Snapshots of health systems

edited by
Susanne Grosse-Tebbe
and Josep Figueras

European
Observatory
on Health Systems and Policies

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European Observatory on Health Systems and Policies

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, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM).

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The Observatory team is led by Josep Figueras, Head of the Secretariat, and research directors, Martin McKee, Elias Mossialos and Richard Saltman.

snapshots of health systems

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Foreword

The *Snapshots of health systems* provide brief overviews of the health systems and health care in those countries which constituted the European Union Member States prior to May 2004 (hereafter referred to as the EU-15), i.e. Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom. Furthermore, the health system in Israel is summarized. The information covers the organization and financing of the health systems, in addition to the provision of and developments in health care in each country.

The reports draw on the *Health care systems in transition* (HiT) series of published profiles (see www.euro.who.int/observatory), as well as on the accompanying summaries and on-going reports. The HiT profiles are key components of the work of the European Observatory on Health Systems and Policies. They provide relevant comparative information on health systems which are extremely useful for policy-makers and analysts involved in developing health care systems in Europe. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services;
- to describe the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis, and
- to provide a tool for the dissemination of information on health care systems and the exchange of experience of reform strategies between policy-makers and analysts in different countries.

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. They provide a source of descriptive information on health care systems and can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to info@obs.euro.who.int. HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's website at www.euro.who.int/observatory.

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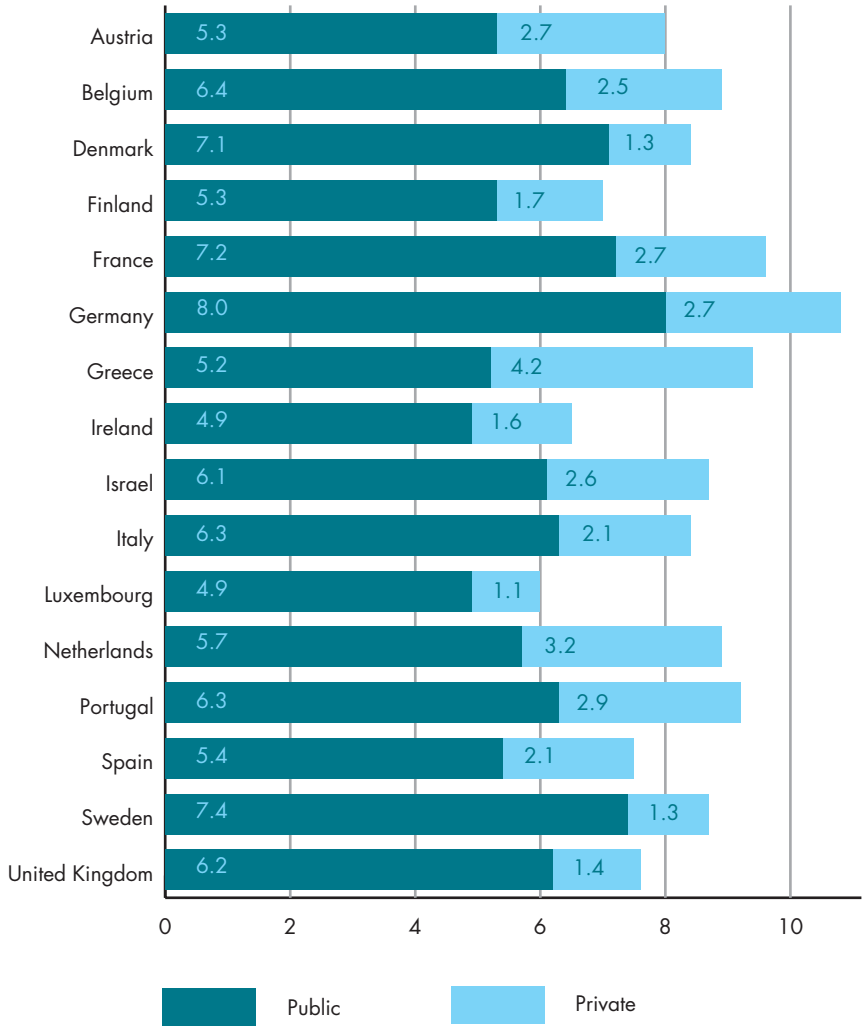
Figures and tables

Figure 1

Public and private expenditure on health as a percentage of the gross domestic product (GDP) in the EU-15 and Israel



Source: OECD Health Data 2004, 1st edition. Data for Israel from World Health Report 2004, estimated for 2001.

Table 1

Total expenditure on health care per capita US$ PPP (public and private) in the EU-15 and Israel

	2001	2002
Austria	2 174	2 220
Belgium	2 441	2 515
Denmark	2 523	2 580
Finland	1 841	1 943
France	2 588	2 736
Germany	2 735	2 817
Greece	1 670	1 814
Ireland	2 059	2 367
Israel	1 623	1 531
Italy	2 107	2 166
Luxembourg	2 900	3 065
Netherlands	2 455	2 643
Portugal	1 662	702
Spain	1 567	1 646
Sweden	2 370	2 517
United Kingdom	2 012	2 160

US$ PPP = purchasing power parity in US dollars.

Source: OECD Health Data 2004, 1st edition. Israel 2001 data from the WHO Regional Office for Europe Health for all (HFA) database 2004. Israel 2002 data from the Central Bureau of Statistics, Israel 2002.

Table 2

Selected health care resources per 100 000 population in the EU-15 and Israel for the latest available year

	Nurses (year)	Physicians (year)	Acute hospital beds (year)
Austria	587.4 (2001)	332.8 (2002)	609.5 (2002)
Belgium	1 075.1 (1996)	447.9 (2002)	582.9 (2001)
Denmark	967.1 (2002)	364.6 (2002)	340.2 (2001)
Finland	2 166.3 (2002)	316.2 (2002)	229.9 (2002)
France	688.6 (2002)	333.0 (2002)	396.7 (2001)
Germany	973.1 (2001)	335.6 (2002)	627.0 (2001)
Greece	256.5 (1992)	451.3 (2001)	393.8 (2000)
Ireland	1 676.2 (2000)	238.3 (2001)	299.5 (2002)
Israel	598.4 (2002)	371.3 (2002)	218.0 (2002)
Italy	296.2 (1989)	606.7 (2001)	394.4 (2001)
Luxembourg	779.3 (2002)	259.3 (2002)	558.7 (2002)
Netherlands	1 328.2 (2001)	314.9 (2002)	307.4 (2001)
Portugal	394.0 (2001)	331.2 (2001)	330.8 (1998)
Spain	367.2 (2000)	324.3 (2000)	296.4 (1997)
Sweden	975.1 (2000)	304.1 (2000)	228.3 (2002)
United Kingdom	497.2 (1989)	163.9 (1993)	238.5 (1998)
Average for EU-15	676.9 (2000)	353.1 (2001)	407.7 (2001)

Source: WHO Regional Office for Europe, HFA database.

Austria

Organizational structure of the health system

The Austrian health system is shaped by statutory health insurance (SHI) that covers about 95% of the population on a mandatory basis and 2% on a voluntary basis. Of the 3.1% of the population not covered in 2003, 0.7% had taken out voluntary substitutive insurance, while 2.4% had no cover at all (for example, some groups of unemployed people as well as asylum seekers).

The 26 SHI funds are organized in the Federation of Austrian Social Security Institutions and do not compete with each other since membership is mainly mandatory and based on occupation or domicile. Since 2001 family co-insurance has required a (reduced) contribution but many household members remain exempt for example children, child-raising spouses or individuals in need of substantial nursing care.

The Federal Ministry of Health and Women is the main policy-maker in health care; it is responsible for supervising the SHI actors and issuing nationwide regulations for example on drug licensing and pricing. The nine *Länder* governments deliver public health services and have strong competences to finance and regulate inpatient care.

Increasingly capacity planning has been undertaken by a structural commission at federal level and nine commissions at *Länder* level and is gradually being extended to all sectors and types of care.

Health care financing and expenditure

In 2002 Austria spent 7.7% of its gross domestic product (GDP) on health and ranked below EU-15 average (Figure 1). Total health expenditure remained stable between 1997 and 2002; the share of public expenditure decreased from 5.8% in 1995 to 5.4 % of GDP in 2002, accounting for 67% of the total expenditure in that year. The rise in private expenditure was attributable mainly to an increase in direct payments and co-payments. Calculated in US$ PPP (purchasing power parity in US dollars) expenditure per capita was US$ 2220 (see Table 1).

In 2000, 43% of total expenditure was financed from social security schemes, 27% from the government, 19% were paid via user charges or direct payments, 4% from other private funds and 7% from voluntary health insurance.

Financing of SHI differs among sickness funds but is always based on contribu-

tions representing equal shares from employers and employees, accounting for 7.4% of salary in 2004. Ceilings for maximum income and contributions apply. Blue-collar workers paid higher contribution rates than white-collar workers until 2003. Rates for civil servants, the self-employed and farmers still differ from the main contribution rate.

Sickness funds contract with individual physicians on the basis of negotiations between the funds and medical associations at *Länder* level. Contracted physicians in private practice are reimbursed by per capita flat rates for basic services and fee-for-service remuneration for services beyond these. The split between these components and possible volume restrictions may vary depending on speciality and *Land* and partly by the type of health insurance fund. For visits to non-contracted physicians the health insurance funds reimburse their SHI-insured at 80% of the regular contracted rate per billed service.

Since 1978, hospital care has been financed from funds at *Länder* level with separate divisions for recurrent and investment expenditure. Since 1997 hospital care has been financed from funds at *Länder* level with separate divisions for recurring and investment expenditure. The funds are financed by federal, *Länder* and district governments and, most importantly, by lump sums from health insurance funds.

Public and not-for-profit hospitals that are accredited in hospital plans for acute care at *Länder* level ("fund hospitals") are eligible for investments and reimbursement of services for individuals covered by SHI. Introduced in 1997, the performance-oriented payment scheme consists of a core component of national uniform diagnosis-related groups (DRG) and a steering system to account for hospital characteristics. The latter may vary considerably between *Länder*. Fund hospitals derive additional income from co-payments, supplementary insurance or their owners. Private for-profit hospitals may contract selectively with health insurance funds and then be reimbursed according to DRGs.

Long-term nursing care benefits are financed mainly from federal taxes. They are granted to about 4% of the population, regardless of income, on the basis of seven categories of need that depend on the hours of nursing care required per month. Pooling and allocation of benefits is carried out by the statutory pension funds.

