European
Observatory
on Health Systems and Policies

Policy brief

Health care outside hospital

Accessing generalist and specialist care in eight countries

by
Stefanie Ettelt
Ellen Nolte
Nicholas Mays
Sarah Thomson
Martin McKee
and the
International Healthcare
Comparisons Network

The International Healthcare Comparisons Network comprises experts in 13 countries who are listed below. The network is part of a research project funded by the United Kingdom Department of Health (grant reference number 0510002), to whom we are grateful. We would also like to thank the members of the Department of Health for their support and feedback, in particular Deborah Roche and Alan Glanz. The views expressed in this policy brief are those of the authors alone and do not necessarily represent those of the Department of Health. The authors are fully responsible for any errors.

The International Healthcare Comparisons Network

***Reinhard Busse**, Department of Health Care Management, Institute of Health Sciences, University of Technology, Berlin, Germany, and European Observatory on Health Systems and Policies*

***Carl-Ardy Dubois**, Faculty of Nursing Sciences, University of Montreal, Canada*

***Isabelle Durand-Zaleski**, Hôpital Henri Mondor, Paris, France*

***Odd Arild Haugen**, Special Advisor on Health Services and Health Systems, Blommenholm, Norway*

***Judith Healy**, Regulatory Institutions Network (RegNet), Research School of the Social Sciences, Australian National University, Australia*

***Alberto Holly**, Institute of Health Economics and Management, University of Lausanne, Switzerland*

***Ingvar Karlberg**, Centre for Health Systems Analysis, Gothenburg, Sweden*

***Niek Klazinga**, Department of Social Medicine, University of Amsterdam, The Netherlands*

***Allan Krasnik**, Institute of Public Health, University of Copenhagen, Denmark*

***Nicholas Mays**, London School of Hygiene & Tropical Medicine, United Kingdom, and part-time Policy Adviser with the New Zealand Treasury, New Zealand*

***Juha Teperi**, STAKES National Research and Development Centre for Welfare and Health, Helsinki, Finland*

***Magdalene Rosenmöller**, IESE Business School, University of Navarra, Barcelona, Spain*

***Walter Ricciardi**, Department of Hygiene and Public Health, Catholic University of the Sacred Heart, Rome, Italy*

Policy brief

Health care outside hospital

Accessing generalist and specialist care in eight countries

The delivery of health care is changing. While the acute hospital will always play a key role in the provision of health care, reflecting its important role in training and research, as well as its capacity to manage complex and severe disorders, in many countries there is an increasing interest in the scope to transfer some types of care out of hospitals. There are a number of factors supporting this interest:

- the perceived high cost of hospital care (although in many cases the same care provided outside the hospital can be as expensive, or more so, because of the loss of economies of scale);
- the challenges of delivering hospital care in the future, especially where there are dispersed populations;
- the belief that moving services out of hospitals will make them more accessible, thus increasing responsiveness and, perhaps, patient choice.

Despite this interest, there is surprisingly little information currently available about how different countries deliver care outside hospitals. This is in contrast to the extensive information on topics such as the numbers of hospital beds. In this policy brief we aim to describe a broad spectrum of models by exploring the arrangements that are in place in eight countries. This is intended to provide a basis for a more informed discussion on the future of health care outside the hospital.

The countries were selected to include a variation: those where health care financing is based predominantly on social health insurance (France and the Netherlands) and those whose systems are mainly funded through taxation (Australia, Denmark, England,* Finland, New Zealand and Sweden). Most of

** The responsibility for health care in the United Kingdom is devolved to England, Scotland, Northern Ireland and Wales. Consequently, the organization of health care is constantly diverging, with the most rapid changes taking place in England. Unless otherwise stated, this policy brief draws on examples and data from England.*

these countries share the vision that publicly-funded health care should provide a comprehensive range of services, should cover the entire population and should aim to improve standards of quality, equity and responsiveness of care. However, the way in which patients have access to generalist and specialist care, the range of choices offered to them and the way health care services are organized vary substantially.

The countries reviewed can be considered to lie on a spectrum where, at one end, there is extensive gatekeeping which controls access to specialist and diagnostic services, while at the other end, there is direct access to specialist care. Systems with direct access tend to offer both a greater choice of provider and faster access to specialist care; however, this is often associated with fragmentation and less continuity of care, (higher) user charges and lower levels of equity and efficiency. Systems with more extensive gatekeeping through primary care physicians and other providers generally require patient enrolment and restrict the choice of provider, but have greater potential to provide enhanced continuity of care and integration of services. These systems are more likely to avoid duplication, thus enhancing the efficient use of resources; in addition, they generally tend to have a stronger division between generalist and specialist providers, and a longer tradition of general practice/family medicine separate from specialist medicine.

It is important to note the considerable volume of research carried out on the association between the strength of primary health care and population health – exemplified by the work of Starfield and colleagues. In a recent analysis looking at countries belonging to the Organisation for Economic Co-operation and Development (OECD), they showed how the strength of a country's primary care system was significantly associated with reduced premature mortality from a range of conditions.[1] This assessment was made using a 10-component scale reflecting structural characteristics such as financing, resource allocation and accessibility, and specific practice features of primary care, such as the extent of gatekeeping, comprehensiveness of primary care and the degree of service co-ordination. This relationship proved to hold even after adjustment for a number of health determinants such as national wealth and alcohol and tobacco consumption, pointing to the potential that strong primary care systems have to improve population health.

This policy brief is organized around three themes:

- accessing generalist (primary) and specialist care in eight countries;
- the relationship between choice and user charges;
- the scope of services provided by general practitioners, specialists and other providers.

The policy brief is based on a review of selected published and grey literature, complemented by information provided by members of the International Healthcare Comparison Network on country experience. It is important to note that we did not aim to undertake a systematic and comprehensive assessment of strategies of care outside hospitals, but rather to provide a snapshot of approaches adopted in different countries as a means to highlight key features of models in place. We provide a more detailed overview of systems in place in each country included in this review in the Appendix (on pages 13–59). However, there is a need for more research to analyse the contextual factors and conditions of change to allow a more systematic comparison of approaches to organize generalist and specialist care.

Accessing generalist and specialist care

The ways in which patients access non-urgent, first-contact health care vary considerably. In Denmark, England and Finland, patients have to register with a general practitioner in the area in which they live, while in the Netherlands they may register with any general practitioner. In Australia, New Zealand, France and Sweden patients can see any general practitioner and claim (some) reimbursement or subsidy, although patients may choose to be enrolled with a general practice in Sweden or with a "médécin traitant" in France.

Usually, patients consult a general practitioner if they require non-urgent first contact care, and they generally have to make an appointment prior to their visit. Waiting times range from same-day appointments to more than eight days. In urgent cases, patients can turn to hospital emergency departments in all countries.

In all eight countries, first-contact care is almost always provided by physicians. This is often driven by reimbursement arrangements, although there is an increasing interest in expanding the roles of nurses and other health personnel, such as pharmacists. Examples of nurse-led care are especially common in England, the Netherlands and Sweden. Thus, in Swedish health centres patients are first assessed by nurses before being referred to a general practitioner or a hospital, as appropriate. Until recently, nurse-led care for medical conditions was generally supervised by a doctor, according to strict protocols. Now, however, especially in England, nurses and pharmacists are increasingly working as independent practitioners. The corresponding regulations have recently been changed, greatly increasing the range of pharmaceuticals that a nurse may prescribe.

Countries have different arrangements for out-of-hours services, and many are in the process of revising accessibility to these services. France, for example, has launched experiments that involve on-call facilities using general practitioners based in hospitals, call centres staffed by physicians, and arrangements with

physicians specializing in the provision of all out-of-hours services in return for higher fees. In the Netherlands, general practitioners have formed larger co-operatives providing services in out-of-hours centres or on-site hospitals; these services are usually accessed through a nurse-led triage system. In New Zealand, larger cities have introduced walk-in centres that are open 24 hours a day and that provide services at night and at weekends. Walk-in centres usually have radiography and diagnostic services on site. Accessing these services, however, incurs higher charges than those provided in standard general practice. In England, patients have various options for accessing care out of hours. These include hospital emergency departments, walk-in centres (often providing extended opening hours in the evenings and at weekends), minor injury units, a telephone helpline (NHS Direct) and services provided by general practitioners (usually organized in the form of general practitioner cooperatives).

There is also variation regarding access to specialist care. Until recently, patients in France (and Germany*) were able to directly consult a specialist without incurring any additional charges. In Australia, the Netherlands and Sweden patients must have a referral from a general practitioner if they want to qualify for reimbursement for specialist ambulatory care. In England, a referral from a general practitioner is usually the only way to consult a specialist in non-emergency cases. In some countries, patients are able to bypass the gatekeeping system if they pay out-of-pocket or accept higher co-payments for publicly-funded care. Thus, in Denmark, patients can choose to enrol either in a scheme with gatekeeping and which is free at the point of use, or in one that allows direct access to specialists; this, however, involves co-payments for visits to both general practitioners and specialists.

A number of countries that offer direct access to medical specialists in ambulatory settings have recently introduced measures to restrict direct access and to develop the gatekeeping role of the primary care physician (e.g. France and, to a lesser extent, Germany**). This development is mainly accounted for by the need to contain the costs of health care and to address inappropriate use of specialists.[3]

** This policy brief draws on some examples from Germany thought to be relevant. However, due to its similarities with the French system and in order to avoid duplication, Germany is not included in the table.*

*** Recent data from Germany suggest that by February 2006 over 23 million insured had been given the option to join a gatekeeper model. Only about 2.6 million are already participating in corresponding models.[2]*

Box 1: "Specialist units" in rural Sweden

In the 1990s, selected small acute hospitals deemed to be inefficient were restructured into "specialist units", while their emergency departments and inpatient wards were closed.

Specialist units may include paediatrics, internal medicine, gynaecology, surgery, orthopaedics, ophthalmology, ENT, psychiatry, diabetes units and rehabilitation centres. Often, these units are managed and financially organized as a branch of a nearby hospital, or they may be joined with a local primary care facility.

The move towards introducing specialist units in Sweden was not necessarily driven by an intentional policy or reform strategy. Yet, it shows how potential inefficiencies of small hospitals and the problem of underprovision of specialist services inherent to remote areas may be addressed.

In contrast, some countries that have strong gatekeeping mechanisms in place are currently introducing new initiatives designed to facilitate access to specialists. Thus, since April 2005 opticians in England can refer a patient directly to a hospital eye department without the patient having to consult a general practitioner first. Others, such as Denmark, exclude selected specialist services from the gatekeeping system so as to enable direct access to, for example, ear, nose and throat (ENT) specialists and ophthalmologists.[4]

Access to specialist care in rural or remote areas is a concern in many countries. Often, hospitals were closed because they were unable to provide services cost-effectively. There are, however, examples of how this problem may be overcome – Sweden has demonstrated how small acute hospitals can be transformed to ensure access to specialist services in remote areas (see Box 1).

The relationship between choice of provider and user charges

Increasingly, choice of provider comes at a price for both patients and health care systems. For public payers, unregulated access may involve higher costs, as patients may consult several providers, resulting in wasteful duplication of services. Patients too may face (higher) user charges if they wish to have a greater choice of provider. Moreover, the provision of care may be less well integrated, and patients may find it more difficult to make their way through the health care system; they may also spend more time moving from one provider to another.

Several countries have introduced some form of user charge for physician consultations, with a wide variation in the extent and level of charges imposed. In New Zealand, general practitioners have always been granted the right to charge their patients beyond what is reimbursed by the public system, and a similar system is in place in Australia. France has gradually introduced user charges for visits to general practitioners and specialists in an attempt to control demand and to create additional revenue. The recent introduction of a new health insurance system in the Netherlands allows patients to choose between health insurance plans, including plans which offer deductibles or "no claim" refunds. These may translate into out-of-pocket payments for a visit to a doctor.

Generally, user charges address patients' willingness to pay for increased choice of provider. France recently introduced a gatekeeping scheme. Patients who bypass the gatekeeper face higher co-payments and a lower level of reimbursement from the public system. A similar system is in place in Denmark; however, less than 2% of Danish patients seem to opt for choice and higher payments. This is mainly because of the financial costs involved and the generally high level of satisfaction with general practitioner services. Those opting for choice in Denmark appear to be older, wealthier and healthier, with lower use of general practitioner and hospital services but higher use of specialists.

