



**THE COMMONWEALTH FUND
2005 INTERNATIONAL SYMPOSIUM ON HEALTH CARE POLICY**

**DESCRIPTIONS OF HEALTH CARE SYSTEMS:
AUSTRALIA, CANADA, GERMANY, THE NETHERLANDS,
NEW ZEALAND, THE UNITED KINGDOM, AND THE UNITED STATES**

Multinational Comparisons of Health Systems Data Selected Indicators for Seven Countries, 2003

		Australia	Canada	Germany	Netherlands	New Zealand	U.K.	U.S.
Total Population (1000s of People)		19,873	31,660	82,502	16,224	4,009	59,554	290,789
Health Status	Life Expectancy at Birth, Males (Years)	77.8	77.2 ^a	75.5	76.2	76.3 ^a	76.2	74.5 ^a
	Life Expectancy at Birth, Females (Years)	82.8	82.1 ^a	81.3	80.9	81.1 ^a	80.7	79.9 ^a
	Life Expectancy at Age 65, Males (Years)	17.6	17.2 ^a	16 ^b	15.8	16.7 ^a	16.1 ^a	16.6 ^a
	Life Expectancy at Age 65, Females (Years)	21.0	20.6 ^a	19.6 ^b	19.5	20.0 ^a	19.1 ^a	19.5 ^a
Spending	Percentage GDP Spent on Health Care	9.7%	9.9%	11.1%	9.8%	8.1%	7.7% ^a	15.0%
	Health Care Spending per Capita	\$2,903	\$3,003	\$2,996	\$2,976	\$1,886	\$2,231 ^a	\$5,635
	Average Annual Growth Rate of Real Health Care Spending per Capita, 1993-2003	3.4%	2.5%	2.3%	3.4%	3.4%	4% ^c	3.4%
	Out-of-Pocket Health Care Spending per Capita ^d	\$590	\$448	312 ^a	\$233	\$296	na	\$793
	Spending on Physician Services per Capita ^d	\$480	\$287	\$304	na	na	na	\$1,271
Public Coverage	Percentage Total Pop with Health Insurance Coverage Through Public Programs	100.0%	100.0%	90.1%	76.4%	100.0%	100.0%	26.6%
Health Manpower	Number of Practicing Nurses per 1,000 Population	10.2	9.8	9.7	12.8 ^b	9.1	9.7	7.9 ^a
	Number of Practicing Physicians per 1,000 Population	2.5 ^a	2.1	3.4	3.1	2.2	2.2	2.3 ^e
	Average Annual Number of Physician Visits per Capita	6.0	6.2 ^b	na	5.6 ^a	4.0	5.2	3.6 ^a
Hospital Spending, Capacity and Utilization	Hospital Discharges per 1,000 Population	157 ^a	88 ^a	202 ^a	97	204	247	117 ^a
	Hospital Spending per Discharge ^d	\$6,196	\$9,107 ^a	\$5,222 ^a	\$12,137	na	na	\$12,466 ^a
	Hospital Spending per Inpatient Acute Care Day ^d	\$1,024 ^b	\$804 ^a	\$554 ^a	\$1,251 ^b	na	na	\$2,180
	Number of Acute Care Hospital Beds per 1,000 Population	3.6 ^a	3.2 ^a	6.6 ^a	3.2 ^a	na	3.7	2.8
	Average Length of Stay for Acute Myocardial Infarction	6.4 ^a	8.1 ^a	10.3 ^a	9.2	7.5 ^a	9.2	5.6 ^a

