

HEALTH CARE SYSTEMS AROUND THE WORLD



CANADA ▪ **DENMARK** ▪ **FRANCE**

GERMANY ▪ **ISRAEL** ▪ **JAPAN**

THE NETHERLANDS ▪ **SWEDEN**

SWITZERLAND ▪ **UNITED KINGDOM**



Alyssa Kim Schabloski, JD, MPH

for

Insure the Uninsured Project

© 2008

TABLE OF CONTENTS

INTRODUCTION.....	1
CANADA.....	2
DENMARK.....	5
FRANCE.....	8
GERMANY.....	11
ISRAEL.....	16
JAPAN.....	18
THE NETHERLANDS.....	22
SWEDEN.....	25
SWITZERLAND.....	28
UNITED KINGDOM.....	31
APPENDIX.....	35
ALPHABETICAL LIST OF REFERENCES.....	38
NOTES.....	42

TABLE OF FIGURES

Figure 1. <i>Health care systems in Canada</i>	2
Figure 2. <i>Obligatory Provisions of the Regional Health Agreements to Coordinate Treatment, Prevention, and Care</i>	5
Figure 3. <i>Ministry of Health Regulatory Functions</i>	8
Figure 4. <i>Statutory Health Insurance (general scheme) Revenues in 2000</i>	9
Figure 5. <i>Statutory Health Insurance Benefits</i>	10
Figure 6. <i>German internal subsidy model</i>	12
Figure 7. <i>2007 Health Reform Financing Model</i>	13
Figure 8. <i>National Health Insurance Law (1994) Benefits Coverage</i>	16
Figure 9. <i>Flow of funding in Japan's health care system</i>	19
Figure 10. <i>Upper ceiling for patient copayments in Japan</i>	20
Figure 11. <i>Three Main Functions of the Health Care Insurance Board</i>	22
Figure 12. <i>Financial flow under the Dutch Health Insurance Act of 2006</i>	23
Figure 13. <i>Deductible levels for reduced premiums</i>	28
Figure 14. <i>Structure of NHS Authorities and Trusts</i>	31
Figure 15. <i>Features of NHS Trusts</i>	32
Figure 16. <i>Health Expenditures by Country (2006)</i>	35
Figure 17. <i>Health Care Resources by Country (2006)</i>	35
Figure 18. <i>Mortality Data by Country in Years (2006)</i>	36
Figure 19. <i>Pharmaceutical & other medical devices as % total expenditure on health (TEH)</i> ...37	

INTRODUCTION

Too long-abandoned after failed Clinton-era reform efforts in the 1990s, universal health coverage is once again at the fore of political issues in the United States. Now, more than 46 million Americans are without health insurance, and 6.6 million of them reside in California alone.¹ The skyrocketing costs of health care and the number of uninsured in the United States show no sign of slowing. Ironically, Americans spend more than 16% of the gross domestic product (GDP) on health care, yet health outcomes in the United States consistently rank on the lower rungs compared to other Western industrialized countries with developed economies. The various figures in the Appendix compare health indicators across the countries presented here.

In debating the creation of an American universal coverage model, examining universal health systems around the world provides helpful insights into what does and does not work for other countries. One of the most striking features is the willingness of other nations to modify their systems. The last serious effort at major health care reorganization in the United States was well over decade ago. Another remarkable feature is the sense of solidarity, which underlies the European systems in particular. The citizenry and government strongly support, both ideologically and financially, the notion that universal access to health care is an entitlement. Whether the government is the primary provider of health care differs across countries; however, the underlying values structuring the different systems are remarkably similar.

Although each of the ten systems presented provide universal coverage to their residents, all are affected by similar challenges. These challenges are fast becoming universal to all health care systems, including that of the United States. For example, increasing health care costs are quickly becoming a problem worldwide. Health care expenditures are mounting worldwide, in part because of aging populations, the prevalence of chronic disease, and increasing pharmaceutical costs. Coping with the rising cost of health care requires reconciling the oft-competing goals of health services; namely, the social goal of providing equal access, the medical goal of providing the highest quality care, the economic goal of cost containment, and the political goal of guaranteeing patient choice and getting input from medical professionals.¹

There are many lessons to be learned from the health systems of the ten countries presented here: (1) Canada; (2) Denmark; (3) France; (4) Germany; (5) Israel; (6) Japan; (7) the Netherlands; (8) Sweden, (9) Switzerland; and (10) the United Kingdom. This report provides a basic overview

¹ If the city of San Francisco's health insurance program meets its goal of covering its 73,000 uninsured residents, none of California's uninsured will reside in San Francisco. Healthy San Francisco provides health care services at the city's twenty-two community-based clinics and public hospitals. This program is financed through state and federal funds, as well as employer and sliding-scale patient contributions. Currently, both the Bush administration and employers in the city are challenging the employer assessment in federal court. Bill Ainsworth, *Health Plan for All Being Fought by Bush Administration, Restaurants*, SAN DIEGO UNION TRIB. (May 25, 2008), available at <http://www.signonsandiego.com/news/state/20080525-9999-1n25sfhealth.html>. The ordinance was recently upheld in the Ninth Circuit Court of Appeals. *Golden Gate Restaurant Ass. Vs. City and County of San Francisco* (Sept. 30, 2008)

of the core features of each system. Links to more detailed information are included at the end of each country's section.

CANADA

Canada provides universal access to health care to the 33.2 million people who reside there through a mixture of public, mixed, and private health care systems. The amalgamation of systems is due to the varied systems that have influenced Canadian health policy throughout the years—in particular, the United States and the United Kingdom. Figure 1, below, illustrates some of the basic features of the Canadian systems.

Figure 1. Health care systems in Canada

	Funding	Administration	Delivery
Public: Canada Health Act (hospital and physician services); public health	<ul style="list-style-type: none"> Public taxation 	Universal, single-payer provincial system under provincial legislative framework	<ul style="list-style-type: none"> Private professional Private not-for-profit Private for-profit Public facilities
Mixed: Goods and services, e.g., prescription drugs, home care, institutional care	<ul style="list-style-type: none"> Public taxation Private insurance Out-of-pocket payments 	Targeted public services, usually welfare-based; private services regulated by government	<ul style="list-style-type: none"> Private professional Private not-for-profit Private for-profit Public facilities
Private: goods and services, e.g., dental, vision, OTC drugs, alternative medicine	Private insurance Out-of-pocket payments (in full, co-payment, deductible)	Private ownership and control; private professions; self- and public regulation	<ul style="list-style-type: none"> Private professional Private for-profit

Source: EOHSP Canada (2005)

Policy and Management

The Canadian provinces and territories set much of their own health care policy and manage their own health services delivery, although the federal government oversees care for certain components and populations. Canada's health care system is highly decentralized. The country's ten provinces and three northern territories are primarily responsible for health care in Canada, collectively called the Medicare systems. They set social policy regarding health, education and social assistance, and other social services. The provinces and territories also govern their respective single-payer systems for universal hospital and medical services, paying for hospitals either directly or through global funding for regional health authorities. In addition, the provincial governments negotiate physician fee schedules with the provincial medical associations. However, rarely do the provinces directly deliver health care. Most of the health services organization and delivery in Canada are through the regional health authorities.

The federal government does retain jurisdiction over certain aspects of the health care system, notably regulating prescription drugs and financing and administering health benefits for indigenous peoples, the armed forces and the Royal Canadian Mounted Police, veterans, and

inmates in federal penitentiaries. Health Canada, the federal department of health, also plays a critical role in health services research and public health and protection.

Financing

Canada finances its health system primarily through tax revenues, but copayments and reimbursements from private insurance also make a significant contribution. Tax revenues at the provincial, territorial and federal governments account for nearly 70% of total health expenditures.² These general revenue funds generally come from income, consumption, and corporate taxes. The provincial and territorial governments set the tax rates of their respective jurisdictions. Patient out-of-pocket copayments and private insurance reimbursements cover much of the remainder at 15% and 12%, respectively. The final 3% comes from myriad sources, including social insurance funds, such as workers compensation, and charitable donations.

In 2004, the C\$130 billion spent on health care went to:

- 43% on hospital (30%) and physician (13%) services
- 23% on provincial social service programs
- 30% on private health care services
- 4% to direct federal services

Canada spent approximately C\$4548 per capita on health care in 2006.³ However, spending varies throughout the country. Per capita spending in Alberta and Manitoba in 2006 was higher than in any other province or territory at C\$4924 and C\$4901, respectively. Yet Prince Edward Island and Québec spent the least per capita in 2006, only C\$4225 and C\$3976, respectively.

Payors

Regional health authorities purchase most health services, but private insurance pays for services that Medicare does not cover. The regional health authorities have become the primary payor of health care services. The regional authorities organize services and allocate a global budget for the defined population. Funding methods vary among the provinces and territories. Regional authorities have great freedom in allocating funds to best serve the particular needs of their population.

Private health insurance mostly covers goods and services not covered by Medicare. Private insurance covered 33.8% of all prescription drugs, 21.7% of all vision care, and 53.6% of all dental care in 2004.⁴ Six of the provinces—British Columbia, Alberta, Manitoba, Ontario, Québec,ⁱⁱ and Prince Edward Island—go so far as to outlaw insurance that attempts to provide alternative or faster access to health care already covered by Medicare.⁵ Most private health insurance is group-based, sponsored by employers, unions, or other like organizations. Although

ⁱⁱ In 2005, the Supreme Court of Canada ruled in *Chaoulli v. Québec* that when an individual suffers seriously comprised health because of a lengthy wait for Medicare services, which could have been redressed through private health insurance, but cannot access private insurance because of Québec's ban on such insurance, the Medicare law was inconsistent with the Charter of Human Rights and Freedoms of Québec. The Court gave Québec one year to amend its Medicare law to be consistent with its Charter.

employer-based insurance is part of the benefits package, this insurance is mandatory and thus most provinces do not tax those benefits.

Providers

General practitioners as well as regional health authorities act as providers in the Canadian system. The regional health authorities manage the delivery of care. They hire salaried staff at a majority of acute care facilities. They also contract with some private providers for specialized ambulatory care services. However, most of Canada's 1.5 million general practitioners and specialists work under fee-for-service arrangements.⁶ Fee-for-service payments account for 79.5% of physician income.⁷ Providers are discouraged from performing services in both the public and private spheres, although it is not illegal to do so.

Hospital funding comes from global budgets transferred by regional health authorities. Although hospitals historically have been private, not-for-profit institutions, hospitalization has created a substantially integrated relationship between hospitals and provincial governments. Most hospitals rely almost entirely on the global budget monies allocated by the regional health authorities.

Access

Canada provides universal, medically necessary care for its residents free of charge, but its essentially single-payor system has created a bottleneck for timely access to services. The Canada Health Act makes all residents of a province or territory eligible for medically necessary services without charge.⁸ Insured services include virtually all hospital, physician, and diagnostic services as well as primary care services covered under the provincial Medicare plans. Although financial barriers to care have essentially disappeared with the elimination of most Medicare user fees, access to timely care is a problem with which the provincial and territorial governments continue to struggle. On the one hand, a single-payor system is much more administratively efficient than a multi-payor one. On the other hand, it can create a bottleneck for access to services. Organizations within the country, such as the Western Canada Waiting List Project and the Canadian Medical Association, have developed waiting time benchmarks. Under the federal Wait Time Guarantee Trust Fund, each province and territory had to specify a patient wait time guarantee in order to qualify for federal funding.⁹

Other Health-Related Social Welfare Services

Canadian provinces and territories provide long-term care and other social services benefits to their populations. Options range from residential care facilities, which provide some assisted-living services, to chronic care facilities, which provide intensive services for patients with high-needs. Home-based care is also available in both the public and private sectors.

