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**DESCRIPTIONS OF HEALTH CARE SYSTEMS:  
FRANCE, GERMANY, AND THE NETHERLANDS**

**NOVEMBER 2009**



**MULTINATIONAL COMPARISONS OF HEALTH SYSTEMS DATA  
SELECTED INDICATORS FOR THIRTEEN COUNTRIES**

		Australia	Canada	Denmark	France	Germany	Italy	Netherlands	New Zealand	Norway	Sweden	Switzerland	U.K.	U.S.
Population, 2007	Total Population (1,000,000s of People)	21.0	33.0	5.5	61.7	82.3	58.9	16.4	4.2	4.7	9.1	7.6	61.0	301.6
	Percentage of Population Over Age 65	13.1%	13.4%	15.5%	16.4%	20.2%	19.7%	14.6%	12.5%	14.6%	17.4%	16.3%	16.0%	12.6%
Spending, 2007	Percentage of GDP Spent on Health Care	8.7% <sup>a</sup>	10.1%	9.8%	11.0%	10.4%	8.7%	9.8%	9.2%	8.9%	9.1%	10.8%	8.4%	16.0%
	Health Care Spending per Capita <sup>d</sup>	\$3,137 <sup>a</sup>	\$3,895	\$3,512	\$3,601	\$3,588	\$2,686	\$3,837	\$2,510	\$4,763	\$3,323	\$4,417	\$2,992	\$7,290
	Average Annual Growth Rate of Real Health Care Spending per Capita, 1997-2007	3.8% <sup>c</sup>	3.8%	3.5%	2.5%	1.7%	2.4%	4.2%	4.5%	2.4%	4.1%	2.3%	4.9%	3.7%
	Out-of-Pocket Health Care Spending per Capita <sup>c</sup>	\$571 <sup>a</sup>	\$580	\$485	\$246	\$470	\$542	\$213	\$351	\$720	\$528	\$1,350	\$343	\$890
	Hospital Spending per Capita <sup>d</sup>	\$1,184 <sup>a</sup>	\$1,070	\$1,554	\$1,240	\$1,027	n/a	\$1,310	\$985	\$1,615 <sup>a</sup>	\$1,488	\$1,564	n/a	\$2,309
	Spending on Pharmaceuticals per Capita <sup>d</sup>	\$431 <sup>a</sup>	\$691	\$301	\$588	\$542	\$518	\$422	\$241	\$381	\$446	\$454	n/a	\$878
	Spending on Services of Nursing and Residential Care Facilities per Capita <sup>d</sup>	n/a	\$399	\$417	\$236	\$275	n/a	\$430	\$225	\$735 <sup>a</sup>	n/a	\$760	n/a	\$435
Physicians, 2007	Number of Practicing Physicians per 1,000 Population	2.8 <sup>a</sup>	2.2	3.2 <sup>a</sup>	3.4	3.5	3.7	3.9	2.3	3.9	3.6 <sup>a</sup>	3.9	2.5	2.4
	Average Annual Number of Physician Visits per Capita	6.3	5.8 <sup>a</sup>	n/a	6.3	7.5	7.0 <sup>b</sup>	5.7	4.7	n/a	2.8 <sup>a</sup>	4.0	5.0	3.8 <sup>a</sup>
Hospital Spending, Utilization, and Capacity, 2007	Number of Acute Care Hospital Beds per 1,000 Population	3.5 <sup>a</sup>	2.7 <sup>a</sup>	2.9	3.6	5.7	3.1	3.0	n/a	2.9	2.1	3.5	2.6	2.7 <sup>a</sup>
	Hospital Spending per Discharge <sup>d</sup>	\$7,295 <sup>a</sup>	\$12,163 <sup>a</sup>	\$9,157	\$4,667	\$4,527	n/a	\$11,988	\$7,312	\$9,131 <sup>a</sup>	\$9,026	\$9,398	n/a	\$17,206 <sup>a</sup>
	Hospital Discharge per 1,000 Population	162 <sup>a</sup>	84 <sup>a</sup>	170	274	227	139 <sup>a</sup>	109	135	172	165	166	126	126 <sup>a</sup>
	Average Length of Stay for Acute Care	5.9 <sup>a</sup>	7.3 <sup>a</sup>	3.5 <sup>b</sup>	5.3	7.8	6.7 <sup>a</sup>	6.6 <sup>a</sup>	n/a	5.0	4.5	7.8	7.2	5.5
Prevention, 2007	Percentage of Children with Measles Immunization	94.0	n/a	89.0	87.0	95.4	89.6	95.9	82.0	92.0	96.0	87.0	86.2	92.3
	Percentage of Population over Age 65 with Influenza Immunization	77.5% <sup>a</sup>	64.3%	53.7% <sup>a</sup>	69.0%	56.0%	64.9%	77.0%	63.7%	n/a	n/a	56.0%	73.5%	66.7%
Medical Technology, 2007	Magnetic Resonance Imaging (MRI) Machines per Million Population, 2007	5.1	6.7	n/a	5.7	8.2	18.6	6.6 <sup>b</sup>	8.8	n/a	n/a	14.4	8.2	25.9
IT, 2006	Physicians' Use of EMRs(% of Primary Care Physicians) <sup>a</sup>	79%	23%	n/a	n/a	42%	n/a	98%	92%	n/a	n/a	n/a	89%	28%
Avoidable Deaths, 2002-03	Mortality Amenable to Health Care <sup>f</sup> (Deaths per 100,000 Population)	71	77	105	65	90	74	82	96	80	82	n/a	103	110
Health Risk Factors, 2007	Percentage of Adults Who Report Being Daily Smokers	16.6%	18.4%	25.0% <sup>b</sup>	25.0% <sup>a</sup>	23.2% <sup>b</sup>	22.4%	29.0%	18.1%	22.0%	14.5% <sup>a</sup>	20.4%	21.0%	15.4%
	Obesity (BMI>30) Prevalence	n/a	15.4%	11.4% <sup>b</sup>	10.5% <sup>a</sup>	13.6% <sup>b</sup>	9.9%	11.2%	26.5%	9% <sup>b</sup>	10.2%	8.1%	24.0%	34.3% <sup>a</sup>