Health care provision

Self-employed providers in single practice deliver most primary and secondary outpatient care. Outpatient clinics owned by hospital providers or statutory health insurance funds deliver secondary outpatient and dental care. General practitioners coordinate care and referrals and serve as formal gatekeepers to inpatient care, except in emergency cases. In practice, however, patients often access outpatient clinics directly. A co-payment for this type of service did not impact substantially on fund revenues and care-seeking behaviour and was abolished in

2003. The number of outpatient contacts was 6.8 per person in 2002. Public health authorities deliver antenatal care, child health care and screening services, many of which are financed by statutory health insurance.

Acute secondary and tertiary inpatient care is provided by fund hospitals accredited in hospital plans or by private for-profit hospitals. In 2001, 28% of beds were provided by private hospitals and 73% by fund hospitals owned by municipalities, the *Länder* and religious or other not-for-profit organizations.

While the number of hospital beds had been reduced to 6.1 beds per 1000 population in 2002, the density of beds in Austria remains high compared with the average for the EU-15 (see Table 2). Admission rates have increased further and reached the highest in Europe at 29 cases per 1000 population in 2002. This may be attributable in part to the introduction of the new DRG system; this shifted many surgery cases from ambulatory care to inpatient care. At the same time, the average length of stay was reduced from 13 days in 1990 to 6 days in 2002 when the occupancy rate was 76%.

The number of physicians increased continuously to 3.3 per 1000 population in 2002, similar to Germany but below the average for EU-15. The ratio of nurses to inhabitants also increased to 5.9 per 1000 but ranks substantially below neighbouring countries and the EU-15 average (Table 2).

Developments and issues

The vast majority of the Austrian population has access to a comprehensive set of statutory benefits in preventive, curative, palliative and long-term care, based on the principles of solidarity and risk pooling. The Ministry of Health and Women aims to expand the health insurance coverage of asylum-seeking immigrants. Quality management initiatives have been intensified and patient ombudsmen have been introduced in all nine *Länder* to handle and report complaints in all sectors of care in order to increase the responsiveness of services.

Recently cost-containment has targeted rising pharmaceutical expenditure by introducing price cuts, new price categorization schemes, margins for wholesalers and pharmacists and measures to increase the low rate of generic prescribing.

Despite substantial achievements in reducing the numbers of hospital beds and shifting acute capacities to nursing, geriatric and palliative care, acute bed capacities and utilization remain high by European standards, particularly in urban areas. Major political debates are also concerned with strategies to curb the (growing) deficits of health insurance funds and to secure the revenue basis of the statutory health insurance system.

Belgium

Organizational structure of the health system

Belgium has a health care system based on a compulsory social health insurance model. Health care is publicly funded and mainly privately provided. The National Institute for Sickness and Disability Insurance oversees the general organization of the health care system, transferring funds to the not-for-profit and privately managed sickness funds. Patients have free choice of provider, hospital and sickness fund.

A comprehensive benefit package is available to 99% of the population through compulsory health insurance. Reimbursement by individual sickness funds depends on the nature of the service, the legal status of the provider and the status of the insured. There is a distinction between those who receive standard reimbursements and those who benefit from higher reimbursements (vulnerable social groups).

Substitutive health insurance covers 80.2% of the self-employed for minor risks. Sickness funds offer complementary health insurance to their insured. Private for-profit insurance remains very small in terms of market volume but has risen steadily as compulsory insurance coverage has decreased.

The federal government regulates and supervises all sectors of the social security system, including health insurance. However, responsibility for almost all preventive care and health promotion has been transferred to the communities and regions.

Health care financing and expenditure

Statutory health insurance is financed mainly through income contributions from employers and employees. There are different schemes for salaried workers and the self-employed although these will merge by July 2006. Currently, these two schemes receive extra funding in parts of the value added tax revenue. Sickness funds are funded partly through a risk adjusted prospective budget, partly retrospectively on the basis of their individual share of total expenditure. Further state subsidies are allocated for administrative costs. Patients finance 19.1% of health expenditure mostly through out-of-pocket payments but also through voluntary health insurance premiums.

In 2002, total health expenditure was above the EU-15 average and accounted for 9.1% of its gross domestic product (GDP), 71.4% came from public sources

(Figure 1). Calculated in US$ PPP (purchasing power parity in US$), health care expenditure amounted to US$ 2515 per capita (Table 1).

A fixed annual budget for compulsory health insurance and sectoral target budgets are set at federal and community level. Health care delivery in Belgium is mainly private: most doctors, dentists, pharmacists and physiotherapists are self-employed and paid on a fee-for-service basis. The fees are negotiated at national level between the National Committee of Sickness Funds and providers' representatives. Other health care professionals are mainly salaried. Hospitals obtain most of their finance through a dual structure: a fixed prospective lump sum for accommodation services and a fee-for-service payment for medical and technical services.

Health care provision

Private sole general practitioners and specialists deliver most primary care. There is no referral system. In 2002 the average number of physician contacts per person was relatively high at 7.3, compared to the EU-15 average of 6.2. In 2002 Belgium had 4.6 acute hospital beds per 1000 population, above the average of 3.8 for the EU-15 (Table 2). In 2003 there were 218 not-for-profit hospitals, 149 general and 69 psychiatric. The majority of hospitals (147) are private. The hospital legislation and the financing mechanism are the same in both the public and private sector. Between 1980 and 2003 the number of hospitals dropped from 521 to 218 and the average capacity of a hospital rose from 177 to 325 beds. Of the 218 hospitals, 55% were located in the Flemish region, 30% in the Walloon region and 15% in the Brussels region.

The communities are responsible for health promotion and preventive services, except for national preventive measures. For this reason public health policies and services differ between the French and Flemish Community. In 2002 there were 4.5 physicians per 1000 population (Table 2). In the last 30 years staff numbers in most health care professions have doubled (or even trebled) mainly due to a lack of supply-side control. Until recently there was no limit on the number of trainees entering these professions, resulting in very high doctor/population and nurse/population ratios compared with the rest of western Europe.

Developments and issues

The Belgian health system provides comprehensive health care coverage to almost all the population while maintaining a wide degree of choice for the insured and the providers. Since the 1980s the Belgian Government's two main objectives have been cost containment and improving access to health care services.

In the hospital sector financing system, the change from per diem rates to a prospective diagnosis-related groups (DRG) payment scheme has been quite

successful in controlling costs. Previously based on structural features such as the number of accredited beds, financing now takes account of the 'justified activity of the hospital'. This justified activity is based upon the hospital's case-mix and the average national length of stay per DRG. To stimulate day care, one-day hospitalization is integrated into this calculation.

In the field of pharmaceutical policy the reimbursement procedures were simplified, the revision process for new and existing medicines was improved and a reference reimbursement system introduced to promote the use of generics.

The efficiency gains from giving greater financial responsibility to sickness funds have been constrained: since the latter are not allowed to selectively contract with providers they only have limited influence over providers' behaviour.

Other measures introduced have aimed at tariff cuts, supply restrictions and increases in co-payments but these have not yet succeeded in curbing public expenditure. In this context the division of power between the federal and regional government is regarded as an additional challenge.

A system of preferential reimbursement and social and fiscal exemptions was introduced to improve access to health care. As the social exemption applies to only certain social categories, and the fiscal exemption provides only for a reimbursement after an average of two years, the system of a 'maximum invoice' was introduced. This aims to improve access by limiting payments for health care to a maximum amount for example a family's out-of pocket expenses. The amount varies according to family income and other socioeconomic factors.

Denmark

Organizational structure of the health system

Denmark has a tax-based, decentralized health system that provides universal coverage for all Danish residents. Hospital care, general practitioners (GP) and public health services are free at the point of use.

Central government, in the form of the Ministry of the Interior and Health, plays a relatively limited role in health care. Its main responsibilities include establishing the goals for national health policy; preparing health legislation and regulation including the supervision of health personnel; promoting cooperation between the different health care actors; and providing health information. The Ministry of Finance plays a key role in setting the overall economic framework for the health sector.

Health care is primarily funded and provided by the counties. These own and run most hospitals as well as control the number and location of the privately practising general practitioners. The municipalities are responsible for providing services such as nursing homes, health visitors, home nurses and school health services.

Health care financing and expenditure

In 2002 Denmark spent 8.8% of its gross domestic product (GDP) on health (Figure 1), calculated in US$ PPP (purchasing power parity in US dollars) this amounted to US$ 2580 per capita (Table 1).

A combination of state, county and municipal taxes financed 83% of the total expenditure on health care. Central government holds overall financial responsibility for the health service: local taxes are supplemented by annual state subsidies calculated according to the size of these local revenues. In addition, resources are transferred between counties and municipalities according to a formula that takes account of age structures and socioeconomic indicators.

Private payments accounted for 17% of total expenditure on health and can be attributed to out-of-pocket expenses such as co-payments for physiotherapy, dental care, spectacles and pharmaceuticals as well as contributions to voluntary health insurance schemes. About 30% of the population purchases VHI in order to cover the costs of the statutory co-payments.

The most significant resource allocation mechanism in Denmark is the annual

national budget negotiation between the Ministry of the Interior and Health, the Ministry of Finance, the Association of County Councils and the National Association of Local Authorities. This sets overall limits for the average growth of county and municipal budgets and the levels of funding.

Public hospital resources are allocated mainly through prospective global budgets set by the counties in negotiation with hospital administrators. In addition, since 2000 diagnosis-related group (DRG) payments for patients treated in hospitals outside their own counties have been introduced. DRG payments are being introduced gradually in all county hospitals and now account for 20% of expenses.

General practitioners' remuneration is a mixture of quarterly capitation payments (30% of remuneration) and fees for service. County-licensed specialists are paid on a fee-for-service basis. Public hospital staff receive salaries.

Health care provision

Self-employed health care professionals and municipal health services provide primary health care. Privately practising general practitioners play a key role in the Danish health care system: as the patient's first point of contact and as gate-keepers to specialists, physiotherapists and hospitals. Danish residents over 16 have been able to choose from two general options: Group 1 patients may access a GP free of charge at the point of use if they accept that this GP acts as a gatekeeper; Group 2 patients may visit any GP or specialist without referral but must pay part of the treatment/consultation costs then. In 2002 only 1.7% of the population opted for Group 2, partly due to the extra costs involved and partly due to general satisfaction with the GP referral system.