Systemic Challenges

Canada struggles with administrative efficiency and service quality. Waiting lists are a point of dissatisfaction with care and erode public confidence in the system. The country as a whole also must address the rising costs of health care to ensure the sustainability of its programs.

Related Links:

[Health Canada](http://www.hc-sc.gc.ca): <http://www.hc-sc.gc.ca>

[Statistics Canada—Health](http://cansim2.statcan.ca/cgi-win/cnsmcgi.pgm?Lang=E&SP_Action=Theme&SP_ID=2966): http://cansim2.statcan.ca/cgi-win/cnsmcgi.pgm?Lang=E&SP_Action=Theme&SP_ID=2966

[Canadian Institute for Health Information](http://www.cihi.ca): <http://www.cihi.ca>

DENMARK

All of Denmark's approximately 5.5 million residents are entitled to health insurance coverage. Although health insurance did not develop in the country until the second half of the nineteenth century, Denmark has a long history of providing social welfare services. This tradition dates back to the eighteenth century, predating both the social democratic parties and organized philanthropy.¹⁰ Historically, the central government set policy related to social benefits and the regional and local authorities implemented them. Taxes levied at all levels of government paid for the services. The country recently enacted some changes to this basic structure, though the framework itself remains mostly intact.

Policy and Management

The 2005 reforms created a more decentralized relationship between the federal, regional, and local authorities, yet retained some federal oversight. The Health Act of 2005 (*Sundhedsloven*) reorganized the administration of the Danish health care system along three administrative levels. Implemented in 2007, the former Ministry of the Interior and Health was split and the Ministry of Health and Prevention now oversees all health policy and sets goals for health care delivery. The decentralized system delegates implementation and management to the five regional and ninety-eight local authorities. The regional authorities administer and deliver hospital services, while the local authorities purchase those services using state block grants. Local authorities also generally manage social welfare services. To facilitate cooperation and coordination between the new administrations, the National Board of Health has required the regions and their municipalities to enter into regional health agreements. Not only must the agreements contain certain provisions, listed at Figure 2,¹¹ but also they must be submitted to the National Board of Health for approval.

Figure 2. *Obligatory Provisions of the Regional Health Agreements to Coordinate Treatment, Prevention, and Care*

1. Hospital discharge for weak, elderly patients
2. Patient treatments during hospital admission
3. Aids and appliances for handicapped persons
4. Rehabilitation
5. Health promotion and preventive services
6. Social services for people with mental disorders

Source: Strandberg-Larsen (2007)

Financing

Financing for Denmark's health care system has become more centralized through taxation only at the national level. Unlike the Canadian county-based system, the new regional authorities have no power to levy taxes. National health care tax revenues make up 81% of the funding for the Danish health care system. The government funds the regional authorities through state block grants. Copayments make up the remaining 19% of the overall health care budget. These payments cover mainly pharmaceutical products, dentistry, and physiotherapy for the majority of residents.

Payors

Local authorities are the primary purchasers of health care in Denmark; however, a small private insurance market exists. Voluntary health insurance traditionally covers patient fees for dental services and medical drugs and devices. About one-third of Danish residents purchase complementary insurance to cover these services.¹² A small number of Danes—approximately 5% of the population—purchase supplementary insurance to move to the head of queues. The popularity of supplementary insurance is increasing due to tax incentives for employer-based coverage.

Providers

While most of Danish hospitals are publicly operated, Danish physicians are mostly private practitioners in solo or group practices. The overwhelming majority of hospitals in Denmark (98%) are publicly funded and operated. Hospitals primarily operate on global budgets, but there are some, albeit limited, services paid on a Danish diagnostic-related group classification.¹³

There are about 3400 general practitioners in Denmark, and each cares for approximately 1600 patients.¹⁴ The distribution of general practitioners is regulated according to population size in a narrow geographic area to ensure an even distribution across the country. Entry is tightly restricted—not only must general practitioners complete sixty months of training, but they can only enter practice by purchasing the goodwill of a retiring physician or obtaining permission from the regional authorities. One-third of general practitioners have a private solo practice, while the others work in some form of group practice.

Health care providers at public health care facilities are salaried civil servants. General practitioners and private specialists are self-employed but bargain collectively through the Association of Private Specialists to contract for services with the regional authorities. General practitioners are paid on a mixed capitation and fee-for-service basis. The same fee schedule applies to all patients in both systems; however, as providers do not receive a capitation payment for the smaller of the two Danish health insurance plans, they are allowed to charge these patients a reasonable fee. The approximately 1200 specialists also negotiate a fee schedule but receive no capitation payments.¹⁵

Access

All permanent residents of Denmark are entitled to coverage under the health system, including primary and hospital care, which are free at the point of service; however, many

also choose to purchase private insurance supplements. Danish residents must choose between one of two health insurance plans. Ninety-eight percent of residents choose Group 1 insurance. These patients have open access to their general practitioner but must get a referral from their general practitioner to access specialist or hospital care (except to see an Ear, Nose and Throat doctor, an ophthalmology specialist, or to seek emergency care).¹⁶ Group 2 patients can access specialist care without a referral but must pay a copayment for all non-hospital based services. Both groups must obtain a referral to access hospital services. Generally, patients are free to choose the hospital where they would like to receive care. In the event that a patient must wait longer than one month for public hospital care, the government will finance treatment at a private or foreign hospital.

Patients may choose a new general practitioner every six months. Children under 16 years of age are covered under the same insurance as their parents.¹⁷ At 16, they are enrolled automatically in Group 1 unless they opt for Group 2 coverage. Reimbursement for pharmaceutical products is based on individual needs and also depends on the patient's prior consumption in the previous year.¹⁸

About 30% of residents purchase private insurance to cover statutory copayments.¹⁹ Danmark, a non-profit health insurance association, offers four levels of supplementary coverage.²⁰ Two-thirds of members have "insurance" that covers half the cost of pharmaceutical copayments. About 500,000 members opt to cover operations at private hospitals. Around 400,000 passive members join not for immediate reimbursement of copayments, but for the option to obtain copayment reimbursement at a later date without age limitation or health certificate.

Social Welfare

Denmark is strongly committed to social protection and inclusion. The country spends 30.7% of its GDP on social protection programs.²¹ Welfare programs for the aging and vulnerable, disadvantaged, or socially excluded groups are key targets. Local government authorities provide long-term care services, financed through local taxes and state block grants.

Systemic Challenges

The new Danish reforms have yet to perfect some systemic issues. The new administrative organization has disrupted the previous formal and informal networks. Adapting to change and ensuring that the new structure helps and not inhibits the system, in order to attain its goals of quality, effectiveness, and efficiency will be a major challenge. Denmark also must make sure that it can sustain universal coverage while satisfying increasing demand due to the aging population.

Related Links:

[Ministry of Health and Prevention \(Ministeriet For Sundhed og Forebyggelse\):](http://www.sum.dk/sum/site.aspx?p=34) <http://www.sum.dk/sum/site.aspx?p=34>

FRANCE

The French government provides health care for all 64 million residents under its jurisdiction, nearly 60.9 million of whom live in France proper; the remainder live in French Guiana, Guadeloupe, Martinique, and Réunion. France has implemented several statutory changes in the past decennial that have substantially changed its health care system. First, the 1996 Juppé reforms changed the funding scheme from a tax on earned income to a tax on total income. In addition, the reforms increased the oversight of the parliament, which set definitive health policy and finance goals, and created regional hospital agencies (*agences regionales hospitalales*). France now provides universal health coverage to all its residents.

Policy and Management

Responsibility for health services is split between the national, regional, and departmental levels of government. At the state level, the parliament sets the national ceiling for health insurance expenditures every year and adopts new provisions regarding benefits and regulation through the Act on Social Security. The Ministry of Health regulates much of the health care system. See Figure 3 for a list of its most important functions. At the regional level, regional hospital agencies are responsible for allocating funds to public hospitals, adjusting taxes for private for-profit hospitals, and planning for all types of hospitals. These agencies report to the Minister of Health. Finally, the general councils provide social, health, and public health services at the departmental level.

Figure 3. Ministry of Health Regulatory Functions

- Allocating national funds among the sectors and regions
- Price setting
- Approving negotiated fee schedules
- Establishing safety standards in hospitals
- Controlling supply-side elements, such as the number of students to admit to medical school each year (*numerus clausus*)
- Defining national priorities in health

Source: EOHSP France (2004)

Financing

Tax revenues from a variety of sources fund the bulk of the French health care system. The vast majority of health insurance revenue, 88.1% in 2000, came from the general social contribution tax and the contributions of employers and employees. Contributions to the social security system differ according to the source of the income. Each resident pays a general social contribution (*contribution sociale général*) based on total income. The health insurance rate for earned income, capital gains, and gambling winnings is 5.25%, while benefits such as pensions or social allowances are taxed at a rate of 3.95%. Earnings-based contributions are levied at 0.75% of gross earnings. The remaining funds are provided through state subsidies and specifically earmarked taxes, such as car usage and alcohol and tobacco consumption. Pharmaceutical companies also contribute, mainly via a tax on advertising. See Figure 4 for a breakdown of the source contributions in 2000.²²

Figure 4. Statutory Health Insurance (general scheme) Revenues in 2000

Source of Revenue	€ (millions)	% of Total
Employee contributions	3.4	3.4
Employer contributions	49.8	51.1
<i>Total Contributions</i>	53.2	54.5
General social contribution (CSG)	33.8	34.6
Specific taxes	3.3	3.3
Pharmaceutical industry taxes	0.7	0.8
<i>Total Taxes</i>	37.8	38.7
State compensation for losses due to policy changes	4.8	4.9
Adjustment between health insurance schemes	0.3	0.3
Other	1.5	1.6
TOTAL REVENUE	97.6	100.0

Source: EOHSP France (2004)

Payors

French insurance schemes are organized according to employment type. Working together under the umbrella of the national union health insurance fund (*Union nationale des caisses d'assurance maladies—UNCAM*), three insurance funds make up the French health care system: (1) the national health insurance fund for salaried workers (*Caisse nationale d'assurance maladie des travailleurs salariés—CNAMTS*); (2) the agricultural scheme (*Mutualité sociale agricole—MSA*); and (3) the national health insurance fund for independent professionals (*Caisse nationale d'assurance maladie des professions indépendantes—CANAM*).²³ Each national health insurance fund distributes monies to regional and local funds. The funds contract for services with self-employed providers and negotiate the level of charges.

CNAMTS covers approximately 85.6% of the population.²⁴ Members include both employees in commerce and industry and their families (84%), as well as those eligible under the Universal Health Care Act (1.6% as of 2001). The agricultural scheme, *MSA*, covers farmers and agricultural employees, amounting to approximately 7.2% of the population. Non-agricultural self-employed people, about 5% of the population, are covered under *CANAM*.

Under the statutory health insurance plan, the reimbursement of health care costs accounts for 84.9% of total expenditures.²⁵ The remaining 15.1% is paid out as cash allowances for maternity, illness, work-related injuries, or disability. Reimbursements are made either to the patient, who paid out-of-pocket, or to the provider. Increasingly, pharmacy and laboratory benefits are being paid directly by the insurers.

