EUROPEAN FACT FILES

HEALTH AND SOCIAL CARE REPORT

2018

- DENMARK
- FINLAND
- FRANCE
- GERMANY
- IRELAND
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MARWOOD GROUP

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INTRODUCTION

Health and care systems in Europe are unique, both in terms of their financing and structure. Their current form has evolved over time driven by politics, cultural expectations and economic conditions. Investors and corporations need to understand these conditions to develop their strategies and make sounds investment choices. To support our clients in their ambitions the Marwood Group produces an annual European Fact file. A reference document, tailored to our clients, that distils in a snapshot the key features of the health and care systems across Europe. This year's edition of the European Fact Files covers 14 different healthcare systems, including the four Nordic countries and the "big five" European countries. In each of them we have covered health and social care.

While it is true that all health systems are unique and each system has its own specificities, some common themes can be drawn across Europe, key among them are:

- Social care services are generally not free at the point of need, requiring co-payments or out-of-pocket payments for individuals falling outside of the safety net.
- In contrast, healthcare services are mostly free at the point of need, or require limited (often capped) co-payments.
- Very few countries have fully integrated health and social care.
- Health and social care services are facing increasing demand in all countries due to an ageing population.
- Funding sustainability is placing pressure on reimbursement in key areas such as pharmaceutical products.

Yet, despite these common themes there are significant differences, including:

- The level of decision making. Some countries like France have a highly centralised decision-making systems while in others, like Spain or the Nordics, the regional or even local level enjoy a high degree of discretion in funding and organisation of services.
- The provision landscape across Europe is a mix of public and private operators. Some countries, like Germany, rely heavily on private provision for healthcare services, while others, like Denmark have almost no private provision. Historically, private providers have been more involved in delivering social care services than healthcare services.
- The approach to quality regulation varies significantly across countries. While everywhere, standards are high and well defined, inspection and monitoring of quality in health and social care is very different, with England presenting the most established independent quality regulator.

Above all, these systems are dynamic. The European Fact Files provide a snapshot of the most recent state of European healthcare systems. However, health and social care systems keep changing, in response to new demographic or financial challenges, or as a result of new policies. These dynamic similarities and differences between the health systems create winners and losers. Investors and corporations who understand these dynamics will ultimately benefit.

We would be more than happy to answer any questions that you may have or further discuss a particular healthcare system, so feel free to contact us.

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HEALTHCARE SYSTEM SNAPSHOT

	HEALTHCARE			
	Funding	**Governance**	**Payers**	**Providers**
DENMARK	Mostly local tax funded, complemented national tax. Limited voluntary private health insurance (PHI) for quicker access	Highly decentralised	Municipalities	Mostly public
FINLAND	Local taxation complemented by national taxation	Decentralised	Municipalities	Mostliy public with limited private provision
FRANCE	Mandatory statutory health insurance (SHI) funded through payroll contributions (78%), top-up private health insurance	Highly centralised	SHI and PHI	Mostly public with some private provision - quasi market
GERMANY	SHI funded through payroll contributions (85%), or PHI (11%)	Shared between federal government and Länder (regional) governments	Sickness funds	Public and private providers
IRELAND	Government safety net (Taxation) Co-payments Voluntary PHI	Highly centralised for public services, decentralised for private services	Health Service Executive and private health insurance	Public and private providers
ITALY	General taxation Limited subscription to voluntary PHI for quicker access	Mostly decentralised	Regional Local Health Authorities	Mostly public with some private provision (regional variation)
NORWAY	General taxation (national and local) limited voluntary PHI for quicker access	Decentralised	Regional Health Authorities	Mostly public
SPAIN	Mostly local tax funded, Complemented National Tax, Limited voluntary PHI for quicker access	Highly decentralised (new trend towards re-centralisation to control costs)	Regional Health Services	Public and private providers - use of public/private partnerships
SWEDEN	68% local tax funded, 18% National Tax, voluntary PHI for quicker access (5%)	Highly decentralised	County Councils	Mix of public and private providers in primary care, mostly public in acute
SWITZERLAND	Mandatory purchase of statutory PHI, premiums subsidised by cantons (taxation) for a minimum basket of services, voluntary top-up PHI	Highly decentralised (new trend towards re-centralisation to control costs)	Multi-payer system including insurance funds, Cantonal and Communal Health Authorities,	Mostly public with some private provision - quasi market
ENGLAND	General taxation, limited subscription to voluntary access	Mostly centralised	NHS England & Clinical Commissioning Groups	Mostly public with some private provision - quasi market
NORTHERN IRELAND	General taxation, limited subscription to voluntary PHI for quicker access	Centralised	Health and Social Care Board	Mostly public with some private provision - quasi market
SCOTLAND	General taxation, limited subscription to voluntary PHI for quicker access	Centralised	NHS boards	Monopoly government provider - no payer/ provider split
WALES	General taxation, limited subscription to voluntary PHI for quicker access	Centralised	Local Health Boards	Monopoly government provider - no payer/ provider split