Although choice of provider is seen by some as increasing access to care, experience has shown that this is not necessarily the case.[5] For example, even in settings where patients can theoretically choose any provider, regional inequalities in access to care remain. In France, uneven regional distribution of physicians is a long-standing concern, as physicians are free to choose any location for their practice. In Denmark, most patients who have chosen to pay for direct access to specialists live in Copenhagen and its environs, where there is the highest density of specialists in the country.

Most countries allow exemptions from user charges or run concessionary schemes to improve access to health care for specific groups. However, countries apply different criteria for eligibility. These may be income-related (based on existing administrative data or means-testing), based on age (e.g. children and older people), high utilization of care (e.g. individuals with chronic conditions) or other priority groups (e.g. pregnant women). There is, however, evidence that criteria are often arbitrary or inconsistently applied, thus potentially creating substantial inequalities. For example, in Sweden, patients with diabetes are exempt from prescription charges, but patients suffering from other chronic conditions are not.

All eight countries analysed here impose prescription charges, either as a fixed charge per item or as a percentage of its price. Some countries base their system of user charges for pharmaceuticals on cost-effectiveness criteria (in some

cases excluding non-cost-effective drugs from the reimbursement schedule) – a practice that is believed to have helped to control pharmaceutical expenditure in Australia and New Zealand.

The scope of services provided by generalists (general practitioners), specialists and other providers

The scope of services that general practitioners are expected to provide varies from country to country. The British concept of the primary care team is among the most comprehensive in the countries considered. A similar approach is found in Finland. In other countries, particularly those with a (social) health insurance system (e.g. France and Germany but not the Netherlands), patients are more likely to seek specialist services for first-contact care in contrast with England, where this would be provided by a general practitioner. This difference may be associated with a number of factors, such as the specialized training for general practitioners and, until recently, the lower ratio of specialists to population existing in England, different traditions in defining the role of the general practitioner, and the professional dominance of specialists in some countries.

Access to diagnostic services is often considered a crucial bottleneck in the patient journey through the health care system. In England, Denmark and Sweden, diagnostic services are mainly provided in hospitals, so patients have to make a separate visit to obtain these services. In countries with a stronger private sector (Australia, New Zealand), patients have the choice to directly access a hospital outpatient department or be referred by their general practitioner to a private clinic for a test and/or diagnosis. In both cases, patients may face substantial waiting times to see a specialist. In the Netherlands, general practitioners cooperate with independent laboratories (often not-for-profit organizations founded by local general practitioners) that provide a growing range of diagnostic services. This evolving market increasingly attracts other for-profit competitors mainly from abroad.

Some countries have developed models that allow or encourage the integration of diagnostic or other specialist services into general practice and community health centres. Health centres in Finland, for example, are allowed to purchase diagnostic and specialist services from hospitals and other providers (see Box 2 overleaf). Centres are staffed with general practitioners, nurses and other health-related personnel, which may include social workers, health education counsellors and medical specialists. However, the number of medical specialists involved in Finnish health centres is relatively small, mainly because of the low professional status associated with working in a health centre.

Box 2: Health centres in Finland

Health centres in Finland purchase diagnostic and specialist services from hospitals and other providers. They often have their own X-ray and laboratory facilities, may integrate an on-site community pharmacy and provide inpatient beds ("primary care hospitals"). Inpatient services mainly comprise skilled nursing care for elderly people who are unable to live in their homes but are not sick enough to be referred to a hospital.[6]

Since the introduction of health centres in the 1970s, an increasingly diverse range of models has emerged. Following extensive administrative reforms in the 1990s, many local hospitals in medium-sized cities were merged with health centres. These mergers have helped to promote the development of specialist polyclinics within health centres, for example, providing diabetic care, stroke rehabilitation and endoscopy services.

In some cities, hospitals and health centres collaborate using a system of e-consultation, in which a general practitioner forwards a query with clinical data to the hospital and receives advice and/or recommendations for further action within one or two days.

In contrast, Germany has introduced regulations to increase the utilization of outpatient diagnostic and treatment services in acute hospitals.[7] Extending hospital capacity for use in ambulatory care reflects concerns about the inefficiency of the alternative in which office-based specialists undertake tests for which they are paid on a fee-for-service basis, thereby providing a strong incentive for supplier-induced demand.

There is an increasing interest in complementary and alternative medicine (CAM) among patients and doctors. However, many countries struggle with the challenge of regulating an increasing number of CAM therapies and professions. The question often arises over whether and which therapies should be reimbursed by public funds or how to integrate them into the portfolio of services offered by public providers. Generally, countries have different approaches to integrating CAM treatments into their health systems. Currently, there is no universal pattern, mainly because countries have different traditions of alternative medicine. Furthermore, there is limited evidence of the effectiveness of most forms of CAM.

In most countries, sexual and reproductive health services are provided mainly by general practitioners or specialists such as gynaecologists or venereologists. Although there are some special arrangements in some countries with regard to sexual health, these mainly consist of social services which provide counselling

and (some) services for family planning and contraception. In the Netherlands, sexual health clinics led by nurses offer confidential and specialized care for the sexual health needs of the whole population (historically, only sailors were targeted). Nurses examine the patient, provide counselling and treatment under the supervision of a physician. A similar approach has been taken in England, although these services are usually provided by salaried doctors employed by a primary care trust (PCT).

Prevention is another area characterized by substantial variation. Most countries have introduced screening for conditions such as breast and cervical cancer, and preventive or early detection programmes are under discussion for many other conditions (e.g. bowel cancer). However, in many cases, screening is opportunistic, and only a few countries (e.g. England and Sweden[8]) have implemented integrated population-based models that involve call and recall, integrated diagnostic systems and quality assurance. Policy-makers often find it difficult to introduce or increase preventive services and to encourage their utilization. Countries with strong gatekeeping systems are often viewed as being more successful in integrating preventive care into general practice. In many countries with a tradition of liberal professions (typically, those funded by social insurance), these services have been provided separately, often by public health services based within local government.[9] New Zealand is increasing the share of public funding for primary care and making this available in the form of capitation payments to the new primary health organizations (PHOs) to try to encourage a greater emphasis on 'wellness' services in primary care.

Suggestions for further research

There is great variation in the provision of care outside hospitals, and there are still many issues where the evidence on the effectiveness of different approaches is incomplete. On the basis of this analysis and the literature review that has informed it, it is possible to identify a number of topics that require further exploration. These are explored below.

Integration of specialist services in general practice

The experience in Finland of establishing multi-specialist centres and networks in which general and specialist practitioners collaborate may provide pointers for the integration of various professions (e.g. doctors, nurses, pharmacists as well as optometrists and physiotherapists) into a single centre for health service provision. Finland's experience demonstrates how health centres can combine a variety of generalist and specialist services, contract with hospitals and run

Box 3: "Polyclinics" in Germany

Polyclinics were a common feature of the health care system in the German Democratic Republic. Following German unification in 1990, they were almost entirely replaced by the model of independent, office-based practices typical of the Federal Republic of Germany.[10] However, recognizing their potential to enhance coordination and integration of care, the model of polyclinics was reintroduced into the German health care system in 2004 under the re-branded name of *Medizinische Versorgungszentren* (medical care centres, MVZs).

MVZs are allowed to provide care across several health care specialties, and their establishment requires a minimum of two physicians with different specializations. Teams usually include at least one general practitioner, but may also involve nurses, pharmacists, psychotherapists or psychiatrists and other health care professionals.

Although MVZs have to be professionally supervised by a fully qualified and registered physician, any health care provider may establish and operate a centre. Sickness funds are excluded from ownership to avoid vertical integration. MVZs are usually run by professional managers dealing with administrative issues. MVZ physicians may be salaried or contracted as self-employed practitioners.

Anecdotal evidence suggests that MVZs are becoming increasingly attractive to physicians, as joining a MVZ minimizes the financial risk associated with establishing an independent private practice, while at the same time maintaining freedom of clinical practice.[11]

their own laboratory facilities. Another example is offered by Germany, which is currently re-introducing the concept of polyclinics (*Medizinische Versorgungszentren*) – a model of integrated provision of services that was common in the German Democratic Republic (see Box 3). There is also a need to evaluate the extent to which access is affected by the deployment of diagnostic services in different settings.

Regulation of direct access to specialists

Several countries provide options for direct access to specialist services. However, approaches to regulating access vary substantially, especially with regard to the incentives and disincentives that patients face (i.e. user charges,

waiting times), and there is a need to understand more clearly the implications of different approaches for equity in access to care. There is also scope to examine the criteria for excluding some specialist services from gatekeeping, such as ENT and ophthalmologist services in Denmark, or paediatric, gynaecologist and ophthalmologist services in France.

Meeting health needs and responding to consumer demand

Patients' expectations concerning the provision and quality of health care have risen over time. International experience shows that countries have developed different approaches in the quest to provide health services that are responsive to the legitimate expectations of the population. In this context, there is a need for further research to explore approaches that are used to enhance accessibility to and flexibility of care, in particular widening the scope of services available in primary care.

Supply of general, specialist and other health-related practitioners

Issues of labour supply cut across many of the areas addressed in this analysis – for example, access to diagnostic services and specialists in and outside hospitals, and the availability of other health-related practitioners such as physiotherapists. There is a need to analyse the impact on health care delivery of arrangements to train, sustain and retain the health workforce in each country.

Responding to the needs of people with chronic conditions

Internationally, there is great interest in identifying optimal health system responses to the rising burden of chronic (long-term) conditions. In the context of the potential (or real) penetration into some European countries of United States providers of structured disease management programmes in primary care, there is a need to better understand the lessons from countries such as Germany, which has developed its own model of a disease management programme.

Appendix: Provision, financing and access to generalist (primary) and specialist health care in eight countries

In addition to the sources quoted, information presented in this appendix has been compiled from the following country informants: Judith Healy (Australia), Allan Krasnik (Denmark), Juha Teperi (Finland), Isabelle Durand-Zaleski (France), Nicholas Mays (New Zealand), Ingvar Karlberg (Sweden) and Niek Klazinga (The Netherlands). Information provided here reflects data available in April 2006.

	Australia[12,13]	Denmark[14,15]
Coverage and payment mechanism	Australia's health care system is mainly funded from taxation. Medicare, the publicly-funded national health insurance system, provides free or subsidized health care services to the resident population. 43% of the population (2004) have private insurance for private treatment in hospitals and for some ancillary goods and services (ambulatory care is covered under Medicare). The Government offers financial incentives to purchase private insurance such as tax rebates; out-of-pocket payments now account for 20% of total health care expenditure.	Funding of health care in Denmark is based on general taxation. Financing and provision of services are integrated at the county level. The statutory system is compulsory for all residents. There is a small private health care sector, and an estimated 28% of the population have some sort of complementary voluntary health insurance. Co-payments account for 18% of all health care expenditure.
Provision of primary/ generalist and specialist care	Over 42% of physicians are general practitioners in private practice, with about two-thirds in solo practice (accounting for about one-third of general practitioners). About 8% of general practitioners work for private health care chains; some have arrangements with companies to provide health checks etc. Specialists work in public and/or private hospitals and in private offices.	General practitioners work mainly in private practices; specialists may work in hospitals or in private settings.

	Australia[12,13]	Denmark[14,15]
Paying for general practitioner visits	General practitioner consultations are covered under Medicare, with patients paying upfront and claiming partial reimbursement; no upfront payment is required if the doctor bulk-bills Medicare and accepts 100% (previously 85%) of the Medicare Benefits Schedule fee as full payment. Although declining, in 2002 bulk-billing accounted for over 70% of consultations. General practitioners can charge their patients beyond the Medicare fee; the patient has to pay upfront and can only reclaim the Medicare schedule fee.	Access to a general practitioner is free at the point of use if the patient has chosen a general practitioner as gatekeeper (group 1 option). If the patient opts for a choice model, s/he must bear part of the costs of the general practitioner visit, but may consult any general practitioner without being enrolled (group 2 option). General practitioners may set their own fee level for group 2 patients. In 2002, only 1.7% of the population opted for group 2 (because of the higher costs involved and general satisfaction with the general practitioner service).
Paying for visits to a specialist	Specialist consultations are covered under Medicare. The Medicare schedule fees for specialist services are set at a higher level than for general practitioner consultations.	Specialist consultations are free for group 1 patients. Group 2 patients have to make a co-payment if they consult a specialist without referral; the specialist can charge group 2 patients at any level of co-payment.
Choice of general practitioner	Free choice of general practitioner and no requirement to register.	Group 1 patients have to register with a general practitioner practising within 10 km of their home address (or 5 km in Copenhagen); patients can change general practitioners every 3 or 6 months; Group 2 patients are free to visit any general practitioner but must make a co-payment.

