

SELECTED EUROPEAN COUNTRIES' HEALTH SYSTEMS AND THE UNITED STATES

Country, population, and various percentages spent on health care	How health care coverage is financed	What benefits are included	The role of health plans, hospitals, and providers
<p>AUSTRIA</p> <p>Population: 8.2M</p> <p>Health care as % of GDP: 10.3%</p> <p>% paid out of pocket: 14.7%</p> <p>% of earnings/income tax: 7.65%, split almost evenly between employers and employees</p>	<p>Health care is financed 45% by the social health insurance system; 25% by the federal government; 21% by user charges and direct payments; 2% from private funds; and 2% from voluntary health insurance. Contributions are 7.65% in 2008, split evenly between employers and employees.</p> <p>Only 2.4% of the population has no coverage, including some groups of unemployed people and asylum seekers. However, these groups may eventually be covered by public health services upon requests put forward individually.</p> <p>About 12% of the population is exempted from direct cost-sharing.</p> <p>Around a third of the population buys private health insurance to supplement the basic package. This typically provides for more comfortable hospital rooms and covers the direct costs of non-contracted physicians. It also covers <i>additional</i> fee-for-service payments for specialists (both inpatient and outpatient services).</p>	<p>Services include:</p> <ul style="list-style-type: none"> • Medical treatment • Dental treatment (without fixed dentures) • Psychotherapy • Physiotherapy • Ergo therapy • Speech therapy • Medicine and therapeutic aids • Medical nursing care • Rehabilitation • Hospital treatment and stays at spas • Sick pay and maternity benefits 	<p>21 social insurance institutions negotiate with regional physicians' chambers for outpatient care provision by contracted physicians. They pay a per-capita flat rate for basic services and fee-for-service remuneration for services beyond these. Non-contracted physicians are reimbursed 80% of the fee usually charged by contracted physicians. There is regulated competition between service providers for patients and contracts with the social insurance institutions, but not between the health insurance funds themselves.</p> <p>Nine provincial governments are responsible for the provision of hospitals and long-term care institutions as well as public health service and ambulances. About 68% of hospital beds are publicly owned; 17.5% are owned by private nonprofit organizations; 8.5% are owned by social insurance institutions; and 6% are private and for-profit.</p>

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<p>BELGIUM</p> <p>Population: 10.5M</p> <p>Health care as % of GDP: 9.8%</p> <p>% of earnings/income tax: 3.55% for employees; 3.8% for employers</p>	<p>Compulsory social health insurance provides a comprehensive benefit package to 99% of the population, funded by employer/employee contributions and mandatory contributions from the self-employed. Patients finance 23.5% of health expenditures through out-of-pocket payments and voluntary health insurance premiums. Subsidies are available for low-income residents, and out-of-pocket payments are capped for everyone.</p> <p>The National Institute for Sickness and Disability oversees the health care system, transferring funds to dozens of not-for-profit and privately managed sickness funds. About 30% of Belgians also carry private insurance.</p>	<p>The health system provides comprehensive health care coverage to almost all the population while maintaining a wide degree of choice for the insured and providers. Patients have free choice of provider, hospital, and sickness fund, and there is no referral system.</p> <p>Ambulatory care is paid at 75% and reimbursed after proof of care. For hospital care, patients have to pay a fee according to their family and employment status and length of stay. The fee ranges between 40.33 € and 4.64 € (euros) a day. Pharmaceuticals are divided into five reimbursement categories. The reimbursement system promotes the use of generic drugs.</p>	<p>Most doctors, dentists, pharmacists, and physiotherapists are self-employed and paid on a fee-for-service basis. Fees are negotiated on a national level between the National Committee of Sickness Funds and providers' representatives.</p> <p>Communities are responsible for most health promotion and preventive services. Hospitals (mostly private) are paid according to a prospective diagnosis-related group (DRG) payment scheme.</p>