SOCIAL CARE SYSTEM SNAPSHOT

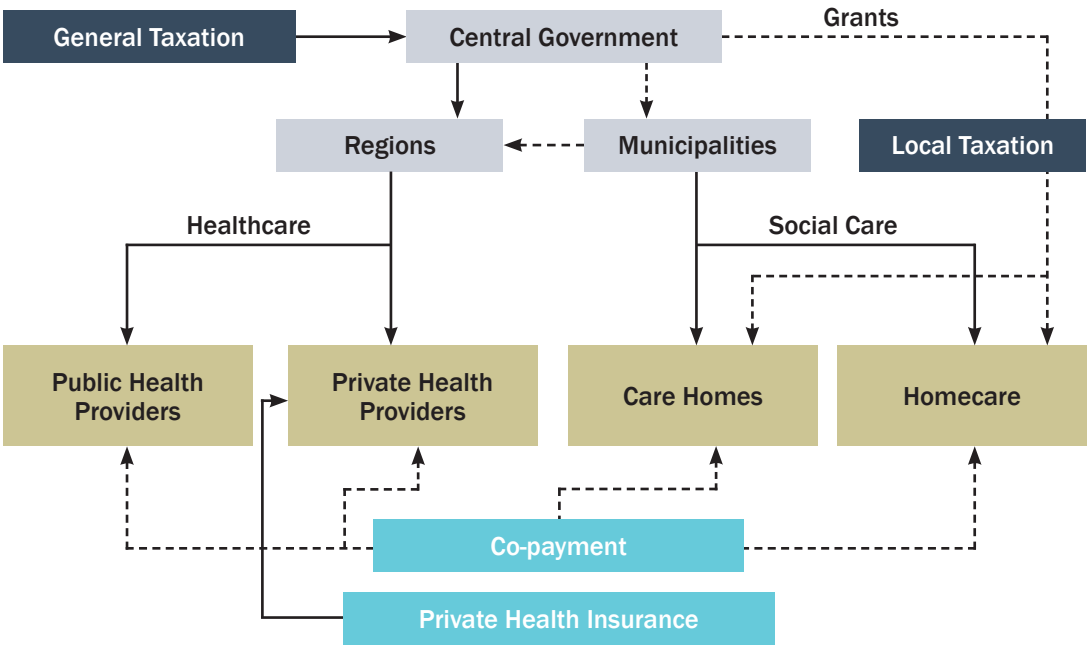
SOCIAL CARE				
Funding	**Governance**	**Payers**	**Providers**	
Local taxation - not free at the point of need	Highly decentralised	Municipalities	Mostly public	DENMARK
Local taxation complemented by national taxation - not free at the point of need	Decentralised	Municipalities and individuals	Mostly public with growing share of private provision	FINLAND
Mix of SHI and local and national taxation - not free at the point of need	Mostly centralised with a degree of local decision	Departments, SHI and individuals	Mix of public and private providers	FRANCE
LTCI funded through payroll contributions - not free at the point of need	Shared between federal government and 16 Länder (regional) governments	LTCI and individuals	Mostly private	GERMANY
National taxation, integrated with healthcare budget - not free at the point of need	Highly centralised (Health Services Executive)	Health Service Executive and individuals	Mostly private	IRELAND
General taxation - not free at the point of need	Decentralised	Municipalities Regional Local Health Authorities Individuals	Mostly public with growing share of private provision	ITALY
General taxation (national and local) - not free at the point of need	Decentralised	Municipalities Individuals	Mostly public with limited private provision	NORWAY
General taxation - not free at the point of need	Highly decentralised (Regions)	Regions and individuals	Mostly private	SPAIN
Local taxation - almost free at the point of need	Highly decentralised (Municipalities)	Mostly municipalities	Mix of public and private providers	SWEDEN
PHI - not free at the point of need	Decentralised (Cantons)	PHI and individuals	Mostly private in residential care, mostly public in homecare	SWITZERLAND
National and local taxation - not free at the point of need	Decentralised (Local Authorities)	Local Authorities and individuals	Mostly private	ENGLAND
National taxation, integrated with healthcare budget - not free at the point of need	Mostly centralised (Local Health and Social Care Trust, on the basis of a single assessment tool)	Health and Social Care Board and individuals	Mostly private	NORTHERN IRELAND
Mostly national taxation - free personal and nursing care for over 65 assessed as needing it	Decentralised (Local Authorities)	Local Authorities and individuals	Mostly private	SCOTLAND
Local taxation - not free at the point of need	Decentralised (Local Authorities) but degree of re-centralisation	Local Authorities and individuals	Mostly private	WALES