Source: OECD Health Data 2009 (June 09) unless otherwise noted.

<sup>a</sup>2006

<sup>b</sup>2005

<sup>c</sup>1996-2006

<sup>d</sup>Adjusted for differences in the cost of living

<sup>e</sup>Source: Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2006

<sup>f</sup>Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, January/February 2008, 27(1):58-71

## The French Health Care System, 2009

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### Who is covered?

Coverage is universal; all residents are entitled to publicly-financed health care. Following the introduction of *Couverture Maladie Universelle* (CMU) in 2000, the state finances coverage for residents not eligible for coverage by the general public health insurance scheme (0.4% of the population). The state also finances health services for illegal residents (*L'Aide Médicale d'Etat*; AME).

### What is covered?

*Services*: The public health insurance scheme covers hospital care, ambulatory care and prescription drugs. It provides minimal coverage of outpatient eye and dental care. Preventive services (immunizations) are covered to a certain extent, usually for defined target populations.

*Cost-sharing*: Cost-sharing is widely applied to publicly-financed health services and drugs and takes three forms: co-insurance, co-payments, and extra billing.

Co-insurance rates are applied to all health services and drugs listed in the publicly-financed benefits package. Co-insurance rates vary depending on:

- the type of care: hospital care (20% plus a daily co-payment of €16/\$20 [\$24/29 USD), doctor visits (30%), dental care (30%)
- the type of patient: patients suffering from chronic conditions and poorer patients are exempt from cost sharing, though only if they are treated with services and supplies listed in the benefit package which is published and updated by the National Health Authority (HAS)
- the effectiveness of the prescription drug: 0% for highly effective drugs, 35%, 65% and 100% for drugs of limited therapeutic value
- whether or not patients comply with the recently-implemented gatekeeping system (*médecin traitant*). Visits to the gatekeeping general practitioner (GP) are subject to a 30% co-insurance rate, while visits to other GPs are subject to a co-insurance rate up to 50%; the difference between the two rates cannot be reimbursed by complementary private health insurance (see below).

In addition to cost-sharing through co-insurance, which can be fully reimbursed by complementary private health insurance, the following non-reimbursable co-payments apply, up to an annual ceiling of €50 (\$74 USD): €1 per doctor visit (\$1.49 USD), €0.50 (\$0.74 USD) per prescription drug, €2 (\$2.98 USD) per ambulance journey and €18 (\$27 USD) for expensive hospital treatment.

Reimbursement by the publicly-financed health insurance scheme is based on a reference price. Doctors and dentists may charge above this reference price (extra billing) based on their level of professional experience. The difference between the reference price and the extra billed amount must be paid by the patient and may or may not be covered by complementary private health insurance depending on the contract. Out-of-pocket payments, including both cost-sharing and expenditure paid directly by private households, accounted for 7% of total national health expenditures in 2007.

*Safety nets*: Exemptions from co-insurance apply to people with 30 chronic illnesses, people with low income, and people receiving invalidity and work injury benefits. Hospital co-insurance only applies for the first 31 days in hospital and some surgical interventions are exempt. Children and people with low income are exempt from paying non-reimbursable co-payments. Complementary private health insurance covers statutory cost-sharing (the share of health care costs not reimbursed by the health insurance scheme). It only applies to health services and prescription drugs listed in the publicly-financed benefits package. Most people obtain complementary private coverage through their employer. Since 2000, people with low income are entitled to free or subsidized complementary private cover (CMU-C) and free eye and dental care; in addition, they cannot be extra billed by doctors. Complementary private health insurance covers over 92% of the population. In 2007 out-of-pocket payments and private health insurance accounted for 8.5% and 13.6% of total health expenditure respectively (comptes nationaux de la santé en 2007).