	Australia	Canada	Germany	Netherlands	New Zealand	U.K.	U.S.
Average Length of Stay for Normal Delivery	2.7 ^a	2 ^a	4.4 ^a	2.3	2 ^a	1.9	1.9 ^a
Coronary Bypass Procedures per 100,000 Population	82 ^a	98 ^a	87	53	97	56	181 ^b
PTCA Interventions per 100,000 Population	130 ^a	140 ^a	270	93	92	99	426
Number of Knee Replacements per 100,000 Population	144	92 ^a	na	107	54	111	155
Technology MRI Units per Million Population	3.7	4.5	6 ^a	na	3.7	5.2 ^b	8.6 ^a
Non-Medical Determinants of Health Percentage of Adults Who Reported Being Daily Smokers	17.4% ^f	17.0%	24.3%	34.0% ^b	25.0%	26.0%	17.5%
Obesity (BMI>30) Prevalence	20.8%	14.3%	12.9%	10.0% ^a	20.9%	23.0%	30.6% ^a

Source: OECD Health Data 2005

^a 2002

^b 2001

^c 1993-2002

^d adjusted for differences in the cost of living

^e MEPS 2002

^f 2004

na - not available

The Australian Health Care System

Who is covered?

- Australia's public health insurance scheme, Medicare, provides universal coverage for citizens, permanent residents, and visitors from countries which have reciprocal arrangements with Australia.

What is covered?

- Services: Free or subsidised access to most medical services; inpatient and outpatient hospital care; physician services; some allied health services for the chronically ill; inpatient and outpatient drugs; specified optometric and dental surgery services; mental health care; and rehabilitation. Free choice of general practitioner.
- Cost-sharing: Medicare reimburses 75% of the scheduled fee for private inpatient services and 85-100% of ambulatory services. Doctors are free to charge above the scheduled fee, or they can treat patients for the cost of the subsidy and bill the Government directly with no patient charge (referred to as bulk billing). There is a bulk-billing incentive scheme and almost 75% of medical services are bulk billed. Prescription pharmaceuticals have a patient copayment. Out-of-pocket payments account for 19.7% of total health expenditure.
- Safety nets: A Medicare safety net for non-inpatient services, and a separate pharmaceutical safety net, protect against high out-of-pocket costs.

How are revenues generated?

- National Health Insurance (Medicare): Compulsory national health insurance administered by the Australian (federal) Government. National health insurance is funded by a mixture of general tax revenue, a 1.5% levy on taxable income (which accounts for 17.3% of federal outlays on health) and fees paid by patients. Additionally, a Medicare Levy Surcharge applies to high-income individuals without private health insurance for hospital coverage. Government funds almost 70% of total health expenditures (46% federal and 22% state/local).
- Private Insurance: Mainly not-for-profit mutual insurers cover the gap between Medicare benefits and schedule fees for inpatient services. Doctors may bill above the scheduled fee. Private insurers also cover

private hospital accommodation, choice of specialists, and avoidance of queues for elective surgery.

- Private insurance covers 49% of the population (43% have hospital cover with nearly all of these also having ancillary cover, while 6% of the population are covered for ancillary services only). Expenditure by private health insurance funds accounts for 7.1% of total health expenditure. Through a rebate, 30% of private health insurance premiums are paid by the Australian Government. The rebate increases to 35% for people aged 65 to 69 years, and to 40% for those aged 70 years and over.

How is the delivery system organized?

- Physicians: Primary care physicians act as gatekeepers. Physicians are generally reimbursed by a fee-for-service system. The Government sets the fee schedules, but these are not maximum prices.
- Hospitals: Mostly public, run by the states. The states pay for public hospitals with Australian Government assistance negotiated via five-yearly agreements. Physicians in public hospitals are either salaried (but may have private practices and fee-for-service income) or paid on a per-session basis.
- Government: The Australian Government has control over hospital benefits, pharmaceuticals, and medical services. States are charged with operating public hospitals and regulating all hospitals, nursing homes, and community-based general services.

How are costs controlled?

- Australia controls its health care costs through a combination of global hospital budgets, fee schedules, limited diffusion of technology, copayments for pharmaceuticals, and waiting lists. Also, the Government restricts the number of medical students and Medicare-licensed providers.