DENMARK

The Danish healthcare system is primarily funded through national and local taxation. Central government allocates funding to each region, and they are responsible for funding most healthcare services. Healthcare services are mainly free at the point of need. However, co-payments are required for services such as dentistry and eyecare. Adult social care services are mostly financed by municipalities, which draw most of their revenue from local taxation. In addition, central government provides a national social care fund using grants.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
5.7m	43,560km^2	Copenhagen	**W** 82.7 | **M** 78.8

THE DANISH FUNDING SYSTEM



Major source of funding

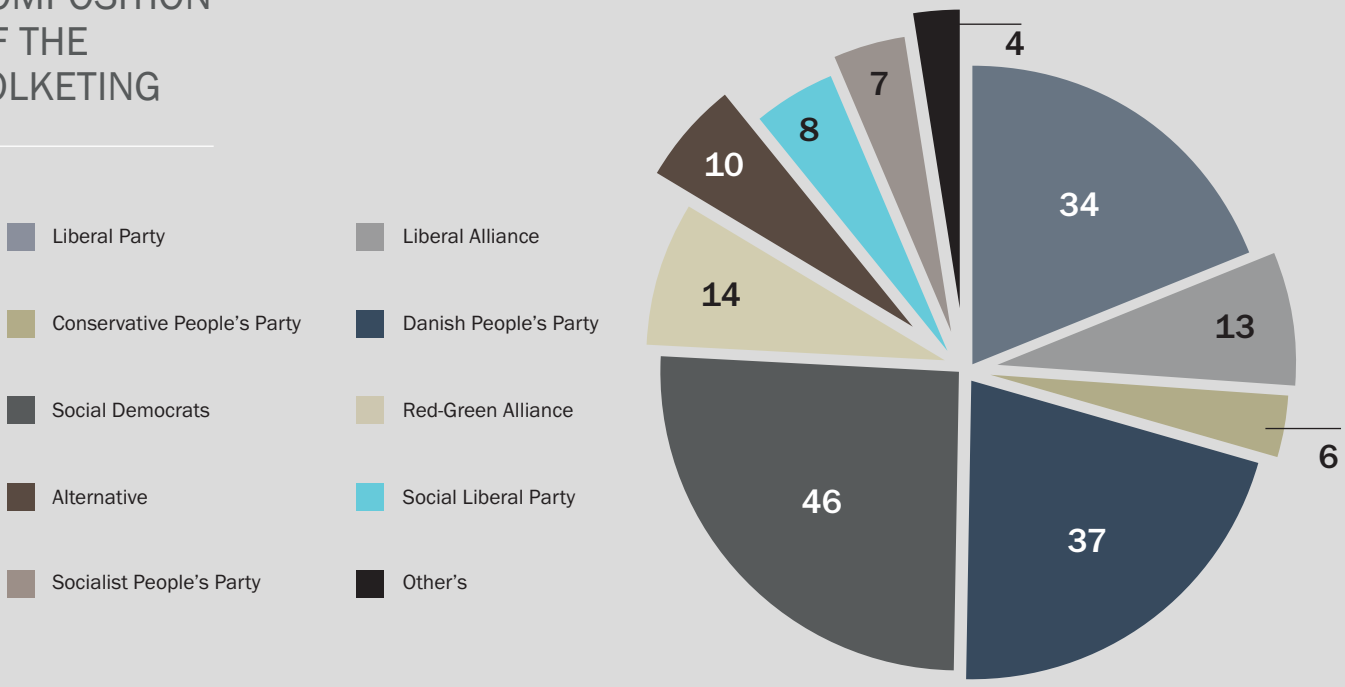
Secondary source of funding

POLITICAL CONTEXT

Denmark is a constitutional monarchy with a population of 5,748,769. Executive power rests with the monarch, and legislative power with parliament. The monarch appoints prime ministers and government ministers, based on the political composition of parliament. The parliament (Folketing) has 179 members.

With a multi-party structure, 13 parties are currently represented in parliament. No party has an absolute majority. The Liberal Party is the largest party. The current government is a coalition of the Liberal Party, the Liberal Alliance and the Conservative Party. General elections are held every four years. The next general election is due to take place in June 2019.

COMPOSITION OF THE FOLKETING



Governance

	HEALTHCARE	SOCIAL CARE
