Health care systems in eight countries: trends and challenges

PREPARED BY THE
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Abbreviations

Monetary values are generally given in national currency units. The abbreviations used in the text and the current exchange rates (GBP1= at 1st January 2002) are listed here for reference.

Australia	AUD	Australian dollar	2.85
Denmark	DKK	Danish krone	12.13
France	EUR	euro	1.63
Germany	EUR	euro	1.63
	(DEM	German mark	3.20)
The Netherlands	EUR	euro	1.63
	(NLG	Dutch guilder	3.60)
New Zealand	NZD	New Zealand dollar	3.50
Sweden	SEK	Swedish krona	15.20
UK	GBP	British pound	1.00
USA	USD	American dollar	1.45

INTRODUCTION

In March 2001, the Chancellor of the Exchequer asked Derek Wanless to undertake a review of the drivers of health care expenditure in the United Kingdom and their likely impact on the resources required for the health service over the next 20 years. In deliberating the appropriate response to these pressures it is useful to see how countries outside the United Kingdom are addressing these challenges. This report, commissioned by the Health Trends Review at HM Treasury, aims to provide up-to-date information on the health care systems of seven countries outside the UK. It also includes a report on the UK health care system as a point of comparison.

The report has been compiled by the European Observatory on Health Care Systems. The Observatory is a project that builds on the commitment of all its partners to improving health care systems. The material used in compiling this report draws heavily on the Observatory's Health Care Systems in Transition profiles for the relevant countries. More detailed reports on the health care systems of all European countries can be found at www.observatory.dk.

The report includes a selection of eight countries representing the diversity of international experience of both funding and delivering health care. Denmark and Sweden represent the decentralised systems of health care funding and delivery common to Scandinavia. Germany and the Netherlands provide examples of social health insurance systems combined with private health insurance for high-income earners. France illustrates a more centralised model of social health insurance, offering universal coverage and with a mixture of public, private non-profit and for-profit providers. Australia and New Zealand have predominantly tax-financed systems of health care with differing degrees of decentralisation and privatisation of provision.

The country reports have all been written following a standard template. This identified six key questions to be addressed:

- Who benefits and what are the benefits?
- Who pays and how much?
- Who collects the money and where does it go?
- How much is spent and on what?
- How do patients access services?
- What are the major challenges facing the health care system?

For each of these sections more detailed questions were provided to the authors of the country case studies.

Each country case study stands alone as a summary of the key features of the health care system in that country. Due to the limitations of internationally available data, differences in definitions, terminology and reporting practices, we have not presented extensive quantitative information on the health care systems of different countries. A selection of summary data can be found in the Appendix. Where possible, nationally available data has been included on similar aspects of the health care system in each country case study.

These case studies highlight that despite significant differences in how health systems are financed, organised and provided, all countries face a number of similar challenges. These

include ensuring equity of access to health services; raising quality; improving health outcomes; sustainable financing; improving efficiency; greater responsiveness; citizen involvement in decision making; and reducing barriers between health and social care. However, the responses to these challenges differ as each country adopts the most appropriate approach given its historical, political, social and cultural context. The reasons for these different responses are outside the scope of this report. It is hoped though that this report by contributing to an understanding of how different countries respond to contemporary health care system challenges will inform the debate in the UK on the future of health care.

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April 2002

AUSTRALIA

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1 INTRODUCTION

There are three tiers of government in Australia: the national government or Commonwealth, the six State and two Territory governments, and local government (although the latter has no independent constitutional status). The critical division for the health care system is that the Commonwealth collects most taxes but the States administer or deliver most public services; in other words, fiscal and functional responsibilities are divided. Thus health policy-making in the Australian federal form of government is characterised by ongoing negotiations between the Commonwealth and the States.

Australia has a complex health care system with many types of services and providers and a range of funding and regulatory mechanisms. The Commonwealth funds rather than provides health services, funding the bulk of the health system, and subsidising pharmaceuticals and aged residential care (nursing homes and hostels). The States, with Commonwealth financial assistance, primarily are responsible for funding and administering public hospitals, mental health services and community health services, as well as for regulating health workers. Private practitioners provide most community-based medical and dental treatment and there is a large private hospital sector.

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

Australia offers universal access to health care, regardless of ability to pay, through the government health insurance system, Medicare. Health care is financed through general taxation and a compulsory health tax levy on income (an opt out clause was offered in the late 1980s for those who took out private health insurance but later rescinded). Additional private health insurance is voluntary but strongly encouraged by the current government.

Benefits are available to people who reside in Australia, who hold Australian citizenship, have been issued with a permanent visa, or hold New Zealand citizenship. The Commonwealth Government has signed reciprocal health care agreements with other countries (namely, Finland, Italy, Malta, the Netherlands, New Zealand, Sweden, the United Kingdom and the Republic of Ireland). Under these arrangements, residents of these countries have restricted access to health cover while visiting Australia.

The percentage of the population with additional private health insurance cover increased from 30% in December 1998 to 45% in March 2001, following the implementation of subsidies for purchasing, and tax penalties for not purchasing, private cover. The intentions of the national government were to halt the decline in private membership that had occurred since Medicare was established in 1984, and to encourage younger and healthier individuals to take out and maintain private health insurance in order to improve the overall risk profile of members, which was expected to result in lower premiums. The private health insurance funds, however, increased premiums in early 2002 citing rising costs resulting from rising claims.

There were three main policy changes to encourage the purchase of private health insurance. First, commencing in July 1997, individuals with a taxable income of up to AUD 35 000 per year (AUD 70 000 for families) received a subsidy for private health insurance. An additional 1% Medicare surcharge was levied upon individuals with a taxable income of over AUD 50 000 (AUD 100 000 for families) who did not have private insurance. Second, from January 1999, a non-means tested 30% tax rebate was offered to those taking out private health insurance (replacing the previous subsidies). The third policy change, from July 2000,

had the most impact on increasing membership. Under 'lifetime health cover', private health funds charge higher premiums for individuals over 30 years of age who have not maintained continuous membership of a private health fund. The premium increases by 2% each year of age above 30 years until an individual has joined. Individuals with hospital cover at 15 July 2000, or who join in future before they turn 31 years of age, will qualify automatically for the lowest premium as long as they retain membership. The tax penalty for the higher income groups without private health insurance has been retained since its introduction in July 1997.

2.2 Benefits

Medical service subsidies are limited to those items listed on the Medical Benefits Schedule. These items include consultation fees for doctors and specialists, radiology and pathology tests, eye tests by optometrists, and surgical and therapeutic procedures performed by doctors. The Medical Services Advisory Committee makes recommendations to the Minister of Health as to which new medical services and technologies should be included, using an evidence-based approach that includes cost-effectiveness criteria.

Individuals eligible for Medicare receive free ambulatory medical care (if the doctor bulk-bills Medicare) and free accommodation and medical, nursing and other care as public patients in State funded hospitals. Alternatively, they may choose treatment as private patients in public or private hospitals, with some assistance from Medicare.

The Pharmaceutical Benefits Scheme (PBS) subsidises the purchase of pharmaceuticals on its extensive approved list for two groups: general beneficiaries, and concessionary beneficiaries (holders of pensioner and other entitlement cards). Pharmaceuticals not listed on the PBS schedule are excluded from subsidies.

The following services are excluded from Medicare: dental treatment, ambulance services, home nursing, physiotherapy, occupational therapy, speech therapy, chiropractic and podiatry services, treatment by psychologists, visual and hearing aids and prostheses, and medical services that are not listed under Medicare as clinically necessary such as cosmetic surgery.

Since the introduction of Medicare in 1984, private insurance is precluded from covering ambulatory care, including any gap between the actual fee charged and the rebate from the Health Insurance Commission. However, the cost of some ancillary items not available under Medicare are covered to some extent by private health insurance funds such as dental and optical services (glasses and contact lenses), physiotherapy, chiropractic and appliances, and prescribed medicines not covered by the Pharmaceutical Benefits Scheme.

There is no limit upon the amount of medical services that an individual may use. Health care benefits are not rationed and there is little public debate on whether or how to ration services. Public hospital services, however, in effect are prioritised through waiting lists. The Australian health care system thus is relatively equitable compared to other industrialised countries, although significant problems remain. These include financial barriers to dental treatment, shortages of health professionals in some areas, geographic and cultural barriers to the use of health services, and notably, the continuing huge differentials in health status between Indigenous people and other Australians.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

Australia has a predominantly publicly funded health care system with 71.2% of revenue in 2000 coming from public sources (Table 1.1). Commonwealth funds for health are raised through general taxes, supplemented by the Medicare levy, the latter being equal to about

20% of total Commonwealth health expenditure and about 8.5% of total national health expenditure. Out-of-pocket payments account for 16.2% of total health expenditure, private health insurance 7.1%, and other sources of finance account for 5.5%.

Table 1.1 Main sources of health care funding in Australia, as a percentage of total expenditure, 1979/1980–1999/2000

	Percentage of total (%)				
Source of finance	**1980**	**1985**	**1990**	**1995**	**2000**
Public					
Taxes (incl. statutory insurance)	60.6	72.0	68.3	66.7	71.2
Private					
Out-of-pocket	17.0	15.5	16.5	18.0	16.2
Private insurance	18.5	9.5	11.6	11.5	7.1
Other	3.6	3.0	3.5	3.8	5.5

Note: Figures are for recurrent expenditure only.

Sources: Australian Institute of Health and Welfare 2000; 2001a

The Commonwealth sets the level of income tax and collects the bulk of revenue, being empowered under the constitution to collect income taxes. Income taxes are progressive and pegged to income. The main form of taxation is income tax levied and collected nationally. Income tax is levied on individuals not households (i.e. husband and wife make separate tax claims). The rates in 2001 were below AUD 5400 no tax, AUD 5401-20 700 17%, AUD 20 701–50 000 30%, AUD 50 001–60 000 42%, and above AUD 60 001 47%.

There are also indirect State taxes and local government rates and taxes. From 1 July 2000, however, Australia implemented a new tax system that abolished many of these taxes and replaced them with a 10% goods and services tax (GST). The States and Territories now receive all GST revenue to assist them in providing essential services including health care, but since indirect taxes are not progressive, the introduction of the GST was controversial.

3.2 Social health insurance contributions

Medicare, the public health insurance system, is basically a tax-funded system, which is collected by the Australian Tax Department with the funds administered by the Health Insurance Commission. The health levy upon individual taxpayers (the Medicare levy) is equivalent to 1.5% of taxable income above certain income thresholds, or 2.5% for higher income earners with no private health insurance. The Commonwealth government sets the level of the Medicare levy, there is an income threshold but no income ceiling, and the employer does not contribute: the full contribution comes from the employee.

3.3 Private health insurance premia

Private health insurance premia differ considerably between funds and plans and until recently were strictly community rated (flat rate premia for all applicants for the same plan offered by the same fund). From July 2000, under ‘lifetime health cover’, private health funds are allowed to charge higher premia for individuals over 30 years of age who have not maintained continuous membership of a private health fund. The rates for Medibank Private, the largest fund, vary for an individual from AUD 257 per year to AUD 961, depending on the level and scope of cover chosen. (The 30% tax rebate reduces this amount).

3.4 User charges

Out of pocket payments by consumers account for 16% of total health care expenditure. The main consumer payments are for pharmaceuticals not covered under the Pharmaceutical Benefits Scheme, co-payments for pharmaceuticals, dental treatment, the gap between the Medicare benefit and the schedule fee charged by physicians, and payments to other health care professionals, such as physiotherapists. Treatment in public hospitals is free to the user, treatment by general practitioners and specialists is free (if the doctor is prepared to bulk-bill), while essential pharmaceuticals are subsidised. Concessions are available to pensioners through the Pensioner Medical Card, to low-income earners, and to those with high annual use of health services.

Medical practitioners charge a fee to patients who then claim a rebate from Medicare of 85% of the schedule fee for out-of-hospital medical services. General practitioners may choose not to charge above the schedule fee and bulk-bill Medicare, who then pays the benefit directly to the doctor. Doctors are entitled, however, to charge more than the schedule fee, in which case their patients must pay the 'gap' between the schedule fee and the Medicare benefit. Most consumers incur out-of-pocket costs above the schedule fee for visits to private specialists. Medicare has various cost safety nets. Where a person or family's gap payments to medical practitioners (the difference between the Medicare rebate and the schedule fee) exceed AUD 302.30 a year (indexed annually), all further benefits in that year are paid up to 100% of the schedule fee.

Treatment as a public patient in public hospitals is free to the user (both for inpatients and outpatients). Treatment as a private patient in a public or private hospital allows a choice of doctor. Medicare will only reimburse 75% of the schedule fee for medical services. Part or all of the balance can be claimed from private health insurers subject to the doctors having a contract with the insurer. The costs of hospital accommodation are not reimbursable by Medicare when treated as a private patient, but may be claimed through private health insurance (depending on the level of cover). Approximately 63% of private hospital activity is funded through private health insurance funds.

The Pharmaceutical Benefits Scheme sets the cost of pharmaceuticals for consumers (indexed to movements in the Cost Price Index). General consumers make a co-payment of the first AUD 21.90 on each prescription and concessional consumers a co-payment of AUD 3.50 per prescription (as at January 2000). Pharmacists dispense generic drugs under the Pharmaceuticals Benefits Scheme (nearly three-quarters of prescriptions from community pharmacies are subsidised) and consumers must pay more if they want patented or branded drugs. The Pharmaceutical Benefits Scheme has a safety net to limit consumer annual expenses on pharmaceuticals covered under the PBS. After reaching the threshold (currently AUD 669.70 in a calendar year for general consumers, AUD 182 for concessional beneficiaries), general consumers pay for further prescriptions at the concessional co-payment rate, while concession cardholders receive all further prescriptions free.

Where a taxpayer's net medical expenses in the year exceed AUD 1250, a tax rebate at the rate of 20% of the excess over AUD 1250 is allowed. From 1999, contributors to private health insurance funds also qualify for a 30% tax rebate on the premium.

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

Taxes used to fund health care are collected nationally by the Australian Taxation Department, including the Medicare levy as part of income tax collection from individuals,

mainly deducted from income by employers. State government funding for health care comes from two main sources: first, Commonwealth general revenue and specific purpose grants, and second, State general revenue. The Commonwealth funds the States through block grants for health, which increasingly are tied to certain conditions, and through untied GST payments. The health portfolio in both the Commonwealth and the States must compete with other portfolios to maintain or increase its budget share, generally obtaining about 16% of the Commonwealth recurrent budget, and about one-third of State recurrent budgets.

The population has a choice among private health insurance funds. In June 1998 there were 44 registered health benefits organisations of which 28 were open to the public and 16 had restricted membership. The largest three funds cover nearly two-thirds of the market, including Medibank Private (which separated from the Health Insurance Commission in 1997 to become a government business enterprise). The current Commonwealth policy, as already noted, is to shore up private health insurance membership by offering financial incentives to join and penalties for not joining.

The private health insurance industry is heavily regulated, principally under the regulatory framework set out in the *National Health Act 1953* and the *Health Insurance Act 1973*, and is administered by a statutory authority, the Private Health Insurance Administration Council. A private insurance fund must be a Registered Health Benefit Organisation and their activities are tightly controlled; for example, insurers must accept all applicants and must not discriminate in setting premiums and paying benefits.

Resource allocation

There is an annual budget cycle (although some programmes have 3-5 year funding cycles) and an annual conference between the Commonwealth and the States where revenue sharing is negotiated. Some grants are subject to 'fiscal equalisation' administered by the Commonwealth Grants Commission; that is, the poorer States are cross-subsidised by the richer States. Commonwealth grants to the States for health care are earmarked via four avenues:

- Medicare benefits (subsidies for ambulatory medical services paid directly by the Health Insurance Commission to the consumer or provider);
- Pharmaceutical Benefits Scheme (subsidised drug prices);
- Australian Health Care Agreements (paid to State governments as purchasers of public hospital services);
- Residential care for the elderly (paid theoretically as per diem vouchers to consumers but in practice to nursing homes).

The Australian Health Care Agreements (funds for public hospitals) are negotiated every five years between the Commonwealth and State governments, the current agreement running from 1999 to 2003. The working assumption is that public hospitals are 'a State responsibility'. The Commonwealth provides capped prospective block grants to the States based on a population formula plus components of performance measurement; thus the States bear most of the risk if demand and costs increase during the five-year period. The renegotiation of these complex agreements involves a debate over the appropriate level of Commonwealth funding, which the States generally regard as insufficient to cover rising hospital costs. The agreements set out a number of conditions and performance indicators, including service targets, but allow the States considerable flexibility over resource allocation to hospitals. The key condition is a requirement for states to provide for treatment in public hospitals to all eligible persons without charge.

4.2 Organisation of purchasing/contracting

Australia does not have a comprehensive system of separate funding and purchasing agents as does the United Kingdom and as formerly in New Zealand. The type of payment methods also varies: medical consultations are reimbursed retrospectively; drug prices are regulated; hospitals are paid prospectively; and nursing homes fees are paid per diem.

Ambulatory/primary care

The Medicare Benefits Schedule sets out a schedule fee for medical services for which the Commonwealth government will pay medical benefits. General practitioners charge a fee-for-service (as explained in Section 3.4) and can bill patients directly, or 'bulk-bill' the Health Insurance Commission provided that the physician accepts 85% of the schedule fee as full payment for their service. Most general practitioners 'bulk-bill' on a regular basis; thus in 1999-2000, nearly 80% of services were effectively free to patients through bulk-billing. General practitioners may also be paid a small amount (in terms of their overall income) to deliver agreed public health services. Patients pay for medical and laboratory services and then are reimbursed for 85% of the schedule fee by Medicare (or else receive free treatment if the doctor bulk bills). There are no significant reimbursement delays.

The Commonwealth has some influence over private general practitioners and specialists through the imposition of the Medicare Benefits Schedule. To prevent over utilisation of services, patterns of GP practice are scrutinised by the Health Insurance Commission. Although the Medical Benefits Schedule acts as a break on medical fees (but also provides guaranteed payments), funding has not been used as a lever to change clinical practice.

Pharmaceuticals

Pharmaceuticals go through an exhaustive assessment process before a drug is listed on the Pharmaceutical Benefits Schedule. First, a drug must be registered for marketing in Australia. Second, the Pharmaceutical Benefits Advisory Committee, an independent statutory authority, must recommend that the registered drug be listed. Third, the Minister of Health must decide whether to accept the recommendation. Finally, the Commonwealth negotiates a price with pharmaceutical wholesalers. Since 1993, in a pioneering innovation internationally, the Pharmaceutical Benefits Advisory Committee has based its recommendation in large part on the cost-effectiveness of the proposed new product. Overall, the PBS scheme has been relatively successful in regulating the quality and costs of drugs compared to other industrialised countries.

Hospital care

Under the Australian Health Care Agreements, the Commonwealth provides prospective block grants for public hospitals to the States, subject to various performance measures. Most public hospitals (as autonomous organisations) are responsible for managing the funds they receive from the State. Most States now fund hospitals via a combination of global prospective budgets and DRG payments.

Australia began to pilot the United States diagnosis related group (DRG) method of payment in 1985 and so has over 15 years experience in the intricacies of DRG systems. Australia has produced its own standardised classification system, currently with 667 categories, known as the Australian National Diagnostic Related Groups (AN-DRGs). Under pressure from the Commonwealth, all States (except New South Wales) now use the DRG system to fund public hospitals. New South Wales has retained a large element of population funding in paying hospitals and uses case-mix information more as a management tool. The States occasionally purchase hospital services from private providers under detailed purchase-of-service contracts. Case-mix funding appears to achieve greater efficiency (targets have been

achieved through efficiencies rather than through service cuts in the context of State government budget constraints), but there is little evidence of the impact of case-mix funding upon effectiveness, that is, upon patient health outcomes and service quality.

The *Workplace Relations Act 1996* shifted the industrial relations focus away from centrally determined awards towards enterprise level bargaining on wages and employment conditions. The contractual terms and conditions and rates of payment of doctors employed by public hospitals vary across States. There are two main categories. Salaried medical officers are engaged as employees of the hospital and are paid a salary to work at the hospital full time. Visiting medical officers are engaged as independent contractors of the hospital and can be paid a fee-for-service for each procedure or on a sessional basis for a certain amount of time per week.

5 HOW MUCH IS SPENT AND ON WHAT?

5.1 Expenditure

Australia spent 8.5% of its GDP on health in 2000 (Table 1.2), which is about average compared to other OECD countries. Expenditure has risen steadily over the past decade with mean annual growth above 4%. Expenditure per capita in terms of purchasing power parity was USD PPP 2085 in Australia in 1998 (compared to USD PPP 1510 in the United Kingdom). Australia is in the mid-range among OECD countries and in line with the predicted level given its per capita income.

The public sector proportion of total expenditure is somewhat lower in Australia (71%) than in some OECD countries (due to the significant private sector primary care and also hospital care) (OECD 2001).

The Commonwealth contributed 48% of health expenditure in 1999-2000 and State and local governments 23% (the latter a very minor amount), while the remaining 29% came from private sources (Table 1.3).

Table 1.2 Trends in health care expenditure in Australia, 1970–2000

	1970	1975	1980	1985	1990	1995	2000
Value in current prices (AUD million)	1 992	5 719	10 224	18 586	31 270	41 783	53 657
Value in constant prices 1990 (AUD million)	9 947	15 119	16 822	20 638	31 270	38 432	NA
Annual growth per person, constant prices, %	NA	NA	NA	4.3	0.7	3.8	1.9
Share of GDP (%)	4.8	7.2	7.0	7.4	7.9	8.2	8.5
Value in current prices, per capita (USD PPP)	207	438	663	998	1 320	1 778	2 085
Public share of total health care expenditure (%)	56.7	72.8	62.9	71.7	67.7	67.7	71.2

Source: Australian Institute of Health and Welfare 2000; 2001a

NA= not available

In 1997, inpatient care accounted for 43% of total expenditure, ambulatory care nearly 23%, and pharmaceuticals 11.3%. Public health (disease prevention and population health promotion) received less than 2% of the total health budget, and investment in the health sector was 6.5%.

Table 1.3 Government and non-government expenditure as a percentage of total expenditure on health services, 1985/1986 to 1999/2000 (current prices)

	1985/1986	1990/1991	1995/1996	1999/2000
Government	**71.9**	**67.7**	**68.1**	**71.2**
Commonwealth	46.0	42.2	45.6	48.0
State and local	25.9	25.5	22.5	23.2
Non-government	**28.1**	**32.3**	**31.0**	**28.8**

Source: Australian Institute of Health and Welfare 2000; 2001a

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

Access, equity and quality issues are monitored by an array of government and private groups using a range of strategies. In relation to consumer rights, Australia has active and vocal consumer groups, such as the Australian Consumers' Association and the Consumers' Health Forum, and a variety of advocate groups for particular health issues or conditions. The States have been required since 1993, under the Healthcare Agreements, to develop Public Patients' Hospital Charters. All States also have grievance procedures in place that cover the whole health system, either through State ombudsmen or though Health Services Commissioners. Private hospital patients can complain to the Private Health Insurance Ombudsman, a statutory body funded by the Commonwealth through a levy on private insurance funds. Patients also can complain to the statutory registration boards for health professionals in each State.

Freedom of Information legislation gives patients' access to their medical records if they so request. There is no single medical record although the possibility of a central electronic record is being discussed, and there is great variability across health professionals/ organisations on the scope and integration of medical records.

Patients can be treated in another country if there is a reciprocal agreement or if they have taken out private health insurance that covers such treatment.

6.2 Ambulatory care

General practitioners provide the bulk of primary medical care, are mostly self-employed and run their practices as small businesses. Some general practitioners also enter into contractual arrangements with companies, for example, to provide health checks for employees; and in a relatively new trend, increasing numbers of GPs now work for private health care chains. Group practices are the norm with solo practitioners now accounting for only 14.5% of total practices. Most general practitioners are self-employed but a small number of them are salaried employees of Commonwealth, State or local governments. Specialists can work in both private practice and in public and private hospitals.

The patient has a choice of general practitioner with no restrictions and may consult more than one general practitioner since there is no requirement to enrol with a practice. Patients usually see a GP that day in an emergency or by appointments within a few days except in poorly served areas.

Australia had 2.4 physicians per 1000 population in 1998 a lower ratio than in many OECD countries, while GPs numbered 1.1 per 1000 population compared to 0.6 in the UK. General practice, therefore, is the main form of medical practice, accounting for 43% of all employed medical practitioners, with the growth of medical specialisation slowing over the last two decades.

In 1998, Australia had 9.5 nurses per 1000 population. Nurse consultations are not reimbursed through Medicare, although nurse practitioners potentially could undertake more primary care since they now work more independently and their roles and functions are expanding; for example, they prescribe a limited range of drugs and order medical tests.

Primary health care is provided also by home nursing services and by nurses in public sector mother and baby health clinics. Allied health professionals, such as physiotherapists and dieticians, also offer primary health care but most are in private employment, with consultations covered through private insurance schemes but not Medicare. State-run services provide dental care for school children and for people on low incomes, but otherwise, dental care is financed and delivered mostly privately. Pharmacists provide a significant but unmeasured amount of health advice. Complementary and alternative medicines are widely used by the public: a recent South Australian survey reported that over 20% of respondents had consulted an alternative health practitioner.

Consultations with doctors (clinic visits) numbered 6.3 consultations per year head of population in 1999 (a rate that was fairly steady throughout the previous decade) and similar to other industrialised countries (OECD 2001), but the Australian consultation rate is much lower in rural than in urban areas. There are no reliable time series statistics on outpatient consultations in hospitals (free to public patients) given differences between the States and across years in reporting categories.

Although the quality of services and facilities in Australia is regarded as relatively good much more attention now is being paid to quality and outcome issues and to better integrated care across the health care system. For example, since 1997, the Commonwealth has funded a series of Coordinated Care trials, the current series running until 2003, to test the cost-effectiveness of various strategies to improve the delivery of health services to people with multiple and/or chronic health needs.

6.3 Secondary care

Patients have a choice of secondary care provider providing that the GP is willing to make a referral, and Medicare insurance rebates for specialist consultations are only available with a referral from a GP, who thus act as gatekeepers to the rest of the health care system.

Inpatient care is provided by public hospitals (70% of the stock of acute care beds) and also private hospitals. Patients with private health insurance may chose to be admitted to either a public or private hospital (usually more quickly than a public patient) and may also chose their specialist.

Waiting times for elective surgery in public hospitals remains a political issue. The National Waiting Times Data Collection has helped to standardise access criteria according to clinical urgency in relation to waiting times: a category 1 patient should be admitted within 30 days, category 2 within 90 days, and category 3 within 12 months. Of patients in the clinically most urgent group, 11% reported a wait for elective surgery of more than 30 days in 1997-98 compared to 20% in 1998-99.

Average waiting time for non-emergency surgery was reported as 1.6 months in Australia, similar to New Zealand and Canada but shorter than in the United Kingdom (with 2.2 months), in a survey by The Commonwealth Fund (1998). The waiting time for public hospitals in Australia has lengthened because hospital budgets are squeezed even though the number of patients using private acute care hospitals has increased throughout the 1990s. The States complain that the Commonwealth should increase funds in response to the rising demand for hospital treatment; the Commonwealth responds that the States should increase their share of hospital funding.

Australia had 4.0 acute hospital beds per 1000 population in 1997, just below the European Union average, the ratio having fallen markedly since the 1970s (Table 1.4). Hospital patient throughput has increased dramatically with rising admissions, shorter stays, and higher occupancy rates. Overall admissions for acute care per 100 persons rose sharply in the 1990s, if same-day admissions are included in the count. The average length of stay (ALOS) in acute care hospitals (excluding same-day admissions) has fallen over the last few decades to 6.3 days in 1997, reflecting more active patient management, less invasive surgical techniques and greater cost pressures. A different estimate gives 4.2 days in acute care hospitals in 1997 including same-day cases, since their inclusion substantially reduces the average stay. Bed occupancy rates have risen during the 1990s to 78% with new treatments and cost-effectiveness pressures resulting in greater throughput. A large and increasing proportion of patients are treated on a same-day basis: 46% in 1997-98. Some may represent new patients who otherwise would not enter hospital (as suggested by rising admissions) rather than patients diverted from longer inpatient stays. The configuration of hospitals is changing in response to new treatment methods with separate centres, particularly in the private sector, being built for same-day treatment such as day surgery and renal dialysis. Thus the hospital sector in Australia has undergone dramatic changes over at least the last decade in its configuration, funding and management of patients.

Table 1.4 Inpatient utilisation and performance in Australia, 1970–1997

	1970	1975	1980	1985	1991*	1995	1997
All hospital beds per 1000 population	11.7	11.9	12.3	10.9	NA	8.7	8.3
Acute hospital beds per 1000 population	6.0	6.1	6.4	5.3	NA	4.2	4.0
Acute admissions per 100 population	17.4	18.0	19.8	17.9	NA	16.2	15.9
Acute admissions per 100 population (incl. same-day)	17.7	19.5	20.6	21.2	23.7	28.5	29.9
ALOS acute beds in days (excl. same-day)	8.9	8.4	7.8	7.4	NA	6.5	6.3
ALOS acute beds in days (incl. same- day)	NA	NA	NA	NA	4.8	4.3	4.2
Acute bed occupancy rate (%)	76	74	68	69	73.8	77	77.9

Source: (Australian Institute of Health and Welfare 1998; Australian Bureau of Statistics 2000; OECD 2000)

Note: * 1990 figures unavailable

NA= not available; ALOS = average length of stay

6.4 Diagnostic services

Diagnostic and laboratory tests are requested by a GP or specialist and provided mainly by private providers. These are subsidised by Medicare rebates (with cost and volume agreements between the industry and the Commonwealth government), which act as a break upon the fees charged. The diagnostic services industry has expanded considerably during the 1990s.

Australia has a two-stage system for the assessment of new medical technologies, as well as pharmaceuticals, with separate approvals for use and for public subsidy. First, the Therapeutic Goods Administration (in the Commonwealth Department of Health) examines the safety and efficacy of diagnostic and treatment devices and pharmaceuticals, prior to approval being given for their use. Second, the Medical Services Advisory Committee considers the cost-effectiveness of medical interventions, and recommends whether the procedure will be covered by medical insurance on the Medicare Benefits Schedule. State health departments and individual hospitals decide whether to purchase new technology. ‘Big ticket’ items inexorably become standard issue in acute care hospitals and specialist community clinics,

such as magnetic resonance imaging units and computed tomography scanners. There is a large supply of technology; for example, in 1998 there were 4.5 MRI units per million population compared to 2.6 in the UK.

6.5 Pharmaceutical care

Virtually all pharmacies (except in public hospitals) are in the private sector. There are no regulations regarding their location but their drug dispensing activities are controlled. The Commonwealth has controlled the supply and costs of drugs through the Pharmaceutical Benefits Scheme (PBS) since 1948, and as the sole purchaser of goods that are listed on the PBS schedule (a monopsony purchaser), thus is in a strong negotiating position with the pharmaceutical industry. Price controls over the dispensing of pharmaceuticals have been instituted under an agreement with the Pharmacy Guild. A pharmacist must be an approved supplier if consumers are to obtain drug subsidies under the Commonwealth Pharmaceutical Benefits Scheme. A dispensing pharmacist must be a member of the Pharmacy Guild in the relevant State.

6.6 Rehabilitation/intermediate care

State governments administer rehabilitation services, through a mix of public and private providers, mainly in day hospitals or as domiciliary services (for example, South Australia has an extensive scheme whereby allied health professionals visit people at home). Short-term intermediate care also is provided in nursing homes. The Commonwealth runs an extensive Rehabilitation Service intended to return people to the workforce but now mainly contracts out for rehabilitation services from the public or private sector.

6.7 Social care

Social care is funded by all levels of government and delivered by a mixed economy of government, voluntary sector and private for-profit providers. The Commonwealth has become increasingly involved in formulating social policies and funding social programmes, but the States traditionally are responsible for social welfare. Many services are delivered by voluntary sector agencies, while much social care relies upon the family. The boundary between health and social care depends upon the area and fluctuates over time; activities across the interface thus are subject to continuing negotiations.