	Australia[12,13]	Denmark[14,15]
Choice of specialist care	Patients generally accept the specialist suggested by their general practitioner and must obtain a referral to qualify for Medicare reimbursement of the specialist fee. Patients covered by private health insurance are referred by general practitioners or specialists to a hospital and may choose any public or private hospital, although a private insurance fund may offer higher reimbursement for preferred provider hospitals.	Group 1 patients require a referral to obtain free access to a specialist. Group 2 patients may visit any specialist without referral but must make a co-payment. Under private insurance, specialists receive a basic fee, but may charge an additional co-payment to be paid directly by group 2 patients. Access to ENT specialists or ophthalmologist services is not conditional on referral for both groups, and their services are reimbursed according to a positive list.
Gatekeeping	General practitioners have a role as gatekeepers, since specialist services necessitate a referral to qualify for Medicare cover. Referral by general practitioner or specialist is also required for hospital treatment, except for treatment at accident and emergency departments. Direct access to specialists is possible but requires full out-of-pocket payment.	A gatekeeping system is in place (group 1). Since 1973 patients over the age of 16 years have been able to opt out, depending on their willingness to pay for greater choice (group 2).
Waiting time/lists	In 2003/2004 the average waiting time for elective surgery in public hospitals was 28 days, with variations across regions (from 22 days in Queensland to 46 days in the Australian Capital Territory) and across specialties (e.g. 11 days for	Waiting times have been considered a problem, but it appears to be comparatively small. Since July 2002 there have been two guarantees: (1) patients with critical/life-threatening illnesses will have to wait no longer than two weeks for diagnosis plus two

	Australia[12,13]	Denmark[14,15]
Waiting time/lists (continued)	cardiothoracic surgery, 46 days for orthopaedic surgery, 60 days for ophthalmology).[16] The national system for standardization of waiting times has set maximum waiting times according to the urgency of treatment (category 1: to be admitted within 30 days; category 2: 90 days; category 3: 12 months). In 2003/2004, 3.9% of patients waited more than 365 days; patients with private insurance can bypass waiting lists by consulting private hospitals; there are five triage categories in emergency departments where non-urgent patients ought to be seen within 120 minutes (the number of urgent cases has increased and non-urgent cases decreased; 65% of all cases are seen within the recommended time).	weeks for treatment plus two weeks for follow-up treatment; and (2) a general waiting time guarantee of a maximum of two months for all types of non-urgent treatments. Counties failing to meet this target are required to pay for their patients to be treated privately or abroad.
Appointment with general practitioner	In urgent cases, a general practitioner will normally be seen the same day – in all cases within a few days by appointment (except in very underserved areas). A 2004 survey found 54% of respondents had seen a general practitioner within 24 hours, 21% the next day and 17% within two to five days.[17]	The patient can be seen the same day in case of an emergency. An agreement between general practitioners and the counties has specified that waiting times for appointments should not exceed five working days. In practice, waiting times can sometimes be longer, but this should be in agreement with the patient.

	Australia[12,13]	Denmark[14,15]
Appointment with specialist	There is no national information on waiting times for specialist treatment (except for hospital treatment, as detailed above). Waiting times vary considerably by type of specialism and across regions.	A specialist can usually be seen within one and two weeks. There is no waiting time for patients with acute conditions. General practitioners are expected to provide information on waiting times for hospital treatment; waiting time information is also available on the Ministry of Health web site.
Degree of integration of services	Various programmes are under way to promote coordinated care at both national and state levels: the 2004 Australian Primary Care Collabora-tives Plan aims to involve 20% of general practices in a geographical area to improve service delivery, access and integration of care for patients with complex and chronic conditions. Various programmes offer financial incentives to general practitioners to improve quality of care and to encourage coordination of care for patients with chronic conditions, including the Practice Incentives Program (involving the majority of general practices), the Enhanced Primary Care scheme and Service Incentives Payments.	As gatekeeper for patients in group 1, the general practitioner is expected to guide patients through the system as it relates to access to secondary care and to ensure follow-up after hospitalization. However, integration of care for chronically ill patients is considered problematic and health centres for rehabilitation of chronic diseases are being piloted in some municipalities in order to ensure follow-up after hospitalization.

	Australia[12,13]	Denmark[14,15]
Services provided by others than general practitioners (e.g. nurses, pharmacists)	The role of nurses is expanding. For example, for the prescription of a limited range of drugs or of medical tests, provision of immunizations, reproductive health checks and health counselling. However, nurse consultations are not reimbursed by Medicare.	Nurses, physiotherapists, dieticians and other health personnel are increasingly being employed by municipalities to provide a range of primary health care services – lately as part of newly established health centres involved in prevention, rehabilitation and home care at municipality level.
Scope of entitlements for patients	Entitlements are listed in the Medicare Benefits Schedule. This includes all services and technologies eligible for reimbursement, such as consultation fees for general practitioners and specialists, radiology and pathology tests, and eye tests by optometrists. The list is extensive but excludes medical services that are not clinically necessary such as cosmetic surgery, dental care and most services provided by allied health professionals. Patients are entitled to free hospital treatment as public patients in public hospitals and are also entitled to subsidized pharmaceuticals, as included in the Pharmaceuticals Benefits Schedule.	Outpatient care is regulated under the Public Health Insurance Act 1998. The statutory system does not cover complementary and alternative medicine and spectacles (except for patients with very poor sight). Physiotherapy, dental care and pharmaceuticals prescribed in a primary care setting are only partly covered. Patients are entitled to free services by general practitioners (except group 2 patients, see above) and to all specialist and hospital services following referral; other services are partly or fully covered according to specific regulations, in some cases depending on referral from the general practitioner or type of health problem.

	Australia[12,13]	Denmark[14,15]
Scope of doctors' decision-making and practice	The Medicare Benefits Schedule is very explicit in defining diagnostic and treatment categories eligible for reimbursement. A range of organizations, including health departments and specialist colleges publish and disseminate treatment guidelines, but these are not binding.	The general practitioner acts as a gatekeeper to specialists and hospital treatment, and is also involved in referral to some specific therapies; in this case, s/he decides whether a procedure qualifies for reimbursement (e.g. cosmetic surgery on psychological grounds). Generally, general practitioners have a considerable amount of freedom regarding benefit-related decision-making.
Diagnostic services	Diagnostic services are mainly provided by private providers, subsidized by Medicare rebates. Diagnostic tests are requested for patients by a physician and the reimbursable fee is set out in the Medicare Benefits Schedule.	Diagnostic services are mainly provided in public hospitals following referral by a general practitioner (no co-payment). Some diagnostic tests such as electrocardiograms are available at general practice level as part of the general service. Private clinics offer tests without referral but this is not common.[18]
Out-of-hours services/online or hotline advice/home visits	In a 2004 survey, 54% of respondents reported that access to out-of-hours care (other than to hospital emergency departments) was difficult.[17] Out-of-hours arrangements are a matter for private physicians but corresponding services are in decline. The Practice Incentives Program requires general practitioners to make some arrange-	General practitioner services are available 24 hours a day, and general practitioners are responsible for ensuring this service. Out-of-hours care is organized jointly by all general practitioners in a district, and in some instances coordinated with hospital emergency services in the district. Access to emergency services varies, with some regions requiring a referral from general

	Australia[12,13]	Denmark[14,15]
Out-of-hours services/online or hotline advice/home visits (continued)	ments for after-hours care. The Australian and state health departments offer online information on health issues and services to support self-care. Some state health departments are experimenting with nurse-run email and telephone information and advice services.	practitioners. General practitioners provide home visits when required.
Complementary and alternative medicine (CAM)	Chiropractic or osteopathy services are reimbursed under Medicare upon referral by a physician. Nearly all private insurance funds provide some reimbursement for traditional Chinese medicine and naturopathy. All other CAM treatments have to be paid for out-of pocket.	CAM therapies are usually not covered. Chiropractic services may be partly reimbursed (for specific conditions). Patients do not require a referral.
Prevention and adult screening	Australia runs two national screening programmes for cancer: BreastScreen Australia offers women aged 50–69 a mammography (bi-yearly); women aged 40–49 and 70+ may also attend. Cervical cancer screening is available to all sexually active women (mainly between ages 20 and 69) and is organized in the framework of a National Cervical Screening Programme. A pilot scheme for bowel cancer screening is currently being undertaken.[19]	Prevention of non-communicable diseases is based on guidelines and action plans (e.g. the government programme on public health and guidelines by the National Board of Health). Screening is in place for cervical cancer (pap smears for women aged 23–59 in all counties) and breast cancer (ages 50–69; currently available in 3 counties; there is a legal requirement to make this service available in all counties by 2008).[20,21] A pilot scheme for colorectal cancer screening has been recommended but has not yet been implemented.[8]

	Australia[12,13]	Denmark[14,15]
Contraception and sexual and reproductive health (SRH)	SRH services are provided by doctors and nurses in general practice, by specialists in complex cases, and by community health centres and non-governmental bodies such as family planning organizations. Special services are provided, by family planning organizations or community health centres, for some groups such as young people or migrants.	Advice on contraception and family planning is free of charge and provided by general practitioners. Payment for contraception is not part of the health basket and contraceptive pills require a prescription (which is not reimbursed).
Medical records (e.g. patient smart card, national databases)	A new national management system for electronic patient medical records, HealthConnect, is being trialled. Information on Medicare claims is maintained by the Health Insurance Commission.	Every resident has a personal card confirming entitlements and containing a personal identification code (CPR), which allows individual services utilized by the patient to be traced. The National Board of Health and the national health insurance keep registers on diagnoses, interventions, contacts/bed days, etc. Individual data are available for specific clinical and research purposes only – access requires special permission. Nationwide requirements for electronic records are presently being developed; there is no joint common national record system.
Consumer/ patient satisfaction	There are reports of rising consumer dissatisfaction with out-of-pocket payments and waiting times in hospitals. In a 2004 survey 71% of respondents rated care provided by a general practitioner as excellent;	Generally high satisfaction with health care (4.2 on a scale of 1–5 in 2000, with 5 representing "very satisfied"); somewhat lower satisfaction with emergency services.[15]

	Australia[12,13]	Denmark[14,15]
Consumer/ patient satisfaction (continued)	however, 29% reported problems in accessing care because of costs during the last 12 months.[17]	
Recent reforms/ developments/ plans	• General practice in Australia has undergone major changes in the last decade.[22] Divisions of General Practice introduced in the 1990s comprise groups of around 100–300 general practitioners in a geographic area, funded to update knowledge, improve cooperation and undertake health promotion; most general practitioners are members. • The accreditation of general practices was introduced in 1997. Although the scheme is voluntary, around 90% are now accredited. • A series of financial incentives are offered to general practitioners to enhance quality of care, including the Practice Incentives Program. • The Australian College of General Practitioners and the Australian College of Rural and Remote Medicine now require their members to undertake continuing professional development.	• Major structural reforms involve introducing five larger regions to replace counties; regions will have responsibility for hospital and general practitioner services; the number of municipalities will be reduced from 275 to 100, and they will now also be responsible for prevention and rehabilitation. The reform is intended to be fully implemented by 2007. • National health care expenditure has recently been increased to implement the general waiting time guarantee of two months.