To cover the cost of “copayments”—i.e., the cost of coverage that is not reimbursed under the statutory health insurance scheme, 86% of the population purchased voluntary health insurance in 2000.²⁶ However, only 43% opt for voluntary insurance of their own initiative—employers purchase most coverage through a group contract.

Providers

The French health care system supports both public and private providers. Approximately 4000 hospitals operate in France.²⁷ Public hospitals account for about 25% of all hospitals (1000). Non-profit private hospitals number 1400, about one-third of all French hospitals.²⁸ Private for-profit hospitals are most numerous at 1750, but tend to specialize in particular medical, surgical, or obstetric procedures.

Although all hospitals receive a per diem, the services covered in that rate vary based on hospital type. Public hospitals receive a single per diem rate that covers all services provided, while private for-profit hospitals bill medical fees and other items, such as prostheses, separately. Patients also contribute €10.67 per day of hospital stay.

The number of general practitioners and specialists in France is almost evenly split—of the 194,000 physicians in France in 2000, 51% were specialists and 49% provided primary care.²⁹ One-half of specialists and 29% of general practitioners are salaried, both working mostly in the hospital setting. Notably, private general practitioners in France still make home visits, which account for about 25% of their care activities. Providers receive payment from patients at the time of service; thus, providers negotiate with insurance schemes over the unit value to apply to the fee schedule to determine the rate of each procedure.

Access

French residents may consume as much health care as they like; however, to increase their price sensitivity, they pay for their care upon receipt and do not receive full reimbursement. Although France provided nearly all of its residents with health insurance prior to 2000, the Universal Health Care Act (*Couverture Maladie Universelle*) expanded coverage to all French residents. Single residents whose taxable income falls below a certain amount per year (€8774 for 2008-09) are entitled to free coverage.³⁰ For a list of some of the covered benefits, see Figure 5.³¹

The system is quite liberal in that patients may choose to see any licensed practitioner at any time without limit. The French average 4.7 contacts with a general practitioner, and not necessarily the same one, each year.³² To make consumers price sensitive at the time the service is provided, most patients pay the full cost of services out-of-pocket and request reimbursement from the statutory plan, with the exception of those requiring hospitalization and low-income beneficiaries under the Universal Health Care Act. Typically, patients receive only partial reimbursement and thus pay the equivalent of a copayment for services. Patients without supplementary insurance typically receive a reimbursement rate of 70% for physician and dentist services and 60% for auxiliary and laboratory services. There are exemptions for patients with a certain chronic or debilitating health status, those receiving a certain type of care, or due to the status of the patient

Figure 5. Statutory Health Insurance Benefits

- Hospital services for health care, rehabilitation, or physiotherapy
- Outpatient care from GPs, specialists, dentists, and midwives
- Prescribed diagnostic services and care
- Prescribed eligible pharmaceutical drugs and devices
- Prescribed health care-related transport
- Certain preventive care practices

Source: EOHSP France (2004)

(such as pregnant women or those injured in the workplace). Out-of-pocket payments accounted for 11.1% of total health care expenditures in 2000.³³

Social Welfare

France also provides services for other health-related services. France provides expansive coverage for those with mental illness and addictions as well as for the elderly and disabled. The local authorities have the primary responsibility for administering these types of services.

Systemic Challenges

Like other health systems, the French scheme must overcome issues related to increasing health care costs and increased demand due in part to the aging population. The WHO has ranked France as the best health care system in the world. Yet even France must address challenges relating to sustainable financing and meeting growing demand due to aging populations.

Related Links:

[Division of Health—Ministry of Health](http://www.sante.gouv.fr/ministere/index.html): <http://www.sante.gouv.fr/ministere/index.html>

[Ministry of Health, Youth, Sports, and Associated Life \(*Ministère de la Santé, de la Jeunesse, des Sports et de la Vie associative*\)](http://www.sante-jeunesse-sports.gouv.fr/): <http://www.sante-jeunesse-sports.gouv.fr/>

GERMANY

Germany has a population of 82.4 million with a life expectancy of 81.9 years in women and 78.7 years in men.³⁴ On other measures, however, quality in Germany is comparatively low, particularly given its cost. In 2004, Germany spent US\$3635 per person on health care. The US\$300 billion total represents 10.6% of the GDP. Prior to 2007, the Social Health Insurance system (*gesetzliche Krankenversicherung—GKV*) covered approximately 88% of the population (72.5 million people), while 9.7% (8 million) purchased private health insurance (*private Krankenversicherung—PKV*) in the marketplace. The remaining citizens were covered through other special state programs, such as care for military personnel. Germany has approximately 200,000 uninsured residents.

The German system, known as the Bismarck model, is the oldest in the world and was established in 1883.³⁵ Although it has undergone many substantial changes since then, the basic structure remains. Within this framework, Germany enacted another significant reform (*Gesundheitsreform*) to its healthcare system in 2007. The reform had four target goals: (1) mandatory universal health insurance coverage; (2) improvement of medical care; (3) modernization of sickness funds; and (4) reform of the health fund, the base of health care financing in Germany.³⁶ As different parts of the reform will take effect at different times, this section describes both the previous system and the impact of the new reform.

Policy and Management

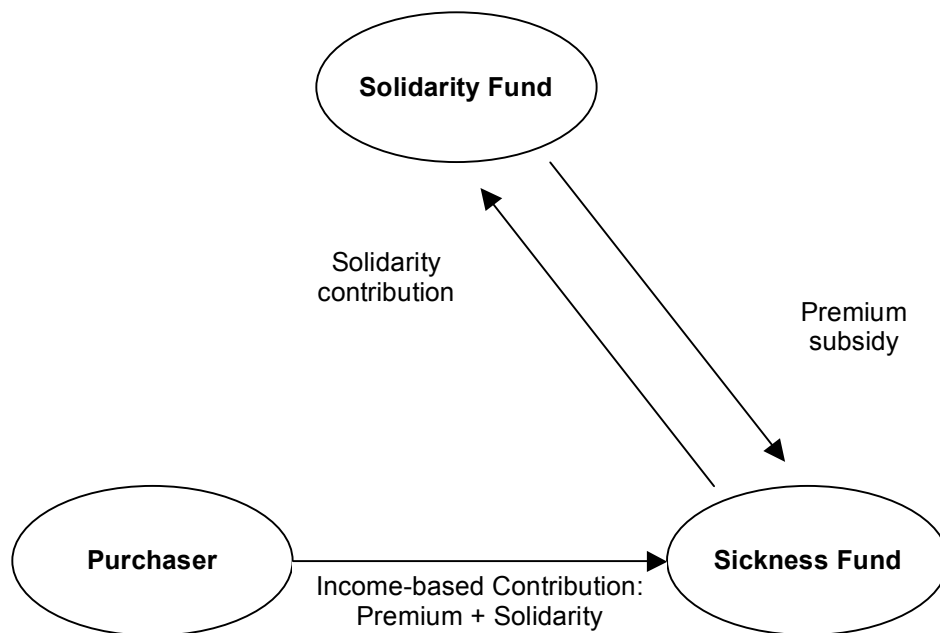
The German government controls most of health policy development and health care delivery. The Ministry of Health (*Bundesministerium für Gesundheit*) introduces and executes health policy for the country. Major policies require approval of both houses of government—the First Chamber (*Bundestag* or Parliament) and the Second Chamber (*Bundesrat*, which represents the German states or *Länder*). The current policy emphasizes solidarity, i.e., the idea that all citizens should have equal access to high quality health care, regardless of ability to pay. The Ministry also administers the health solidarity fund, which will be reorganized as of January 1, 2009, under the 2007 reform. The Social Health Insurance system, a coalition of sickness funds that provide a standardized package of benefits, also falls under government regulation.

Financing

The German model is currently in a state of transition, reorganizing its internal subsidy model to be more streamlined. Health care financing in Germany currently follows an internal subsidy model.³⁷ In this system, consumers pay both their solidarity tax and health insurance premium directly to the applicable sickness fund. The sickness fund then remits the solidarity fund contribution to the government health fund, while the solidarity fund distributes premium subsidies to the sickness funds. At present, the government subsidizes premiums for certain low-income or special classes of residents, in keeping with the solidarity principle. Basically, the total government subsidy to the sickness funds equals the difference between the aggregate solidarity contributions and premium subsidies. The model is illustrated in Figure 6 below.³⁸

Figure 6. German internal subsidy model

Source: Van de Ven et al. (2003)

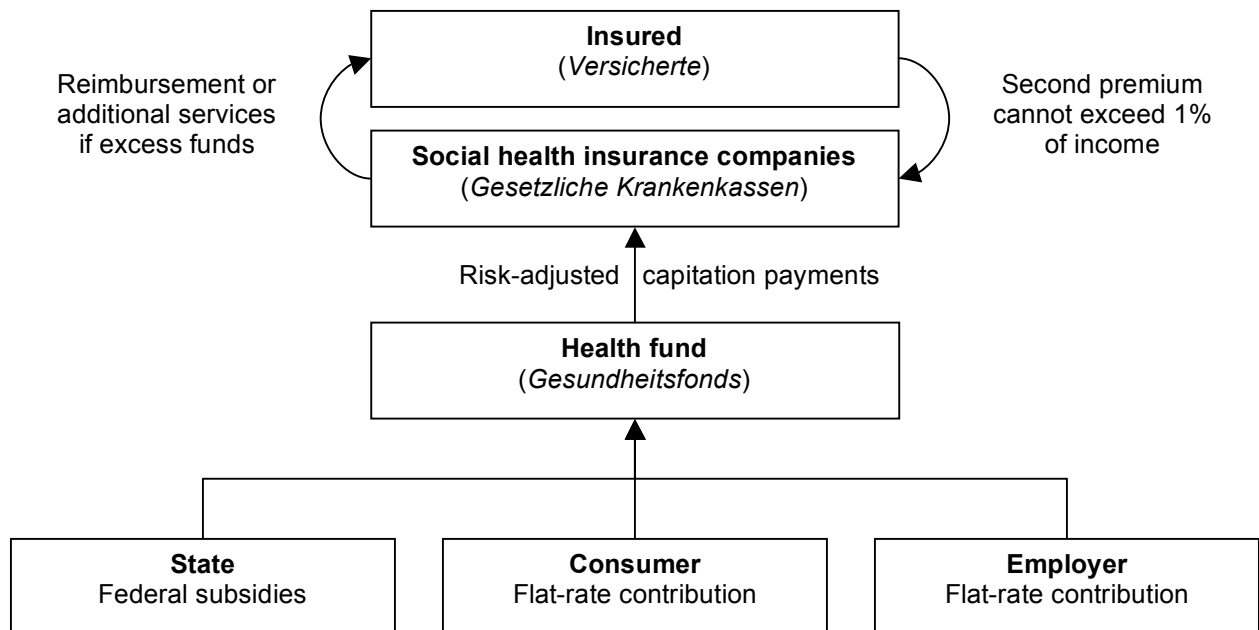


Under this current model, both employees and employers pay their contributions directly to the applicable sickness fund. Contributions are calculated based on a percentage of wage or salary, and differ among sickness funds. At the individual level, employers and employees divide the contribution payment equally. On average, though, employees contribute 7.6% of their salary for health insurance and employers contribute 6.6%.³⁹ Premium subsidies are available for workers who earn less than US\$60,000 per year, retired persons, students, and those who are unemployed, disabled, or homeless.⁴⁰

The 2007 reform will reorganize the financing system. Rather than a progressive percentage based on income contributed to a sickness fund, individuals and their employers will contribute a flat percentage rate directly to the health fund (*Gesundheitsfonds*) starting on January 1, 2009.⁴¹ Federal subsidies also will be paid directly to the new fund. The fund will then distribute monies to the insurance plans on a capitation basis; however, payments will be risk-adjusted based on age, sex, and disease status. Well-managed, efficient insurance plans can remit excess monies back to the insured or provide additional benefits not included in the standard package.⁴² Insurance plans that run at a deficit have the option of levying an additional premium on the insured, but it is capped at 1% of gross income. However, if the plan imposes the second premium, the insured is immediately free to change plans. The 2007 reform model is displayed at Figure 7 below.⁴³

Figure 7. 2007 Health Reform Financing Model

Source: *Welcome to Solidarity (2007)*



The 2007 financing reform has several goals. First, it attempts to increase transparency for consumers. It also standardizes the contribution rate for the mandatory insurance program. Flat-rate contributions already exist for long-term care, retirement, and unemployment insurance; now they will exist for the mandatory insurance program. The reform also tries to ensure

equitable risk-sharing by risk-adjusting capitation payments. More importantly, the reform increases competition among insurers. For example, insurers have additional tools, such as discount negotiation rights and optional contribution rates, to increase their ability to economize. Further, the expansion of consumer-choice through the immediate ability to change plans if the company imposes additional costs also incentivizes companies to use monies efficiently.