Aged care, for example, is strongly influenced by Commonwealth policies (the main source of funding), and since 1986 residential aged care has been guided by regional planning ratios, the intention being to reduce excessive institutionalisation and support older people where possible in their own homes. A cap was set on residential care places so that the supply was constrained as the older population increased. Australia has 13 per cent of its population aged 65 years and over compared to 16 per cent in the United Kingdom. However, between 1995 and 2020 (using medium variant projections), the 80 plus age group is projected to grow by 34 per cent in the United Kingdom and by 71 per cent in Australia. By 1997, Australia had 147 total beds (nursing home and hostel) per 1000 population aged 75 plus, compared to 134 beds per 1000 population aged 75 plus in the United Kingdom in 1996. Disability services are funded under Commonwealth and State agreements; State level responsibility has shifted back and forth between health and welfare portfolios, while the delivery involves both public and private sectors.

7 THE PATIENT JOURNEY

A patient needing, for example, a hip replacement operation first visits her GP private practice, where she is likely to be a long-standing patient. The patient pays for the GP consultation and claims the rebate, or no payment is required if the doctor bulk-bills Medicare, but probably the patient has a Pensioner Medical Card and so pays no extra. If the patient (or her husband) was a member of the defence forces (in World War II), she may be fast-tracked by Veterans' Affairs (who now mainly purchase mainstream services rather than run a parallel health care system) and any excess fees are covered. The GP refers the patient to a specialist, who books her into a hospital where the specialist has operating rights (and works as a public and/or private orthopaedic surgeon). The same fee arrangement as for the GP applies to consultations with the specialist. As a public patient one may expect to wait a month or more for an elective operation. All care in a public hospital is covered. If the patient elects to be referred as a private patient (either to a public or a private hospital) in order to receive faster access (and because she has private health insurance) the amount of rebate depends upon the level of private cover. For private patients in public or private hospitals, Medicare will meet 75% of the schedule fee for medical services, with part or all of the balance claimed from private health insurers and the cost of private hospital accommodation. The District Nursing Service provides post-hospital care by (either a voluntary or a State-run organisation depending upon the State) for an income-tested fee. Home help or meals and wheels may also be available from government or voluntary organisations for a short period.

8 WHAT ARE THE MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM?

Several topics currently receive considerable play in the media: the perennial issue of hospital waiting lists for elective surgery; shortages of trained nurses in hospitals with nurses on strike in some States for better pay and working conditions; the huge costs to the Commonwealth of tax rebates to encourage people to take out private health insurance; the occasional cases of alleged medical malpractice/incompetence before the courts; and the frustrations of the 'buck passing' involved in a federal system of government illustrated by the annual Commonwealth/State arguments over revenue sharing and block grants for health at the State Premiers' conference.

The supply and quality of secondary care services in Australia is relatively good, but consumer dissatisfaction with some aspects of health care, such as consumer costs and hospital waiting lists, has risen over the last decade. The survey of public opinion in five nations in 1998 undertaken by The Commonwealth Fund showed that Australians gave a higher rating to the quality of care (than did respondents in Britain, Canada, New Zealand and the United States), but that public dissatisfaction with the health care system overall in Australia had risen compared to earlier surveys. In 1998 in Australia, 24% of above-average income earners and 36% of below-average income earners believed that the health system needed to be redesigned (compared to less than 16% in Britain).

The major challenges facing the health care system are as follows. Improving cost-effectiveness is an ongoing concern given that per capita health expenditure (in real terms) in Australia has increased on average by 2.7% each year between 1985 and 1997, with a raft of cost-containment mechanisms in place, including exhortations to apply 'new public management' methods. Improving quality and health outcomes now receives more attention with better information systems being set up and requirements to measure and achieve better health outcomes. Improving access and equity has bipartisan agreement, particularly in relation to Medicare: huge disparities in health status continue, however, between Indigenous and other Australians, and various programmes have been set up recently to improve access and equity in rural areas.

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Australian Department of Health and Ageing	http://www.health.gov.au
Australian Institute of Health and Welfare	http://www.aihw.gov.au
Health Insurance Commission	http://www.hic.gov.au
ACT Dept of Health, Housing & Community Care	http://www.health.act.gov.au
New South Wales Health Department	http://www.health.nsw.gov.au
Queensland Health	http://www.health.qld.gov.au
South Australian Dept of Human Services	http://www.health.sa.gov.au
Tasmanian Dept of Health & Human Services	http://www.dchs.tas.gov.au
Victorian Dept of Human Services	http://www.dhs.vic.gov.au
Western Australia Health Dept	http://www.health.wa.gov.au

DENMARK

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1 INTRODUCTION

The Danish health care system is predominantly financed through local (county and municipal) taxation with integrated funding and provision of health care at the local (county) level. Most primary care is provided by privately practising GPs, who are paid on a combined capitation and fee-for-service basis, but the number and location of GPs is controlled by the counties and GPs' fees and working conditions are negotiated centrally. Hospital care is mainly provided by hospitals owned and run by the counties (or the Copenhagen Hospital Corporation in the Copenhagen area). Private hospital providers are limited, accounting for less than one per cent of hospital beds.

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

Access to GPs and hospital care is free at the point of use for all Danish residents. It is not possible for Danish residents to opt out of the statutory health care system. Individuals choosing the Group 2 option (see Section 6.2) must pay part of the cost of visits to GPs and specialists.

Additional voluntary health insurance (VHI) has developed rapidly in the past five or six years due to the perceived shortcomings of the statutory health care system (expected waiting times etc). VHI is now included in many job contracts and sometimes in centrally negotiated work agreements in particular sectors or firms. VHI policies mostly cover people of working age. Since diseases are less prevalent in this group and all acute illnesses are treated immediately in the public sector, these policies have so far been put to limited use. A major barrier to usage is the limited capacity of the private sector. While alternatives are available or being developed in northern Germany or Sweden, the experience to date suggests that patients are reluctant to travel abroad for treatment. Overall, the market for VHI appears to be driven by a degree of 'hype' about the poor quality of the statutory health care system. As individuals and employers become more aware of the limitations of VHI, and the government increases public spending on health care, it is possible that the demand for VHI will stagnate or fall.

Precise levels of VHI coverage are not known as there is no central source of data, voluntary health insurers are reluctant to reveal aggregate figures and there are no detailed studies of the characteristics of those covered by VHI. However, estimates suggest that about 28% of the population have some sort of VHI coverage. Approximately a quarter of the population purchase VHI from 'Danmark', a mutual association. 17.5% of the population have purely complementary cover from Danmark, while 7.7% have combined complementary and supplementary cover from Danmark. A further 2-3% of the population purchase purely supplementary cover from commercial insurance companies.

2.2 Benefits

There is no positive list of the benefits provided by the statutory health care system in Denmark. Certain types of treatment must be considered to be useful or necessary by a doctor in order to qualify for public funding. For example, cosmetic surgery will only be performed free of charge if a doctor finds it to be necessary on psychological grounds. These decisions are taken by individual doctors on a case by case basis. Infertility treatment is unusually carefully regulated, with fixed restrictions for some procedures such as assisted or in vitro fertilisation.

The statutory health care system does not pay for treatment that is considered to be 'alternative' (for example, zone therapy, kinesiology, homeopathy and spa treatment) and spectacles (unless patients have very poor sight). The costs of physiotherapy, dental care and pharmaceuticals prescribed in a primary care setting are only partially covered by the statutory health care system. Statutory reimbursement of pharmaceuticals is based on a positive list of drugs drawn up by the National Medicines Agency.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

In 1999 82.2% of total expenditure on health care in Denmark was financed by a combination of state, county and municipal taxes.

Local (county and municipal) taxes are levied proportionately on personal income and property. Every year the central government and the county and municipal councils agree maximum rates of local taxation. In 2002 the average county and municipal tax rate is 32.6%. In 1999 the average rate of county personal income tax was 11.5%. Health care accounts for about 70% of county expenditure.

State taxes used to finance health care include personal income tax, value-added tax (a single rate of 25%), energy and excise duties, a labour market contribution (8% on all personal income) and corporate income tax. Personal income tax accounts for almost half of the state's total tax revenue and is payable on wages and almost all other forms of income, including profits from personally owned business. It is levied on a progressive basis, with a basic rate of 5.5%, a medium rate of 11.5% and a top rate of 20.5% levied on earned and capital income.

Income tax (whether collected at state, county or municipal level) is only levied on 59% of income. This ceiling significantly reduces the progressivity of income tax in Denmark.

3.2 Social health insurance contributions

There are no social health insurance contributions by employers in Denmark.

3.3 Voluntary health insurance premiums

The premiums of VHI policies sold by the dominant mutual association (Danmark) are usually group-rated and vary according to the level of coverage chosen. Commercial premiums are set on the basis of age and employment status. The maximum age limit for coverage is 60 and pre-existing conditions are excluded from coverage. There is no regulation of premiums and no tax relief for policies purchased by individuals. Employers purchasing policies on behalf of employees may deduct the cost of these premiums from tax. Almost all policies sold by Danmark are purchased by individuals, while over 80% of commercial policies are purchased by employers. Tax relief (for employers) for employer-paid policies is likely to fuel demand for VHI in future. There are no cross-subsidies to the statutory health care system.

3.4 User charges

There are no user charges for non-clinical services in Denmark. User charges in the form of co-payments (a percentage of the total cost) are applied to physiotherapy, dental care and spectacles. The size of dental co-payments varies according to the procedure undertaken, but they are generally large and have therefore caused some controversy, as many claim they are inequitable. User charges for GP visits and hospital stays have been discussed as a means of

reducing unnecessary utilisation, but have always been rejected for fear of reducing the utilisation of people on low incomes (who may need health care the most).

Drugs prescribed in a primary care setting (that is, outside hospitals) are subject to varying levels of co-payment at the following rates, on the basis of an individual's drug expenditure during a defined period:

- below DKK 500 – patients pay 100%
- DKK 501 to DKK 1200– patients pay 50%
- DKK 1200 to DKK 2800 – patients pay 25%
- above DKK 2800 – patients pay 15%

Chronically ill patients with a permanent and high utilisation of drugs can apply for full exemption from co-payments once their expenditure on drugs has reached an annual ceiling of DKK 3600. Special rules for pensioners have been abolished, although pensioners who find it difficult to pay for pharmaceuticals can apply to their municipality for financial assistance. Patients with very low incomes can receive partial exemption from drug co-payments on a case by case basis.

Patients in Group 2 (see Section 6.2) must pay for visits to GPs and specialists.

Out-of-pocket payments are not exempt from tax. Many individuals purchase VHI to cover the cost of co-payments.

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

Taxes used to fund health are collected nationally (state taxes) and locally (county and municipal taxes). Local taxes are supplemented by state subsidies that are calculated annually according to the size of local tax revenues. In addition, resources are transferred between counties and municipalities on the basis of a formula that takes into account the following factors: age distribution, the number of children in single parent families, the number of people living in rented accommodation, the rate of unemployment, the number of uneducated people, the number of immigrants from non-EU countries, the number of people living in socially-deprived areas and the proportion of elderly people living alone.

There are no hypothecated or earmarked taxes in Denmark, but some national taxes are partly motivated by a concern for health, such as excise duty on motor vehicles, energy, spirits and tobacco products. In the 1990s the central government introduced a green excise duty that is levied on the consumption of polluting or scarce goods such as water, oil, petrol and electricity.

The most significant resource allocation mechanism in Denmark is the national budget negotiation that takes place once a year between the Ministry of Health, the Ministry of Finance and the county and municipal councils and agrees the following allocations:

- the recommended maximum level for county and municipal taxes
- the level of state subsidies to the counties and municipalities, in the form of block grants that depend on the size of local tax revenues and needs (Table 2.1)
- the level of redistribution between counties and municipalities in order to compensate for variations in local tax revenues
- the size of extraordinary grants earmarked for specific areas needing additional resources.

Although the counties and municipalities are responsible for providing most health care in Denmark, they must do so within the targets for health care expenditure agreed at this annual negotiation. Although these targets are not legally binding, in practice there are few examples of significant tax increases beyond the agreed level and the central government can, in principle, sanction county and municipality behaviour by withholding the block and extraordinary grants.

VHI is mainly provided by the mutual association 'Danmark' and a small number of for-profit commercial insurers.

Table 2.1 Main sources of funding for all county and municipal expenditure in Denmark, in billion DKK and as a percentage of total, 2001

	County		Municipality	
	DKK billions	%	DKK billions	%
Local taxes	68.6	71.3%	127.2	56.6%
Income from services and rent etc	16.1	16.8%	49.1	21.8%
Interest, loans etc	0.2	0.3%	2.4	1.1%
State reimbursement	0.6	0.6%	25.9	11.5%
State subsidies and redistribution between counties/municipalities	10.7	11.1%	20.1	8.9%

Source: Ministry of Interior Affairs and Health (http://www.im.dk/publikationer/kommunal_udligning/kap02.htm#2.1)

4.2 Organisation of purchasing/contracting

Primary health care in Denmark is purchased and provided by counties and municipalities. Counties own pre-natal centres and purchase services from licensed GPs, specialists, physiotherapists and dentists. Municipalities own most nursing homes and provide services such as home nurses, health visitors, municipal dental care and school health services. Funding for municipal services is allocated through global budgets and services are provided by salaried professionals.

GPs' remuneration is a mixture of capitation (on average a third of their remuneration) and fees for service (per consultation, examination, operation etc), including special fees for out of hours consultations, telephone consultations and home visits. These fees are based on a schedule agreed by their professional organisation and the National Health Security System (NHSS).[1] This combined payment system is expected to create incentives for greater GP activity in specific areas. For example, a fee introduced in 1995 for preventive consultations is supposed to encourage GPs to offer longer consultations focusing on broader health and preventive activities such as education regarding smoking or dietary habits, weight control etc. Previously this type of activity was not paid for by the NHSS. About 23% of doctors work as GPs.

Physiotherapists, dentists and pharmacists are funded by the NHSS on a fee-for-service basis.

County-licensed specialists practising privately (that is, on a non-salaried basis) are paid a fee for service. The fees charged to patients in Group 1 are negotiated with the Association of County Councils, but specialists are free to charge patients in Group 2 any fee they like. Most county-licensed privately practising specialists provide NHSS services on a full-time basis and therefore derive most of their income from the NHSS. Some specialists provide part-time

[1] The use of the term 'national' may be slightly misleading as the NHSS is not a national system in the sense that it is centrally administered, but only in the sense that negotiations are centralised. In practice, health care is provided by the counties according to the rules negotiated by the Association of County Councils.

NHSS services and are also employed on a full-time basis by a county hospital. A small number of specialists working in county hospitals on a full-time basis are allowed to provide three hours of fee-for-service care per week at the hospital (paid for by the NHSS). Previously, this type of contract was much more common, but the counties have tried to restrict it in order to contain costs and maximise hospital-based specialist services. There are no restrictions on how much private work specialists employed by county hospitals are permitted to undertake in their spare time, probably because only a very small number of specialists choose to engage in such activity. A handful of specialists work without a county licence on a fully private basis. Hospital staff (including doctors) are paid a salary.

Counties own and run most hospitals in Denmark (with the exception of hospitals in the Copenhagen area and for-profit hospitals). Hospital resources are allocated through prospective global budgets based on past performance and modified at the margin to account for new activities, changes in tasks and areas of specific need. Global budgets are set by counties in negotiation with hospital administrators.

Since 1993 some counties have introduced contracts for hospitals, which supplement the global budget and are intended to raise awareness of costs and increase activity (rather than introducing competition between hospitals) by setting targets for activity, service and quality. These contracts are not legally binding and do not include specific sanctions if targets are not reached, but persistent failure to fulfil a contract may be sanctioned by salary cuts or changes in managers' employment conditions.

In 1999 it was decided to introduce full diagnostic-related group (DRG) payments for patients treated at hospitals outside their own county (under the 'free choice' scheme introduced in 1993 - see Section 6.3), a change that is expected to increase incentives to treat patients from other counties. This change may also lead to greater competition between hospitals (depending on who is permitted to keep the extra revenue generated – the county, the hospital or the hospital department providing the treatment), since in many cases DRG rates are higher than the deliberately low rates that were initially applied to the free choice scheme.

The Copenhagen Hospital Corporation was set up in 1994 to take over the state hospital in Copenhagen and manage hospital services in Copenhagen and Frederiksberg. It is run by a board of directors whose members are local politicians and central government appointees. The aims of this reform were to enlarge the hospital sector in the greater Copenhagen area, to rationalise the services, and to create a higher degree of autonomy for managers in the hospital sector.

5 HOW MUCH IS SPENT AND ON WHAT?

5.1 Expenditure

In 1999 total expenditure on health care in Denmark accounted for 8.4% of GDP and USD PPP 2275 per capita. Public expenditure on health care accounted for 6.9% of GDP and private expenditure accounted for 1.5% of GDP (Table 2.2). Table 2.3 shows a breakdown of health care expenditure by type of service.

Table 2.2 Main sources of health care funding in Denmark, as percentage of total and percentage of GDP, 1999

	% of total expenditure on health	% of GDP
Public	82.2%	6.9%
Private	17.8%	1.5%
Out-of-pocket	*16.2%*	*1.4%*
VHI	*1.4%*	*0.1%*

Source: OECD Health Database 2001

Table 2.3 Health care expenditure by type of service in Denmark, current prices in million DKK, 1980-1999

	1980	1985	1990	1995	1999
Public expenditure	**23 137**	**34 084**	**43 212**	**52 744**	**64 530**
Hospitals	17 616	26 009	32 072	38 576	47 072
Individual health services[1]	5 192	7 576	10 390	13 131	16 148
Administration[2]	173	280	577	771	982
Other	155	218	173	266	328
Private expenditure	**4 299**	**7 915**	**12 114**	**14 477**	**18 247**
Pharmaceuticals (including vitamins)	1 065	1 975	3 451	3 864	4 831
Spectacles, hearing aids etc	751	1 263	1 894	2 140	2 495
Doctors and dentists	1 226	2 449	4 358	5 087	6 082
Hospitals	565	1 039	704	985	1 389
Nursing homes	396	762	810	1 425	1 895
Voluntary health insurance	296	427	897	976	1 555
Total expenditure on health care (national definition)	**27 436**	**41 999**	**55 326**	**67 221**	**82 777**
Care of the elderly[3]	7 733	13 045	14 298	15 844	18 671
Total expenditure on health care (OECD definition)	**35 169**	**55 043**	**69 624**	**83 065**	**101 448**

Source: Data provided by the Ministry of Health

[1]These include services financed by the NHSS and some elements of home nursing.

[2]Administration comprises county and municipal administrative bodies responsible for health care, as well as the Ministry of Health and the National Board of Health; hospital administration is included in hospital budgets.

[3]In Denmark, contrary to most other countries, nursing homes for sick or disabled elderly people and other disabled people are part of the social welfare system rather than the health care sector, which means that official statistics regarding the number of beds in health care institutions and health care costs have not been directly comparable to those of other countries. However, more recent OECD statistics account for this discrepancy.

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

Waiting time guarantees do not form part of the legislation on patient rights (which provides general statements regarding the counties' obligation to provide free health care and statements regarding patient access to information etc). However, in addition to several county-based initiatives and guarantees, two separate national waiting time guarantees have been introduced/will be introduced shortly:

- a *waiting time guarantee for critical illnesses* (life-threatening conditions) was introduced by the previous government in 2000. It covers all conditions/diagnoses that are considered to be 'critical' by the national health authorities (most cancers, heart conditions etc), guaranteeing a maximum waiting time of two weeks for investigation plus two weeks for

treatment plus two weeks for follow-up treatment. If counties are unable to provide treatment within the maximum time allowed, they must find alternative options in other counties or through the private sector. By 2001 counties had not had to resort to using these alternative options as they have generally managed to provide treatment within the given timeframe.

- a *general waiting time guarantee* of two months for all types of non-acute treatment, with effect from July 2002. If counties are unable to provide treatment within two months, patients will have a right to seek treatment at private facilities or abroad at the counties' expense.

6.2 Ambulatory care

Ambulatory care is provided by GPs, specialists, dentists and physiotherapists. About a third of GPs operate a solo practice. The current trend is towards a decrease in solo practices. GPs' services are available 24 hours a day. Many hospitals provide open emergency services, although some counties have restricted access to these services to cases referred by GPs or brought in by special emergency services.

Since 1973 Danish residents over the age of 16 have been able to choose from two GP options known as Group 1 and Group 2.

Individuals in Group 1 (and their children):

- register with a GP practising within 10 km of their home (5 km in the Copenhagen area), which gives them free access to general preventive, diagnostic and curative services
- can only gain free access to specialist and hospital treatment if they are referred by their GP (although anyone can consult an ear, nose and throat specialist or an ophthalmologist without referral)
- seeking specialist care without their GP's referral must pay part of the specialist's fee
- are entitled to change GP every six months.

Individuals in Group 2:

- are free to visit any GP and any specialist without a GP's referral, but must pay part of the cost of all services except hospital treatment
- comprise only 1.7% of the population, partly due to the extra costs involved and partly due to general satisfaction with the referral system.

About 23% of doctors in Denmark work as GPs and about 4% are full-time specialists practising privately. About 60% of doctors work as salaried employees in hospitals, of whom about 7% practise privately on a part-time basis. A further 10% of doctors are involved in non-clinical work such as administration, teaching and research.

The majority of county-licensed privately practising specialists that provide NHSS services on a full-time basis are located in Copenhagen and other urban centres. Most of them specialise in dermatology, ear, nose and throat diseases and eye diseases.

Because Denmark trains many doctors and the counties control the number of GP licences (for NHSS reimbursement) issued in a particular area, GPs are distributed evenly across the country, with very little variation between counties in the number of inhabitants per GP. In 1998 there were between 1507 and 1610 inhabitants per GP, with the exception of the small island county of Bornholm, which had only 1317 inhabitants per GP. The Danish health care system has succeeded in achieving short distances to GPs and reasonable equity in access to

GP services. However, the number of GP contacts per person (six per year) is still close to the European average, in spite of increases in recent years and free and relatively easy access.

Every year there are about 800 hospital outpatient consultations per 1000 population.

The Danish Ministry of Finance publishes current analyses of citizens' views of the public sector, including satisfaction with health care. According to the latest analysis (2000), Danish citizens are in general most satisfied with general practitioners (4.2 on a scale from 1 = very dissatisfied to 5 = very satisfied). Citizens express slightly less satisfaction with emergency medical services (3.5).

In 2000 the Danish Ministry of Health, together with the Association of County Councils in Denmark, carried out the first national survey of patients' views of Danish hospitals. Results from this survey show that 89% of patients are satisfied with their stay in hospital, 92% are satisfied with doctors and 94% are satisfied with nurses.

This is in accordance with the 1998 Eurobarometer survey prepared by the European Commission in collaboration with the London School of Economics and Political Science, which showed that 90% of Danes were satisfied with their health care services, more than residents in any other EU member state. The 1999 Eurobarometer survey prepared by Eurostat showed that 76% of Danes were satisfied with their health care services, placing Denmark fourth among EU member states.

6.3 Secondary care

Access to specialists varies considerably between specialists. Patients with acute conditions do not have to wait for a specialist appointment. Other patients may have to wait between one and two weeks.

Prior to 1993 patients were restricted to the use of hospitals in the county in which they lived. Since then patients have been free to choose to be treated at any hospital (at the same level of specialisation). So far only a limited number of patients have taken advantage of this reform (2.1% of all non-acute admissions), although the number is increasing slightly. To date, the reform's strongest impact has been in the area of planned surgery. The reform has reduced the planning and prioritisation capacity of individual counties, since counties are obliged to pay for the treatment of their residents at hospitals in other counties.

In 1999 there were 3.7 acute beds per 1000 population and 203 admissions[2] per 1000 population. The average length of stay was 5.6 days and the occupancy rate was 84%.

There are about 10 nurses per 1000 population (although not all these nurses work full-time).

See Section 6.2 for information on patient satisfaction with secondary care.

6.4 Diagnostic services

Public hospitals provide most diagnostic services. Some are provided by private clinics.

[2] In Denmark an admission is defined as the occupation of a bed in a hospital ward, which means that transferring a patient from one department to another counts as a new admission. A patient may therefore undergo several 'admissions' in the course of a year, leading to a much higher number of admissions than admitted persons. The difference between these two figures is increasing. In 1980 there were 43% more admissions than admitted persons in somatic wards; by 1996 there were 59% more admissions than admitted persons. Healthy new-born babies are also counted as separate admissions. Length of stay includes the day of admission but not the day on which the patient leaves hospital.

6.5 Pharmaceutical care

Pharmaceutical products are distributed by privately-owned pharmacies in the primary care sector and by hospital pharmacies in the secondary care sector (with each county running several hospital pharmacies). Private pharmacies are subject to strict regulation and their number and geographical location is decided by the Ministry of Health. Since October 2001, other outlets have been authorised to sell non-prescription drugs. Hospitals purchase approximately 90% of their drugs from hospital pharmacies.

6.6 Rehabilitation/intermediate care

Rehabilitation is mainly provided by public hospitals. A few private clinics provide physiotherapy etc.

6.7 Social care

Most social care is provided by municipalities, including: social welfare allowances (sickness allowances and disability pensions), care of elderly people, disabled people and people with chronic diseases (including mental disorders) outside hospitals, and community mental health centres (in some areas). Municipalities are also responsible for providing housing for the mentally disabled and homeless people. Increasingly, geriatric departments for rehabilitation of elderly people are being set up in county hospitals. If patients cannot be placed in municipal care as soon as they are discharged, due to waiting lists, then municipalities are liable for any extra hospital expenses incurred.

Municipal services are mainly provided by municipal health authorities and salaried professionals, although in an attempt to provide more efficient services, contracting with private non-profit agencies is becoming more common. Privately-contracted non-profit services include long-term inpatient care in nursing homes, day care centres and social services for chronically ill and elderly people. Some additional services, such as catering and cleaning, have been contracted out to private for-profit firms.

The counties provide some social services for special groups, such as the distribution of special technical aids and care for seriously mentally or physically disabled people and the treatment of drug addicts. Since 1994 Danish legislation requires municipalities and counties to undertake joint planning for health and social care in order to achieve better co-ordination between the two levels.

Since 1987 nursing homes have been considered as ordinary housing. The rights and duties of nursing home inhabitants therefore closely resemble those of the rest of the population. Following this change in legislation no new nursing homes have been set up. Consequently, the number of people in nursing homes has fallen from about 50 000 in 1987 to 36 500 in 1996. This has been accompanied by a large increase in the number of home nurses and home helps employed by municipalities. Many municipalities provide home care around the clock.

The increasing number of elderly people in Denmark is expected to pose a serious challenge for municipalities in future. Health and social authorities are attempting to place more and more emphasis on self care, increased support for people to remain in their homes for as long as possible, and effective preventive and health-promoting activity. However, it seems likely that contracting services to private non-profit agencies and patient co-payments will become increasingly popular tools for reducing costs and raising revenue in the future.

7 THE PATIENT JOURNEY

A woman in need of a hip replacement due to arthritis would take the following steps:

- during a free visit to the GP with whom she is registered, the GP refers her to a hospital orthopaedic department
- she has free access to any public hospital in Denmark and her GP advises her which hospital to go to on the basis of information about waiting times (available on the Ministry of Health's website), quality, her special needs etc.
- if she does not want to wait at all she can choose to go to a private hospital (although the number of private beds in Denmark is limited); she must pay for treatment in a private hospital either directly or through VHI; currently only a handful of patients would choose this option
- her GP prescribes any necessary medication
- after referral the patient may have to wait for three months or more for an outpatient hospital appointment for examination by a specialist
- after this she will have to wait for inpatient admission and surgery
- following surgery and primary rehabilitation at the hospital the patient goes home, where she might need home care (home nurse and/or home assistance); if this is prescribed by the hospital or her GP it will be provided by the municipality free of charge
- the GP receives a discharge summary from the hospital and is responsible for further follow-up such as referral to a physiotherapist (to whom the patient will have to pay a small co-payment)
- a follow-up hospital visit is likely to take place to check the treatment's outcome.

8 WHAT ARE THE MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM?

General challenges and important political issues in the medium to long term include:

- Denmark's relation to the European Union
- immigration and integration of refugees and immigrants
- the ageing of the population and pressure on health care expenditure and pensions
- limited human resources in the productive age
- future organisation of the welfare state

Several of these issues have a direct impact on health care and health policy was a major issue during the recent national parliamentary election in November 2001 (along with immigration).

The new liberal/conservative government has taken several initiatives in health care:

- an election promise to increase national health care expenditure by DKK 1.5 billion in order to reduce waiting times to fewer than two months for all treatment areas; the additional resources will be distributed to the counties based on documented increases in activity rather than through block grants, which represents a change in power relations and county autonomy
- a general waiting time guarantee of two months, with effect from July 2002 (see Section 6.1)
- an expert commission to review the organisation of health care will investigate and evaluate possible alternative organisational models, with a particular focus on rigidity caused by labour relations, salary structures etc; it will also consider the future of the

counties and the possibility for new types of public-private collaboration in health care; a final report is due in April 2002.

The new government signals some structural changes, but its rhetoric (and the general political consensus) remain committed to welfare state ideals of a tax-based and universal health care system. However, we are likely to see ongoing experiments with new management instruments and new types of public-private mix.

Table 2.4 lists the most important recent reforms, many of which continue under the new government.

Table 2.4 Summary of key reforms in Denmark, recent years

	National initiatives	County or organisation initiatives
Supply side	National Quality Indicators initiative (2000) Recommendations of restructuring into 'functional units' (2000) Report from the Commission Regarding Specialist Medical Services (2000) 90/10 activity-based financing (2000; not fully implemented) DRG classification (1999) National IT strategy for health care (1999) Evaluation and Health Technology Assessment Institute established (1997) Recommendations for service and quality targets in counties National database on waiting times (1996) National productivity analysis (1996) Health plans for the population to be developed through co-operation between counties and municipalities every fourth year based on themes decided by the national authorities (1994)	Contracts or target-based management (soft/negotiated contracts with specification of activity, service and quality targets) Quality assurance programmes Accreditation (2000) Activity-based financing in selected areas Regional agreements and collaboration Local waiting time initiatives and guarantees Restructuring delivery on the basis of 'functional units' (usually a matrix structure connecting several physical treatment units in one integrated delivery structure)
Demand side	National Public Health Programme (1999) Waiting time guarantees (1993, 1995, 1999) Extended legislation on patient rights (1998) Free choice of hospitals (1993) Ongoing prevention and health promotion initiatives	Practice and patient counsellors (intermediaries between the hospital system and GPs/patients) Prevention and health promotion initiatives (many traditional public health activities are run by the municipalities)

Source: Vrangbæk K. and Christiansen T. Research Paper for the European Health Care Systems Discussion Group Meeting (draft). London: London School of Economics and Political Science. February 2002.

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VRANGBÆK K. AND CHRISTIANSEN T. Research Paper for the European Health Care Systems Discussion Group Meeting (draft). London: London School of Economics and Political Science. February 2002.

10 WEBSITES

Association of County Councils	http://www.arf.dk
Copenhagen Hospital Corporation	http://www.hosp.dk
Danish Medical Association	http://www.laegeforeningen.dk
Ministry of Finance	http://www.fm.dk
Ministry of Taxation	http://www.toldskat.dk
Ministry of the Interior and Health	http://www.sum.dk
National Association of Local Authorities	http://www.kl.dk
Parliament	http://www.folketinget.dk

FRANCE

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1 INTRODUCTION

The French health care system is predominantly funded through tax revenues and social health insurance contributions from employers and employees. Health care is purchased and paid for by health insurance schemes and the government and provided by private (self-employed) practitioners and public and private (non-profit and for-profit) hospitals. Most general practitioners and specialists in the ambulatory sector are paid on a fee-for-service basis according to agreed fee schedules, while staff working in public hospitals are salaried. French patients have free choice of doctor and hospital.

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

All legal residents of France are covered by public health insurance. The population has no choice to opt out.