The counties own and finance the majority of hospitals. Exceptions include hospitals in the Copenhagen area and private for-profit hospitals, the latter accounted for less than 1% of the total number of hospital beds in 2002. The number of beds per 1000 population fell from 7.6 in 1980 to 3.4 in 2001. The general decline in the number of beds in both general and psychiatric hospitals has been associated with a large increase in the number of outpatient visits.

In 2002 there were 3.7 physicians and 9.7 nurses per 1000 population (Table 2). It is felt that the recruitment of nurses may become increasingly problematic as the profession is associated with low salary levels, a heavy workload and poor working conditions.

Developments and issues

National and local reforms initiated during the last decade have focused on increasing productivity and quality and reducing waiting lists for non-acute care. These include the introduction of free choice for hospital treatment in 1993,

contracts and target-based management in hospitals, restructuring delivery on the basis of functional units, DRG classification, in parts activity-based hospital financing, the development of quality indicators and waiting-time guarantees. Most current reform initiatives focus on hospitals and inpatient care.

Primary care continues to be a key strength of the Danish health care system and a source of high-level satisfaction for the population. Further structural changes, possibly associated with a greater role for the private sector, are being considered but the Danish system will remain committed to the welfare ideals of tax financing and universal access to high quality health care, in accordance with general political consensus.

The Government has proposed a radical change to the regional administrative structure of Denmark to reduce the numbers of municipalities and counties/regions. The reform is being negotiated with the political parties in parliament (June 2004).

Finland

Organizational structure of the health system

Finland has a compulsory tax-based health care system that provides comprehensive cover for the entire resident population.

Central government and the municipalities are the main players in the organization of health care in Finland. At national level the Ministry of Social Affairs and Health issues framework legislation on health and social care policy and monitors its implementation. Municipal health committees, councils and executive boards plan and organize health care at local level. Municipalities (444 in 2004) also have responsibility for health promotion and prevention, primary medical care, medical rehabilitation and dental care. The country is divided into 20 hospital districts, federations of municipalities are responsible for arranging and coordinating specialized care within their area.

Health care financing and expenditure

The Finnish health care system is mainly tax financed. Both the state and municipalities have the right to levy taxes. In 2002 about 43% of total health care costs were financed by the municipalities, 17% by the state (mainly through state subsidies), 16% by National Health Insurance and about 24% by private sources.

In both absolute and relative terms there has been an overall increase in private financing, from 20.4% of total health expenditure in 1980 to 24.3% in 2002. This is accounted for by increased user charges for municipal services, the abolition of tax deductions for drugs and other medical treatment costs and reductions in the NHI reimbursements for pharmaceuticals.

Total health expenditure accounted for 7.3% of Finland's gross domestic product (GDP) in 2002 – for that year the lowest among the Nordic countries and lower than the EU-15 average. In the same year health expenditure in US$ PPP (purchasing power parity in US dollars) was US$ 1943 per capita (Table 1). Public expenditure on health was 75.3% of total health expenditure.

Municipalities pay hospitals for the services used by their inhabitants. Hospital physicians and most doctors in municipal health centres are salaried employees. Under the personal doctor system, physicians are paid a combination of basic salary (approximately 60%), capitation payment (20%), fee-for-service (15%) and local allowances (5%).

Finland

Health care provision

Primary curative care, preventive care and public health services are provided by multidisciplinary teams working in primary health care centres. These publicly owned centres are the responsibility of municipalities and play an important role in guiding patients through the different levels of care. The personal doctor system introduced in the 1980s includes the requirement that doctors see their patients within three days and made salaries more workload-related. This has improved access to GPs and reduced waiting times. Public health policy has been particularly successful in reducing mortality and risk factors related to cardiovascular diseases.

Outpatient and inpatient departments provide secondary and tertiary care in public hospitals. Acute hospitals had 2.3 beds per 1000 population in 2002 (Table 2).

In 2002 there were 3.2 physicians per 1000 population, matching the average for the EU-15. At 21.7 per 1000 population the ratio of nurses was the highest in western Europe (Table 2). The ageing population is expected to increase demand on the existing shortage of doctors and other health personnel.

Developments and issues

Over the past few decades Finland's health care system has been very successful in many ways: it provides generally good quality care, is fairly efficient compared to other countries and, in overall terms, the Finns are satisfied with their system. Reforms are intended to solve specific problems rather than promote major structural changes. The introduction of the personal doctor system in the 1980s was an attempt to address increasing waiting times for health centre doctors.

Since 1997 cost-containment measures have been implemented in response to rising pharmaceutical costs. In 2001 quality guidelines for mental health care services were negotiated and approved in order to facilitate the development of community care in parallel with rapid reductions of capacity in the hospital sector. In the same year a national programme of health promotion was approved, setting guidelines for the next 15 years based on WHO's health for all policy. Also a number of local projects and pilots have been developed recently for example experimenting with the integration of primary and secondary providers.

Some challenges that remain include enhancing access to care, increasing the system's responsiveness to patients' preferences, addressing the limited freedom to choose GPs and hospital, improving coordination between primary and secondary health care, addressing the shortage of personnel and increases in out-of-pocket payments.

France

Organizational structure of the health system

The French health system is based on a national social insurance system complemented by elements of tax-based financing (especially the General Social Tax – CSG) and complementary voluntary health insurance (VHI). The health system is regulated by the state (parliament, the government and ministries) and the statutory health insurance funds. The state sets the ceiling for health insurance spending, approves a report on health and social security trends and amends benefits and regulation.

There are three main schemes within the statutory health insurance system. The general scheme covers about 84% of the population (employees in commerce and industry and their families). The agricultural scheme covers farmers and their families (7.2% of the population). The scheme for self-employed people covers 5% of the population. In 2004 an insurance fund was established specifically for dependent elderly people. In 1999 universal health insurance coverage (CMU) was established on the basis of residence in France (99.9% coverage).

Complementary VHI has expanded significantly over recent decades and, since the introduction of CMU in 2000, has been available free to those on low incomes. VHI covered about 85% of the population in 2000 and now covers over 95%.

The French health system is gradually decentralizing from national to regional level. At the same time, power has shifted from the health insurance funds to the state.

Health care financing and expenditure

In 2002, total expenditure on health care in France was estimated at 9.7% of gross domestic product (GDP) and amounted to US$ 2736 per capita when calculated in US$ PPP (purchasing power parity in US dollars) (Figure 1; Table 1). Public expenditure constituted 76% of total health expenditure in the same year. As shown in Figure 1, as a proportion of GDP France spends the second highest amount on health in the EU-15. In 2002 social health insurance constituted 73.3% of total health expenditure, the remainder consisted of VHI (13.2%), out-of-pocket payments (9.8%) and national taxes (3.7%).

Since 1996 parliament has approved a national ceiling for health insurance expenditure (ONDAM) annually. Once the overall ceiling is set, the budget is

divided between four subgroups: private practice, public hospitals, the regions, private for-profit hospitals and social care.

The main health insurance scheme pays public hospitals through prospective global budgets. For-profit hospitals are paid a fixed rate covering all costs except doctors, these are paid on a fee-for-service basis. Private not-for-profit hospitals can choose between the two systems of payment (public or for-profit). A reform currently underway aims to introduce an activity-linked reimbursement system and to harmonize the financing of the public and private sectors.

Self-employed physicians provide the majority of outpatient and private hospital services. Patients pay direct fees for service and are then partially reimbursed by the statutory health insurance system. The national agreement between doctors and the funds specifies a negotiated tariff. Alternatively, from 1980 all doctors, but since 1990 only those with specific qualifications, have been able to join 'Sector 2' (currently about 24% of doctors) which allows them to charge higher tariffs. Doctors in public hospitals are paid on a salary basis, since 1986 they have been permitted to engage in part-time private practice within their hospitals as an incentive to remain in the public hospitals.

Health care provision

Self-employed doctors, dentists, medical auxiliaries, around 1000 health centres managed by local authorities and, to a lesser extent, salaried staff in hospitals deliver primary and secondary health care. There is no gatekeeping and patients have free choice of doctor. Recent attempts to introduce a gatekeeping system have not been particularly successful, despite financial incentives for both doctors and patients. Hospitals in France are either public (65% of all inpatient beds), private not-for-profit (15%) or private for-profit (20%). Private for-profit hospitals deal mainly with minor surgical procedures; public and private not-for-profit hospitals focus more on emergency admissions, rehabilitation, long-term care and psychiatric treatment. With 8.4 beds per 1000 inhabitants, half of which are acute beds, France is close to the average for the EU-15.

The many actors and sources of finance involved in public health policy and practice in France lead to a lack of cohesion among the actors and diluted responsibilities. In March 2003 a new bill was proposed to tackle this problem. It set out a comprehensive legislative framework for a public health policy that developed strategic plans in designated priority areas and established a framework of objectives and targets.

There are approximately 1.6 million health care professionals in France, accounting for 6.2% of the working population. In 2002 there were 3.3 physicians and 6.9 nurses per 1000 population, both figures below the EU-15 average (Table 2). The distribution of doctors shows geographical disparities favouring Paris and the south of France and urban rather than rural areas.

France

Developments and issues

The French health system is noted for its high level of freedom for physicians and choice for patients, plurality in the provision of health services, easy access to health care for most people and, except for some specialties in certain parts of the country, the absence of waiting lists for treatment. In recent years a number of reforms have transformed its original characteristics by increasing parliament's role, replacing employees' wage-based contributions with a contribution (tax) based on total income and basing universal coverage on residence rather than employment.

Financial sustainability has been a key issue for the French health system since the 1970s. The system's organizational structure makes it difficult to control expenditure and, although relatively high levels of expenditure on health have resulted in patient satisfaction and good health outcomes, cost containment remains a permanent policy goal. However, during the late 1990s concerns for equity led to a major reform (CMU) aimed at removing financial barriers to access but which went against the general trend of cost containment.

In May 2004 the conservative government proposed a series of reforms to raise revenue and reduce expenditure, purportedly to save €15 billion by 2007. The government proposes the introduction of several changes: charge all patients €1 per visit to a doctor; oblige pensioners who can afford it to pay substantially more; raise health care levies on firms; reduce waste and overconsumption (particularly of pharmaceuticals); reduce reimbursement of expensive pharmaceuticals; prevent national health insurance card fraud; establish a computerized, personal medical record accessible by any French health care professional to prevent patients from "shopping around"; and continue to move towards gatekeeping.

