

# **Report on the European Fact Finding Mission**

**February 28 to March 6, 2006**

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**Lillehammer and Oslo, Norway**

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## Overview

In the February 2006 Speech from The Throne, the government announced the Premier and a small delegation from B. C. would travel to Sweden, Norway, France, and the United Kingdom to learn first-hand how those jurisdictions are acting to transform their health care systems. The government is committed to seeking the world's best advice on how to improve our health care system in British Columbians' long-term interests.

This 8 day fact finding mission provided a first-hand opportunity to talk directly with political leaders, health planners, administrators and health care professionals to learn how they are responding to the growing demands on their health care systems. Like British Columbia, the countries visited face similar challenges in regard to the fiscal and human resource sustainability of their health care systems, an aging population and increased public expectations for health services. Patient and provider satisfaction are priority issues in each country visited. All their health systems were generally rated higher than Canada by the OECD.

Each country visited is looking for innovation and improvements to their health care systems. None of them believe that they can simply accept the status quo. Each country is looking at ways to ensure a quality customer service culture for anyone using their health care services which includes a range of patient choices in both the public and private health systems.

Premier Gordon Campbell led the fact finding mission, accompanied on the trip by Dr. Les Vertessi, the BC government representative to the Health Council of Canada; Dr. Moira Stillwell from BC Children's and Women's Hospital in Vancouver; Lara Dauphinee, Deputy Chief of Staff and Executive Assistant to the Premier and Craig Knight, Assistant Deputy Minister of Health for Strategic Policy, Legislation and Intergovernmental Relations.

While all the jurisdictions visited are different than British Columbia, each had some lessons that are worthy of consideration as we look to improve and protect our health care services for the future. This report describes key facts about the health systems in the countries visited and what was learned from each of them which may be useful in promoting further innovation and improvements for the delivery of quality health care to the people of British Columbia.

## SWEDEN

In Stockholm, Sweden, the BC delegation met with political leaders, health officials and planners from the Stockholm County Council, visited St. Goran's Hospital - a privately operated emergency hospital - and Kvarterakuten Matteus, a primary health care centre, both located in Stockholm.

### *Overview of the Swedish Health System*

The Swedish health care system serves a population of 9 million people, with about 85% of the population living in the southern half of the country. It is predominately a publicly funded and operated system. Its management is the shared responsibility of the federal government, county councils and municipalities. Sweden has a compulsory public insurance system that provides coverage for all residents. Coverage encompasses physician services, hospital services, pharmaceuticals and dental care. Long-term care and home care are publicly ensured for the elderly, disabled and long-term psychiatric patients.

The 1982 *Health and Medical Services Act* provides the legislative framework for the Swedish health system. It decentralized delivery of health services from the national level and placed financial responsibility and cost-liability at the county council level. The 1992 *ÄDEL* reforms further decentralized the system, shifting responsibility for long-term and social welfare services to municipalities.

In 1995, new primary health care legislation extended county councils' responsibilities to include regulation of private, contracted out ambulatory care in their regions and gave them authority to sign agreements with new and pre-existing private facilities.

At the national level, the Ministry of Health and Social Affairs is responsible for leadership, legislation and regulations in health care and overall system efficiency. The National Board of Health and Welfare is the federal advisory and supervisory board for all local health and social services. The National Social Insurance Board processes all insurance claims and benefits.

At a regional level, the 21 county councils are essentially free to choose how they organize health care in their regions, a unique feature of the Swedish system. They are responsible for hospitals and primary health care and own and operate the majority of these facilities. They also regulate the private sector, although the provision of contracted-out private services is limited by law. The 21 counties are grouped into 6 medical care regions to facilitate cooperation in tertiary care. Regional hospitals treat rare and complicated diseases and injuries. These facilities are also university teaching hospitals and conduct health research.

There are 9 regional hospitals, some 70 county hospitals and over 1,000 primary health centres. County hospitals have both out patient clinics and wards for in-patients.

At a local level, the 290 municipalities, also called the local authorities, are responsible for primary care, home care, social welfare services, elderly and nursing home care, disabled care and long-term mental health care. They also regulate the private sector and can contract out these services. The municipalities are not subordinated or accountable to the county councils.

Primary care services include both basic curative care and preventive services provided primarily through local health centres, hospital out-patient departments and private clinics. The public/private split in the provision of primary care is 50/50 for the 1,000 health centres in the country. It is also provided at district nurse surgeries; child and maternity health clinics; occupational health services and school health services. 10% is provided through privately owned services. Services are also increasingly being provided in the home for conditions such as heart disease and diabetes. Preventive and population-oriented health care has been integrated into primary health care. Public health education also takes place in the childcare sector, schools, institutional housing for the elderly and at the workplace.

Primary Health centres employ a wide variety of health professionals including physicians, nurses, auxiliary nurses, midwives and physiotherapists. These centres facilitate team work. Health centre physicians must be trained in general practice. Everyone has the right to choose their own family doctor (GP) and can be registered with them. GPs act as gate keepers, guiding the patients to the right level of care within the system.

There has been increasing decentralization in the Swedish health system. The responsibility of county councils and municipalities within the health care system was extended to the regulation of the private health care market (1995), pharmaceuticals (1998) and residential care of the elderly and the disabled (1992).

There has been increased contracting-out of services and expanded opportunities for choice in health care providers. However, by the end of the 1990s, awareness of some of the challenges of this reform model led to partial re-orientation, through initiatives aimed at increasing cooperation among purchasers and providers, and re-centralizing some of the delegated powers to higher management levels.

Reforms have focused on improving accessibility and quality, patients' rights, reducing wait times and containing pharmaceutical expenditures (a reference price system was introduced in 1993).

A coordinated reform strategy has been difficult to achieve, due to changes in government, increasing fragmentation of governance and provision, problems of coordination among different administrative levels and lack of a global perspective.

## ***Health Care Challenges***

Health Minister Ylva Johansson has promised cheaper dental care for all by 2007, although where the money will come from has not yet been disclosed.

Ten years after the reform of Swedish psychiatric care, the National Board of Health and Welfare and county councils have concluded that local authorities are still not meeting the goals set out for them.

An aging population is putting increased demand on the Swedish health care system.

Physicians are lobbied heavily by pharmaceutical companies regarding medications they prescribe to patients.

Obesity and inactivity in the Swedish population are a growing concern.

## ***Wait Times***

Sweden has experimented with wait time guarantees in various formats since the early 1990's. The first attempt was in effect from 1992 to 1995. It included 12 areas of elective surgery and a three month maximum wait time, after which patients could opt for treatment through another provider, either public or private. However, a critique of care guarantees published in 1995 noted that the guarantees had tended to distort treatment priority levels, meaning that more basic treatments were being performed at the expense of more severe or important needs.

A revised form of guarantee was introduced in 1996 that formulated the guarantee in terms of access or contact to respective parts of the health system (i.e., primary care within 24 hours, primary care doctor within 7 days and a specialist within 3 months).

In 1997 the three month guarantee for the 12 areas of treatment was revoked by the national government, but roughly half of the councils decided to adopt their own three month guarantees in 1998-99, with considerable variation in the implementation and workings of these guarantees among councils.

In order to better monitor and evaluate waiting times, a national database was established in 2000. Councils are obligated to report their wait time data on elective secondary care. Both waiting time for a first visit and waiting time for treatment are included. A similar database for primary care data was set up in 2003.

Following an extensive and heated debate at the national level, work on an expanded care guarantee covering all treatments, including the re-introduction of the three month maximum allowable wait time, began in 2004.

The new national guarantee adopted in November 2005, referred to as “0-7-90-90”, is presently in the implementation stages. “0-7-90-90” refers to:

- 0 days: same day contact with Primary Healthcare Centre (PHC)
- 7 days: access to a GP
- 90 days: access to a specialist
- 90 days: treatment/procedure (as of November 2005)

This latest guarantee initiative offers patients the option of having their treatment performed in an alternate facility, public or private, if they have waited beyond the maximum waiting time for their particular treatment. They may also be sent to another county for services if their home county is unable to provide treatment within the designated wait time for the procedure.