Payors

Germany offers residents coverage through the statutory system with the option to purchase supplemental private insurance. Germany had 253 nonprofit sickness funds in 2006, which is a substantial decrease from more than 1200 in 1991. In 2004, the Social Health Insurance system spent US\$168 billion on health care, or 56.3% of total spending that year.⁴⁴ The top three expenditures were for: (1) inpatient care—US\$70 billion or 34.1% of spending; (2) outpatient care—US\$27.7 billion or 15.3%; and (3) pharmaceuticals—US\$26 billion or 14.5%. The country also supported 49 private health insurers during that time, which provided mainly substitute and supplementary coverage. Private health insurance charges risk-based premiums, so they may or may not be more cost-efficient for some consumers.

To contain costs, patients may shoulder costs in addition to the premium and solidarity fund contributions. Copayments and direct payments are not uncommon, and are still allowed under the 2007 reform.

Providers

Health care in Germany is delivered in both the public and private sectors. Both public and private providers deliver in-patient hospital care. The majority of hospitals are enrolled in a hospital plan, which means that hospitals receive funding through the same mechanisms no matter the ownership (except psychiatric care, which is reimbursed on a per diem schedule). There are two primary channels of hospital financing.⁴⁵ Sickness funds provide approximately 93% of the total funds, covering recurrent expenditures and maintenance costs. In addition, the sixteen state governments plan investments in hospitals, which are financed by both the state and local governments. These investments cover the remaining 7% of hospital financing. Hospital reimbursements are based on the German diagnosis-related groups. DRG over- or under-payments are adjusted marginally, at 65% withholding in the subsequent year and 60% reimbursement at years end, respectively.⁴⁶

Private, for-profit providers deliver ambulatory care in Germany. German physicians number 133,000; of those, 118,000 are authorized providers in the Statutory Health Insurance system.⁴⁷ Half of these providers are family practitioners, while the other 59,000 provide specialty care. Presently, seventeen regional associations of social insurance physicians (*Kassenärztliche-vereinigungen*) negotiate annual contracts for ambulatory care on behalf of their members. Each association receives a lump sum, which it then parses into two funds—one for the primary care providers and one for specialists. Individual physicians receive payment based on an invoice of total services provided and calculated according to a relative value scale.⁴⁸ The morbidity risk-adjustment of the 2007 reform will decrease the disparity between services provided and reimbursement levels, but will not likely significantly change overall provider reimbursements.⁴⁹

Access

The 2007 reforms mandate universal coverage but look to past coverage to determine how individuals satisfy the mandate. Currently, certain classes of citizens are insured by law. Workers who earn less than US\$60,000 per year as well as pensioners, students, and persons who are unemployed, disabled, poor, or homeless are covered under the Social Health Insurance system. All insured in this system have equal access to benefits and services—in fact, statutory plans cannot refuse any applicant.⁵⁰ Benefits include inpatient and outpatient care, all necessary medication, rehabilitation therapy, and even dental benefits. These plans include family insurance, so unemployed spouses and children of workers are coinsured for no additional charge.

Access to private insurance is limited. Individuals who have made more than US\$60,000 per year for three consecutive years or the self-employed may opt-out of social insurance and purchase private insurance instead. Civil servants are eligible for a 50% reimbursement on their health care costs if they purchase private insurance to cover the remainder.⁵¹ However, choosing private insurance coverage may be disadvantageous. In addition to risk-based premiums for all family members, opting for private coverage makes reenrolling in the social system difficult.

The German mandate for universal coverage takes effect intermittently. Plan eligibility depends on the type of plan the uninsured person was eligible for prior to coverage termination. Those eligible for the Social Health Insurance plans must have re-enrolled by April 1, 2007. Those who previously had private health insurance were guaranteed eligible for private health insurance starting July 1, 2007, and must have minimum coverage by January 1, 2009. The 2007 health reform also excludes children from the social insurance plans; however, children are not abandoned. The reform merely switches funding for dependents to a different source—from social insurance financing to subsidies derived from federal taxes.⁵²

The reforms attempt to keep solidarity ideals intact. Standard social insurance benefits will be similar to current ones. All eligible applicants must be accepted, and physicians have an obligation to treat. If patients are unable to pay their premiums, the welfare system will cover the payments. In addition, private insurance premiums will be capped at the average maximum contribution in the statutory system.⁵³

Systemic Challenges

The transition to the universal mandate poses the most immediate challenge to the German system. Germany must vigilantly monitor the progress of the 2007 health reform implementation. Unexpected and unintended consequences may arise, and the health ministry must be prepared to meet unanticipated challenges. In addition, the Organization of Economic Cooperation and Development has criticized the plan for not doing enough to alleviate the rising costs of health care in Germany to the detriment of the population.⁵⁴

Related links:

[German Ministry of Health](http://www.bmg.bund.de): <http://www.bmg.bund.de>

[The 2007 Reform](http://www.die-gesundheitsreform.de): <http://www.die-gesundheitsreform.de>

The health care system in Israel existed well before even the state itself. The British Mandate authorities and the Jewish community built the foundation of the current health care network between 1918 and 1948.⁵⁵ This framework has evolved into a highly technologically advanced system that provides universal coverage to all of its 6.4 million residents. Israelis enjoy high life expectancy at birth, reaching 82.6 and 78.5 years for females and males, respectively.⁵⁶ The infant mortality rate is low, with 5.4 deaths per 1000. Israel spends approximately US\$1890 per person on health care, which comprises about 9.1% of the GDP.⁵⁷

The population growth in Israel has been due in large part to immigration.⁵⁸ After the Holocaust and World War II, waves of immigrants increased the population size substantially. The end of the Cold War raised population size by another 14% and brought Soviet physicians, which doubled the size of the Israeli physician corps. Today, 80% of the population is Jewish, with people of Arab descent comprising another 15%, and Christians and Druze making up the rest. Although the various populations have differences in health status, the health system itself does not differentiate between them. In fact, under the Geneva Conventions, the Israeli government is responsible for the health of the Palestinian territories.⁵⁹

Policy and Management

The Israeli Ministry of Health is responsible for licensing, supervising, and planning all health services. It sets policy objectives and oversees their implementation.⁶⁰ The Ministry also regulates national medical standards and food and drug quality. In addition, the agency promotes medical research and evaluates health services. Furthermore, the Ministry performs public health functions concerning the environment and preventive medicine.

Figure 8. National Health Insurance Law (1994) Benefits Coverage

- Medical diagnosis and treatment
- Preventive medicine and health education
- Hospitalization (general, maternity, psychiatric, chronic)
- Surgery and transplants
- Preventive dental care for children
- First aid and transportation to a hospital or clinic
- Medical services at one's workplace
- Medical treatment for drug or alcohol abuse
- Obstetrics and fertility treatment
- Treatment of injuries caused by violence
- Medication ordered by a ministry of health provider
- Treatment for chronic illnesses
- Physical, occupational, and other therapies

Source: Holtz (2008)

Although the government provides universal coverage for its residents, it rations care to control costs, as do many nations. Government mandates do not offer totally comprehensive health care coverage. The national health insurance plans do not cover adult dental services, private physician fees, or privately ordered medications. The sickness funds provide a standard bundle of services, listed in Figure 8.⁶¹

Financing

Employer contributions, tax revenues from residents and the national budget fund the Israeli health care system. Funding for health services primarily comes from two sources: (1) a monthly health insurance tax of up to 4.8% of income; and (2) employer contributions.⁶² The government also subsidizes health care costs through allocations in the national budget. Consumers make no premium payments by law. The National Insurance Institute serves as the central collection point and allocates the monies to the four sickness funds based on a capitation model. Premiums paid to each fund are risk-adjusted according to member age and disease status.⁶³ Sickness funds receive 3.5 times more money per person aged 75 years or older than for younger members.⁶⁴ The plans also receive additional premiums payments for five specific diagnoses: (1) thalassemia; (2) Gauche's disease; (3) end-stage renal disease; (4) multiple sclerosis; and (5) HIV/AIDS.

Payors

Four sickness funds purchase care in Israel. Israel passed the National Health Insurance law in 1994 to create universal access to health services for all residents of Israel.⁶⁵ Three of the sickness funds are privately held, while remaining one, General Health Services, is government-run. Residents may choose from one of four sickness funds, which are precluded from denying any eligible applicant, as often as every twelve months. Enrollment periods begin on the first day of January and July of every year.⁶⁶ The sickness funds share risk with consumers through copayments, which are quite high compared to those in the European community.⁶⁷

Providers

Both public and private providers offer health care services in Israel. A total of 354 general and specialty hospitals operate in Israel.⁶⁸ The government network of hospitals provides approximately half of all beds in the country. The sickness funds also provide primary and secondary care through a number of outpatient clinics and other health-related centers. Most of Israel's 26,000 physicians work as salaried employees of hospitals and sick funds. Israel has a physician-population ratio of 4.6 physicians per 1000 residents.

Access

Israel provides universal coverage for a specific basket of benefits but allows insurance companies to offer supplemental insurance to enrollees. The Israeli government provides its citizens with universal coverage for a specific bundle of health care services, noted above. Patients unable to afford copayments are not denied access; instead, government subsidies ensure that care is provided based on need, not ability to pay.⁶⁹ Low-income enrollees are exempt from copayments.⁷⁰ Approximately 50% of the population chooses to purchase supplementary insurance to cover services not offered through sickness funds. The same insurance companies that administer the sickness funds are permitted to sell supplementary plans. Patients who purchase these plans tend to be wealthier and better-educated.

Social Welfare

The National Insurance Institute administers many social welfare programs in addition to health care. Old age and survivor pensions account for 38% of the Institute's distributions.⁷¹ To fight poverty, the agency provides benefits to those whose income falls below a certain minimum. Combined with child allowances and maternity grants, 33% of the Institute's benefits go toward increasing individual and family resources. The Institute also administers programs related to disability of all kinds, unemployment insurance, and reserve service payments.