The French health system is institutionally complex leading to tensions between the state, the health insurance funds and providers. In future it will be important to improve relations by clarifying the responsibilities of these key actors.

Germany

Organizational structure of the health system

The roots of the German health system date back to 1883, when nationwide health insurance became compulsory. Today's system is based on social health insurance and characterized by three co-existing schemes. In 2003, about 87% of the population were covered by statutory health insurance; based on income, membership was mandatory for about 77% and voluntary for 10%. An additional 10% of the population took out private health insurance; 2% were covered by governmental schemes and 0.2% were not covered by any third-party-payer scheme.

The health care system has a decentralized organization, characterized by federalism and delegation to nongovernmental corporatist bodies as the main actors in the social health insurance system: the physicians' and dentists' associations on the providers' side and the sickness funds and their associations on the purchasers' side. Hospitals are not represented by any legal corporatist institution, but by organizations based on private law. The actors are organized on the federal as well as the state (*Land*) level.

The Ministry of Health and Social Security proposes the health acts that – when passed by parliament – define the legislative framework of the social health insurance system. It also supervises the corporatist bodies and – with the assistance of a number of subordinate authorities – fulfils various licensing and supervisory functions, performs scientific consultancy work and provides information services.

The 292 sickness funds collect the contributions of the statutory insurance for health and long-term care. They also negotiate contracts with the health care providers. Since 1996 almost every insured person has had the right to choose a sickness fund freely, while funds are obliged to accept any applicant. Since 2004, decision-making in statutory health insurance has been integrated into a trans-sectoral joint federal committee that is supported by an independent institute for quality and efficiency.

Health care financing and expenditure

In 2002, health expenditure in Germany comprised 10.9% of its gross domestic product (GDP), and 79% was covered by public funds, giving the country the highest rank among those shown in Figure 1 and ranking it third among countries in the Organisation for Economic Co-operation and Development (OECD). In the same year, German total per capita expenditure, when calculated in US$ PPP

(purchasing power parity in US dollars), amounted to US$ 2817 (Table 1) and public per capita expenditure ranked fifth among the OECD countries.

Of total expenditure, 57% of the funds came from statutory health insurance, 7% from statutory long-term care insurance, 4% from other statutory insurance schemes and 8% from government sources. Private health insurers financed 8%, employers 4% and non-profit-making organizations and households 12%. Most out-of-pocket payments were spent to purchase over-the-counter drugs and to cover co-payments for prescribed drugs. On 1 January 2004, co-payments were introduced for outpatient visits and raised for virtually all other benefits.

The risk-compensation scheme among sickness funds aims to level out differences in the age, sex and health-status structure of those insured through the different schemes. This system has been complemented by a high-risk pool since 2001 and by incentives for disease-management programmes for the chronically ill since 2003.

In ambulatory physician care, a regional physicians' association negotiates a collective contract with a single sickness fund in the form of a quasi-budget for physician services. The physicians' association distributes the funds among the general practitioners (GPs) and specialists who claim reimbursement mainly on a fee-for-service basis; limitations of service volumes apply.

Hospitals are financed on a dual basis: investments are planned by the governments of the 16 *Länder*, and subsequently co-financed by the *Länder* as well as the federal government, while sickness funds finance recurrent expenditure and maintenance costs. Since January 2004, the German adaptation of the Australian diagnosis-related group (DRG)-system is the sole system of paying for recurrent hospital expenditure, except for psychiatric care where per diem charges still apply.

Health care provision

Ambulatory health care is mainly delivered by sickness fund-contracted GPs and specialists in private practice. Patients have free choice of physicians, psychotherapists, dentists, pharmacists and emergency care. There is no formal gate-keeping system for GPs (about half of ambulatory physicians), although their coordinating competences have been strengthened in recent years, and sickness funds have been obliged to offer gate-keeping models to their members since January 2004.

Acute inpatient care is delivered by a mix of public and private providers, with the public sector accounting for 53%, non-profit-making organizations for 39% and the private sector for 8% of acute hospital beds in 2001. Although the number of beds and average length of stay in acute hospitals have been reduced

substantially – to 6.3 beds per 1000 population and 9.3 days in 2001 – Germany still ranks high on these indicators among the EU-15 (Table 2). The traditionally strict separation between ambulatory and hospital care has been eased in recent years by encouraging outpatient clinics at hospitals, trans-sectoral disease-management programmes and delivery networks.

From 1990 to 2002, the number of physicians increased by 20%. The number of nurses increased by 8% in 2001 (Table 2). In 2001, salaried employees in inpatient care comprised about half of the health care workforce.

Developments and issues

Since 1990, the health care system in the eastern part of Germany has quickly been transformed to a Bismarck model of care. By 2001, the gap in life expectancy between eastern and western Germany had narrowed to 1.5 years for men and 0.5 years for women.

In international comparison, the German health care system has a high level of financial resources and physical facilities. The population enjoys equal and easy access to a health care system offering a very comprehensive benefits package at all levels of care; waiting lists and explicit rationing decisions are virtually unknown. There is doubt, however, whether the high spending on health translates into a sufficiently cost-efficient use of resources.

Various cost-containment measures – including sectoral budgets, reference prices, rational prescribing and user charges – have kept statutory health expenditure at the level of GDP growth. Yet, since fund revenues grew less than expenditure, sickness funds ran into deficit in most years, and had to raise their contribution rates in the following year: from a mean of 12.4% of gross salaries in 1991 to 14.3% in 2003.

Current discussions focus on two alternative concepts of reforms on the revenue side: either to introduce a flat-rate health premium for people currently covered by statutory health insurance, with tax support for the poor, or to extend contribution-based insurance to the entire population, including, for example, civil servants and the self-employed.

Greece

Organizational structure of the health care system

The Greek health care system is characterized by the coexistence of the National Health Service (NHS), a compulsory social insurance and a voluntary private health insurance system. The NHS provides universal coverage to the population operating on the principles of equity, equal access to health services for all and social cohesion. In addition, 97% of the population is covered by approximately 35 different social insurance funds (compulsory social insurance and 8% of the population maintains complementary voluntary health insurance coverage, bought on the private insurance market.

The Ministry of Health and Social Solidarity decides on overall health policy issues and the national strategy for health. It sets priorities at the national level, defines the extent of funding for proposed activities and allocates resources. Seventeen Regional Health Authorities (PeSYPs) are given extensive responsibilities for the implementation of national priorities at regional level, coordination of regional activities and organization and management of health care and welfare services' delivery within their catchment areas. Decentralization efforts devolved political and operational authority to Regional Health Authorities but stopped short of granting full financial responsibility. The PeSYPs were not given individual budgets and all financial transactions still have to be validated by the Ministry itself.

Health care financing and expenditure

Health services in Greece are funded almost equally by public and private sources. Public expenditure is financed by taxes (direct and indirect) and compulsory health insurance contributions (by employers and insured persons). Voluntary payments by individuals or employers represent a very high percentage of total health expenditure (more than 42% in 2002), making the Greek health care system one of the most "privatized" of the EU countries.

In 2002, Greece's expenditure on health was 9.5% of gross domestic product (GDP), with a per capita expenditure in US$ PPP (purchasing power parity in US dollars) accounting for 1814 USD (Figure 1; Table 1). 4.5%, i.e. 47.4% of total expenditure accounted for private health expenditure, the highest percentage in absolute terms in all 15 countries and Israel (Figure 1).

The NHS budget is set annually by the Ministry of Economy and Finance based on historical data. Taxes provide approximately 70% of all hospital funding, the remaining 30% are derived from a mixture of social security and out-of-pocket

payments. It should be noted that tax revenue is used often to fill the gap between the officially determined level of social security funding (by fixed per-diem or per-case fees) and the actual cost of the provided services.

Despite the latest law on primary care (February 2004) that contains provisions for the gradual establishment of financial and administrative autonomy for primary care centres the latter are currently still financed through the budget of the respective hospital covering their administration.

All NHS staff (doctors, nurses, dentists, pharmacists and technical and administrative support staff) are salaried government employees. NHS doctors are forbidden to practise privately (except within the hospital premises during out-of-office (afternoon) hours, for which they are compensated on a per-case/appointment basis). Following the new government's pre-election commitment to remove it, this restriction is currently under review. IKA, the largest social security fund, is mainly responsible for primary health care delivery to 5.5 million beneficiaries through its 350 units. It is currently implementing a pilot programme to introduce GPs into the health care delivery structure and is in the process of reviewing a comprehensive GP contract, based on a mixed capitation- and performance-related remuneration system.

Health care provision

Primary health care in the public sector is delivered through a dual system of primary health care centres and hospital ambulatory (outpatient) services that belong to the NHS and IKA primary care units that belong to the largest social insurance fund.

Most secondary and tertiary care is provided in 123 general and specialized hospitals totalling 36 621 beds, and 9 psychiatric hospitals totalling 3500 beds. Public hospitals outside the NHS include 13 military hospitals financed by the Ministry of Defence, 5 IKA hospitals and 2 university teaching hospitals. In Greece there were 3.9 acute beds per 1000 inhabitants in 2000 (Table 2). Approximately 75% of beds are provided by the public sector; 243 private hospitals, mainly general hospitals and maternity clinics, account for 25% of all hospital beds. The establishment of new regional university hospitals has counteracted the inequalities in the distribution of hospital beds to some extent, but there are still significant patient flows to hospitals in the capital. In 2001 there were 4.5 practising physicians per 1000 inhabitants, one of the highest ratios in the EU-15. Meanwhile, despite concerted efforts to increase the number of nurses at 3.9 per 1000 inhabitants in 1999, this remains one of the lowest in Europe (Table 2).

Developments and issues

In the early 1980s the inception of the NHS coincided with the introduction of the socialist principles of equity, solidarity and equal access to services that the newly-

elected government was trying to infuse in public administration. The development of rural surgeries, primary health centres, public hospitals and regional teaching hospitals resulted in a number of significant advances in the population's access to effective health care services and an improvement in vital health status indicators. Despite these achievements a number of challenges remain, for example: drafting a National Action Plan for Public Health, integrating primary care services, establishing a clear distinction between the purchaser and provider sides of the health care market, reducing the high level of pharmaceutical expenditure and the need to modernize NHS management by introducing market mechanisms. The latest NHS reform (Law 2889/2001) underpins the effort to introduce private sector efficiency tools into the NHS, but has remained largely inspirational and is currently under review.