Implementation of the guarantee will vary among the county councils. With the help of additional funds and a strong push from the national government, each county council takes on the responsibility of formulating its own plans to meet guarantees within their own jurisdiction (much like the situation faced by Canadian provinces determining how to meet wait time benchmarks established under the 2004 FMM Accord).

The accepted mechanism for defining indicators for medical interventions has been to develop a consensus in the medical specialist group responsible for a particular treatment or service. Specialty groups are asked to form their definitions using an evidence based approach.

Much like reforms underway in the UK, the long-term goal is to eliminate wait lists altogether and replace them with electronic booking systems that provide patients with firm treatment dates for treatment at the point of referral.

A major component of the new wait time guarantee is the need to enhance efficiency and productivity of the overall health system, since it is expected that demands on the system will continue to rise as a result of guarantees.

While there are no formal sanctions regarding the guarantee, officials believe that media and public scrutiny will act as major incentives for service providers to meet their treatment objectives.

Results as of February 2000 indicate that the number of patients who have waited longer than the three month guarantee for treatment has dropped by 47 per cent. 70 per cent of the patients get their treatment within the 3 month limit.

## ***Funding and Expenditures***

Regional taxes covered almost 70% of total public health care expenditures, with central state expenditures covering 10% in the form of earmarked and general grants, based on weighted capitation based on sex, age, civil status, occupation, income, housing and other indicators of health needs and the remaining 20% covered by the social insurance system (1999). The purchase of private health insurance is legal in Sweden, but traditionally only a small minority of Swedes has done so. This has changed in recent years due to Sweden's continuing problems with growing wait lists.

The 2006 Euro Health Consumer Index ranks Sweden as having the 4th best health system in Europe. The report indicates that Sweden excels in the area of quality health outcomes. However, Sweden falls behind the top three countries as result of long patient wait times which continue to be an issue. (*Euro Health Consumer Index 2006* <http://healthpowerhouse.com/media/RaportEHCI2006en.pdf>)

Public health care expenditure as a percentage of GDP is 7.4% and private health care expenditure is 1.3% (2004).

The public share of total health expenditure is 85.9% (this is among the highest in the OECD). The other 14% was made up by voluntary health insurance (VHI), which is provided by almost 90% of all Swedish employers as supplementary coverage, and direct consumer spending (2002).

County councils spend 62.3% of total expenditures on hospital care; 22.4% on primary health care; 9.5% on psychiatric care; and 5.8% on geriatric care (1999).

Each county council determines independently how to allocate its portion of the national, global health care budget. Ambulatory care in Sweden is forecast regionally and funded by fixed capitation-based budgets (e.g., "planning by need"). The councils' base regional ambulatory care planning on these budgets and are in charge of direct reimbursement of private practice physicians and regulation of any public financing of private practitioners.

Pharmaceuticals are 13.1% of total health care expenditures, due to an increase in prescriptions and the introduction of new and more expensive drugs (2002). In 2004, pharmaceuticals accounted for 12.3% of total health expenditures well below the OECD average of 17.7%. More recently, ceilings for patient charges have been introduced in several countries, including Sweden. In 1993 a reference price system for pharmaceuticals was introduced. However, the growth in sales of products that were not covered by the reference price system, easily outweighed the cost-savings generated by prescribing reference-priced drugs.

50% of the municipalities have received transfers from county councils for home care. Municipalities charge for services, although fees are subsidized, are usually income-related and cannot exceed real costs.

The social insurance system covers individual income losses due to illness and also pays for about one fifth of health care costs, such as cross-boundary flows, a part of pharmaceutical and dental care expenditure and patient fees over a high cost-protection limit. A significant part of these payments is made out of the state contribution to the national insurance fund.

Patients must pay some costs, such as out-patient co-payment charges for general practitioners (GPs), nurses and specialists up to the federally set cost ceiling, pharmaceutical deductibles, dental care, and hospital per diems. Co-payments are differentiated to direct the patient to the proper level of care; e.g. primary care fees are less than hospital emergency fees. The maximum annual deductible for patient fees is \$900 SEK (\$146 CAD). The maximum annual deductible for prescription drugs covered by the health plan is SEK 1800 (\$293 CAD).

### ***Key Features and Innovations***

50% of primary care is delivered in privately operated health centres, 50% in publicly operated health centres. 25% of health professionals are private providers mainly in small specialist clinics.

With the exception of pharmacists, health care professionals can work in both the public and private sectors. Pharmacists are all employed by the government and the government operates all pharmacies.

Patients can choose whether to seek services from the public or private sector, but all health care is publicly funded with co-payments for some services and income testing for others such as home care.

Acute care services are provided at either emergency hospitals or elective hospitals. An emergency hospital admits 75% of its patients through the emergency department. The other 25% are elective admissions. An elective hospital receives all of its patients on pre-booked admission basis.

Multi-disciplinary primary care health centres facilitate team work among health professionals and virtually same day access for requested visits or walk in appointments.

Private hospitals take publicly funded patients and patients with private insurance.

St. Goran's, a private hospital in Stockholm, is moving away from an old hierarchy of solitary departments and instead is focusing on the patient's journey through the health care system. Their emphasis is on what the patient needs and wants. This hospital, as do others, has a system for monitoring quality, patient safety, efficiency, continuous improvement, benchmarks. The administration is seeking to change the culture, attitude and behaviour of health care providers and the way services are delivered. This is reflective of the emerging competition for patients in the Swedish health care system.

Nurses have significant roles in the Swedish health care system. A registered nurse completes a three year university program. Nurse Anaesthetists are a licensed profession. Emergency department nurses may book an appointment for a patient to go to a primary health care centre if their need is not urgent.

Kvarterakuten Matteus in Stockholm is a good example of a Swedish Primary Health Care Centre. This clinic is privately owned and operated by six specialist doctors and features:

- 4 district health nurses for home care
- 4 assistant nurses (2 years training)
- 5 physiotherapists
- 7 specialists in family medicine
- 3 medical residents
- a podiatrist and acupuncturist
- a wide range of diagnostic, treatment and prevention services
- 2,000 patients per doctor
- 180 patients on their home care roster
- Nurses and assistant nurses provide home care
- 3 doctors available on call on weekends
- 24 hours service
- Tuesday and Thursday open in the evening
- Have walk-in hours for each doctor
- Prevention services with an emphasis on preventing child abuse and managing life stresses
- They have moved from population-based medicine to patient-centered, personal medicine with an emphasis on continuity of care.

The government is planning to create a national blood bank containing stem cells from donated umbilical cords, used to treat deadly diseases like leukemia more effectively, at a cost of about 15 million kronor (\$2.8 M CAN). Donation will be voluntary. The decision to set up the bank aims to reduce the use of so called private blood banks where parents pay large amounts of money to store their children's stem cells just in case they one day fall ill.

Public health innovations:

- In order to reduce obesity, promote exercise and reduce the rate of smoking, the government provides funding to employers to stimulate healthy living activities.
- Bar and nightclub staff in Stockholm have been trained in how to spot and intervene when people are high on drugs and alcohol. Local GPs and nurses are trained in how to counsel "risk drinkers".
- Municipalities have been upgrading and introducing new cycle routes to encourage people to get out of their cars.
- Schools have increased the number of sport and health lessons.
- County councils have been encouraging GPs to give "exercise on prescription" and fund more home visits by nurses to address lifestyle.

- Local governments have introduced better street lighting to make people feel comfortable going out for walks and jogging in the evening.
- Public health policy focuses on creating the right environment for people to improve their own health through influencing workplace and education policy and providing opportunities for people to adopt healthier lifestyles.
- The system of patient registration may have improved the quality of services and the sense of connection between a physician and the patient. It was suggested that this in turn leads to far less pursuit of second and third opinions by patients.

## **NORWAY**

In Norway, the BC delegation met with health professionals at the Lillehammer Hospital and Dr. Roald Bahr, Chair of the National Physical Activity Council for Norway.