	England[23,24]	Finland[25,26]
Coverage and payment mechanism	In England, health care is predominantly funded from general national taxation, with an additional element of national insurance contributions paid by employers and employees. Public and private health care sectors are generally separate, with public services predominantly provided by the National Health Service (NHS), which covers all residents. In the NHS, health care is free at the point of use; there are, however, charges for prescription drugs and ophthalmic and dental services. Just under 12% of the population in the United Kingdom have supplementary voluntary health insurance (VHI). In 2002, private spending accounted for 16.6% of total health care expenditure.	In Finland, public health care is funded by taxation (43% local, 18% national), National Health Insurance (NHI) (15%) and private payments (24%). Provision of primary care is organized by municipalities; all residents are covered. In 2003, out-of-pocket payments accounted for 19% of total health expenditure (the share of out-of-pocket payments has risen steadily since 1990). Voluntary health insurance (VHI) appears to be of minor importance (in 2003, it accounted for 1.5% of the total health care expenditure).
Provision of primary/ generalist and specialist care	Most general practitioners are self-employed and contracted by a primary care trust (PCT, the local NHS body responsible for purchasing services, including primary health care); others are directly salaried by a PCT. General practitioners mainly work in group practices, while most specialists are based in hospitals. Outreach clinics for certain specialties are becoming more common (i.e. hospital	Primary care is mainly provided by health centres run by the municipalities. In addition, most employers provide primary care services to their employees as part of occupational health services (financed jointly by NHI, employers and employees, and provided by company-owned health care units, municipality health centres or, in most cases, private providers). Specialists mainly provide services in public hospitals

	England[23,24]	Finland[25,26]
Provision of primary/ generalist and specialist care (continued)	specialists offering services in primary care settings). General practitioners may offer private consultations but are not permitted to treat privately NHS patients registered with their practice. In contrast, specialists may offer their NHS patients the option of being treated privately.	or private offices. Specialists may sometimes be contracted by a health centre (mainly in larger cities and selected specialties such as gynaecology). Many specialists work part time in the public and private sectors; the private sector is concentrated in urban areas.[21]
Paying for consulting a primary care provider	Access to a general practitioner in the NHS is free at the point of use. In the private sector patients are required to pay for services provided, either out-of-pocket or through VHI, although few private insurance policies cover general practitioner services.	Most municipalities charge patients for consulting a health centre physician. There are two options: a fee of €22 per year for any number of visits or €11 per visit. Changes to payment policies are planned. Patients have to pay the full fee upfront when consulting a physician in private practice and are reimbursed at 60% of the fee by NHI (the actual reimbursement rate is less than 40% of the true total costs, as private practitioners are allowed to charge beyond the reference fee).
Paying for consulting a specialist	There is no charge for consulting a specialist in the NHS. In the private sector, patients pay out-of-pocket.	Patients are charged for specialist services at a public hospital (€22 per visit at the policlinic; €72 for an outpatient surgical procedure; inpatient day charge is €26 in medical wards and €12 in psychiatric wards); private provision is partly reimbursed

	England[23,24]	Finland[25,26]
Paying for consulting a specialist (continued)		under NHI. Following 2004 legislation, public hospitals are permitted to charge higher fees for services provided after 4 pm during weekdays and at weekends; this arrangement is to replace an earlier system where patients had to pay an extra fee to see a doctor of their choice.
Access to/ choice of provider	General practitioners act as gatekeepers to specialist and hospital services in both the public and private sector, the only exception is emergency care. Efforts have been made to gradually increase choice of general and specialist providers.	In the public sector, health care is provided in primary health centres that comprise a range of different activities. Health centres are owned by one or several municipalities; staff comprise general practitioners, sometimes medical specialists, nurses, public health nurses, dentists, social workers, physiotherapists, psychologists and administrative personnel. Services usually include outpatient and inpatient care (30–60 beds, mainly long-term care for elderly patients), school health and occupational care, care for the elderly, family planning and others. Health centres can make arrangements with hospitals to optimize the provision of services.[6]

	England[23,24]	Finland[25,26]
Choice of general practitioner	Patients may choose to register with any general practitioner within a defined geographical area of residence. General practices may refuse an application for registration – for example, if they have formally closed their list of patients. However, patients who have repeatedly been rejected will be allocated to a practice by the PCT responsible for that area. There are only a few private general practices.	In the public sector, patients are usually assigned to a general practitioner at their local health centre. Changing the assigned doctor within the centre can be arranged but will depend on availability. In the private sector, patients may choose any general practitioner. The possibility of consulting a doctor outside the municipality of residence is currently discussed.
Choice of specialist care	Patients require a referral from their general practitioner to consult a specialist. Limited choice of providers for NHS elective care was recently introduced, although this refers only to the hospital and not to an individual specialist. In the private sector patients may consult a specialist without referral if they pay out-of-pocket; however, it is common that patients visit a general practitioner first. VHI usually only covers specialist consultations if the patient has a referral.	Patients require a referral by a health centre physician or any other physician (including private practitioners) for treatment in an outpatient department in a public hospital. 30–40% of patients access the hospital through hospital emergency departments. The choice of hospital for treatment is limited (there is some discussion of whether choice should be increased). Patients have direct access to any specialist in the private sector, and this usually requires an appointment.

	England[23,24]	Finland[25,26]
Gatekeeping	The NHS operates a strict gatekeeping system; in the private sector the major insurers demand a referral from a general practitioner (and few cover primary care), but those paying for themselves may in some cases be able to self-refer.	Patients require a referral to access public specialist care; however, only a minority of hospital patients are referred by a health centre general practitioner. Many patients get access through hospital emergency departments, or through referral by private practitioners.
Waiting time/lists	Reducing waiting lists and waiting times for elective care has been a key governmental priority since 1997, various targets introduced since have resulted in the reduction of long periods of waiting. In 2004, the Government introduced a new target stipulating that by 2008 no NHS patient should wait longer than 18 weeks from the time of referral by a general practitioner to hospital treatment.[27]	Waiting times are a long-standing policy issue. In 2005, the Government introduced standards according to the 3-3-3 principle: 3 days' maximum wait for non urgent care (general practitioner); 3 weeks' maximum wait from referral to assessment of need for treatment in hospital polyclinic/bed ward; a maximum of 3 (in some cases 6) months to actual treatment. Providers failing to deliver these targets have to cover the costs of treatment by another provider (public or private) with no extra costs to the patient. Preliminary experience suggests some success but, at the end of 2005, also highlighted the need for further improvement to enable the standards to be met.
Appointment with general practitioner	The 2000 NHS plan set a specific target for waiting such that by 2004 all patients should be able to see a primary care professional within 24 hours and a general practitioner	There is no reliable information on waiting times in general practice. The Government has introduced a maximum wait of 3 days for an appointment with a general practitioner.

	England[23,24]	Finland[25,26]
Appointment with general practitioner (continued)	within 48 hours of requesting an appointment.[28] According to a 2005 survey, 74% of patients reported that they were seen within 2 days; appointments were more likely to be delayed if the patient wished to see a particular doctor. Difficulties with making an appointment on the phone have been reported.[29]	
Appointment with specialist	In December 2005, the maximum waiting time for an outpatient appointment with a hospital specialist was 13 weeks (26 weeks in April 2002). The maximum waiting time for elective care was 6 months (15 months in April 2002).[30]	There is no reliable information on waiting times for specialist services. In the private sector, a specialist appointment can usually be arranged within a few days, although some specialists have very long waiting times. Availability of private services is regionally imbalanced, with only few services available in the eastern and northern parts of the country.
Degree of integration of services	Integration of health services as a means to improve the management of chronic illness has been a key priority of recent NHS reforms. A systematic approach was set out in the NHS Improvement Plan (2004) that takes account of the level of support needed by patients with long-term conditions, involving self-manage-	Ensuring continuity of care between health centres and hospitals is often a problem, and there is debate whether health centre general practitioners (as "responsible doctors") should have a better overview over the patient's journey. The level of integration achieved within health centres may be considered fairly good because of the comprehensive range of services provided (general

	England[23,24]	Finland[25,26]
Degree of integration of services (continued)	ment, disease management and case management. Some models, mainly drawing on experiences from the United States (Kaiser Permanente, United Healthcare's Evercare), are currently being tested. All PCTs are expected to implement some form of case management by 2008.	practitioner surgery, mother and child care, family planning, laboratory and imaging, school health care, occupational care, dental care, mental health care, etc.).
Services provided by others than general practitioners (e.g. nurses, pharmacists)	Many general practices employ nurse practitioners (specially trained nurses who work independently and are regulated by an explicit protocol) who attend to patients for minor health problems. Limited nurse prescribing has been in place since 1998; this was further expanded in 2006 to include prescription of any licensed medicine for any medical condition with the exception of controlled drugs. Recently established walk-in centres are usually led by nurses; so-called community matrons to support patients with complex chronic conditions are progressively being introduced (to reach 3000 by year 2008). The role of community pharmacists is currently being reviewed; it is planned to introduce pharmacist-prescribing as an additional qualification.	Nurses play an essential role in health care provision beyond assisting doctors; some offer consultation hours for injections, run policlinics for simple respiratory infections, measure blood pressure, are responsible for health promotion programmes, provide family planning consultations, school health care, etc. However, nurses do not act as gatekeepers; maternal and child care is largely carried out by specifically trained nurses. New initiatives (including limited rights to prescribe medicines) are being discussed.

	England[23,24]	Finland[25,26]
Scope of entitlements for patients	NHS benefits are not explicitly defined. The National Institute for Clinical Excellence (NICE) develops recommendations based on cost-effectiveness as to what services should (or should not) be offered by the NHS either to the population as a whole or to population subgroups with specific indications. Difficulties have arisen when decisions were required on interventions that NICE had yet to reach a conclusion about such as expensive cancer treatments. A further difficulty is that different decisions have been made by authorities in England and Scotland.	The Finnish Constitution states that every person residing in Finland has to be provided with sufficient health (and social) care services. More specific definitions are found in other legislation, including the Act on the Status and Rights of Patients.
Scope of doctors' decision-making and practice	Doctors are requested to follow treatment guidelines as, for example, set out in the National Service Frameworks (NSFs), although adherence to the guidelines is not enforced. The 2004 Quality and Outcomes Framework (QoF), introduced as part of the new general practitioner contract, provides financial rewards to general practices for the provision of high-quality care.[31] Participation is technically voluntary but virtually all practices participate. The system is currently being revised.	The medical profession has had a central role in producing a large number of national guidelines. Non-adherence by doctors does however not incur formal penalties.

	England[23,24]	Finland[25,26]
Diagnostic services	Currently, most diagnostic services are only available in hospitals; however, shifting diagnostic services into the community (e.g. in contracted diagnosis and treatment centres) has become an increasingly important focus for the government; general practices offer some simple diagnostic tests (such as urine tests), but services are increasingly contracted to the private sector to improve access (e.g. pathology).	Health centres are usually equipped with X-ray facilities, clinical laboratory, facilities for minor surgery, endoscopy and equipment such as electrocardiogram and ultrasound. Some centres have arranged for specialists to come from nearby hospitals (e.g. radiologists to read X-rays). There are no additional charges for these services. Pharmacies are not included. Treatment and examination (i.e. laboratory tests and X-rays) ordered by a doctor are reimbursed at 75%.
Out-of-hours services/online or hotline advice/home visits	Options for out-of-hours care comprise hospital emergency departments (A&E), general practitioners' cooperatives, or doctors directly employed by PCTs (responsible for organizing out-of-hours services in general practice since 2004), NHS walk-in centres and minor injury units offering services in the evenings and at weekends, and the telephone hotline and internet website NHS Direct. These services are provided by nurses.[32] General practitioners provide home visits but only if a patient is too ill to consult a doctor in an office.	Health centres, often in collaboration, provide out-of-hours services. In some areas, primary care walk-in services are provided at hospital premises in late evening and the early hours of the morning. Hospital emergency departments only accept urgent cases. General practitioners rarely undertake home visits, which are mainly provided by nurses.

	England[23,24]	Finland[25,26]
Complementary and alternative medicine (CAM)	There is no official list of CAM services covered by the NHS, and there is no legal requirement for the NHS to fund such services, although many PCTs purchase some CAM services. CAM treatments are often offered within the primary care team in general practices – most commonly homeopathy and acupuncture, followed by osteopathy, aromatherapy and chiropractic services;[33] patients may or may not be charged for these services.	Acupuncture and other alternative therapies are reimbursed by the National Health Insurance if they are provided by a doctor. Consultations with a registered chiropractor, osteopath and naprapath (a type of manual therapist) are covered if the patient has been referred by a doctor.[34]
Prevention and adult screening	Population-based screening programmes are in place for women aged 50 and over for breast cancer and for women aged 25–64 for cervical cancer (3–5 year intervals). Opportunistic screening for *Chlamydia* is offered to those under 24. A bowel cancer screening programme was scheduled to begin in April 2006 for people aged 60–69 (biyearly).[35] A Vascular Disease Risk Factor Assessment and Management programme was proposed in 2005 targeting diabetes and coronary artery disease[36] but has not yet been implemented.	Municipalities are obliged to offer screening programmes for breast cancer (for ages 50–59) and cervical cancer (ages 30–60). Other screening programmes are not uniformly undertaken at the national level. Many municipalities offer additional programmes (e.g. various fetal screening schemes and colon cancer screening). Some municipalities also offer breast cancer screening to wider age groups. The Ministry of Social Affairs and Health established a screening working group in 2004, aimed at establishing uniform practices and standards.