## How is the health system financed?

*Publicly-financed health care:* Public expenditure accounted for 78% of total expenditure on health in 2008, of which the public health insurance scheme contributed 76.6%. The public health insurance scheme is financed by employer and employee payroll taxes (43%); a national income tax (*contribution sociale généralisée*; 33%) created in 1990 to broaden the revenue base for social security; revenue from taxes levied on tobacco and alcohol (8%); state subsidies (2%); and transfers from other branches of social security (8%). There is no ceiling on employer (12.8%) and employee (0.75%) contributions, which are collected by a national social security agency. Coverage for those not eligible for the public scheme or complementary private coverage is mainly financed by the state through an earmarked tax on tobacco and alcohol and a 5.9% tax on the revenue of complementary private health insurers.

*Government:* The public health insurance funds are managed by a board of representatives, with equal representation from employers and employees (trades unions). Every year parliament sets a (soft) ceiling for the rate of expenditure growth in the public health insurance scheme for the following year (ONDAM<sup>1</sup>). In 2004 a new law created two new associations, the National Union of Health Insurance Funds (UNCAM<sup>2</sup>) and the National Union of voluntary health insurers (UNOCAM<sup>3</sup>), incorporating all public health insurance funds and private health insurers respectively. The law also gave the public health insurance funds responsibility for defining the benefits package and setting price and cost-sharing levels.

*Private health insurance:* Complementary private health insurance reimburses statutory cost-sharing. It is mainly provided by not-for-profit employment-based mutual associations (*mutuelles*), which cover 87% to 90% of the population. It only covers those services that are already covered by the public health insurance scheme. There is some evidence to show that the quality of coverage purchased (in other words, the extent of reimbursement) varies by income group. Since 2000, people with low income (unemployed people, people with low income and people receiving

single parent subsidies) and their dependants have been entitled to obtain complementary private cover at little to no cost (CMU-C). CMU-C covers about five million people via a voucher which can be used to obtain cover from a variety of insurers, although most choose to obtain cover from the public health insurance scheme. More recently, for-profit commercial insurers have begun offering coverage for services not included in the public benefits package such as psychotherapy or acupuncture.

## How is the delivery system organized?

*Health insurance funds:* Public health insurance funds are statutory entities and membership is based on occupation, so there is no competition between them. There is limited competition among mutual benefit societies providing complementary private health insurance, but as they are employment-based, most employees usually only have a choice of one or two *mutuelles*. There is no system of risk adjustment among *mutuelles*, even though there is inadvertent risk selection based on occupation.

*Physicians (non-hospital based physicians):* The 2004 health financing reform law introduced a voluntary gatekeeping system for adults (aged 16 years and over) known as *médecin traitant*. There are strong financial incentives for patients to encourage gatekeeping, with higher co-payments for visits and prescriptions without a referral from the gatekeeper. Physicians are self-employed and paid on a fee-for-service basis. The cost per visit is slightly higher for specialists (€23 [\$34 USD]) than for GPs (€22 [\$33 USD]) and is based on negotiation between the government, the public insurance scheme and the medical unions. Depending on the total duration of their medical studies, physicians may charge above this level. There is no limit to what physicians may charge, but medical associations recommend tact in determining fee levels.

The 2009 “Hospital, Patients, Health, Territories” Reform Act attempted to improve access to care in deprived areas by creating negative incentives for physicians who set up practice in areas with current oversupply. Opposition from the physicians unions has led to the withdrawal of the measure; however; nurses’ unions have agreed to a similar arrangement with the MoH.

<sup>1</sup> Objectif National de Dépenses d’Assurance Maladie.

<sup>2</sup> Union Nationale des Caisses d’Assurance Maladie.

<sup>3</sup> Union Nationale des Organismes Complémentaires d’Assurance Maladie.

*Hospitals:* Two-thirds of hospital beds are in government-owned or not-for-profit hospitals. The remainder are in private for-profit clinics. All university hospitals are public. Hospital physicians in public or not-for-profit facilities are salaried. Since 1968, hospital physicians have been permitted to see private patients in public hospitals, an anachronism originally intended to attract the most prestigious doctors to public hospitals, and one that has survived countless attempts to abolish it. From 2008, all hospitals and clinics will be reimbursed via the DRG-like prospective payment system (the original DRG scheme was only to be fully implemented by 2012). Public and not-for-profit hospitals benefit from additional non activity-based grants to compensate them for research and teaching (up to an additional 13% of the budget) and for providing emergency services and organ harvesting and transplantation (on average an additional 10-11% of a hospital's budget).

#### **What is being done to ensure quality of care?**

An accreditation system is used to monitor the quality of care in hospitals and clinics. The quality of ambulatory care rests on a system of professional practice appraisal. Both systems are mandatory, under the responsibility of the national health authority (HAS) created in 2004. Hospitals must be accredited every four years by a team of experts. The accreditation criteria and reports are publicly available via the HAS website ([www.has-sante.fr](http://www.has-sante.fr)). Every fifth year, physicians are required by law to undergo an external assessment of their practice in the form of an audit. For hospital physicians, the practice audit can be performed as part of the accreditation process. For physicians in ambulatory practice, the audit is organized by an independent body approved by HAS (usually a medical society representing a particular specialty). Dentists and midwives will soon have to undergo a similar process. In addition, HAS undertakes comparative effectiveness review of all new drugs, devices, and medical procedures before their inclusion in the public benefit package. It also publishes guidelines on care and defines best-care standards.