National	Ministry of Health	Ministry of Health
Regional	Five councils	Five councils (limited role)
Local	98 municipalities	98 municipalities

Healthcare

Denmark is divided into five regions governed by councils and 98 municipalities. Healthcare governance operates at three levels.
The current system is the result of major health reforms introduced in 2007, which led to an administrative reorganisation of the healthcare system. As part of that reorganisation, central government expanded its role in the coordination and oversight of healthcare services.

At the national level, the government has responsibility for establishing, regulating, coordinating and supervising cost-control measures for the provision of healthcare services in the country. The Ministry of Health defines the framework for the national health system and for social care health services for older adults.

At the regional level, authorities coordinate, administrate and finance the provision of specialised healthcare services, general practice and psychiatric care. At the local level, municipalities are responsible for preventative services.

Social Care

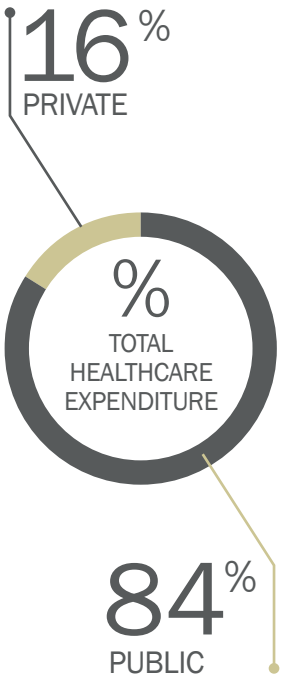
Municipalities are responsible for financing and delivering social care. This includes general prevention and rehabilitation services and specialised care for older adults. Each municipality has a Senior Citizen Council in which all citizens over 60 can take part to make decisions on local issues relevant to their age-group and then communicate their position to the municipal administration.