Systemic Challenges

In addition to the standard problems of sustainability and the aging population, Israel also faces health care issues related to violence in its jurisdiction. Like many developed nations, Israel's health system faces challenges due to rising health care costs and the aging population. Older adults in Israel make up 19.5% of the total population—a proportion higher than any country in the European Union or in the United States.⁷² The volatile political situation also impacts health. Daily security fears increase stress and anxiety.⁷³ Children are particularly vulnerable to psychiatric disorders following violence.

Related links:

[Ministry of Health](http://www.health.gov.il/english/): <http://www.health.gov.il/english/>

[Gertner Institute at the Ministry of Health](http://www.health.gov.il/english/Pages_E/default.asp?maincat=2): http://www.health.gov.il/english/Pages_E/default.asp?maincat=2

JAPAN

Japan has a population of about 127.3 million, and the third largest economy in the world. The Health Insurance Law of 1922 first provided public health insurance to private sector employees.⁷⁴ The coverage was quite limited in scope and duration. Not until just before World War II did the government make a concentrated effort to expand and improve the health insurance system. Now, Japan has broad health insurance coverage, featuring a private delivery system with a public financing scheme.

Policy and Management

Quite centralized, the Japanese system favors the national government's role in both health policy and administration. The Ministry of Health, Labor and Welfare performs functions related to policy development, data collection, and health status and sector monitoring. The Ministry administers some of Japan's health insurance funds and undertakes quality and cost control initiatives. Among its most important functions is regulating the social insurance funding system. The Ministry facilitates negotiations about reimbursement levels. A national, fixed reimbursement schedule is one of the hallmark cost-containment measures in Japan. Nearly all health services are paid at the same fee-for-service rate, no matter who provides them or where they were provided. Certain hospitals, mostly long-term care or geriatric facilities, are

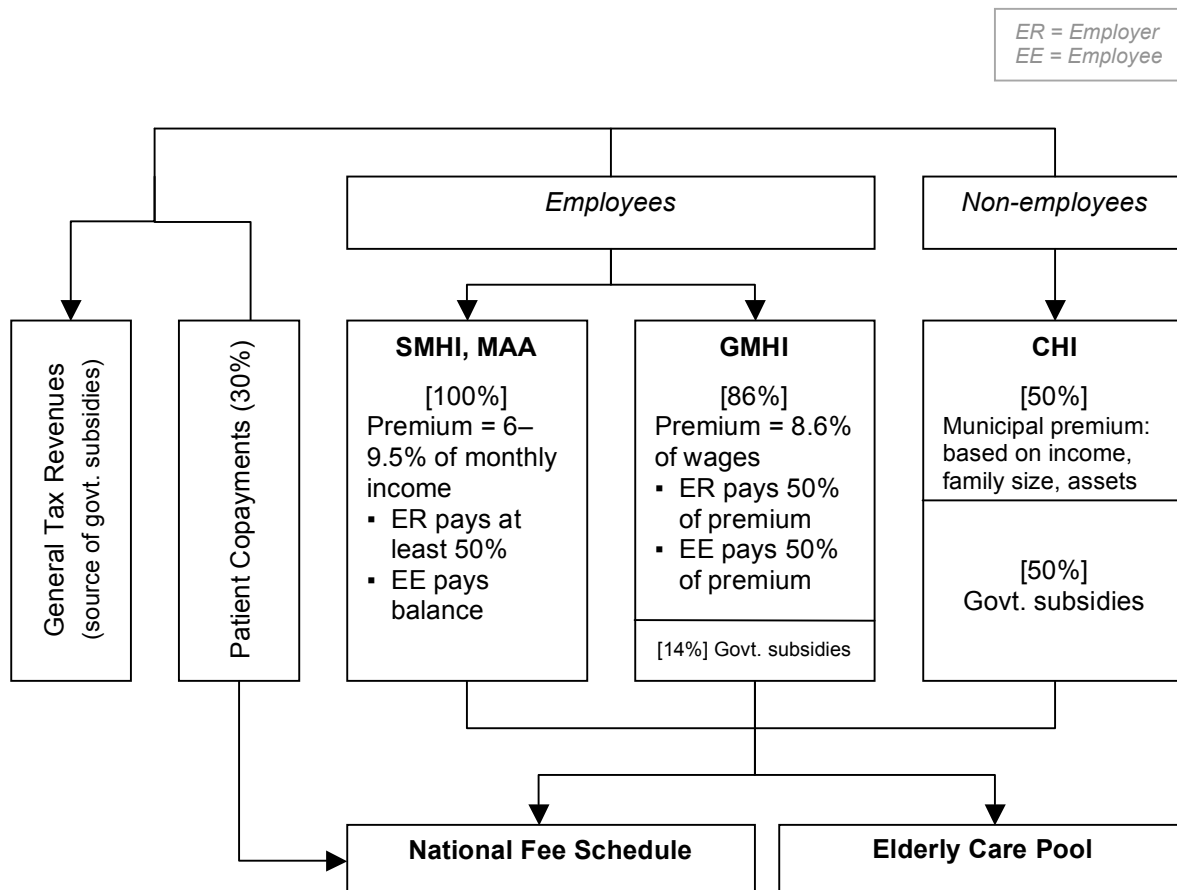
reimbursed according to both the fee-for-service schedule and the Japanese diagnosis-procedure combination (DPC) group.⁷⁵

Financing

Japan’s universal health care system is financed by a combination of public and private funds. The system is organized around three types of insurance: (1) the Society-Managed Health Insurance (SMHI) and Mutual Aid Association (MAA) plans, which cover employees of large companies and public sector employees, respectively; (2) the Government-Managed Health Insurance (GMHI; *Seifukansho Kenko Hoken*) plan, which covers employees of small and medium enterprises; and (3) Citizens Health Insurance (CHI; *Kokumin Kenko Hoken*), which is made up of prefectural-level plans that cover the self-employed or retired.⁷⁶ Figure 9, below, displays the financing scheme.⁷⁷

Figure 9. Flow of funding in Japan’s health care system

Sources: Ikegami (2007); Ikegami & Creighton Campbell (1999); Ito (2004)



Consumers do not have a choice of plan. Premiums vary based on income even though the entitlements and their reimbursement rates are standard. Only GMHI and CHI plans receive government subsidies. All plans, however, contribute to the elderly care pool according to the

proportion of elderly enrolled in a plan compared to the national average. For example, if the national average of elderly enrollment across plans is 9% and the elderly population of Plan A equals 3%, then Plan A would contribute 3 times more to the elderly care pool, in order to bring its costs in line with the national average. The government implemented this cost-sharing structure because a disproportionate number of elderly were enrolled in CHI.

Patient cost sharing varies based on age, income, and disease status. Premiums can vary from 6-9.5% of monthly income, while copayments typically range from 10-30%. All residents, with the exception of children, the elderly, and those with certain chronic diseases, have a 30% copayment.⁷⁸ Most of those aged 70 and older contribute a 10% copayment. Children age 3 or younger pay 20%. The government insulates patients from excessive costs by capping copayments based on patients' ages and incomes. The upper ceiling on cost-sharing is displayed in Figure 10, below.⁷⁹

Figure 10. Upper ceiling for annual patient copayments in Japan

	< 70 yrs	≥ 70 years	70–74 years (as of 2008)
High income	(Income ≥ US\$4913/mo) US\$1391 per year + 1% of costs in excess of \$4636	(Income > US\$13,442) ▪ Outpatient: US\$412 ▪ Inpatient: US\$743 per year + 1% of annual costs in excess of \$2476	
Middle income	US\$743 + 1% of costs in excess of \$2476	▪ Outpatient: US\$111 ▪ Inpatient: US\$412	▪ Outpatient: US\$228 ▪ Inpatient: US\$576
Low income (exempt from local tax)	US\$328	▪ Outpatient: US\$74 ▪ Inpatient: US \$228 or US\$139	

Source: Fukawa (2007)

Payors

Reimbursements in Japan are set nationally without regional variation. The government-imposed national fee schedule fixes the amount payors will pay for a given service. Every two years, the cabinet revisits the global reimbursement rates for services, drugs, and other health necessities.⁸⁰ A twenty-member council composed of payors, providers, and academics set the new reimbursement levels. More than 3000 service fees are revised individually to control utilization rates. Typically, fees for high-tech or over-utilized services are decreased—even below cost—to discourage their use, while rates for under-utilized, necessary services, typically found in ambulatory care, increase and even exceed cost.⁸¹ Drug prices are revised to reflect the volume-weighted average market price, which has created a downward spiral in drug prices.⁸² New drugs are reimbursed according to their innovation and effectiveness. Because benefits and reimbursement rates are standard across the country, insurers do not actively compete for patients for any of the standard benefits.

Providers

Physicians are key players on the provider side, both in their own practices and as hospital staff, owners and administrators. One-third of Japanese physicians work in office-based

practices, called clinics. Ninety-four percent of the clinics are privately operated.⁸³ Because these practitioners rarely have hospital admitting privileges, they tend to focus on primary care. The remaining two-thirds of physicians are hospital staff members and, with the exception of the physician owners, receive fixed salaries. Because hospital-based physicians are salaried and do not share hospital profits, they have little incentive to provide care based on profitability.

Physicians also own a majority of the hospitals in Japan—in fact, the chief executive officer of any hospital must be a physician. Approximately 80% of hospitals are privately operated; however, the most prestigious are public sector or university-owned hospitals. In addition to their acute care function, many hospitals in Japan have long-term care units. Some have become de facto nursing homes.

Reimbursement through the fixed fee schedule is the only method available. Balance billing is strictly prohibited. Moreover, should a physicians give unlisted care, the patient is responsible, out-of-pocket, for all costs associated with the service, not just the unlisted care.⁸⁴ Exceptions are made for “specified medical costs,” known as *Tokutei Ryoyohi*, such as hospital rooms with additional amenities or emerging technologies.

Access

The universal Japanese system has no gatekeeper component.⁸⁵ Patients have free access to any provider at any time. The standard reimbursement system allows patients to seek care at a hospital or private clinic as they see fit. Financially, however, access is less equitable. Lower-income patients pay a larger percent of their total income toward premiums and copayments, even with government assistance. The regressive nature of the system may make health care less affordable as costs continue to rise.

Social Welfare

Health insurance is only one part of the social insurance program. Japan also provides cash allowances for maternity and pension and sick leave benefits in its social insurance package.

Systemic Challenges

Japan faces several challenges in sustaining its health care system. The aging population may affect Japan more than other countries. More than one-third of all health expenditure is spent on health care for the elderly.⁸⁶ Japan’s elderly population is also increasing at a faster rate than other countries in this report. In addition, the Japanese cannot continue to increase patient-cost sharing. At 30% copayments on top of employment-related taxes, Japanese patients bear a high burden of their health care costs.