Ireland

Organizational structure of the health system

Ireland's health care system is characterized by a mix of public and private health service funding and provision. The government holds overall responsibility for the health care system, exercised through the Department of Health and Children (DOHC). Until January 2005 the provision of health care and personal social services remains with seven regional health boards and the Eastern Regional Health Authority (ERHA) that serves the Dublin area.

All residents are eligible for all services. Category I patients, 29% of the population, hold medical cards that entitle them to free services, particularly in primary care. The qualification criteria for these cards are largely income- and age-related. Category II patients have cover for public hospital services, subject to some capped charges, but must make a contribution towards the cost of most other services.

Voluntary health insurance (VHI) has played an important role in the Irish health system for almost 50 years. In 2002 community-rated voluntary health insurance covered almost 50% of the population. The Voluntary Health Insurance Board, set up in 1957, operates as a not-for-profit, semi-state private insurance body with board members appointed by the Minister of Health and Children. The Board holds 80% of the market share. Approximately one quarter of the population have neither a medical card nor health insurance. Individuals join VHI because this guarantees more immediate access to some hospital interventions. Care funded through VHI may be provided within state, voluntary sector and private hospitals.

Health care financing and expenditure

The health service remains predominantly tax-funded: approximately 75.2% of health expenditure came from public sources in 2002 (Figure 1). Other expenditure can be attributed to out-of-pocket payments for primary care services, pharmaceuticals and private hospital treatment as well as payments to voluntary health insurance providers. According to the Irish Central Statistical Office, in 2002 total expenditure on health amounted to 8.2% of gross domestic product (GDP), with 6.6% on public expenditure. OECD estimates were 5.5% for public and 1.8% for private expenditure (Figure 1). This seems low as expenditure has increased substantially but is masked by strong economic growth. US$ PPP (purchasing power parity in US dollars) per capita expenditure on health care in 2002 was US$ 2367 (Table 1).

Ireland

Health service funding is determined annually in negotiations between the Department of Finance and the DOHC. These budgets are influenced by demographic factors, commitments to service provision and national pay policies. The Department also provides some direct funding to voluntary hospitals and other service delivery agencies in the voluntary sector. The Eastern Regional Health Authority (ERHA) enters directly into agreements with these agencies.

Health care provision

General practitioners (GPs) are self-employed, 50% are in single-handed practices, others in partnerships of (typically) two or three. The majority treat both private and public patients, and enter into contract agreements to provide services for Category I individuals in return for capitation-based payments for treatment. The GPs have a complex gatekeeping role: individuals who are not entitled to free primary health care may go to secondary care facilities. There is a small charge for consultations of non-emergency cases that have not been referred by a GP.

Multi-disciplinary primary care teams are being developed and are intended to serve a population of between 3000 and 7000 people depending on whether the location is urban or rural. Between 600 and 1000 primary care teams will be phased in over 10 years, the first 40 to 60 by the end of 2005. The health boards also are responsible for delivering a range of health promotion and public health services across the country, taking account of both local needs and national strategies for the general population as well as specific groups such as Travellers. The public hospital sector incorporates voluntary and health board hospitals. Health board hospitals are funded directly by the state and administered by the boards.

Public voluntary hospitals are financed primarily by the state but may be owned and operated by religious or lay boards of governors. In 2000 there were 60 acute hospitals in Ireland, 23 of which were located in the ERHA. In addition there is a small number of purely private sector hospitals. Hospital consultants are paid on a salaried basis for the treatment of public patients. Furthermore, the contracts permit extensive private practice reimbursed on a fee-for-service basis. Public/voluntary hospital beds are designated for either public or private use (80:20 recommended ratio) in order to protect access to hospital care. Data from 2000 indicate that private use of beds is higher for elective procedures, at around 30%. In 2002 there were 3.0 acute care beds and 2.4 physicians per 1000 population, both below the average for the EU-15 (Table 2). With 15.3 nurses per 1000 population in 2002 the number of nurses is among the highest in the EU-15 (Table 2). There is an identified need for significantly higher numbers of general practitioners, other primary care workers and hospital consultants to implement planned reforms and comply with the requirements of the European Working Time Directive.

Ireland

Developments and issues

Health is a significant sociopolitical issue that features consistently as a source of dissatisfaction, particularly among poorer non-VHI members. Significant additional resources have been invested, with concerted attempts to reduce the inequalities in health outcomes between socioeconomic groups and to improve access to and availability of public health and social care services. However, the proportion of the population fully entitled to free services has been decreasing because of economic growth. Private patients are treated more rapidly within public hospitals, especially day cases. The National Treatment Purchase Fund, a major initiative intended to reduce public waiting lists, has made some progress by paying private hospitals to treat public patients at high expense but private patients continue to be treated in public hospitals at less than the market rate. Another weakness has been the lack of evaluation or an evidence-based approach to resource allocation.

The system is now undergoing the most extensive reforms since 1970. The DOHC, all the health boards and ERHA will be abolished. From January 2005 the Health Service Executive (HSE) will manage services as a single national entity, accountable directly to the Minister for Health. It will have three divisions: a National Hospitals' Office (NHO); a Primary, Community and Continuing Care Directorate; and a National Shared Services Centre to promote wider economies of scale.

The ongoing Primary Health Care Strategy is delivering multi-sector primary care teams. Significant modernization and reform of mental health care is now under way. Cross border cooperation with Northern Ireland on common health objectives is increasing. Following the 1998 British-Irish (also known as Good Friday or Belfast) Agreement, an all Ireland Institute of Public Health has been established and the possibility of a joint air ambulance service examined.

Israel

Organizational structure of the health system

The Israeli health system is financed through social insurance and taxation and based on regulated competition between health plans. The introduction of national health insurance (NHI) in 1995 achieved universal coverage. The Ministry of Health has overall responsibility for the health of the population and the functioning of the health system.

Four competing health plans, voluntary not-for-profit organizations, cover the entire population and offer their members a benefits package defined by legislation. Enrolment is mandatory but there is free choice of plan. About 65% of Israelis have supplementary voluntary health insurance (VHI) offered by the health plans, 26% are covered by commercial supplementary VHI and 20% are covered by both health plan and commercial supplementary VHI.

Although the Ministry of Health has devolved some central government authority to lower administrative levels through its regional offices, it retains substantial authority at national level. Similarly, although the health plans have regional offices, authority remains with the national headquarters. The NHI law has increased government control of the health system, particularly for the regulation of benefits and health plan financing. Efforts to transfer responsibility for service provision from the government to the voluntary sector have been unsuccessful to date.

Health care financing and expenditure

Total expenditure on health care in Israel was estimated to be 8.8% of gross domestic product (GDP) in 2002, similar to the EU-15 average. Public expenditure accounted for 68% of total expenditure on health (Figure 1). Calculated in US$ PPP (purchasing power parity in US dollars) the per capita expenditure of US$ 1531 was below the above-mentioned average (Table 1).

In 2000 total health expenditure consisted of general taxation (46%), the health tax (25%) and private sources of finance (29%). The health tax is an earmarked payroll tax collected by the NHI Institute with exemptions for several groups (for example pensioners and recipients of income maintenance allowances). Private funding consists of out-of-pocket payments and VHI. The latter accounts for about 16% of private spending on health care.

Each year the government sets the NHI budget based on the previous year adjusted automatically for inflation. It may also be adjusted to take account of

demographic and technological changes. The four health plans are allocated 95% of public NHI financing on the basis of a capitation formula that takes account of two factors: the number of members and the age mix. The remaining 5% is allocated on the basis of the number of health plan members with certain diseases (AIDS, endstage renal disease etc).

Currently, public hospitals (both government-owned and not-for-profit privately-owned hospitals that together constitute 96% of acute beds) are reimbursed according to fee-for-service charge lists for hospital outpatient care in ambulatory clinics and emergency departments and by per diem fees for inpatient admissions and case payments (diagnostic-related groups) for about 30 types of admission. A hospital revenue cap was established in 1995 to reduce the growth in hospital utilization and lower the health plans' expenditure for services above the cap.

The largest health plan, Clalit, covers 60% of the population. Clalit offers primary care from its own clinics with free choice of physicians. These are paid by salary and monthly capitation payment based on enrolment. In the other health plans, most primary care physicians work independently and are paid on a capitation basis based on either actual patient visits or enrolment lists (as in Clalit). Community-based specialists may be salaried or independent (paid on an 'active' capitation basis in addition to fee-for-service payments). Hospital-based physicians generally are paid salaries based on their clinical/administrative responsibility and years of experience.

Health care provision

Access to primary health care has improved substantially in the past decades. In three out of four health plans, the cost of primary care visits to health plan physicians is covered fully by NHI and waiting times are minimal. For all health plans, primary care physicians act as gatekeepers to hospital-based specialists. However, members of the small health plans have access to plan-affiliated community- based specialists without prior authorization. The number of outpatient contacts in Israel was 7.1 per person in 2000.

Approximately 50% of all acute hospital beds are in government-owned hospitals. Clalit (33%), private for-profit hospitals (5%) and voluntary not-for-profit hospitals own the remainder. Israeli health care is characterized by a low overall general care bed-population ratio of 2.2 (2002) (Table 2), a very low average length of stay and high admission and occupancy rates. The Ministry of Health operates a Public Health Service that coordinates regional and district offices. Vaccination coverage in Israel is high. Key issues in public health centre around the low levels of spending (0.8% of national health expenditure); developing methods for prioritizing and funding public health interventions; and changing ownership and modernization of family health centres (the primary source for screening).

Israel

Israel has a high physician-population ratio (3.7 physicians per 1000 population in 2002) that approximates to the EU-15 average of 3.5. However, there are shortages in some medical specialities and urban-rural discrepancies in physician density. The number of nurses (6 per 1000 inhabitants) is also close to the average in the EU-15 (Table 2).

Developments and issues

Israel's health system represents a synthesis of government and market forces; consists of organizations that combine funding and delivery functions; employs risk-adjusted capitation financing to limit creaming-off by insurers; has an explicit method of setting priorities and defining the benefits package; and maintains a strong focus on equity.