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<p>CZECH REPUBLIC</p> <p>Population: 10.3M</p> <p>Health care as % of GDP: 7.2%</p> <p>% paid out of pocket: 10.4%</p> <p>% of earnings/income tax: 4.5% for employees and 9% for employees. (Self-employed pay 13.5%.)</p>	<p>Health care is financed through compulsory health insurance (80%), taxes (10%), and out-of-pocket payments (10%). Nine nonprofit health insurance funds receive compulsory contributions from employees and employers (4.5% and 9% of gross wages respectively). The self-employed pay 13.5%, but only on 35% of their profits. All contributions have a ceiling.</p> <p>The state contributes on behalf of the unemployed, retired, children, dependents under 26, students, women on maternity leave, military personnel, prisoners, and those on welfare.</p> <p>There is only a very small market (less than 0.1% of health expenditures) for voluntary insurance due to the very high level of benefits covered by statutory health insurance, which even includes spas and over-the-counter drugs.</p>	<p>Individuals, not employers, choose health insurance funds and can switch once every 12 months.</p> <p>The level of benefits is very high, virtually eliminating the demand for supplementary private health insurance. Benefits include full or partial coverage of:</p> <ul style="list-style-type: none"> • Preventive services • Diagnostic procedures • Ambulatory and curative care, including rehabilitation and care for the chronically ill • Drugs and medical devices • Medical transportation services • Spa therapy (if prescribed by a physician) <p>Only a few services are excluded, including purely cosmetic surgery, certain kinds of dental care (such as dentures), and specific prostheses, eyeglasses, and hearing aids.</p>	<p>Mainly private ambulatory care (95%) providers and public hospitals (90% of beds) work under contract with the health insurance funds, which compete for members. A number of polyclinics and small hospitals have been privatized, along with 75% of outpatient facilities.</p> <p>Citizens register with a primary care physician of their choice, and can re-register with a new doctor once every 3 months. Primary care facilities provide preventive services, immunization, and antenatal services. Health promotion and education programs are usually organized and funded by the Ministry of Health.</p> <p>General practitioners are reimbursed mostly by capitation (70%), along with fee-for-service (30%) for preventive and health promotion services. Hospitals have typically been reimbursed according to a budget, but diagnosis-related group (DRG) payments are being introduced.</p>

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<p>DENMARK</p> <p>Population: 5.4M</p> <p>Health care as % of GDP: 9.1%</p> <p>% paid out of pocket: 13.9%</p> <p>% of earnings/income tax: 8% for state income tax</p>	<p>Universal coverage for all Danish residents financed by taxes and administered through five regions (most health care) and 98 municipalities (some primary care). About 82% of health care expenditures are financed by a combination of state and municipal taxes, while the remainder comes from out-of-pocket payment and voluntary health insurance.</p> <p>Citizens pay 8% of their taxable income to health care through state income taxes, and the state makes block grants to the five regions (80%) and the municipalities (20%). Municipalities raise income through income tax and property tax. They pay the regions for services such as consultations and hospital admissions through a general tariff schedule.</p> <p>About 30% of population purchases Voluntary Health Insurance (VHI) in order to cover the costs of statutory copayments. Chronically ill patients with high utilization of drugs can apply for full exemption from copayments once they reach an annual ceiling. Increasingly, private insurance is purchased for care in private clinics to shorten waiting time.</p>	<p>There is no precise list of the benefits provided, except for health checks for children and pregnant women and for children's dental care, but treatment must be considered useful by a doctor in order to qualify for public funding. General practitioners act as gatekeepers to specialists, physiotherapists, and hospitals.</p> <p>Physiotherapy, adult dental care, and pharmaceuticals are only partially covered; and pharmaceuticals must be on a positive list of drugs drawn up by the National Medicines Agency. Patients can also phone or e-mail their doctors, and physicians are paid for these consultations.</p>	<p>Self-employed health care professionals and municipal health services provide primary health care. General practitioners' (23% of MDs) remuneration is a mixture of quarterly capitation payments (30%) and fees for services. Specialists are paid on a fee-for-service basis.</p> <p>Public hospital resources are allocated through prospective global budgets and DRGs. Public hospital staff (60% of MDs) receives salaries. Patients can choose private hospitals and clinics if the waiting time is more than one month, but private hospitals account for less than 1% of all hospital beds.</p>

