays the same premium. In 2006, an insured person was eligible for a refund of €255 if they incurred no health care costs. If they incurred costs of less than €255, they would receive the difference at the end of the year. This ‘no claims bonus’ system was abolished in 2007, following a change of government, and has been replaced by a system of deductibles. Every insured person aged eighteen and over must now pay the first €150 of any health care costs in a given year (with some services excluded from this general rule). Out of pocket payments as a proportion of total health expenditure have not changed following the 2006 reforms (around 8%).

Safety nets: children are exempt from cost sharing. The government provides ‘health care allowances’ for low income citizens if the average flat-rate premium exceeds 5% of their household income.

How are revenues generated?
Statutory health insurance: the statutory health insurance system (ZVW) is financed by a mixture of income-related contributions and premiums paid by the insured. The income-related contribution is set at 6.5% of the first €30,000 of annual taxable income. Employers must reimburse their employees for this contribution and employees must pay tax 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 of self-employed people is individually assessed by the Tax Department. Contributions are collected centrally and distributed among insurers based on a risk-adjusted capitation formula. In 2006, the average annual premium was €1,050. The government pays for the premiums of children up to the age of eighteen. In 2005, public sources of finance accounted for 65.7% of total health expenditure. In 2006, this proportion had risen to around 78%.

Private health insurance: substitutive private health insurance was abolished in 2006. Most of the population purchase a mixture of complementary and supplementary private health insurance from the same health insurers who provide statutory cover. This has given rise to concerns about the potential for risk selection, as the premiums and products of voluntary cover are not regulated. In 2005, private health insurance accounted for 20.1% of total health expenditure. In 2006 this proportion had fallen to about 7%.

How is the delivery system organised?
Health insurance funds: insurers are private and governed by private law. They are permitted to have for-profit status. They must be registered with the Supervisory Board for Health Insurance (CTZ) to enable supervision of the services they provide under the Health Insurance Act and to qualify for payments from the risk equalisation fund. The insured have free choice of insurer and insurers must accept every resident in their coverage area (although most already operate nationally). A system of risk equalisation/adjustment is used to prevent direct or indirect risk selection by insurers.

Physicians: physicians practise directly or indirectly under contracts negotiated with private health insurers. GPs receive a capitation payment for each patient on their 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 in primary and hospital care are underway. Most specialists are hospital based. Two-thirds of hospital-based specialists are self-employed, organised in partnerships and paid on a capped fee-for-service basis. The remainder are salaried. In future, payment will increasingly be related to activity through the Dutch version of Diagnosis Related Groups (DRGs) known as Diagnosis Treatment Combinations (DTCs).

Hospitals: most hospitals are private non-profit organisations. Hospital budgets are developed using a formula that pays a fixed amount per bed, patient volume and number of licensed specialists, in addition to other factors. Additional funds are provided for capital investment, although hospitals are increasingly encouraged to obtain capital via the private market. From 2000, payments to hospitals were rated according to performance on a number of accessibility indicators. Hospitals that produced fewer inpatient days than agreed with health insurers were paid less, a measure designed to reduce waiting lists. A new system of payment for specific treatments (DTCs) is currently being implemented. 10% of all hospital services are now reimbursed on the basis of DTCs (up to 100% of all services in some hospitals). In future, it is expected that most care will be reimbursed using DTCs, although there is still considerable debate about the desired speed of further liberalisation of the hospital market (for example, through giving hospitals greater freedom in negotiating the price and quality of DTCs).

What is being done to ensure quality of care?
At the health system level, quality of care is ensured through legislation regarding professional performance, quality in health care institutions, patient rights and health technologies. A national inspectorate for health is responsible for monitoring and other activities. Most quality assurance is carried out by health care providers in close cooperation with patient and consumer organisations and insurers.