Until recently the basis of entitlement was employment status. Since the Universal Health Coverage Act (CMU) came into force in January 2000, the small proportion of the population without public health insurance[1] is now entitled to public coverage on the basis of legal residence in France.

Three main health insurance schemes cover 96% of the population (see Section 4.1), with the National Fund for the Insurance of Employed Workers (CNAMTS) covering about 83% of the population. The population has no choice of insurer. All residents are automatically affiliated to a health insurance scheme on the basis of their professional status and place of residence.

In 2000 86% of the population had additional (complementary) voluntary health insurance (VHI) coverage. Since the introduction of CMU in 2000, which provides free complementary VHI coverage for low income people, an additional 7.2% have gained VHI coverage, bringing the proportion of the population covered by complementary VHI to over 90%.

The quality of VHI is highly variable. For example, in most contracts the level of reimbursement for a basic dental prosthesis is 150% of the official rate. A quarter of contracts reimburse less than 55%, while 10% reimburse more than 285%. People with higher incomes tend to have better contracts.

There is no significant difference in levels of coverage between men (85.3%) and women (86.1%), although levels of coverage are lower for young people (81% between 20 and 30 years old) and elderly people (82%).

2.2 Benefits[2]

In order to be covered by public health insurance, health services must be produced or prescribed by a doctor, dentist or midwife and distributed by health professionals or institutions registered with the health insurance system or figure on one of the following positive lists:

[1] Some were covered through social assistance provided by local communities (0.5%) and a small percentage was not insured (less than 0.5%).

[2] Since 2001 there is no variation in the benefits provided by the three main insurance schemes covering 96% of population.

Table 3.1 Level of complementary VHI coverage in France, as a percentage of total, 2000

	VHI % of total	CMU % of total
Employment status		
Employed	89.9	2.2
Unemployed	60.1	20.3
Retired / widowed	88.7	1.5
Housewife	80.1	9.1
Other non-employed	66.1	12.8
Students, children	84.6	6.9
Occupation		
Farmers	89.3	1.5
Artisans, retailers	82.0	5.9
Executives and professionals	93.5	0.9
Intermediary professions	94.4	1.0
Office clerks	85.2	8.1
Customer-service clerks	69.2	12.4
Skilled workers	84.0	5.0
Unskilled workers	71.8	12.1
Total	**85.7**	***5.0**

Source: Health and Health Insurance Survey (ESPS) 2000.

* Figures in mid 2000; this figure has since about 7%.

- approved procedures: the lists are established jointly by the health insurance schemes and the professions represented in the Permanent Committee on Official Schedules of Professional Procedures; their proposals have to be approved by the Ministry of Health
- drugs and medical devices: these lists are established and updated by the Economic Committee for Medical Products (only recently for medical devices); again, proposals have to be approved by the Ministry of Health

These rules only apply to the fee-for-service sector (that is, ambulatory care in private practice and care in private hospitals). All diagnostic and curative procedures carried out in public hospitals are covered by a global budget (even if they are not reimbursed in private practice, such as osteodensitometry). However, public hospitals are not entitled to perform certain activities such as cosmetic surgery.

Procedures, drugs and medical devices are included in the positive lists on the basis of their clinical effectiveness. The effectiveness of drugs (and medical devices since 2000) is assessed by the Commission on Transparency, which advises the Economic Committee for Medical Products. Procedures performed by doctors and other professionals are evaluated by the National Agency for Accreditation and Evaluation of Health Care (ANAES) created in 1997. Recently, an exhaustive review of 8000 drugs found 835 to have an insufficient level of effectiveness; these drugs are currently in the process of being removed from the list of reimbursable drugs. A similar review is under way for medical procedures.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

Earmarked taxes include:

- the 'general social contribution' (CSG): since 1998 this tax based on total income has replaced most of the employee component of social health insurance contributions; the CSG rate is 5.25% (3.95% on pensions, unemployment benefits and sickness benefits); the CSG financed 6.2% of health care in 1997 and 30.1% in 1998; it now accounts for a third of the health insurance funds' revenue
- taxes paid by pharmaceutical firms (based on sales and promotional expenditure)
- specific taxes on tobacco, alcohol (and cars until 2001); these taxes are allocated to the main health insurance fund (the general scheme covering 84% of the population) and accounts for 3.4% of its revenue

The CSG is proportional to income, but the lower rate applied to benefits makes it progressive.

3.2 Social health insurance contributions

Social health insurance contributions are regressive for self-employed people and farmers, but proportional for salaried workers (although they could be considered to be regressive because they only apply to earned income, which accounts for a larger proportion of total income among the poor than among the rich).

Social health insurance contributions rates are set by parliament through the annual Financing of Social Security Act.

Non-contributing people are funded from the global pool of social health insurance revenues.

Table 3.2 Social health insurance contributions in France

Salaried workers in industry and commerce	Total contribution 13.55% of gross earning (no ceiling)	Employer's contribution 12.80% (no ceiling)	Employee's contribution 0.75% (no ceiling)
Self-employed people	6.50% of net earnings up to an annual ceiling of EUR 28 000 5.90% of net earnings between EUR 28 000 and EUR 141 000 the minimum contribution is 6.50% of EUR 11 000		
Farmers	8.13% up to an income ceiling of EUR 164 000		

Source: Official rules found at http://vosdroits.service-public.fr/ARBO/17011201-NXSAN115.html

3.3 Voluntary health insurance premiums

There is no general rule for calculating premiums. Rates depend on the type of insurer (commercial insurers, non-profit mutual associations or non-profit provident institutions)[3] and the type of policy (that is, group or individual). Salaried workers purchase VHI through their employers (55% of policies, of which half are compulsory and half are voluntary) or they may be purchased on an individual basis.

[3] The mutual benefit movement was a precursor (on a voluntary basis) to the health insurance system. It developed rapidly during the nineteenth century and is still an important force in French political life.

Premiums for individual policies sold by commercial insurers usually vary according to age and (sometimes) self-reported health status. Mutual associations usually community-rate premiums. Until recently, provident institutions have mostly sold group policies.

Premiums for group policies are negotiated and based on some form of experience rating; they are highly customised by commercial insurers and provident institutions, and more standardised for mutual associations' policies.

Data on premiums are not publicly available. A proxy of the average premium can be calculated on the basis of national health accounts: the average annual per capita amount reimbursed by VHI is estimated at EUR 290; administrative costs and profits should be added to estimate the average premium, but data are only available for mutual associations' administrative costs (20% of the amount reimbursed).

On the whole, group policies are cheaper than individual policies.

There is no tax relief for VHI premiums, although there is an indirect state subsidy to mutual associations as their rate of insurance premium tax is lower than the rate applied to commercial insurers.

The CMU gives those on low incomes access to free complementary VHI coverage.

3.4 User charges

There are several types of user charges that are not eligible for reimbursement by the public health insurance system:

- co-payments for ambulatory care and drugs: 30% (of EUR 18.50) for a GP visit, 30% (of EUR 22.87) for a visit to a specialist (although these amounts are often paid by complementary VHI), usually 35% for drugs (0% for some drugs and 65% for drugs considered of debatable therapeutic value – but these categories only account for a small proportion of the total) and 40% for laboratory tests – with exemptions for patients with serious illnesses (31 illnesses including diabetes, cancer, schizophrenia, severe hypertension etc)
- co-payments for non-maternity-related hospital care: 20% of hospital costs for the first 31 days in hospital up to a ceiling of EUR 200
- per diem charge for accommodation in hospital: EUR 10.67
- extra billing for private practitioners in 'Sector 2' (38% of specialists and 15% of general practitioners)
- the difference between actual prices charged and official reimbursement tariffs, particularly for dental prostheses and spectacles
- services in hospitals aimed at improving patients' comfort (such as single rooms)
- medical goods and services that are not on the positive reimbursement lists (such as some blood tests, osteodensitometry etc) or that are purchased or used without prescription

In summary, there are two categories of co-payments:

- statutory co-payments resulting from a deliberate decision to leave some part of the cost of care to be paid directly by the patient
- other co-payments that have emerged as a result of more implicit policy measures (such as a decision not to add a new procedure to the positive reimbursement list or to let the gap grow between the official reimbursement tariff and the actual charged price)

Private agents (households and complementary voluntary health insurers) finance about a quarter of total expenditure on medical goods and services, but the level of co-payment varies according to the type of care provided (from 10% for hospital costs to 65% for dental care).

Average household expenditure on health care was EUR 253 per capita per year in 2000, of which average expenditure on co-payments for doctor visits was EUR 10.

All co-payments are eligible for reimbursement by complementary VHI policies. The level of reimbursement varies according to the policy.

There is no annual out-of-pocket limit or tax relief on out-of-pocket payments. However, there are two mechanisms that can be used to avoid heavy charges:

- co-payment exemptions (the *ticket modérateur*) for people with serious illnesses and hospital procedures costing over EUR 200
- free complementary VHI coverage for those with low incomes (CMU)

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

Taxes

Taxes used to fund health care are collected nationally. There is no funding of health care by local taxes (but local authorities finance non-medical services for elderly people and the disabled). Tax rates are set by parliament in the annual Financing of Social Security Act.

Taxes are earmarked (see Section 3.1).

Social health insurance contributions

The three main health insurance schemes cover 96% of the population:

- the general scheme covers salaried employees in commerce and industry and their families (84% of the population) and CMU beneficiaries
- the agricultural scheme covers agricultural farmers and employees (7%)
- the scheme for non-agricultural self-employed people (5%)
- small schemes for certain categories (for example, miners, seamen)

The population has no choice of insurer. All residents are automatically affiliated to a health insurance scheme on the basis of their professional status and place of residence.

Contributions are collected separately for each main scheme:

- the self-employed scheme and the agricultural scheme collect contributions and reimburse their enrolees through their own network of local offices
- contributions to the general scheme are collected by a specific organisation with its own regional offices (Agence centrale des organismes de sécurité sociale; ACOSS)

There are two systems of pooling risks:

- a system of bilateral risk-pooling between the general scheme and small schemes compensates for differences in the demographic structure and incomes of their enrolees; theoretical revenues and expenses are calculated for each small fund, as though their level of contributions and level of benefits were the same as those of the general scheme; if this shows a loss there is a transfer from the general scheme to the small schemes and vice versa

Table 3.3 Market share of the three types of insurer offering complementary VHI in France (CMU excluded)

	% of insured	% of total expenditure	Number of insurers
Mutual associations	61%	7.5	*1300
Commercial insurers	22%	2.8	**51
Provident institutions	17%	2.1	75

Source: Household Survey Santé et Protection Sociale, CREDES 2001 and National Health Accounts

* Some large mutuals and many small local associations

** 51 commercial insurers are equal to 95% of the commercial insurers' market share

- a global risk pooling between the three main schemes compensates for demographic differences in the populations enrolled; the general scheme and the self-employed scheme pay for the agricultural scheme, whose population is much older

Complementary VHI coverage is provided by commercial insurers and non-profit mutual associations and provident institutions (Table 3.3). Some mutual associations own their own health care facilities (optical or dental centres, ambulatory care centres and in some areas, even small hospitals) but the insured have no obligation to use these networks.

4.2 Organisation of purchasing/contracting

Purchasing responsibility is shared by the health insurance schemes and the state; payers and purchasers are integrated.

As a general rule, for outpatient care patients have to pay for services first and then obtain partial reimbursement (see Section 3.4), but there are increasingly frequent exceptions to this rule:

- two thirds of drugs are paid directly to pharmacists by the health insurance schemes
- CMU beneficiaries do not have to pay up front for treatment
- inpatient and outpatient hospital care is paid for directly by the health insurance schemes

These days it is common for the bill sent to the health insurance scheme for reimbursement to be directly transferred to the complementary voluntary health insurer of the patient, who only has to fill in one claim form. On average patients have to wait 12 days to be reimbursed (7 days if they have a 'smart card').

Payment of providers

Ambulatory care

Ambulatory care is mainly provided by professionals practising privately, who are paid on a fee-for-service basis, according to fee schedules set by the Ministry of Health on the basis of proposals by the Permanent Committee on Official Schedules of Professional Procedures. Private practitioners in 'Sector 2' (38% of specialists and 15% of general practitioners) are allowed to charge more than the official tariffs.

An element of capitation has been introduced for GPs who agree to be 'referring GPs' (that is, a kind of gate-keeper), but this affects only 10% of GPs and 1% of patients.

Pharmacists are paid according to a mixed system combining fixed sum components and a sliding scale margin. Since 1999 they have had a financial incentive to provide generic drugs.

Public (and most private non-profit) hospitals

Public (and most private non-profit) hospitals receive a prospective global budget defined by the regional hospital agency[4] on the basis of:

- historical budgets
- relative cost per DRG
- regional strategic plan objectives

Staff (including doctors) working in public hospitals are salaried. Some hospital doctors are allowed to treat private patients in the hospital. This private activity is limited to two half days of consultations or two to four beds to hospitalise patients, or a combination of visits and hospitalisation. The fees are defined by the doctor, who gives back a percentage to the hospital (for example, 15% for a visit to a non-university hospital; 60% for x-rays).

Private for-profit hospitals

Private for-profit hospitals have an itemised billing system (separate from the fees paid to doctors working in these facilities) with:

- a per diem rate for accommodation and care by staff employed by the hospital (other than doctors)
- a per diem rate for drugs
- a separate payment for the use of operating rooms, prostheses etc

Prices vary between private hospitals and between regions. Staff other than doctors are salaried, but doctors are paid on a fee-for-service basis.

Contracting

Professionals in private practice

For professionals in private practice a collective negotiation is conducted nationally by the three health insurance schemes funds with all the unions of a given profession, and the agreement concluded applies automatically to all individual professionals. There is no latitude for negotiation at the regional or local level, except for marginal experiments of networks of providers.

Public and private hospitals

A process of contracting between individual hospitals and the regional hospital agency started a few years ago. The contract defines the commitments of the hospital (concerning the development of defined activities, quality of care, economic efficiency etc) and the way they will be funded by the regional hospital agency.

5 HOW MUCH IS SPENT AND ON WHAT?

5.1 Expenditure

In 2000 total expenditure on health care in France was estimated at EUR 140.6 billion or 10% of Gross Domestic Product (GDP). Health care consumption (Table 3.5) accounted for EUR 122.2 billion or 86.9% of total health care expenditure (EUR 2017 per capita on average).

[4] The regional hospital agencies (ARHs) were created by the 1996 reform (the Juppé Plan). These are joint ventures between the services of the State and those of the health insurance schemes, operating at the regional level, but with a pre-eminence of State influence (the directors of the agencies are appointed by the Council of Ministers and are directly responsible to the Minister of Health). The regional hospital agencies now have both planning and financial allocation responsibilities for the hospital sector, both public and private.

Public expenditure accounts for 7.7 % of GDP and private expenditure for 2.3%. Since 1996, a maximum rate of increase in the health insurance schemes' expenditure has been defined (prospectively) every year. This target (the *Objectif national des dépenses d'assurance maladie*; ONDAM) is then split into four sub-budgets (public hospitals, private for-profit hospitals, ambulatory care and institutions/services for the elderly and the disabled). ONDAM is a target rather than a cash-limited budget. Actual expenditure may be higher than the targets set and over-spending has taken place every year except the first that the ONDAM was set (1997).

Table 3.4 Main sources of health care funding in France, in million EUR and as a percentage of total, 2000

	National current expenditure		Health care consumption	
	Amount (million EUR)	% of total	Amount (million EUR)	% of total
Health insurance schemes	10 2428	72.8%	92 290	75.5%
State and local authorities	6 110	4.3%	1 285	1.1%
Private	32 083	22.8%	28 623	23.4%
- Mutual associations	*11 004*	*7.8%*	*9 110*	*7.5%*
- Provident institutions	*2 569*	*1.8%*	*2 569*	*2.1%*
- Commercial insurers	*3 372*	*2.4%*	*3 372*	*2.8%*
- Households	*13 610*	*9.7%*	*13 571*	*11.1%*
- Other private	*1 528*	*1.1%*	*0*	*0%*
Total	140 628	100%	122 197	100%

Source: DREES. National Health Accounts. Paris: DREES; 2001.

Table 3.5 Health care expenditure by type of service in France, million EUR and as a percentage of total, 2000

	Million EUR	% of total
Hospital care	56 821	40.4%
Ambulatory care	31 861	22.7%
- of which doctors	*15 324*	*10.9%*
- of which nurses, physiotherapists etc	*6 465*	*4.6%*
- of which dentists	*6 430*	*4.6%*
- of which medical laboratories	*2 789*	*2.0%*
- of which spas	*853*	*0.6%*
Transport	1 873	1.3%
Medical goods	31 642	22.5%
- of which drugs	*25 070*	*17.8%*
Total health care consumption	**122 197**	**86.8%**
Sickness benefits	8 109	5.8%
Subsidies to the health care system	1 507	1.1%
Preventive care	3 355	2.4%
Research and training	3 042	2.2%
Administration costs	2 418	1.7%
Total national current expenditure	**140 628**	**100%**

Source: DREES. National Health Accounts. Paris: DREES; 2001.

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

Patients have free choice of provider. Patients can visit any GP or specialist practising privately or working in hospital outpatient departments, without referral or any limit on the number of consultations. Patients can be hospitalised in the public or private hospital of their choice. In practice there are some limits to this legally-defined principle due to financial barriers (co-payments) or problems with geographical accessibility in rural or suburban areas.

Patients can be given prior authorisation for treatment abroad if the treatment is considered to be medically justified and not available in France. This does not apply to emergency care.

Patients do not have a single medical record (except in experiments with local networks). Currently, patient smart cards contain administrative information (health insurance fund affiliation and co-payment exemption status etc). Plans for smart cards to hold a patient's medical record for use in case of emergency are being formulated but implementation may be delayed due to concerns about privacy and confidentiality.

6.2 Ambulatory care

Most outpatient care is delivered by doctors, dentists and medical auxiliaries working in their own practices. Most of them work alone. Only 38% of doctors are involved in group practices.

Outpatient care is also provided, to a lesser extent, in hospitals and, marginally, in health centres (run by local authorities or mutual associations).

The number of annual per capita contacts with doctors in private practice is 4.7 to 4.9 for GPs and 3 to 3.5 for specialists (estimated figure). The number of contacts with doctors in hospital outpatient departments (GP and specialists) is 15% of the total. The total number of per capita contacts is 7.6 - 11.5 per year.

One per cent of patients has agreed to sign up with a 'referring GP', a gate-keeping mechanism introduced in 1987. Patients are referred by their 'referring GP' to a specialist (but this referral system is not an enforced obligation). However, the incentive for patients is that they do not have to pay for consultations up front.

In 2000 there were a total of 194 000 doctors in France; 51% are specialists and 49% are general practitioners, as defined in Table 3.6.

The number of doctors providing ambulatory care is estimated at 110 000 (186 per 100 000 inhabitants), of which 60% are GPs (50% are GPs without a specialised practice) and 40% specialists (50% if we include GPs with a specialised practice). There are 114 GPs per 100 000 inhabitants. 62 000 nurses work in the ambulatory sector.

To provide out-of-hours services, all GPs in a given geographical area are on a duty roster (this is increasingly difficult in rural areas). There are also specialised call centres, but people increasingly turn to hospital emergency departments.

It is usually possible to obtain an appointment with a primary care doctor on the same day. In consumer surveys people generally express a high level of satisfaction with their GP.

6.3 Secondary care

Patients have free choice and access. Waiting times for an appointment are highly variable (see examples below).

Table 3.6 Health care personnel France, 2000

	Total		Private practice	
	Numbers	per 100 000 population	Numbers	per 100 000 population
Doctors	194 000	330	117 041	199
*-of which GPs**	*95 000*	*161*	*67 072*	*114*
-of which specialists	*99 000*	*169*	*49 969*	*85*
Midwives	14 000	24	1 938	3
Dentists	40 500	69	37 834	64
Pharmacists	58 000	99	52 603	90
Speech therapists	13 000	23	10 675	18
Nurses	383 000	652	57 023	97
Physiotherapists	52 000	89	40 327	69
Orthoptists (eye disease)	2 100	4	1 686	3
Chiropodists	8 800	15	0	0

* Here GPs are defined as doctors without a specialist diploma, but some of they may have specific training in areas such as sports medicine, angeiology, homeopathy, emergency care etc; this is the case for 22 000 doctors, which leaves 72 000 doctors who actually practise as general practitioners.

Source: Audric et al., 2001 and Darriné and Niel, 2001

Hospital beds

- 4.2 acute beds per 1000 people (of which 29% are in private for-profit hospitals)
- considerable discrepancies between *départements* from 2.5 beds to 6, excluding Paris (9.8)
- recent policies have encouraged the merging of hospitals and the closure of beds

Staff

- 140 000 doctors (54 000 employed full-time)
- 234 000 full-time-equivalent nurse (that is, 397 FTE nurses per 100 000 population); the shortage in nursing personnel is a major problem for hospitals, which has been exacerbated by the implementation of the 35-hour week law[5]

Activity

- 20.4 admissions per 100 people in acute care services (1999)
- the average length of stay is 5.5 days
- the occupancy rate is 80.9%

In consumer surveys people generally express a high level of satisfaction with secondary care. Doctors and hospitals complain about the lack of specialised equipment.

6.4 Diagnostic services

Outpatient diagnostic and laboratory services are provided by specialists in private practice and hospital outpatient departments. There are 4000 private medical laboratories and 5000 private radiologists. There are 9.8 CT scanners and 2.6 MRI scanners per million population.

[5] This law passed in 1999 by the socialist government reduces the legal working week from 39 hours to 35 hours.

6.5 Pharmaceutical care

Pharmacies have a monopoly on the dispensing of medicines (even for OTC drugs). Pharmacists cannot own more than one pharmacy. In 2000 there were approximately 22 700 retail pharmacies in France. The establishment of pharmacies is theoretically regulated by a quota that takes into account both the size of the population to be served and the distance involved in getting to the nearest pharmacy. Each hospital has its own pharmacy.

6.6 Rehabilitation/intermediate care

Rehabilitation and intermediate care is provided by public and private hospitals. Private for-profit hospitals account for about a quarter of capacity and bed days in this field. The average number of beds is 1.5 per 1000 people.

Long-term care is also provided by hospitals (public hospitals account for more than 90% of long-term care beds) and in 1999 there were 1.4 beds per 1000 people.

Psychiatric care is mainly provided by the public sector.

6.7 Social care

Residential care and home services for dependent elderly people and disabled adults falls under the responsibility of local authorities at the *département* level. They are financed by individuals themselves, with social benefits for disabled adults, allowances for dependant elderly people and social assistance for the poor and elderly. However, health care for people in residential care (care provided by health professionals, doctor visits, nursing care, drugs, medical devices etc.) is financed by the health insurance system, usually on a per diem basis.[6] The health insurance system also covers all costs of residential care and treatment in specialised institutions for disabled children.

Social care is mainly provided by private non-profit organisations. In 2000 social care capacity was as follows:

- 8.6 beds and places per 1000 people aged 0-19 years for residential care and home services for disabled children
- 1.7 beds per 1000 adults in residential care for 'heavily' disabled adults and 3.36 places in work centres for disabled people able to work
- 129.7 beds (of which 54.2 are 'medical beds') per 1000 senior citizens (75 and over) for residential care and 14.2 places for home services

7 THE PATIENT JOURNEY

'A', a seven year old girl living in Paris, suffers from chronic otitis. Her mother decides to take medical advice. She could choose to visit a specialist first but she goes to her preferred GP (who treats all members of the family). She obtains an appointment very quickly and the GP examines the young girl and advises her to consult an ear, nose and throat specialist. She refers the patient to one of her colleagues, Dr P. As usual, A's mother pays for the consultation (EUR 18.50) and then sends a claim to her health insurance scheme to be reimbursed up to 70%. The remainder will be reimbursed by complementary VHI.

Dr P's office is located in the private for-profit hospital in which he hospitalises his patients needing surgery. A's mother obtains an appointment within the week. Dr P prescribes antibiotics to treat an acute episode of otitis, gives some advice (to avoid swimming pools etc) and indicates that a tympanum transplant will have to be performed once the chronic infection

[6] Two recent laws concerning the funding of nursing homes and allowances for dependant elderly people aim to clarify existing rules for funding health and personal care separately.

is eliminated (a specialised procedure that he does not perform himself). As he is a 'Sector 2' doctor, he bills EUR 46 (instead of EUR 22.87) for the consultation. A's mother pays the entire amount. Because he has a computer and a professional smart card, Dr P sends an electronic claim to the health insurance scheme, who transmits it to the complementary voluntary health insurer. Due to the high quality of this complementary VHI (obtained by the mother's employer), all expenses are subsequently reimbursed. The prescribed medicines are bought in a pharmacy and A's mother pays the full price, which is later reimbursed (alternatively, she could paid the co-payment).

A second appointment is made to carry out an audiogram. Then, to try to get rid of the chronic infection, Dr P carries out an adenoïdectomy in the private hospital (same day surgery). An electronic claim is directly transmitted to the public and complementary health insurers by the hospitals, so that A's parents do not know the amount of the bill.

A keeps on suffering from chronic infection with regular acute episodes and visits Dr P periodically over two years. Seeking additional advice, A's parents hear about a famous professor in a Paris university hospital. Due to his reputation and experience, Professor G, who is employed by the hospital, is able to also receive private patients. A's mother chooses this option in order to obtain an appointment more quickly (two months). The consultation is billed at EUR 92 (instead of EUR 46) and this time, a small co-payment remains to be paid by A's mother.

After a second visit Professor G decides to operate on A. The procedure is originally planned for 19 January (two months after the second visit), but a few days before, the operation is cancelled by the hospital because its nurses are on strike to negotiate better working conditions and higher wages. The procedure finally takes place on 3 March. A stays in the hospital for four days, sharing a room with another girl. On leaving hospital, A's mother pays for telephone use and for her own meals; (the per diem rate of EUR 10.67 not covered by public insurance is covered by her complementary VHI policy).

8 WHAT ARE THE MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM?

Health care supply

The dissatisfaction of doctors and other professionals and the increasing difficulty of concluding agreements with health care professionals

Relations with doctors have deteriorated since 1996, when a major reform that put a ceiling on doctors' fees was passed. Since then the main doctors' union has never signed an agreement with the health insurance schemes, and currently there is no agreement, either for GPs or for specialists. At the present time, GPs are on strike over out-of-hours care; they are pushing for a large increase in their fees and in some *départements* they have increased their tariffs without authorisation.

The demography of the medical profession and other health professionals

The number of doctors will decline as a result of past decisions to impose quotas in medical schools. Many fear a shortage of doctors, and this fear also raises the question of geographical distribution - it is already difficult to find doctors to practise in some rural or suburban areas. Doctors' (geographical) freedom of choice in setting up their practice and the optimal skill mix required are among the issues debated.

Evolving needs and demands

Patients' rights and the use of 'patients' voice' in the system

A bill on patients' rights and the quality of the health care system is currently being debated in parliament. The bill contains measures to increase and enforce patients' rights and more generally to enhance the ability for health care consumers to use have their views heard within

the system, in order to improve responsiveness and accountability. This represents a major challenge for the health care system.

The ageing of the population and its impact on health care needs and costs is also a subject of concern.

Regulation and cost containment

The general management of the health care system

The 1996 reform has changed the institutional equilibrium of the health care system in France, shifting power from the health insurance schemes to the state (government and parliament) and from the national to the regional level. The current 'mixed organisation' is the source of much debate, and faces a crisis with the departure of the main employer union from the health insurance schemes' boards in September 2001[7]. Should the process of regionalisation be pursued, and if so with which institutions?

Costs and sustainability of public finances

This issue undoubtedly will remain a major problem in the future given trends in demand and the availability of new technologies. This has led to debate on what should be publicly financed.

The emphasis on public health issues

Public health approaches are developing as the result of evidence that the performance of the French health care system is mixed, with very good results in some areas but some weaknesses as far as premature deaths and avoidable deaths are concerned. There are increasingly greater numbers of health programmes organised at the national and regional levels. There is also a growing demand for safety in the health care field, with no less than three agencies created to cope with questions of safety (for drugs, food and the environment).

[7] This union now advocates competition between health insurance schemes and private health insurers to manage the health care system.

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DREES (data on line)	http://www.sante.gouv.fr/drees/statiss
INSEE	http://www.insee.fr

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1 INTRODUCTION

The German political system is characterised by federalism (sharing of power between *Länder* and the federal government) and corporatism. The responsibilities for health reflect this. They are shared between the federal government, the *Länder* and corporatist bodies (representative bodies of the professionals, providers and the insurers). The health care system is predominantly funded through social health insurance contributions. Ambulatory care and hospital care have traditionally been distinct domains with almost no outpatient care delivered in hospitals. Ambulatory care is delivered by private office-based physicians (generalist and specialists) who are paid fee-for-service. Hospital inpatient care is provided by a mix of public and private providers (only a small proportion of total beds are in for-profit hospitals).

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

88% of the population are covered by statutory health insurance (SHI); 74% are mandatory members and their dependants while 14% are voluntary members and their dependants. 9% of the population are covered by private health insurance, 2% by free governmental health care (i.e. police officers, soldiers and those doing the civil alternative to military service, and people on social welfare) while less than 0.2% are not insured.

In principle, the Social Code Book (SGB) requires that all people in gainful employment – as well as other defined groups such as unemployed, pensioners, farmers, students, artists, the disabled – must be insured against sickness under the SHI scheme. However, employees whose income reaches a certain level (which is adjusted annually in accordance with movements in average earnings by the Federal Labour Ministry: EUR 3375 monthly income in 2002), permanent civil servants ("*Beamte*" and judges) and soldiers, as well as a few others (e.g. those covered by the EU) are explicitly exempted from this requirement. Non working spouses and children of SHI members are covered without any surcharge.

Those with incomes in excess of the ceiling may chose whether or not to remain within the SHI scheme. As a result, there are 7.4 million (1999) with comprehensive private health insurance.

Everybody else is eligible to purchase complementary/ supplementary VHI products. But, "[n]ot even the member companies can accurately determine the number of people with private supplementary insurance, as they also count those insured who hold private comprehensive medical insurance with a different company or as part of a group insurance scheme. Consequently, many of the insured are counted twice. In total, the member companies counted 13 775 million people on 31.12.1999" (PKV 2001). Based on micro-census data, the number of people with supplementary insurance is around 7.5 million (9% of the population; excluding VHI during travel). It increased from 5.3% in 1991 to 7.0% in 1997 and 7.6% in 1998. This figure has risen considerably from 1996 due to the introduction of new insurance products to cover crowns and dentures, which were excluded from the benefits package of people born after 1978.

Around 4.4 million VHI policies (equivalent to 6% of people with SHI) are issued for optional hospital benefits ("supplementary" VHI). About the same number of supplementary outpatient insurance policies ("complementary" VHI) are issued. The number of complementary VHI policies peaked in 1997/98 when dental care was restricted/ excluded from the benefits package. The number of complementarily insured children dropped from 2.2 million to 1.4 million between 1998 and 1999 after the reintroduction of the benefits.

2.2 Benefits

Benefits to be covered by SHI are defined, usually in generic terms, in Chapter 3 of the Social Code Book V (SGB V). The following benefits are currently legally included: prevention of disease, screening for disease, treatment of disease (ambulatory medical care, dental care, drugs, non-physician care, medical devices, inpatient/hospital care, nursing care at home, and certain areas of rehabilitative care), and transportation. In addition to these benefits in kind, sickness funds have to give cash benefits to members who are unable to work due to illness after the first six weeks (for which employers are responsible). While employers have to pay 100% of income, sickness funds pay 80% for up to 78 weeks per period of illness.

The Social Code Book regulates preventive services and screening in considerable detail (e.g. concerning diseases to be screened for and intervals between screening), leaving residual regulations to the Federal Committee of Physicians and Sickness Funds. This committee has considerable latitude in defining the benefits catalogue for curative, diagnostic and therapeutic procedures. The range of procedures that are covered is wide, ranging from basic physical examinations in the doctor's surgery to home visits, antenatal care, care for terminally ill patients, surgical procedures and laboratory tests to imaging procedures including MRI. Benefits for ambulatory care are legally defined in generic terms only. However, dental care, especially prosthetic benefits, are described in more detail in the Social Code Book V. This is partly due to the dysfunction of the Federal Committee of Dentists and Sickness Funds which would otherwise be responsible for the definition of benefits in this area.