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<p>FRANCE</p> <p>Population: 63M</p> <p>Health care as % of GDP: 11.1%</p> <p>% paid out of pocket: 7.6%</p> <p>% of earnings/income tax: Between 22% and 25% of gross salaries go to Social Security, which includes sickness, pensions and old age, maternity and social welfare, workers' compensation unemployment insurance, and long-term care. This is split between employers and employees but only finances 64% of health care. A specific tax called "generalized social contribution" based on every source of income and profit finances 34% of health care, while a tax on alcohol and tobacco finances the remaining 2%.</p>	<p>A national social insurance system is complemented by tax-based financing and voluntary health insurance. This national insurance covers 99.9 % of population and finances 78.4 % of health care expenditures. Since the Juppe Reform of 1996, there has been a shift from a social insurance model based on wages to a more tax-financed model based on total income.</p> <p>Direct payments by household constitute 7.6% of total health expenditures, while 13.8% are paid by complementary health insurance schemes. Since the law on Universal Sickness coverage (called CMU), almost 100% of the population has complementary health insurance that pays all or part of patients' share of the costs from the public system and private system, depending on the contract. Private care is available by paying providers out-of-pocket. Out-of-pocket costs include extra fees charged above the conventional price negotiated and accepted by complementary schemes. Some complementary schemes go beyond that tariff and they become supplementary insurance.</p>	<p>While benefits initially focused on curative care, more recently preventive care has been eligible for reimbursement. Certain services are not covered, such as cosmetic surgery, spas, and services with unknown effectiveness, defined by the High Authority for Health created by the 2004 reform.</p> <p>For most services, patients make a direct payment and are reimbursed afterward, with the exception of laboratories, pharmacies, hospitals, and outpatient clinics. Traditionally patients do not need a referral from their general practitioner to consult a specialist, and have free choice of doctor. The 2004 Health Insurance Reform modified the principles of care coordination in France by introducing in January 2005 a system of noncompulsory coordinated care pathways for patients. It had three main features: introduction of a primary care doctor (preferred doctor scheme), initiation of capitation in ambulatory physician payment, and reduction in patient's freedom of choice through financial incentives.</p>	<p>Self-employed doctors, dentists, medical auxiliaries, and, to a lesser extent, salaried staff in hospitals delivery primary and secondary care. Patients pay direct fees for services and are then partially reimbursed by the statutory health insurance system and by the complementary insurer if they are covered.</p> <p>Public hospitals (65% of all beds) have salaried physicians and have adopted a charging procedure based on medical activity, similar to a diagnosis-related group mechanism. Private for-profit hospitals (20% of all beds) are paid a fixed rate covering all costs except doctors, who are paid fee-for-service. Private nonprofit hospitals (15% of all beds) can choose between the two methods of payment. Private hospitals tend to focus on minor or standardized surgical procedures while public hospitals focus on emergency admissions, complex surgery, rehabilitation, long-term care, and psychiatric treatment.</p>

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<p>GERMANY</p> <p>Population: 82.3M</p> <p>Health care as % of GDP: 10.7%</p> <p>% paid out of pocket: 13.3%</p> <p>% of earnings/income tax: 14.2%, split almost evenly between employers and employees</p>	<p>About 87% of population is covered by statutory health insurance (with individuals enrolling in 242 statutory sickness funds) and another 10% buys private health insurance; 2% is covered by other governmental schemes. Employers and employees share premium costs, each paying about 7.1% of employee wages, for a total of 14.2 % (with ceilings). Since July 2005, employees have to pay an additional contribution of 0.9% that covers dentures and sick pay.</p> <p>Out-of-pocket payments total 13%, mostly for over-the-counter drugs and copayments for prescription drugs, outpatient visits, and hospital stays. About 9% of the population purchases supplementary health insurance to cover items that aren't part of the standard benefit package.</p> <p>Separate long-term care insurance was introduced in 1995. The contribution rate is 1.7% of gross personal income. Insurees without children have to pay an extra contribution of 0.25% since January 2005.</p>	<p>The benefits package is comprehensive at all levels of care. Exclusions include funeral benefits, patient transport, over-the-counter medications, lifestyle medications, glasses, and a few other medical aids. Under the 2007 reform, the benefits package was extended to include palliative care, rehabilitative care for the elderly, certain vaccinations, and treatment at rehabilitative facilities for families with children. Formal waiting lists exist only for transplantations.</p> <p>No referrals are needed for specialty care. However, with the introduction of a quarterly practice fee of 10 euros per visit, referrals from the GP or family doctor to a specialist have a financial incentive for patients – with a referral, the practice fee doesn't have to be paid, without referral, patients will be charged.</p>	<p>The 242 sickness funds are the collectors, purchasers, and payers of statutory health and long-term care insurance. Every individual can freely choose a sickness fund, while funds are obligated to contract with any applicant. A risk structure compensation scheme compensates the sickness funds for differences in actual morbidity and need of care.</p> <p>The regional physicians' associations negotiate collective contracts with single sickness funds and then distribute the funds among the GPs and specialists mainly on a fee-for-service basis. Since 2004 selective contracting is also possible (to promote new forms of care such as integrated care) but still plays a minor role. Most ambulatory care is delivered by private, for-profit solo practice (average practice size is 1.58 doctors, CMWF Primary Care physician survey 2006).</p> <p>Inpatient care is delivered by a mix of providers, with the public sector accounting for 53%, nonprofit organizations for 39%, and for-profit sector 8%. Hospital doctors are salaried but may also treat privately insured patients on a fee-for-service basis. Hospitals are paid on a DRG basis.</p>