#### **What is being done to improve efficiency?**

Improving efficiency is the major challenge facing the public health insurance funds, which are currently working on structural and procedural changes. Structural changes involve the creation of a national computerized

system of medical records to limit duplication of tests, over-prescribing and adverse drug side effects, and to facilitate the implementation of prospective payment for all hospitals and clinics from 2008. Procedural changes on the supply side mainly focus on two issues: the reorganization of inputs (for example, by transferring some physician tasks to nurses or other professionals) and improved coordination of care (particularly for patients with chronic illnesses). On the demand side, the main health insurance scheme is experimenting with patient education and hotlines. From 2008 it will also transfer some drugs to over-the-counter status. The "Hospital, Patients, Health, Territories" Reform Act voted on in July 2009 reformed the governance of public and not-for-profit hospitals by increasing the role of the hospital director in defining the strategies and deciding on the hospital's operations. At the regional level, one single authority (regional health agency) combines the roles of purchaser of hospital and ambulatory care, planner and regulator. Notably for a Bismarckian health system, the 2009 reform merged State and Sickness Fund administration.

#### **How are costs controlled?**

Cost control is a key issue in the French health system, as the health insurance scheme has faced large deficits for the last 20 years. More recently the deficit has fallen, from €10-12 billion per year in 2003 (\$15-18 billion USD) to €5 billion (\$7.4 billion USD) in 2009. This may be partly attributable to the following changes, which have taken place in the last three years:

- a reduction in the number of acute hospital beds
- limits on the number of drugs reimbursed; around 600 drugs have been removed from public reimbursement in the last few years
- an increase in generic prescribing and the use of over the counter drugs
- a requirement to deliver a generic drug unless otherwise specified on the prescription
- the introduction of a voluntary gatekeeping system in primary care
- a basic benefit packages for the management of chronic conditions
- since 2008, new co-payments for prescription drugs, doctor visits and ambulance transport are not reimbursable by complementary private health insurance

At the same time, there has been an increase in the number of medical students admitted to university due to an expected shortage of doctors in the coming decade. Public funding has also had to increase to accommodate a rise in the fee schedule, since GPs are now considered as specialists and their cost per visit has risen from €20 (\$30 USD) to €23 (\$34 USD).

The economic downturn constitutes a threat for the state budget in general (the forecasted public deficit for 2009 is 3.9% of GDP) and the health insurance scheme as the revenue base shrinks.

### **What recent system innovations and reforms have been introduced?**

The major innovations concern the governance of public and not-for profit hospitals and the creation of regional health agencies that merge sickness funds and State administrations at the regional level. More than simply creating administrative economies of scale, this merger creates one department responsible for health care and public health policies, managed care, and social services (previously overseen by seven departments). This is intended to be a major step towards a more consistent system.

In April 2009, the SHI launched a series of individual contracts with office-based physicians (Contrats d'Amélioration des Pratiques Individuelles CAPI). These contracts link monetary rewards up to €5,000 (\$7,357 USD) per year to the achievement of targets in the process of care for asthma, diabetes, hypertension, immunization, and breast cancer screening. The contracts also stipulate the prescription of generic drugs, particularly for cardiovascular conditions. The physicians' unions, the national physicians' regulation authority and the union of pharmaceutical industry opposed these contracts in court, on the grounds that 1) individual contracts (opposed to contracts negotiated between the SHI and the unions) undermine the basis of a Bismarckian health system; 2) the physician-patients relationship should not be polluted by the suspicion that physicians may not prescribe in the best interest of the patients; 3) by setting targets for generic prescribing, the contracts might limit patients access to innovative medicines. Three months after implementation, however, the contracts had been accepted by over 5,000 GPs (or 10% of the total GP population) – far more than the initial forecasts. Some incentives to coordinate care are available; GPs who manage patients with chronic conditions receive an additional €40 (\$59 USD) per patient. Social

health insurance also finances a number of providers' networks that coordinate hospital and out-of-hospital care for diabetes, cancer, chronic renal failure and multiple sclerosis.

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## The German Health Care System, 2009

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### Who is covered?

Since 2009, health insurance is mandatory in Germany for all citizens, either in the social or in the private health insurance scheme, depending on previous insurance and/or job status. All employed citizens earning less than €4,050 (\$5,959 USD) per month or €48,600 (\$71,514 USD) per year [in 2009] are covered by a mandatory public health insurance scheme – the Statutory Health Insurance (SHI). Their dependents (non-earning spouses and children) are covered free of charge. Exception rules apply to the self-employed and civil servants. Individuals whose gross wages exceed €48,600 per year for three consecutive years (around 20% of the population) may either choose to remain in the publicly-financed scheme on a voluntary basis (and 75% of them do) or may choose to purchase private health insurance. The SHI scheme covers about 85% of the population. Around 10% of the population are covered by private health insurance, with civil servants and the self-employed being the largest groups. The remaining persons, e.g. soldiers, policemen and others, fall under special regimes.