### ***Overview of the Norwegian Health System***

The Norwegian health care system serves a population of 4.6 million people. The system is predominately publicly funded and operated and is increasingly decentralized. There are three main political tiers involved in the provision of health care: the federal government, 19 counties and 435 municipalities.

At a national level, the Ministry of Health and Social Affairs, the National Institute for Public Health and the Norwegian Board of Health are responsible for high level health system planning, regulation and supervision of the delivery system.

Health service delivery planning occurs at the county and municipal levels. Plans are submitted to the Ministry of Health and Social Affairs for approval.

The 19 county councils, organized into five health regions, are responsible for financing, planning and provision of hospital services and specialized care, including laboratory, radiology, ambulance, drug and alcohol treatment services and dental care. The five health regions each have their own regional tertiary teaching hospital. Four of these teaching hospitals are owned by the counties and the fifth is federally owned. There are many small hospitals, many with their own specialties, owned by the counties.

There is also a small private hospital sector, consisting of five very small private hospitals that emerged as a result of waiting lists for specific areas of care in public hospitals. There are tight statutory restrictions on private hospitals in Norway.

While most services from medical and radiology laboratories are delivered by the hospitals, there are also 25 private laboratories and institutes that receive funds from the National Insurance Scheme (NIS).

The 435 Norwegian municipal governments are responsible for provision and financing of primary care (including nursing and home care) and social services. Each

municipality is responsible for providing primary health care for its population, and must guarantee integrated services for disease prevention and health promotion, environmental health, diagnosis and treatment of illness, rehabilitation and long-term care.

General practitioners (GPs) are a central part of the primary care system, and their most common organizational form is in groups of between two to six practitioners. They employ auxiliary personnel, although the amount of help depends on the size of the practice allowance from the municipality.

The majority of GPs are either municipal employees or private practitioners contracted out by the municipality, although there are some GPs in private practice. For private GPs, NIS funding is limited and practitioners are allowed to charge patients whatever fees they see fit.

### ***Health Care Challenges***

The aging population poses one of the biggest challenges to Norwegian health policy. The percentage of elderly in the population has risen rapidly since the 1970s, creating an ever-increasing need for curative, rehabilitation, nursing and care services.

The sick pay scheme and the frequency and length of absences are matters of recurring debate. It is generally agreed that absenteeism is too high and a less generous compensation scheme would help lower the rate.

Obesity, including an increase in the number of overweight newborns, along with a rise in physical inactivity, is a growing concern.

A World Health Organization study of recent influenza vaccination revealed Norway as the least protected nation in the Western world, with only 102 in 1,000 inoculated. Norwegian health authorities do not believe that this will create problems if Europe is hit by a potentially deadly epidemic, as the country practices a policy of inoculating risk groups, such as the elderly, diabetics and people with chronic or serious respiratory or cardiovascular ailments.

The Ministry of Health wants to set up a list of preferred pharmaceutical products to reduce the prescribing of expensive medications and is in the process of introducing a reference-based pricing model based on the BC reference-based pharmaceutical system. The government believes that at least \$56.5 M CAN a year can be saved by restricting physician choice on cholesterol medication alone. Health authorities will create a list of medicines documented to have the same effect and safety levels. Doctors will only be able to deviate from prescribing the cheaper drugs by providing reasonable grounds.

### ***Wait Times***

Norway adopted a six month maximum wait-time guarantee in 1990, but abandoned it in 1997 because:

- the guarantee did not adequately protect the patients with highest need (who needed the treatment earlier); and
- there were no practical consequences for the providers that were not respecting the guarantee.

The guarantee was replaced in 2001 with the introduction of ‘the right to necessary health care’. The patient has the right to receive the treatment in an ‘appropriate’ time limit, but this needs to be assessed on an individual basis. According to the Norwegian Health Act, patients must have the right to medically necessary procedures (this is dependant on the seriousness of the illness, expected results of the treatment and that costs associated with the treatment are reasonable in relation to the benefits of the procedure). A patient will not get approval for an out-of-country treatment if the treatment is available in Norway. Low capacity and long waitlists do not constitute grounds for seeking treatment out of country. On September 1, 2004, the Norwegian government delegated each county or region the responsibility for making decisions around out-of-country medical treatments. (Source: <http://www.helse-vest.no/sw8957.asp> This site is published in Norwegian)

Patients have choices for surgical care. They can choose their hospital; however, they are prohibited from choosing one with a higher degree of specialization compared to the one to which they were referred (for example from local hospitals to county or regional hospitals). Information on wait times and quality indicators for both public and private hospitals is available to patients and GPs on the web and through a call centre.

The government also introduced partial activity based remuneration in 1997, covering an increasing percentage of the average diagnosis related group (DRG) based costs per inpatient treated (55% in 2002 from 30% in 1997). A study of 48 acute hospitals suggested that the policy led to a rise in the annual growth rate of hospital activity from 2% between 1992-1996 to 3.2% between 1997-1999, while the overall real public health expenditure on health remained stable or decreased (OECD). However, no evidence is available on the impact on waiting times.

Norway, in an effort to further reduce waiting times, has been sending a significant number of patients abroad for several years, mainly for orthopaedic patients and to a lesser extent, plastic surgery patients. The cost of their treatment has been estimated to be approximately the same as at home. Critiques of this policy believe this funding could have been used more effectively to finance national initiatives and that returning patients may still need further treatment from local hospitals (which increases the estimated cost).

Since 1988, the Ministry of Health and Social Affairs has encouraged projects aimed at reducing the waiting times for patients on sick leave, in order to reduce the cost of sick benefits. Parliament has considered making this initiative a permanent one but some criticisms have been raised about giving priority to people that are employed, as opposed to the unemployed or retired.

- All employed persons have a right to sick pay from the first day of absence, with the employer covering the costs for the first 16 calendar days and national

- insurance providing coverage for up to a year. After twelve months, if they are still unfit for work, the national insurance scheme provides other forms of economic support.
- Sick pay equals normal wages, because national insurance covers up to a set ceiling (\$53,128 CAN) a year and the state, municipalities and individual companies make up the difference.

### ***Funding and Expenditures***

The Norwegian health care system guarantees universal access to a publicly funded benefit package consisting of most preventive and curative services, excluding dental and eyewear. Some prescription drugs are covered by the National Insurance Scheme (NIS), with a limited (up to 36% of cost) co-payment by the patient.

Health expenditures are predominantly funded through public, tax-financed, block grant funding (82.2%), with capped patient out-of-pocket payments (10%) and National Insurance Scheme financing (mainly for pharmaceuticals, fees for privately contracted doctors and transportation). The maximum annual deductible for patient co-payments was \$230 CAN in 2000.

Per capita GDP is \$51,373 CAN (2005), which is the third highest in the world. Health expenditures as a percentage of the GDP were 9.6% in 2002.

The municipalities spent on average \$145 CAN per inhabitant on primary physician services in 2002, with total spending (i.e., including NIS payments) at \$207 CAN per inhabitant. However, there is a great deal of variation on spending, depending on the size of the population. Municipalities with a population of less than 2,000 reported an average expenditure of \$455 CAN per inhabitant. Municipalities pay for 60% of costs on average, with the rest largely paid by NIS.

Public health expenditures have grown, mainly due to higher expenditure on pharmaceuticals, care for the elderly and disabled and specialized psychiatric care.

Counties pay for less than 30% of health expenditures and federal expenditures increased to more than 50% (1997).

In 1997, the pressure to reduce waiting lists led to the move away from global budgeting and to the introduction of the current activity-based financing system. Hospital activity is financed based on diagnosis related groups (DRGs).

### ***Key Features and Innovations***

In 1997, an official patient registration list was introduced countrywide. As of 2001, patients have the right to be assigned to a General Physician (GP), called the “regular doctor arrangement”, and the GP is responsible for providing services to the patients on

their list. Citizens may choose another physician as their GP and also may obtain a second opinion from another GP.