There have been limited changes to social care in the past five years. The most recent major change was the Social Service Act of 2005.

Regulation

The government sets the regulatory framework for the national health system and older adults' care services. This is undertaken through the Ministry of Health, the Danish Health Authority, the Danish Medicines Agency and the Danish Patient Safety Authority. National health regulators also approve health agreements with and between regions and municipalities to ensure the coordination of service delivery.

In social care, central government is responsible for the coordination and quality standards underpinning the provision of social care services for older adults.



Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Denmark is mostly public. About 84% of total healthcare expenditure comes from public sources. General taxation is the main source of public funding. Taxes are levied at a national level by the central government and at local level by the 98 municipalities. Alongside public expenditure, about 16% of healthcare expenditure is financed privately. This mostly takes the form of user co-payments for a small number of services and, to a lesser extent, private health insurance (PHI). Total healthcare expenditure in Denmark makes up about 10.4% of GDP. This figure has been stable for the past five years.

Healthcare Financing Flows

Central government allocates healthcare funds to the five regions which are responsible for organising and delivering the majority of healthcare services. Municipalities also contribute to the regions' healthcare budgets by redistributing some of their local taxation revenue to their region. Each municipality's contribution is proportional to the size of its population. Within their healthcare budgets, regions allocate resources to a wide range of services, on the basis of a national framework. Over the past five years, regional expenditure on healthcare has increased continuously. However, the 2017 Budget Bill suggests that regional healthcare expenditure will experience a real-time decrease between 2017 and 2020, from €14.77bn in 2017 to €14.74bn in 2020.

Healthcare System Structure

Services

Although there is no defined basket of services, there are few restrictions on provision. The Danish healthcare system gives access to a comprehensive range of healthcare, including primary, secondary and specialist care, as well as mental health services. These services are free at the point of need. Access to specialised care is subject to a referral from a primary care General Practitioner (GP). Some services such as dentistry, physiotherapy and eyecare require co-payments.

Payers

The regions are the main payers for healthcare services.

GPs are paid through a mix of capitation and a fee-for-service system. Payment rates are agreed nationally between representatives of each region and GPs' associations.

Specialist hospital-based outpatient services are paid on a fee-for-service basis. Inpatient secondary care in hospital is funded mostly through global budgets and activity-based payments. The Danish hospital sector is currently undergoing a transformation programme. Central government has assigned a fund of €6.4bn to modernise existing hospitals to provide specialised care in fewer, larger units, with the aim of improving the efficiency and quality of care.

Providers

The majority of healthcare providers in Denmark are public providers.

Primary care services are delivered by 3,700 private GPs operating under contracts with the public healthcare service. Historically, GPs have worked in individual practices but are increasingly working in group practices.

Secondary care is mainly provided by public regional hospitals. Specialist hospital functions are allocated among one to three hospitals per region. The organisation of specialised services is planned nationally by the Danish Health Authority in cooperation with medical associations and regional authorities. Exceptions to this rule include ophthalmology and dental care. Hospital infrastructure is organised regionally.

Adult Social Care Financing

Social Care Financing Context

Social care expenditure is mostly public in Denmark, though individuals are expected to contribute towards some of the costs. As municipalities are responsible for the organisation of social care services for older people, public support is mostly financed through local taxation. In addition, central government assigns grants through a national fund called Satspuljeaftalen, which aims to improve living conditions for disadvantaged groups. Public expenditure on social care services, including specialised care for older adults, represented 2.8% of GDP in 2014. In the 2016 National Budget, central government allocated €40.2m to be spent between 2016 to 2019, and a similar annual spend from 2020, for investment in a preventative healthcare service for older adults with complex care needs.

Social Care Financing Flows

Social care financing is straightforward in Denmark. Funds are raised locally and municipalities are responsible for allocating them among social care services. Providers are paid directly by municipalities. There are no personal budgets or cash benefits for patients in Denmark.