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<p>IRELAND</p> <p>Population: 4.2M</p> <p>Health care as % of GDP: 7.5%</p> <p>% of earnings/income tax: Employers contribute 10.75% for all PRSI benefits, including health care; employees contribute 2% on incomes up to 100,000 euros a year but 2.5% in excess of this salary.</p>	<p>All residents are eligible for all services. Category 1 patients receive a medical card to access free services (based on income) and make up 29% of the population. Category II patients make a contribution toward most services, except for public hospital services. About 50% of the population has voluntary health insurance to gain more immediate access to some hospital interventions.</p> <p>About 75.2% of health expenditures are tax funded; 13% are out-of-pocket payments for primary care services, pharmaceuticals, and private hospital treatment; and the rest comes from voluntary health insurance.</p>	<p>General practitioners have a complex gatekeeping role. Individuals who are not entitled to free primary 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.</p> <p>Health boards are responsible for delivering a range of health promotion and public health services, taking account of both local needs and national strategies.</p>	<p>GPs are self-employed, 50% are in solo practices, with most of the rest being in partnerships of two or three. They treat both public and private patients, with capitated payments for Category 1 patients. Multidisciplinary primary care teams are being phased in to care for specific populations.</p> <p>Public voluntary hospitals are financed primarily by the state but may be owned and operated by religious or lay boards of governors. There are also a small number of purely private sector hospitals. Hospitals consultants are paid on a salaried basis for treatment of public patients but may be reimbursed on a fee-for-service basis for private patients.</p>

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<p>ITALY</p> <p>Population: 58.8M</p> <p>Health care as % of GDP: 9.0%</p> <p>% paid out of pocket: 21%</p> <p>% of earnings/income tax: National Health Service is financed from general tax revenues.</p>	<p>Universal coverage through National Health Service financed by general taxation. The health system is run by the governments of the Regions.</p> <p>21% of health care costs are paid out-of-pocket by consumers.</p> <p>Regions transfer funds to local health authorities, who are responsible for the delivery of services at the local level, serving average populations of about 300,000. Moreover, local health authorities provide services directly to patients, or they pay other providers, based on DRGs for inpatient services and other PPS schemes for outpatient services</p> <p>About 15% of the population has complementary private health insurance either individually subscribed to or offered by employers. However, only a small amount of private health expenditure is financed by private insurance, while most of it is financed out-of-pocket.</p>	<p>While universal access to a uniform benefits package has been achieved, there are wide differences in health care and health care expenditures between regions. Since 1993, patients have had to pay for the cost of outpatient care up to a maximum (small) amount. There are also copayments for diagnostic procedures and specialist consultations.</p>	<p>Local health units are responsible for protecting and promoting public health through disease prevention (especially immunization), health promotion, and food control.</p> <p>GPs and pediatricians work as independent contractors to the NHS paid mainly on a capitation basis. There may be additional fees for specific treatments and financial rewards for effective cost-containment.</p> <p>Local health units also control and accredit public hospitals (61%) and private, nonprofit facilities. Hospital physicians are salaried employees. A DRG-based prospective payment system is in place, excluding rehabilitation and long-term care.</p>