During the 1990s a broad range of reforms were undertaken in the following areas: the regulation of patients' rights, including patients' choice of hospital, the regulation of regional planning of health care services, the establishment of a prospective hospital financing system, the approval of a reference price system for pharmaceuticals and the reduction of wait lists.

The Free Hospital Choice Program allows patients, once they have received a referral from their GP, to choose their hospital. To inform that choice, the government provides on the Web ([www.sykehusvalg.net](http://www.sykehusvalg.net)) and through a call centre the following information about the participating public and private hospitals:

- Waiting times for 90 treatments;
- Quality indicators;
- News and information about treatments and procedures, patient rights, laws and the free choice of hospitals: and
- Access to online tools for administrators and patient advisers, who update waiting times, quality indicators and other information.

The Northern Norwegian Health Network has developed a closed and secure network for the distribution of telemedicine services in the health sector. Information on medical conditions that can be documented using sound or images can be transmitted via PCs in a network or via videoconferencing. The primary care doctor or nurse can send questions by e-mail to a specialist to make a diagnosis, with sound, images or video as attachments, or to consult with colleagues. It can be used to e-mail the sounds of a heart or pictures of an eye or ear, for example. Telepathology makes it possible to transmit live images of tissue specimens using videoconferencing and a remote-controlled microscope. Teleradiology is the electronic production, storage and transmission of X-ray images.

The National Council on Nutrition and Physical Activity monitors the levels of physical activity and mental fitness of the population, reports on the relationship between physical activity and health and produces specific recommendations on the physical activity of the population. The government of Norway has developed a plan titled, **The Action Plan on Physical Activity 2005-2009 Working Together for Physical Activity**, which aligns eight different ministries to implement initiatives in conjunction with stakeholders to improve the health of adults and children. Norway is working towards increasing the number of children and youth who are active for at least 60 minutes per day, and increasing the number of adults and seniors who are moderately physically active for at least 30 minutes per day. Plans include improving physical activity in daily life by working with schools and employers to create an active environment and increasing leisure and sport opportunities. (Source: [http://www.shdir.no/vp/multimedia/archive/00004/IS-0162\\_E\\_Kort\\_4546a.pdf](http://www.shdir.no/vp/multimedia/archive/00004/IS-0162_E_Kort_4546a.pdf) )

The *National Cycling Strategy* is part of the National Transportation Plan. It aims to make cycling a safer and more attractive means of transport. Measures include lowering

speed limits for cars and the construction of special paths and tracks for pedestrians and cyclists. Spending on construction of paths/zones will be increased by approximately \$489M CAN during the period 2006-2015.

Strategies at the primary health care level focus on increasing GPs' knowledge about the benefits of physical activity, providing a computer-based manual with recommendations on physical activity, encouraging GPs and home care nurses to provide lifestyle advice to patients and prescribe them physical activity.

In an effort to reduce health care costs related to preventable injuries, Norway created an injury register to track injuries across the country. Requiring snow boarders and skiers to wear helmets has reduced head injuries by 60%. Information on prevention of injuries is widely available to the public.

The National Physical Activity Council focuses on dealing with physical inactivity in the population. Norway also has a long tradition of healthy diets and the Council provides leadership for the Norwegian nutrition policy reports that a decline in heart disease is attributed to an emphasis on healthy nutrition.

In the new Norwegian labour act, employers are required to consider how to facilitate physical activity in the workplace.

There is a national telephone help line on how to quit smoking.

Nurse Anaesthetists have been introduced to facilitate access to surgery.

## **FRANCE**

In Paris, France, the BC delegation met with the Canadian ambassador to France, Mr. Claude Laverdure; The Honourable Xavier Bertrand, French Minister of Health; M<sup>me</sup>. Dominique Polton, head of the National Office of Sickness Insurance for Salaried Workers (Caisse nationale de l'assurance maladie des travailleurs salariés); and M<sup>me</sup>. Martine Burdillat, head of the Observatoire nationale de la démographie des Professions de la santé, an observatory similar to the Canadian Institute for Health Information which tracks data on health professionals in France. The delegation also visited George Pompidou European hospital, a large public hospital in Paris and the Institut Mutualiste Montsouris (IMM) a private hospital in Paris.

### ***Overview of the French Health System***

The French health care system serves a population of 61 million people through a combination of public and private providers and facilities, including the hospital sector. Patients benefit from easy access to care (freedom of choice, direct access to medical specialists) and an abundant supply of self-employed doctors. Use of supplementary, voluntary health insurance to cover the cost of statutory co-payments is widespread.

France has a true public/private mix of hospital service delivery with public, private not-for-profit and private hospitals providing patients with equal access to publicly subsidized care. Private hospitals and clinics are responsible for a high volume of minor elective surgery in France. The mix of public and private is about equal across the country. The provision of health services by private practitioners and at private facilities does not appear to be an issue of public concern in France.

In 2000, the French health care system was ranked number one by the World Health Organization, due in part to France's high level of population health, degree of freedom for physicians and patients, easy access to health care for most people, absence of waiting lists for treatment and universal health care coverage.

Jurisdiction over policy and regulation of the French health care system is divided between the federal government (the National Assembly and various ministries), the statutory health insurance funds and local communities at the regional and department level.

Once a year, the French National Assembly establishes a framework for the French health care system through an *Act on Social Security Funding*, which sets the annual ceiling on projected health insurance expenditures and indicates funding for specific provisions. It also sets health targets for the coming year.

The Ministry of Health implements the National Assembly's annual framework and is responsible for health policy, social policy for specific population groups, system resource management, and supervision of financial matters and social security, including the health insurance funds. The Ministry of Health also:

- Distributes global funding between different sectors and regions;
- Approves remuneration agreements between the health insurance funds and health professional representatives;
- Sets prices for specific procedures and drugs;
- Establishes safety standards for hospitals; and,
- Defines priority areas for national programs.

The French Minister of Health oversees planning for public, private non-profit and private for-profit hospital building programs, capacity development (e.g., increased bed numbers), equipment purchasing, and certain kinds of service provision (e.g., organ transplantation, treatment of major burns, cardiac surgery, neurosurgery and medically assisted reproduction). Authorization for any of these hospital planning activities requires Ministry of Health approval, granted only if proposals are in line with geographical and demographic target capacities, based on regional strategic health plans (SROS).

At a regional level, regional hospital agencies (ARH) are responsible for hospital planning (which includes public hospital contract negotiation/global budget allocation and private hospital tariff/remuneration negotiation) and overall strategic management of

the health care system. The regional hospital agencies are directly responsible to the French Minister of Health.

At the regional level, elected general councils have jurisdiction over public health, preventive care services and social services and welfare programs for the elderly, disabled and low-income residents and children. This includes residential care, home care, and long term care, all financed through the statutory health insurance funds.

Primary, secondary and tertiary inpatient care is available through public, private non-profit and private for-profit hospitals. Primary and secondary health care that is provided outside of hospitals is delivered by self-employed, private practice doctors and specialists, dentists and allied professionals.

In France, delivery of primary care services is dominated by solo-based physicians in fee-for-service private practices. There are also private group practices, health centres, occupational health services in large enterprises, and a strong public sector program for maternal and child health care. To a lesser extent, hospitals deliver primary care (roughly 15%).

In comparison to other countries, the French health care system is based on a well established public-private mix of health services whereby private clinics handle the majority of day and minor elective surgeries, specialists are remunerated on a fee-for-service basis and activity-related funding is given to private hospitals. Patients have virtually unlimited access to the doctor or specialist of their choice with virtually no gate keeping by GPs to other health services.

### ***Health Care Challenges***

France is currently facing a shortage of nurses. As a result, the government and hospitals are actively recruiting nurses from other countries as well as increasing the number of nurses educated in France.

France has always had a surplus of practicing physicians, to the extent that strict medical school enrollment caps have been in effect since the 1970s. Now a shortage of practitioners is forecast by 2010 and the French government anticipates health human resource challenges for the country.