Related links:

[Ministry of Health, Labour, and Welfare](http://www.mhlw.go.jp/english/index.html): <http://www.mhlw.go.jp/english/index.html>

[Social Insurance Agency](http://www.sia.go.jp/e_old/index.html): http://www.sia.go.jp/e_old/index.html

[Citizens Health Insurance Organization](http://www.kokuho.or.jp/english/index.htm): <http://www.kokuho.or.jp/english/index.htm>

A country of approximately 16.6 million, the Netherlands recently enacted changes to its health insurance system. The Health Insurance Act (*Zorgverzekeringswet—Zvw*, 2006) is the most current of a string of market-oriented reforms that began in the early 1990s and is based on Alain Enthoven's managed competition model. The government enacted a gradual yet steady series of reforms to transition the system from supply-side regulation to managed competition. The Netherlands is the first nation to fully implement his construct, making it likely that health care stakeholders around the world will watch closely to see how the Enthoven model performs in the Dutch setting.

Policy and Management

The national government works in conjunction with an independent board to allocate and distribute health care funding. The Minister of Health, Welfare and Sport (*Ministerie van Volksgezondheid, Welzijn en Sport*) oversees the mandatory Dutch insurance scheme. Dutch residents are required to purchase two kinds of health-related insurance: (1) insurance under the 2006 Health Insurance Act; and (2) insurance under the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten—ABBZ*).

The Health Care Insurance Board (*College voor zorgverzekeringen—CVZ*), is responsible for ensuring that each of these insurance schemes offers the basic package of care and that the care is accessible and affordable. The Board acts independently as a non-departmental government body, even though the Minister of Health, Welfare and Sport appoints its three-member Executive Board. One of the Board's three primary tasks is the calculation and allocation of payments to insurers from the €15 billion risk equalization fund. These payments are risk-adjusted based on age, sex, disability and socioeconomic status, as well as pharmacy-based cost groups, diagnostic cost groups, and self-employed status. See Figure 11 for an overview of its three main functions.

Figure 11. Three Main Functions of the Health Care Insurance Board

1. Risk-based budgeting: allocate risk equalization payments to insurers
2. Care for special groups: implement the provisions and regulations for Dutch citizens who live abroad and Dutch residents who either refuse to enroll in health insurance or refuse to pay their contributions
3. Benefits package management: monitor and adjust the basic benefits package

Source: Cvz: *Taking Care of Health Care* (2008)

Financing

The 2006 reforms completely reconfigured the flow of health care financing. A graphic of the new model is reproduced in Figure 12 below.⁸⁷ Financing for the new system primarily comes from two sources. Employees contribute one-half of all revenues directly to the risk equalization fund through an income-based contribution calculated at 7.2% (or 4.4% for the self-employed and elderly) of the first €31,200 of annual income (2008).⁸⁸ Whether the employers are legally obligated to pay this sum on behalf of their employees is unclear;⁸⁹ however, employers are responsible for deducting the contribution directly from wages or allowances.⁹⁰ Any

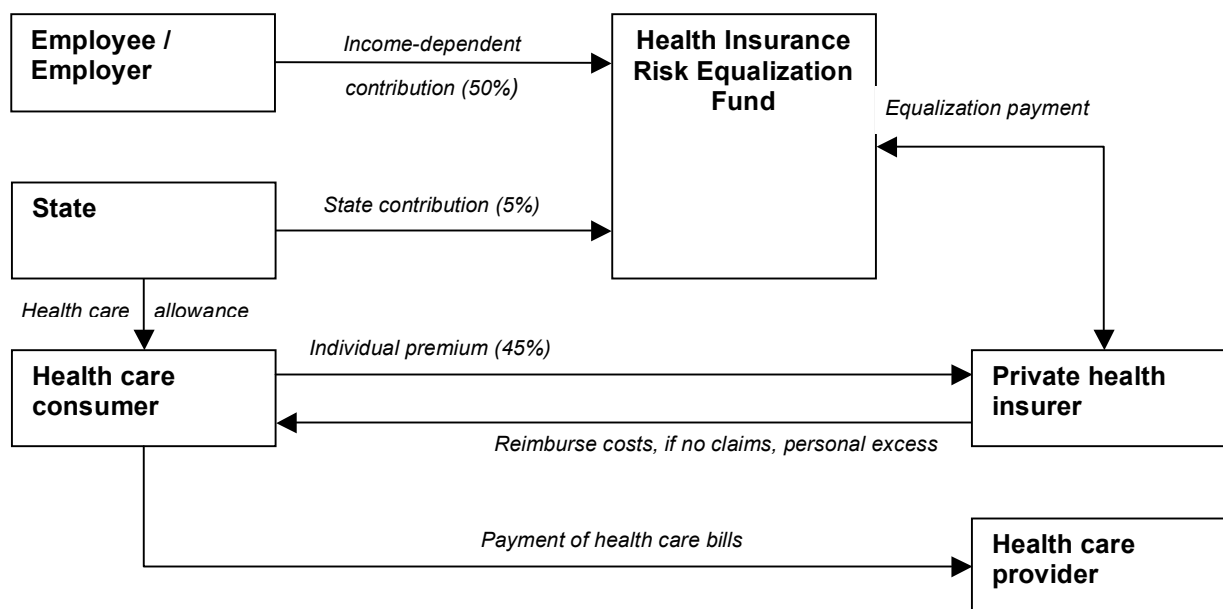
compensation employers give toward this contribution is treated as taxable income and may be capped.⁹¹

Individual adults contribute 45% of the costs of the system in the form of community-rated premiums fixed according to province, which averaged €1100 per year in 2008.⁹² Under the 2006 Act, all adults also have a €150 per year deductible, excluding general practitioner services and maternity care. Those willing to assume more risk can lower premiums by paying a higher deductible, limited to €650 per year.⁹³ For lower-income families, the state provides a “care allowance” (*Zorgtoeslag*). About two-thirds of Dutch households receive the care allowance, which is triggered when the average community-rated premium exceeds a percentage of income (4% for single adults).⁹⁴ The state also finances the premiums for children aged 18 years and younger.

Private insurers may both receive funds from and pay into the risk equalization fund. The Health Care Insurance Board allocates funds to the insurers based on their case-mix severity, allocating additional funding for the high-risk insured. If, however, the insurers have low-risk insured profiles, they must pay an equalization amount back into the fund.⁹⁵ Insurers can offer partial rebates to those consumers who claim less than €255 per year, excluding visits to general practitioners.⁹⁶ In 2005, almost 4 million insured consumers received a rebate of the fixed premium.

Figure 12. Financial flow under the Dutch Health Insurance Act of 2006

Source: The New Care System in the Netherlands (2006)



Payors

The 2006 Act privatized health insurance in the Netherlands. All fourteen Dutch health insurance companies are now privately owned. Under the Act, they have the increased ability to

negotiate average, fixed prices for many predefined diagnosis/treatment combinations. No longer obligated to contract with every provider, insurers can negotiate for discounts with particular providers and use incentives to encourage patients to see preferred providers. Although each offers the same legally prescribed benefits package, they can adjust the coverage levels of the statutory benefits scheme. Insurers also may offer group discounts of up to 10% to members of any legal entity. However, they are not allowed to risk-adjust premium rates for consumers nor deny any applicant for basic coverage.

Providers

General practitioners provide primary care and act as gatekeepers for specialist and hospital care. They are paid on both a capitation and consultation fee basis. Specialists receive a salary, a service fee, or both. Most work in hospitals and are self-employed.

General practitioners also have expanded their traditional gatekeeper role. While each insured consumer must still register with a single general practitioner to authorize access to and coordinate care across specialties, these providers are also contracting directly with insurers, increasingly turning to integrated care. Integration with the insurance plans seeks to control costs, with forms of integration ranging from being on staff at an insurer-owned primary care center to participating in financial incentives, such as prescribing generics over brand-name drugs, and even risk-sharing.

More than 90% of Dutch hospitals are privately owned; those that are publicly funded are typically university hospitals.⁹⁷ A case-mix method has replaced the former budgeting system.⁹⁸ Hospitals can now set prices and selectively contract with insurers for services categorized as Diagnostic Treatment Combinations, which comprised 20% of all hospital revenues in 2008.⁹⁹

Access

The Dutch mandate provides a basic package of benefits; no one can be denied coverage. For those who cannot afford the premium, the government offers a subsidy to help cover the cost. To cover benefits excluded from the basic plan, such as adult dental care, eyeglasses, alternative medicine, or cosmetic surgery, 90% of consumers choose to purchase a supplementary policy.¹⁰⁰ This supplementary policy does not have to be purchased from the same insurer that provides basic coverage, but patients often do purchase a combination package. To increase competition among insurers, patients are allowed to change plans every January 1.

Social Welfare

Local authorities are responsible for long-term and other social support services. Long-term care is funded through the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten—AWBZ*). The Social Support Act (*Wmo*) delegates many responsibilities to the municipalities. Provisions covered under these acts include primary care, home care, assisted living, and nursing home care.

Systemic Challenges

Full implementation of the 2006 reforms is the major challenge the Netherlands faces now and in the near future. Controlling costs is one of the main reasons the Dutch enacted health care reform. The 2006 Act is expected to stem the 4.4% annual increase in health care costs from 2001–2006.¹⁰¹ Health care costs are projected to increase to 5.5% annually during 2008–2011. The government intends the reform to slow this growth and even reduce health spending.

Enforcement of the coverage mandate, one of the primary tasks of the Health Care Insurance Board, is also problematic. About 1.5% of the insured have not made any premium payments for six months.¹⁰² In the event of default, the insurer is allowed to terminate the policy and refuse coverage for the next five years; however, other insurers must still accept the defaulter. The government hopes to combat premium defaults by allowing premiums to be deducted directly from wages or allowance, as are the income-related contributions. The penalty for triggering this mechanism will consist of paying a premium higher than any in that market.

Also, even in light of the risk equalization payments, risk selection is a concern. Should the risk equalization formula prove inadequate, insurers will attempt to select only healthy, low-risk consumers into their risk pool. Finally, now that the Dutch have an institutional framework encompassing both universal coverage and managed competition, the Netherlands must develop quality, integrated delivery networks that meet consumer preferences.

Related Links:

[Ministry of Health \(Ministerie van Volksgezondheid, Welzijn en Sport\):](http://www.minvws.nl) <http://www.minvws.nl>

[MinVWS – Health insurance information:](http://www.minvws.nl/en/themes/health-insurance-system/default.asp) <http://www.minvws.nl/en/themes/health-insurance-system/default.asp>

[National Health Insurance Board \(College voor zorgverzekeringen\):](http://www.cvz.nl/default.asp?verwijzing=/speciaal/english/index.asp) <http://www.cvz.nl/default.asp?verwijzing=/speciaal/english/index.asp>

SWEDEN

The goal of health care in Sweden is to provide equal access to good quality health care for all of its nine million citizens.¹⁰³ Quite successful in meeting this goal, the Swedish system is the model of an effective and efficient universal health care system. Sweden delivers high-quality care at a modest cost. The country consistently ranks at or near the top for nearly all health outcomes when compared to other industrialized countries,¹⁰⁴ with a particularly low infant mortality rate of 3 per 100,000 live births¹⁰⁵ and a particularly high life expectancy (78 years for men and 82.8 years for women in 2005).¹⁰⁶

Sweden achieves these superior outcomes at a relatively low cost. Data based on figures from 2002 indicate that, while the United States spends US \$5267 per capita on health care, Sweden spends less than half that amount (US \$2517 per capita) yet achieves vastly better health outcomes.¹⁰⁷

Policy and Management

Highly decentralized, the Swedish health care system delegates both health services management and health care financing to regional and local authorities. Twenty county councils and 290 municipalities handle both the financing mechanisms and the health care delivery services needed to provide quality care, including pharmaceutical services.¹⁰⁸ Individual municipalities provide elder care and social support services for the physically and mentally disabled.¹⁰⁹ The county councils' mandate includes purchasing health care delivery. Altogether, the county councils are responsible for nine regional hospitals, seventy county and provincial hospitals, and 1000 health centers across the country.¹¹⁰

While the councils have broad power to provide and manage the delivery of health care, health policy directives are made at the national level in Government and Parliament.¹¹¹ On behalf of the county councils and municipalities, the Swedish Association of Local Authorities and Regions (*Sveriges Kommuner och Landsting, SKL*) negotiates with the national-level authorities, notably, the National Board of Health and Welfare (*Socialstyrelsen*).¹¹²

Financing

Sweden funds its health care system through multiple levels of taxation. Health care costs consume approximately 9% of the total Swedish GDP (US \$196.8 billion).¹¹³ Seventy-one percent of funds are raised through local income taxes levied by the county councils, taxed, on average, at 11% of income. The state subsidizes approximately 16% of overall health care costs through national taxation. Patient contributions account for a mere 3% of all health care funds, with the remaining 10% coming from other sources.