The Canadian Health Care System

Who is covered?

Coverage is universal for eligible residents of Canada.

What is covered?

- **Services:** Through the *Canada Health Act*, the federal government requires that provincial and territorial health insurance plans cover all medically necessary physician and hospital services to qualify for full federal transfers. The federal government is also directly responsible for health care services for specific groups, including the Royal Canadian Mounted Police, serving members of the armed forces, eligible veterans, First Nations people living on reserves, the Inuit, and inmates in federal penitentiaries.
- Provincial and territorial governments also provide supplementary benefits for certain groups such as senior citizens and social assistance recipients. Benefits include services such as prescription drugs, dental care, home care, aids to independent living, and ambulance services.
- **Cost-sharing:** No cost-sharing for insured physician and hospital services. However, there may be charges for other, non-insured services.

How are revenues generated?

- **Publicly Funded Health Care:** Public health insurance plans are administered by the provinces/territories and generally funded by general taxation. Three provinces charge additional health care premiums. Federal transfers to provinces/territories are tied to population and other factors and are conditional on meeting the principles of the *Canada Health Act*. Public funding accounts for approximately 70 percent of total health expenditures.
- **Privately Funded Health Care:** Many Canadians have supplemental private insurance coverage through group plans, which extend the range of insured services to include such services as vision and dental care, prescription drugs, rehabilitation services, private care nursing, and private rooms in hospitals. Private health expenditures represent approximately 30 percent of total health expenditures.

How is the delivery system organized?

- **Physicians:** Most physicians are in group or private practice and are remunerated on a fee-for-service basis. However, many Canadian physicians receive some payment for clinical care through alternative public payment plans. In 2002-03, about 17.5% of total clinical payments to physicians were made through these types of arrangements. Provincial/territorial medical associations generally negotiate the fee schedule for insured services with provincial/territorial health ministries. Physicians must opt out of the public system of payment to have the right to charge their own rates for medically necessary services.
- **Nurses:** Most nurses are primarily employed either in hospitals or by community health care organizations, including home care and public health services. Nurses are generally paid salaries negotiated between their unions and their employers.
- **Other health professionals** such as dentists, optometrists, therapists, psychologists, pharmacists, and public health inspectors may be employed or self-employed, and are generally paid salaries negotiated between their unions and their employers.
- **Hospitals:** Mainly public and private non-profit hospitals that operate under annual, global budgets, negotiated with the provincial/territorial ministries of health or regional health authority, with some fee-for-service payment.
- **Government:** Provincial/territorial governments have the authority to regulate health providers. However, they typically delegate control over physicians and other providers to professional “colleges” whose duty is to license providers and set standards for practice.

How are costs controlled?

- Cost control measures include mandatory annual global budgets for hospitals/health regions, negotiated fee schedules for health care providers, formularies for public drug plans, and limits on the diffusion of technology.

The German Health Care System

Who is covered?

- Up to the determined income level, every employee has to enroll with any of the Sickness Insurance Funds (SIFs) offering the same comprehensive health care coverage. Individuals above that income level have the right to opt out to obtain private coverage instead.

What is covered?

- Services: Statutory benefit package includes preventive services; inpatient and outpatient hospital care; physician services; mental health care; dental care; prescription drugs; rehabilitation; and sick leave compensation. Long-term care is covered by a separate insurance scheme. Free choice of ambulatory care physicians.
- Cost-sharing: Traditionally few cost-sharing provisions confined to copayments for all services and products. Out-of-pocket payments (glasses, OTC drugs, others) accounted for 11 percent of health care expenditures.

How are revenues generated?

