

## Sweden

### Structure, delivery, administration

- Single payer, universal healthcare system, with 21 county councils as the primary payer (reimbursing)
- Administration of healthcare plan is decentralized in the hands of the county councils
- Central government's role is to give grants to councils for care
- Delivery: providers are mainly public with some private practitioners, whereas hospitals are mostly independent public facilities. The degree of privatization in hospitals varies among counties

### Healthcare Financing Mechanisms and Health Expenditures

- Funding comes from:
  - County, municipal, and parish taxes (66% of financing)
  - Central government grants to counties (7-11% of financing)
  - Patient fees (2% of financing)
  - Mandatory payroll tax from employers and employees (21-25%)
- User fees
  - National ceiling for patient fees in a year (~ EUR 99); fees exist for doctor visits and other services
  - Sliding scale rate for drug co-payments (in 2002, patient responsible for 100% prescription drug expenses up to EUR 99, 0% past EUR 472)
- Reimbursement
  - Physicians
    - Private: fee-for-service
    - Public: salaried
  - Hospitals
    - Short-term care: DRG
    - Psychiatry, geriatrics, emergency services: global budget

### Quality of Benefits, Choice, Access

- Quality: Generally comprehensive, but no dental services after age 18 and only certain drugs are subsidized by national insurance funds
- Choice: Can choose where to receive primary care, as well as their doctor
- Access: Few financial barriers for primary care, but waiting times are a problem for elective hospital procedures

### Problems and Reforms

- Increasing privatization of hospitals
- Waiting times, possibly exacerbated by healthcare professional shortage
- Aging population is increasing cost of long-term care
- Difficulties meeting patient choice and care guarantees of 1997

## Canada

### Structure, delivery, administration

- Single payer, universal healthcare system
- 10 provincial and 3 territorial governments are the primary payer (reimbursers); in addition, they have the responsibility of administering the healthcare plan for their residents
- Central government's role is to give grants (transfer payments) to provincial/territorial governments for care, provided the healthcare plans administered by these governments meet the following criteria outlined in the Canada Health Act of 1984: public administration, universality, portability, comprehensiveness, accessibility
- Private health insurance exists for services not publicly covered; such insurance cannot duplicate publicly covered benefits
- Delivery: providers are mostly private practitioners, whereas hospitals are mostly not-for-profit entities

### Healthcare Financing Mechanisms and Health Expenditures

- Funding comes from:
  - Public contributions (69.9% of funding)
    - Provincial, territorial, and municipal taxes
    - Central government transfer payments
  - Private contributions (30.1% of funding)
    - 55% of private contributions comes from out-of-pocket costs and 35% comes from the cost of purchasing private health insurance
- User fees
  - Minimal user fees for public system, but cost-sharing exists for non-covered benefits such as prescription drugs
- Reimbursement
  - Physicians
    - Private: fee-for-service
    - Public: salaried
  - Hospitals
    - Private: Fee-for-service or per-diem (per-day) payments
    - Public: Global budgets

### Quality of Benefits, Choice, Access

- Quality: Guaranteed coverage for hospital and physician services; no guaranteed outpatient prescription drug, dental care, or home care coverage. Provinces cover these benefits to various degrees, and private insurance is available to cover these services
- Choice: Can choose doctor and hospital
- Access: Few financial barriers overall, but waiting times are a problem for certain elective hospital procedures

### Problems and Reforms

- Underfunding of the system and a subsequent trend towards privatization
- Waiting times for certain elective hospital procedures
- Gaps in coverage (prescription drugs and long-term care)
- Ongoing tension between federal and provincial governments
- Relatively high expenditures on healthcare compared to other industrialized countries

## Japan

### **Structure, delivery, administration**

- Three main sources of insurance:
  - Employee health insurance pool, which is divided into 3 further programs:
    - Kenpo associations for large companies (~1800 Kenpo associations exist)
    - Seikan program for small to mid-sized companies
    - Kyosai program for public employees and private-school teacher enrollees
  - Roken system for the elderly
  - Kokuho program for the self-employed, retired, and others who don't qualify for the other two programs
- Delivery: hospitals are the center of medical care. Providers are mostly private practitioners, and hospitals are mostly private entities owned by physicians