### What is covered?

*Services:* The SHI benefits package covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, prescription drugs, medical aids, rehabilitation, and sick leave compensation. Since 1995, long-term care is covered by a separate insurance scheme, which is mandatory for the whole population.

*Cost-sharing:* Traditionally, the SHI scheme has imposed few cost-sharing provisions (mainly for pharmaceuticals and dental care). However, in 2004 co-payments were introduced for office visits in ambulatory care (GPs, specialists and dentists) for adults aged 18 years and older (€10; \$15 USD for the first visit per quarter or subsequent visits without referral). Other co-payments were made more uniform: €5 to €10 (\$7-15 USD) per outpatient prescription (except if the price is at least 30% below the so-called

reference price, i.e. the maximum reimbursable amount for drugs of equivalent effectiveness, which is the case for more than 12,000 drugs), €10 per inpatient day for hospital and rehabilitation stays (up to 28 days per year), and €5 to €10 for prescribed medical aids. In total, out-of-pocket payments accounted for 13% of total health expenditure in 2007.

*Safety Nets:* Cost-sharing is generally limited to 2% of household income. For additional family members, part of the household income is excluded from this calculation. For chronically ill patients, there is a cost-sharing threshold of 1% of annual gross income. A directive lists conditions which are regarded as chronic disease; patients who suffer from breast cancer, cervical cancer and colon cancer have to demonstrate that they attended recommended counselling on screening measures prior to the illness in order to qualify for the 1% threshold.

### How is the health system financed?

*Statutory Health Insurance Scheme (SHI):* The SHI scheme is operated by about 180 competing health insurance funds (called “sickness funds”): autonomous, not-for-profit, non-governmental bodies regulated by law. The scheme is funded by compulsory contributions levied as a percentage of gross wages up to a certain threshold. Earnings exceeding €3,675 (\$5,408 USD) per month or €44,100 (\$64,897 USD) per year [in 2009] are exempt from contribution payments. As of July 2009, the insured employee (or pensioner) contributes 7.9% of the gross wage, while the employer (or the pension fund) adds another 7.0% on top of the gross wage, so the combined maximum contribution is around €548 (\$806 USD) per month. This includes dependents (non-earning spouses and children), who are covered through the primary sickness fund member. Unemployed people contribute in proportion to their unemployment entitlements, but for long-term unemployed people with a fixed low entitlement (so-called “Hartz IV”), the government pays a fixed per capita premium.

Since 2009, a uniform contribution rate is set by the government and, although sickness funds continue to collect contributions, all contributions are centrally pooled by a new central health fund, which allocates resources to each sickness fund based on an improved risk-adjusted capitation formula. This formula takes age, sex, and morbidity from 80 chronic and/or serious illnesses into account. This means that sickness funds will receive considerably more for patients with cancer, AIDS or cystic fibrosis than for “ordinary” insured. Since 2009, sickness funds may charge the insured person an additional nominal premium if the received resources are insufficient (or pay back money if they have left over funds). So far, just one small sickness fund has raised an extra premium. Since 2004, there is a growing amount of tax-financed federal subsidy for “insurance-extraneous” benefits provided by the SHI (especially coverage of children). These expenses are considered to be of common interest and therefore are (partly) covered from general taxes. The subsidies will rise from €7.2 billion (\$10.6 billion USD) up to €14 billion (\$21 billion USD) in 2012. In 2007, the SHI scheme accounted for 61% of total health expenditure.

*Private health insurance (PHI):* Private health insurance plays a substitutive role in covering the two groups who are mostly exempt from the SHI (civil servants, who are refunded parts of their health care costs by their employer, and the self-employed), as well as high earners who choose to opt out of the SHI scheme. All pay a risk-related premium, with separate premiums paid for dependents; the risk is assessed upon entry only, though contracts are based on life-time underwriting. Private health insurance is regulated by the government to ensure that the insured do not face massively increasing premiums by age and that they are not overburdened by premiums if their income decreases. Since January 2009, private insurers offering substitutive coverage are required to take part in a risk adjustment scheme (separate from SHI) to be able to offer basic insurance for persons with ill health who are assigned to PHI due to previous insurance or profession and who could otherwise not afford a risk-related premium. In addition recent legislation aimed to intensify competition between insurers. Private health insurers are forced by law to set aside savings (i.e., “aging reserves”) for old age from the insurance premiums when the insured are young in order to slow the increase of premiums as they age. Previously, these aging reserves remained with the insurer when a person cancelled his/her policy or changed to another insurer. Since January 2009, individual aging reserves are transferable if privately insured persons cancel their

policy and change to another insurer. PHI also plays a mixed complementary and supplementary role, adding certain minor benefits to the SHI basket, providing access to better amenities, such as single/double hospital rooms, and covering some co-payments, especially for dental care. In 2007, PHI accounted for 9.3% of total health expenditure.