	England[23,24]	Finland[25,26]
Contraception and sexual and reproductive health (SRH)	Many providers within the NHS offer sexual health services, including general practitioners, family planning clinics and genito-urinary clinics targeting young people (often offering walk-in options). Quality and availability of sexual health services varies.[37] Emergency contraception is available from licensed pharmacies.	Sexual health services are mainly provided through health centres (MCH units, family planning services, school health services). University students have access to the Finnish Student Health Service, a foundation financed by the Social Insurance, students and student unions, university cities and the national government.
Medical records (e.g. patient smart card, national databases)	Currently, medical records are held by the general practice where the patient is registered, and by hospitals. A centralized electronic database is currently being introduced; this nationally procured database aims to improve the information flow between different health care providers. If successful, it will allow patients easier access to their own medical records. However, implementation difficulties have been reported.[38]	At present, local and regional providers are in charge of keeping patient records to be replaced by a new national electronic system in 2007. The nature of the new system is not yet clear, but it will probably be based on a regional information system subject to national standards and protocols, allowing data to be transferred across regions. The need for a standardized system emerged because of the level of decentralization. A national database to serve as a long-term archive is being planned.
Consumer/ patient satisfaction	Patient satisfaction with the NHS has been reported to be generally high, although concerns about waiting times, choice and responsiveness have been expressed. Patients' experience in the NHS seems	In a 2002 *Eurobarometer* survey, satisfaction with the Finnish health care system ranked first in Europe.[40] There is, however, public concern about access to primary health care in some urban areas,

	England[23,24]	Finland[25,26]
Consumer/ patient satisfaction (continued)	to be improving, particularly in areas where concerted efforts on improvement have been made (e.g. in cancer care, coronary heart disease and waiting times).[39]	as well as about waiting lists for surgery. The high proportion of out-of-pocket payments is probably seen as most problematic in relation to pharmaceuticals and in dental care. Choice within the public system is limited, but does not appear to cause concern among the general public.
Recent reforms/ developments/ plans	• Following a White Paper in January 2006 a series of measures are under way to shift care from hospitals into the community, especially with regard to early diagnosis and the management of chronic care.[41] • Recent policies also seek to strengthen the role of general practice in purchasing ("practice based commissioning"), to shift resources towards prevention and to expand the role of the private/ independent sector.[41] • Since 2004, a new system of activity-based payment in the hospital sector ("payment by results") has been introduced. • Regulation of complementary and alternative health professions was revised in 2005.	• Proposed legislation aiming at improving financial sustainability foresees separating NHI into two funds: (1) sickness insurance to cover health care expenses, and (2) income insurance to cover sick pay, maternity allowance, etc. as a means to improve financial sustainability. • 2004 legislation introduced a voucher system for health and social care, mainly targeting the elderly population and with the aim to encourage small firms to enter the home care market.[42] • There was a gradual reform of dental care during 2001–2004. Differences in cost-sharing between private and public provision have been markedly reduced. • Strengthening supervision of professionals and

	England[23,24]	Finland[25,26]
Recent reforms/ developments/ plans (continued)	• A new payment system was introduced for dentistry in April 2006.[42] • From spring 2006, qualified Extended Formulary Nurse Prescribers are permitted to prescribe any licensed medicine for any medical condition, with the exception of controlled drugs.[43]	health care providers through the Agency for Medico-Legal Affairs (2005–2007). • Piloting of new forms of service provision and of variations of purchasing models with some municipalities purchasing some (or all primary) health care services from the private sector (including non-profit foundations or for-profit providers). • A major process of reviewing the structure of local governments has begun with potentially fundamental implications for health care. Major changes are not expected before the next general elections in spring 2007.

	France[44,45]	Netherlands*[46,47]
Coverage and payment mechanism	The health care system is based, mainly, on social health insurance (SHI). Since 2000, SHI has been compulsory for all residents. 91% have additional complementary voluntary health insurance (VHI) (to offset co-payments); statutory co-payments are common for goods and services. Usually patients pay upfront and claim reimbursement from their insurance fund. Co-payments can be a proportion (i.e. co-insurance) or a lump sum, and vary according to the type of service, type of provider, age and family status of the insured person but not income. Exemptions from co-payments apply to persons with certain chronic diseases and disabilities, etc. (although not on the basis of income). In 2003, direct out-of-pocket payments accounted for 10.9% of the total health care expenditure.	As of 2006 all residents have to take out health insurance, replacing the old system where only those below a certain wage threshold had compulsory insurance. Under the new system the insured pay a nominal premium which may differ according to the health plan; however, those with the same plan will pay the same premium. Insurance companies have to accept every resident in their area of activity. A 'risk equalization' scheme to compensate for unequally distributed insurance risks is funded by additional income-related contributions by the insured and supplemented by a compulsory employers' payment administered by the new Health Insurance Fund. The new system covers a statutory package of essential curative health services. The insured may choose to upgrade their insurance plan to cover additional services not included in the statutory benefit package.

** Since a new health insurance system was introduced in January 2006 some information may not yet be available.*

	France[44,45]	Netherlands[46,47]
Provision of primary/ generalist and specialist care	Most general practitioners and specialists (except for those working in hospitals) practise privately in their offices outside hospitals.	General practitioners are mostly self-employed and work in group practices. Secondary care is mainly provided in hospitals in which specialists provide inpatient and outpatient care. About one-third of specialists have a salaried position (mainly in academic centres and specialized hospitals, e.g. cancer centres). The remaining two-thirds are self-employed and form "partnerships" that are contracted by the hospital.
Paying for general practitioner visit	Social insurance covers up to 70%; a statutory co-payment applies that may be reimbursable by VHI (if covered in the plan). Patients usually pay upfront and are reimbursed by their health insurance. Patients registered with a gatekeeping general practitioner do not have to pay upfront. In all cases, patients have to pay a symbolic fee of €1 per visit.	Services provided under the basic package do not require a co-payment. However, under the new insurance scheme patients may wish to choose a health plan offering a deductible based on their personal risk so that they eventually would be charged for a general practitioner consultation if the costs are within the limit of the deductible. Patients may also choose a "no claim" contract which offers them a refund if they do not utilize health services. However, as per state regulation, general practitioner consultations do not count as a "claim", and the patient thus qualifies for a refund despite consulting a general practitioner.

	France[44,45]	Netherlands[46,47]
Paying for visits to a specialist	Specialist consultations are covered by social health insurance plus co-payment and/or VHI. The co-payment is €1 + €8 for a specialist visit with referral and €1 + €17 for a specialist visit without referral (contractual fee). Some specialists may also charge beyond this level, and in this case only the contractual fee is reimbursed by SHI, whether or not a patient has a referral; some specialist consultations do not require a referral, e.g. gynaecologists for contraception, antenatal care, routine examinations, termination of pregnancy; ophthalmologist for prescription of glasses, screening and follow-up of glaucoma.	Services provided under the basic package do not require a co-payment. However, under the new insurance scheme patients may have to bear some of the costs for specialists if they choose a health plan offering a deductible or a "no claim" clause.
Access to/choice of provider	Until recently, patients could choose any registered provider outside hospital. 2005 saw the introduction of a form of gatekeeping practitioner ("médécin traitant"). Patients now have to choose a practitioner acting as gatekeeper; this can be any general practitioner or specialist (e.g. women can choose their gynaecologist to act as their gatekeeper). As of 2005 services are only fully reimbursed if the patient has obtained referral from his/her gatekeeping practitioner before consulting any other doctor, otherwise the patient has to bear half of the cost of the consultation. Consultations with ophthalmologists, psychiatrists, gynaecologists and paediatricians are excluded from gatekeeping, as is the treatment of urgent cases.	Patients may choose any registered provider, but have to register with a general practitioner (compulsory gatekeeping). Every general practitioner is member of a group of practitioners (so-called HAGROs). Frequently, these groups make arrangements with hospitals, and other providers to enhance coordination of care.

	France[44,45]	Netherlands[46,47]
Choice of general practitioner	Until recently, patients were able to consult any general practitioner. Patients who choose to participate in the recently introduced gatekeeping system register with a general practitioner. If patients choose to see a different GP, they will have to pay €1 + €8 (plus any additional fee the physician may charge beyond the contractual fee).	Patients have to be enrolled but may register with any general practitioner of their choice.
Choice of specialist care	Until recently, patients did not require a referral to consult a specialist outside hospital. Under the new gatekeeping system, patients require a referral to specialist treatment; however, they may choose to consult a specialist directly, which will then incur a higher co-payment.	Every insured person requires a referral to receive specialist treatment. Referrals specify the speciality but not the individual specialist. Except for emergency cases, patients are not permitted to directly consult an outpatient department or polyclinic of an acute hospital.
Gatekeeping	The gatekeeping system was introduced in 1998 on a voluntary basis. Physicians receive an enrolment fee (recently doubled to €46). By 2004, 1% of patients had registered with a "médécin traitant"; 10% of general practitioners participated. Gatekeeping became enforced in 2005[6] and by	A strict gatekeeping system is in place. Entitlement to medical, surgical and obstetric care is conditional upon referral from a general practitioner, another specialist to whom a general practitioner had referred the patient or, in case of obstetric care, a midwife.[46] Under the previous regulation, bypassing the system

	France[44,45]	Netherlands[46,47]
Gatekeeping (continued)	24 November 2005, 33.2 million people (out of a 60 million population) had affirmed their gatekeeper. 99.6% of gatekeepers are general practitioners. 99% of general practitioners have signed a gatekeeping contract.	of referrals was rare; it is too early to assess whether this will continue under the new system.
Waiting time/ lists	There are no reported general waiting lists, although individual doctors may have waiting lists. There is no official information available on waiting times; unofficial estimates range between 15 days and 2 months.	Waiting lists for hospital care have been recognized as a problem since the late 1990s. Entitlement to essential curative services is guaranteed by law; the public thus considers waiting lists as a violation of patients' rights since they impede on legally guaranteed access. In recent years waiting lists for hospitals decreased with 68% of patients on a list being treated within 4–5 weeks.[47]
Appointment with general practitioner	An appointment with a general practitioner is usually possible within a day. Urgent cases (one in four consultations) do not require an appointment.	An appointment with a general practitioner is usually possible within a day. Urgent cases often do not require an appointment. Appointment arrangements usually depend on the individual practice, as do call-in or walk-in opportunities.

	France[44,45]	Netherlands[46,47]
Appointment with specialist	Waiting times for an appointment with a specialist are highly variable (e.g. one week for an ENT specialist); waiting times for specialist consultations have been estimated to range between 1 week and 3 months. For ophthalmologists (considered to be particularly rare) waiting times of up to 12 months have been reported.	Waiting times from referral to diagnosis is on average 6 weeks (3 for surgery, 4 in internal medicine); an additional 11 weeks from diagnosis to treatment (2 in internal medicine and 9 for surgery). Under the new system, health insurance companies are allowed to directly contract with hospitals if they wish to offer their insurees faster access to services. Increasing differences in waiting times between health plans have become a matter of public debate.
Degree of integration of services	There is concern about the lack of coordination and continuity of care, and usually patients have to organize their journey through the health care system.[6] Provider networks were introduced in 1996 (pilot programmes at local and regional level, with the possibility to define patients' own financial rules). Since 2004, patients with certain serious illnesses have been exempt from user charges if they accept a protocol of care agreed upon by their usual doctor and their sickness fund. The patient has to show this protocol at all visits to a physician to qualify for full reimbursement. This policy is aimed at cost containment, deterring patients from	1994 saw the introduction of "transmural care" (care given "across the walls"), encompassing different forms of care to bridge the organizational and financial gap between primary care and specialized hospital care. Transmural care tends to focus on one or two crucial transition-steps between different types of health care providers;[48] while widely practised across the country, sustainable implementation faces continuing challenges due to the lack of adequate financing.