Cost containment is a major concern of the Ministry of Health. Attempts are being made to change physician prescribing practices. The use of pharmaceuticals is considered to be out of control. The government is seeking to establish an independent authority to educate physicians on more appropriate prescribing practices. French patients are also known for their habits of seeing several practitioners for a health concern.

The French government is closely monitoring avian flu outbreaks and migratory patterns of birds as part of their pandemic influenza preparedness.

## *Wait Times*

France reports no wait times for access to care or to specific surgical treatments. France's reported absence of significant wait times could possibly be attributed to:

- The high density rate for practicing physicians per 1,000 population (3.4 per 1,000 in France vs. 2.1 in Canada in 2003), which may have led to a plentiful, even an over-supply of ambulatory care practitioners in France. (Specialist density is only moderately high at 1.7 per 1000 compared to 2.3 in Sweden and 1.1 in Canada);
- The unpopularity of "gate keeping," or the regulation of access to specialists and hospitals by general practitioners, with both the medical community and the general public although the government did introduce reforms in regard to this issue in 1996. A recent OECD report: Health Care Systems in Transition Summary – France, states that tensions between the government and medical professional organizations have "prevented effective implementation of reforms such as experiments with gatekeeping" over the last decade (p. 8). This issue is compounded by consumer resistance to gatekeeping. A policy analysis conducted by the Brookings Institute entitled "Health Care in France and The United States: Learning from Each Other," wrote: "French health care consumers are extremely attached to calling directly at a specialist's office. To date, the establishment of gate keeping primary care doctors has achieved only limited success" (Paul Dutton, 2002);
- Fee-for-service remuneration of specialists and activity-related funding in private hospitals;
- France's higher expenditure on health compared to other OECD countries (sixth highest at 10.1% of total GDP expenditure on health vs. 9.9% in Canada);
- High acute bed capacity in the hospital sector;
- Open access to private hospitals (which manage 30% of all hospital beds) and patient reimbursement for private care through supplementary health insurance; and,
- Private hospitals' high volume provision of minor elective surgery, relieving capacity strain on public hospitals.

France suffers from unequal and uneven distribution of resources and regional disparities across the country. This applies to both public hospitals and private ambulatory care. For instance, recourse to certain treatments like cataract surgery, interventional cardiology and endoscopy varies widely from region to region. In general, resources are more generously granted to the metropolitan area of Paris and to southern France.

Unlike in other countries, private insurance in France is not used to jump private sector queues or to obtain access to elite providers. 85% of French residents purchase supplementary health insurance to cover cost-sharing and co-payment charges or medical goods and services that are poorly covered in the public system, most notably dental and optical care.

### ***Funding and Expenditures***

Since the 1940s, health insurance coverage has evolved and expanded and, today, all members of French society, regardless of employment status, are covered. Full, free health coverage for the unemployed and low-income groups is provided through a universal health insurance scheme, which was established in 2000.

Patient cost-sharing and co-payments are required for most French health care services, in particular: 30% of a visit to a doctor, 20% of hospital care (with exceptions), and anywhere from 0% to 40% for such things as medical devices and pharmaceuticals.

85% of French citizens purchase supplementary health insurance which reimburses them for patient co-payment charges for publicly-insured services and provides coverage for uninsured services like dental and optical care.

Funding for health coverage (roughly 80-100% of the total cost of service) is generated through statutory health insurance schemes, organized around employment-related categories. The three main funds are the *régime général*, the agricultural scheme and the scheme for self-employed people. Other schemes garnish insurance funds from civil servants, doctors, students, military personnel, etc. Full, free coverage for the unemployed and low-income groups is provided through *CMU*, universal health insurance provided out of the *régime général*.

Funding of health care expenditure in France in 2003 was predominately met through statutory health insurance funds (77%). Private expenditure accounted for the other 23%, with voluntary health insurance (VHI) representing 13% of all health spending and direct consumer spending accounting for 10%.

Total health care expenditure in France has been relatively stable in France, hovering around 10% of the Gross Domestic Product (GDP) since 1995. In 2003, it represented 10.1%, with the public share constituting 7.7%, or 76% of the total. Private share constituted 2.4% or 24%.

The French Minister of Health wants patients to understand the cost of health care and that they are responsible for their health. The public has little awareness of the true cost of delivering health services and tends to over utilize them because they are perceived as a right and a free good. Because of rising concerns over sustainability and budget deficits in the health sector, the government wants patients to understand that health care is expensive. So now every patient will have to pay a doctor 1 euro per visit to see that it is not entirely free.

Public hospitals and partnered private non-profit hospitals receive an annual global budget, negotiated between the Ministry of Health, regional agencies and the hospitals and allocated from the statutory health insurance funds.

Eighty five per cent of French residents purchase supplementary VHI to cover cost-sharing and co-payment charges and effectively offset any consumer out of pocket expenses. VHI is not used to purchase access to services (e.g., jumping the queue) or to access a quality of care better than what is available through public services.

### ***Key Features and Innovations***

The main focus of health system reform efforts in France over the last fifteen years are cost containment, improving management of the system, health care system performance and concern for public safety, and equity in mortality and access to treatment.

The Minister of Health announced in February 2006 a national prevention program and national quality indicators to combat and reduce hospital infection rates. In 2004, a report detailing the results from a national survey of facilities' infection rates (captured in an index known as ICALIN - *indice composite des activités de lutte contre les infections nosocomiales*) put forward a series of measures, to be rolled out at a national level from 2005-2008, for improving health facility activities for combating and reducing infection rates. In February 2006, a circular was issued outlining plans for the program and a copy of the report to all regional agencies with instructions to examine the report and for all facilities to institute policies to meet any measures not yet realized. (*Circulaire DHOS/E2/DGS/5C n\* 2006-82 du 24 février 2006 relative aux mesures à envisager pour l'amélioration du niveau d'activités des établissements de santé en matière de lutte contre les infections nosocomiales*)

Decision-makers and the public have been increasingly concerned with public health and patient safety issues. Reforms have taken the form of disseminating practice guidelines, lengthening general practice training periods, experiments with networks of health care providers to improve coordination and continuity of care, developing information systems and designing national programs to improve treatment in areas such as cancer, asthma, mental health, pain control and chronic renal failure.

Interest has emerged to replace fee-for-service payment and perceived discrepancies between public and private for-profit hospitals tariffs with Diagnosis Related Group-based remuneration.

In 1996, the French health care system underwent extensive changes under the Juppé reforms. These reforms shifted power from the various health insurance funds to the government, introduced a greater role for the National Assembly and have gradually decentralized the system to the regional level. The reforms include:

- Introduced wide-ranging budgetary reforms through amendments to the Constitution;
- Changed the way the health insurance funds operate and gave a larger role to the National Assembly; it now adopts every year, as part of the law on the financing of social security, a national health spending objective which sets targets on spending and reimbursement for ambulatory care, public hospitals, private clinics and the medical-social sector. (NB: With the exception of 1996, targets have been exceeded every year since the Juppé Plan's implementation);
- Shifted the social insurance model based on wage to a more tax-financed model based on total income;
- Created regional hospitalization agencies (ARHs) to allocate global budgets to hospitals and ensure that objectives are in line with regional health plans;
- Established the National Agency for Accreditation and Evaluation of Health Care (ANAES) to promote health care evaluation, prepare hospital accreditation procedures and establish medical practice guidelines;
- Modernized the health system's coding and collection of information on all ambulatory care consultations and prescriptions and provided subsidizations to practitioners to assist in computerization of offices and
- Experimented with a gate keeping role for general practitioners.

All public, private and some military hospitals in France must receive a certificate of accreditation in order to open or to remain in operation. The accreditation process and the issuance of certificates are the responsibility of the National Agency for Accreditation and Evaluation of Health Care (ANAES).

France is proceeding with a five-year investment plan for capital expenditures to modernize its information technology systems.

The patient chooses the service they want. They will be reimbursed through their supplemental insurance plans if a doctor charges more than what the tariff agreement pays.