### **How is the delivery system organised?**

*Physicians:* General practitioners have no formal gatekeeper function. However, since 2004 sickness funds are required to offer their members the option to enroll in a “family physician care model” which has been shown to not only provide better services, but often also a bonus for complying with gatekeeping rules. Ambulatory care in all specialties is mainly delivered by physicians working in solo practices, although polyclinic-type ambulatory care centers with employed physicians have been allowed since 2004. Physicians in ambulatory care are generally reimbursed via fee-for-service, which however are increasingly bundled. Sickness funds annually negotiate aggregate payments with the regional associations of physicians, which ensures service provision and cost control.

*Hospitals:* Hospitals are mainly non-profit, both public (about half of all beds) and private (around one-third of all beds). The private, for-profit segment has been growing in recent years (around one-sixth of all beds), mainly through takeovers of public hospitals. Independent of ownership, hospitals are principally staffed by salaried doctors. Senior doctors may also treat privately insured patients on a fee-for-service basis. Doctors in hospitals are typically not allowed to treat outpatients. Exceptions are made if necessary care cannot be provided on an outpatient basis by specialists in private practice. Since 2004, hospitals may also provide certain highly specialized services on an outpatient basis. Inpatient care is paid through a system of diagnosis-related groups (DRG) per admission, currently based on 1,192 DRG categories. The system was made obligatory in 2004 and is revised annually to take new technologies, changes in treatment patterns, and associated costs into account.

Individuals have free choice of ambulatory care physicians and, if referred to inpatient care, of hospitals.

*Disease Management Programs (DMPs):* Legislation in 2002 implemented DMPs for chronic illnesses in the SHI to incentivize the sickness funds to better care for chronically ill patients. Sickness Funds are paid a lump sum for each enrollee and can waive co-payments for insured in the programs. DMPs currently exist for diabetes types 1 and 2, breast cancer, coronary heart disease, asthma and chronic obstructive lung disease. They are based on evidence-based treatment recommendations with mandatory documentation and quality assurance. Sickness funds receive a per capita administration compensation of €62 per year (\$386 USD) for each insured enrolled in a DMP. In October 2009 there were 13,087 regional DMPs registered with more than 5 million patients enrolled (more than 7% of all SHI-insured).

*Government:* The German government delegates regulation to the self-governing corporatist bodies of both the sickness funds and the medical providers' associations. The most important body is the Federal Joint Committee (G-BA), which was created in 2004 to replace several sectoral committees. Within the legal framework, the G-BA has wide-ranging regulatory power to formulate and implement in detail what services will be provided by the sickness funds. One of its most important responsibilities is to assess new methods of medical diagnosis and treatment, which must gain a positive evaluation in terms of benefits and efficiency before they can be reimbursed by the sickness funds. Some purchasing powers have also been given directly to the individual sickness funds, e.g. to contract providers directly, to negotiate rebates with pharmaceutical companies or negotiate contracts with manufacturers.

### **What is being done to ensure quality of care?**

Quality of care is addressed through a range of measures: *Structural quality* is addressed by the requirement to have a quality management system for all providers, the obligation for continuous medical education for all physicians, and health technology assessment for drugs and procedures (for which the Institute for Quality and Efficiency, IQWiG, was founded in 2004). Hospital accreditation is voluntary. Minimum volume requirements were introduced for a number of complex procedures (e.g. transplantations), thereby requiring hospitals to provide this number in order to be reimbursed. *Process and partly outcome quality* is addressed through the mandatory quality reporting system for all of about 2,250 acute care

hospitals. Under this system, more than 150 indicators are measured for 30 indications covering about one-sixth of all inpatients in Germany. Hospitals receive an individual feedback. Since 2007, around 30 indicators are made public in annual, mandatory hospital quality reports. From 2010, a new institute has been charged with developing quality assurance across ambulatory and inpatient care.

### **What is being done to improve efficiency?**

Besides the measures to improve quality listed above, a set of other measures addresses efficiency more directly. All drugs, both patented and generic, have been subject to reference prices since 2004, unless they can demonstrate a clear added medical benefit. Since 2008, IQWiG is legally charged with explicitly evaluating the cost-effectiveness of drugs, thereby adding pressure on pharmaceutical prices. As mentioned, all hospitals are reimbursed through DRGs, so hospitals are paid the same for the same type of patient. As DRGs weights are calculated based on average costs, this puts enormous pressure on less efficient hospitals.

### **How are costs controlled?**

In line with placing more emphasis on quality and efficiency, previously imposed, relatively crude, but successful cost-containment measures (especially overall budgets for ambulatory physicians, hospital budgets, collective prescription caps for physicians on a regional basis) have been carefully revised. The prescription cap, which complemented the reference prices for pharmaceuticals, was lifted in 2001, initially leading to an unprecedented increase in spending on pharmaceuticals by the sickness funds. Then, prescription caps with physicians liable for exceeding regular volume for their patient mix were introduced. More recently negotiated rebates between sickness funds and pharmaceutical manufacturers and incentives to lower prices below the reference prices are the major instruments. Hospital budgets have been phased out between 2005 and 2009, while per-case DRGs have become the main instrument to reimburse inpatient care. Since 2009, the fixed budgets for ambulatory care have been replaced by more flexible budgets that take population morbidity into account.