Payors

The county councils are the primary purchasers of health care services. The councils contract with both the county and private hospitals and doctors in the area. Although the councils monopolize the purchasing of health care services, council members are elected every four years, which helps to legitimize the process.¹¹⁴

Patient contributions to care differ by the type of service. Hospital per diems are set at SEK80 (approximately US\$13.24) per day. County councils determine the rates for outpatient services. The cost of a primary care visit may range from SEK100 (US\$16.56) to SEK150 (US\$24.83). Patient contributions are capped at SEK900 (US\$149.01) in a twelve-month period.¹¹⁵ This fee ceiling aggregates all contributions made for all members of a family.¹¹⁶ Similarly, for prescription medication, patient costs are limited to SEK1800 (US\$298.01) every twelve months.

Providers

The county councils and municipalities also provide the vast majority of health services in Sweden. Municipalities contract for services with both private and public providers. Private providers deliver only about 10% of health care services, mainly in primary care.¹¹⁷ The counties contract with private primary care centers, which make up about 25% of all primary care centers.

Access

Sweden provides universal health coverage to its citizens, but limits choice outside the home region in the absence of a referral. Within their own county council, patients are generally free to choose where to receive care. Referrals may be necessary if a patient wishes to receive care outside the home region, but referrals to specialists are not required within the council's jurisdiction.

Prior to 2005, patients in Sweden experienced scheduling delays exceeding three months for pre-planned care such as cataract or hip replacement surgery. Patient dissatisfaction led the county councils and national government to establish a care guarantee. The 2005 guarantee promised that, if three months expired after the provider determined the necessary care, the patient could receive care elsewhere and the home county council would pay for both the care and any associated travel expenses.

The county councils also provide other relatively comprehensive services. Basic services include comprehensive dental and mental health care.¹¹⁸ Other services include sex education, family planning counseling, and abortions.

Social Welfare

Sweden offers social welfare benefits through social insurance. Swedish Social Security Insurance provides old age pensions for its elderly citizens.¹¹⁹ It also supports those who cannot work due to illness or childcare needs. In addition, Sweden provides guaranteed, free child care for all children ages 1–5 years. Each parent is entitled to 480 days paid leave of absence over the period from the birth of a child to its eighth year.

Systemic Challenges

Although ranked one of the best in the world, the Swedish health care system has weaknesses related to care provision and coordination.¹²⁰ Hospitals provide a disproportionate share of primary care,¹²¹ exacerbated by a shortage of primary care providers and short working hours for physicians. The decentralized system creates varying levels of efficiency, quality, and patient safety across the counties. Coordinating care between the municipal and county level is also difficult. Finally, the financing system is quickly becoming less sustainable. The income tax base may not grow quickly enough to support the aging population, and the flat cost-protection ceilings may need to be reassessed according to income or realigned with the real value of services.

Related links:

[The Government Offices of Sweden](http://www.sweden.gov.se): <http://www.sweden.gov.se>

[National Board of Health and Welfare](http://www.sos.se): <http://www.sos.se>

[Swedish Association of Local Authorities and Regions](http://www.skf.se): <http://www.skf.se>

[Swedish Institute](http://www.sweden.se): <http://www.sweden.se>

SWITZERLAND

Although united under one flag, Switzerland is a confederation of twenty-three fiercely independent cantons. The cantons generally fall within one of four regions, based on the predominant languages of French, German, Italian, or Romansh. Cultural differences among the regions are also evident in health care. Utilization varies significantly, with the French-speaking region often having the highest health services density and specialist utilization.

Policy and Management

Federalism and liberalism are guiding principles in both Swiss law and policy. National authorities may legislate only as permitted under the constitution.¹²² Moreover, the element of liberalism provides that the government may act to guarantee health care only when the private markets fail. Given this dynamic, the extreme decentralization of the Swiss system is not surprising. Although the federal tier of government set the standard basket of benefits required for each resident under the Federal Health Insurance Law, the organization and administration of the health care system falls within the purview of the cantons.¹²³

Cantons are responsible for regulating and financing health care as well as accrediting hospitals. The cantons also engage in disease prevention and health regulation. The cantonal authorities delegate responsibility for nursing and home care services (*Spitex*) to the 3000+ local authorities under their collective jurisdiction.

Financing

The Swiss model of health care financing is inconsistent between the cantons and has minimal government regulation. Sickness funds collect most of the financing directly from the insured. All members of a fund contribute a flat premium based on broad age categories (0 to 18 years; 19 to 25 years; and 26+ years).¹²⁴ The federal government does not limit the amount of the premium contribution required of enrollees, and premiums can vary wildly in the same region. Although the contribution is determined according to age group, it is not truly risk-adjusted, as it is community-rated and not modified directly based on disease status or health risk. In addition, premiums are regressive in that they are not based on ability to pay. In fact, only one-third of funds collected are based on ability to pay. However, those whose premiums exceed 8–10% of their income receive state assistance.¹²⁵ In some cantons, more than 40% of the population receives means-tested subsidies.¹²⁶

Patient copayments take the form of an annual minimum deductible (*franchise*). The lowest deductible, the *franchise ordinaire*, starts at SwF230 (US\$200).¹²⁷ Consumers are allowed to hedge risk and take a higher deductible for a decrease in premiums (*franchise à option*). The maximum allowable deductible is capped at SwF1500 (US\$1315). The percent premium deductions are displayed at Figure 13. Spending in excess of the deductible incurs an

Figure 13. Deductible levels for reduced premiums

Franchise amount	Premium reduction
SwF230	None
SwF400	Up to 8%
SwF600	Up to 15%
SwF1200	30%
SwF1500	40%

additional contribution of up to SwF600 (US\$525). A flat SwF10 (US\$9) per diem is charged for inpatient hospital stays.

Most of the tax monies for health care are levied and collected at the cantonal and local levels of government. The Confederation contributes a mere 20% to the overall budget.¹²⁸ The level of acceptable costs for which the government will provide subsidies is the funds' *actual* costs. The subsidies are given retrospectively.¹²⁹ Notably, voluntary employer contributions are generally absent in the Swiss system.¹³⁰ The extreme decentralization of the Swiss federalist model complicates the financing structure, which make managing and controlling expenditures generally more difficult.

Although the sickness funds provide nearly half of the direct cost reimbursement, patient contributions, through premiums and copayments, make up 65% of total health care financing, according to WHO data from 1997.¹³¹ Direct reimbursements from patients through copayments account for about 24% of all payments for care.

Payors

Sickness funds often act in concert with general practitioners to control costs. About ninety-three sickness funds operated in Switzerland in 2002. Each canton typically supports between forty to seventy sickness funds. Within the canton, funds engage in different tactics to minimize their risk exposure.¹³² Some funds offer plans through life insurance companies, which may inquire into health status. Others use managed care and physician gatekeepers to control cost. As in the United States, sickness funds are sometimes able to deny coverage for certain treatments. Some even go so far as to close offices in high-cost, unprofitable cantons. Competition among payors varies mostly on premium price and deductible levels, since the basic benefits package is set in law. All of the funds now offer HMO-style insurance for which the premiums are approximately 10–20% less expensive than the *franchise ordinaire*.

Providers

While physicians are allowed to participate in managed care arrangements, hospitals cannot. The sickness funds are required by law to contract with any physician. To help control costs, the funds and providers are allowed to enter into managed care arrangements.¹³³ Two preferred provider models are relevant in Switzerland.¹³⁴ In the first, physicians generally work on a salary basis for the insurance fund itself. While the fund-owned model is most common, physician-owned HMOs do exist. The second model is a network of independent providers who act as gatekeepers for the sickness fund to prevent unnecessary hospitalizations. The physicians are independent providers who contract with the funds under a risk-sharing agreement. The network physicians share in the yearly profit or loss. Losses are capped at SwF 10,000 per physician per year.

Hospitals are excluded from managed care arrangements.¹³⁵ Because the cantons provide half of the financing for public hospitals, they alone hold the authority to enter into contractual price arrangements. The cantons also determine with which hospitals the sickness funds must contract on a national level. Competition in the hospital sector is thus stifled.

Access

The standard benefits package covers a wide scope of health care services, with patient choice centering mainly on premium price. Coverage ranges from inpatient and ambulatory care to unlimited inpatient nursing home and hospital stays for the elderly and physically and mentally handicapped or disabled. Diagnostic and pharmaceutical treatments as well as complementary and alternative medicine are also guaranteed. Services that are not already included must be appropriate, clinically effective, and cost-effective to be offered as part of the standard benefits package.

Typically, between forty and seventy sickness funds operate in a given canton. Shopping around for the best rate is encouraged. Coverage for family members is not included in the standard benefits package, but sickness funds have low premiums for dependent children. Consumers are free to switch sickness funds twice yearly—open enrollment occurs as of the first of January and July. Funds must notify members of premium increases two months in advance. Should a fund increase member premiums, enrollees must give the plan one-month advance notice that they intend to switch.¹³⁶

Approximately 70% of the population in Switzerland purchases non-mandatory, supplemental health insurance for additional benefits not covered by the standard scheme.¹³⁷ The Swiss courts forbade tie-in sales, so consumers are free to choose a supplementary insurer other than their primary sickness fund.¹³⁸

Social Welfare

Switzerland requires contributions to social insurance. The Swiss provide sickness, old age, and/or disability insurance. The premiums for this insurance are income-based, and employer contributions are mandatory.

Systemic Challenges

Switzerland must carefully weigh the costs and benefits of its highly decentralized system. The benefits of the decentralized Swiss system do make national policy setting extremely difficult. Because cantonal health care regulation varies so significantly, reforming the system is exceedingly difficult. Timely reforms would help increase competition among providers, which in theory should increase health care quality. Increasing costs on a national scale is a problem that is more difficult to address with the variance in regulation.