- Sickness Insurance Funds (SIFs): There are approximately 249 SIFs autonomous, not-for-profit, nongovernmental bodies (although regulated by the government). They are funded by compulsory payroll contributions averaging 14.2 percent of wages, equally shared by employers and employees. SIFs cover approximately 88 percent of the population. Dependents are covered through the primary SIF enrollee. While the unemployed continue to contribute to the SIF proportionate to their unemployment entitlements, health care costs incurred by welfare recipients, asylum seekers, and the homeless, are financed through general revenues. In 1998, SIFs accounted for 81 percent of health care expenditures.
- Private Insurance: Private insurance, which provides health insurance based on voluntary, individual premiums, covers 8.1 percent of the population (the affluent, the self-employed, and civil servants). Private insurance accounts for 8 percent of health care expenditures.

How is the delivery system organized?

- Physicians: General practitioners have no formal gatekeeper function. However, special GP contracts in 1994 required all SIFs to offer at least one model of GP gatekeeping to their insurees. All physicians in the outpatient sector are paid on a fee-for-service basis. Representatives of the sickness funds negotiate with the regional associations of physicians to determine aggregate payments.
- Hospitals: Hospitals are mainly non-profit, both private and public. They are staffed with salaried doctors. Senior doctors may also treat privately insured patients on a fee-for-service basis. Representatives of the sickness funds negotiate payment rates with hospitals at the regional level. A new payment system based on diagnosis-related group (DRG) per-admission payments was introduced in 2004.
- Government: The German government delegates regulation to the self-governing corporatist bodies of both the sickness funds and the medical providers' associations. However, given lack of efficacy and compliance, the Government is increasingly willing to replace the self-regulating system and delegate more purchasing powers to the sickness funds.

How are costs controlled?

The government imposes sector-wide budgets for physician and hospital services. Budget ceilings for prescription drugs were abolished in early 2001, leading to an unprecedented increase of expenditures for pharmaceuticals increasing financial strain on the SIFs. Health care reforms in the 1990s included increased competition among sickness funds; the introduction of a per-admission hospital payment system; the control of physician supply; and moderate cost-sharing provisions.

The Dutch Health Care System

Who is covered?

- Public and private coverage is nearly universal.

What is covered?

- Long-term care and high-cost treatments are covered for all by the Exceptional Medical Expenses Act (AWBZ).
- Normal, necessary medical care:
 - The Sickness Funds Act (ZFW) compulsorily insures people whose annual salary falls below a statutory ceiling and all recipients of social security benefits up to age 65 (about 65 percent of the population).
 - Other health insurance schemes cover various categories of civil servants, accounting for around 5 percent of the population.
 - Those not covered by the ZFW or schemes for civil servants can obtain private health insurance coverage on a voluntary basis. Approximately 30 percent of the population is privately insured.
 - Beginning January 1, 2006, all citizens will have a compulsory basic insurance, the distinction between private and public insurance will no longer apply. Insurers will be obliged to accept patients for this basic insurance, and will need to compete on price and quality.
- Public universal insurance for “exceptional medical expenses” which include long-term care, mental health, etc; compulsory social health insurance for the low income and voluntary private health insurance for the high income; and voluntary supplemental insurance for all. Ambulatory care is provided by independent GPs, who mostly work in private practices. Almost all Dutch citizens have a regular GP, who handles 95% of health problems within primary care practices. Patients with more complex problems are referred to other care providers.
- Cost-sharing: Each insurance arrangement, including public sickness funds and private plans, require some form of cost-sharing, including co-payments and deductibles. All those insured by the ZFW incur a 20 percent co-insurance rate.

How are revenues generated?