### **What recent system innovations and reforms have been introduced?**

*Rating quality of care in nursing homes and ambulatory long-term care providers:* Since 2009 nursing homes and ambulatory long-term care providers are evaluated in 5 areas with respect to over 50 quality indicators by an independent institution. They are rated on grades equivalent to school marks and the results are posted on the internet. This simple procedure is designed to improve transparency in several important areas of long-term care.

*Incentives for minimizing health service utilization and taking part in prevention programs:* Sickness funds may offer reduced contributions or lower copayments to patients who agree to take part in schemes thought to reduce the burden of morbidity and health care costs—for example, minimizing use of health care services or taking part in specific disease management programs. Some schemes are binding for a minimum of three years.

*Sustainability of health care financing:* The central health fund ("Gesundheitsfonds"), introduced in 2009, has provided social health

insurers with stable and reliable revenues, which is of particular importance for coping with the financial and economic crisis. Despite the major challenges of the previous year the sickness funds have reported surpluses for the first half of 2009; so far, nominal premiums above the uniform contribution rate are a very rare exception, but may become introduced by more sickness funds in 2010.

*Enhancing competition:* A central element of the latest health care reform (2007) is enhancing competition in health care services. The introduction of various elective insurance schemes or plans by the sickness funds – including new forms of health care provision such as DMPs or family physician care models – offers more choices for the insured and gives leeway for insurers to compete. Elective insurance plans include, for example, sick pay for the self-employed, or patients can opt for alternative deductible or cost-sharing schemes. The sickness fund may charge an extra premium covering additional costs or – e.g. in the case of deductibles – pay a premium to members signing up. The sickness funds are obliged by law to report regularly on the results of elective insurance plans, notably on efficiency and savings.

## The Dutch Health Care System, 2009

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### Who is covered?

Since January 1, 2006, all residents or those paying income tax in the Netherlands are required to purchase health insurance coverage, excepting those with conscientious objections and active members of the armed forces. Coverage is statutory under the Health Insurance Act (*Zorgverzekeringswet*; ZVW) but provided by private health insurers and regulated under private law. In 2007, roughly 231,000 persons (1.5% of the Dutch population) were uninsured, and there were 240,000 defaulters. In 2009-10 additional policy measures will enforce the mandate and payment of the insurance premiums. Asylum seekers are covered by the government and several mechanisms are in place to reimburse the health care costs of illegal immigrants unable to pay for care. New legislation creating a government fund to cover some of the health care costs of illegal immigrants was implemented in 2008.

Prior to 2006, people with earnings above approximately €30,000 (\$44,200 USD) per year and their dependants (around 35% of the population) were excluded from statutory coverage provided by public sickness funds and could purchase coverage from private health insurers. This form of substitutive private health insurance was regulated by the government to ensure older people and people in poor health had adequate access to health care and to compensate the publicly-financed health insurance scheme for covering a disproportionate amount of high risk individuals. Over time, growing dissatisfaction with the dual system of public and private coverage led to the reforms of 2006.

### What is covered?

*Services:* Insurers are legally required to provide a standard benefits package covering the following: medical care, including care by general practitioners (GPs), hospitals and midwives; hospitalization; dental care (up to the age of 18; coverage from age 18 is confined to specialist dental care and dentures); medical aids; medicines; maternity care; ambulance and patient transport services; and paramedical care (limited physiotherapy/

remedial therapy, speech therapy, occupational therapy and dietary advice). Insurers may decide by whom and how this care is delivered, which gives the insured a choice of policies based on quality and costs. In addition to the standard benefits package, all citizens are covered by the statutory Exceptional Medical Expenses Act (*AWBZ*) scheme for a wide range of chronic and mental health care services such as home care and care in nursing homes. Most people also purchase complementary private health insurance for services not covered by the standard benefits package, such as adult dental care, although insurers are not required to accept all applications for private health insurance.

*Cost-sharing:* The insured pay a flat-rate premium (set by insurers) to their private health insurer. Everyone with the same policy pays the same premium, regardless of age or health status. Every insured person aged 18 and over must pay the first €155 (\$228 USD) of any health care costs in a given year (with some services, like GP-care, excluded from this general rule). Out-of-pocket payments, including both cost-sharing and expenditure paid directly by private households, accounted for 6% of total national health expenditures in 2007.

*Safety nets:* Children are exempt from cost-sharing. The government provides 'health care allowances' for low income citizens if the average flat-rate premium exceeds 5% of their household income.