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<p>THE NETHERLANDS</p> <p>Population: 16.4M</p> <p>Health care as % of GDP: 9.2%</p> <p>% paid out of pocket: 7.8%</p> <p>% of earnings/income tax (if applicable): Individuals pay a community-rated premium to their chosen insurer, while employers pay an income-related contribution (6.5%) on behalf of their employees to a Risk Equalization Fund that allocates risk-adjusted payments to the insurers. In addition, everybody must pay 12.55% of income (up to a certain level) to finance the Exceptional Medical Expenses Act (see third column).</p>	<p>The Health Insurance Act of 2006 obliges everyone who legally lives or works in The Netherlands to buy individual private health insurance from one of 11 insurers (both nonprofit and for-profit), who in turn must accept everyone regardless of age or health status and provide a standard benefits package. Individuals pay a community-rated premium to their chosen insurer, plus an income-related contribution (6.5%) to a Risk Equalization Fund that allocates risk-adjusted payments to the insurers. Employers pay this contribution for their employees. In addition, everybody must pay 12.55% of income (up to a certain level) to finance the Exceptional Medical Expenses Act (see column at right).</p> <p>More than 90% of the population purchases supplementary health insurance coverage as well, such as for dental care, glasses, and physiotherapy. Low-income citizens can qualify for a Healthcare Allowance toward the cost of their premiums.</p>	<p>The Health Insurance Act covers:</p> <ul style="list-style-type: none"> • Physician services • Prescribed pharmaceuticals • Hospitalization (365 days) • Maternity care • Medical devices • Dental care for children • Some paramedic care • Transport of patients • Industrial accidents • Occupational diseases <p>The maximum reimbursement for pharmaceuticals is set on the average price of the medicines in a therapeutically interchangeable group. An insured person who chooses a more expensive medicine must pay the difference out of his own pocket.</p> <p>In addition, the Exceptional Medical Expenses Act, a second “national health insurance,” provides everybody with coverage for long-term care, mental health care, and hospitalization in mental health facilities after one year.</p>	<p>The 11 insurers and many providers of care negotiate about the quality, quantity, and price of services, and may selectively contract with each other. Some insurers directly provide care in their own facilities with their own staff, such as primary care centers and pharmacies. Insurance contracts specify who provides the care (they may or may not have lists of preferred providers), where, and under what procedural conditions (such as requirements for obtaining referrals and prescriptions).</p> <p>Most primary health care is provided by GPs who act as gatekeepers to specialists and inpatient care. GPs are paid on a per capita basis as well as a fee per service.</p> <p>More than 90% of hospitals are private, nonprofit facilities; the rest are public university hospitals. Hospital payment is performance related and moving toward a kind of DRGs, with one price both for hospital care and specialist treatment.</p>

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<p>SPAIN</p> <p>Population: 44.7M</p> <p>Health care as % of GDP: 8.3%</p> <p>% paid out of pocket: 23.6%</p> <p>% of earnings/income tax: Health care is included in contributions to Social Security.</p>	<p>Tax-based system covers 99.8% of population, including immigrants. About 18% of population purchases private insurance policies to cover services outside the basic package and to avoid waiting lists. Out-of-pocket expenditures account for about 24% of total costs.</p> <p>About 71% of health spending is funded by public sources while the remaining 29% is funded by private sources. Interestingly, civil servants are allowed to choose between public and private health care systems – the state pays for either. Currently 87% of the 2.5 million civil servants choose the private system.</p>	<p>The 1986 General Health Care Act outlines the main principles of the Spanish National Health Service, including universal coverage with free access to health care. There is no cost-sharing except for pharmaceuticals and in most prosthesis cases.</p>	<p>Governance of the health system is decentralized into 17 autonomous communities, which hold health planning powers as well as the capacity to organize their own health services in their regions.</p> <p>General practitioners have a gatekeeper role and are the first point of contact between the population and the health system. GPs receive a salary. However, most communities have moved away from the solo practitioner model to primary health care teams. Outpatient ambulatory centers work alongside the hospital system, with specialist teams in clinical departments covering outpatient care in ambulatory centers on rotation. All specialists working in hospitals and ambulatory settings are salaried.</p> <p>While hospitals have traditionally been reimbursed retrospectively, they are moving to prospective financing, especially in the private hospital sector.</p>