- The AWBZ is funded by premiums paid by people covered by the scheme, local taxes, and government subsidies.
- Contributions through the tax system to the national government provide funding for all national health insurance schemes. A portion of employed individuals’ income is deducted by employers and paid to the national health insurance funds. The percentage withheld corresponds to level of income. Those insured by the ZFW pay an additional non-income-related premium.
- Local taxation: Local taxes are a supplementary source of funding for most health insurance arrangements.
- Central government grants and payments: A series of grants are available for the purchase of services not covered by entitlement programs. These include services earmarked for future inclusion in the entitlement package, as well as innovative forms of care. The central government also uses a portion of general revenues to supplement funding of entitlement programs.
- Out-of-pocket expenditure accounts for approximately 9 percent of total health care costs: 4 percent is covered by co-payments under the AWBZ, 2 percent by co-payments and deductibles under the ZFW, and 3 percent by direct payments for private complementary or supplementary insurance plans. Those covered by private insurance pay a nominal premium, averaging \$1,277 (USD) in 2003. From 2006 on, all patients will have compulsory basic insurance with a nominal premium of about \$1,300-\$1,400 (USD) and an income-related premium add on.
- Private Insurance: Private insurance coverage is funded out of premiums and cost sharing. Those who opt for private coverage are required to pay “solidarity” contributions to the national health insurance scheme. A portion of each individual’s premium accounts for this contribution. Private insurance packages are available as stand-alone and supplementary coverage.

How is the delivery system organized?

- **Physicians:** Physicians practice under national contracts negotiated by health insurers and providers' representative organizations. GPs are paid on a capitation basis for patients insured under the ZFW and on a fee-for-service basis for privately-insured patients. From 2006 on, GPs will receive a capitation payment for each patient on the practice list and a fee per consultation. Additional budgets can be negotiated for extra services, practice nurses, complex location, etc. Experiments with pay-for-performance quality are underway. Specialists working in hospitals are self-employed, and are paid a capitated amount based on negotiations between insurers and specialists' organizations. Some specialists are paid a fix income/salary and have a contract with the hospital. Future payment will be related to Diagnose-Treatment-Combination (see below).
- **Hospitals:** The majority of hospitals are private non-profit. Hospital budgets are developed based on a formula that pays a fixed amount per bed, patient volume, and number of licensed specialists, in addition to other considerations. Additional funds are provided for capital purchases. As of 2000, payments to hospitals are rated according to performance on a number of accessibility indicators. Hospitals that produce fewer inpatient days than agreed with health insurers are paid less, a measure designed to reduce waiting lists. A new system of payment (Diagnose-Treatment Combinations - DBCs) is currently being introduced: 10% of all medical interventions are now reimbursed

on the basis of these DBCs. In some experimental hospitals 100% of all interventions are based on DBCs. It is expected that most of the care will be defined in these new entities in the future, although there is a lot of debate about the feasibility of this new system.

- **Government:** Much of the responsibility for managing the health insurance schemes is handled at the regional level. Thirty-one regional health care offices carry out duties such as contracting with providers, collecting patient contributions, and organizing regional alliances. The national government approves all contracts negotiated between regional councils, insurers, and providers.

How are costs controlled?

- **Providers** negotiate contracts which dictate the volume of services to be delivered as well as charges to be assessed to users. These contracts are subject to the approval of the national government, which sets limits on the amounts that doctors, hospitals, and nursing homes can charge. Costs are expected to be increasingly controlled by the new DBC system in which hospitals have to compete on price for specific medical interventions.

The New Zealand Health Care System

Who is covered?

- All New Zealand residents have access to a broad range of health services with substantive government funding.

What is covered?

- Services: Public health preventive and promotional services; inpatient and outpatient hospital care; primary health care services; inpatient and outpatient prescription drugs; mental health care; dental care for school children; and disability support services. Free choice of general practitioner.
- Cost-sharing: Co-payments are required for General Practitioner (GP and general practice nurse primary health care services) and non-hospital prescription drugs. Health care is substantially free for children under age 6 and is partially subsidized for most other people depending on age and income. Patient co-payments (out-of-pocket payments) account for 16 percent of health care expenditures.

How are revenues generated?