### **Healthcare Financing Mechanisms and Health Expenditures**

- Funding:
  - Kenpo associations financed through payroll tax
  - Government programs (Seikan, Kyosai, Roken, Kokuho) financed through taxes and in many cases through cross-subsidizations from insurance programs that make a profit (especially Kenpo).
- User fees
  - Relatively high cost-sharing, with as much as 10-30% co-insurance rates for services
- Reimbursement
  - Physicians: Fee-for service for non-hospital physicians; hospital physicians are salaried
  - Hospitals: file highly detailed item-by-item claims, which get reimbursed by insurance companies within two months

### **Quality of Benefits, Choice, Access**

- Quality: Comprehensive benefits
- Choice: Can choose doctor and hospital
- Access: Good access overall (many hospitals, excessive numbers of specialists, highest number of MRI's and CT's per capita), although the best hospitals often have very long waiting lines because hospitals compete with each other on the basis of quality, not on the basis of price (since prices are uniform by law)

### **Problems and Reforms**

- 75% of Kenpo associations in debt, and with rapidly aging population, cross-subsidization system may be unstable
- Over-prescription of drugs, in part due to guaranteed profit margin in national pharmaceutical price schedule
- Reforms have included creating a nursing care insurance scheme, increasing cost-sharing, and shifting reimbursement from fee-for-service to a DRG payment scheme

## The Netherlands

### Structure, delivery, administration

- Three main components:
  - AWBZ: universal coverage for catastrophic costs and long-term care
  - Social insurance for non-catastrophic, medically necessary services
    - ZFW: for those making under EUR 30700 annually, there is mandatory ZFW coverage through sickness funds (66% of population covered this way)
    - Private substitutive voluntary health insurance: For those who make more than EUR 30700 annually, there is the option of buying private substitutive VHI (29% of population covered this way)
    - 5% of Dutch people are civil servants, who receive coverage under a separate insurance scheme
  - Private voluntary health insurance for other services such as dental care
- Delivery: Hospitals are predominantly private, non-profit entities; physicians are both public and private, but private providers dominate

### Healthcare Financing Mechanisms and Health Expenditures

- Funding:
  - National, provincial, and municipal taxes
  - AWBZ: 10.25% of first EUR 27009 of an employee's income was withheld from their paycheck.
  - ZFW: payroll tax and employee contributions, as well as annual flat-rate premium
  - Substitutive VHI: Annual premiums that are risk-rated
  - User fees (9% of health expenditures)
- User fees
  - AWBZ: nursing home care has a co-pay capped at EUR 1631/month in 2001
  - ZFW: 20% co-insurance rate, but this does not apply to GP visits, general dental services, or inpatient pregnancy fees
- Reimbursement
  - Physicians:
    - ZFW: GP's reimbursed on capitation basis, and specialists are reimbursed on fee-for-service basis
    - VHI: reimburse on a fee-for-service basis
  - Hospitals: size-dependent budgets

### Quality of Benefits, Choice, Access

- Quality: Comprehensive benefits except for some services such as dental and eye care
- Choice: Can choose sickness fund, GP, and specialist
- Access: Good access to primary care; some waiting times for elective procedures and specialty care

### Problems and Reforms

- Inequitable second component (income-based) has prompted proposals to get rid of income criteria and thus unify the second component of the system.
- There also have been proposals to unify the first and second components of the system, but to keep the third component

## France

### Structure, delivery, administration

- Multi-payer system that depends on a combination of Sickness Insurance Funds (SIFs) and supplementary insurers
- 3 main SIF's, dependent on occupation
  - Industrial, commercial, and government workers (83% of population)
  - Farmers (9% of population)
  - Professionals, craftspersons, small business workers (6% of population)
- Supplemental insurance is obtained by over 90% of the French to reimburse for co-payments and other out-of-pocket expenses
- Delivery: Hospitals are both public and private; private providers predominate

### Healthcare Financing Mechanisms and Health Expenditures

- Funding:
  - General taxation
    - General social contribution funds (5.25% income tax)
    - Tax on pharmaceutical companies
    - Tax on tobacco and alcohol
  - Social health insurance contributions (payroll tax)
  - User fees
- User fees
  - 30% co-insurance for physician visits, 35% of drug costs, 40% of lab test costs, etc.
  - Can apply for cost-sharing exemptions for catastrophic health incidents
  - Many out-of-pocket costs are reimbursable through complementary voluntary health insurance
- Reimbursement
  - Physicians:
    - Sector I: Fee-for-service, according to national fee schedule (these physicians receive government benefits, including free health coverage)
    - Sector II: Fee-for-service, but the amount charged can be above the national fee schedule (these physicians do not receive government benefits)
  - Hospitals:
    - Private not-for-profit and public hospitals: global budget
    - Private for-profit: itemized billing system