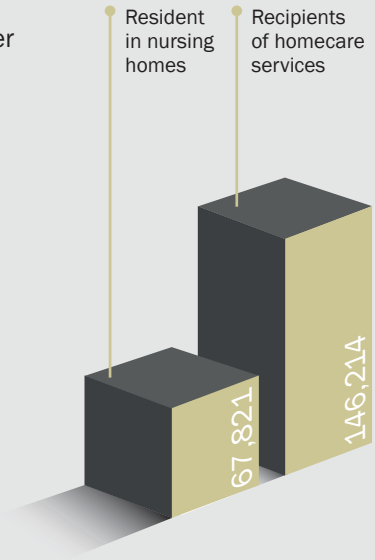
Adult Social Care System Structure

Services

Services for older adults in Denmark include homecare, medical homecare and nursing homes. In 2014, there were 642,168 beds in nursing homes and homes for the elderly in Denmark. The total number of beds has increased every year since 1993.

Social care services are not free at the point of need. Most people receive services in their own home. In 2016, 67,821 people aged over 65 were resident in nursing homes and specialised accommodation for older adults and 146,214 were recipients of homecare services.

Central government has introduced initiatives to improve the quality and capacity of homecare services.



Payers

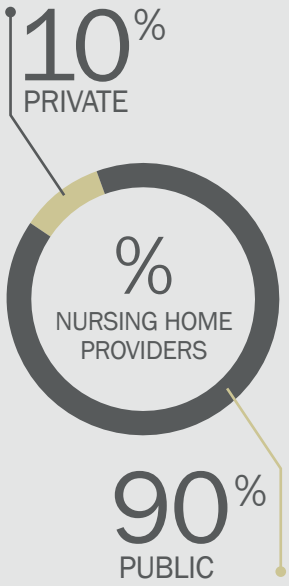
Municipalities are the main payers for social care services. However, individuals are expected to contribute towards some of the cost of their care.

Permanent homecare is provided at minimal cost. Some services such as help with cleaning, laundering, bathing and shaving are free of charge. There is a co-payment system for food provision and this varies between municipalities. Individuals receiving temporary homecare may have to contribute towards the cost of their care, depending on their income.

In nursing homes, individuals may have to contribute towards the cost of their care, food and private expenses. Contributions are means tested against their income and available savings. However, nursing and healthcare services are free of charge. All services are provided based on an assessment of individual need or as prescribed by a doctor. There is a maximum waiting time of two months for a place in a nursing home, provided the place applied for is in the applicant's municipality of residence. Places are randomly assigned within the municipality.

Providers

The majority of services are public and provided by the municipalities, with 90% of nursing homes run by public providers. However, municipalities are legally obliged to open the social care services market to private providers in order to offer alternative options to users of homecare and food services. Home nursing and rehabilitation services (including physical and mental training) are provided by municipalities as part of healthcare provision. They are available to all citizens free of charge when prescribed by a doctor or on the basis of a personal need assessment.