Mechanisms to ensure quality in the care provided by individual professionals involve re-registration/re-validation for specialists based on compulsory continuous medical education; regular onsite peer assessments organised by professional bodies; as well as profession-owned clinical guidelines, indicators and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programmes based on the breakthrough method (Sneller Beter). Patient experiences are systematically assessed and, since 2007, a national centre has been working with validated measurement instruments comparable to the Consumer Assessment of Health Plans Survey (CAHPS) approach in the United States. The centre also generates publicly available information for consumer choice.
The health system in Sweden

Anders Anell

What is being done to improve efficiency?
The main approach to improving efficiency in the Dutch health system rests on regulated competition between insurers, combined with central steering on performance and transparency about outcomes via the use of performance indicators. This is complemented by provider payment reforms involving a general shift from a budget-oriented reimbursement system to a performance-related approach (for example, the introduction of DTCs). In addition, various local and national programmes aim to improve health care logistics and/or initiate ‘business process re-engineering’. At a national level, health technology assessment is used to enhance value for money by informing decision-making about reimbursement and encouraging appropriate use of health technologies. At the local level, several mechanisms are used, including those to ensure appropriate prescribing.

How are costs controlled?
The new Health Insurance Act aims to increase competition between private health insurers and to encourage providers to control costs and increase quality, but it is still too early to say whether these aims have been achieved. Increasingly, costs are expected to be controlled by the new DTC system in which hospitals must compete on price for specific treatments.

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Who is covered?
Coverage is universal. All residents are entitled to publicly-financed health care.

What is covered?
Services: the publicly-financed health system covers public health and preventive services; inpatient and outpatient hospital care; primary health care; inpatient and outpatient prescription drugs; mental health care; dental care for children and young people; rehabilitation services; disability support services; patient transport support services; home care; and nursing home care. Possibilities for residents to choose primary care provider and hospital vary by county council.

Cost-sharing: cost sharing arrangements exist for most publicly-financed services. Patients pay SEK 100–150 per visit to a primary care doctor, SEK 200–300 for a visit to a specialist or to access emergency care and up to SEK 80 per day in hospital.1 For outpatient pharmaceuticals, patients pay the whole cost up to SEK 900 per year, while costs above this are subsidised at different rates (50%, 75%, 90% and 100%) depending on the level of out-of-pocket expenditure. Out-of-pocket payments accounted for 13.9% of total health expenditure in 2005.2 Safety nets: the maximum amount to be paid out-of-pocket for publicly-financed care in a twelve month period is SEK 900 for health services and SEK 1,800 for outpatient pharmaceuticals. Children are exempt from cost sharing for health services. An annual maximum of SEK 1,800 for pharmaceuticals applies to children belonging to the same family. Limited subsidies are available for adult dental care.

How are revenues generated?
The publicly-financed system: public funding for health care mainly comes from central and local taxation. County councils and municipalities have the right to levy proportional income taxes on their residents. The central government provides funding for prescription drug subsidies. It also provides financial support to county councils and municipalities through grants allocated using a risk-adjusted capitation formula.

One-off central government grants focus on specific problem areas such as geographical inequalities in access to health care. County councils provide funding for mental health care, primary care and specialist services in hospitals. Municipalities provide funding for home care, home services and nursing home care. Local income taxes account for 70% of county council and municipality budgets; the remainder comes from central government grants and user charges. Overall, public funding accounted for 85% of total health expenditure in 2005.2 Private health insurance: about 2.5% of the population is covered by supplementary private health insurance, which provides faster access to care and access to care in the private sector. In 2005 private health insurance accounted for less than 1% of total expenditure on health.2

How is the delivery system organised?
Government: the three levels of government (central government, county councils and municipalities) are all involved in health care. The central government determines the health system’s overall objectives and regulation, while

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local governments determine how services are to be delivered based on local conditions and priorities. As a result, the organisation of the delivery system varies at the local level.