	France[44,45]	Netherlands[46,47]
Degree of integration of services (continued)	"shopping around", reducing wasteful duplication of services and improving integration and quality of care.[42]	
Services provided by others than general practitioners (e.g. nurses, pharmacists)	Utilization of nurses and other non-medical personnel is not promoted owing to the dominant role of the medical profession.	Nurses have become an important primary care provider since the 1970s, mainly as part of the municipal public health system, covering, among others, infectious diseases, sexual health,[49] health programmes for children and adolescents (e.g. childhood immunization), as well as some aspects of health promotion. Nurses work according to a protocol which enables them to perform physical and laboratory examinations, diagnosis and treatment, usually under the supervision of a physician.
Scope of entitlements for patients	Reimbursement of services is defined in an official list. All other goods and services are available, but depend on VHI coverage or out-of-pocket payments. In April 2005 there were six lists; medical procedures are listed in the *Classification commune des Actes Medicaux* (CCAM).	Under the new system, all insured persons are entitled to receive a basic package of essential curative care. The insuree may choose to receive services by contracted care providers, to be reimbursed for the costs incurred, or a mixture of both. Insurance companies only have to reimburse costs within "what is reasonable in the Dutch market of health care".[50]

	France[44,45]	Netherlands[46,47]
Scope of doctors' decision-making and practice	Traditionally, doctors have enjoyed considerable freedom of practice, although they have to adhere to practice guidelines (RMOs) and, until 1999, faced financial penalties when failing to do so (although the system was rarely used). A new contractual agreement between physicians' unions and the social health insurance (2005) defines, among others, prescription rules for common conditions such as hypercholesterolaemia and vascular disease (the "*Accord de bon usage de soins*" (AcBUS)). The AcBUS system does not involve any penalties; it was designed in response to the (relative) failure of the RMO and a means to persuade rather than coerce.	Decisions about the services offered to a patient have traditionally been left to the physician; however, practice guidelines have increasingly been introduced. Guidelines are based on available evidence and reflect a consensus of professional associations and national health authorities. Clinical guidelines for medical specialists have been introduced in 1987; a national programme for practice guidelines for general practitioners began in the early 1990s.
Diagnostic services	Most diagnostic services are provided by private laboratories or imaging facilities. The provision of diagnostic services to outpatients in a hospital is not encouraged. Diagnostic services are reimbursed if prescribed by a doctor and if they are included in a positive list.	Diagnostic services are provided partly by general practitioners and in hospitals. General practitioners often collaborate with independent laboratories, offering a range of laboratory services. Many laboratories are not-for-profit foundations set up by general practitioners or are linked with a local insurer; these laboratories are increasingly involved in the coordination of care.

	France[44,45]	Netherlands[46,47]
Out-of-hours services/online or hotline advice/home visits	Provision of out-of-hours services has remained controversial since the voluntary roster system was abolished in 2003 and a legal basis for doctors' after-hours duties was established. There are various options: (1) on-call houses (*maisons de garde*), usually consulting rooms in a local hospital staffed by a rotating team of local general practitioners; (2) individual physicians providing after-hours services for higher remuneration; and (3) call centres staffed by general practitioners who contact the physician on call, if necessary. Doctors may charge higher fees for this service (a €30 basic fee, an additional €10 on Sundays and an additional €20 at night). If the visit is not medically justified, the patient is only reimbursed €20. Patients increasingly turn to hospital emergency departments, particularly during the holiday season. Home visits of general practitioners have become increasingly infrequent.	Out-of-hours services are increasingly offered by large general practitioner out-of-hours centres comprising 45–120 practitioners. These cooperatives have largely replaced traditional locum arrangements.[51] Out-of-hours centres are often organized by a group of general practitioners and linked to an insurer. Other centres are located within a hospital. Access to out-of-hours general care often involves a nurse-led triage system.
Complementary and alternative medicine (CAM)	Acupuncture and homeopathy are reimbursed under SHI if provided by a physician (osteopathy and chiropractic treatment are not included but can be assimilated to other procedures included in the list).	The basic health care package does not include complementary or alternative treatments. Under the new health insurance system coverage will depend on the individual contract.

	France[44,45]	Netherlands[46,47]
Prevention and adult screening	An opportunistic national programme offers mammography screening for women aged 50–74 for breast cancer (biyearly). Some regions offer colon cancer screening (age 50 and over). Prevention is organized at the regional/departmental level, and the degree of activity varies considerably. Routine medical check-ups are covered by SHI.	There are national screening programmes for breast cancer (ages 50–70), cervical cancer, congenital metabolic defects and, more recently, genetic hypercholesterolaemia. Most screening programmes are organized by municipal public health services.[52] Screening for colon cancer is under consideration.
Contraception and sexual and reproductive health (SRH)	Prevention and diagnosis of sexually transmitted infections (STIs) are the responsibility of the general councils (at department level), who have to offer free anonymous testing for certain diseases. HIV/AIDS tests are co-financed by SHI. SRH can be obtained from private physicians or family planning clinics; most clinics provide STI testing and treatment as well as contraceptive care. There are also 'anonymous free HIV information and screening centres'.[53] Services for adolescents are provided by the school nurse. The French Planned Parenthood affiliate offers adolescent-friendly walk-in services on a weekly basis.[54]	Contraception and sexual services are provided by general practitioners and, mainly in larger cities, by sexual health clinics run by nurses.

	France[44,45]	Netherlands[46,47]
Medical records (e.g. patient smart cards, national databases)	Currently, there is no single medical record. Doctors maintain their own information system. A national electronic medical patient record system is planned to be introduced by 2007, comprising all consultations, procedures, medical and surgical treatments, drugs and medical devices prescribed. All doctors will be able to access the data. Patients who do not want an electronic record will have to pay higher user charges. Costs are estimated at between €0.65 billion and €1.2 billion per year for the first 3 years.[42] Patient smart cards contain only administrative information. There are plans to introduce smart card medical records for emergency care; there are, however, concerns about privacy and confidentiality.	Currently, medical records are kept only by doctors and other individual providers. There has been extensive discussion about introducing an electronic medical record system; however, presently only a few smaller networks exist.[55]
Consumer/ patient satisfaction	There is generally high satisfaction with general practitioners. Patients appeared to be satisfied with the proximity of general practitioners, although in a recent survey 36% of residents in rural areas said that more specialists should be available.[44]	A 2002 survey found 78% of Dutch patients to be satisfied with making an appointment (compared with 62% in the UK and 94% in Germany). 61% were positive about the waiting time in the waiting room (UK: 50%: Germany: 70%) and 85% were satisfied with access to services for urgent health care needs (UK: 71%; Germany: 95%).[56]

	France[44,45]	Netherlands[46,47]
Recent reforms/ developments/ plans	• Several consecutive SHI reforms: expansion of SHI to cover all residents in 2000; gradual rise in importance of taxation for health care financing; new agreement between sickness funds and physicians (AcBUS) (2005). • Expansion of gatekeeping in 2004, further enforcement planned for 2006. • Hospital payment reform (2005). • Enforcement of evaluation of all (office-based, salaried and hospital-based) physicians (mandatory at national level since 2004); failure to adhere may lead to withdrawal of a doctor's licence. • Reorganization of after-hours ambulatory care (2004).[57]	• The Health Insurance Act 2006 fundamentally changed the SHI system by reducing government control (pro-market approach) and creating incentives to increase cost-awareness among patients and insurers. Health care should no longer be supply-regulated but should follow consumer preferences. The 2006 Act introduced: (1) compulsory basic insurance; (2) income-related premiums; (3) a comprehensive uniform benefits package described in functional terms; (4) open enrolment; and (5) limited provider plans. • The possibility of excluding and limiting certain services (e.g. physiotherapy, psychotherapy) is being discussed at present.

	New Zealand[58]	Sweden[59]
Coverage and payment mechanism	New Zealand's health system is mainly financed through general taxation and private payments. There is also compulsory social insurance for injuries and accidents (ACC). Hospital inpatient and outpatient treatment and public health services are provided free of charge to all residents, but there are charges for general practitioner and related services. Approximately one-third of the population has complementary or supplementary voluntary health insurance. Out-of-pocket payments account for 16% of total health expenditure (2002/2003). In recent years, public funding has been expanded to reduce the impact of co-payments.	Sweden's health care system is mainly funded by regional and local taxation, occasionally supplemented by earmarked grants from the national government. All residents are covered, and there is no substitutive private coverage available. An estimated 5–10% of citizens have supplementary voluntary health insurance (usually paid by the employer, mainly covering elective surgery). User charges are low, representing 2.8% of total public expenditure for health (2003). There are direct patient fees for most medical services in the form of a flat-rate payment ("unit price"). User charges are determined by the county councils.
Provision of primary/ generalist and specialist care	Most general practitioners work in private practice, with two-thirds in private group practices. Specialist care is provided in private and public clinics or private/public hospitals. Most specialists are employed by the public sector, although many maintain a private practice on a part-time basis. Private clinics mainly specialize in elective surgery or long-term care. With the new Primary Health Care Strategy (2001), the Government encourages the	General practitioners work in public primary care centres (staffed by general practitioners, nurses, midwives and physiotherapists), in company health centres contracted by the county ("independent"), as private providers contracted by the state-financed insurance system or without any such contract. Most private providers are contracted by the public sector. The private sector is very small, comprising less than 5% of general practitioners and is concentrated in

	New Zealand[58]	Sweden[59]
Provision of primary/ generalist and specialist care (continued)	development of "primary health organizations" (PHOs) as local non-governmental bodies which serve the needs of the people registered with them.[60] Also, funding for primary care has been significantly increased and is largely channelled through PHOs, gradually transforming payment from fee-for-service at the practice level to capitation at PHO level; the PHO, in turn, contracts with individual practitioners. In July 2005, there were 79 PHOs covering 93% of a 4 million population.[61]	Stockholm, Gothenburg and Malmö. The proportion of general practitioners working in each setting varies across counties; specialists work in hospitals, polyclinics, specialist centres outside hospitals or in affiliation with a primary care centre; physicians are required to choose whether they wish to work in the private or public sector full time (although there are exemptions).
Paying for general practitioner visits	Primary care has traditionally been provided on a fee-for-service basis, with public subsidies for those on low incomes, children under 6 and high users, comprising about 40% of the population. Additional public funding introduced with the Primary Health Care Strategy is aimed at reducing user charges and widening the population eligible for subsidies to include those aged 6–18 years in 2003 and the over-65s from 2000.[60] Presently, average general practitioner consultation fees for those in the upper income brackets who receive little or no subsidy are NZ$40–50 (€20–26).	Patients aged over 20 pay €11–15 (2000) for a visit to a general practitioner in a primary care centre (public or contracted). Consultations with private practitioners in ambulatory care (general practitioner or specialist) incur higher co-payments as patients can only partly reclaim their expenses. Direct payment of private practitioners in primary care is relatively rare. Many patients turn to hospital emergency departments for first contact care, and as a consequence strong financial disincentives have been introduced: patients are now required to pay a fee which is three times as high as a general

	New Zealand[58]	Sweden[59]
Paying for general practitioner visits (continued)	General practitioners may still define consultation fees but have to negotiate so-called reasonable user charges with their PHO in return for PHO funding. There is no general regulation of fees despite the increase in public funding.	practitioner consultation; however, the scheme's effectiveness is undermined by an annual €100 ceiling for all out-of-pocket payments.[62]
Paying for visits to a specialist	Specialist care provided in public hospital outpatient departments is free of charge. Services provided by specialists in private practice are paid for by patients either out-of-pocket or through VHI.	Patients pay €16–27 for a consultation with a specialist based in a hospital polyclinic without a referral. Specialist services are free of charge for patients with referral.
Access to/ choice of provider	Patients may still choose to use any general practitioner despite the establishment of PHOs with patient registration, but they require a referral to access secondary care. Under the ACC choice may be restricted, as the ACC runs a preferred provider scheme. Patients also usually require a referral to access private secondary care.	Since 2003, patients may choose any provider and may seek outpatient care anywhere in the country on the same terms as in their county of residence.[63]

	New Zealand[58]	Sweden[59]
Choice of general practitioner	Patients can choose and may consult more than one general practitioner. Under the new PHO system, patients are registered with a specific PHO via their 'usual' general practitioner, but may still use any general practitioner. Patients choosing a general practitioner not affiliated to their PHO will require their PHO to be invoiced for the public share of the treatment cost.	Patients may choose any first contact care provider either in primary care centres or hospital outpatient departments (where almost half of first contacts take place).[64] However, patients may choose to be registered with a primary care centre providing enhanced access; counties try to encourage people to consult primary care centres first by imposing higher charges on hospital emergency services.
Choice of specialist care	Patients require a referral to access secondary care in both the private and public sector (except for accident and emergency care). In theory, private patients can bypass the general practitioner, but self-referral to specialists remains relatively rare. Public hospitals are not permitted to treat private patients.	In the public sector, patients can access specialist care only through a hospital outpatient department. County councils decide on the rules of referral to specialists. In many counties patients can select the hospital, but usually the general practitioner makes an appointment with a specialist, a diagnostic centre, a laboratory or a hospital on behalf of the patient. In most counties, patients require a referral for a specialist appointment. Patients may also turn to a private provider for a specialist consultation.