The health system is predominantly publicly funded through progressive taxation, provides broad population coverage and good geographical access to primary health care. However, equity remains an issue due to the relatively high proportion of private finance. While health care is highly equitable within the public system, private health services have expanded in recent years and several important components of health care remain outside the public system – for example, dental care and institutional long-term nursing care.

The 1988 Netanyahu Commission critique of the health system stimulated recent reforms that sought to improve efficiency. Some of these efforts were implemented quite effectively for example introducing NHI and improving patients' rights, but so far there have been no efforts to reduce government responsibility for health service delivery. Efforts to reform mental health care are underway and it is likely that the foundation has been laid for future improvements in this area.

Current issues on the policy agenda include continued financial strain and the need to improve methods of measuring and rewarding quality of care. The challenges facing Israel's health system include adapting to the special health needs of a large number of immigrants, making effective use of the large number of physicians, ensuring adequate and responsive care to the Arab population and managing the strain on emergency and rehabilitative services due to a high number of casualties from terrorism and conflict.

Italy

Organizational structure of the health system

In 1978 the National Health Service (NHS) was established. The system aimed to grant universal access to a uniform level of care throughout the country, financed by general taxation. Universal coverage has been achieved although there are wide differences in health care and health expenditure between the regions, with a clear cut north-south divide.

Under the 2001 reform of the Italian constitution, the central state and the regions share responsibility for health care. The state has exclusive power to define the basic benefit package (Livelli Essenziali di Assistenza – LEA) that must be provided uniformly throughout the country. The 20 regions have responsibility for the organization and administration of the health care system. Local health authorities are responsible for the delivery of health care services at the local level and serve geographical areas with average populations of about 300 000.

Health care financing and expenditure

Although one of the principal tenets of the 1978 reform was a quick move toward progressive financing of the NHS, throughout the 1990s social health insurance contributions still made up more than 50% of total public financing. In 1998 a regional business tax replaced social contributions. This tax is supplemented by a central grant financed from value added tax revenues, in order to ensure adequate resources for each region.

Out-of-pocket payments cover cost-sharing for public services for example co-payments for diagnostic procedures, pharmaceuticals and specialist consultations. Since 1993, patients have had to pay for the cost of outpatient care up to a maximum amount (€36 since 2000). Co-payments for drugs and ambulatory specialist services have had a limited impact, however. In 1996 these peaked at 4.8% of total NHS revenues but fell to 2.9% in 2002 after drug co-payments were abolished at the national level.

Furthermore, patients need to pay out-of-pocket for private health care services and over-the-counter drugs. Approximately 15% of the population has complementary private health insurance either individually subscribed to or offered by employers.

In 2002, Italy's total expenditure on health amounted to 8.5% of gross domestic product (GDP) (Figure 1); per capita expenditure in US$ PPP (purchasing power parity in US dollars) was US$ 2166 (Table 1). Public sources covered 75% of the

costs. Since the introduction of co-payment schemes private expenditure has increased, reaching 25% in 2002.

In 1997 a weighted capitation rate for the regional resource allocation was introduced. This took account of the age structure and health status of the population. Based on capitation formula, regions also transfer funds to the local health units (LHUs). Tertiary hospitals have trust status and enjoy expanded financial freedoms. Public secondary hospitals are granted some financial autonomy but remain under the control of LHUs. A (diagnosis-related group) DRG-based prospective payment system for inpatients is in place, excluding rehabilitation and long-term care, with the tariffs defined by the regions.

Hospital physicians are salaried employees. General practitioners and paediatricians are independent contractors of the NHS paid mainly on a capitation basis. Reforms have aimed to provide additional incentives for efficiency: additional income from fees for specific treatments and financial rewards for effective cost containment.

Health care provision

GPs and paediatricians working as independent contractors to the NHS provide primary health care. They act as gatekeepers to secondary care.

LHUs are responsible for protecting and promoting public health mainly through disease prevention (especially immunization), health promotion and food control. Specialized services are provided either directly by LHUs, or through contracted out public (61%) and private (mainly not-for-profit) facilities accredited by LHUs. The number of beds per 1000 population decreased from 7.2 in 1990 to 4 in 2001 (Table 2).

There were 6.1 physicians per 1000 population in 2001, among the highest ratios in western Europe. The number of nurses was among the lowest in the EU-15 at 3.0 per 1000 population in 1989 (Table 2).

Developments and issues

The inception of the Italian NHS in 1978 represented an ambitious, laudable effort to rationalize and expand public health care services. The initial reform aims have been achieved only partially due to mounting financial pressures and incomplete implementation. The market-oriented reforms in 1992 and 1993 aimed to address some of the most pressing issues. The period between 1997 and 2000 witnessed a series of radical and innovative changes, including the devolution of administrative and fiscal responsibilities to the regions. Remaining challenges concern the guarantee of free provision of a basic benefit package as well as ensuring uniform levels and quality of health care across the regions.

Luxembourg

Organizational structure of the health system

Luxembourg's health care system is based on three fundamental principles: compulsory health insurance, patients' free choice of provider and compulsory provider compliance with the fixed set of fees for services.

The standard contribution level is set by the Union of Sickness Funds that, together with nine profession-based funds, manages and provides statutory health insurance for 99% of the population. Civil servants and employees of European and international institutions have their own health insurance funds; furthermore, any unemployed person who is receiving neither unemployment benefit nor a public pension is excluded.

Voluntary health insurance has always played a limited role in Luxembourg. Nevertheless, approximately 75% of the population purchases complementary health insurance coverage, mostly to pay for services that are categorized as non-essential under the compulsory schemes.

Health care financing and expenditure

Similar to its neighbouring countries of Belgium, France and Germany, Luxembourg's health care system is mainly publicly financed through social health insurance. In 2000 total health expenditure was funded by statutory insurance (72.7%), taxes (15.1%), out-of-pocket payments (7.7%) and voluntary health insurance (1.6%). Total health expenditure was estimated to be 6.2% of gross domestic product (GDP) in 2002, the lowest share in the EU-15. Public sources were estimated to account for 86% (Figure 1). In the same year, health care expenditure per capita calculated in US$ PPP (purchasing power parity in US dollars) was US$ 3065, the highest figure in the EU-15 (Table 1).

This apparent contradiction can be explained by two factors:

(i) per capita expenditure calculations are based on the resident population which can be misleading since 25% of Luxembourg's insured workers are commuters from neighbouring countries; and

(ii) Luxembourg's per capita GDP is the highest in the EU.

Luxembourg is very small so few resource allocation decisions are delegated to local authorities. The exceptions are hospital budgets that are negotiated between individual hospital administrative boards and the Union of Sickness Funds.

Luxembourg

Health professionals' payments are based on a fixed statutory fee level. Individual hospitals negotiate global prospective budgets with the Union of Sickness Funds. For pharmaceuticals, a comprehensive list of drugs is approved for use as a national formulary and guide for reimbursement. It is maintained by the Directorate of Health's Division of Pharmacy.

Health care provision

Usually providers are contracted out. The insured can choose their providers freely and any level of care provision that they choose (hospital, clinic, etc) is eligible for reimbursement.

On 1 January 2004 there were 14 acute care hospitals. One of these, specialized in maternity services, is run for profit. The remaining 13 are run by local authorities as well as not-for-profit and mainly religious organizations. The number of acute care beds decreased from 7.4 in 1980 to 5.7 per 1000 population in 2003.

Preventive services are the responsibility of the Ministry of Health. Interventions are provided by public services, private practitioners and not-for-profit associations paid from the Ministry's budget.

The number of physicians, specialists and dentists per 1000 population increased during the 1980s and 1990s but remained below the numbers in other EU countries. In 2002 there were 2.6 physicians and 7.8 nurses per 1000 population (Table 2). The Directorate of Health's Division of Pharmacy maintained relatively constant pharmacist numbers over this period. Luxembourg imports all pharmaceutical products and bases most retail prices on those determined in the country of origin.

Developments and issues

Luxembourg provides a compulsory social health insurance system under which the insured enjoy access to a comprehensive benefit package and free choice of providers. Health care expenditure as a percentage of GDP has remained low over the past decades compared to other EU-15 states.

The reforms of the 1980s and 1990s mostly focused on attaining financial stability for the sickness funds. The main measures introduced during this period were an increase in co-payments, the establishment of the Union of Sickness Funds' reserve for dealing with any budget imbalance and the transfer of responsibilities from individual sickness funds to the Union of Sickness Funds.

In 1995 a change in the payment system was introduced in response to spiralling hospital costs: a tariff scheme with annually negotiated global prospective

budgets between the individual hospitals and the Union of Sickness Funds.

While Luxembourg is small in area and population size it has a very high GDP. Therefore, although cost-containment has been a priority area on the political agenda it has not been pursued as urgently as in other European countries.

The Netherlands

Organizational structure of the health care system

The Netherlands has a health insurance-based system. Three parallel compartments of insurance coexist: the first includes a national health insurance for exceptional medical expenses. The second comprises different regulatory regimes – compulsory sickness funds for persons under a certain income on one side and private, mostly voluntary health insurance on the other. The third includes voluntary supplementary health insurance.

The first compartment: under the Exceptional Medical Expenses Act (AWBZ) the insurance for exceptional medical expenses associated with either long-term care or high-cost treatment was set up. Almost everyone living in the Netherlands is covered by this insurance.

The second is intended to cover standard medical care. Sixty-five per cent of the population, i.e. anyone whose annual salary is below a ceiling (currently €30 700) as well as all social security recipients are insured by sickness funds (ZFW). Anyone with earnings above this ceiling is insured by private health insurance (WTZ) that covers 28% of the population. The health insurance schemes for public servants cover another 5% of the total population.

The third compartment includes forms of care that are considered less vital, such as dental care, prostheses, hearing aids, etc., and therefore not covered by the other compartments. The costs in this sector are covered largely by supplementary private medical insurance.

These different compartments and the systems that constitute them are steered and supervised by different ministries and have (at least) partly different relationships with the insured on one and the providers on the other side.

Over recent years responsibilities have shifted from government to the private sector (delegation or functional decentralization) and there has been a transfer of competences from central to provincial/local governments (devolution or territorial decentralization). This is illustrated by the local and provincial governments' increased influence on planning.

Health care financing and expenditure

Long-term care (AWBZ) is financed by payroll deductions and government funds and represents 41% of health expenditure. The ZFW funds for normal medical care make up 38% of health expenditure. Aside from these major sources of

funding, the main complementary sources are private health insurance (15%) and out-of-pocket payments (6%).