- General taxation: Public funding is derived from taxation. It accounts for about 78.3 percent of health care expenditures.
- The government sets a global budget annually for publicly funded health services. This is distributed to District Health Boards (DHBs). DHBs provide services at government-owned facilities (about one-half, by value, of all health services) and purchase other services from privately owned providers, such as general practitioners (most of whom are grouped as Primary Health Organizations or PHOs), disability support services, and community care.
- Patient co-payments (out-of-pocket expenditures): People pay fee-for-service co-payments to GPs and for pharmaceuticals, some private hospital or specialist care and adult dental care. In addition, complementary and alternative medicines and therapies are paid for out-of-pocket.
- Private insurance: Not-for-profit insurers generally cover private medical care. Private insurance is most commonly used to cover cost-sharing requirements, elective surgery in private hospitals, and specialist outpatient consultations. About one-third of New Zealanders have private health insurance and it accounts for approximately 6 percent of total health care expenditures.

How is the delivery system organized?

- Physicians: GPs act as gatekeepers and are independent, self-employed providers paid through a combination of payment methods: fee-for-service with partial government subsidy, mostly capitation funded through PHOs. Consultants (specialists) working for District Health Boards are salaried but may supplement their salaries through treatment of private patients in private (noncrown) hospitals.
- Primary Health Organizations (PHOs): The government has injected substantial additional funding into subsidising primary health care to improve access to services. From July 2002 to date, 79 PHOs have been formed under government policy to reduce health disparities and take a population approach to primary health care. 92 percent of the New Zealand population is now enrolled with and receiving care from a PHO. PHOs will have a range of different clinical and non-clinical health practitioners on staff and be funded partly by capitation and partly by fee-for-service. By July 2007, all New Zealanders will be able to receive low cost access to primary health services provided by PHOs.
- District Health Boards: The Boards (21 in the country) are partly elected by the people of a geographic area and partly appointed by the Minister of Health. The Boards are responsible for determining the health and disability support service needs of the population living in their districts, and planning, providing, and purchasing those services. A Board's organization has a funding arm and a service provision arm, operating government-owned hospitals, health centers, and community services.
- Government: New Zealand's government has responsibility for legislation, regulation, and general policy matters, funds 78.3 percent of health care expenditures, and owns DHB assets.

How are costs controlled?

- The government sets an annual publicly funded health budget. In addition, New Zealand is shifting from open-ended, fee-for-service arrangements to contracting and funding mechanisms such as capitation. "Booking systems" are being introduced to replace waiting lists to ensure that elective surgery services are targeted to those people best able to benefit. Early intervention and health promotion and disease prevention are being emphasized in primary care and by DHBs.

The British Health Care System

Who is covered?

Coverage is universal.

What is covered?

- Services: Publicly funded coverage – the National Health Service - includes preventive services; inpatient and outpatient hospital care; physician services; inpatient and outpatient drugs; dental care; mental health care; and rehabilitation. Free choice of general practitioner.
- Cost-sharing: There are relatively few cost-sharing arrangements for covered services (e.g., drugs prescribed by family doctors are subject to a prescription charge, but many patients are exempt, , dentistry services are subject to co-payments). Out-of-pocket payments account for 8 percent of health expenditures.

How are revenues generated?

- National Health Service (NHS): The NHS is administered by the NHS Executive, DH, and by Health Authorities. In 1997 the new government shifted from the internal market to integrated care, partnership, and long-term service agreements between providers and commissioners. More recent policy developments include an expansion of patient choice and a move to case-mix reimbursement of hospitals. The NHS, which is funded by a mixture of general taxation and national insurance contributions, accounts for 88 percent of health expenditures.
- Private Insurance: Mix of for-profit and not-for-profit insurers covers private medical care, which plays a complementary role to the NHS. Private insurance offers choice of specialists, avoidance of queues for elective surgery, and higher standards of comfort and privacy than the NHS. Private insurance covers 12 percent of the population and accounts for 4 percent of health expenditures.

How is the delivery system organized?