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<p>SWEDEN</p> <p>Population: 9.1M</p> <p>Health care as % of GDP: 9.1%</p> <p>% of earnings/income tax: Employers pay 8.78% for health care, employees 0%.</p>	<p>Predominantly tax-based system provides coverage for entire resident population. Health system is run by an elected regional government. Public expenditures financed mainly by regional taxes account for 86% of health care expenditures. The remaining 14% consists mainly of out-of-pocket payments and voluntary insurance, which typically provides only supplementary coverage to the public health system. In 2003, only 2.3% of the population had supplementary insurance.</p>	<p>While no basic health package is defined within the Swedish health system, priorities are determined according to three principles: human dignity, need and solidarity, and cost-effectiveness. Patients can choose primary care physicians without geographical restrictions. They must pay the entire cost of pharmaceuticals up to a certain monetary limit.</p> <p>At a regional level, services are divided into health care districts with one hospital and several primary health care units. Primary care physicians do not act as gatekeepers but guide the patient to the right level of care within the system. However, the patient fee for seeing a specialist is higher than the fee for a GP visit.</p> <p>At a local level, the municipalities deliver and finance social welfare services, including child care, school health services, care for the elderly, people with disabilities, and long-term psychiatric patients. They also operate public nursing homes and home care services.</p>	<p>Most health care personnel are publicly employed. Physicians at public facilities are paid a monthly salary from the counties and also receive a capitation fee. Basic care and preventive services are delivered through local health centers and hospital outpatient departments and private clinics.</p> <p>Using global budgets, most counties have decentralized financial responsibility to health districts. DRG payment system is used for short-term somatic care. Secondary and tertiary care is provided through regional (mainly for highly specialized), central county, and district county hospitals.</p>

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<p>SWITZERLAND</p> <p>Population: 7M</p> <p>Health care as % of GDP: 11.3%</p> <p>% paid out of pocket: 31.9%</p> <p>% of earnings/income tax: Medical insurance is the sole responsibility of employees; individuals pay for premiums.</p>	<p>Compulsory health insurance since 1996 with a defined benefit package, community rating, and subsidies for those below a certain income level. Every resident must purchase insurance from one of about 90 insurance companies (sickness funds). No profit can be made from compulsory health insurance activities and no applicant can be refused, as defined by the Federal Office of Public Health. In addition, about 70% of residents choose to purchase supplemental insurance from sickness funds or private insurance companies.</p> <p>Employers have no role in subsidizing premiums or providing carriers. About a third of Swiss residents receive subsidies. Health care is financed about 29% by compulsory health insurance; 25% by taxes; 8% by other statutory insurance schemes; and 38% by private payments, which include out-of-pocket expenses and supplementary health insurance. Switzerland has one of the lowest proportions of public expenditures on health care in Europe.</p>	<p>Patients are free to choose providers within their canton (geographic area) and can change their insurance company (sickness fund) twice a year. Standard benefit packages include:</p> <ul style="list-style-type: none"> • All necessary outpatient and inpatient care • Disease prevention • Unlimited stays in nursing homes and hospitals • Home care • Diagnostic and therapeutic equipment • Transport • Limited dental treatment, eyeglasses, therapies in thermal baths, medical aids, and transportation and emergency rescue services. • Approved medicines • Choice of deductible levels <p>Supplementary health insurance policies often cover superior inpatient accommodations as well as dental care and drugs that are not on the list of medicines.</p>	<p>The 90 insurance companies generally reimburse physicians on a fee-for-service basis for itemized services, although there are some health maintenance organization-type group practices in which physicians are salaried employees of the practice or financed by risk adjusted capitation fees. About 17% of the population is in managed care/gatekeeper systems. Insurance companies have banded together to negotiate fees with service providers.</p> <p>Most areas of Switzerland operate their own public hospitals based (for the government part of financing) on global budgets; some also subsidize private hospitals. Insurance companies usually pay hospitals on a per-diem basis (some cantons already use AP-DRG, which should become the standard reimbursement scheme in the future), but hospital doctors are typically salaried employees of the hospital. Leading doctors often augment their salaries through private consultations with people who have additional insurance. Patients are usually referred to hospital-based specialists, but may also have direct access to specialists in an ambulatory care setting.</p>