Total health care expenditure was estimated to account for 9.1% of gross domestic product (GDP) in 2002 (Figure 1). Calculated in US$ PPP (purchasing power parity in US dollars) this amounted to an expenditure of US$ 2643 per capita (Table 1).

Sickness funds have a budgeting system in which they negotiate with providers about the quality, quantity and (to some extent) price of services. This offers the funds some flexibility and provides incentives to purchase care as effectively as possible, as well as encouraging market competition. Since 2000 hospital payment has been performance-related, the first step towards changing the hospital payment system to a (diagnosis-related group) DRG-type treatment system. Furthermore, hospitals receive additional budgets for major capital expenditure. Physicians in specialist training are salaried employees of the hospitals. GPs are paid on a per capita basis for patients insured under the ZFW and on a fee-for-service basis for the privately insured.

Health care provision

Primary health care is well-developed and provided mainly by general practitioners (GPs). Each patient is supposed to enrol with one GP who acts as a gatekeeper for specialist and inpatient care. The majority of medical problems (two-thirds of all ambulatory care contacts) are treated by family physicians so the referral rate is low.

Most secondary and tertiary care is provided by medical specialists in hospitals with both outpatient and inpatient facilities. More than 90% of the hospitals are private, not-for-profit facilities, the rest are mainly public university hospitals. Hospitals are classified as general (100), teaching (8) and specialist hospitals (28). Hospitals have increased their capacity through mergers or expansion despite the required decrease in beds in each region. In 2001, 3.1 acute beds per 1000 population were available (Table 2). The so-called "transmural care" sector, introduced in the early 1990s to bridge the organizational and financial gap between ambulatory and institutional care, continues to grow.

Public health is organized at municipal or district level and supervised and monitored at regional and national level by the Health Care Inspectorate. The leading theme of public health services has been strengthening preventive policies. Emphasis is placed on longer and healthy lives/lifestyles as well as reducing health inequalities.

According to WHO estimates in 2002, 3.2 physicians and 13.3 nurses (2001) per 1000 population worked in the Dutch health system (Table 2).

The Netherlands

Development and issues

A prominent trend over the last decade has been the shift of responsibility for purchasing care from government to insurers. There has also been a trend towards more competition between providers of care. Efforts are made to combine market and non-market elements in health care.

There are ongoing discussions about whether health insurance should be merged into one system. Furthermore, reform of the health insurance system with a per capita, risk-independent premium instead of a percentage contribution are discussed. The new health insurance scheme to be set up would combine statutory and private (voluntary) health insurance in one single mandatory scheme. Parliament, including the biggest opposition party, supports the health insurance reforms and these are scheduled to come into effect on 1 January 2006.

Portugal

Organizational structure of the health system

The Portuguese health system is characterized by three co-existing systems: the National Health Service (NHS), special social health insurance schemes for certain professions (health subsystems) and voluntary private health insurance. The NHS provides universal coverage. In addition, about 25% of the population is covered by the health subsystems, 10% by private insurance schemes and another 7% by mutual funds.

The Ministry of Health is responsible for developing health policy as well as managing the NHS. Five regional health administrations (RHAs) implement the national health policy objectives, develop guidelines and protocols and supervise health care delivery. Decentralization efforts have aimed at shifting financial and management responsibility to the regional level. In practice, however, RHA autonomy over budget setting and spending has been limited to primary care.

Health care financing and expenditure

The NHS is funded predominantly through general taxation. Employer (including the state) and employee contributions are the main funding sources of the health subsystems. In addition, direct payments from patients and voluntary health insurance premiums account for a large proportion of funding.

In 2002 Portugal's expenditure on health amounted to 9.3% of its gross domestic product (GDP) (Figure 1). Calculated in US$ PPP (purchasing power parity in US dollars) this accounted for US$ 1702 per capita (Table 1). As a percentage of GDP (1.4% in 2001) Portugal has the highest level of public expenditure on pharmaceuticals in the EU-15. In 2002 private health expenditure accounted for 29% of total expenditure, reflecting a large share of out-of-pocket payments (including co-payments). These co-payments and the heavy reliance on indirect taxes make the funding system slightly regressive.

The NHS budget is set annually by the Ministry of Finance based on historical spending and plans put forward by the Ministry of Health. The Ministry of Health allocates a budget to each RHA for the provision of primary health care to a geographically defined population.

Public hospitals are financed through case-mix adjusted global budgets drawn up by the Ministry of Health. Since 1997 a growing proportion of the budget has been based on diagnosis-related groups (DRG) and on non-adjusted outpatient

activity. Primary health care centres (HCs) are financed by the RHAs and have neither financial nor administrative autonomy.

All NHS doctors are salaried government employees. Private practice and additional payments such as overtime constitute significant additional sources of income. An experimental payment system for groups of GPs/family doctors based on capitation and professional performance was introduced in 1999 and is under revision.

Health care provision

GPs/family doctors working in the HCs deliver most primary health care in the public sector. GPs act as gatekeepers so there is no direct access to secondary care. The number of outpatient contacts per person (3.4 in 1998) is among the lowest in the European Region.

Secondary and tertiary care is provided mainly in hospitals, although some health centres still provide specialist ambulatory services. There is an uneven distribution of health resources between the regions, however, hospitals in rural/inland areas have benefited from a programme of additional investments in recent years.

In 1998 Portugal had 3.3 acute hospital beds per 1000 population, approximately 75% of which were provided in the public sector. Of the 205 hospitals, 84 were private and half of them were for-profit. Non-clinical services often are outsourced to the private sector. Private providers also deliver most diagnostic and therapeutic services in the ambulatory sector.

In 2001 there were 3.3 physicians per 1000 population. The Portuguese ratio of nurses per 1000 inhabitants has increased steadily but remains one of the lowest in Europe (3.9 in 2001) (Table 2).

Developments and issues

In the early 1970s Portugal was one of the first European countries to adopt an integrated approach to primary health care through the development of a comprehensive network of health centres. This resulted in significant advances in the population's health status such as the dramatic decline in infant mortality since the 1960s. The reform agenda since 2002 has included measures to reduce surgical waiting lists; innovations in the management of hospitals and primary HCs; positive changes in drug policy and a stronger role for the private sector.

Despite the remarkable achievements in health policy, a number of challenges remain for the Portuguese health care system. These include low efficiency and accountability in comparison with other NHS-based systems; high levels of private expenditure; high levels of pharmaceutical expenditure; inequities in the health

sector; and the need to modernize the organizational structure and management of the NHS. After a first attempt in the recent past, there appear to be good prospects for developing a comprehensive health strategy for Portugal.

Spain

Organizational structure of the health care system

The Spanish health care system is tax-based. During the last two decades responsibility for health care largely has been devolved to Spain's 17 regions – the autonomous communities. The National Health Survey of 1997 showed population coverage to be 99.8%, including the low-income and immigrant population. Civil servants are free to opt for coverage under one of the three publicly funded mutual funds. Private insurance companies provide complementary health care coverage and increasingly cover services outside the basic package. Often they are bought also to avoid waiting lists. In 2003, 18.7% of the population purchased private insurance policies.

The Spanish Ministry of Health and Consumer Affairs establishes norms that define the minimum standards and requirements for health care provision. It has legislative power, sets up information systems and assures cooperation between national health authorities and the autonomous communities. The Ministry also is responsible for inter-territorial and international health issues and publishes comparative reports (benchmarking and highlighting 'best practice').

The autonomous communities decide how to organize or provide health services and implement the national legislation. The inter-territorial council (Consejo Interterritorial del Sistema Nacional de Salud – CISNS) is composed of representatives of the autonomous communities and the state administration and promotes the cohesion of the Spanish health system. The municipalities' role is limited to complementary public health functions linked to hygiene and the environment.

Health care financing and expenditure

The health care system is financed out of general taxation (for example VAT and income tax) and regional taxes. The rate of taxation at the regional level may be modified up to a threshold fixed by the national government. Some autonomous communities also receive grants from the central state; the Basque Region and Navarra, for example have gained relatively large fiscal autonomy. Public financing is complemented by out-of-pocket payments to the public system (for example co-payments for pharmaceuticals), as well as to the private sector (for example private outpatient care) and contributions to voluntary insurance.

Spain has one of the lowest levels of health expenditure in the EU-15. In 2002, expenditure in US$ PPP (purchasing power parity in US dollars) was estimated to amount to US$ 1646 per capita (Table 1), total health care expenditure accounted for 7.6% of gross domestic product (GDP). In the same year public

expenditure was relatively low at 71.4% of total health expenditure (Figure 1).

The autonomous communities have varying hospital payment mechanisms. Traditionally hospital expenditure has been retrospectively reimbursed, with no prior negotiation and no formal evaluation. During the last two decades the use of contract programmes with prospective financing of target activities has increased, this is especially the case in the private hospital sector.

Most physicians are employed by the public sector and receive fixed salaries.

Health care provision

Following the General Health Act of 1986, primary health care (PHC) was given an independent, reinforced status. The law strengthened the role of the general practitioner as the first point of contact in the health system acting as a gatekeeper. By 2001, most autonomous communities had moved away from the traditional model of a sole practitioner working part-time to the reformed model based on a PHC team working full-time on a salaried basis.

Despite the political focus on PHC the health system still centres around hospitals. In 2001, Spain had 4.0 hospital beds per 1000 population; in 2002, an estimated 39% of the hospitals was publicly owned. An extensive network of outpatient ambulatory centres works alongside the hospital system. In the reformed model, members of the specialist teams in clinical departments cover outpatient care in ambulatory centres on rotation. While waiting times have been reduced, they still remain considerable.

Most medical staff have a status similar to that of civil servants. In 2000 the total number of doctors approached the EU-15 average with 3.2 per 1000 population, increasing from 2.3 in 1990. The total number of nurses remained relatively low at 3.7 per 1000 population in 2000 (Table 2).

Health care reforms

During the 1980s and 1990s the Spanish health system underwent major change that achieved a significant extension of coverage, developed a new reformed PHC network and rationalized financing and management structures. The extension of the public network and the transition from a social security system to a tax-funded system has reaped particularly favourable results. Furthermore, the system has largely been decentralized to the autonomous communities.