Physicians who chose to work in rural areas are paid more than urban doctors. The Minister is implementing a plan this year to pay more to physicians working in underserved areas.

Plans are underway to give nurses authority to do more things that doctors do.

As of July 2006, osteoporosis exams are free since early detection can prevent injuries and related operations. According to a June 30, 2006 French Ministry of Health press release, citizens who undergo their first osteoporosis exams will be reimbursed 70% of the base price of 39,96 euros. Citizens who receive a second osteoporosis exam required upon completion of osteoporosis treatment or within 3-5 years after a first examination will also be reimbursed up to 70% of the cost of the exam.

## ENGLAND

In London, England, the BC delegation received a briefing from Canadian High Commissioner to England, Mr. Mel Capp; met with Lord Warner, Minister of State for National Health Service Delivery and Duncan Selbie, Director of Programs and Performances for the Department of Health. The delegation toured Royal Free Hampstead Hospital and the Manor Park Primary Care Centre.

### *Overview of the British Health System*

The British health system serves a population of 61 million people. The United Kingdom Department of Health (DH) is the overseer of health and social care services for England, Scotland, Wales and Northern Ireland. The DH is responsible for the overall planning, regulation and inspection of the health service. It develops policies and decides the general direction of healthcare.

The organizational mechanism through which the DH delivers health and social services is the National Health Service (NHS), a centrally-managed and publicly funded entity created in 1948. The NHS is responsible for ensuring that all citizens of the United Kingdom have access to comprehensive, universal and free medical care (and in that respect it is similar to the *Canada Health Act*).

In England the NHS is divided into 28 Strategic Health Authorities (SHA) created in 2002 to manage the local NHS on behalf of the Secretary of State for Health. As the primary link between the Department of Health and the National Health Service, SHAs are responsible for ensuring that national priorities are fully integrated into local health service plans. They also undertake performance management and monitoring duties ensuring that service providers are performing well and taking action when they are not. This latter role is expected to diminish as a result of the Patient Choice initiative presently underway across the UK (where, in theory, patients choosing where they receive treatment will demonstrate to the DH which providers are doing the best job). The UK government is presently considering reducing the number of SHAs from 28 to as few as 11 in 2006.

Within the SHAs, service delivery is based on an internal market scheme wherein “purchasers” are given budgets to commission health care services from “providers.” In principle, the Blair government has tried to de-emphasize the competitive aspects of this market structure in favour of a more collaborative approach to service delivery. Nevertheless, in practice, the structure remains.

There has been an increased focus on quality care and patient satisfaction, becoming much more customer-focused and attempting to shift from a provider-focus.

The main “purchasers” in the system are the more than 300 Primary Care Trusts (PCT). Each is given a budget with which to identify and commission the appropriate level and types of services (both primary and secondary, despite their name) required to

meet the needs of citizens within their respective local jurisdictions. PCTs are directly accountable to their local Strategic Health Authority. At present, PCTs control roughly 80% of the NHS budget as a whole.

The 150 Primary Care Centres in England are the product of a program known as LIFT which is co-established between local primary care trust and capital development companies with a 60 private and 40 public cost split. LIFTs are also focused on the determinants of health and mental health services at the community level. One of the goals of LIFT facilities is to reduce pressure on acute care facilities and reduce pressure to build more hospitals.

In the case of Manor Park Primary Care Centre, LIFT enables them to challenge the GPs in the area to practice in a more modern and appropriate approach. They are charged with improving the health of the community in a significantly deprived area by 2020.

The majority of services in the market scheme are provided by various other types of NHS Trusts. At present, other than Primary Care Trusts, there are five main types of NHS Trusts:

1. **Acute Trusts:** manage hospitals and make sure they provide high quality health care.
2. **Foundation Trusts:** a new type of NHS hospital run by local managers, staff and members of the public which are tailored to the needs of the local population and have come to represent the Government's commitment to de-centralising the control of public services.
3. **Ambulance Trusts:** There are 31 ambulance services covering England, which provide emergency and other transport services for patients.
4. **Care Trusts:** organizations that work in both health and social care. They may carry out a range of services, including social care, mental health services or primary care services.
5. **Mental Health Trusts:** provide specialized health and social care services for people with mental health problems.

Since 2002, public health in England is the responsibility of nine Public Health Groups, each with a regional director of public health and linked to a regional DH office. These groups are responsible for:

- the development of a cross-government and cross-sector approach to tackling the wider determinants of health
- informing regional work on economic regeneration, education, employment and transport
- ensuring there is a proper health contribution to local strategic partnerships

- accountability for the protection of health (including against communicable diseases and environmental hazards) across the region
- making sure the public health function is properly managed at local level
- emergency and disaster planning and management
- being the main point of contact for serious concerns about clinical standards and associated enquiries.

There is a long history of fully private hospitals taking about 10 percent of the pressure off wait lists: the patient pays the full cost or has private insurance. There is no public funding of these hospitals. There are also private health care facilities which do receive public funding on a contracted basis to treat NHS public sector patients as a means for reducing wait time pressures on the public system.

Historically the private sector has played a relatively minor role in the delivery of health care in the UK. Private insurers such as The British United Provident Association (BUPA) have existed alongside the public system, providing a type of second tier of service. Since private insurance limits patients to services provided by practitioners outside of the NHS, these private insurers often operate their own medical and surgical hospitals, which constitute a major component of the UK's private health sector. As of 2002, 11.5% of the UK population receives coverage through private health insurance, a majority from high-income brackets.

While the relationship between the public system and private service providers has often been strained, the Department of Health and the Independent Healthcare Association signed a concordat in 2000 that set out parameters for a longer term, more pro-active partnership between the sectors.

The Concordat covers joint workings in the areas of elective care, critical care and intermediate care facilities. The government estimates that private sector organizations will provide up to 15% of procedures on behalf of the NHS by 2008. In particular, the private sector has been of increasing importance in streamlining care in the areas of diagnostics, ophthalmology and orthopedics.

Under the agreement, NHS patients in England are expected to be treated free of charge in the private and voluntary health care sector (note that this arrangement of publicly funded service in private facilities presently exists in several jurisdictions across Canada). The partnership has been of importance for the government's Patient Choice program, under which patients are able to choose from a menu of four to five options when their GP decides that they need to be referred for hospital treatment or diagnostic procedures. Typically, at least one private sector provider will be among the options.

Regulation and inspection of public and private health services is carried out through a number of mechanisms in England: the National Institute for Clinical Excellence (NICE); the Healthcare Commission (HC); the Commission for Social Care Inspection (CSCI); the National Patient Safety Organization; the Health Service Ombudsman; the General Medical Council; and the Council for Regulatory Healthcare Excellence.

## *Health Care Challenges*

Overarching priorities identified are: reducing health inequalities; reducing smoking rates; reducing obesity and improving diet and nutrition; encouraging and supporting sensible drinking; improving sexual health; and improving mental health. Particular attention is to be paid to promoting health amongst young people.

Increased rates of obesity in youth are a concern in regard to future demand on the health system for obesity related illnesses such as diabetes, heart disease and kidney failure. Through the Healthy Start Initiative, the Healthy Schools Program, has invested 235M British pounds to transform school lunches. From 2003-2008, the UK government will have invested 1.5B British pounds in school sport. This investment supports the national school sports strategy which aims to ensure that at least 75% of 5-16 year olds spend a minimum of two hours a week (up from 30 minutes in many schools) on high quality PE and school sport by 2006. By 2008 this will be 85%. The latest figures reveal that 69% of pupils are spending at least two hours in a typical week on high quality PE and school sport, up 11 percentage points on the 2003/04 survey. The National School Sport Strategy is firmly on track to meet its 2006 and 2008 targets. The UK Department of Health has also introduced a new Obesity Social Marketing campaign to raise awareness and tools to support healthcare professionals, such as an Obesity Care Pathway and weight loss guide.