- Physicians: General practitioners (GPs) act as gatekeepers and are brought together in Primary Care Trusts—with budgets for most of the care of their enrolled population and responsibility for the provision of primary and community services. Most GPs are paid directly by the government through a combination of methods: salary, capitation, and fee-for-service, but some are employed locally and a new GP contract is about to introduce greater use of local contracting and introduce quality incentives. Private providers set their own fee-for-service rates but are not generally reimbursed by the public system.
- Hospitals: Mainly semiautonomous, self-governing public trusts that contract with Primary Care Trusts (PCTs). Latterly, some routine elective surgery has been procured for NHS patients from purpose built Treatment Centres, which may be owned and staffed by private sector healthcare providers. Consultants (specialist physicians) work mainly in NHS Trust hospitals but may supplement their salary by treating private patients.
- Government: Responsibility for health legislation and general policy matters rests with Parliament at Westminster and in Scotland and with the Assemblies in Wales and Northern Ireland.

How are costs controlled?

The government sets the budget for the NHS on a 3 year cycle. To control utilization and costs, the United Kingdom has controlled physician training, capital expenditure, pay, and PCT revenue budgets. There are also waiting lists. In addition a centralized administrative system results in lower overhead costs. Other mechanisms which contribute to improved value for money include arrangements for the systematic appraisal of new technologies (the National Institute for Clinical Excellence) and for monitoring the quality of care delivered (the Healthcare Commission).

The United States Health Care System

Who is covered?

- Public and private health insurance covers 84 percent of the population. 45.8 million Americans were uninsured in 2004.

What is covered?

- Services: Benefit packages vary according to type of insurance, but often include inpatient and outpatient hospital care and physician services. Many also include preventive services, dental care, and prescription drug coverage.
- Cost-sharing: Cost-sharing provisions vary by type of insurance. Out-of-pocket payments account for 14 percent of health expenditures.

How are revenues generated?

- Medicare: Social insurance program for the elderly, some of the disabled under age 65, and those with end-stage renal disease. Administered by the federal government, Medicare covers 14 percent of the population. The program is financed through a combination of payroll taxes, general federal revenues, and premiums. It accounts for 17 percent of total health expenditures. Beginning January 2006, Medicare will be expanded to cover outpatient prescription drugs.
- Medicaid: Joint federal-state health insurance program covering certain groups of the poor. Medicaid also covers nursing home and home health care and is a critical source of coverage for frail elderly and the disabled. Medicaid is administered by the states, which operate within broad federal guidelines. It covers 13 percent of the population and accounts for 16 percent of total health expenditures.
- Private Insurance: Provided by more than 1,200 not-for-profit and for-profit health insurance companies regulated by state insurance commissioners. Private health insurance can be purchased by individuals, or it can be funded by voluntary premium contributions shared by employers and employees on a negotiable basis. Private insurance covers 68 percent of the population,

including individuals covered by both public and private insurance. It accounts for 36 percent of total health expenditures.

- Others: Private and public funds account for 18 percent of expenditures.

How is the delivery system organized?

- Physicians: General practitioners have no formal gatekeeper function, except within some managed care plans. The majority of physicians are in private practice. They are paid through a combination of methods: charges, discounted fees paid by private health plans, capitation rate contracts with private plans, public programs, and direct patient fees.
- Hospitals: For-profit, non-profit, and public hospitals. Hospitals are paid through a combination of methods: charges, per admission, and capitation.
- Government: The federal government is the single largest health care insurer and purchaser.

How are costs controlled?

- Payers have attempted to control cost growth through a combination of selective provider contracting, discount price negotiations, utilization control practices, risk-sharing payment methods, and managed care.
- Recently, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included new provisions for tax credits for Health Savings Accounts (HSAs) when coupled with high deductible (\$1,000+) health insurance plans. HSAs allow individuals to save money tax-free to use on out-of-pocket medical expenses. Tax incentives plus double digit increases in premiums have led to a shift in benefit design toward higher patient payments.