### How is the health system financed?

*Statutory health insurance:* The statutory health insurance system (ZVW) is financed by a mixture of income-related contributions and premiums paid by the insured. The income-related contribution is set at 6.9% of the first €32,369 (\$47,644 USD) of annual taxable income. Employers must reimburse their employees for this contribution and employees must pay tax on this reimbursement. For those who do not have an employer and do not receive unemployment benefits, the income-related contribution is 4.8%. The contribution of self-employed people is individually assessed by the Tax Department. Contributions are collected centrally and distributed

among insurers based on a sophisticated risk-adjusted capitation formula, which considers age, gender, labor force status, region, and health risk (based on past drug and hospital utilization). In 2009 the average annual premium was €1,065 (\$1,568 USD). The government pays for the premiums of children up to the age of 18. In 2008 the total spending on health care was €9 billion (\$116 billion USD).

*Private health insurance:* Substitutive private health insurance was abolished in 2006. Most of the population purchase a mixture of complementary and supplementary private health insurance from the same health insurers who provide statutory coverage. This has given rise to concerns about the potential for risk selection, as the premiums and products of voluntary coverage are not regulated. In 2005, private health insurance accounted for 13% and in 2006 for 3.1% of the total costs.

### **How is the delivery system organized?**

*Health insurance funds:* Insurers are private and governed by private law. They are permitted to have for-profit status. They must be registered with the Supervisory Board for Health Insurance (CVZ) to enable supervision of the services they provide under the Health Insurance Act and to qualify for payments from the risk equalization fund. The insured have free choice of insurer, and insurers must accept every resident all applicants. A system of risk equalization/adjustment is used to prevent direct or indirect risk selection by insurers.

*Physicians:* Physicians practice directly or indirectly under contracts negotiated with private health insurers. GPs receive a capitation payment for each patient on their 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 for quality in primary and hospital care are ongoing.

*Hospitals:* Most specialists are hospital-based. Two-thirds of hospital-based specialists are self-employed, organized in partnerships; the remainder are salaried. Most hospitals are private non-profit organizations. Hospital budgets were previously developed using a formula that paid a fixed amount per bed, patient volume, number of licensed specialists, and other factors. Additional funds were provided for capital investment. Since 2006,

hospitals are increasingly encouraged to obtain capital via the private market. Currently, payment of 34% of the hospital care takes place through the Dutch version of DRGs known as Diagnosis Treatment Combinations (DTCs). These DTCs cover both the hospital costs and the specialists costs, thereby strengthening the integration of the specialist in the hospital organization. Although a substantial part of the hospital/specialist reimbursements through DTCs are still budgetary framed and based on fixed prices, an increasing part is subject to market forces through negotiation on price with the insurers.

### **What is being done to ensure quality of care?**

At the health system level, quality of care is ensured through legislation regarding professional performance, quality in health care institutions, patient rights and health technologies. The Dutch Health Care Inspectorate is responsible for monitoring and other activities. Most quality assurance is carried out by health care providers in close cooperation with patient and consumer organizations and insurers. Mechanisms to ensure quality in the care provided by individual professionals involve re-registration/re-validation for specialists based on compulsory continuous medical education; regular on-site peer assessments organized by professional bodies; profession-owned clinical guidelines, indicators and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programs based on the breakthrough method (Sneller Beter). Patient experiences are systematically assessed and, since 2007, a national center has been working with validated measurement instruments comparable to the CAHPS approach in the United States. The center also generates publicly-available information for consumer choice.

### **What is being done to improve efficiency?**

The main approach to improving efficiency in the Dutch health system rests on regulated competition between insurers combined with central steering on performance and transparency about outcomes via the use of performance indicators. This is complemented by provider payment reforms involving a general shift from a budget-oriented reimbursement system to a performance-related approach (for example, the introduction of

DTCs mentioned above). In addition, various local and national programs aim to improve health care logistics and/or initiate 'business process re-engineering'. At a national level, health technology assessment (HTA) is used to enhance value for money by informing decision making about reimbursement and encouraging appropriate use of health technologies. At the local level, several mechanisms are used to ensure appropriate prescribing. Dutch authorities are working to establish a central HIT network to enable information exchange across sites of care.

### **How are costs controlled?**

The new Health Insurance Act aims to increase competition between private health insurers and providers to control costs and increase quality. Insurers are required to charge the same premiums for the same benefits but may selectively contract with providers, leading insurers to compete on quality rather than risk-selection, and publicly reported quality information provides transparency. However, there is an awareness of rising costs. Increasingly, costs are expected to be controlled by the new DTC system in which hospitals must compete on price for specific services.

### **What system innovations have been introduced?**

The major change of the insurance system took place in 2006 with the introduction of a universal insurance scheme executed by private insurers. This created a level playing field. There is an ongoing review about the coverage of both the standard insurance scheme and the Exceptional Medical Expenses Act. Progress has been made on producing indicator information, although improving transparency remains a focus. In the budget for 2010, reductions are foreseen for specialists costs (which rose more in the past year than planned) and for care allowances via tax reductions. The economic crisis has so far not significantly affected health care costs, but major cost reductions are foreseen once the economy recovers. Renewed emphasis has been given to prevention (i.e. support to quit smoking will be included in the standard benefit package) and disease management on specific chronic disease groups will be strengthened through the introduction of new financing schemes for integrated care.

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