Rising alcohol and drug abuse among young people is resulting in increased demand on the health system for alcohol and drug treatment and for illnesses associated with heavy consumption of alcohol. On June 29, 2006, Public Health Minister, Caroline Flint, and Home Office Minister, Vernon Coaker, released a press report on the 'Drinkaware Trust.' The 'Drinkaware Trust' which is voluntarily funded by the alcohol industry and is to be up and running later this year, is a unique initiative born from the Government's 'Choosing Health' White Paper and Alcohol Harm Reduction Strategy. The Trust will bring together - for the first time - industry, charities, lobby groups, medical professionals and experts in the field to address alcohol misuse and promote sensible drinking across the UK. The Drinkaware Trust was established in September 2002 as the charitable arm of the Portman Trust (originally known as The Portman Group Trust). In 2005 the Trust awarded a total of 100,000 British pounds to 55 projects around the UK.

The Department of Health is implementing programs to reduce smoking rates across England. Legislation banning smoking in all public places passed overwhelmingly in February 2006. The ban is expected to be implemented by summer 2007. On July 26, 2005, the Information Center for Health and Asocial Care published the report entitled "Statistics on NHS Stop Smoking Services in England, April 2004 to March 2005." 46.1M British pounds were spent on nicotine replacement therapy (NRT). NHS's total expenditure on stop smoking services, not including the cost of prescription NRT was 46.8 million British pounds.

There is an increase in sexually transmitted diseases primarily in the youth population. On July 20, 2005, Public Health Minister Caroline Flint issued a press release

announcing a further 15M British pounds to help transform sexual health services across the country. The funding is to be added to the 130M British pounds already committed for genitor-urinary medicine (GUM) services in the Public Health White Paper, and will be made available immediately for use over the next year - allowing sexual health clinics to improve their buildings, expand their services, increase capacity and reduce waiting times. In November 2004, the UK Department of Health issued a press release announcing that they would be allocating 300M British pounds (over 3 years) for sexual health including the following initiatives:

- a 50M British pound sexual health campaign to educate people on the danger of the top five STIs;
- 130M British pounds to improve GUM services to ensure that all patients will be seen in GUM clinics within 48 hours by 2008;
- 80M British pounds to ensure the National Chlamydia Screening Program covers the whole of England by March 2007; and
- 40M British pounds for upgrading contraceptive services including an audit to identify and address the gaps in contraceptive services.

On May 17, 2006, the UK Department of Health published the 2005/06 National Survey of Investment in Mental Health Services. The total planned reported investment in adult mental health services in 2005/06 was 4.68B British pounds or 150 British pounds per head of weighted working age population. This increases to 4.90B British pounds (153 British pounds per head of weighted population) once allowance is made for unreported investment, and a continued increase in reported planned investment in adult mental health. The identified planned cash increase in resources reported was 360M British pounds between 2001/02 and 2002/03, 421M British pounds between 2002/03 and 2003/04, 564M British pounds between 2003/04 and 2004/05 and 205M British pounds between 2004/05 and 2005/06. If the reported investment is adjusted to include the estimated value of unreported investment, there is a total increase in spending of 1.65B British pounds from 2001/02 to 2005/06. There is a **trend** of annual increases in investments: (14%) between 2001/02 and 2002/03, 234M British pounds (6.3%) between 2002/03 and 2003/04, 577M British pounds (14.6%) between 2003/04 and 2004/05 and 384M British pounds (8.5%) between 2004/05 and the current year. (*Source: UK Department of Health website (Publications and Statistics/Publications/Publications Statistics/Publications Statistics Article).*)

GPs are now paid significantly more but not getting productivity gains and they are often less willing to be helpful in reforming the system.

The UK has significantly increased the number of nurses and have an over supply at the moment as result of heavy foreign recruiting in the 90s. Registered Nurses are educated in a three year diploma program. Nurse Practitioners earn a masters degree.

The European Union legislated target of a 48 hr maximum work week will come into effect in 2009 in England. It is anticipated that this, along with the lifestyle expectations

of younger doctors, will require more physicians to sustain the services in the UK health system.

### ***Wait Times***

In its 2000 policy paper *The NHS Plan: A Plan for Investment, A Plan for Reform*, The UK Department of Health developed an ambitious wait time reduction strategy. The policy objective is to reduce maximum wait times for inpatient treatments to six months and outpatient treatments to three months by the end of 2005, with the further reduction of the inpatient time to eighteen weeks by 2008.

Meeting stated wait reduction targets proved to be a work in progress requiring re-evaluation along the way. For example, in 2002-03 it had become apparent to the Department of Health that “despite unprecedented investment aimed at increasing the existing capacity in the National Health Services, growth will not happen fast enough to meet the NHS Plan targets.” One of the more successful wait time reduction targets has been in the area of emergency room services where the maximum wait time of four hours is met 98% of the time and gives expanded authority to nurses to achieve the target.

Efforts to increase capacity were therefore ramped up, particularly in three key strategic areas, two of which had been in operation since 2002, and all of which involve one form or another of service out-sourcing:

- The creation of new public and private treatment centres starting in 2003: as of the end of December 2005, over 245,591 patients have been treated in 44 public and 14 independent treatment Centres. (Note: treatments in these private centres are covered entirely by public funds. There are no co-payments. Similar private clinics which meet the standards of the *Canada Health Act* and the *BC Medicare Protection Act* already exist in Canada).
- The commissioning of overseas treatments for UK patients: as of 2005, more than 400 patients have been referred to France, Germany and Belgium for orthopaedic, ophthalmological and cardiac procedures.
- The procurement of overseas medical teams to conduct procedures for brief terms within UK facilities: the first schemes started in July 2002 and have so far treated over 10,000 patients in 17 schemes.

Alongside these efforts the “Choice at Six Months” policy was introduced in 2004 and fully rolled out in January 2006. The short term objective of the policy is to help clear the backlog of patients who have already exceeded the six-month wait time guarantee by offering them treatment in facilities outside of their own jurisdiction. The longer term objective is to offer new patients expecting to wait longer than six months a

number of treatment options immediately at the point of GP referral (rather than having them wait).

The policy is also intended to (eventually) replace wait lists with a centralized booking system wherein patients can select and confirm their own treatment date. From the patient's perspective, this will reduce some of the uncertainty and inconvenience associated with being placed on a wait list, and will also allow them to plan their lives accordingly in preparation for their treatment.

To complement efforts to meet wait times, the Department of Health has introduced the "Payment by Results" financial framework. DH payments to service providers (via the Primary Care Trusts) are linked to activity and adjusted for case mix. The aim of the new financial system is to provide a transparent, rules-based system for paying all trusts in the same manner. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions (in short, those that *do* more, *get* more).

In January 2006 Secretary of State for Health, Patricia Hewitt was able to announce that all wait time reduction targets for 2005 had been successfully met. The number of patients, for whom English commissioners are responsible, waiting longer than 6 months for admission to an English trust, is 12. These figures compare with 66,000 waiting over 6 months in December 2004 and 284,000 in March 1997.

The UK Department of Health implemented a range of programs to improve patient care and meet the four-hour A&E target. The Department introduced the A&E Capital Incentive Scheme. Under this scheme each acute NHS trust with a major A&E that met specific thresholds could access payments of up to .5M British pounds. (UK Department of Health Website Policy and guidance/Organization policy/Emergency Care/Emergency Care Programs/Emergency Care Programs Articles)

On February 13, 2006, the NHS announced a new initiative to help NHS reduce emergency admissions to hospital. In response to the report, *Keeping people out of hospital- the challenge of reducing emergency admissions*, NHS implemented a new initiative that will provide GPs and primary care trusts with access to High-impact User Managers (HUM). HUMs identify those patients who are at most risk of repeat emergency admissions to hospital. There is a high human- as well as financial - cost of frequent hospital admission.

However, this success in the UK should be viewed with some caution since there has been some concern over the accuracy of the reporting. For instance, there have been several recent news stories suggesting that UK health authorities are at best inaccurately and at worst, failing to report or falsely reporting UK wait time data. (On August 15, 2006, the Guardian reported that a recent audit carried out by the Department of Health discovered that one in five ambulance trusts systematically misreported response times, making it look as if they reached serious life-threatening emergencies within government targets.)