**Primary care: organisation of primary care varies across county councils.** Most health centres are owned and operated by county councils and general practitioners and other staff are salaried employees. Traditionally, health centres have been responsible for providing primary care to residents within a geographical area. This model is being replaced, with increased possibilities for residents to choose their provider and physician. Primary care has no formal gate-keeping function. Residents may choose to go directly to hospitals or to private specialists contracted by county councils. Increasingly, residents are encouraged to visit their primary care provider first. Higher co-payments for specialist visits are used to support such behaviour. Payment of public primary care providers is largely based on capitation, topped up with fee-for-service and/or target payments. The number of private primary care providers and ambulatory specialists working under a public contract is increasing; in some county councils about half of primary care physicians are private. Fee-for-service arrangements with cost and volume contracts are more common for payment of private providers, in particular for ambulatory specialists.

**Hospitals: almost all hospitals are owned and operated by the county councils.** There are no private wings in public hospitals. Hospitals have traditionally had large outpatient departments, reflecting low levels of investment in primary care. For tertiary care the county councils collaborate in the six regions with at least one university hospital. Private hospitals mainly specialise in elective surgery and work under contract with county councils. Physicians and other hospital staff are salaried employees. Payment of hospitals is usually based on DRGs (diagnosis-related groups) combined with global budgets.

**What is being done to ensure quality of care?**

At the national level, the Swedish Council on Technology Assessment in Health Care (SBU) and the National Board of Health and Social Welfare support local government by preparing systematic reviews of evidence and guidance for priority setting respectively.

At the local and clinical level, medical quality registers managed by specialist organisations play an increasingly important role in assessing new treatment options and providing a basis for comparison across providers. Transparency has increased and some registers are now at least partly available to the public. Since 2006, performance indicators applied to county councils and, to some extent, providers are systematically applied by the county councils in collaboration with the National Board of Health and Welfare. Further improvements in the transparency of national quality assessment include setting up a register of drug use.

Concern for patient safety has been growing. The five most important areas with potential for improvement are: unsafe drug use, particularly among older people; hospital hygiene; falls; routines to control for fully avoidable patient risks; and communication between health care staff and patients.

**What is being done to improve efficiency?**

Several initiatives are being implemented to improve general access to health services and to treatment. According to an agreement between the county councils and the central government, all non-acute patients should be able to see a primary care physician within seven days, visit a specialist within ninety days of referral by a GP and obtain treatment within ninety days of the prescription of treatment by a specialist. Most county councils struggle with longer waiting times for some patients and services (particularly for elective surgery). If patients are required to wait more than ninety days they can choose an alternative provider with assistance from their county council.

In primary care, residents in several counties are encouraged to choose a provider based on their own assessment of access and quality, with money following the patient. A parallel policy is to increase the number of private primary care providers and encourage general competition for registration by residents. At the same time, however, there is a call for closer collaboration between primary care providers, hospitals and nursing home care, particularly where care of older people is concerned. There are similar calls for increased integration of health and social services for mental health patients.

**How are costs controlled?**

County councils and municipalities are required by law to set annual budgets for their activities and to balance these budgets. In the past the central government had introduced temporary financial penalties (by lowering its grant) for local governments that raised their local income tax rate above a specified level. For prescription drugs, the county councils and the central government agree on subsidies to the county councils for a period of five years. The national Pharmaceutical Benefits Board (Läkemedelsför- mänsnämnden) engages in value-based pricing of prescription drugs, determining reimbursement based on an assessment of health needs and cost-effectiveness.

At the local level, costs are controlled by the fact that most health care providers are owned and operated by the county councils and municipalities. Most private providers work under contract with county councils. Financing of health services through global budgets and contracts and paying staff a salary also contributes to cost control. Although several hospitals are paid on a DRG basis, payments usually fall once a specified volume of activity has been reached, which limits hospitals’ incentives to increase activity. Primary care services are mainly paid for via capitation or global budgets, with minimal use of fee for service arrangements. In several county councils, primary care providers are financially responsible for prescribing costs, which creates incentives to control pharmaceutical expenditure.

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