	New Zealand[58]	Sweden[59]
Gatekeeping	Patients do not have to register with a general practitioner, but general practitioners serve as gatekeepers to specialist care and most patients have a regular general practitioner. New models of care are being developed under the Primary Health Care Strategy requiring patients to register with a "provider of first-contact care" (normally their 'usual' GP) in order to access the new public funding. The scheme is voluntary for both practices and patients, but higher subsidies are available only through PHOs and to their enrollees and practitioners.	The gatekeeping role of general practitioners varies across counties. In the public sector patients require a referral to consult a specialist; however, patients may choose to access secondary care directly through a hospital polyclinic if they are prepared to pay a fee.
Waiting time/ lists	Waiting lists are managed in the public sector by using "clinical priority assessment criteria" (CPAC) based on a point system for urgency and type of condition. A booking system for elective surgery reflects the intention of the Government to move away from implicit rationing to a system of explicit rationing in which patients are only listed for surgery if they can be offered a booked appointment within six months.[65]	Waiting times in Sweden have been an issue of concern. New commitments to reduce waiting times with a guarantee based on a "0-7-90-90" rule came into effect in November 2005: immediate contact for urgent cases; 7 days' maximum wait for a general practitioner consultation; 90 days' maximum wait for diagnosis by a specialist; and 90 days' maximum wait for specialist treatment. In some counties, patients who wait more than 30 minutes (or 45 minutes) in a waiting room for an appointment will have their user charge returned.[62] At least 80% of general practitioner consultations are within the guarantee

	New Zealand[58]	Sweden[59]
Waiting time/ lists (continued)		limits. Some counties face difficulties meeting the target for psychiatric services and hip and knee surgery. There is concern that while long waits may have been reduced, short waits have increased.[62]
Appointment with general practitioner	Most patients make an appointment but waiting times are not considered problematic. A 2004 survey found that 60% of respondents saw a general practitioner the same day and 24% the following day, while 11% were waiting 2–5 days and 2% waited six days or more.[17]	Following the 2003 regulations, an appointment with a general practitioner must be offered within seven days. Patients should be able to see a nurse practitioner within a day. A 2004 survey found half of the respondents reported difficulties in getting an appointment by telephone in a health centre. However, 50% saw a doctor within a day and 80% within a week.[62] The management of telephone calls to primary care centres has recently been strengthened through technical improvements; most primary care centres provide walk-in opportunities.
Degree of integration of services	PHOs are expected to improve the integration of care by encouraging practitioners to cooperate across professional boundaries.[60] Several models of integrated care have been tested, such as the integration of primary and secondary care for the elderly in Canterbury.	Following the ADEL-reform in 1992 cooperation between health care and social care providers has increased; however, integration of care is still seen as having potential for improvement.[66]

	New Zealand[58]	Sweden[59]
Services provided by others than general practitioners (e.g. nurses, pharmacists)	Nurses can qualify as nurse practitioners who are allowed to prescribe within certain limits and within the context of a primary health care team. The scope of practice of a nurse practitioner is defined under the Health Practitioner Competence Act 2003, which came into effect in September 2004. Nurse practitioners work within a nursing framework, they lead community clinics and offer independent primary health care.[60] They are also involved in providing specialized care for young people, mobile care and care for people in remote areas, as well as mental health services.[67]	District nurses play a crucial role in the Swedish health care system, as they often assess patients before referring them to a general practitioner or a hospital. District nurses are also involved in the care of the elderly and make regular home visits. District nurses have limited prescription rights (as have midwives who prescribe contraceptives); nurses give advice and treatment usually under the supervision of a physician and are increasingly involved in models of managed care for patients with chronic and complex conditions. Nurse-led clinics provide care for patients with long-term conditions such as diabetes, chronic obstructive pulmonary disease and neurological conditions.
Scope of entitlements for patients	In the publicly funded health care sector, there is no legal definition of entitlements, although subsidies are defined and a "service coverage" document defines what people can generally expect from the public system. Under ACC, entitlements comprise both in-kind and employment compensation. As the public share of general medical services expenditure has risen under the Primary Health Care Strategy,	Entitlements are not explicitly defined but based on three principles: human rights, need or solidarity, and cost-effectiveness. Some treatments are explicitly excluded from public funding such as cosmetic plastic surgery.

	New Zealand[58]	Sweden[59]
Scope of entitlements for patients (continued)	PHOs are increasingly required to secure for their enrollees access to a defined range of primary health care services.	
Scope of doctors' decision-making and practice	National guidelines are in place but enforcement is weak. Under ACC, doctors' scope for decision-making may be more restricted because of its preferred provider scheme.	Guidelines are in place for many treatments, although adherence is not enforced. In cases of malpractice non-adherence to guidelines may potentially be penalized.
Diagnostic services	Diagnostic services are free, including those ordered by general practitioners, and are mainly provided in the private sector or in hospitals for inpatients; a referral is generally required.	Basic diagnostic services are available in primary care centres (such as most routine laboratory tests), specialised diagnostic services are provided in public hospitals; waiting times for some diagnostic services may be substantial in some counties.
Out-of-hours services/online or hotline advice/home visits	General practitioners are required to offer out-of-hours services and do so mainly through cooperatives. Commercial walk-in centres are common in urban areas. A telephone hotline offers professional health care advice 24 hours a day.[68] A 2004 survey found	87% of general practitioners provide out-of-hours services organized in a rota system (mid-1990s). General practitioners rarely provide home visits. Opening hours of primary care centres have been reported to be inconvenient for many.[62] Some

	New Zealand[58]	Sweden[59]
Out-of-hours services/online or hotline advice/home visits (continued)	33% of respondents describing it as "very or somewhat difficult" to receive care at weekends, holidays or at night outside hospital emergency departments.[17]	centres provide joint walk-in opportunities in the evenings. Marginal costs of these services have been questioned.
Complementary and alternative medicine (CAM)	Osteopathy, acupuncture and chiropractic services are covered by ACC only; a co-payment is usually required.[60]	Acupuncture is partly reimbursed if it is provided by a doctor.[34] Licensed chiropractors can be contracted by the county or be employed by a primary care centre; beyond that, CAM therapies are excluded from public provision.
Prevention and adult screening	New Zealand runs national population-based screening programmes for breast and cervical cancer (BreastScreen Aotearoa established in 1998, offering free mammogram screening to women aged 45–69; and free 3-yearly cervical cancer screening for women aged 20–69). Opportunistic screening is available for prostate cancer; there are currently no plans for a national screening programme.[69] A national colorectal screening programme has been decided against (1998) because of lack of evidence of its effectiveness. This decision is periodically reviewed.	Sweden does not run screening programmes for adults at a national level; however, the National Board of Health and Welfare releases guidelines for screening, which are implemented by the counties. Counties run population-based screening programmes for breast and cervical cancer and may apply different age ranges for programmes. Colorectal cancer screening is currently being discussed.

	New Zealand[58]	Sweden[59]
Contraception and sexual and reproductive health (SRH)	A variety of providers offer advice on family planning, namely general practitioners, private specialists, clinics run by the national Family Planning Association, student health clinics, sexual health clinics and Maori community centres. Services are usually free for adolescents.	Family planning services are mainly provided by general practitioners, district nurses and midwives. General practitioners may provide preventive services to women (e.g. cervical smears and breast examinations). Maternal health centres provide antenatal care, contraceptive services, as well as testing, prevention and treatment of STIs. Increasingly, youth centres offer services for adolescents located in the community, staffed by doctors and midwives. Contraceptive services are free of charge.[70]
Medical records (e.g. patient smart card, national databases)	There is no single patient record; providers keep the information on their patients; however, linking information on patients is considered a long-term goal. As a first step towards a single integrated electronic patient record, patient identification numbers have been introduced.	Computerized medical records are held in primary care centres, and technical solutions to link these with other providers are currently being developed. However, there are legal barriers to link information between centres, hospitals and communities automatically. There is discussion about introducing electronic records or smart cards; however, this has not been implemented at a national level yet.

	New Zealand[58]	Sweden[59]
Consumer/ patient satisfaction	Patient satisfaction with general practitioner services seems to be high; in 2004, 74% of respondents rated the care received from their usual general practitioner as "excellent or very good" and 15 % as "good" although 34 % reported access to care to be problematic because of the costs involved.[17]	Patients are generally satisfied with the choice offered by the system. A minority of those on very low income face financial barriers to access because of co-payments. Access to psychiatric care may be difficult.
Recent reforms/ developments/ plans	• The biggest reform effort is the recent re-organization of providers into PHOs and the increase in public funding of primary care, especially general practitioner services. This reform has major implications for the whole sector of primary care provision. Its prime objectives are to improve equity of access to care, to enhance its responsiveness to the needs of the community and to improve integration of care.	• There is ongoing discussion about the public-private mix of services (e.g. with regard to private providers running public hospitals as introduced by recent legislation, although with certain restrictions). • Since the early 1990s, the health care system has clearly moved towards increasing patient choice of provider, including doctor, primary care centre and hospitals within the public system. • The growing market for company-financed (private) insurance has diversified access to specialist care (i.e. the privately insured increasingly enjoy faster access) and caused a rise in the number of independent clinics and hospitals; however, equity and safety in the primary care system seems to have been well preserved.[71]

References

1. Macinko J, Starfield B, Shi L (2003). The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. *Health Services Research* 38: 831–865.

2. Bundesministerium für Gesundheit (2006). *Regionale Hausarztmodelle in Deutschland*. (http://www.diegesundheitsreform.de/zukunft_entwickeln/hausarztmodell/beispiele/pdf/uebersicht_hausarztmodelle_deutschland.pdf, accessed15 February 2006).

3. Riesberg A (2004). Choice in the German health care system. *Euro Observer* 6(4): 6–9.

4. Bech M (2004). Choice in the Danish health care system. *Euro Observer* 6(4): 5–6.

5. Thomson S, Dixon A (2004). Choices in health care: the European experience. *Euro Observer* 6(4): 1–4.

6. Saltman RB, Rico A, Boerma WGW (2006). *Primary care in the driver's seat? Organizational reform in European primary care.* Maidenhead: Open University Press.

7. Riesberg A, Busse R (2004). *Health care systems in transition: Germany*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

8. Holland WW, Stewart S (2005). *Screening in disease prevention. What works?* Oxford: Nuffield Trust and European Observatory for Health Systems and Policies.

9. McKee M, Delnoij DMJ, Brand H (2004). Prevention and public health in social health insurance systems. In: Saltman RB, Busse R, Figueras J (eds). *Social health insurance systems in western Europe*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies: 267–280.

10. Busse R, Nolte E (2004). New citizens: East Germans in a united Germany. In: Healy J, McKee M (eds). *Healthcare: responding to*

diversity. Oxford: Oxford University Press: 127–144.

11. Blumenbach-Ostermann K (2004). *Konkurrenz oder Chance für Vertragsärzte.* Deutsches Ärzteblatt online. 20 December 2004: 1–8.

12. Hilless M, Healy J (2001). *Health care systems in transition: Australia.* Copenhagen: The European Observatory on Care Health Systems.

13. Healy J, Sharman E, Lokuge B (forthcoming). *Health care systems in transition: Australia.* Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

14. Bilde L, et al. (2005). *The health benefit basket in Denmark.* Dublin: European Health Management Association. (http://www.ehma.org/_fileupload/File/Projects/Benefit_Report_Denmark.pdf, accessed 5 July 2006).

15. Vallgarda S, Krasnik A, Vrangbaek K (2001). *Health care systems in transition: Denmark.* Copenhagen: The European Observatory on Health Care Systems.