The non-physician care sector comprises the personal medical services of professionals other than physicians, such as physiotherapists, speech therapists, and occupational therapists. These services are covered under SHI unless explicitly excluded by the Federal Ministry of Health (currently none are). However, non-physician services may only be delivered to the insured if they are approved by the Federal Committee of Physicians and Sickness Funds as being effective and of sufficient quality.

The range of services provided in the hospital sector is determined through two factors: the hospital plan of the state government, and the negotiations between the sickness funds and each individual hospital (a result of the fact that the hospitals do not have a collective corporatist body). A Hospital Committee with similar competencies as the Federal Committee in ambulatory care has just been set up, i.e. a higher degree of benefit standardisation may be expected in the future.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

At 8.4% of total expenditure on health, taxes play only a minor role in German health care (Table 4.1) and therefore are not discussed in detail.

3.2 Social health insurance contributions

SHI contributions account for the majority of health care funding in Germany. Contributions are levied as a proportion of income and are not risk-rated. Contributions are based on income only (i.e. not on savings or wealth). Income above the income ceiling of EUR 3375 (2002) is not liable to contributions (this is the same threshold which determines the right to opt out or become a voluntary member). Contributions are shared equally between the employee and the employer. Funds are free to set their own contribution rates. Their decision is, however, subject to approval (in the case of regionally operating funds, through the respective state government, and in the case of countrywide funds, through the Federal Insurance Office).

The average contribution rate in 2002 was 14% (of which the insured person would pay 7% out of their pre-tax income below the threshold and the employer would pay the same amount in addition to wages). For people with earnings below a threshold of EUR 325, only employers have to pay contributions (at a rate of 10% for all funds). In the case of retired and unemployed people, the retirement and unemployment funds respectively take over the financing role of the employer. Only the farmers' funds receive a tax-subsidy to compensate for the gap between old-age farmers' contributions and actual expenditure.

3.3 Voluntary health insurance premia

Premiums vary with age, sex and medical history at the time of underwriting. Unlike in SHI, separate premiums have to be paid for spouses and children – making private health insurance more attractive to single people or double-income couples. Policies and premiums vary greatly – even within substitutive VHI.

As the substitutive insurance segment has DEM 25bn (approx. EUR 13 billion) in premiums and 7.4 million insured (1999), an average premium can be estimated at DEM 3500 (EUR 1790) annually or DEM 300 (EUR 153) monthly. This figure should be treated with caution as it includes civil servants, children etc. who pay reduced premiums. Compared to the average maximum contribution to SHI in 1999, which was DEM 10 000 (EUR 5113), it does, indicate that VHI is worthwhile for single people. Group insurance is not significant in the German VHI market. Health insurance premiums are deductible from taxable income in the same way as expenditure for other types of insurance, whether statutory or private, and within certain specified limits. They do not constitute a real incentive to purchase VHI products, either because the limits are quite low for the average person with substitutive VHI (as the limit for tax-deductible expenses *decreases* with rising income) or people interested in purchasing complementary/ supplemental products will have already exceeded the limit through their statutory contributions.

In principle, the State is no longer obliged to approve insurance conditions and tariffs under the Third Non-Life Directive. However, the general policy conditions for substitutive health insurance must be submitted to the Federal Supervisory Office for the Insurance Sector (under the authority of the Federal Finance Ministry) before they are first implemented and every time there is an amendment. The supervisory authority checks that the conditions comply with the minimum standard laid down in the Law on the Supervision of Insurance Undertakings and other regulations. The obligation to submit insurance conditions applies equally to insurance undertakings registered in Germany and foreign undertakings.

Insurance undertakings registered in Germany must also submit their premium calculations to the Federal Supervisory Office for the Insurance Sector which checks that the calculation complies with the legal provisions on calculations designed to ensure that the interests of the insured are protected and that obligations arising under contracts taken out for life can be fulfilled. In addition, any modifications in policy conditions and premiums must be agreed by an independent trustee.

One of the most strictly regulated areas concerns the financial reserves for elderly VHI clients. The problem was that those insured under VHI (compared to SHI) faced considerable premium increases with age. Therefore, part of the current premia are now used to build up financial reserves which are used to maintain premia equilibrium over a person's life-time. Since 2000, a surcharge of 10% has been added to substitutive health insurance premia. This is used to subsidise premium increases after the insured person turns 65.

3.4 User charges

Cost-sharing has existed in the pharmaceutical sector for some time. In 2002, the rate of co-payment per pack of drugs (i.e. not per prescription) varies between EUR 4 and EUR 5, depending on pack size. In addition, patients are required to pay the difference between the actual price and the reference price. Mostly pharmaceutical companies, however, set prices at the reference price. The following user charges apply to other benefits:

- the first 14 days in hospital or rehabilitation care per calendar year (EUR 9/ day)
- ambulance transportation (EUR 13/ trip)
- non-physician care (15%)
- crown and dentures treatment (35-50% depending on the frequency of dental check-ups).

Ambulatory care and preventive dental care do not require any co-payments.

Patient cost-sharing is limited by a range of measures:

- People with very low incomes (monthly EUR 938 for singles, EUR 1289.50 for two people and EUR 234.50 for each additional person), and those on unemployment benefits or on social welfare are exempt from most cost-sharing requirements – with the notable exception of co-payments for hospital treatment.
- People up to the age of 18 years are exempt from cost-sharing except for co-insurance payments for crowns/dentures and co-payments for transportation.
- An annual out of pocket limit, equal to 2% of gross income for single people, applies to all other sickness fund members for pharmaceuticals, non-physician care and transportation (but not for hospitals and rehabilitation). If two or more people are dependant on this income the threshold is lowered by EUR 4221 for one person and EUR 2814 for each additional person per year. Co-insurance payments for crowns/-dentures are also lower for these people.
- Chronically ill patients who have paid at least 1% of their gross income for pharmaceuticals, non-physician care and transportation are exempted from these payments for the duration of that illness. This exemption only applies to the individual.

In a few exceptional cases, where out-of-pocket expenditure is very high, health care expenditures can be deducted from taxable income. No insurers offer policies aimed at covering cost-sharing expenses (though such policies probably would not be illegal).

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

(Due to its low share of total expenditure, taxes are not discussed here.)

The contributions from both employers and employees are directly collected by the funds. In most cases the employer directly transfers both parts (i.e. the employees' contribution is automatically deducted from their payslip).

In 2000, the SHI system consisted of 420 statutory sickness funds, legally differentiated into seven different groups: 17 general regional funds (*Allgemeine Ortskrankenkassen*, AOK); 12 substitute funds (*Ersatzkassen*) which are further subdivided into seven "white-collar" (EAN) and five "blue-collar" (EAR) funds; 337 company-based funds (*Betriebskrankenkassen*, BKK); 32 guild funds (*Innungskrankenkassen*, IKK), 20 farmers' funds (*Landwirtschaftliche*

Krankenkassen, LKK); 1 miners' fund (*Bundesknappschaft*); and 1 sailors' fund (*See-Krankenkasse*).

Traditionally, the majority of insured people had no choice over their sickness fund and were assigned to the appropriate fund based on geographical and/or job characteristics. This mandatory distribution of fund members led to greatly varying contribution rates due to different income and risk profiles. Only voluntary white collar members – and since 1989 voluntary blue-collar members – had the right to choose among several funds and to cancel their membership with two months' notice. Other white-collar workers (and certain blue collar workers) were able to choose when becoming a member or when changing jobs. Since this group grew substantially over the decades, around 50% of the population had at least a partial choice in the early 1990s.

The Health Care Structure Act gave almost every insured person the right to choose a sickness fund freely (from 1996) and to change between funds on a yearly basis with three months' notice (from 30 September 1996 to 1 January 1997). All general regional funds and all substitute funds were legally opened up to everyone and have to contract with all applicants. The company-based funds and the guild funds may choose to remain closed but if they open up, they too have the obligation to contract with all applicants. Only the farmers' funds, the miners' fund and the sailors' fund still retain the system of assigned membership.

In order for all competing sickness funds to be operating on a level playing field, a compensation scheme operates to equalise differences in contributory income (due to differences in the average income of members) and expenditure (due to age and sex). The risk structure compensation scheme requires all sickness funds to transfer money in or out depending on the differences in their contributory incomes and in averaged expenditures.

Those who have exercised choice of fund are mainly young and healthy, thereby necessitating high transfer sums (8.1% of total expenditure in 1996 increasing to 9.6% in 2000). They have moved to funds with lower contribution rates, usually company-based funds with a service infrastructure relying on a hotline and a website. In 2001, several changes to the scheme were passed:

- the once-a-year date for changing fund was abolished in favour of a continuous right but there is an obligation to then remain in the new fund for at least 18 months;
- the introduction of a high risk pool across funds which would cover 60% of an individual's expenditure in excess of EUR 20 000
- the provision of extra compensation for those enrolled in disease management programmes
- a move to a morbidity-based compensation mechanism from 2007.

Germany has the largest VHI market in Europe. It is offered by 52 private health insurers which are united in the Association of Private Health Insurance Companies (in 1999); of these 46 offer substitutive insurance. 18 insurers each had more than 100 000 fully insured people and thus a total of 91.3% of the total insured. Three of these insure more than 500 000 each. Ten insurers had more than EUR 500 million in premium income and thus 72.8% of the total. Of the 52 major private insurers, 22 were mutual insurance societies while 25 had the legal form of a joint stock company. Both groups were about equal in size: 48.6% vs. 51.4% in terms of premium income and 52.8% vs. 47.2% in terms of fully insured people. (Eight of the stock companies with a market share of 3.6% [people] or 4.0% [premiums] are subsidiaries of mutual insurance societies.) All insurers are specialist health insurers; policies are not sold in conjunction with other insurance policies.

4.2 Organisation of purchasing/contracting

For SHI, sickness funds are the purchasers of health care. When negotiating contracts and conditions with providers, sickness funds have traditionally acted in groups or even jointly. Only recently, selective purchasing has become an issue (after the introduction of competition among the funds). As a general rule, sickness fund members receive all services as benefits in kind, i.e. the sickness funds are also the payers of care. People voluntarily insured under SHI may opt for cost-reimbursement.

Ambulatory care

The payment of office-based SHI-affiliated ambulatory physicians follows a two-step process. Firstly, the sickness funds allocate a global budget to the physicians' associations. This budget is usually negotiated as a capitation per member or per insured person. The capitation – which varies between substitute and other funds within a *Land* and between *Länder* – covers all services by all SHI-affiliated physicians of all specialties. Secondly, the physicians' associations then pay their members according to a Uniform Value Scale (EBM) and additional regulations. Each medical procedure is allocated a point value (hence the name "value scale") and lists certain preconditions for claiming reimbursement, e.g. particular indications for use or exclusions of other services during the same visit. A separate joint committee at the federal level, the Valuation Committee, sets the point value. At the end of each quarter, every office-based physician invoices his/her physicians' association for the total number of service points delivered. The total budget negotiated with the sickness funds is divided by the total number of delivered and reimbursable points for all services within a - regional physicians' association. The monetary value is then used to calculate the physicians' quarterly remuneration.

The reimbursement is subject to control mechanisms to prevent over-utilisation or false claims. Physicians may be subject to utilisation reviews at random or if their levels of service provision or hospital referrals per capita are higher than those of colleagues in the same specialty and under comparable circumstances. To escape financial penalties, the physician has to justify the higher rates of utilisation and referral.

Unlike SHI, privately insured people generally have to pay ambulatory providers directly and then are reimbursed by their insurer. While a price list for privately delivered medical services exists as an ordinance issued by the Federal Ministry for Health, physicians usually charge more – by a factor of 1.7 or 2.3 (which are the maximum levels for reimbursement by the government and by most private health insurers for technical and personal services respectively) or even more. The real fee-for-service reimbursement for privately insured people has led to cost increases which were on average 40% higher than for SHI-covered people over the 1989-1999 period – with costs doubling for dental care, pharmaceuticals and ambulatory care.

Hospital care

Hospitals receive their money from two main sources: investment costs through the *Länder* and running costs (including personnel costs) through the sickness funds (plus private patients). In order to be eligible for *investment costs*, hospitals have to be listed in the hospital plans which are set by the *Länder*.

A target budget is set for *running costs*. The budget is established during the negotiations between the sickness funds and the hospital. The target budget establishes service numbers (for cases to be reimbursed by case and procedure fees as well as for cases reimbursed by per diems) as well as the per diems. If the hospital meets its target, then no financial adjustment has to be made. If actual activity exceeds the target, then it has to pay back a certain part of the

extra income – 50% of case fees for transplantation, 75% of other case- and procedure-fees and 85–90% of per diems. If actual activity is lower than the target, then it receives 40% of the difference.

Hospitals are reimbursed through a combination of *prospective case-fees and procedure-fees* as well as *per-diems*. The Reform Act of SHI 2000 mandates the introduction of a new payment system for hospitals based on case-fees (DRGs) for all patients (except psychiatry). It will be introduced on a voluntary basis from 2003 and will be mandatory from 2004.

All hospital staff are salaried. The heads of medical departments usually have the right to charge private patients a fee-for-service on top of their salary; how much of that income they may keep depends on their contracts with the hospital.

5 HOW MUCH IS SPENT AND ON WHAT?

Since unification, health care expenditure has been around 11% of GDP according to national accounting figures and ca. 10.5% according to international figures (Table 4.1). The introduction of long-term care insurance in the mid-90s led to a decrease in tax funding and an increase in social insurance funding (Table 4.2). Due to the well-developed ambulatory care sector, expenditure on hospitals is relatively low in international comparison (Table 4.3).

Table 4.1 Trends in health care expenditure in Germany, 1992–1998

Total expenditure on health care	1992	1994	1996	1998
Value in current prices (billion DEM)	320.6	352.9	405.8	412.7
Value in current prices, per capita (DEM)	3980	4330	4960	5030
Share of GDP (%)*	10.4	10.6	11.3	10.9

Source: Federal Statistical Office 2001

Note: Data are based on new health accounting methods.

* OECD puts figure about 0.5% lower.

Table 4.2 Main sources of health care funding in Germany, as a percentage of total, 1992 and 1998

Source of finance	1992	1998
'Public'		
- Public budgets	13.1	8.4
- Statutory health insurance	60.3	56.1
- Statutory retirement insurance	2.4	1.6
- Statutory accident insurance	1.7	1.7
- Statutory long-term care insurance	-	7.0
'Private'		
- Out-of-pocket	9.0	11.0
- Private health insurance	7.2	7.7
- Employers	4.3	4.1
- Private organisations	2.1	2.4

Source: Federal Statistical Office 2001; Note: Data are based on new health accounting method.

Table 4.3 Health care expenditure by type of service and provider in Germany, as a percentage of total, 1992 and 1998

Expenditure by type of service	1992	1998
Prevention and health protection	4.5	4.2
Services by physicians	28.9	25.9
Services by nurses and other health professionals	18.5	21.4
Sickness-related consequences (= non-medical rehabilitation)	2.4	3.2
Accommodation and food	8.3	7.0
Goods (pharmaceuticals, devices etc.)	27.0	26.1
Transport	1.2	1.5
Administration	7.2	5.2
Education and Research	2.1	1.9
Expenditure by type of provider	**1992**	**1998**
Public health offices/ health protection institutions	2.5	2.4
Ambulatory sector	45.9	45.2
- Physicians' practices	*13.4*	*13.4*
- Dentists' practices	*8.7*	*6.1*
- Practices of other health professionals	*2.6*	*2.7*
- Pharmacies	*14.3*	*12.7*
- Health sector trade handicraft	*5.6*	*7.8*
- Institutions for ambulatory nursing care	*1.1*	*2.3*
In-patient sector	42.5	38.2
- Hospitals	*32.5*	*28.8*
- Preventive and rehabilitative institutions	*3.5*	*3.0*
- Nursing homes	*6.5*	*6.5*
Transportation providers	0.7	1.2
Administration	5.9	5.3
Others	2.5	3.7

Source: Federal Statistical Office 2001; Note: Data are based on new health accounting method.

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

The Social Code Book is the principle legislation setting out the rights of members of social protection schemes. Social courts, which exist at the local, regional, and federal level, are devoted entirely to issues of social insurance. They rule in cases of dispute between individuals and social insurance institutions or between social insurance institutions. Decisions taken by sickness funds, provider (associations), joint decision committees as well as governmental regulations may be challenged before the social courts.

The Social Code Book limits care to German territory, except under EC Regulation 1408/71, which enables migrant workers and their dependants to obtain health care in the country in which they are living for work purposes. Sickness funds are pushing for the option to contract providers across borders, enabling their members to access them directly.

While German SHI-insured people have a 'smart card' which, in principle, would allow the storage of medical information, it *de facto* contains only administrative data. Also, as there is not really one physician responsible for each patient, the issue of medical records is problematic – i.e. there is no single record and obtaining information on previous (and sometimes even current) therapies, operations, x-rays etc. is difficult. Hospitals usually report back to the referring physician who might not continue the treatment after discharge. The issue of storing additional information on the smart card was back on the agenda in 2001 following publicity about drug interactions.

6.2 Ambulatory care (= primary and secondary care)

All ambulatory care, including both primary care and outpatient secondary care, has been and is organised almost exclusively on the basis of office-based physicians (who have a legal monopoly for providing ambulatory care). The majority of physicians have a single practice – only around 30% share a practice. Their premises, equipment and personnel are financed by the physicians' associations. Ambulatory physicians offer almost all specialties with all technical equipment up to MRI scanners. Besides GPs, the most frequent specialties are internists (c. 16 per 100 000 population), gynaecologists (c. 9), paediatricians (c. 6), ophthalmologists (c. 5), orthopaedists, neurologists (both c. 4), ENT physicians, surgeons and dermatologists (each c. 3), urologists, and radiologists (both c. 2). All treat both SHI and private patients; in addition there is a very small minority (< 3%) who treat only private patients.

Germany has no gate-keeping system; instead patients are free to select a doctor of their choice. According to the Social Code Book, sickness fund members select a family practitioner which cannot be changed within 3 months (the usual period of reimbursement). Since there is no mechanism to control or reinforce this self-selected gate-keeping, patients frequently choose to access office-based specialists directly. Family practitioners (c. 47 per 100 000) consist of both GPs and physicians without specialisation. General internists and paediatricians may choose whether to be registered as either family practitioners or specialists (different reimbursement schemes apply). Despite efforts by the federal government to improve the status of family practice in the ambulatory care sector, the number of office-based specialists has increased more rapidly than the number of family practitioners over the past few decades. GPs, as a share of all office-based physicians, dropped to less than 40%. Waiting times are not reported; most physicians (except for the highly specialised ones) have divided their office hours into times for appointed patients and walk-in patients. The physicians associations are legally required to provide around-the-clock services. While in rural areas, every physician will take the calls of his/ her own patients, physicians usually rotate with out-of-hours services in small towns. In cities, the physicians' associations often provide an emergency service at a central location. In spite of these services, quite a number of patients do access hospitals directly. As hospitals are not really geared for such purposes this causes unnecessary costs.

6.3 Secondary care (= inpatient care):

"Secondary" care is inpatient care in Germany; Table 4.4 provides the main data on structures and processes in the 1990s. As can be seen, there has been a process of rapid convergence between the eastern and the western parts of Germany. In the east, the poor physical condition of many facilities enabled the closure of an above-average number of beds, while the downsizing process in the west was 'only' as fast as the EU average, i.e. numbers have remained 50% above the EU average.

Except in emergency conditions (especially if transport is by ambulance), access to hospitals requires a referral from an ambulatory physician (GP or specialist). All hospitals are legally required to accept urgent cases (these are broadly defined, i.e. including cases which in other countries would be considered elective) at all times, even if the occupancy rate exceeds 100%. Patients can choose the hospital, although in reality the referring physician will have an important say. Therefore, admissions are usually carried out the same day as the referral note is issued (except for certain university departments). In urban areas with more than one hospital, an individual hospital may indicate to the emergency call centre (where all the emergency calls are handled and ambulance services co-ordinated at the county level) that they do not have further vacancies.

Table 4.4 Structure and utilisation data on general and psychiatric hospitals in western and eastern parts of Germany, 1991–1998

	beds/ 1000			cases/ 1000			length of stay (days)			occupancy rate (%)		
	West	East	E/ W ratio	West	East	E/ W ratio	West	East	E/ W ratio	West	East	E/ W ratio
1991	8.19	8.89	1.09	179.3	151.1	0.84	14.3	16.1	1.09	86.0	74.9	0.87
1992	8.02	8.08	1.01	180.4	159.4	0.88	13.9	14.2	1.02	85.3	76.0	0.89
1993	7.80	7.50	0.96	180.3	162.9	0.90	13.2	13.0	0.98	83.9	77.4	0.92
1994	7.68	7.16	0.93	181.9	169.0	0.93	12.7	12.2	0.96	82.7	79.0	0.95
1995	7.55	7.03	0.93	185.4	175.9	0.95	12.2	11.7	0.96	82.0	80.1	0.98
1996	7.30	6.98	0.96	186.8	181.9	0.97	11.5	11.2	0.97	80.3	79.6	0.99
1997	7.12	6.87	0.96	189.4	187.5	0.99	11.1	10.8	0.97	80.7	80.5	1.00
1998	7.01	6.78	0.97	194.4	194.9	1.00	10.8	10.5	0.97	81.8	82.3	1.01

Source: based on data from Federal Statistical Office 1999 and preliminary data for 1998

The overall bed reductions occurred entirely as a result of bed reductions in public hospitals while private non-profit hospitals kept their numbers stable and private for-profit hospitals even increased their number of beds by two thirds (Table 4.5) – mainly through take-overs. Take-overs of previously public hospitals by private investors were more frequent in the East (where the share of privately owned beds in the acute sector is now above 10%, i.e. twice as high as in the West). In other cases, only management is contracted to private companies.

Table 4.5 Ownership of German general hospitals, 1990-1999

	Public		Private non-profit		Private for-profit		Total
	Beds	% share	Beds	% share	beds	% share	Beds
1990	387 207	62.8	206 936	33.5	22 779	3.7	616 922
1999	287 127	54.3	204 059	38.6	37 760	7.1	528 946
Change	-26%		-1%		+66%		-14%

Source: own calculations based on Federal Statistical Office data

The private for-profit segment has, as in other countries, two very different sub-segments – those hospitals which are contracted by the sickness funds to provide publicly financed health care services and those which deliver services for private payers only. Private hospitals that do not have a contractual relationship with health authorities or sickness funds are exempt from most regulations regarding equal distribution, access and financial sustainability. In Germany, the vast majority of private for-profit hospitals (and all private non-profit ones) fall into the contracted group. Therefore, the impact of privatisation on access, financing and utilisation is marginal. From the perspective of the insured patient, the status of a hospital does not matter – and usually is not even known.

Reliable and comparable data on patients' views are rare; according to a recent survey taken with the same questionnaire in five countries, German patients were generally reporting the second lowest rates of problems after Switzerland (Table 4.6). The problem most often mentioned was "continuity and transition", perhaps unsurprisingly given the strict separation between sectors.

Table 4.6 Proportion of patients reporting problems with hospital care, in Germany, Sweden, Switzerland, UK and US, 1998-2000

	Germany	Sweden	Switzerland	UK	US
Problems with ...					
- Information and education	20.4	23.4	16.7	28.7	25.2
- Co-ordination of care	17.2	NA	13.1	21.9	21.7
- Physical comfort	6.7	4.0	2.6	8.3	10.1
- Emotional support	21.9	26.0	14.7	27.1	26.8
- Respect for patients' preferences	17.9	21.2	15.6	30.7	19.9
- Involvement of family and friends	16.6	14.6	11.5	27.5	19.3
- Continuity and transition	40.6	40.2	30.0	45.1	28.4
Overall care NOT GOOD	6.6	7.4	3.7	8.5	8.1
Would not recommend this hospital to friends/family	5.0	2.8	3.6	7.8	4.8

Source: Coulter & Cleary 2001

6.4 Diagnostic services

All diagnostic services are offered in the ambulatory sector. The joint planning of certain high-technologies across sectors was abandoned in 1997, i.e. there are currently no special regulations governing them. The usual planning mechanisms apply to radiologists and laboratory specialists.

6.5 Pharmaceutical care

"Public" pharmacies – which are actually all privately-owned and which have a monopoly over drug dispensing except to hospitals – sold drugs worth DEM 52.0 billion (EUR 26.6 billion). Hospitals purchased drugs with an ex-factory volume worth DEM 4.8 billion (EUR 2.5 billion) (in 1998). There is no public planning of pharmacy locations but a restriction that each pharmacist may only own and operate one pharmacy, i.e. chains (and internet) pharmacies are illegal. Also, the surcharges on ex-factory prices are legally defined. As most products considered to be pharmaceuticals may be marketed as 'pharmacy-only', they need to be purchased in pharmacies. The second threshold is 'prescription-only'.

6.6 Rehabilitation/ intermediate care

Approximately 1400 institutions with 190 000 beds (2.32 beds per 1000) are dedicated to preventive and rehabilitative care. Compared with general hospitals, ownership is very different with 15%, 16% and 69% of beds being public, private non-profit and private for-profit respectively. There are also other differences: 1. Capacities of these institutions are not publicly planned. 2. Investments costs are not covered publicly. 3. Sickness funds (and especially pension funds) own some of these institutions (included in the non-profit ones). 4. Sickness funds contract these institutions selectively, i.e. not collectively. The latter two mechanisms limit patient choice for rehabilitative measures.

6.7 Social care

In the mid-1990s, the boundary of the health care sector was redefined when statutory long-term care insurance was founded. All members of statutory sickness funds (including pensioners and unemployed) as well as all people with full-cover private health insurance were declared mandatory members – making it the first social insurance with universal membership. Unlike in SHI, a uniform contribution rate of 1.7% is applied (split in half

between employers and employees [except in the Land of Saxony]). The long-term care insurance is administered by the sickness funds (as an entity separate from the health insurance part but without any separate associations) and by the private health insurers. Professional care in the ambulatory sector is paid on a fee-for-service basis while institutionalised care is financed by per-diem charges. The prices are negotiated between care funds and provider associations at *Länder* level. The duty to guarantee access to professional ambulatory care has been legally handed over to statutory long-term care funds while the *Länder* remain obliged to guarantee access to institutionalised care. The principle of 'dual financing' (as for hospitals, see above) means in the case of nursing care that the *Länder* have to cover investment costs for institutions and partly for ambulatory suppliers. The *Länder* are also responsible for planning but they are legally not allowed to limit the number of providers in the ambulatory sector in order to enhance competition. The Social Code Book XI ended the legal priority of welfare organisations over private for-profit providers explicitly in order to introduce competition for prices and quality. Thus, for-profit providers take part in the annual negotiations with care funds. No reliable per capita figures are available. Beneficiaries may choose whether or not to receive in-kind or cash benefits for long-term care.

7 THE PATIENT JOURNEY

A typical patient journey may start anywhere in the ambulatory care sector, either in a GP practice or in a specialist's practice. Patients receive an appointment with a physician of their choice quickly or simply go to the practice and wait for one or two hours to get 'squeezed' in. If necessary, patients are then referred to another ambulatory physician for further diagnostic work or they may go to another ambulatory physician without referral. If a hospital admission were considered necessary, the patient would probably be admitted the same day (or a day later). A referral note would accompany the patient, stating the reason for admission and possibly the latest test results. In the hospital, diagnostic checks may very well be repeated. The letter from the hospital to the referring physician usually consists of two parts: a hand-written note upon discharge (focusing on diagnosis and further treatment as the hospital will not give pharmaceuticals to the patient for the period after discharge), and a lengthy more detailed document which often arrives weeks later.

8 WHAT ARE THE MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM?

The current discussion has focused on various points: One is the morbidity-orientation of the risk structure compensation mechanism to lower opportunities for cream-skimming by sickness funds by advertising themselves on the internet etc. As a short-term measure, sickness funds will receive extra compensation for insurees enrolled in disease management programmes which, in turn, leads to the question: who decides which indications qualify for disease management programmes, which quality measures do programmes need to fulfil, who should "accredit" programmes and on what basis, and who decides which patients may be enrolled. It is envisaged that some of these decisions will be taken jointly between sickness funds. To enable sickness funds to really develop a disease management programme, they would require the right to selectively contract providers – another major discussion point. Other topics of current importance relate to the planned introduction of DRGs from 2003/2004 and other unsolved questions, in particular, how can the system simultaneously be 'budget-neutral' (as promised to the sickness funds) and 'open-ended' (as promised to the hospitals, as well as to the pharmaceutical sector, e.g. ownership of pharmacies, uniform prices for pharmaceuticals). In addition, renewed growth in health care expenditure in 2001 – mainly due to the abolition of the regional spending caps for pharmaceuticals – has brought cost-containment back onto the agenda in early 2002.

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10 WEBSITES

Association of Private Health Insurance	http://www.pkv.de/
Association of Substitute funds	http://www.vdak.de
Federal associations of sickness funds	http://www.g-k-v.com
Federal Institute for Drugs and Medical Devices	http://www.bfarm.de/gb_ver/
Federal Physicians' Association	http://www.kbv.de
Federal Physicians' Chamber	http://www.bundesaerztekammer.de/
Federal Statistical Office Germany	http://www.destatis.de/e_home.htm
Federal Supervisory Office for the Insurance Sector	http://www.bav.bund.de/index_en.html
General regional sickness funds	http://www.aok.de/
Ministry of Health	http://www.bmgesundheit.de/engl/english.htm

THE NETHERLANDS

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1 INTRODUCTION

Dutch health care comprises three main elements: public universal insurance for so-called "exceptional medical expenses" which includes long-stay care, mental health, etc.; compulsory social health insurance for the low income and voluntary private health insurance for the high income; and voluntary supplementary insurance open to all. Ambulatory care is provided by independent GP practitioners paid on a capitation basis. The majority of hospitals are private non-profit institutions.

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

There are three components of health insurance in the Netherlands:

1. Long-term care and high-cost treatments are covered by the Exceptional Medical Expenses Act (AWBZ).

With a few exceptions, the Act covers everyone resident in the Netherlands and all non-residents who are employed in the Netherlands and subject to Dutch income tax.

2. Normal, necessary medical care is covered by a variety of insurance arrangements.

a) People whose annual salary is below a statutory ceiling (EUR 30 700 in 2002) and all recipients of social security benefits are compulsorily insured under the Sickness Funds Act (ZFW) up to the age of 65. Since 1998, people aged 65 or over who were insured under the act before they turned 65, will continue to be insured by the ZFW after they reach the age of 65, regardless of income. In 2001 almost 65% of the Dutch population were covered by the ZFW.

b) Other health insurance schemes cover various categories of civil servants, accounting for around 5% of the total population.

c) Those who are not covered by the ZFW or the schemes for civil servants can obtain cover from a private health insurer on a voluntary basis. Approximately 29% of the population take up this type of substitutive voluntary health insurance (VHI). If the annual taxable income of a voluntarily insured individual aged 65 and over (and his/her partner) falls below EUR 19 550, they can register with a sickness fund in the ZFW ('opting in'). Fourteen percent of those with substitutive VHI (4% of the total population) have standard cover under the Health Insurance Access Act (WTZ) (see Section 3.3).

Only 1.6 per cent of the population has neither statutory nor voluntary health insurance; according to the Ministry of Health, Welfare and Sport, most of these uninsured people were homeless, while a few refused to insure themselves for reasons of principle.

3. Care regarded as being 'less necessary' is covered by sickness funds and private health insurers in the form of complementary or supplementary VHI.

Data on levels of complementary VHI coverage are only available for subscribers who are insured by the ZFW. In 1999/2000 93% of those insured by the ZFW purchased complementary VHI or a combination of complementary and supplementary VHI (although the latter is marginal). However, the quality of coverage varies widely. Some substitutive VHI subscribers may also purchase additional complementary and/or supplementary benefits.