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<p>UNITED KINGDOM (including England, Northern Ireland, Scotland, and Wales)</p> <p>Population: 60.7M</p> <p>Health care as % of GDP: 8.3%</p> <p>% of earnings/income tax: The National Health Service is financed from general tax revenues.</p>	<p>Coverage is available to all legal residents. The National Health Service (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.</p> <p>Private funding can be broken down into out-of-pocket payments for prescription drugs, ophthalmic and dental services, and private medical insurance premiums. About 12% of the population has supplementary private medical insurance.</p>	<p>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 commendations from the National Institute for Clinical Excellence (NICE) about whether a particular treatment 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.</p>	<p>Appointed local statutory bodies called Primary Care Trusts are responsible for the health of a defined local population. Primary care is typically provided by self-employed GPs who often practice in small groups (on average 3 GPs per practice), with each GP responsible for an average of 1800 members of the local community. GPs are typically paid based on capitation and quality points. Although there are some walk-in clinics, GPs typically act as gatekeepers to hospitals and specialty care.</p> <p>Hospitals receive activity-based and contract financing. Most hospital staff is salaried, but hospital consultants are permitted to earn money in the private sector as well. The great majority of hospitals are public, but managed as semi-autonomous public trusts, with fewer than 5% privately owned.</p>

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<p>UNITED STATES</p> <p>Population: 302M</p> <p>Health care as % of GDP: 15.3%</p> <p>% paid out of pocket: 13.2%</p> <p>% of earnings/income tax: The amount employers pay for employees' health care varies widely and is tax-deductible. The amount employers deduct from employee paychecks for health care also varies widely according to benefits offered (if any).</p>	<p>Taxes finance about 46% of American health care, through the government programs of Medicaid (for the poor), Medicare (for the elderly), and the Veterans' Administration (for veterans of wars), as well as health care coverage for government employees and their families.</p> <p>About 32% comes from individuals, including their portion of employer-sponsored health insurance premiums as well as care not covered by insurance, such as nonprescription drugs, dental and nursing home care, medical products, and alternative forms of care.</p> <p>About 26% of the total money spent comes from employers who purchase health care coverage for their current and retired employees and their employees' dependents.</p> <p>U.S. employers pay an average of \$4,500 per year per employee, while employees pay an average of \$2,000 a year for this coverage.</p>	<p>There is no standard benefit package outside of the government programs. Benefits vary widely depending on the plan and extent of coverage.</p> <p>About 84% of the population is covered either through employer plans (61%) or governmental plans such as Medicaid (14% of population), Medicare (17%), and the Veterans Administration (2%). (Note: These numbers do not add up to 84% because some people have double coverage.) About 16% of the population is uninsured, and the law only guarantees these people care in Emergency Departments.</p> <p>Less than half of all firms with fewer than 10 workers offer health benefits, compared to more than 90% of firms with 50 or more employees.</p>	<p>In addition to the government programs described in the columns at left, the U.S. has more than 1,300 health plans serving some 200 million Americans.</p> <p>Most hospitals (for-profit, nonprofit, and public) and physicians are reimbursed on a diagnosis-related group (DRG), capitation, or fee-for-service basis by private health plans or the government. A small percentage of hospitals belong to prepaid health plans and receive an annual budget for their operations. Physicians are salaried in these hospitals as well as in government-run hospitals.</p> <p>The U.S. has a number of large, successful multispecialty group practices that make good use of electronic medical records, such as Kaiser Permanente, the Mayo Clinic, the Cleveland Clinic, and Intermountain Healthcare. However, less than 4% of all U.S. physicians work in practices of 50 or more physicians.</p>

Note:

All the countries included in the comparison chart are among the 30 OECD (Organization for Economic Cooperation and Development) countries (which include Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Spain, Sweden, Switzerland, Turkey, the United Kingdom, and the United States): Of OECD countries:

- 12 use general taxation as their primary way of financing universal access to health care.
- 12 use segregated taxation or a social insurance program.
- 4 have mixed financing systems.
- 2 - the United States and Mexico - do not provide universal access to care.
- The average percentage of Gross Domestic Product spent on health care according to 2005 data was 9%.

Sources:

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- 3) *Reform of the Danish Public Sector, Ministry of the Interior and Health, August 2005*
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- 6) *HealthyPolicyMonitor, Country Fact Sheet: Switzerland*
- 7) *Germany, Canada, and the United Kingdom Health Systems: A Brief Comparison*
- 8) *Examining Health Care in Canada, France, Germany, The Netherlands, Switzerland, and the UK, Nadeem Esmail, The Fraser Institute, July 2007*
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- 10) *OECD Health Data 2007 (national data from 2005 and 2006)*
- 11) *Eco santé 2007*
- 12) *High-Performance Health Care Systems with Universal Access, Annual of Internal Medicine, January 2008, Volume 148, No. 1*

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