16. Australian Institute of Health and Welfare (2005). *Australian hospital statistics 2003–04.* Canberra: AIHW. (http://www.aihw. gov.au/publications/index.cfm/title/10130, accessed 5 July 2006).

17. Schoen C, et al. (2004). Primary care and health system performance: adults' experiences in five countries. *Health Affairs – Web Exclusive* 28 October 2004. (http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.487v1.pdf, accessed 1 November 2005).

18. Jensen MSA, et al. (2005). Electrocardiogram interpretation in general practice. *Family Practice* 22(1): 109–113.

19. Australian Institute of Health and Welfare (2004). *Australia's Health 2004. The ninth biennial health report of the Australian Institute of Health and Welfare.* Canberra: AIHW. (http://www.aihw.gov. au/publications/aus/ah04/ah04-050222.pdf, accessed 5 July 2006).

20. Olsen AH, et al. (2005). Breast cancer mortality in Copenhagen after introduction of mammography screening: cohort study. *BMJ* 330: 220–224.

21. Micheli A, et al. (2003). European health systems and cancer care. *Annals of Oncology* 14(Supplement 5): 41–60.

22. Department of Health and Ageing (2005). *General practice in Australia 2004–5*. Canberra: Commonwealth of Australia. (http://www.aihw.gov.au/publications/index.cfm/title/10189, accessed 5 July 2006).

23. European Observatory on Health Systems and Policies (forthcoming). *Health systems in transition: England*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

24. Dixon A, Robinson R (2002). The United Kingdom. In: Dixon A, Mossialos E (eds). *Health care systems in eight countries: trends and challenges. Commissioned by the Health Trends Review, HM Treasury*. Copenhagen: The European Observatory of Health Care Systems: 103–113.

25. Jaervelin J (2002). *Health care systems in transition: Finland*. Copenhagen: The European Observatory on Health Care Systems.

26. Organisation for Economic Co-operation and Development (OECD) (2005). *OECD Reviews of Health Systems: Finland*. Paris: OECD.

27. Harrison A, Appleby J (2005). *The war in waiting for hospital treatment*. London: King's Fund.

28. Department of Health (2000). *The NHS Plan: A plan for investment. A plan for reform. Presented to Parliament by the Secretary of State for Health*. London: The Stationery Office.

29. Healthcare Commission (2005). *Survey of patients 2005. Primary care trust*. London: Healthcare Commission.

30. Department of Health (2006). *NHS waiting will be history, says Patricia Hewitt*. Press release 3 February. (http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4127912&chk=H4YDu7, accessed 6 February 2006).

31. Department of Health (2003). *Delivering investment in general practice: implementing the new GMS contract*. London: Department of Health.

32. Chapman JL, et al. (2004). Systematic review of recent innovations in

service provision to improve access to primary care. *British Journal of General Practice* 54: 374–381.

33. Dixon A, et al. (2003). *Complementary and alternative medicine in the UK and Germany: Research and evidence on supply and demand.* London: Anglo-German Foundation for the Study of Industrial Society.

34. WHO (2001). *Legal status of traditional medicine and complementary/alternative medicine: A worldwide review*. Geneva: World Health Organization.

35. Atkin WS (2006). Impending or pending? The national bowel cancer screening programme. *BMJ* 332: 742.

36. National Health Service NHS National Electronic Library for Health. (http://rms.nelh.nhs.uk/screening/, accessed 6 February 2006).

37. Department of Health (2001). *Better prevention, better services, better sexual health. The national strategy for sexual health and HIV.* London: Department of Health.

38. Hendy J, et al. (2005). Challenges to implementing the national programme for information technology (NPfIT): A qualitative study. *BMJ* 331: 331–336.

39. Coulter A (2005). *Opinion and experience: Do they concur?* Oxford: Picker Institute Europe.

40. Ministry of Health (2003). *Guidelines for capital investment.* Wellington: Ministry of Health. (http://www.moh.govt.nz/moh.nsf/49b6bf07a4b7346dcc256fb300005a51/e3c114507edccd8bcc256dda00132da2/$FILE/GlinesCapitalInvestment.pdf, accessed 5 July 2006).

41. Department of Health (2006). *Our health, our care, our say: a new direction for community services.* London: The Stationery Office.

42. International Network for Health Policy. *Reform Health Policy Monitor*. Gütersloh: Bertelsmann Foundation. (http://www.healthpolicymonitor.org/index.jsp, accessed 26 October 2005).

43. Department of Health (2006). *Independent nurse prescribing*. (http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAnd

Industry/Prescriptions/NonmedicalPrescribing/NursePrescribing/fs/en, accessed 27 February 2006).

44. Sandier S, Paris V, Polton D (2004). *Health care systems in transition: France*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

45. Bellanger M, Cherilova V, Paris V (2005). *Health Basket Project: France*. Dublin: European Health Management Association. (http://www.ehma.org/_fileupload/File/Projects/Benefit_Report_France.pdf, accessed 5 July 2006).

46. Stolk EA, Rutten FFH (2005). *The health basket in the Netherlands. A contribution to Work Package II of the EU funded research project "Health BASKET": Description of benefits, entitlements, actors and decision making processes in the Dutch health care sector.* Dublin: European Health Management Association. (http://www.ehma.org/_fileupload/File/Projects/Benefit_Report_Netherlands.pdf, accessed 5 July 2006).

47. den Exter A, et al. (2004). *Health care systems in transition: The Netherlands*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

48. Vondeling H (2004). Economic evaluation of integrated care: an introduction. *International Journal of Integrated Care* (4): 1–12.

49. Miles K, et al. (2003). Nurse-led sexual health care: international perspectives. *International Journal of STD & AIDS* (14): 243–247.

50. Ministry of Health Welfare and Sport (2004). *The new health insurance system in brief*. The Hague: Ministry of Health Welfare and Sport.

51. van Uden CJT, et al. (2005). Patient satisfaction with out-of-hours primary care in the Netherlands. *BMC Health Services Research 5*(6).

52. Glenngard AH, Hjalte F, Svensson M (2005). *Health care systems in transition: Sweden*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

53. Darroch JE, et al. (2001). *Teenager sexual and reproductive behaviour in developed countries. Can more progress be made?* New York and Washington: Alan Guttmacher Institute.

54. Bajos N, Durand S (2001). *Teenage sexual and reproductive health: Country report for France*. New York and Washington: Alan Guttmacher Institute.

55. Nik Brown N, et al. (2001). *Annexes to the final report of the Formakin Project.* Part 7. (http://www.york.ac.uk/org/satsu/ OnLinePapers/ formakinannex2.pdf#search='electronic%20patient%20record%20 netherlands, accessed 5 July 2006).

56. Wensing M, et al. (2002). Patient satisfaction with availability of general practice: an international comparison. *International Journal for Quality in Health Care* 14(2): 111–118.

57. Couffinhal A, Lucas V (2004). *Reorganization of after hours ambulatory care.* (http://www.healthpolicymonitor.org/en/Policy_ Survey/Search_ for_Policy_Reforms/Survey_Details/Reorganization_of_after_hours_ ambulatory_care.html?issue=0&content_id=251&whichSearch= searchHomepage&search.x=72&single_country:184=184&language= en&search.y=9, accessed 6 April 2006).

58. French S, Old A, Healy J (2001). *Health care systems in transition: New Zealand.* Copenhagen: The European Observatory on Health Care Systems.

59. Hjortsberg C, Ghatnekar O (2001). *Health care systems in transition: Sweden*. Copenhagen: The European Observatory on Health Care Systems.

60. Cumming J, et al. (2005). *Evaluation of the implementation and intermediate outcomes of the primary health care strategy.* Victoria: University of Wellington, Health Services Research Centre.

61. McAvoy B, Coster G (2005). General practice and the New Zealand health reforms – lessons for Australia? *Australia and New Zealand Health Policy* 2 (26). (http://www.anzhealthpolicy.com/content/2/1/26, accessed 5 July 2006).

62. Siciliani L, Hurst J (2004). *Explaining waiting-time variations for elective surgery across OECD countries*. Paris: OECD.

63. Ministry of Health and Social Affairs (2005). *Health and medical care in Sweden* (Factsheet). Stockholm: Ministry of Health and Social Affairs.

64. Leon S, Rico A (2002). Sweden. In: Dixon A, Mossialos E (eds). *Health care systems in eight countries: trends and challenges. Commissioned by the Health Trend Review, HM Treasury.* Copenhagen: European Observatory on Health Care Systems: 91–102.

65. Dew K, et al. (2005). Explicit rationing of elective services: implementing the New Zealand reforms. *Health Policy* 74: 1–12.

66. Andersson G, Karlberg I (2000). Integrated care for the elderly. The background and effects of the reform of Swedish care for the elderly. *International Journal for Integrated Care* 1. (http://www.ijic.org/, accessed 5 July 2006).

67. Ministry of Health (2005). *Evolving models of primary health care nursing practice*. Wellington: Ministry of Health.

68. Ministry of Health (2005). *Towards accessible, effective and resilient after hours primary health care services. Report of the After Hours Primary Health Care Working Party.* Wellington: Ministry of Health.

69. Minister of Health (2003). *The New Zealand Cancer Control Strategy*. (http://www.moh.govt.nz/moh.nsf/0/3D7504AD140C7EF0CC256D88000E5A16/, accessed 5 July 2006).

70. Danielsson M, Rogala C, and Sundstroem K (2001). *Teenager sexual and reproductive behaviour in developed countries: Country report for Sweden.* New York and Washington: Alan Guttmacher Institute.

71. Saltman RB, Bergman S-E (2005). Renovating the commons: Swedish health care reforms in perspective. *Journal of Health Politics, Policy and Law* 30(1–2): 253–275.

The European Observatory on Health Systems and Policies produces a wide range of analytical work on health systems and policies. Its publishing programme includes:

☐ **The Health Systems in Transition profiles (HiTs)**. Country-based reports that provide a detailed description of the health systems of European and selected OECD countries outside the region, and of policy initiatives in progress or under development.

HiT profiles are downloadable from: www.euro.who.int/observatory

☐ **Joint Observatory/Open University Press -McGraw Hill Series. A prestigious health series exploring key issues for health systems and policies in Europe.** Titles include**:** Mental Health Policy and Practice across Europe ■ Decentralization in Health Care ■ Primary Care in the Driver's Seat ■ Human Resources for Health in Europe ■ Purchasing to Improve Health Systems Performance ■ Social Health Insurance Systems in Western Europe ■ Regulating Pharmaceuticals in Europe

Copies of the books can be ordered from: www.mcgraw-hill.co.uk

☐ **The Occasional Studies**. A selection of concise volumes, presenting evidence-based information on crucial aspects of health, health systems and policies. Recent titles include: Patient Mobility in the EU ■ Private Medical Insurance in the UK ■ The Health Care Workforce in Europe ■ Making Decisions on Public Health ■ Health Systems Transition: learning from experience

Studies are downloadable from: www.euro.who.int/observatory

☐ **Policy briefs**. A series of compact brochures, highlighting key policy lessons on priority issues for Europe's decision-makers, such as cross-border health care, screening, health technology assessment, care outside the hospital.

Policy briefs are downloadable from: www.euro.who.int/observatory

☐ ***Eurohealth***. A joint Observatory/LSE Health journal, providing a platform for policy-makers, academics and politicians to express their views on European health policy.

☐ ***Euro Observer***. A health policy bulletin, published quarterly, providing information on key health policy issues and health system reforms across Europe.

*** * * Join our E-Bulletin * * ***

Are you interested in signing up for the European Observatory's listserve to receive E-Bulletins on news about health systems, electronic versions of our latest publications, upcoming conferences and other news items? If so, please subscribe by sending a blank e-mail to: subscribe-observatory_listserve@list.euro.who.int

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in Europe. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues.

The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

More information on the European Observatory's country monitoring, policy analyses and publications (including the policy briefs) can be found on its web site at: www.euro.who.int/observatory

WHO European Centre for Health Policy
Rue de l'Autonomie 4
1070 Brussels
Belgium

Please address requests about publications to:

Publications
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark

for copies of publications:
publicationrequests@euro.who.int

for permission to reproduce them:
permissions@euro.who.int

for permission to translate them:
pubrights@euro.who.int

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

This policy brief is intended for policy-makers and those addressing the issue of accessing generalist and specialist care outside the hospital.