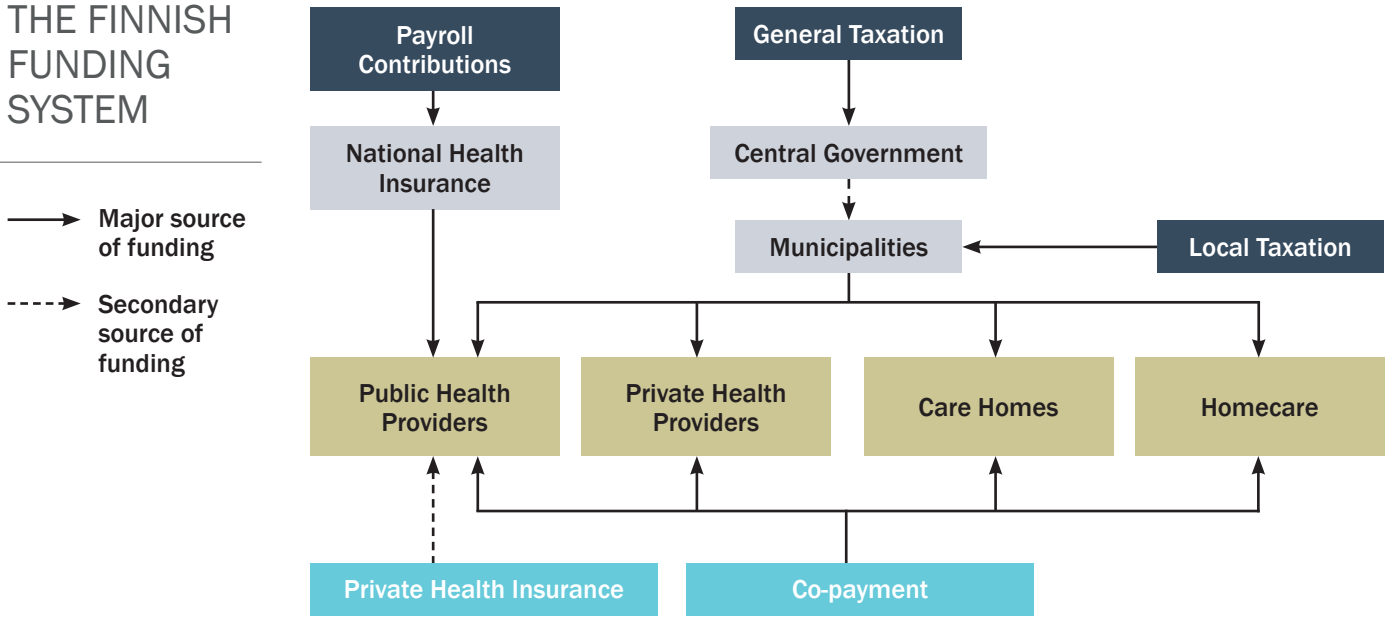


FINLAND

The Finnish healthcare system is primarily funded through local taxation and further supported by user co-payments that are capped at an annual threshold. Healthcare services are not free at the point of use. Social care is the responsibility of local government, and there is wide variation between municipalities in the amount of provision and cost of private care.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
5.5m	338,424km^2	Helsinki	**W** 84.4 | **M** 78.7