Related Links:

[Federal Office of Public Health – Health in Switzerland](http://www.bag.admin.ch/index.html?lang=en): <http://www.bag.admin.ch/index.html?lang=en>

[Federal Office of Public Health – Health Insurance](http://www.bag.admin.ch/themen/krankenversicherung/index.html?lang=en): <http://www.bag.admin.ch/themen/krankenversicherung/index.html?lang=en>

[Federal Social Insurance Office](http://www.bsv.admin.ch/index.html?lang=en): <http://www.bsv.admin.ch/index.html?lang=en>

[Swiss health insurance](http://www.ch.ch/private/00045/00047/index.html?lang=en): <http://www.ch.ch/private/00045/00047/index.html?lang=en>

UNITED KINGDOM

The National Health Service Act of 1946 set the framework for the health services finance and delivery system of the United Kingdom (UK). The National Health Service (NHS) began operating in 1948 under the principle that the state had the collective responsibility to provide equal access to a comprehensive health system free at the point of service.

Policy and Management

The Department of Health oversees health policy, while health care delivery falls under the purview of the trusts. The responsibility for health and personal social services of each of the constituent countries of the UK lies with the Department of Health, which oversees local planning, regulation, inspection, and policy development. The secretary of state for health answers directly to the UK parliament. The central government sets health priorities for NHS as a whole and controls the overall pool of funds; NHS authorities, in turn, provide planning guidance to the health authorities in terms of service and financial networks. The ten strategic health authorities manage health care and disburse funds on a regional basis, linking the Department with the NHS.

The NHS is divided into primary and secondary care services. Primary care services are delivered by primary care trusts. The primary care trusts contract with local general practitioners, surgeons, dentists, and opticians to delivery primary care. These trusts receive about 75% of the overall NHS budget. Secondary care, or acute care, essentially refers to either emergent or elective care. Acute trusts manage the delivery of care in hospitals and ensure that hospitals deliver care efficiently. The 209 NHS hospital trusts oversee 1600 NHS hospitals and specialty care centers. Figures 14 and 15 below display the structure and features of the NHS.

Figure 14. Structure of NHS Authorities and Trusts

Source: NHS, <http://www.nhs.uk/aboutnhs/HowtheNHSworks/Pages/NHSstructure.aspx>

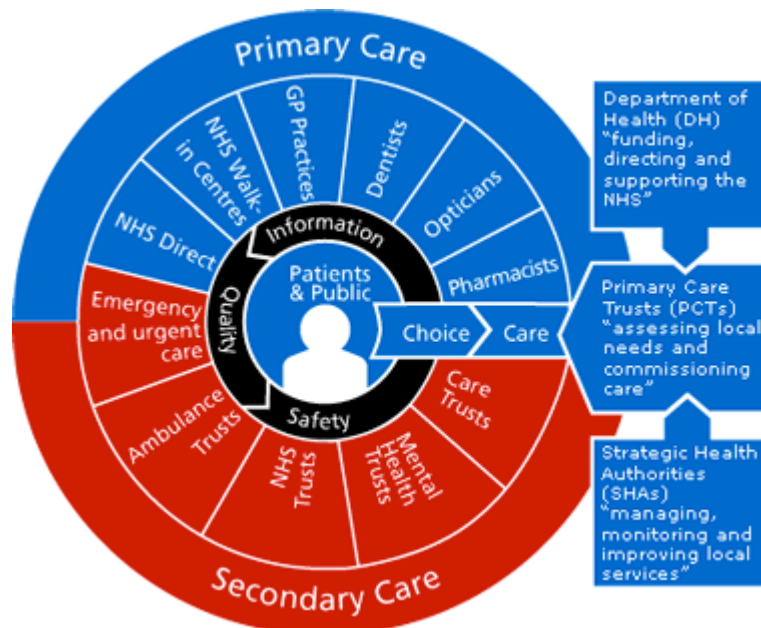


Figure 15. Features of NHS Trusts

Type of Trust	Entity concerned	Features
Acute trusts	Hospitals	<ul style="list-style-type: none"> • Monitor quality of care • Efficient use of resources • Strategy and development
Ambulance trusts	Emergency transportation	<ul style="list-style-type: none"> • Category A: immediate, life-threatening • Category B, C: non-life-threatening
Care trusts	Health, social care	<ul style="list-style-type: none"> • Social care • Mental health services • Primary care services • Integration of health and social care services
Foundation trusts	Hospitals	<ul style="list-style-type: none"> • Locally managed • Tailored to needs of local population • Decentralized public services
Mental health trusts	Primary care provider, specialist	<ul style="list-style-type: none"> • Health and social care for mental health problems
Primary Care Trusts	Physicians, out-patient clinics, hospitals	<ul style="list-style-type: none"> • Health care purchasing and management for the region • Coordinate integration of health and social care
Special health authorities	Varied	<ul style="list-style-type: none"> • Nationwide health services, e.g., National Blood Authority
Strategic health authorities	Administrative	<ul style="list-style-type: none"> • Manage local NHS staff for secretary of state • Develop strategy to improve local health services • Monitor quality and performance • Increase local capacity • Integrate national priorities into local service plans

Financing

With a budget of more than £90 billion, the NHS is the largest publicly funded health system in the world.¹³⁹ The NHS relies primarily on general tax revenues. In 2006, 87% of health spending was financed by public funds—nearly 80% of the total budget is disbursed to primary care trusts.¹⁴⁰ The Consolidated Fund of general tax revenues provided 81.5% of NHS financing in 1997.¹⁴¹ National Insurance contributions comprised another 12.2%. Patient charges accounted for 2.1%, and the remaining 4.2% came from repayments of NHS trust interest bearing debt (3.0%) and other sources (1.2%). That year, private funds accounted for 14.6% of total health expenditures.

Payors

Health care in the UK is mostly purchased through the primary care trusts and the insurers. The UK reduced the number of primary care trusts from 303 to 152. Primary care trusts oversee 29,000 general practitioners and 18,000 NHS dentists. The trusts are responsible

for assessing the health care needs of its population and contracting for the appropriate level of services to meet those needs, all within a fixed budget.

Private health insurance is mainly of two kinds: employment-based and individual insurance. More than half of those with private insurance have employer-based plans—around 59%. Individuals may purchase private insurance in the market, which is how 31% of those with private plans acquired them. The final 10% is comprised of umbrella organizations whose members voluntarily purchase coverage. Private coverage is drastically skewed toward those of higher socioeconomic status. Only 10.8% of the population had private insurance in 1996.¹⁴²

Providers

The overwhelming majority of providers operate in the public sector. General practitioners are the entry point to the NHS. More than 99% of the population has a registered general practitioner, and about 90% of all patient contact is with a general practitioner.¹⁴³ These providers are generally self-employed—they work for the NHS as independent contractors rather than salaried employees. Contract negotiations occur between doctors’ representatives and the government. Very little primary care in the UK is privately offered.

District general hospitals are the foundation of hospital care in the United Kingdom. These hospitals are widely disbursed throughout NHS. Highly specialized tertiary facilities operate on more regional or supra-regional levels. Patients enter tertiary care facilities after being referred from the district hospitals. Community hospitals often provide long-term care, particularly for the elderly. More than 300 private hospitals operate in the United Kingdom. At times, NHS patients do have access to these private facilities.

Access

All UK residents are eligible for care through the NHS. Services are provided free of charge at the point of care unless expressly authorized under the law, namely, the Health Service Act of 1977. Patients are free to choose their general practitioner within their region. Only through their general practitioner do patients have access to specialist care, unless in an emergency situation.

The NHS does allow patients to upgrade their services without acquiring private insurance. Patients may receive an “amenity room,” typically a private room, through the NHS for an additional fee. For privately insured patients who need care, NHS trusts also may offer these “pay beds” at NHS facilities.

Social Welfare

Although the local governments have primary responsibility for social services, the NHS also contributes to the provision of these services. The UK also provides social care for those with mental illness, learning disabilities and for the elderly. Care ranges from long-term residential or nursing home care to domiciliary services provided in the home. The local government and social services departments share responsibility for these services with the NHS.

Systemic Challenges

Sustainability and improved quality are two of the major challenges facing the NHS. Although patient satisfaction with primary care is generally high, delays in receiving specialist care decrease consumer confidence in the system.

Related Links:

[UK Department of Health](http://www.dh.gov.uk): <http://www.dh.gov.uk>

[National Health Service](http://www.nhs.uk): <http://www.nhs.uk>

APPENDIX

Figure 16. Health Expenditures by Country (2006)

Source: OECD Health Data (2008) except as indicated

	Total Expenditures on Health (TEH)				Public Expenditures	
	Rank	% GDP	Rank	\$'s Per Capita	Rank	% TEH
Canada	7	10.0	9	3678	5	70.4 ^c
Denmark	6	9.5	5	3349	10	82.9 ^a
France	9	11.1	8	3449	7	79.7
Germany	8	10.6	6	3371	6	76.9
Israel*	1	7.8 ^b	1	2143 ^b	4	66.5 ^b
Japan	2	8.2 ^b	2	2474 ^b	9	82.7 ^b
Netherlands	5	9.3	7	3391	3	62.5 ^a
Sweden	4	9.2	4	3202	8	81.7
Switzerland	10	11.3	10	4311	2	60.3
United Kingdom	3	8.4	3	2760	11	87.3
United States	11	15.3	11	6714	1	45.8

* = WHO Statistical Information System

^a = 2002 data; ^b = 2005 data; ^c = 2007 data

Figure 17. Health Care Resources by Country (2006)

Source: OECD Health Data (2008) except as indicated

	Physician density		Acute care beds		MRI units		CT scanners	
	Rank	(per 1000)	Rank	(per 1000)	Rank	(per million)	Rank	(per million)
Canada	11	2.1	8	2.8 ^e	8	6.2	7	12.0
Denmark	4	3.6 ^d	6	3.1 ^d	4	10.2 ^d	5	15.8
France	7	3.4	4	3.7	10	5.3	8	10.0
Germany	6	3.5	2	6.2	6	7.7	4	16.7
Israel	3	3.7*	3	6.0*	11	1.4 ^{†, b}	11	6.3 ^{†, b}
Japan	11	2.1	1	8.2	1	40.1 ^e	1	92.6 ^c
Netherlands	2	3.8	7	3.0	7	6.6 ^e	9	8.2 ^e
Sweden	6	3.5 ^e	11	2.2	5	7.9 ^{†, a}	6	14.2 ^{†, a}
Switzerland	2	3.8	5	3.5	3	14.0	3	18.7
United Kingdom	8	2.5	11	2.2	9	5.6	10	7.6
United States	9	2.4	9	2.7	2	26.5	2	33.9

* = WHO Statistical Information System; [†] = Sharona et al.; [‡] = OECD Health Data – Sweden (2006)

^a = 1999; ^b = 2000; ^c = 2002; ^d = 2004; ^e = 2005

Figure 18. Mortality Data by Country in Years (2006)

Source: OECD Health Data (2008) except as indicated

	Life Expectancy at Birth			Life Expectancy at Age 65	
	<i>Population</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>
Canada ^a	80.4	82.7	78.0	21.1	17.9
Denmark	78.4	80.7	76.1	19.2	16.2
France	80.9	84.4	77.3	22.6	18.2
Germany	79.8	82.4	77.2	20.5	17.2
Israel [†]	80.6	82.8	78.5	--	--
Japan	82.4	85.8	79.0	23.4	18.5
Netherlands	79.8	81.9	77.6	20.1	16.7
Sweden	80.8	82.9	78.7	20.8	17.6
Switzerland	81.7	84.2	79.2	22.1	18.5
United Kingdom ^a	79.1	81.1	77.1	19.5	17.0
United States ^a	77.8	80.4	75.2	20.0	17.2

[†] = CIA World Fact Book source

^a = 2005