### Quality of Benefits, Choice, Access

- Quality: Comprehensive benefits overall
- Choice: Can choose provider and hospital
- Access: Good access with relatively few problems with waiting times

### Problems and Reforms

- Inequitable second component (income-based) has prompted proposals to get rid of income criteria and thus unify the second component of the system.
- There also have been proposals to unify the first and second components of the system, but to keep the third component

## Germany

### Structure, delivery, administration

- Multi-payer system that depends on a combination of a compulsory Social Health Insurance (SHI) network and private substitutive insurance for those who can afford to opt out of the SHI system
  - The SHI network consists of 192 sickness funds that cover 88% of the population
  - Substitutive voluntary health insurance (VHI) covers 9% of the population
  - 2% of the population qualifies for free government care
- Administration is decentralized in the hands of hospital associations, sickness funds, health professionals, and state governments
- Delivery: Hospitals are both public and private; private providers predominate the ambulatory care market

### Healthcare Financing Mechanisms and Health Expenditures

- Funding:
  - General taxation (8.4% of healthcare expenditures)
  - SHI: Monthly payroll tax shared equally between employers and employees. This tax is compulsory for those making a certain amount per month
  - Voluntary health insurance premiums are risk-rated; the average premium is in the range of 1790 EUR per year
  - User fees account for 12.2% of German health expenditures
- User fees
  - Co-insurance rates for certain services are limited to 2% of gross income for an individual
  - Average drug co-payment is about 4-5 EUR
- Reimbursement
  - Physicians:
    - Hospital physicians: salaried
    - Ambulatory physicians: physician's associations receive budget based on capitation, and physicians are reimbursed by the associations on a fee-for-service basis
  - Hospitals:
    - Investment costs through the state government
    - Operational costs through the sickness funds

### Quality of Benefits, Choice, Access

- Quality: Comprehensive benefits, but significant cost-sharing exists
- Choice: Can choose sickness fund and physician, but usually most use closest available hospital for non-emergency care
- Access: Good access overall, with very few problems with waiting times

### Problems and Reforms

- High health expenditures in comparison to other European countries, although this is partly because of the generous benefits extended to employees when they become ill
- Overconsumption and underconsumption have been both characteristic of the system in recent years
- There are too many physicians in Germany, which has prompted the German government to close certain oversaturated areas to additional ambulatory care physicians

## **The United Kingdom**

### **Structure, delivery, administration**

- National Health Service (NHS) provides the majority of care in the UK, although there is a growing parallel private insurance sector
- Administration of care is in the hands of both county health authorities and “primary care trusts”, which are groups of healthcare professionals that are given funding to plan health services for their local communities
- Delivery: providers are predominantly public, as are hospitals

### **Healthcare Financing Mechanisms and Health Expenditures**

- Funding:
  - General taxation (80% of NHS costs)
    - 17.5% value-added tax
    - Graduated income tax
  - National Insurance contributions from employees and employers (12% of NHS costs)
  - User fees and miscellaneous expenses account for 4% of NHS costs each
- User fees
  - No cost-sharing for GP visits or hospital stays
  - Cost-sharing does exist for long-term care, private care, drugs, dental care, and eye services
    - Certain groups are exempt from prescription drug co-payments
- Reimbursement
  - Physicians:
    - Hospital physicians: salaried
    - Ambulatory physicians: capitation
  - Hospitals: global budgets

### **Quality of Benefits, Choice, Access**

- Quality: Comprehensive benefits, except for certain services (e.g. dental and eye care) that can be covered through the purchase of private insurance
- Choice: Can choose GP
- Access: Good access to primary care, but significant waiting times for specialist appointments and elective hospital procedures/treatments

### **Problems and Reforms**

- Increased administrative costs due to fragmentation of purchaser role between primary care trusts and county health authorities
- Underfunding in the face of rising healthcare expenditures; the government has recently committed to increasing level of healthcare funding
- Health disparities by socioeconomic class are significant