The formal goal of shifting the health care system's focus towards PHC has not been accomplished yet. Citizens' satisfaction regarding topics such as waiting times and administrative procedures for accessing hospital care remains low. Outstanding challenges include information development, managerial autonomy and the expansion of social and community care.

Sweden

Organizational structure of the health system

Sweden has a compulsory, predominantly tax-based health care system providing coverage for the entire resident population. Voluntary insurance is very limited and typically provides only supplementary coverage to the public health system.

The Swedish health care system is mainly regionally-based and publicly operated. It is organized on three levels: national, regional (21 counties) and local (290 municipalities). At national level the Ministry of Health and Social Affairs is responsible for ensuring that the system runs efficiently. The National Board of Health and Welfare (NBW) is the government's central advisory and supervisory agency for health and social services. There are several associated national institutions such as the National Social Insurance Board (NSIB) that guarantees uniformity and quality in the processing of insurance and benefits.

At regional level the county councils provide and finance health care services. Usually these are divided into health care districts consisting of one hospital and several primary health care (PHC) units that are separated further into PHC districts. The 21 counties are grouped into 6 medical care regions to facilitate cooperation in tertiary care.

At local level the municipalities deliver and finance social welfare services including childcare, school health services and care for the elderly, people with disabilities and long-term psychiatric patients. They also operate public nursing homes and home care services.

Health care financing and expenditure

During the 1990s a combination of recession and cost-containment led to relatively slow growth in health expenditure. In 1990 health care expenditure amounted to 8.2% of gross domestic product (GDP) with a relatively small increase to 8.7% in 2001. In 2002, it was calculated to be 9.2% of GDP (Figure 1), representing a US$ PPP (purchasing power parity in US dollars) expenditure of US$ 2517 per capita (Table 1). In the same year total public expenditure accounted for 85.9% of total Swedish health expenditure. Regional taxes finance the major part of health expenditure. Private expenditure (14.1% in 2002) consisted mainly of out-of-pocket payments and voluntary insurance. In about 90% of cases employers pay for voluntary insurance to avoid payments for employees' long-term sick leave.

Sweden

Resource allocation varies among counties. Using global budgets most counties have decentralized financial responsibility to health districts. Moreover, about half of the county councils have introduced some form of purchaser-provider organization. For short-term somatic care diagnosis-related groups (DRG)-based payment systems are most widely used. Most health care personnel are publicly employed. Physicians at public facilities are paid a monthly salary from the counties and also have received a capitation fee since the mid-1990s. The National Social Insurance Board (NSIB) reimburses private dentists through a fee-for-service system.

Health care provision

The PHC services deliver both basic curative care and preventive services through local health centres and hospital outpatient departments and private clinics. Compared to other EU-15 states, outpatient visits to hospitals are relatively higher than those to health centres. Health centre physicians must be trained in general practice. They act as gatekeepers, guiding the patients to the right level of care within the system. Public funding for private health care providers is dependent on an agreement of cooperation with the country.

Secondary and tertiary care is provided through regional (mainly for highly specialized care), central county and district county hospitals. In 2002 there were 2.3 beds per 1000 population (Table 2). Municipalities play a central role regarding preventive measures and the National Institute of Public Health is responsible for managing public health at national level.

The number of people employed in the health care sector increased substantially during the 1970s and the early 1980s. However, the number of physicians (3.0 per 1000 population in 2000) remains below the average for the EU-15 and there is a shortage of physicians in isolated rural areas. As in other Nordic countries, Sweden has a relatively high number of nurses (9.8 per 1000 inhabitants in 2000) but there is a countrywide shortage of nurses with specialist skills.

Developments and issues

The Swedish health care system has undergone several major structural changes, particularly during the 1990s. Responsibilities were transferred gradually to local governments and providers and new management and organizational schemes were introduced. This was the continuation of the devolution process initiated in the 1970s. In the late 1980s internal market reforms were launched against a background of tightened cost-containment policies. As a result, there is evidence of productivity gains in regional and county health services and successful containment of health care expenditure.

While the Swedish health care system is among the best performing in the world,

some relatively minor challenges remain. Changes in government, increasing fragmentation of governance and provision, problems of coordination among different administrative levels and lack of a global perspective have impeded a coordinated reform strategy.

The United Kingdom of Great Britain and Northern Ireland

Organizational structure of the health system

The United Kingdom has devolved health care responsibilities to its constituent countries: England, Northern Ireland, Scotland and Wales. All these countries fund health care mainly through national taxation, deliver services through public providers and have devolved purchasing responsibilities to local bodies (Primary Care Trusts in England, Health Boards in Scotland, Local Health Boards in Wales and Primary care partnerships in Northern Ireland).

Coverage is available to all legal residents of the United Kingdom, residents of the European Economic Community and citizen of other countries with which the UK has reciprocal agreements. For this reason, there is a quite low uptake of private medical insurance. In 2001, 11.5% of the population had supplementary private medical insurance.

Although NHS benefits are comprehensive, they are not explicitly defined. Since 1999 in England and Wales, the Secretary of State for Health and the Welsh Assembly Government have received recommendations from the National Institute for Clinical Excellence (NICE). These state whether a particular service is both effective and cost-effective and should be made available to all or part of the population. Although the implementation of approved NICE guidance is mandatory, early indications suggest that implementation has been variable.

Health care financing and expenditure

The NHS is funded mainly through general taxation: direct taxes, value added tax and employees' income contributions. Further funding for social services is available via local taxation. Private funding can be broken down into out-of-pocket payments for prescription drugs, ophthalmic and dental services, and private medical insurance premiums. In 2003 the Government announced that an extra 1% of income was to be levied as an earmarked tax through national health insurance.

Total health expenditure in the United Kingdom has remained quite low relative to the EU-15 average. In 2002, it accounted for 7.7% of gross domestic product (GDP), with public sources estimated to provide 83% of total expenditure (Figure 1). In the same year, health care expenditure calculated in US$ PPP (purchasing power parity in US dollars) was US$ 2160 per capita (Table 1).

In England budgets for health care are set every three years, following negotiations between the Chancellor of the Exchequer and Department of Health. Budgets are set separately by the devolved administrations in the rest of the United Kingdom. Local Health Boards (LHBs) and Primary Care Trusts (PCTs), covering populations of between 50 000 and 250 000 people, are the main purchasers of health services. A weighted capitation formula is used to allocate central government funding to the PCTs and LHBs.

General practitioners (GPs) are self-employed. On 1 April 2004 remuneration of their services moved from a system based mainly on capitation and fixed allowances to one which combines capitation and quality points. Most of the population is concentrated in urban areas so access to, and the sustainability of, quality services are reduced in remote and rural areas.

Hospitals receive activity-based and contract financing. Most hospital staff are salaried, but hospital consultants are permitted to earn money in the private sector too.

Health care provision

In the United Kingdom primary care is publicly provided by GPs in group practices (on average three GPs per practice). A patient must be a resident of the designated practice area in order to register with a GP. In England, in 2002, each GP was responsible for an average of 1800 members of the local community.

Although there is a small number of NHS walk-in clinics, GPs act as gatekeepers in the system and a referral is required in order to access specialist services. In 2002 the United Kingdom had 3.9 acute hospital beds per 1000 population (Table 2). In 2004 secondary care in the English NHS was provided by 209 NHS Trusts. In addition 23 Mental Health Trusts provided specialist mental health services in hospitals and the community. There are about 240 private acute hospitals. Less than 5% of all beds are in private hospitals. Patients must have a referral from their GP in order to access secondary care.

In 2001, there were 0.6 GPs per 1000 population. There is considered to be an undersupply of skilled staff in the NHS. In view of this, the government has committed to increase the NHS workforce by establishing staff growth targets to be met by 2004, for example an additional 2000 GPs. The Welsh Assembly Government also has set targets to increase the numbers of doctors, nurses and dentists in Wales.

The organizational structures for health service administration and delivery differ between the United Kingdom's countries. In England, for example, public health personnel function within the Central and Regional Department of Health, the Strategic Health Authorities and the PCTs. In Wales, a National Public Health

Service has been established to provide services and support to the LHBs, other organizations in the NHS and local authorities.

Developments and issues

In the United Kingdom tax-based funding provides universal coverage. Out-of-pocket payments for patients are relatively low as the system is mostly free at the point of use. Although difficult to measure, the funding system based on national taxation is indicated to be mildly progressive.

Recent issues surrounding health care in the United Kingdom have focused on improving the efficiency, responsiveness and equity of the system. The "Delivering the NHS Plan" in England is to give patients wider choice of hospitals although their choice of treatment remains limited. In particular, from summer 2004 all patients waiting six months for surgery should be able to obtain treatment from another hospital or provider. Concordats have been agreed with the private sector to deliver treatments where necessary or even to send patients abroad. National Service Frameworks have been developed to ensure that a common approach to prevention, treatment and rehabilitation is adopted across the country. The independent Healthcare Commission is responsible for monitoring the clinical and financial performance of NHS Trusts, and determining whether NICE guidance is being implemented.

Furthermore, initial legislation has been passed to create NHS Foundation Trusts in England. Already 20 have been granted foundation status. Foundation Hospitals remain within the NHS, but have greater management and financial responsibilities and freedoms. Such measures have been introduced to achieve particular aims including reduced waiting lists; improved quality of provision, increased funding and staff numbers; encouragement of innovation and extended patient choice.

A recent review of public expenditure on health recommended greater investment in health promotion and public health interventions, with the subsequent publication of a consultation paper on the future of public health.

Devolution increasingly is leading to quite different directions in reform across the United Kingdom. In Scotland major differences include the funding of both personal and nursing care for people in long-term care; and the decision not only to reject Foundation Trusts but also to abolish hospital trusts and reorganize primary care and develop community health partnerships. In contrast to the rest of the United Kingdom, Northern Ireland has always had integrated health and social care services.

In Wales, the Welsh Assembly Government has reformed the NHS by establishing LHBs to plan and commission services to meet most health needs while an

all-Wales body commissions specialist hospital services. There is increased emphasis on preventing ill health and reducing health inequalities. Developments include adjustments to the way that NHS resources are allocated in order to take account of the needs of disadvantaged areas, and an Inequalities in Health Fund to help people to reduce their risk of heart disease and to address inequities in access to health services. The Assembly Government also has announced the phased abolition of co-payments for prescriptions for all, regardless of income, over a five-year period beginning in 2004.

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