Also, while many hospitals have policies that mandate that 95% of people admitted via casualty should be found a bed within four hours, in reality, the average wait time in emergency rooms at present is 10 hours not 4 hours. (BBC News Story, Tuesday January 11, 2005 entitled "Two day wait for hospital bed." For more up to date information, Quarterly statistics on Accident & Emergency (A & E) performance can be seen at:

[www.performance.doh.gov.uk/hospitalactivity/data\\_requests/.](http://www.performance.doh.gov.uk/hospitalactivity/data_requests/))

## ***Funding and Expenditures***

The National Health Services Plan (NHS) is funded by the Department of Health mainly through general taxation (e.g., direct taxes, value added tax and employees' income contributions), with a small element also coming from private sources (such as private medical insurance premiums or out-of-pocket expenditures by patients).

The Department of Health's 2005-06 estimate for planned total expenditure is 87.8 billion British pounds (\$CDN 180B), which represents roughly 18% of the total UK budget. 94.1 % of this will come from public sources such as taxation and employee contributions, and the rest from various charges and receipts. This is an increase in the public share from 83% prior to May 2004.

Expenditures on health in the UK are projected to increase by almost 40 billion British pounds from 2002 to 2007 (from 54 British pounds in 2002 to 92 billion British pounds in 2007 or 70% over five years), at an average increase of 7.3% per year. This represents the largest ever spending increase on health in UK history.

Total UK spending on health for 2004-05 was 8.3% of GDP (6.9% public, 1.4% private). This figure is expected to be almost 10% of GDP by 2008.

Health expenditure per capita in the UK for 2002 was \$2,607 (CAD).

With the increase focused on patient choice, the money tends to follow the patient in their health care system, ensuring that where the patient chooses to go for treatment or services, the money moves with them and becomes an incentive for better service in a competitive market.

The Private Finance Initiative (PFI) is the primary mechanism for funding capital expenditures in the UK system. The PFI provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by a public authority.

By requiring the private sector to put its own capital at risk and to deliver clear levels of service to the public over the long term, PFI helps to deliver high quality public services and ensure that public assets are delivered on time and to budget. The number of PFI projects signed has continued to increase with over 700 projects with a total value of

over 46B British pounds closed to date. Over 500 PFI projects have now completed construction across a broad range of sectors, delivering 185 new or refurbished health facilities; 230 new and refurbished schools; and 43 new transport projects. ([www.hm-treasury.gov.uk](http://www.hm-treasury.gov.uk))

### ***Key Features and Innovations***

The UK is implementing a new approach to public health, entitled *Choosing Health*, which is guided by three principles: providing people with the support they need to make their own informed choices; personalization of services and support so that they are tailored to the realities of individual lives; and working together in partnership to make health everyone's business.

Overarching priorities identified are: reducing health inequalities; reducing smoking rates; reducing obesity and improving diet and nutrition; encouraging and supporting sensible drinking; improving sexual health; and improving mental health. Particular attention is to be paid to promoting health amongst young people.

In the area of mental health services, the government is introducing measures through the SureStart program to improve the mental health of children and young people. It is publishing an action plan to ensure equality of access to mental health services for ethnic minorities. There are also published guidelines on how mild to moderate mental health issues should be managed in the workplace.

To address lengthy wait times for treatment and admission in ERs, the Emergency Services Collaborative Project, which involved all hospitals working together on the problem, led to creative solutions to ER challenges. One result of the project is that emergency room nurses have the authority to admit and discharge patients and make referrals to other more appropriate services. This has helped to reduce wait times and improve patient flow in the ER. In addition, psychiatric liaison nurses are used to quickly assess mental health patients present in the ER.

A new service called Health Direct provides clear information on health choices by telephone, online and digital television information services.

NHS health promotion trainers provide advice to individuals on how to achieve a healthier lifestyle. Everyone will be given the opportunity to develop a personalized health plan.

By 2010 every Primary Care Trust will be resourced with at least one full-time school nurse working with primary and secondary schools in their area.

Employers are encouraged to find ways of helping people who have been off sick to return to work, even if it means temporarily altering their jobs.

In 2004 the UK Department of Health announced a 12M British pounds National Prevention Research Initiative involving some of the country's leading charities, research organizations and government. The initiative aims to tackle some of the major health problems in the UK, such as cancer, diabetes and heart disease, by investing in research into disease prevention. Previously, in 2002, the Department of Health announced the creation of a National Suicide Prevention Strategy. The Department has also allocated 300M British pounds to programs for preventing and reducing drug misuses in 2005-06.

A *Fitter Britain* scheme will be launched as part of the build up to the 2012 London Olympics.

A big emphasis is being placed on schools, which will be tasked with providing healthier meals, free fruit and sport both within and outside of school hours.

Children will be encouraged to cycle to school and adults to get active at work.

Agenda for Change is a new initiative focused on increasing provider productivity and dealing with the sustainability of the health care system which faces an average annual increase in expenditures of 7-8%.

## **SUMMARY OF FINDINGS AND INNOVATIONS:**

- A mix of public & private providers of health care services and health care facilities is an accepted reality in the countries visited.
- All governments are looking at strategies for managing the fiscal sustainability of their health care systems with an emphasis on health promotion and disease and injury prevention.
- Health professionals and health systems are shifting their focus to provide timely, high quality customer service to patients and families.
- Patient choice and continuity of care are integral to health service delivery, including a significant investment on follow-up contact after services are completed.
- Patients can generally choose whether to receive health services from a public or private provider, including which hospital they wish to use and are insured in either venue for medically necessary services.
- Health care reforms are an ongoing feature of planning and change management.
- Prevention and health promotion are increasingly central elements to health system redesign.
- Promotion of physical activity for children in schools and adults in the workplace is increasing in an effort to reduce the rise of obesity among all age groups. Programs promoting cycling, walking and team sports are common.
- All countries are concerned about the impact of aging health care providers and an aging population.
- There is a general concern about the emergence of a pandemic influenza.
- Primary health care is a key element of frontline health service delivery using multi-disciplinary teams providing diagnostic, treatment and prevention services. Primary health care centres are a common feature of health service delivery.
- Health Human Resource deployment is a common challenge in each jurisdiction.
- Wait times initiatives are producing positive results for patients.
- Mental health care is inconsistent, but better planning and more community based service delivery models are being introduced across Europe.
- England's SureStart mental health initiative is placing an emphasis on community mental health services, public education, help for immigrant populations and guidelines on how mild to moderate mental health issues should be managed in the workplace.
- Co-payments are an accepted and common feature in funding the health care systems visited.
- There is some health care provider dissatisfaction despite increases in income.
- Nursing roles in some countries have been expanded to include authority to admit or discharge patients in emergency rooms, make referrals in ERs to more appropriate health services, prescribe exercise and healthy lifestyle habits and as Nurse Anaesthetists to facilitate access to surgery.
- Sweden has a system of emergency and elective hospitals to better manage acute care services.

- In some jurisdictions, health professionals can work in both the public and private sector.
- In England, NHS health promotion trainers provide advice to individuals on how to achieve a healthier lifestyle. Everyone will be given the opportunity to develop a personalized health plan.
- Health services for children, including free dentistry, are a priority in the jurisdictions visited.
- In France, there is renewed interest in replacing fee-for-service payment for physicians and perceived discrepancies between public and private for-profit hospitals tariffs with Diagnosis Related Group-based remuneration.
- Patients in Norway have the right to be assigned to a GP, called the “regular doctor arrangement”, and the GP is responsible for providing services to the patients on their list. Citizens may choose another physician as their GP and also may obtain a second opinion from another GP.
- In the recently adopted Norwegian labour act, employers are required to consider how to facilitate physical activity in the workplace.
- Co-payments for many health care services are a long standing practice for involving patients in the cost sharing of health care. Often co-payments are reimbursed through employer supplemental insurance plans.

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