2.2 Benefits

The main areas of health care to which those covered by the AWBZ are entitled include: admission to and stay in hospital after the first year; care in nursing homes or homes for disabled people; psychiatric care; mental health care; care of mentally and physically disabled people; some pre- and post-natal care; child immunisation etc.

The main areas of health care to which those covered by the ZFW are entitled include: medical and surgical treatment (by general practitioners, specialists, physiotherapists and speech therapists); obstetric care; dental care (limited to dental care for children and preventive and specialist surgical care for adults); pharmaceuticals; admission to and stay in a general hospital up to 365 days; medical aids and appliances; transport; maternity care; rehabilitation etc

The standard policy of the WTZ provides similar benefits to the ZFW. The benefits offered by substitutive VHI policies vary.

The benefits offered by complementary and supplementary VHI policies and the conditions under which they are offered are determined by the insurers themselves and may include: dental care, spectacles, better accommodation in hospital or alternative treatment. Private insurers and almost all sickness funds offer complementary VHI to their existing subscribers.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

Taxes are levied nationally (by the Kingdom) and locally (by the provinces and municipalities). There are four rates of national income tax: 32.35%, 37.60%, 42% and 52%. The first two rates include both tax and national insurance contributions (see Section 3.2); the last two rates are for tax alone. The level of personal allowances varies. At 5.3% of total expenditure taxes appear to play a minor role in health care funding (Table 5.3) however there are significant tax-financed grants to both the AWBZ and ZFW (Section 5).

3.2 Social health insurance contributions

Under the provisions of the National Insurance Financing Act, insured persons are liable to pay contributions. National insurance contributions, which include AWBZ contributions, are levied on taxable income together with income tax. In 2001 the uniform contribution rate was 10.25% of taxable income up to EUR 27 009. Employed people's contributions are deducted from their earnings and paid to the tax authorities by their employer. People who do not receive wages or a salary but who are liable for tax and social security contributions are issued with an assessment of how much they should contribute.

ZFW contributions payable up to the age of 65 are related to the insured person's income (earned or in the form of social security benefits). In 2002 employers (or the institutions providing social security benefits) contribute 6.25% of the insured person's income, while employed people contribute 1.7% of their income up to a ceiling of EUR 28 188 (only wages) for employees, EUR 19 650 (taxable income) for self-employed people and EUR 19 550 for pensioners.

Those insured by the ZFW pay an additional non-income-related premium (which varies between sickness funds). In 2002 monthly/yearly flat-rate contributions vary between EUR 9.50/114 and EUR 19.90/238.80 per person (that is per insured person and their spouse, but not their children). On average, the flat-rate contribution constitutes about 10% of total contributions paid to the sickness funds.

Health insurance contribution rates are set by the Ministry of Health on the recommendation of the Health Insurance Board (CVZ).

3.3 Voluntary health insurance premiums

Premiums for individual VHI subscribers are rated according to individual risk. Applicants must complete a medical questionnaire that includes questions about family disease history. Group rating is applied to premiums for groups. Premiums tend to rise with age. The average annual substitutive VHI premium per insured in 1999 was NLG 1538 (EUR 698), although premiums vary substantially.

Applicants who are refused substitutive VHI cover by a private insurer can obtain a 'standard policy' through the WTZ. The WTZ Act enables the government to determine the level of benefits and the price of a fixed premium for a standard policy. In 1999 this premium was fixed at NLG 2500 (EUR 1135) per year for those aged under 65 and NLG 2809 (EUR 1275) for those aged 65 and over (Vektis, 2000). Unlike statutory cover, however, a standard policy does not cover the insured individual's dependants, who must be separately insured. Children under the age of 18 and children between the ages of 18 and 27 who are studying and who are included in the policy of the principal policyholder pay only half the amount paid by the main policyholder.

Premiums for substitutive VHI are subject to two statutory surcharges:

- The MOOZ surcharge finances the transfer of funds from substitutive VHI to the sickness funds to make up for the higher proportion of older people covered by the ZFW. In 2002 insured people under the age of 20 pay EUR 40.80, those between 20 and 64 pay EUR 81.60 and those 65 and older pay EUR 65.28 per year; students are exempted.
- The WTZ surcharge covers the difference between WTZ expenditure and premium income; in 2002 all those with substitutive VHI under 20 pay EUR 117.12; those aged between 20 and 64 pay EUR 234.24 per year; students and the elderly are exempted.

Expenditure on health care, including premiums, can be deducted from taxable income once it exceeds a certain percentage of income, but the percentage is set relatively high, so that in practice, the tax incentive is not significant.

3.4 User charges

The government estimates that up to 9% of total health care costs is covered by households' out-of-pocket spending; 4% is covered by co-payments under the AWBZ, 2% by co-payments/deductibles under the ZFW and 3% by direct payments/private complementary or supplementary VHI.

Co-payments under the AWBZ apply to care in nursing homes. In determining cost-sharing regarding admission to an AWBZ institution, account is taken of individuals' circumstances, notably whether they are married or co-habiting or live alone; the latter face higher charges since their household expenses are reduced to a greater extent by an admission than those of someone living with a spouse or partner. In 2001 the maximum co-payment amount was fixed at NLG 3595 (EUR 1631) per month.

All those insured by the ZFW faced a co-insurance of 20% of medical costs up to a maximum of NLG 200 in 1997/98. There is no co-insurance for general practitioner visits, basic dental care and the inpatient costs of pregnancy. Other hospitalisations are subject to a fixed co-payment of NLG 8 per day (EUR 4). The following deductibles apply: EUR 180 for artificial breasts, EUR 51 or EUR 102 for orthopaedic shoes (per year up to age 16 and over 16, respectively), EUR 454 for hearing aids and EUR 252 for wigs.

Many voluntarily-insured persons are subject to paying a deductible on their health care costs. Through complementary VHI or direct payment citizens can receive treatments that are no longer covered by the ZFW such as physical therapy, dental care, prosthesis, hearing aids, alternative treatment and costs incurred abroad.

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

National insurance contributions (including contributions to the AWBZ) and income tax are deducted from the payroll by employers or social security institutions. With the exception of the flat-rate contribution (which is collected by individual sickness funds), all health insurance contributions (ZFW) are channelled into a Central Fund, which is managed by the Health Insurance Board (CVZ).

Since 1998 the administration of the ZFW has been entrusted to a regional single payer, usually the largest sickness fund in each of 31 areas. There are currently 24 sickness funds. Citizens have a choice of sickness fund and may change fund once a year.

A system of budgets introduced in 1991 has aimed at encouraging sickness funds to purchase and provide care as flexibly and effectively as possible and to increase their financial responsibility. Sickness funds must consult with care providers to determine the quantity, quality and (to a certain extent) the price of health services provided. Budgets only apply to those costs over which the funds may have some control (such as drugs, GP care, specialist care). Fixed costs such as capital expenditure of hospitals are not budgeted.

Under substitutive VHI each insurer has to cover expenditure out of its premium income (with the exception of those insured by the WTZ).

Transfers and subsidies between the different elements of the Dutch health insurance system

The introduction of the AWBZ and the switch to an insurance-based system led to considerable savings for the government, so the government uses some of these savings to make structural grants to the AWBZ Fund.

The government also makes an annual tax-financed grant to the ZFW. In 2000 this grant amounted to about 24% of ZFW expenditure.

Sickness funds receive risk-adjusted capitation payments from the Central Fund. Their flat-rate contributions must cover the shortfall between income from the Central Fund and expenditure (after two retrospective corrective measures called *equalisation* and *recalculation* have been applied – see below). Capitation payments to sickness funds are adjusted for age and gender, region of residence and disability status. The share of prospective payment in their total reimbursement has risen from 3% in 1995 to 35% 1999 (Table 5.1). Two retrospective adjustment mechanisms limit the financial risk borne by sickness funds:

- first, any difference between the budget allocated and the actual costs for each sickness fund is partly shared between the sickness funds up to a specific percentage (the *equalisation percentage*); resources are shifted from sickness funds that were allocated too much money (that is, those with low expenditure) to those that were allocated too little.
- second, an adjustment is made for any difference between the total budget allocated to sickness funds and actual expenditure arising from sickness funds' inability to influence all costs; the difference is financed by the Central Fund up to a specific percentage (the *recalculation percentage*).

Since 1997 sickness funds have been allowed to reclaim 90% of the expenditure of an insured individual from a pool (financed by a percentage deduction of the budget for non-fixed costs) if the expenditure exceeds a specified limit.

Table 5.1 The changing mix of payments to sickness funds in the Netherlands, 1992-1999

Year	Share of prospective payment in total sickness fund expenditure (%)	Risk adjusters	High-risk pool
-1992	0	-	-
1993-95	3	Age, gender	-
1996	15	Age, gender, region, disability status	-
1997	27	Age, gender, region, disability status	90% of annual expenditure above NLG 4500 (EUR 2042)
1998	29	Age, gender, region, disability status	90% of annual expenditure above NLG 4500 (EUR 2042)
1999	35	Age, gender, region, employment/social security status	90% of annual expenditure above NLG 7500 (EUR 3403)

Source: Schut & van Doorslaer 1999

4.2 Organisation of purchasing/contracting

The AWBZ and the ZFW provide benefits in kind (although the AWBZ provides some cash benefits) by contracting with institutional providers (hospitals) and individual providers (GPs and specialists). Sickness funds must contract all accredited institutional providers, but since 1992 they are no longer obliged to contract all individual providers. Voluntary health insurers and sickness funds involved in the AWBZ are prohibited from employing personnel to provide health services, except in special cases and with the approval of the Health Care Board (CVZ).

Contracts are signed following a national consultation between health insurers' and providers' representative organisations. If the parties cannot come to an agreement, the CVZ draws up a 'model contract'.

Fees are subject to approval by the Board for Tariffs in Health Care (CTG). As of 1 January 1992, independent medical practitioners or groups of practitioners working together are subject to a system of maximum fees under which it is possible to charge fees lower than those set or approved by the CTG.

GPs are paid on a capitation basis for patients insured under the ZFW and on a fee-for-service basis for voluntarily-insured patients.

Hospital budgets are calculated on the basis of a fixed rate:

- per person in the service area
- per licensed hospital bed
- per licensed specialist unit
- per negotiated volume of production units (for example, hospital admissions, inpatient days, first outpatient contacts, day surgery and special treatments such as renal dialysis, open-heart surgery, IVF, neuro-surgery etc)

These fixed rates vary according to hospital size, with larger hospitals receiving higher rates on the assumption that they perform more complicated procedures.

Hospital budgets are financed by the rates charged to insurers or patients, which may not be the same as the rates used to set budgets. Rates charged to insurers fall into two categories:

- national ancillary rates covering about 1600 procedures based on real average costs
- daily nursing rates derived from individual hospital budgets and calculated as follows: income from ancillary procedures (laboratory tests, x-rays, surgical procedures etc) are deducted from the hospital budget and the remaining amount is divided by the estimated number of inpatient days; insurers are therefore charged the same rate for all patients in a given hospital, although daily nursing rates vary between hospitals

Hospitals receive additional funds for capital expenditure. Major renovations and the construction of new hospitals are entirely covered by increasing the daily nursing rate, so hospitals do not bear any financial risk for capital expenditure.

Since 2000, hospital payment has been performance-related, so hospitals producing fewer inpatient days than agreed with health insurers are paid less. Performance-related payment aims to stimulate activity in order to combat waiting lists.

Doctors training to become specialists are salaried but specialists working in hospitals are formally self-employed. They were originally paid fees for service but since 1995 expenditure caps have been put in place. Insurers sign contracts with specialists concerning the volume of care to be provided and any overrun of expenditure caps must be compensated by a cut in fees in the following year(s). These *ex post* cuts generally give rise to conflict between the government and specialists' organisations. Increasingly, medical staff negotiate lump-sum payments. The future DRG-type hospital payment system will include specialists' fees.

5 HOW MUCH IS SPENT AND ON WHAT?

Taxation is mainly used to fund research in health and, to a lesser extent, public health. Data on tax expenditure on health does not include government subsidies to the ZFW, nor to the AWBZ. Total tax expenditure, including these subsidies, is estimated to be around 13-14% of total expenditure on health.

Table 5.2 Trends in health care expenditure in the Netherlands, 1980-2000

Total expenditure on health care	1980	1985	1990	1995	1996	1997	1998	1999	2000
Total expenditure in USDPPP per capita	714	958	1 403	1 891	1 928	2 009	2 150	2 259	2 245
Share of GDP (%)	8.3	8.1	8.8	8.9	8.8	8.7	8.7	8.7	8.1
Public share of total expenditure on health care (%)	69.2	71.0	67.7	72.0	67.3	68.9	68.6	68.5	73.2

Source: WHO Regional Office for Europe, health for all database

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

As mentioned in section 2.2, benefits under the various insurance schemes are legally defined and are enforceable through court action. In recent cases, courts have stressed the insurance

Table 5.3 Main sources of health care funding in the Netherlands, as a percentage of total expenditure on health, 1980-1999

Source of Finance	1980	1990	1995	1996	1997	1998	1999
Public							
- Taxes	9	11	10	9.7	4.3	5	5.3
- Statutory Insurance (AWBZ)	37	33	43	31	36.8	36.6	36.5
- Statutory Insurance (ZFW)	23	31	27	35.7	35.6	35.9	36
Private							
- Private insurance	24	16	12	15.5	14.7	14	14.5
- Out-of-pocket	7	10	8	7.8	8.2	7.8	6.9
Other	-	-	-	0.3	0.4	0.6	0.8

Source: MoH various years

Table 5.4 Health care expenditure by type of service in the Netherlands, in 1000 million NLG and as a percentage of total, 1990-2000

Expenditure category	1990	1995	1997	1998	1999	2000
Inpatient care ('intramural')	23.0 (53.2%)	30.0 (53.3%)	28.9 (47.4%)	30.6 (47.1%)	32.2 (47.1%)	34.0 (46.7%)
- hospitals	*13.3* *(30.8%)*	*17.2* *(30.6%)*	*18.7* *(30.7%)*	*19.6* *(30.2%)*	*20.6* *(30.1%)*	*NA*
- psychiatric hospitals	*2.6* *(6.0%)*	*3.4* *(6.0%)*	*	*	*	*
- institutions for the mentally weak	*2.5* *(5.8%)*	*3.3* *(5.9%)*	*3.7* *(6.1%)*	*4.0* *(6.2%)*	*4.1* *(6.0%)*	*NA*
- nursing homes	*4.2* *(9.7%)*	*5.6* *(9.9%)*	*6.2* *(10.2%)*	*6.6* *(10.2%)*	*7.0* *(10.2%)*	*NA*
Ambulatory care ('extramural')	17.9 (41.4%)	23.6 (41.9%)	24.6 (40.3%)	26.4 (40.7%)	28.0 (40.9%)	30.0 (41.2%)
- general practitioners	*1.6* *(3.7%)*	*2.0* *(3.6%)*	*2.2* *(3.6%)*	*2.2* *(3.4%)*	*2.3* *(3.4%)*	*NA*
*- specialists **	*2.5* *(5.8%)*	*2.8* *(5.0%)*	*2.8* *(4.6%)*	*3.0* *(4.6%)*	*3.2* *(4.7%)*	*NA*
- dental care	*2.0* *(4.6%)*	*2.2* *(3.9%)*	*2.5* *(4.1%)*	*2.6* *(4.0%)*	*2.7* *(3.9%)*	*NA*
- midwives and paramedics	*1.3* *(3.0%)*	*1.5* *(2.7%)*	*1.5* *(2.5%)*	*1.6* *(2.5%)*	*1.7* *(2.5%)*	*NA*
- pharmacies, suppliers of dressings etc.	*5.2* *(12.0%)*	*7.8* *(13.9%)*	*8.4* *(13.8%)*	*9.3* *(14.3%)*	*10.0* *(14.6%)*	*NA*
*- institutions for public health care**	*4.4* *(10.2%)*	*6.1* *(10.8%)*	*5.9* *(9.7%)*	*6.3* *(9.7%)*	*6.6* *(9.6%)*	*NA*
Mental health care	*	*	4.7 (7.7%)	5.0 (7.7%)	5.3 (7.7%)	5.7 (7.8%)
Food and water inspection	0.1 (0.2%)	0.2 (0.3%)	0.2 (0.3%)	0.2 (0.3%)	0.2 (0.3%)	NA
Policy, administration and management	2.1 (4.9%)	2.5 (4.4%)	2.6 (4.3%)	2.6 (4.0%)	2.8 (4.1%)	NA
Total expenditure	**43.2**	**56.3**	**61.0**	**64.9**	**68.4**	**72.8**

Source: Statistics Netherlands, 2001 NA = not available

* Since 1997, all expenditure for mental health care forms one category while it previously was categorised as expenditure for psychiatric hospitals and parts of specialist care as well as public health care.

aspect (that the insured has an entitlement to the services listed if his/her condition necessitates them) over other aspects such as cost containment policies. Waiting lists are therefore seen not only as a burden, but a violation of patients' rights as they impede legally guaranteed access.

6.2 Ambulatory care

Primary care is well developed and is provided largely by GPs. GPs maintain independent and mostly solo practices in each community and have an average of 2300 patients on their list. Insured persons are free to register with the GP of their choice. The number of group practices and health centres (staffed by GPs, social workers, physiotherapists, and sometimes midwives) is increasing rapidly. GPs are also typically members of so-called locum groups consisting of 8 to 10 members which provide out-of-hours services as well as substituting for each other in the case of holiday or illness.

GPs are the central gatekeepers in the health care system. Patients covered by sickness funds require a referral card for access to specialists or hospital care, while the voluntarily-insured must have a referral letter. These name the specialty but not the individual specialist; choice of specialist is up to the patient.

GPs 'specialise' in common and minor diseases, in care for patients with chronic illnesses and in addressing the psychosocial problems related to these complaints. The impact of gate-keeping is illustrated by the low referral rate: the vast majority of medical problems are treated by GPs. Patients are referred to specialists in only 6% of contacts. Referral rates to surgical specialists are relatively high. Referrals for common conditions, such as hypertension, low back pain, and upper respiratory tract infections are very low; nearly all cases are treated by family doctors who have developed an internationally acclaimed system of guidelines and quality care. On the other hand, diseases such as myocardial infarction, low back pain with radicular symptoms and chronic tonsillitis account for a relatively high percentage of referrals. Specialists are therefore responsible for a select and limited segment of the total spectrum of morbidity.

Physician-patient contacts, including specialist care, have been around 5.7 per capita per year in the 1990s (about 0.5 higher than in the 1980s), and primary care constitutes about two thirds of all contacts in ambulatory care. The average number of annual patient contacts is higher for sickness fund patients then for privately insured patients. (According to the European Community Household Panel Survey, the figures for 1996 were 2.9 contacts with general practitioners and 1.8 with specialists.) To compare internationally, the overall figure of 5.9 contacts per capita in 2000 is slightly less than the EU average. A striking aspect is the low prescription rate; a prescription is given in only two-thirds of contacts. Moreover, drugs are prescribed for slightly more than half of all diagnoses only – compared to 75% to 95% in other European countries. GPs do not have hospital privileges: they cannot admit their patients to, nor treat them, in a hospital. However, they may use hospitals for diagnostic procedures, e.g., blood tests, X-rays, endoscopies, and lung-tests.

6.3 Secondary care

Secondary and tertiary care is predominantly provided by medical specialists in hospitals. Nearly all hospitals have outpatient as well as inpatient facilities. Outpatient services are provided primarily by specialists who carry out pre-admission diagnostic examinations as well as outpatient treatment. Except in cases of emergency, patients are not allowed to go directly to an outpatient department or policlinic of an acute hospital. About 40% of the population contact a medical specialist per year; those who do have around 4.8 contacts per

capita per year with them. As mentioned above, specialists are accessible via referral only (and the Dutch do not seem to try to bypass this system).

There is a well developed hospital system in the Netherlands consisting of 136 hospitals in 1999 (excluding psychiatric hospitals). More than 90% of the hospitals are private and non-profit; the rest are public (university) hospitals. Hospitals may be classified as teaching, general and specialist hospitals. The eight university hospitals are attached to faculties of medicine and fulfil general specialist, advanced clinical and final referral functions.

Hospitals have increased their capacity through mergers or expansion despite the required decrease in beds within each region, which has lowered the number of acute care beds by over a third since 1980 to 3.3 beds per 1000 population (Table 5.5). Admissions to acute care hospitals are equally low by international comparison, while the occupancy rate is extremely low (around 20 percent lower than in other EU countries).

Table 5.5. Inpatient utilisation and performance in the Netherlands, 1980-1998

	1980	1985	1990	1995	1996	1997	1998	1999	2000
Beds per 1000 population, all hospitals	-	6.4	5.8	5.3	5.2	5.2	5.1	5.0	4.8
Beds per 1000 population, acute care	5.2	4.7	4.0	3.5	3.5	3.5	3.4	3.4	3.3
Beds per 1000 population, psychiatric	1.7	1.7	1.8	1.7	1.6	1.7	1.7	1.6	1.6
Admissions per 100 population, all hospitals	11.7	11.4	10.9	11.1	11.1	NA	NA	NA	NA
Admissions per 100 population, acute care	11.2	10.9	10.3	10.3	10.2	10.3	NA	NA	NA
Average length of stay (days), all hospitals	NA	NA	16.0	14.3	14.2	13.8	13.6	13.1	12.9
Average length of stay (days), acute care	14.0	12.5	10.0	8.8	8.6	8.4	8.3	7.9	7.7
Occupancy rate (%), acute care	83.5	79.1	66.1	65.5	65.1	63.1	62.9	59.7	58.4

Source: WHO Regional Office for Europe, health for all database

NA = not available

In the late 1990s waiting lists emerged as the major problem of the Dutch health care system (at least from the public's point of view). Waiting times and lists are counted twice, for the diagnostic process and for treatment itself. In March 2000 around 150 000 patients were waiting for treatment in general hospitals, with more than 92 000 of them waiting longer than one month. By October 2001 the number – excluding psychiatry and paediatrics – had increased to 185 000. The specialities of orthopaedics (35 000), general surgery (35 000), ophthalmology (34 000) and plastic surgery (24 000) had the largest waiting lists; plastic surgery had the longest waiting time: 12 weeks for diagnosis and 23 weeks for treatment (both figures are about twice as high as the average).

At the end of 2001 a report put the total social costs of waiting lists at NLG 6.96 billion (EUR 3.16 billion) per year. These included NLG 4.1 billion due to loss of welfare, NLG 1.3 billion due to loss of income and productivity, NLG 1.5 billion due to long term disability and NLG 18 million due to bureaucracy (SEO 2001).

Partly related to waiting lists is an increased pressure from patients to access services across borders. Sickness funds have contracted hospitals across borders (e.g. in Belgium) to ease pressure but there is additional demand for unauthorised, non-contracted care as recent the European Court of Justice cases have demonstrated.

6.4 Diagnostic services

Diagnostic services are provided as part of ambulatory and secondary care; all providers are private.

6.5 Pharmaceutical care

Pharmaceuticals are mainly available through community pharmacies (while hospitals may have their own pharmacies). While these used to be solo operations, each owned by a pharmacy, recent years have seen an increase in groups of pharmacies owned by groups of pharmacists (co-operatives). Chain pharmacies are allowed but do not play a role; in fact, a large UK chain entered the market but withdrew (as did the largest Dutch department store). The location of (new) pharmacies is not regulated.

6.6 Rehabilitation/intermediate care

Rehabilitation is a medical specialty of its own and often is based in acute hospitals although there is some care of ambulatory patients. Rehabilitation benefits include examinations, treatment and counselling by medical specialists, paramedical staff and behavioural or rehabilitation therapists as well as accommodation, if necessary.

6.7 Social care

The most important social services consist of nursing homes and homes for the elderly (residential homes). Compared to other European countries, the Netherlands has almost the highest rate of residential care for the elderly in nursery homes and psychiatric and medical hospitals. The institutions are usually private, i.e. either privately owned or operated as foundations under private law.

Mental health care encompasses a whole range of organisations and practising professionals, all pursuing the common aim of treating mental health problems. The 90 regional institutes for ambulatory mental health care (*Regionale Instelling voor Ambulante Geestelijke Gezondheidszorg*, RIAGG) as well as the 76 psychiatric hospitals (all figures for 1999) and sheltered housing schemes have a regional character. They are responsible for the psychiatric and psycho-social care of the population for a specified catchment area. In principle, mental health care is only accessible to those who have been referred by their GP. Waiting times have become very long and reached 29 weeks for psychiatric treatment in 2001. However, in both acute and crisis situations, a direct appeal is made to the mental health care services for assistance.

7 THE PATIENT JOURNEY

A patient will first visit his/her permanent GP. Except in certain areas of large cities where there is a shortage of GPs, access is not a problem. Most patients do not require further referral (see above). If further diagnosis is required, the family practitioner will issue a referral card/note, indicating the specialty. S/he will most likely also recommend a particular specialist (but the patient is not required to follow that suggestion). The waiting time for the specialist appointment will be, on average, 6 weeks (3 in surgery, 4 in internal medicine). The specialist might then initiate an ambulatory or inpatient treatment; the average waiting time for this will be 11 weeks (2 in internal medicine, 9 in surgery). Upon discharge, the patient will be referred back to his/her GP and/ or the specialist. Many projects on continuity of care ("transmural care") try to smooth out this process. Transmural care projects utilise specialised nurses, guidelines, home care technology, discharge planning and other methods. Transmural care often is geared towards specific groups of patients, e.g., chronic patients with intermittent acute care needs, such as those with cancer, chronic obstructive pulmonary disease, diabetes or rheumatoid arthritis. At no point is the patient required to pay a co-payment.

8 WHAT ARE THE MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM?

Waiting times/lists are by far the most visible public issue. But they also cause concern from a legal perspective as they indicate that the system cannot provide services to which insurees are entitled. Waiting lists are not related to hospital capacity *per se* as the extremely low occupancy rates demonstrate. From the government's point of view, a restructuring of the three health insurance components is (again) on top of the agenda in order to ensure higher equity in contributions/premiums (currently one Euro more or less income on either side of the threshold can more than double the contribution). The plan, published as "Vrag aan bod" in July 2001, proposes first to unify the various schemes in the second component and then merge it with the first component to have one national insurance scheme which would be managed by the sickness funds as well as private health insurers. Extension into the first component raises the question of which benefits need to be exempted from such a competitive environment.

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10 WEBSITES

Health care, health policies and health care reform in the Netherlands	http://www.minvws.nl/documents/staf/Folder/Healthcare07.pdf
Health Insurance Board	http://www.cvz.nl
Health insurance in the Netherlands	http://www.minvws.nl/documents/Health/health_insur.pdf
Ministry of Health, Welfare and Sport	http://www.minvws.nl/index.html
Social and Economic Council report on medical insurance	http://www.ser.nl/overdeser/default.asp?desc=adviezen_00_12
Statistics Netherlands	http://www.cbs.nl/en/
Zorgverzekeraars Nederland (ZN) [Health insurers Netherlands]	http://www.zn.nl/international/english/about-zn/introduction.asp

NEW ZEALAND

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1 INTRODUCTION

New Zealand's health system is financed predominantly from general taxation and covers all residents in the country. Public hospital outpatient and inpatient services are free; however most people meet some costs of primary health care (although some groups are exempt or have health concession cards), and make a co-payment for pharmaceuticals. New Zealand targets subsidies for primary care and prescriptions on low-income patients (using concession cards), children and high users of services. Health services are delivered by a mix of public and private providers. The New Zealand health care system has undergone several phases of restructuring. The Labour/Alliance coalition government (1999-) has ended the strict purchaser/provider split, returned to regional funding and delivery of health services, and is moving toward more comprehensive access to primary health care through capitation funding to general practice groups.

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

Entitlement for state health care is based on residency or citizenship status. There is no universal social insurance; the exception being the Accident Compensation Corporation that provides comprehensive no-fault insurance for health and social care costs and income replacement in all cases of accidental injury or occupational illness.

Public hospital outpatient and inpatient services are free, with public hospitals accounting for just over half the total bed stock including the large tertiary care hospitals. The costs of primary health care are met or subsidised for certain groups. Over 40% of the New Zealand population hold concession cards, but perhaps another one-quarter of eligible people do not, while people whose incomes are just above the eligibility threshold (another 5-10% of the population) face financial barriers in accessing primary care. In 1999, concession cardholders were estimated as 43% of European New Zealanders (Pakeha), 64% of Māori and 68% of Pacific people.

Consumers make a maximum co-payment of NZD 15 for items on the Pharmaceutical Benefits Schedule and co-payments are waived or reduced for young children and concession cardholders.

Private insurance is voluntary and the funds insure people against 'gap' and 'supplementary' costs but do not offer comprehensive health cover. About 33-37% of the population have private health insurance, down from an estimated 51% in 1990. While those in low-income households are relatively intensive users of health care, uptake of health insurance is strongly skewed towards higher income earners. For example, only 13% of households in the bottom income quintile report buying health insurance compared to 59% in the highest quintile.

2.2 Benefits

The National Health Committee in the early 1990s was charged with defining what health services should be publicly funded. Although ultimately the Committee decided it was inappropriate to define either a positive list of covered services or a negative list of exclusions from public funding, the Committee did succeed in defining criteria for service priorities based on identifying the most effective treatments for particular conditions according to clinical practice guidelines from "evidence-based" medicine.

All services received as a hospital inpatient, outpatient or day patient are fully subsidised. The state subsidises consultations with general practitioners by health concession cardholders and

children; pregnancy services are fully subsidised; laboratory and x-rays tests ordered by a doctor are subsidised while inpatient and outpatient tests are free. Mental health and drug and alcohol services are free. Public health screening (such as breast cancer screening for women aged 50-64 years) and immunisation services for children generally are free to the user. Dental care is free for children but the government pays only for urgent dental services on a means-tested basis for adults so that most adults pay for their own dental care. A co-payment is required for ambulance transport except in accident cases. Adults pay part of the cost of medical equipment and prostheses (except in cases of financial hardship), and eye tests and glasses/contact lenses are not covered.

A government organisation, the Pharmaceutical Management Agency (PHARMAC), decides what drugs should be listed on the Pharmaceutical Schedule based on an independent advisory committee's evaluation of the evidence of clinical and cost effectiveness. PHARMAC also decides the price that government is prepared to pay the supplier within a reference-pricing scheme. The Pharmaceuticals Schedule lists almost 3000 drugs and services that are subsidised by government.

In New Zealand, social services for older people, children and adults with disabilities, and people with long-term mental illness are a national responsibility financed by the health system. However, long-term nursing home or residential care home services for the elderly are subject to an income and means test (as in the UK), and some home care services attract income-tested charges.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

The New Zealand health care system is financed predominantly through general taxation, with total public funding amounting to nearly 78% in 1999 and private funding of 22% (Table 6.1). The public sector component of total expenditure on health in New Zealand thus was higher than Australia with 70% in 1998 but lower than the United Kingdom with 83% (OECD 2001). Over the last two decades in New Zealand, public funding has decreased while out-of-pocket payments by consumers and private insurance has increased.

In 1998/99, 77.5% of health sector finance came from taxation and social insurance contributions, 15.9% from consumer out-of-pocket payments, 6.2% from private insurance, and 0.4% from non-profit organisations. The New Zealand government remains committed to a predominantly tax-funded health care system but is reviewing its financing arrangements for health and disability services.

Taxation is national (in the unitary system of government) plus there are minor local government rates and taxes. Government revenue comes mainly from Pay as You Earn (PAYE) income tax and a Goods and Services Tax (a form of value-added tax at 12.5%). PAYE income tax is progressive with the rates for personal income tax as follows: income earners below NZD 38 000 are taxed 19.5 cents in the dollar, income earners between NZD 38 001–60 000 pay 33 cents in every dollar, those earning above NZD 60 000 are taxed 39 cents in every dollar. Direct taxes account for 60% of central government revenue. A part of general taxation is allocated to the government health system budget each year.

3.2 Social health insurance contributions

The second compulsory contribution from tax-payers to health system revenue is through the Accident Insurance scheme (4.7% of total health expenditure in 1998/99). The Accident Compensation scheme is the only form of social health insurance fund. The previous

government set up a compulsory competitive insurance market for work-related injuries in 1998 but the Labour-led coalition government renationalised from July 2000.

Table 6.1. Main sources of health care funding in New Zealand as a percentage of total, 1980- 1999

Source of Finance	1979/80	1984/85	1989/90	1994/95	1998/99
Public					
Vote: Health	80.5	78.9	72.7	65.0	68.9
ACC	0.7	2.8	4.4	5.4	4.7
Other Govt agencies	6.6	5.0	4.8	2.9	2.9
Local Authority's	0.3	0.3	0.5	0.6	0.7
CHE/HSP deficit financing	-	-	-	3.2	0.3
Total Public Funding	**88.1**	**87.0**	**82.4**	**77.2**	**77.5**
Private					
out-of-pocket	10.4	10.8	14.5	16.2	15.9
private insurance	1.1	1.8	2.8	6.4	6.2
non-profit organisations	0.4	0.4	0.3	0.3	0.4
Total Private funding	**11.9**	**13.0**	**17.6**	**22.8**	**22.5**

Source: Ministry of Health 1999

3.3 Voluntary health insurance premia

Private health insurance finances some 6.2% of health expenditure. Private health insurance funds insure people against 'gap' and 'supplementary' costs but do not offer comprehensive health cover. The population can choose among 15 private health insurance funds but one of them - Southern Cross - has an estimated 75% market share. There is no regulation of the private health insurance industry apart from the regulation applying to general insurance, and there are no tax rebates on an insurance premium. Given the large and complicated range of insurance plans it is not meaningful to present an average premium. However premia are rising with increasing costs, resulting from, for example, the ageing population, new technology such as imaging, and more elective surgery. Premia may be based upon 'risk rating' and thus rise with age but in the absence of regulation there are few 'community rated' schemes.

3.4 User charges

Out-of-pocket expenditures account for nearly 16% of total health expenditures.

Primary care is charged on a fee-for-service basis (with subsidies for low-income earners, children and high users of services), with children under six receiving free services. Average GP consultation fees for upper income adults are around NZD 32-35.

General practitioners claim subsidies from the government for consultations with Community Services or High Use Health Cardholders, which reduce the co-payment made by a patient. Since government subsidies to patients for GP consultations are flat rate (and thus not cost-indexed) the real value has eroded. Government subsidies in 2001 were as follows: NZD 32.50 per visit for all children under six years; NZD 15 per visit for children aged 6-18 years (families without a card); NZD 20 per visit for children aged 6-18 years (family with a card); NZD 15 per visit for adults (over 18 years) with a card.

The Community Services Card was introduced in February 1992 to provide health care subsidies to people on low to middle incomes. This includes people on income-tested welfare benefits, and families who earn below a certain threshold. In 2001 the income limits start from NZD 18 586 for a single person sharing accommodation and increase depending on the size

of the family. For example, the limit for a family of four is NZD 39 089. At 1 July 2001 there were 1 127 517 current cards in circulation.

The High Use Health Card offers the same subsidies as the Community Services Card, for people with greater health needs for GP services. In 2001 the criteria were that the individual must have visited their GP more then 12 times in the previous 12 months for an ongoing condition(s). This is irrespective of an individual's income. Unlike the Community Services Card, which is issued to families, the High Use Health Card is specific to one person. At 30 October 2001, 35 280 people held High Use Health Cards, 55% of these in the over 60 age group.

The Free Child Health Scheme, introduced in 1996, subsidises general practitioner consultations for children under six. The subsidy of NZD 32.50 was intended to cover most of the consultation fee, but the amount has not changed since its introduction, so that GPs are finding it difficult to maintain the service without co-payment. Children between six and eighteen years also have their GP visits subsidised, and children whose parents have a concession card attract a higher level of subsidy.

Pharmaceuticals are free for public hospital inpatients and outpatients. People pay a maximum co-payment of NZD 15 per item on the Pharmaceutical Schedule from community-based pharmacies with children under six being exempt. Pharmaceutical co-payments are reduced for people with Community Services or High Use Health Cards to NZD 3. These costs apply to pharmaceuticals on the Pharmaceutical Schedule (administered by PHARMAC), but any prescription written for a non-schedule or partially subsidised item[1] will incur an additional charge, regardless of the patient's card-holding status. Prescribing of generics is encouraged by the reference-pricing scheme. *The Pharmaceutical Subsidy Card* entitles the holder and their family to prescription charges of only NZD 2 per item for the rest of the year after the first 20 pharmaceutical items. If the holder of a Pharmaceutical Subsidy Card also holds a Community Services Card then they pay no prescription fee at all after the first 20 prescriptions.

Maternity services are free (although some services such as extra ultrasounds are charged) and women can choose their provider (medical practitioner or midwife) and location for birth (hospital or home delivery). The government pays a set fee for each birth. Women register with their chosen professional (lead maternity carer), who undertakes a woman's care through pregnancy, birth and after, and is able to attend the patient for delivery in the public hospital of their choice. The government also pays the hospital with no cost to the patient.

Medical aids and prostheses are free for children under 16 years. For adults over 16 years, the government fully subsidises medical items required for employment or educational training purposes; a small co-payment is required for some other items, for example, NZD 37 for an artificial limb.

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

The government of New Zealand (a unitary government) has overall responsibility for ensuring the provision of health care services, which are funded mainly through nationally

[1] Under the reference pricing scheme, at least one drug (the reference priced drug) in each therapeutic class is available without any additional charge (apart from the co-payment). Other drugs in the same therapeutic class are subsidized at the "reference price", but pharmaceutical manufacturers are free to charge an additional price, and many – not all – do so.

collected taxation revenue (although some minor environmental health and health protection functions are funded by local government).

The health budget is determined in the government annual budgetary process, from 1997/98 taking into account 'a sustainable long-term path' formula that adjusts for various pressures on health expenditure including predicted price increases and the net effect of technological changes. Health care funding, based upon increases from the previous round plus the above formula, achieved annual real growth of about 2% in the health budget, though typically there were additional annual 'top-ups' to the health budget amounting to another 1% in some years. In December 2001, the Minister of Health announced a move to a three-year funding package so that District Health Boards could plan ahead with more certainty (and also theoretically manage within their budgets).

The Ministry of Health negotiates the health budget with the Treasury, with the final appropriation determined in the health budget line (named 'Vote: Health'). The appropriation is divided into departmental (the Ministry of Health's own budget) and non-departmental blocks (allocated to District Health Boards on the basis of a needs-weighted population formula to finance health and social care expenditure). 'Ring fencing' within the allocations to District Health Boards and other programmes is used to protect several categories of expenditure, such as public health, mental health and disability support services.

4.2 Organisation of purchasing/contracting

The New Zealand health care sector has undergone major structural changes over the last two decades. From 1993-1999, a purchaser-provider split was put in place and purchasing was undertaken, first by four regional health authorities and then by one central Health Funding Authority. Public hospitals and community services during this period were organised as 23 autonomous Crown-owned enterprises, analogous to NHS Trusts. In 1999, the Labour/Alliance government mostly eliminated the purchaser/provider split and decentralised many aspects of health resource allocation. The New Zealand Health and Disability Act 2000 disestablished the Health Funding Authority and created 21 District Health Boards, returning responsibility for health care funding and delivery to these Boards. The District Health Boards cover geographically defined populations, own and manage public hospitals and community health services and public health programmes (that take the majority of the DHB budget), and also purchase services from private providers of primary and community services within their regions. They are crown entities (statutory corporations) and are responsible to the Minister of Health for setting their strategic direction, for appointing their chief executive, and for their own performance. A majority of members of the Boards are locally elected, with the balance of members appointed by the Minister of Health.

The Ministry of Health allocates resources to the 21 District Health Boards, from 2002 in a three-year funding package, and is gradually moving from historic expenditure allocations to formula allocation, based on population-based funding (which has been operating in New Zealand since 1983). This is based upon the number of people living in each region, the ethnicity and age structure, and population characteristics that affect the need for health and disability services.

The New Zealand Public Health and Disability Act 2000 requires the District Health Boards to develop and make public the following accountability documents: a 5-10 year strategic plan developed in consultation with the community and endorsed by the Minister of Health, an annual plan and funding agreement to be agreed with the Minister, and regular monthly and quarterly reports against the annual plan. A District Health Board is not supposed to unduly favour its own hospital and other services above those of other providers (such as general practitioners, Māori health services, and disability services). Crown funding

agreements are drawn up between the Crown, District Health Boards and other providers of services. Detailed purchase of service contracts are drawn up between the District Health Board and state and private providers. Providers must be given notice on the terms and conditions under which payments will be made. The Act requires these notices to be nationally consistent where possible in order to keep down transaction costs and maintain a degree of national consistency and equity of access.

Ambulatory care

General practitioners are predominantly private practitioners with two-thirds working in group practices. Most practices receive their income from government subsidies for consultations with concession cardholders and children (received retrospectively as fee-for-service subsidies by 85% of GPs) and via capitation-based contracts (15% of GPs mostly in lower income areas). The other main sources of GP income are patient fees and payments from the Accident Compensation scheme, which reimburses GPs for patient consultations and also for a range of diagnostic and treatment services for accidental injury. GPs set their own fees but these are influenced by the flat rate government subsidies. Dating from the 1993 Health and Disability Services Act, GPs were encouraged to form Independent Practitioner Associations (described later), which took responsibility for managing the budget for a wider range of primary care expenditure, the incentive being that practices could retain part of any savings. Subsidies to GPs (and also pharmaceutical prescriptions) are monitored, audited and paid by Health Benefits Ltd, a stand alone business unit in the Ministry of Health, which handles about NZ1.2 billion annually.

Hospital care

A hospital is given a prospective fixed operating budget for the year, currently by its District Health Board, which is intended to cover all operating expenses apart from major capital expenditure. Hospitals are paid for each patient on the basis of case weights (diagnosis related groups), which set a price/volume schedule for the year, although a hospital can trade volumes between specialities to fill areas of needs. Hospitals now have more financial incentives to manage within their budgets given prospective funding and DRG case-mix payments, which payment methods both encourage cost-effective care.

District Health Boards enjoy a high degree of financial autonomy. They are able to retain and carry forward cash surpluses, can operate bank accounts with any private sector bank, and can access overdraft facilities on normal commercial terms. They are free to borrow from private capital markets without explicit government guarantee to finance major capital investment, although major capital projects are subject to government approval.

The majority of specialists in the public sector are paid a salary. Most hospital specialists also supplement their incomes with private practice. In the private sector, doctors providing services to hospitals are paid primarily on a fee-for-service basis. After a period of individual bargaining during the 1990s between employers and employees, the new Employment Relations Act 2000 encourages collective agreements. Hospital specialists' employment contracts and all other staff employment contracts are negotiated locally, directly with their employers, the District Health Boards**.**

The Accident Compensation scheme pays for patients to receive hospital and specialist care in the hospital of the choice, from the specialist of their choice, whether in the public or private sectors. In practice, emergency hospital care is only available in public hospitals, so this choice is exercised for non-urgent care. The Accident Compensation scheme contracts with public hospitals on a prospective basis but pays private hospitals and specialists on a fee-for-service basis.

5 HOW MUCH IS SPENT AND ON WHAT?

5.1 Expenditure

Total expenditure on health care in New Zealand in constant prices (1998/1999 prices) increased steadily in the 1980s and 1990s, with a 2.8% annual rise from a relatively low level (Table 6.2). New Zealand's total health care expenditure as a percentage of Gross Domestic Product (GDP) was only 5.2% in 1987, reflecting the depressed economy of the time, then rose steadily to 8.2% of GDP by 1997/98. New Zealand spends a similar amount on health care to OECD countries with similar levels of GDP. In 1998, New Zealand was 16th for health expenditure in the OECD as a percentage of GDP and 19th for per capita health expenditure. Total per capita expenditure (controlling for purchasing power parity PPP) in 1998 was USD 1440 compared to USD 1510 in the United Kingdom. Per capita expenditure in 1997 was lower than the European Union average of USD 1771 and ranked about 18th in the OECD.

Table 6.2 Health care expenditure, Consumer Price Index (CPI) deflated trends

	Total expenditure (NZD million 1998/99)		
	Public	Private	Total
1979/80	4369	596	4965
1984/85	404	629	4833
1989/90	473	1061	6033
1994/95	589	1624	7112
1995/96	5534	1683	7218
1996/97	5843	1717	7560
1997/98	6208	1851	8059
1998/99*	6490	1886	8376
RAAGR**	2.1%	6.2%	2.8%

Source: Ministry of Health

Note: Totals may not always add up due to rounding. 1997/98 expenditure has been revised.

*Estimated

**Real annual average growth rate between 1979/80 and 1998/99 for total funding.

New Zealand reduced the role of government as the dominant provider of health care services in its quasi market environment during the 1990s, and the share of government spending on health that went to private and non-profit providers increased from 31% in 1992/93 to 39% in 1996/97. The public share of total expenditure on health care has decreased since 1979/80 (as shown earlier in Table 6.1) mainly because out-of-pocket payments by patients have increased such as co-payments for prescriptions, while subsidies for GP consultations are not adjusted for inflation. In addition, waiting times in public hospitals for outpatient consultations and elective surgery increased, with the result that patients who could afford to 'go private' increasingly did so. Over 60% of private insurance finance goes to private hospitals, then payments to general practitioners and then on pharmaceuticals. Moreover, more private non-profit provision was encouraged in community health services, Māori health services and long-term care.

Little comparative information is available in relation to areas of expenditure. The shift in responsibility during the 1990s for funding and purchasing, from the Ministry of Health to regional and then to the central purchasing authority and from 2000 to the District Health

Boards, means that trends within the health budget are difficult to trace. About 60% of total health expenditure went on inpatient care in the early 1990s (Table 6.3), which in OECD terms is a relatively high proportion, but in New Zealand, public hospitals provide a wide range of community health services and social care services.

Table 6.3 Health care expenditure by type of service, as percentage of total expenditure on health, 1990-97

	1990	1991	1992	1993	1994	1995	1996	1997
Inpatient care (%)	60.4	59.1	56.5	59.1	NA	NA	NA	NA
Psychiatric care (%)	0.1	0.1	0.1	NA	NA	3.2*	4.3*	4.1*
Outpatient care (%)	7.4	7.3	7.1	NA	NA	NA	NA	NA
Pharmaceuticals (%)	NA	NA	NA	NA	12.8	13.3	12.5	12.2
Investment (%)	2.8	3.6	3.5	3.9	NA	NA	NA	NA

Source: Ministry of Health 1999

NA = not available

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

Patients' rights are set out under various pieces of legislation. The Health and Disability Commissioner (under the Health and Disability Commissioner Act 1994) is responsible for protecting the rights of health and disability consumers, set out under a Code of Rights. The recent New Zealand Health Strategy identifies individual rights and consumer consultation as key issues (Ministry of Health 2000).

The many service providers, such as general practitioner and hospitals, keep their own patient information and there is no single medical record.

6.2 Ambulatory care

General practitioners (GPs) provide most primary medical care from their private practices. About 27% of GPs work in sole private practices, two-thirds in group practices and the remainder (about 6%) in other organisations such as community health centres. Patients have a choice of general practitioners and are free to see more than one GP, although in practice continuity of care is high. GPs perform a gate-keeping role since an individual cannot access public secondary and tertiary services unless they are referred by their GP (except for accident and emergency services) and most private specialists only see patients referred by a GP. All GPs are required to provide an after-hours service and many have developed GP co-operatives for after-hours care. The waiting time to see a GP is not regarded as a major problem and most patients attend on an appointment basis. The quality of GP services generally is perceived to be good with no major problems emerging in small surveys of patient satisfaction. The Commonwealth Fund 1998 survey also reported higher levels of satisfaction with visits to doctors in New Zealand, Australia and Canada (over 87% rated care as good) than in Britain and the United States.

Dating from the 1993 Health and Disability Services Act, GPs were encouraged to form larger organisations, often called Independent Practitioner Associations (IPAs), which took responsibility for managing the budget for a wider range of primary and ambulatory care expenditure, such as prescriptions, diagnostic tests and a range of other community services. The incentive was that practices could retain part of any savings and by 1999 over 80% of GPs were members of IPAs. These organisations also aimed to improve clinical quality and cost effectiveness of service delivery within primary care and initiated a range of pilot projects

to improve the integration of primary care, social care and secondary care services, particularly in relation to management of chronic conditions.

The Primary Health Care Strategy 2001 announced the creation of Primary Health Organisations. These non-profit bodies, formed in large part by groups of GPs thus building upon the IPAs, will manage capitation funds for enrolled patients with funds allocated by the local District Health Board. People will be encouraged to join a Primary Health Organisation, usually by enrolling with a 'provider of first-contact' (a GP) who will become responsible for managing their care. The practice would be paid a capitation fee per enrolled patient. As well as improving the quality of primary health care, these organisations are expected to improve access for low-income patients.

National data collection on the number of GP visits per person per year is based on a household survey, since administrative data are collected only on subsidised visits. According to the 1996/97 Health Survey over 80% of the population visited a GP at least once in the preceding year. Access to primary health care remains an issue, however, since surveys have shown that people living in disadvantaged areas make less use of primary health care services. A 1998 survey of five countries by The Commonwealth Fund reported that 25% of below average income respondents in New Zealand reported difficulty in getting health care (compared to 20% in Australia, 17% in Britain, 25% in Canada and 48% in the United States). The New Zealand Primary Health Care Strategy is intended to address this inequity.

About 37% of practising physicians are general practitioners. There were 2.25 medical practitioners per 1000 population in 2000 (Table 6.4), fewer than many OECD countries, and 8.5 per 1000 registered nurses (plus another 1.1 lesser-trained nurses), a higher proportion than many OECD countries.

Table 6.4 Health care personnel in New Zealand, per 1000 population, 1990, 1995 and 2000

Professionals per 1000 population	1990	1995	2000
Medical practitioners	1.88	2.11	2.25
Registered nurses & Midwives	7.3	8.3	8.5
Enrolled Nurses	1.9	1.8	1.1
Dentists	0.36	NA	0.42
Pharmacists	1.03	NA	0.99
Physiotherapists	0.53	NA	0.65
Occupational Therapists	0.23	NA	0.36
Optometrists	0.08	NA	0.13

Source: New Zealand Health Information Service 2001

NA = not available

The 'third sector' of non-profit, non-government organisations has expanded rapidly, particularly with the contracting out of services during the 1990s. These organisations include disability services, community trusts including Māori health care providers, and other primary care services. During the 1990s, Health Authorities were charged with fostering the development of Māori health services oriented to meeting the specific health needs of Māori in culturally acceptable ways and with Māori leadership/participation. The 1990s saw a ten-fold growth in the number of independent Māori providers, typically non-profit primary and community health services under contract to health authorities.

6.3 Secondary care

Patients access secondary care via a GP referral and generally the referral would be limited to the geographic boundary of the District Health Board (21 across NEW ZEALAND), except for tertiary health services. Specialist physicians and surgeons provide ambulatory care in community-based public or private clinics or in hospital outpatient departments. Most specialists are employed by public sector hospitals but many also maintain their own private practices. Although no comparative data are available, hospital outpatient departments play a larger role in the health system since treatment is free while consultations with community-based practitioners are charged, compared to, for example, Australia where ambulatory care is subsidised by Medicare.

Publicly owned hospitals provide most secondary and tertiary care, while the growing private sector specialises mainly in elective surgery and long term care. Public hospitals are not permitted to treat private patients (there are no 'private pay beds' in NEW ZEALAND public hospitals).

The waiting times for specialist assessment and treatment have long been regarded as a public policy priority with a new booking system introduced in 1996 that has improved the selection, management and scheduling of patients for surgery (partly by eliminating double booking). This initiative has attracted considerable international attention. Waiting lists are managed using 'clinical priority assessment criteria' based on point system by urgency and type of condition that is standardised across New Zealand. Patients follow three possible paths after initial assessment: a) certainty of treatment for all within 6 months; b) active review every 6 months; or c) back to their GP for management. The government policy is that patients should be treated within 6 months, and offered a booked appointment. This initiative has been successful in reducing numbers waiting and average waiting times. Of patients waiting for elective treatment in the first half of 2000/2001, 59% received specialist assessment within two months and over 83% of patients received a specialist assessment within 6 months. This represented a 40% drop in those waiting more than 6 months compared to the previous year. The Health Funding Authority (now abolished) also tied a minimum level of hospital funds to elective services since, otherwise, surgery schedules concentrated upon acute cases. Finally, the government set up a special fund to clear the public hospital backlog by contracting out some elective surgery to the private sector or out-of-area public hospitals.

The population ratio of all hospital beds (acute and long term) was 6.2 per 1000 population in 1998, when New Zealand had fewer overall beds for its population, than for example, Australia, but more than the United Kingdom. Acute hospital beds have been reduced but as there is no clear distinction made as yet in New Zealand between acute and long term care beds, OECD time series statistics are not available. The number of public hospitals beds dropped by 22% between 1993 and 2001 (with the closure of many small public hospitals), but private hospital beds increased by nearly 60% (private beds now make up 48% of the bed stock).

Admissions per 100 population to all New Zealand hospitals have decreased slightly over the last decade, but urgent medicine discharges from acute care hospitals have risen, which is in line with upward trends in most OECD countries. The average length of stay in acute care hospitals in 1998 was 4.9 days, similar to the United Kingdom and Australia. Day patients accounted for 25% of hospital discharges in 1997/98, a lower proportion than in Australia. A 1998 government report promised to improve the cost-effectiveness of New Zealand hospitals; however recent data have not been published although reports in the early 1990s showed some decline in unit costs when more 'market-like' practices were introduced.

6.4 Diagnostic services

Diagnostic and laboratory services are provided mainly by the private sector upon referral from a physician. Service providers (currently the District Health Boards) make decisions on the purchase of new technology. Given the many structural changes, decentralised purchasing and also funding constraints, there has been little overall planning or regulation of new technologies. New Zealand seems to have a plentiful supply of high tech equipment. In 1998 there were 4.5 MRIs per million population and 8.9 CT scanners, a much higher proportion than in the UK.

6.5 Pharmaceutical care

Most pharmacies are community-based and in the private sector. Two government agencies regulate the use of pharmaceuticals: Medsafe is responsible for the licensing of medicines for distribution in the New Zealand market and is charged with ensuring that medicines are safe and effective; PHARMAC is the price regulator, and decides on subsidy levels after Medsafe has approved drugs for use. The Pharmaceutical Schedule lists almost 3000 drugs and services that are subsidised by government. This schedule, updated monthly and reprinted three times a year, also sets out prescription guidelines and records the price of each drug and the subsidy. About 50 new products are added to the Schedule each year. A wide range of subsidised medicines, approved appliances and related products are listed on the Pharmaceutical Schedule, and can be prescribed by medical practitioners, midwives, nurses and dentists. Consumers make a small co-payment, (a dispensing charge) while concession mechanisms ensure that people can afford drugs.

As a monopoly purchaser with considerable bargaining power, PHARMAC has applied supply-side controls with some success. For example, the application of reference pricing means that all pharmaceuticals in a given sub-group are subsidised at the level of the lowest priced pharmaceutical. The Health Funding Authority (now abolished) contracted with GPs to manage pharmaceutical budgets; slightly more efficient contracts were negotiated with pharmacies; and more efficient and effective prescribing by GPs and specialists was encouraged, including more use of generic drugs. Consumer co-payments for pharmaceuticals were also intended to manage consumer demand and contain expenditure. Demand side controls have been less successful.

6.6 Social care

Social care services are predominantly publicly funded and are offered by a mix of public and private providers, depending upon the area, with responsibility for social care mostly being integrated into the health system. Most mental health specialist services are provided by District Health Boards, and most community-based residential and day services are provided by around 250 non-governmental organisations. Typically, a person with a psychiatric disability living in the community is treated by a public sector community mental health team but receives day-to-day support from non-governmental organisations.

Funds and responsibilities for disability services and long term care for older people were transferred from the Department of Social Welfare to the Ministry of Health between 1993-1997. This move was also associated with introduction of a global cash-limit for open-ended social care subsidies for residential care. During this period, independent needs assessment and service co-ordination was established to make access more equitable and to facilitate better co-ordination for the patient/client among health and social care partners. Independent needs assessment was also seen as a form of consumer protection from excessive rationing within the newly cash-limited social care system. Historically, most community-based

services for people with disabilities under the age of 65 years have been provided by non-profit agencies.

Aged residential care is provided mostly by private for-profit and voluntary sector agencies. The Ministry of Health monitors nursing homes for older people, who are means-tested for their ability to pay for their own care. The care of older people will become a more important public policy issue in New Zealand, since the proportion of people aged 60 years and over is projected to increase from 15.6% of the population of the population in 2000 to 29.3% in 2050.

7 THE PATIENT JOURNEY

A patient needing, for example, a hip replacement operation first visits her GP private practice where she is likely to be a long-standing patient. The patient pays a reduced fee (about half), since as a low-income pensioner she holds a Community Services Card or may hold a High Use Health Card. She may have taken out private health insurance to cover the gap. The GP refers the patient to a specialist at the hospital outpatient clinic where the specialist works as a public orthopaedic surgeon. If she is a high priority she should get an operation within 2 months, otherwise she should wait no more than 6 months (for public hospital treatment). All care in a public hospital is covered. If the patient elects to be referred by her GP as a private patient (to a private specialist's rooms or a private hospital) in order to receive faster access (and because she has private health insurance) the amount of rebate depends upon the level of private cover. She will get rehabilitation and some post-discharge home nursing care free in the short-term (funded by the District Health Board), if the care is needed for a longer period it is subject to means testing. If she needed hip surgery as a result of a fall, however, her care at all points would be paid for by the Accident Compensation scheme. In this case, all of her care would be free of charge and free of means testing. She would have choice of referral to a public outpatient clinic or a private consultant and to a public or private hospital. In this case, she would encounter no waits at any point in the patient journey.

8 WHAT ARE THE MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM?

The main issues being debated include the ongoing restructuring of the New Zealand health care system which has undergone major structural changes over the last two decades, more so than in most OECD countries, such that providers are 'weary and wary of change'. It has moved from a nationally-financed but local-government based system of health service delivery in the post-war years, through regionalised services in the 1980s, to a stronger focus on national standards and accountability in the late 1980s, through variations on a quasi-market model in the 1990s, to the current model where regional governance is again a major feature but within a stronger framework of national regulation and oversight. The view of the new Government that came into power at the end of the 1990s was that the 'internal market' had not delivered significant improvements in efficiency, the quality of care had not improved, and the public had lost confidence. Prior to the apparent rejection of the quasi-market model of health care by voters, a five-nation survey by The Commonwealth Fund conducted in 1998 showed that nearly 90% of New Zealanders (and particularly those on lower incomes) thought that the health care system needed fundamental change compared with nearly 80% in Australia, Canada and the United States, and 72% in the United Kingdom.

Equity of access remains a key issue since the health care system relies on significant user co-payments for primary health care. Out-of-pocket expenditures have risen with an increasing array of charges and patient co-payments. The proposed Primary Health Organisations funded through patient capitation are intended to extend access and improve the quality of care for

such patients. There is also a perception that the health care system is under-funded since many District Health Boards are in deficit.

Citizen participation in decision-making has been reinforced with the establishment of elected District Health Boards. While these will be more democratic than a purely appointment based system, there is the danger they may be captured by special interest groups. The challenge will be to balance the needs of special interest groups against the population needs identified in assessment exercises. The expansion and development of Māori health care is a policy priority as is making mainstream providers more culturally sensitive. Māori claims for more say over their own health care are linked to the political goals of indigenous people for greater power in their own land. Despite the continued disparities in health, there have been significant gains for Māori health over the last decade.

Quality of care is a current policy priority with initiatives planned to promote clinical excellence. There is little evidence as to whether quality of care improved or faltered during the 1990s and there are few outcome measures in place to evaluate hospital or physician performance.

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10 WEBSITES

Health Research Council	http://www.hrc.govt.nz
Statistics New Zealand	http://www.stats.govt.nz
The Medical Council of New Zealand	http://www.mcnz.org.nz
The Ministry of Health	http://www.moh.govt.nz
The National Health Committee	http://www.nhc.govt.nz
The New Zealand Health Information Service	http://www.nzhis.govt.nz

SWEDEN[1]

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[1] This case study draws extensively on *Health Care Systems in Transition: Sweden* http://www.euro.who.int/document/e73430.pdf . The authors would like to acknowledge the valuable work of Catharina Hjortsberg and Ola Ghatnekar.

1 INTRODUCTION

Health and social care in Sweden are mainly a devolved responsibility to the county councils, while long-term care is devolved further to the municipalities. The majority of funding comes from county council taxes, supplemented by grants from the national government. The county councils are responsible for the purchasing of health services and either act as purchasers themselves or devolve this responsibility to other purchasing agents. Ambulatory care is provided by a mix of public (salaried) doctors, private doctors and hospital outpatient departments. Hospitals are publicly owned but have independent status: the extent of privatisation varies between counties.

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

The Swedish national health service (NHS) provides coverage for all residents irrespective of their nationality. In addition, it guarantees emergency care for all EU/EEA citizens and for nine other countries with which Sweden has signed bilateral agreements. As the NHS provides care services to all residents, no substitutive private coverage is available. There is a negligible percentage of the population that has taken out supplementary voluntary insurance. It is generally thought that voluntary health insurance is taken out by the better off and predominantly in urban areas (although there is no specific information available on this factor).

2.2 Benefits

No basic or essential health care package has been defined. Instead, there are three major, nationally-stipulated, ranked principles which should be used for priority-setting in the health care sector (human rights, need or solidarity, and cost-effectiveness). The only benefit for which partial coverage restrictions apply to particular age groups is dental care, although this is fully provided free-of-charge until the age of 19. The National Social Insurance Board (NSIB) is responsible for deciding which new drugs should be included in the Drug Benefit Scheme (which lists publicly subsidised pharmaceuticals), based on applications from pharmaceutical companies. Negotiations are confidential and are based on information supplied by the individual company, as the NSIB does not accept independent research.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

Health and social care in Sweden are mostly financed by local taxation. Local taxes are composed of three elements: municipal, county and parish taxes. The county councils and municipalities have the right to levy income tax on their residents and to decide the rates of taxation. Local taxes are proportional to income. In 1998 the average combined rate of local income taxation was 31.65%.

Health care is governed and managed at the county level and represents 85% of total county expenditure. It is mostly financed by county taxes, which represent 66% of total health care expenditure. Central taxes, through state grants to councils, account for an additional 7-11% of expenditure. In total, therefore, taxes represent some 73-77% of public expenditure on health. Patient fees and social insurance contributions constitute the two main additional sources of funding (see below). Total health care expenditure was SEK 127 billion in 1998 (8.4% of GNP), and the sector employed some 300 000 people.

Social care is mainly financed by municipal taxes, and it represents some 27% of total municipal expenditure. Total expenditure on care for the elderly represented SEK 60 billion in 1998, some 3.4% of the GNP. The sector employed 180 000 people in 1999.

Central state grants to the county councils are financed through national income taxes and indirect taxes. Even though central taxes are strongly progressive, overall the financing system is slightly regressive. This is mainly due to local taxes being proportional, to the high level of co-payments (which are markedly regressive) and to high, regressive indirect taxes (which were 24% of the total tax revenue in 1998).

3.2 Social health insurance contributions

The national social insurance system financed 21-25% of total health care expenditure in 1999. Social insurance contributions are compulsory for all those in employment. However, all Swedish residents are entitled to the benefits. In 2000, public and private employers paid a contribution to the social insurance system of 8.5% of employees' salaries, while the self-employed paid 8.23% of their wages in 1999. There is no income ceiling, and as a result contributions are slightly progressive.

3.3 Voluntary health insurance premiums

In Sweden the voluntary health insurance market is extremely marginal. Voluntary health insurance is usually issued by employers on behalf of their employees, and it is often taken out in order to have faster access to treatment. There is no tax break for private insurance premiums. The Swedish insurance company Skandia currently is the largest company in the private health insurance market with about 30 000 people (approximately 0.13% of the population) insured. In addition to Skandia, most for-profit insurance companies offer private health insurance, and it is estimated that approximately 120 000 people are insured, mostly through employer-purchased insurance plans.

3.4 User charges

User charges represent 2% of total public funding. There are direct patient fees for most medical services in the form of flat rate payments. Each county council determines its own fee schedule although the national parliament has set ceilings on the total that any one citizen can pay in any 12-month period (annual out-of-pocket maximum currently set at EUR 99) not including inpatient care. After the ceiling is reached, the patient pays no further charges for the remainder of the 12-month period.

The following basic fees apply (amounts show variation between county councils):

- Consultation with a public physician in primary health care: EUR 11 – EUR 15 (2000)
- Consultation with a specialist in a hospital: EUR 16 – EUR 27 (1999)
- Inpatient stay daily charge: EUR 8.6 per day (reductions are possible for pensioners and low income groups)
- Transportation to health care facilities: EUR 5.5 – EUR 6.5 (the elderly and the disabled are normally entitled to subsidies)

A patient will have to meet the additional cost of a consultation with a private, contracted ambulatory doctor out-of-pocket (the public sector often subsidises less than 50% of the total cost). Vaccinations, health examinations and consultations, as well as other types of treatment provided at primary care clinics, are free-of-charge to all children of school age.

The ceiling for individual co-payments for prescribed drugs is separated from other health care services and is administered by the National Corporation of Swedish Pharmacies. The ceiling is uniform throughout the country and determined by the central government. The Drug Benefit Scheme establishes a ceiling on co-payments for technical devices of about EUR 225 for each twelve-month period. For the same period, the ceiling for co-payments for outpatient prescribed drugs is EUR 198. The patient has to pay the full cost for prescribed drugs up to EUR 99 (SEK 900), after which the coinsurance rate gradually decreases in accordance with the cost of drugs, up to a maximum level of EUR 472 (SEK 4301) after which the drugs are free to the consumer (Table 7.1).

Table 7.1. Cost of prescribed drugs and associated coinsurance rates in Sweden

Cost of pharmaceuticals in SEK	Coinsurance rates
0-900	100%
901-1700	50%
1701-3300	25%
3301-4300	10%
4301 and upwards	0%

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

The National Tax Board (RSV) and its regional (21) and local administration offices collect both social insurance contributions and central taxes. The regional social insurance offices also offer a public service and handle matters relating to the social insurance and other benefits system at regional and local level, the only exception being unemployment insurance. The social insurance system subsidises prices for all pharmaceuticals, dental care for citizens over 20 years of age, the cost of private contracted-out care and cross-county flows.

Municipalities and county councils levy and collect their own taxes. In 1999, 66% of county councils' total income was generated through county taxes. In 2000, 56% of the municipalities' total income was generated through municipality taxes. Most of the remainder is met through grants from the central government and the social health insurance board. The allocation formula that determines state grants to county councils for health care is based on weighted capitation, according to sex, age, whether living alone, occupation, income, housing tenure and other indicators of health needs.

Taxes are not earmarked. However, because county taxes are the main source of financing and health care is almost the only public programme managed by counties (more specifically, it represents 85% of total counties expenditure) there is the appearance of earmarking. In addition, most central state transfers to counties (both through the state and the national insurance board) are earmarked.

There is no information on the premiums collected by voluntary insurance companies, or on the level of competition within the private insurance health market.

4.2 Organisation of purchasing/contracting

Since the beginning of the 1990s, county councils have progressively introduced a purchaser-provider split, following the launch of the internal market reforms in 1989. By 1999, three quarters of county councils had established this model. The purchasing organisations vary across (and, in some cases, within) the county councils. Some of them introduced one large central county council purchasing organisation, while others introduced purchasing organisations at district level. Two county councils, Dalarna and Bohus, introduced local

purchasing so that each local municipal boundary constitutes one purchasing organisation. As providers are mostly public, purchasers and providers belong to the same public organisation. Administrative staff, rather than political appointees, carry out the actual negotiations with providers.

The purchaser-provider split has been tempered during the second part of the 1990s and early 2000s. This has been interpreted as part of a general move to promote co-operation rather than competition among the main actors operating in the health care field, motivated partly by an awareness that competition and incentives were driving both costs and activity upwards.

Since 1995 the attempt to promote competition among public providers was progressively slowed down partly due to a change in government (with the Social Democrats regaining office at the central government level), and partly due to public discontent. In fact, between 1996 and 1998 public satisfaction with the public system decreased from 68 to 58% of the population, one of the biggest decreases experienced within the EU. But this has to be examined against the background of the sustained effort at cost-containment during the 1990s.

District purchasing agencies were integrated into unified county agencies, and in several counties, the management of many county hospitals was transferred to a single managerial team during the period 1997-1998 as a result of broader political and financial factors. Some counties even promoted mergers and agreements at the regional level in order to expand the scale of operation of both purchasers and providers.

The 1998 elections brought liberal coalitions to power in several county councils, and this resulted in a renewed emphasis on introducing private-like arrangements within public provision, as well as expanding the role of private providers within the public system. Among the former, the most important measures are the contracting out of technical and hotel services, and the reorganisation of hospitals as publicly owned companies. The latter development has involved on the one hand a small but sustained increase in private contracted ambulatory doctors.

On the other hand, in 1999 a general hospital in Stockholm was sold to a private company (Capio BA) by the county council. Capio operates in several Scandinavian countries, Switzerland, Poland and the UK. The company maintains that its contract with the government is 7%-12% cheaper than those of other comparable public hospitals. The initial 3-year contract was extended for another 4 years by the county council, up to 2006. However, the measure was fiercely opposed by the central government, which since January 2001 has banned the transfer of public hospitals to the private sector. The Stockholm County Council subsequently announced plans to promote further competitive tendering of hospitals by 2004. In addition Stockholm County Council has promoted the creation of new private-like organisational forms (mainly co-operatives) out of former public health centres, mainly in the fields of primary care, geriatrics and psychiatry.

The purchaser-provider split required new contractual arrangements and reformed payment schemes. The general underlying principle is that ‘money follows the patient’. The contracts are usually based on prospective per-case payments complemented with price or volume restrictions and quality guarantees. In short-term somatic care, DRGs (diagnostic-related groups) are the most common per-case payment scheme. With respect to hospital outpatient care, weighted visits are a common per-case payment scheme. In addition, per diem payments may complement per-case payments in the case of complex patients who exceed the average cost per case. Per-case payment systems vary substantially among county councils and hospitals. Psychiatric care, geriatric care and emergency services are usually reimbursed through global contracts. Highly specialised and resource demanding regional (tertiary) health care services are often reimbursed through capitation or global budgets. The prevailing

systems of payment are based, without exception, on fully absorbed costs, without a profit margin.

Primary health care providers at public facilities are employed by, and receive a monthly salary from, the county councils. They also receive extra payment for non-regular working hours. Capitation payments for ambulatory physicians were introduced by some counties in order to compensate for the expanded patient choice, as well as to create incentives to attract new patients and improve services. Most recently, target payments for some preventive services have been introduced. Some ambulatory doctors operate privately under contract with the county councils. Private practitioners are reimbursed by the county council on a fee-for-service basis (for only part of the cost of the consultation). They are also permitted to treat privately insured patients.

5 HOW MUCH IS SPENT AND ON WHAT?

5.1 Expenditure

Total expenditure on health as a percentage of GDP in Sweden amounted to 8.4% in 1998, slightly less than the EU average of 8.6%. The public share of total health expenditure decreased from 89.9% in 1990 to 83.8% in 1998, which is mainly explained by increased patient co-payments. In 1998, Sweden's health care expenditure in USD PPP per capita was 1746, slightly lower than the EU average. This reflects a sustained effort at cost-containment, which was translated into expenditure levels that remained relatively constant during most of the 1990s. In addition, the latter also partly reflects the transfer of long-term care for the sick elderly to the municipal social care sector. In 1999, secondary and tertiary health care accounted for 62.3% of county councils' total health care expenditure; 22.4% was spent on primary health care; 9.5% in psychiatric care and the remainder (5.8%) was spent on geriatric care.

Table 7.2: Trends in health care expenditure in Sweden, 1980-1998

	1980	1985	1990	1995	1996	1997	1998
Total expenditure on health care (billion ECU/EUR)	8.5	12.0	15.9	14.9	17.3	17.1	16.9
Thousands SEK per capita (1995 prices)	14.7	15.6	17.3	15.8	16.8	17.1	17.5
Share of GDP (%)	9.4	9	8.8	8.4	8.7	8.5	8.4
Public share of total exp. on health (%)	92.5	90.4	89.9	85.2	84.8	84.3	83.8

Source: Hjortsberg and Ghatnekar, 2001, based on OECD Health Data 2000

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

Residents in Sweden have access to a comprehensive package of health care services. Equity of access in primary and hospital care was high in Sweden according to a recently published comparative European study (van Doorslaer 2000). However, in general, access to secondary outpatient care services was better for the well-off. Particularly problematic is private specialist ambulatory care which is subsidised at a different rate than publicly provided care (see Section 3.4).

During the 1990s, several reform measures were passed in Sweden which expanded and regulated patients' rights. These were implemented through negotiations between the central government and the federation of county councils. Most notably, they include:

- In 1989 the Patient Choice and Care Guarantee reforms were passed. These require that hospital appointments should be given within a three-month period, and provide the possibility for patients to choose their hospital. These guarantees were removed again in 1996.
- In 1997, these provisions were introduced to the ambulatory sector. Care guarantees were regulated as follows: patients should receive care from a nurse practitioner at the health centre the same day; an appointment to see a GP must be offered within eight days; referrals to specialist care should be made within three months; and when the diagnosis is uncertain it must be offered within a month.
- In 1999, some additional paragraphs were added to the *1982 Health Care Act*, incorporating these and other measures which expanded patients' rights. Among the new provisions were the right to individually tailored information about one's medical condition, examinations, and care and treatment; patient choice of treatment when several alternatives are available; and the right to a second opinion.

Swedish citizens, as in other EU Member States, have the right to health care if they fall ill in another Member State.

The 1998 Medical Registers Act regulates the content and protection guarantees which should apply to all patient records in Sweden, and incorporates, together with other pieces of regulation, EU Directive 95/46/EC into Swedish legislation. In addition, the Swedish Health Care Standards Institution for IT development is currently in charge of achieving uniformity in patient records as well as allowing joint utilisation of patient information across health care providers.

6.2 Ambulatory care

Patients have the freedom to choose among first-contact care providers. First, they can choose between primary care centres or hospital outpatient departments. In fact, around 50% of all outpatient visits in Sweden are made at hospitals instead of health centres. One way in which county councils influence the decisions of patients is by charging patients higher fees for services in hospital outpatient departments than for visits to primary care centres.

Second, patients can also choose to use a private physician or clinic as first-contact care. However, as visits are only partially subsidised by the public sector, and private providers concentrate in urban areas, this alternative is not equally available to all social groups. Certain special rules apply when patients choose health care facilities outside their own county council and it is up to each county council to set such rules.

Around the mid-1990s, 90% of Swedish GPs had undertaken some sort of specific vocational training in family medicine, a figure clearly above the EU average. In 1995, a corresponding EU Directive was adopted, according to which all GPs must be specialists in general practice. Others directly employed at this level are nurses, midwives, physiotherapists and gynaecologists, who also form part of health centre staff. There are very few private physicians who receive direct remuneration from their patients for consultation and treatment. In 1997, of all the GPs working in primary health care 7% were independent private practitioners and 12% worked in private health centres.

Table 7.3. Length of wait for consultation and length of consultation in primary care in Spain, Finland, Portugal and Sweden, 1997

N = 6495	Spain	Finland	Portugal	Sweden	Average
Days waiting for consultation (%)					
0-1 day	92	39	50	37	57
2-4 days	8	22	10	9	13
5-8 days	0	33	15	27	18
> 8 days	0	6	25	27	13
Patients/week per doctor (average)	154	94	89	90	103
Duration of consultation (%)					
<5 minutes	52	29	30	36	37
5-9 minutes	35	27	25	27	29
10-14 minutes	10	29	29	17	22
15 minutes	3	15	16	20	13

Source: Pastor et al. (1997).

Sweden has relatively few physician contacts per person. In 1997 it had 2.8 outpatient contacts per person while the EU average was 6.2. In 1993 there were 2800 inhabitants per general practitioner; and in 1997 there were 0.56 GPs per 1000 population. These are among the lowest rates of primary care professionals per population within the EU. A related problem is the comparatively high waiting times for primary care, which since 1997 have been the target of several reform initiatives. In 1997, 37% of patients had to wait between 0 and 1 day for consultation; 9% between 2-4 days, 27% between 5-8 days and 27% more than 8 days.

By the mid-1990s, 87% of GPs in Sweden provided out-of-hours care; one of the highest levels within the EU. This service is provided by participation in a rota system. In 1997, the length of consultations at the primary level was higher than in other countries with similar organisational features at this level. Quality of services and facilities, in general, are considered to be good and since the mid-1990s a new set of regulations on quality issues has come into force.

The internal market reforms opened possibilities for primary care professionals to be involved in local purchasing boards, therefore expanding the powers of primary care over other levels of care. Currently, some counties are piloting the decentralisation of budgets for other services to the primary level and more recently, GPs have been appointed by hospitals and local boards as the co-ordinators of other levels of care.

6.3 Secondary care

Patients can access secondary care directly through a hospital outpatient department. Since the early 1990s, patient choice of provider has been guaranteed (including private doctors on contract with county councils). In many county councils patients can also select which hospital to be treated at, and in some cases, without referral. Most hospitals are publicly owned. There is currently a debate as to whether a law should be stipulated that prohibits private for-profit hospitals.

In 1999, the number of acute beds per 1000 population was 2.5, well below the European average. The number of total hospital beds sharply dropped from 12.4 beds per 1000 population in 1990 to 5.2 in 1997. Hospital productivity is over the EU average level. In 1996, the average length of stay, in days, for inpatient care was 7.5 days, while in the acute care sector it was 5.1 days. There were 15.6 acute care admissions per 100 population in 1998. The occupancy rate for acute hospital care was 77.5% in 1996.

The evolution of inpatient care partly reflects the introduction of new and more effective treatments, such as day-surgery. It also reflects the 1992 Ädel reforms, which transferred to municipalities economic responsibility for elderly patients whose clinical treatment at hospitals has been completed (the so-called *bed-blockers*). The reforms resulted in a parallel expansion of nursing homes and long-term care for the elderly at the municipal level, partly subsidised by the central state (see section 6.6.).

6.4 Diagnostic services and rehabilitation

Basic diagnostic and laboratory services are provided within primary health centres; and more specialised services in public hospitals. Rehabilitation falls under the responsibility of primary care centres, which either have salaried physiotherapists on board or contract out these services to private professionals.

6.5 Pharmaceutical care

The state has the exclusive right to conduct retail trade in drugs through the National Corporation of Swedish Pharmacies (NCSP), which maintains countrywide distribution, decides on the number and location of sale outlets (pharmacies) and runs all hospital pharmacies under a one-year contract with the county councils. Hospital pharmacies are only allowed to dispense drugs to public health care units. When buying pharmaceuticals only to be used at the hospital, hospitals may negotiate directly with suppliers. However, the process is regulated under the Law on Public Purchase. Within the county councils' health districts, pharmaceutical committees draw up drug formularies of which pharmaceuticals are to be used. This list is primarily intended for pharmaceuticals used in outpatient care. The latest pharmaceutical reform (1998) aimed at gradually giving county councils full responsibility (financial and other) for pharmaceuticals, after a transition period during which the social insurance system would continue to subsidise pharmaceuticals.

6.6 Social care

Social welfare services, integrated long-term care of the elderly and the disabled, and psychiatric patients are the responsibility of the municipalities. In 1992, the Ädel reforms transferred nursing homes to municipalities and made them financially and statutorily responsible for geriatric patients admitted to hospitals and who had completed their treatment there. This means that from the moment a patient is ready to be discharged, the municipality is responsible for the daily hospital bill. As the costs of hospital care to these patients are higher than the costs of residential care, the transfer of financial risk generates incentives for municipalities to seek early discharge of patients.

In addition, in 1999 about 50% of the municipalities had received transfers from county councils in the field of home care. During the 1990s, emphasis on internal markets, as well as the need for rapid capacity development resulting from the Ädel reforms, has led to the progressive contracting-out of municipal services. Some 10% of publicly funded social care was provided by for-profit private providers in 1999.

7 THE PATIENT'S JOURNEY

Patients have free choice of first-contact care provider. If they attend a health centre they should be able to see a nurse the same day, or obtain an appointment with a GP within 8 days. Patients have to pay a charge of between EUR 11 – EUR 15 for the consultation. If a patient opts to go to a hospital outpatient department he or she will have to pay higher fees, as would be the case if a private practitioner were to be chosen (contracted by the county council). If necessary a referral is made to specialist care. If an inpatient stay is required patients will have

to pay something towards their transport costs and also a daily charge for every night in hospital. If a patient is discharged early and still needs care the municipality will mange his or her transfer to a nursing home or to special housing. However, patients will have to pay higher out-of-pocket payments for community care than for hospital care.

8 MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM

Problems of access to health care resulting from long waiting times remain one of the most persistently problematic features of the Swedish health care system. In spite of the considerable efforts made during the 1990s to reduce waiting lists, currently they continue to be a problem at the core of the health care debate. Recent evidence points to waiting times for hospital care resuming the relatively high levels reached during the early 1990s, prior to the implementation of care guarantees for inpatient care.

Long waiting times might be associated with the relative shortage of health care professionals in Sweden. There is a general shortage of nurses with specialist skills across the country, as well as a shortage of physicians in isolated rural areas.

Another major issue is the capacity and quality of municipal community care. It is perceived to be too weak (in terms of under-capacity as well as quality) to absorb the increase in demand promoted by the Ädel reforms. In 1995, SEK 50 million were earmarked to support local initiatives to expand the long-term care network and raise quality standards. The reforms also have been criticised from the point of view of equity, based on the fact that patients who are discharged early have to face out-of-pocket payments in long-term health care that are not applicable in hospitals, as well as with reference to the substantial differences in the fee schemes set by counties (for primary care) and municipalities (for home care).

A very important challenge facing the health care system is a rapidly ageing (and considerably aged) population, which currently puts particular pressure on municipalities, which since the 1992 *Ädel* reforms have full responsibility for long-term care for the elderly and the disabled. Current problems with under-capacity as well as lagging quality levels will probably continue to require sustained action by policy-makers.

Another important policy debate focuses on the issue of private provision. Liberal coalitions, in power in several county councils since the late 1990s, have favoured an expanded role for the private sector. The increased use of private contracted-out providers for first-contact specialist care, whilst expanding freedom of choice does, however, push expenditure upwards. It also mainly favours the well-off, therefore increasing inequality across social groups. In addition, recent moves towards the privatisation of public providers, such as the recent privatisation of the management of a general hospital in Stockholm, will probably be at the centre of policy debates in the foreseeable future. This might exacerbate differences in the availability of providers between urban and rural areas, differences which have tended to increase during the 1990s following the expanded role of private physicians who are mainly concentrated in affluent urban areas.

Finally, the issue of cost-containment has remained high on the political agenda at the central government level, irrespective of the political party in office. This suggests that the old consensus that legitimised welfare expansion seems to be weaker than in the past. Since the mid 1990s, economic recovery has increased pressure from the Left and Green opposition parties to raise public expenditure in areas such as education and health. In addition, public dissatisfaction with austerity policies and expenditure cuts in social policies seems to have increased recently. This, together with the change in government, may be behind the evolution of expenditure during the late 1990s, which shows an increase of per capita health care expenditure. However, the relatively high GDP growth rates during these years accounts

for a constantly declining percentage of GDP spent on health care (which dropped from 9% in 1990 to 8.4% in 1998). The good results achieved for this specific indicator therefore look increasingly as if they are based on the favourable evolution of the economy, rather than cost-containment in health care.

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10 WEBSITES

Ministry of Health and Social Affairs	http://www.social.regeringen.se/inenglish/index.htm
National Board of Health and Welfare	http://www.sos.se/sosmenye.htm
National Institute of Public Health	http://www.fhi.se/english/pubHealth.asp
Statistics Sweden	http://www.scb.se/eng/index.asp
Swedish Federation of County Councils	http://www.lf.se/lfenglish/default.htm
(on health care)	http://www.si.se/docs/infosweden/engelska/fs76.pdf
(on social insurance)	http://www.si.se/docs/infosweden/engelska/fs5z.pdf

THE UNITED KINGDOM[1]

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[1] Unless otherwise specified the report will describe the situation in England. Where significant differences exist between the constituent countries, due to devolution of responsibilities for health care to the authorities in Scotland, Wales and Northern Ireland, these will be included.

1 INTRODUCTION

The responsibility for health care is devolved to the constituent countries of the United Kingdom: England, Wales, Scotland and Northern Ireland. In all countries, health care is predominantly funded through national taxation. Within each county, the responsibility for purchasing health services is being devolved to local bodies (Primary Care Trusts in England, Health Boards in Scotland, local health groups in Wales and Primary Care Partnerships in Northern Ireland). Primary care services are mainly provided by GPs and multi-professional teams in health centres (under a capitated budget). Hospitals are mainly publicly owned with independent trust status. Private hospitals mainly provide services to privately insured patients or those who are willing to pay directly.

2 WHO BENEFITS AND WHAT ARE THE BENEFITS?

2.1 Coverage

All legal residents of the United Kingdom are entitled to cover under the UK National Health Service (NHS). In addition residents of the European Economic Area (EEA) are entitled to care, as are residents and citizens of other countries with which the UK has reciprocal agreements (http://www.doh.gov.uk/overseasvisitors/patientguide.htm).

In the UK, 11.5% of the population have supplementary private medical insurance (Laing and Buisson 2001). Those most likely to have private medical insurance are in the higher income groups (40% of adults with PMI are in the highest income decile compared to less than 5% in the lowest) (Emmerson et al 2000). According to data from the General Household Survey 1995 12% of those between 45-64 years old had PMI compared to only 5% of those over 65 years old. PMI is also concentrated amongst those in the professional and managerial occupations (of whom around 22% have PMI compared to only 2% of those in semi-skilled manual and personal services). PMI policy holders are concentrated in London and the South East of England where around 20% of the population have PMI. In Scotland and the North the figure is as low as 5% of the population (Laing and Buisson 2001).

2.2 Benefits

NHS benefits are not explicitly defined. The National Health Service Act 1977 places a general responsibility on the Secretary of State to provide services "to such extent as he considers necessary to meet all reasonable requirements".

More recently with the establishment of the National Institute for Clinical Excellence (NICE) recommendations are being made to the Secretary of State as to whether the NHS should cover certain services for all of the population or for certain indications or defined subgroups of the population. NICE is a special health authority and is accountable to the Secretary of State for Health and to the National Assembly for Wales. Its decisions are based on analysis of the costs and benefits of a particular technology by the Appraisal Committee (http://www.nice.org.uk). NICE's guidance is not yet mandatory though recent government announcements suggest this is likely to change. The equivalent body in Scotland is the Scottish Intercollegiate Guidelines Network (SIGN).

Health authorities, with some discretionary powers, have generally made rationing decisions. With the further shift towards local purchasers (e.g. PCTs) it is likely that some rationing decisions will be further devolved.

The British National Formulary lists all drugs licensed for sale in the UK. It is not a positive list of drugs, however it does indicate which drugs are not available on NHS prescription.

Some products are excluded from NHS cover due to poor therapeutic value or excessive costs (Section 8a of the drug tariff). Other drugs are only available on NHS prescription in particular circumstances. There are hospital formularies and local formularies e.g. for Primary Care Trusts (PCTs) but no national formulary in the UK.

3 WHO PAYS AND HOW MUCH?

3.1 Taxation

Direct taxes are levied at the following rates: 10% (on first GBP 1880 of taxable income), 22% (GBP 1881–GBP 29 400) and 40% (over GBP 29 400) (http://www.inlandrevenue.gov.uk/rates/it.htm). The standard rate of value added tax (VAT) is 17.5%. Certain goods and services are zero rated or reduced rate (5%).

Rates of local taxation (council tax) vary between local authorities and are banded according to the value of the property within authorities. Some exemptions apply depending on the status of the occupiers (e.g. students, single occupants, second home). These revenues are not used to fund health care but do fund social services including home care and residential care for the elderly.

The progressivity of the taxes used for health care – as measured by the Kakwani Index (1977) – indicates that direct taxes in the UK were progressive (+0.28) and indirect taxes regressive (-0.15). Overall taxes were mildly progressive (+0.05) (Wagstaff et al 1999). Data on the distribution of the tax burden between income groups shows that direct taxes account for 24% of gross income of top quintile compared to 12% of the bottom quintile. Indirect taxes account for 12% of gross income of the top quintile and 28% of the bottom quintile. Overall the bottom income group pays 40% of income on taxation compared to 36% in the top income group. This measure of progressivity suggests that overall taxation in the UK might be regressive (Commission on Taxation and Citizenship 2000).

3.2 Social health insurance contributions

The equivalent to social insurance in the UK is National Insurance. The employee contribution is 10% of earned income between GBP 87 and GBP 575 per week and the employer contribution is 11.9% on earnings above GBP 87 with no upper ceiling (http://www.inlandrevenue.gov.uk/rates/nic.htm). A lower rate of GBP 2 per week applies to the self-employed plus a percentage of profits. These revenues go into the National Insurance Fund (which is managed by the Treasury). When funds are insufficient to pay out the required benefits (e.g. during periods of high unemployment) transfers are made from general taxation. However, any surplus is accumulated in the Fund. The rates are set every year by the government in the budget. Some groups such as the unemployed and carers are credited with contributions for purposes of benefit entitlement. Others may make voluntary contributions to retain entitlement. National Insurance contributions are less progressive than direct taxes according to the Kakwani Index (+0.19) (Wagstaff et al 1999).

3.3 Voluntary health insurance premia

Premia for private medical insurance (PMI) are risk rated for individual polices and group rated for group insurance. There is no regulation of premia. Income tax relief on policies for over 60s was introduced in 1991 but subsequently abolished in 1997. Employers may purchase PMI for employees out of pre-tax income. However employers must pay National Insurance contributions on the value of the PMI benefit and employees must pay income tax on the value of the in-kind benefit. Recently, insurance companies have been required to pay an Insurance Premium Tax levied at 5% on the value of the premia.

The majority of PMI policies are group insurance policies purchased by the employer (8% compared to 3.5% of the population with individual/ employee purchased PMI). The proportion has been rising in recent years so that currently over two-thirds of policies are employer-purchased. Premia vary significantly depending on the product on offer. The average premiums in the individual subscriber market have increased throughout the 1990s and sharply in 2000. The average premium rise in the group insurance market was much less. Individual subscribers' premia on average are higher than group premia.

3.4 User charges

Charges are levied on prescription drugs, ophthalmic services and dental services.

The prescription charge is flat rate (GBP 6.20 in England and GBP 6.00 in Wales from April 2002). However, there are exemptions for the following groups:

- children under 16 and young people under 19 in full time education (England) or all young people aged under 25 (Wales) people over 60;
- people on certain social security benefits including income support, Working Families' Tax Credit, income-based Jobseeker's Allowance, Disabled Person's Tax Credit;
- war pensioners, for prescriptions relating to their war disability;
- pregnant women and women who have had a child in the past year;
- people who are housebound, who have a continuing physical disability which means they cannot go out without help from another person;
- people with a listed medical condition;
- NHS in-patients or those people attending an STD clinic.

Approximately 85% of prescriptions are exempt from the charge. In addition people who frequently need prescriptions may apply for a prepayment certificate which costs GBP 31.90 for four months or GBP 87.60 a year.

Charges are levied for eye tests except for pensioners and children under 16 and young people under 19 in full time education, adults on low income and people who have or are predisposed to certain eye diseases. The cost of an eye test can range from approximately GBP 10-GBP 20. The cost of spectacles is usually met by the individual, although NHS vouchers are available to help certain groups.

Under the NHS, patients must pay 80% of the cost of dental care up to a ceiling of GBP 354. There is a charge of GBP 4.76 for a dental check up. The following groups receive dental care free (or largely free): children and young people under 18 years old or under 19 and in full time education; pregnant women and women who have had a child in the past year; people in receipt of Income Support, Working Families' Tax Credit, income-based Job-Seekers Allowance or Disabled Person's Tax Credit (or your partner is); an NHS in- or out-patient (if the treatment is carried out at the hospital). Approximately 1 in 4 patients pay privately for dental care (80% out of pocket and only 20% through some form of prepayment scheme). There is a growing market for private dental insurance: about 9 million people had some private cover in 1998.

There are no charges for GP consultations or inpatient stays. Patients may chose to pay for a bed in private room (where these are available) in NHS hospitals (so called amenity beds). There is no tax relief on out of pocket medical expenses. No specific VHI polices exist to cover co-payments in the NHS.

In the social care sector, a new policy recently introduced by the government entitles the population of England and Wales to free residential nursing care, but costs of accommodation and personal care are subject to means testing. In Scotland both personal care and nursing care are free.

4 WHO COLLECTS THE MONEY AND WHERE DOES IT GO?

4.1 Organisation of funding

National taxation is the main source of revenue for health care. Budgets are currently set every three years as part of the general public expenditure planning process, Budgets for spending departments are set through negotiation between the Chancellor of the Exchequer and the relevant Departmental Minster. There is no strict earmarking of revenue or expenditure; budgets can be adjusted during the three-year cycle. In addition National Insurance contributions account for 12% of NHS funding.

Private health insurance is provided by for-profit and non-profit companies. The main providers of PMI by subscription income are BUPA, PPP, Norwich Union and Standard Life Healthcare. These have a 40%, 27%, 8% and 5% share of the market respectively (Laing and Buisson 2001). Only BUPA retains its provident status, the other three are commercial companies.

4.2 Organisation of purchasing/contracting

The system is in transition. Purchasing responsibilities are being passed from health authorities (HAs) to primary care trusts (PCTs) in England and to local health groups (LHGs) in Wales. By 2004 primary care trusts and local health groups will be the main purchasers of health care services. Most PCTs cover populations of between 50 000–250 000 people, although some larger ones are being formed. In Scotland, NHS Trusts and Health Boards are being unified thus creating integrated purchasing and provider units.

Since the 1970s, a weighted capitation formula has been used to allocate resources from central government to health authorities (England and Wales) and health boards (Scotland). Health authorities then allocate resources to PCTs/ LHGs. From 2003/2004 (subject to legislation) allocations will be made directly to PCTs/LHGs following recommendations of the Advisory Committee on Resource Allocation (http://www.doh.gov.uk/pub/docs/doh/nhsadvisory.pdf).

PCTs directly provide primary care and community health services (under an integrated model) and commission services from hospital trusts and other secondary and tertiary care providers. PCTs may also commission other primary care services e.g. physiotherapy, alternative therapies, counselling, etc.

Over the period 1991-2000, the NHS developed a contracting system. Many elements have been retained but is it now operated through a system of Service and Financial Frameworks (SaFFs). These are designed to be longer term and based upon more collaborative arrangements between purchasers and providers. A system of DRGs known as Health Related Groups is being developed for recording activity and payment.

Hospital staff are salaried. NHS consultants (senior specialists) on full-time contracts are permitted to earn up to 10% of their gross income from private practice. Those consultants working on maximum part-time contracts are permitted to engage in private practice without restriction on their earnings by giving up payment for one NHS session per week. The consultant contract is currently under review.

GPs remuneration is a mix of fixed allowances, capitation fees and fees for a number of specific services. The current GP contract is also under review. It is currently the subject of negotiation between the General Medical Services Committee of the BMA and the National Association of Health Authorities and Trusts on behalf of the Department of Health.

Services that are provided to privately insured patients are normally charged on a fee-for-service basis. Both the consultant and the hospital will normally issue separate itemised bills. These fees are not fixed.

Dispensing contractors, such as pharmacists, are reimbursed for the total price of the medicine, less a deduction from the discount received by the wholesalers, plus a professional fee for each item dispensed, plus an allowance for containers and measuring devices. The pharmacist is reimbursed by the NHS for the total price of the medicine according to the brand dispensed or if the doctor prescribes generically, the pharmacist is paid the Drug Tariff price.

The Drug Tariff sets a maximum reimbursement price for an unbranded generic medicine. Pharmacists can retain the margin between the Drug Tariff and the wholesale or manufacturers price. Manufacturers are permitted to offer discounts to purchasers (i.e. wholesalers, dispensing physicians, pharmacists, hospital pharmacies) in contract negotiations, as long as all discounts are visible to the Pharmaceutical Services Negotiating Committee.

The rules that govern purchasing arrangements by community pharmacists and NHS hospitals are centrally set and uniform across the NHS. However, both of these latter groups have autonomy to make purchasing decisions. Community pharmacists negotiate and purchase from wholesalers. There are a number of pharmacy chains, the larger of which have more power in price negotiations.

All unbranded generics are purchased by tender collectively for hospitals at the regional level. Original brands are generally purchased through different procurement arrangements. Hospital pharmacies have to pay 17.5 per cent VAT while community pharmacies do not.

5 HOW MUCH IS SPENT AND ON WHAT?

5.1 Expenditure:

Total expenditure on health in 1999 was 6.9% of GDP according to OECD data (OECD average = 7.8%). This is equivalent to USD 1569 per capita (in purchasing power parities). Expenditure from public sources was 5.8% and expenditure from private sources 1.2% of GDP (Table 8.1).

NHS revenues are comprised 80% taxation, 12% NIC contributions, 4% charges and miscellaneous 3% from Trust interest receipts and 1% from capital receipts (http://www.doh.gov.uk/dohreport/report2001/drchap3.pdf).

Comparative data on total UK health care expenditure by source of revenue show that in 1998 73.5% of total health expenditure on health was from taxation, 9.8% from national insurance contributions, 11.1% out of pocket spending, 3.5% private medical insurance and 2.1% from other sources. (Table 8.2)

Table 8.1 Trends in health care expenditure in the United Kingdom, 1980-1999

Total expenditure on health care	1980	1985	1990	1995	1996	1997	1998	1999
Share of GDP (%)	5.6	5.9	6	6.9	7	6.7	6.8	6.9
Total expenditure in USD PPP per capita	444	669	968	1301	1410	1407	1510	1569
Public share of total expenditure on health care (%)	89.4	85.8	84.3	84.9	83.7	83.7	83.3	83.3

Within the NHS, the largest component of expenditure was current expenditure on hospital and community health services and family health services discretionary spending (81% of total NHS expenditure). The remainder was divided between capital spending (3%), family health services non discretionary spending (including GP remuneration, dental services, ophthalmic services and charges for dispensing and pharmaceutical services) (10%), central health and miscellaneous services (including public health functions) (1%) and departmental administration (1%).

Table 8.2 Main sources of health care funding in the United Kingdom, as percentage of total expenditure, 1980-1999

	1980	1990	1995	1996	1997	1998	1999
Public	89.4	84.3	84.9	83.7	83.7	83.3	83.3
Private*	10.6	15.7	15.1	16.3	16.3	16.7	16.7
Out-of-pocket	*1.3*	*3.3*	*3.2*	*3.3*	*3.5*	*3.5*	*3.4*
VHI	*8.6*	*10.6*	*11*	*11.1*	*10.9*	*11.1*	*11.2*

Source: OECD Health Database 2001

*Other sources of private funding are not shown thus out-of-pocket and VHI do not sum to private.

6 HOW DO PATIENTS ACCESS SERVICES?

6.1 Access

Patient rights and responsibilities are set out in *Your Guide to the NHS* http://www.nhs.uk/nhsguide/home.htm. All NHS trusts, health authorities, GPs, dentists, opticians and pharmacists have a complaints procedure. If a patient is not happy with the local resolution they may ask for an independent review. If the patient is still not satisfied with the recommendations of the independent review panel they may refer their complaint to the health service commissioner, or ombudsman. Under new legislation Patient Advocacy and Liaison Services will be set up in every Trust and locally based Independent Complaints Advocacy Service.

UK residents have the right to emergency treatment abroad in the EEA countries if they carry an E111 form and in about 40 other countries under reciprocal agreements. Until recently elective treatment abroad was subject to prior authorisation under the E112 and was granted in exceptional cases. Following the decision of the European Court of Justice concerning the treatment of patients within the EU who were subject to "undue delay", the Secretary of State announced that NHS patients could be treated abroad. Further guidance on this issue is expected following an assessment of three pilots.

Currently a patient's medical record is held by the GP practice at which they are registered. The implementation of the NHS information strategy by 2005 (http://www.doh.gov.uk/ipu/strategy/full/contents.htm) will create an integrated electronic health record, ensure the secure transfer of data within the NHS and link PCTs and hospital trusts through a unified IT

system. Currently medical records may be electronically held by GP practices or hospitals or paper records.

6.2 Ambulatory care:

Most ambulatory care is provided by general practitioners in group practices. The mean practice size is 3 GPs. However, the majority of practices consist of 4 or more GPs. Patients may choose to register with any GP, if they are resident within the designated practice area. GPs are not obliged to accept everyone who asks to be registered. The average GP list size is about 1800 patients.

Private general practice is very small. There are only about 200 exclusively private GPs in the United Kingdom mostly concentrated in London. GPs are not allowed under their contract to see patients registered on their NHS list privately.

There are currently 36 NHS walk-in clinics and several similar facilities run by the private sector. There are no specialists currently working directly in primary care, although specialist outreach clinics are becoming more common (whereby a hospital specialist holds a clinic in a primary care setting). In addition to GPs, practice nurses, community nurses (i.e. district nurses, midwives, health visitors) and other health care professionals (e.g. chiropodists, physiotherapists, occupational therapists, speech and language therapists) are common in primary care.

Patients must have a referral from a GP to access specialist care apart from access through accident and emergency departments or minor injury units. Out of hours services are arranged by GP practices usually using locums or agencies. NHS Direct provides a 24 hour telephone helpline.

Access to primary care is generally good. Normally an appointment can be arranged the same day for urgent cases and within a week for routine appointments. Amongst patients interviewed about their last visit to a GP, 81% thought they were seen as soon as was necessary, 15% thought they should have been seen a bit sooner and 4% thought they should have been seen a lot sooner (http://www.doh.gov.uk/public/gpnhsurvey.htm). Where access to primary care is more limited e.g. inner city areas, inappropriate presentations at accident and emergency departments are a problem.

According to WHO data there were 60 GPs in primary care per 100 000 population in the UK in 1998 (WHO 2001). According to UK workforce data there were 261 340 full-time equivalent (FTE) nurses in 1999 (including midwifes and health visitors). It is not possible to identify how many of these were working exclusively in primary care. There are currently about 36 000 GPs in the NHS. The NHS Plan sets targets for an extra 2000 GPs, 20 000 nurses and 6500 therapists in the NHS by 2004. On average a person in the UK will have 5.4 outpatient contacts per year.

GPs are able to borrow money for investment in premises from the General Practice Finance Corporation. In 1989 this corporation was privatised and between 1990 and 1998 loans offered rose from GBP 158.8 million to GBP 983.3 million. Ministerial emphasis on private finance initiatives in primary care were reaffirmed through a GBP 10 million investment programme announced in 2001. This programme - based on Local Improvement Finance Trusts (LIFT) - involves public-private partnerships.

6.3 Secondary care:

Secondary care in the NHS is provided in general acute NHS trusts (about 200), small-scale community hospitals (about 400), and highly specialised tertiary level hospitals. In the private sector, there are about 230 private hospitals, dominated by 5 for-profit chains. Independent

hospitals or wings are sometimes built on NHS hospital sites as an integrated part of the NHS hospital. In total less than 5% of the total bed stock is in private hospitals.

NHS patients must have a referral from a GP to access secondary care. Most GP referrals are made to local hospitals and follow contractual arrangements between the HA/HB or PCT/LHG and the hospital. Under the Concordat signed between the Secretary of State for Health and the Independent Healthcare Association (http://www.doh.gov.uk/commissioning/guidance.htm#concordat) HAs/HBs or PCTs/LHGs are free to commission services from the private and voluntary sector. At present this activity is small scale and mainly used to meet winter pressure and other peaks in demand. Three pilots have been established to allow patients to be sent abroad for elective care. Waiting times for specialist appointments vary between specialties.

Data on human resources show that there were 1.5 practising specialists per 1000 in 1999 (OECD 2001) and 505 FTE nurses per 100 000 population in 1998 (WHO 2001). According to UK workforce data there were 261 340 FTE nurses in 1999 (including midwifes and health visitors). Approximately 87% of nurses work in hospitals and the majority of specialists. Over 68 000 hospital medical staff (FTE) are employed in the NHS in Great Britain amongst whom there are 25 000 hospital consultants. The NHS Plan set targets for an extra 7500 specialists and 20 000 nurses in the NHS by 2004.

Data on hospital capacity show there were 3 general and acute beds (includes geriatric and maternity) per 1000 in 1998 (http://www.doh.gov.uk/nationalbeds1.htm). Utilisation rates for the general and acute sector show that average length of stay (ALOS) was around 7 days and the admission rate 150 per 1000 population in 1998. National data for England (2000-2001) show there were 186 091 beds in the NHS and the occupancy rate was 84.0%. The number of beds was deemed to be too few following the NHS Bed Review. Occupancy rates are extremely high but this prevents NHS hospitals from coping with seasonal fluctuations in demand. Use of the private sector to manage demand might enable NHS hospitals to continue operating at high occupancy rates without needing to cancel elective treatment. Length of stay for elderly patients could be further reduced with the expansion of intermediate care facilities and if better co-ordination between the NHS and local authorities to find residential places for the elderly in long term care.

An increasing proportion of hospital capital expenditure is funded through the private finance initiative. By the end of 2000, 23 major PFI contracts had been signed. These had a combined value of GBP 2.2 billion. In addition, another estimated GBP 2 billion was in the pipeline. The PFI currently funds about 85% of major NHS investment projects. By 2003/2004 it is expected to account for around 22 per cent of all NHS capital expenditure.

In the 2nd quarter of 2001/2002, 22% of patients waited more than 13 weeks for first outpatient appointment. 27% of patients waited six months of more for an inpatient admission (http://www.doh.gov.uk/waitingtimes/booklist.htm). Analysis of patient satisfaction of acute care is reflected in the findings of the NHS survey of coronary heart disease patients 1999. One-third of patients (34%) on the waiting list considered that they should have been admitted to hospital sooner than they were. Understandably the proportion holding this view varied according to the length of time on the waiting list. Nearly all (93%) of those who had been on the waiting list for 3 months or less considered that they were admitted as soon as necessary. Those who had been on the waiting list longer than this were more critical. Of those who had

been on the waiting list for 12 months or more, three-quarters considered that they should have been admitted sooner (http://www.doh.gov.uk/nhspatients/chdsurvey2b.pdf).

6.4 Diagnostic services:

Most diagnostic and laboratory services are located within the NHS. Although some diagnostic procedures take place in primary care, most diagnostic procedures are carried out at community and acute general hospitals. GPs may now refer patients directly to hospitals to obtain some tests (open access). Some services (e.g. pathology) are increasingly contracted to the private sector.

There were 6.1 CT scans per million and 4.5 MRI units per million in the UK in 1999.

6.5 Pharmaceutical care

Pharmaceutical services are provided mainly by community pharmacists, who supply drugs and appliances prescribed by GPs. In 2001 there were 10 482 community pharmacies in the UK. In 2001 a pilot scheme for local pharmaceutical services was established. Some GPs also dispense medicines.

The OTC pharmaceutical market can be broken down into two categories: pharmacy-only (P) medicines and general sales list (GSL) medicines. P status medicines may only be sold in registered pharmacies by, or in the presence of a qualified pharmacist. In some cases, these medicines are identical to prescription medications. By contrast, GSL medicines may be sold in retail outlets such as drug stores and supermarkets, as well as at pharmacies. These medicines may be of less potent formulation or a smaller quantity per pack than P status medicines.

6.6 Rehabilitation/ intermediate care

The provision of an increased number of intermediate care beds is currently a government policy priority designed to reduce unnecessary acute hospital admissions and to avoid unnecessarily long hospital in-patient lengths of stay. Intermediate care is essentially a short-stay facility - covering up to six weeks - designed to prepare a patient for a return to home or community settings. The NHS Plan makes a commitment for the provision of 5000 additional intermediate care beds by 2003/2004. In 2001/2002, the government has earmarked GBP 188 million for intermediate care and the provision of community equipment. The concordat between the NHS and the private sector indicates that a large portion of additional intermediate care beds will be provided by the private sector, although publicly funded. A national evaluation programme was launched in 2001 by the NHS policy research division in order to establish the most cost-effective forms of intermediate care.

6.7 Social care

Social care in Britain is usually defined as long-term domiciliary and residential care for elderly people, people with mental illness, and people with learning difficulties. Responsibility for making sure that these services are provided is shared between local government social services departments and the NHS. Local government has the major responsibility for social care. Funding mainly comes from local government and personal payments whilst services are mainly provided by the private and voluntary sector.

The role of the independent sector in social care provision expanded rapidly during the 1980s. Beds in the private sector (for-profit) rose from 31 218 in 1980 to nearly 140 000 in 1994. However between 1994 and 2001 the trend has reversed and there has been a slight decline in private bed numbers of 4%. The voluntary sector (non-profit) provision has continued to expand and in 2001 provided 31 639 beds. The number of places in local authority residential

homes has fallen dramatically from 100 343 in 1980 to under 39 185 in 2001. Between 1993 and 2000 the proportion of home-care contact hours provided by independent contractors rose from 5% to 56%.

Due to the low level of fees paid by local authorities, private nursing and residential homes are closing. In some areas the demand for places outstrips supply leading to bed blocking in the NHS.

7 THE PATIENT JOURNEY

A typical patient in need of non-emergency medical care will seek a consultation with a GP. No payment is made for this consultation. The GP will treat the patient in the surgery and if necessary prescribe medicines for which charges may be levied (see above). In around 5 per cent of cases, usually after more than one primary care consultation, the patient may be referred for a hospital outpatient appointment with a specialist. This will usually involve a wait of around two and a half months depending on the specialism and severity of the case. No payment is made for this consultation. After the consultation, if deemed necessary, the consultant may recommend hospital in-patient treatment. Again a wait of up to about three months is likely, depending on circumstances. In an increasing number of cases this will be offered on a day-case basis involving no or only one overnight stay. Following hospital treatment the patient may be discharged home, to an intermediate care facility or to a nursing home. NHS services are not subject to charges, but accommodation and personal care (the latter in England but not in Scotland where it is free) in a nursing home is subject to means tested charges, as is domiciliary social care delivered to the patient at home.

8 WHAT ARE THE MAJOR CHALLENGES FACING THE HEALTH CARE SYSTEM?

Health policy is currently *the* most high profile item on the political agenda. Debate and public policy is focusing on both the finance and provision of health care. On the finance side, there is currently a recognition that health care in the UK has been underfunded in comparison with most other Western European countries for at least the last two decades. Long waiting lists for hospital appointments and often poor quality hospital buildings are two manifestations of this situation. The government is committed to rectifying this situation. Increased public spending on the NHS of around 6 per cent per year in real terms (i.e. deflated by the GDP deflator) over the next 4 years has been announced by the Chancellor of the Exchequer. In fact, increased spending on the NHS in England this year will probably reach around 9 per cent in real terms. If achieved, these will represent unprecedented, sustained rates of increased spending.

At the same time a review of expenditure needs on health and social care over the next 20 years has been carried out for the Chancellor by Derek Wanless, the former Group Chief Executive of Nat West Bank. This aimed to clarify what the UK health system is likely to need in terms of future expenditure. An interim report was published in November 2001.

On the supply side, the NHS Plan has set out a set of ambitious targets for increasing NHS workforce numbers (consultants, GPs and nurses) as well as targets for service improvements (e.g. reduced waiting times). A Modernisation Board has been set up to drive these changes through. A Commission for Health Improvement has been set up to monitor and improve performance. Despite these initiatives, many people remain concerned about whether improvements are achievable in the timescale the government has set (Timmins 2001).

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10 WEBSITES

British National Formulary	http://www.bnf.org/Index.htm
Commission for Health Improvement	http://www.chi.gov.uk
Department of Health	http://www.doh.gov.uk/dhhome.htm
Department of Health and Social Services and Public Safety, Northern Ireland	http://www.dhsspsni.gov.uk/
HM Treasury	http://www.hm-treasury.gov.uk/index.cfm
National Health Service	http://www.nhs.uk/
National Institute for Clinical Excellence	http://www.nice.org.uk/
National Statistics	http://www.statistics.gov.uk/
NHS Plan	http://www.nhs.uk/nationalplan/
NHS Plan for Wales	http://www.wales.gov.uk/healthplanonline/
NHS Wales	http://www.wales.nhs.uk/
Scottish Executive Health Department	http://www.show.scot.nhs.uk/sehd/

APPENDIX

Statistics presented in the appendix are taken from international databases to which national governments submit data (OECD 2001; WHO 2002). Due to some variation in the availability of data and definitions applied in each country some of the figures presented may not be directly comparable. The country reports present the most recent data available from national sources and therefore might include data that differ slightly from those presented here.

Table A1. Expenditure on health in selected countries, 1988 and 1999 or latest available year (LAY)

	Total expenditure on health (TEH) % GDP		Mean annual real growth rate in TEH 1988-1998 ***	Mean annual real growth rate in GDP 1988-1998	Total expenditure on health per capita USD PPP**		Public expenditure on health % total expenditure on health		Difference in public expenditure on health 1988 to 1999 or LAY
	1988	1999 or LAY			1988	1999 or LAY	1988	1999 or LAY	
Australia*	7.4	8.6	4.9	3.4	1177	2085	68.4	70	-1.6
Denmark	8.8	8.4	1.4	2	1360	2275	84.7	82.2	-2.5
France	8.4	9.3	2.9	1.8	1297	2115	74.7	76.2	+1.5
Germany*	9.4	10.3	4.3	3.4	1487	2361	77.2	75.8	-1.4
Netherlands	8.2	8.7	3.6	3	1162	2259	67	68.5	+1.5
New Zealand	6.5	8.1	4.3	2	800	1505	85.6	77.5	-8.1
Sweden*	8.4	7.9	0.7	1.3	1332	1732	89.4	83.8	-5.6
United Kingdom	5.9	6.9	3.4	1.9	834	1569	84.3	83.3	-1.0

* Data for Australia, Germany and Sweden are for 1998.

** Purchasing Power Parities (PPPs) are the rates of currency conversion that equalise the purchasing power of different currencies. This means that a given sum of money, when converted into different currencies at the PPPs rates, will buy the same basket of goods and services in all countries. Thus PPPs are the rates of currency conversion which eliminate differences in price levels between countries.

*** Calculated as the mean of the annual growth rates in national currency units at 1995 GDP prices

Source: OECD HEALTH DATA 2001

Table A2. Expenditure on health by source of funding in selected countries (percentage of total expenditure on health), 1999 or latest available year

	General government revenue (taxation)	Social security schemes (social health insurance)	Out-of-pocket payments	Private insurance	Other private funds*
Australia**	70.0	0	16.2	7.9	5.9
Denmark	82.2	0	16.2	1.6	0
France	2.5***	73.7	10.1	12.6	1.0
Germany**	6.4***	69.4	12.8	7.1	4.3
Netherlands**	4.1***	64.5	8.0	17.5	5.9
New Zealand	77.5	0	15.9	6.2	0
Sweden****	61.8	21.7	16.4	0.1	0
United Kingdom*	73.5	9.8	11.1	3.5	2.1

* Health expenditure incurred by corporations and private employers providing occupational health services and other unfunded medical benefits to employees plus expenditure by non-profit institutions serving households (excluding social insurance) such as red cross, philanthropic and charitable institutions, religious orders, lay organisations; benefits provided for free by medical care providers plus health expenditure incurred by the rest of the world.

** Data for Australia, Germany, the Netherlands and the United Kingdom are for 1998.

*** Data do not reflect the total contribution of taxation to health care expenditure because this revenue is allocated through the social security schemes/ insurance funds and therefore appears as social security expenditure.

**** Data for Sweden is estimated using national sources (http://www.euro.who.int/observatory/Hits/20020123_1) .

Note: some rows may not sum to exactly 100 due to rounding.

Source: OECD HEALTH DATA 2001

Table A3. At a glance: important characteristics of health care systems in selected countries relating to financing, 2000 (unless noted)

	Australia	Denmark	France	Germany	Netherlands	New Zealand	Sweden	United Kingdom
Coverage (percentage of population with public/social insurance/ type)	100% (Medicare)	100%	100%	88%	100% (AWBZ [Exceptional Medical Expenses Act]) 64% (ZFW [Sickness Funds Act])	100% (hospital care) 40% (primary care - children & pregnant women free; concession card holders subsidised by state)	100%	100%
Private insurance (percentage of population with private insurance/ type)	45% (mostly supplementary)	28% (mostly complementary; some supplementary)	>90% (mostly complementary)	9% (substitutive); approx. 10% of SHI members (supplementary and/or complementary)	29% (substitutive); 93% of ZFW members (mostly complementary)	33-37% (complementary and supplementary)	1-1.5% (supplementary)	11.5% (complementary and supplementary)
Benefits defined? By whom?	Yes (Medical Benefits Schedule/ Pharmaceutical Benefits Schedule). Recommendations from Medical Services Advisory Committee/ Pharmaceutical Benefits Advisory Committee to Ministry of Health.	No for medical services. Positive list of drugs drawn up by National Medicines Agency.	Yes for ambulatory care and private hospitals. Medical procedures are based on recommendations from Permanent Committee on Official Schedules of Professional Procedures to Ministry of Health. Reimbursement for drugs and medical devices are based on recommendations from relevant Commissions and the Economic Committee for Medical Products to Ministry of Health.	Yes. Generic terms in Social Code Book V. More detailed benefits in ambulatory care are defined by Federal Committee of Physicians and Sickness Funds. Hospital benefits to be defined by Federal Committee of Hospitals and Sickness Funds in future.	Yes. Defined in respective laws. Exceptional Medical Expenses (Entitlement to Care) Decree for AWBZ and Health Insurance (Treatment and Services) Decree for ZFW.	No for medical services. Positive list for drugs (Pharmaceutical Schedule) drawn up by Pharmaceutical Management Agency (PHARMAC)	No for medical services. Partial cover for dental care. Positive list for drugs (Drug Benefit Scheme) drawn up by National Social Insurance Board.	No for medical services. Except where the decisions of NICE make explicit the inclusion/ exclusion of certain drugs or services. Negative list of drugs (Section 8a Drug Tariff)

	Australia	Denmark	France	Germany	Netherlands	New Zealand	Sweden	United Kingdom
Main taxes/ contributions	Commonwealth taxes – 4 income tax bands (17%, 30%, 42% and 47%); 10% goods and services tax (GST) (transferred to states and territories); State taxes – various	National taxes – 3 income tax bands (5.5%, 11.5% and 20.5%); average combined local taxes for all public services 32.6%	Uniform rate for employed workers: Employer 12.8%, Employee 0.75% on gross earnings CSG (general social contribution) 5.25% on income (3.95% on benefit income e.g. pension)	Varying by fund: Employer 6.75% mean, Employee 6.75% mean 10% rate for people earning below EUR 322. employer only.	Uniform rate: AWBZ 10.25% employee only ZFW Employer 6.25%, Employee 1.7%	Income tax bands (19.5%, 33% and 39%) Goods and Services Tax (GST) (12.5%)	Local taxation – average combined local taxes 31.65% for all public services	Income tax bands (10%, 22%, 40%) VAT (17.5%)
Other contributions/ taxes	Medicare levy (1.5% of taxable income or 2.5% for high income earners with no private health insurance): employee only	None.	Social debt repayment contribution 0.5% Taxes on tobacco and alcohol for health care	No	Plus monthly premium per capita (varying by fund), EUR 9.50–EUR 19.90 (2001) Tax grant to AWBZ Tax grant to ZFW	Accident Insurance scheme contributions.	Grants from central government. Social insurance contributions – Employer 8.5% of salary	National Insurance contributions Employer 11.9% Employee 10%
Ceiling on contributory income	No.	Yes – 59% of income for county taxes	No	Yes. DEM 6525 monthly income in 2001.	Yes (AWBZ: EUR 27 847; ZFW: EUR 28 188; EUR 19 650 for self-employed; EUR 19 550 for pensioners) (2002)	No	No.	Yes for national insurance contributions Employee Lower GBP 87, upper GBP 575 Employer Lower GBP 87, no upper
Determines contributions/ taxes	Commonwealth set income tax, GST and Medicare levy; States set state taxes	Maximum rates of local taxation negotiated between central government (Ministry of Health/ Ministry of Finance) and county and municipal councils.	Parliament (Financing of Social Security Act)	Individual funds subject to approval by Länder (regional) government or Federal Insurance Office	Government (Ministry of Health on recommendation of Health Insurance Board) *	Government	Tax rates are set locally.	Treasury
Collection of contributions/ taxes	Commonwealth (Australian Tax Department)	State Counties Municipalities	Local/ regional offices of schemes; general scheme transferred to Central Agency for Social Security Institutions	Individual funds	Tax authorities to Central Fund managed by Health Insurance Board *	National	National Tax Board and local offices for social insurance and central taxes. Municipalities and county councils collect local taxes.	Inland Revenue

	Australia	Denmark	France	Germany	Netherlands	New Zealand	Sweden	United Kingdom
Global budget (frequency)	Yes. Annual	Yes partial. Annual.	Yes. Annual.	No. Sectoral budgets.	Soft budget.	Yes. Annual moving to 3-year cycle.	Yes. Annual.	Yes. 3-year cycle.
Mechanism for national pooling or financial risk-sharing among funds	Commonwealth and States negotiate grants at annual conference. Administered by Commonwealth Grants Commission.	State subsidies adjusted annually according to size of local tax revenues. Transfers between counties and between municipalities are risk adjusted.	Risk adjustments between funds and government subsidies for the agricultural scheme	Risk-structure compensation mechanism at the federal level (for >90% of income)	Risk adjusted capitation from Central Fund to funds (ZFW: 35% of budget in 1999 after recalculation, equalisation and high-risk pool)	Currently allocations to District Health Boards are moving more to population based funding in addition to historical budgets.	National grants to county councils are risk adjusted.	Risk adjusted allocations to health authorities/ health boards and in future direct to local purchasers (e.g. PCTs)

*Individual funds for per-capita premiums.

Note: substitutive insurance is defined as insurance which provides cover that would otherwise be available from the state; supplementary insurance is defined as cover for faster access and increased consumer choice; and complementary insurance is defined as cover for services not included or not fully covered by the state including cover for co-payments imposed by the statutory health system see Mossialos E and S Thomson (2002), Voluntary health insurance in the European Union, Report prepared for the Directorate General for Employment and Social Affairs of the European Commission, Brussels: European Commission.

Table A4. User charges for different health care services in selected countries, 2001 unless specified

	General practitioner	Specialist	Inpatient	Pharmaceutical	Exemptions or annual out or pocket maximum
Australia	Medicare coinsurance rate of 15% of schedule fee for each item plus 'gap' payment if doctor extra bills. None if direct bulk billing.	Coinsurance rate of 15% of schedule fee plus 'gap' payment if doctor extra bills. None if direct bulk billing.	None in public hospitals. Medicare 25% coinsurance for medical treatment for private patients in private or public hospitals.	Flat rate AUD 21.90 per prescription or AUD 3.50 for concession. No reimbursement for drugs not included on the Pharmaceutical Benefits Schedule.	If exceed AUD 669.70 on PBS drugs then pay concession rate. If on concession rate and exceed AUD 182 on PBS drugs then no further co-payment If total 'gap' payments to GP and specialists exceed AUD 302.50 (annually indexed) then exempt from coinsurance rate on schedule fee. If total out-of-pocket expenditure exceeds AUD 1250 receive 20% rebate on excess.
Denmark	None for most people, although balance billing applies to about 2% of the population who choose to have direct access to general practitioners and specialists.	Same as general practitioner services.	None	Co-insurance rates vary depending on the individual annual out-of-pocket expenditure: 100% up to DKK 500 per year, 50% for DKK 501–1200, 25% for DKK 1201–2800 and 15% over DKK 2800.	For chronically ill patients who spend over DKK 3600 on drugs per year, the co-insurance rate is 0%. Pensioners may apply to municipality for financial assistance. Exemption from drug co-payments for low income patients case by case.
France	Co-insurance rate of 30% plus balance billing by GPs in Sector 2 (15% of GPs).	Co-insurance rate of 30% plus balance billing by specialists in Sector 2 (38% of specialists).	Co-insurance rate of 20% (up to 31 days in acute care) plus per diem (EUR 10.67).	Co-insurance rates of 0%, 35% and 65% depending on category of drugs. No reimbursement for products not included on national list.	Majority of citizens have complementary VHI to cover co-payments. Since 2000, low income can receive state subsidy for complementary insurance. Exemption from co-payments for all types of care for people with one of 31 defined serious illnesses and for disabled people. Exemption from co-payments for hospital care for stays over 31 days and/or costly procedures (over EUR 200) for everyone.
Germany	None	None for physician care. 15% coinsurance rate for non-physician care.	EUR 9 per day up to a maximum of 14 days per year. Ambulance transport EUR 13 per trip	Charges of EUR 4- 5 depending on pack size plus 100% of cost above the reference price.	Full or partial exemptions for children (under 18 years), unemployed people, those on income support and students receiving grants. Annual out of pocket limit equal to 2% of gross income (or less for those with dependants) for drug, transport and non-physician care co-payments. Chronically ill who have paid at least 1% of gross income for drug, transport and non-physician care co-payments are exempt for duration of illness.

	General practitioner	Specialist	Inpatient	Pharmaceutical	Exemptions or annual out or pocket maximum
Netherlands	None.	None.	None.	Gap between reference price and actual price.	
New Zealand	Full cost with flat rate subsidies per visit: NZD 32.50 children under six years; NZD 15 children aged 6-18 years (without concession card); NZD 20 children aged 6-18 years (with concession card); NZD 15 adults (over 18 years) with concession card	Free in public hospitals and clinics, fee-for-service in private clinics.	None in public hospitals.	NZD 5 per item (NZD 3 with concession card). No reimbursement for products not included on Pharmaceutical Schedule.	Children under 6 years old exempt from drug co-payments.
Sweden	Co-payments of between EUR 11-15. Rates determined by municipalities.	Co-payments of EUR 16-27 for outpatient visits to hospital specialists. Rates determined by municipalities. At least 50% of fee for contracted ambulatory specialist.	Per diem charge of EUR 8.6. Ambulance transport EUR 5.5 – 6.5 per trip.	Deductible of SEK 900 (EUR 99) and thereafter tapered co-insurance of 50% (SEK 901–1700), 25% (SEK 1701–3300), 10% (SEK 3301–4300) and 0% (over SEK 4300).	Maximum liability EUR 198 in any 12-month period for outpatient prescribed drugs. A 12-month ceiling of EUR 99 on direct patients fees for medical services not including inpatient care.
United Kingdom	None.	None.	None.	Co-payment of GBP 6.20 (England) and GBP 6.00 (Wales) per item (2002).	Exemptions from drug co-payments for children (under 16 or 19 if in full-time education [England], under 25 [Wales]), people over 60, on certain benefits, pregnant women, housebound, listed medical conditions.

Note: This table draws primarily on data presented in the country case studies where fuller explanation is given.

GLOSSARY

Useful glossaries of terms used in this report can be found on line.

- *Glossary of Healthcare Related Terms* produced by the Academy for Health Services Research and Health Policy available at http://www.academyhealth.org/publications/glossary.htm last updated February 2002
- *Observatory's health systems glossary* produced by the European Observatory on Health Care Systems available at http://www.euro.who.int/observatory/Glossary/TopPage last updated February 2002