THE FINNISH FUNDING SYSTEM

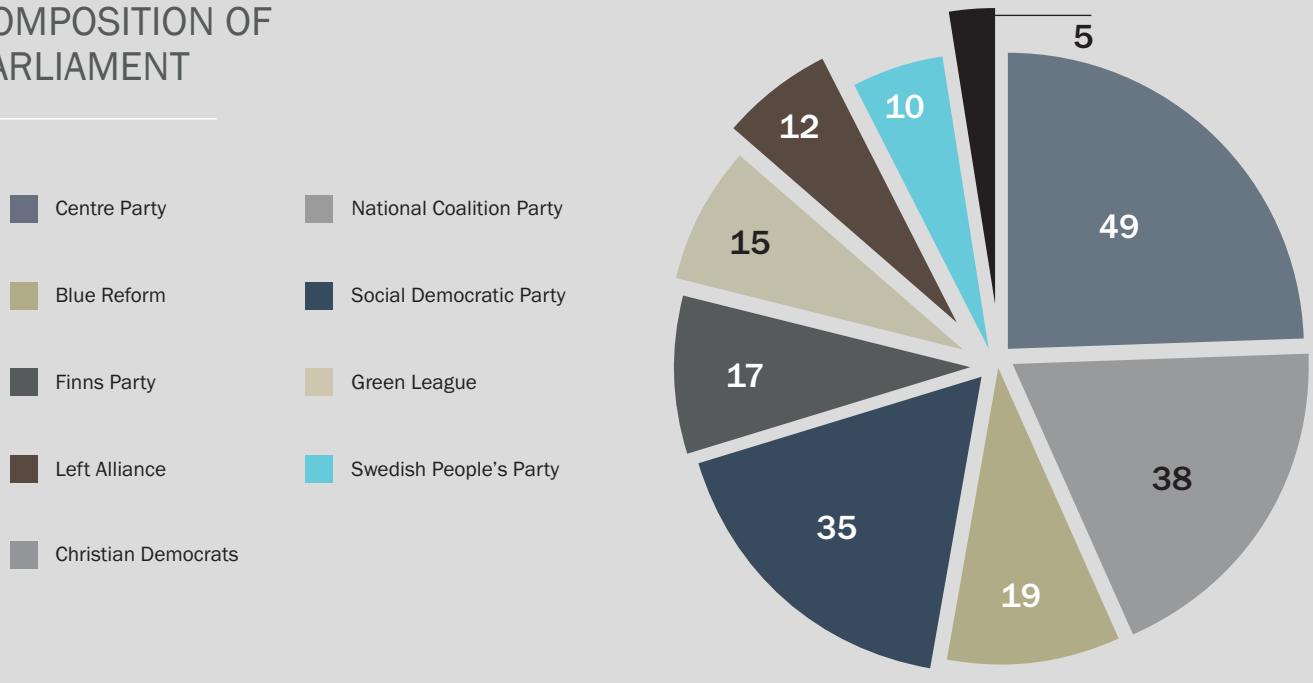


POLITICAL CONTEXT

Finland is a parliamentary republic with a population of 5,503,297. Executive power is shared between the president, whose primary concern is the country's foreign policy, and the government. The government is represented by a prime minister and 12 ministers. The prime minister is nominated by the president and the nomination put to parliament for approval. The president may dismiss the government as a whole, or individual ministers, if they no longer enjoy the confidence of parliament.

Legislative power is exercised by a single chamber parliament. 200 members, represent 13 electoral districts and nine parties are currently represented. No party has an absolute majority. The largest party is the Centre Party with 49 members. The next elections will take place in April 2019.

COMPOSITION OF PARLIAMENT



Governance

	HEALTHCARE	SOCIAL CARE
National	Ministry of Social Affairs and Health	Ministry of Social Affairs and Health
Local	311 municipalities	311 municipalities

Healthcare

Finland has two levels of healthcare governance. Nationally, the government, via the Ministry of Social Affairs and Health, sets policy objectives for health and welfare improvement and has overall responsibility for healthcare standards.

The system is highly decentralised. Finland is divided into 311 municipalities, which collaborate across eight sub-regions. Each municipality has the freedom to own and run primary healthcare centres. They also plan and regulate the provision of primary and secondary healthcare services in their area. This is done in cooperation with the local government regional authorities.

The government is also active locally through the allocation of funds for the development of local health initiatives. Ongoing health reforms have increased the involvement of government in the regulation of funding and the provision of local services.

Social Care

The Social Welfare Act 1301/2014 stipulates the social care services that municipalities must provide. It sets out the responsibilities local authorities have to support the older population.

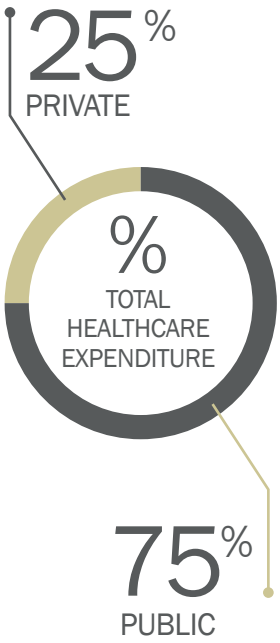
There are two levels of social care governance. As with healthcare governance, authorities at the local level are responsible for organising the delivery of social care, while the Ministry of Social Affairs and Health proposes legislation and oversees its implementation.

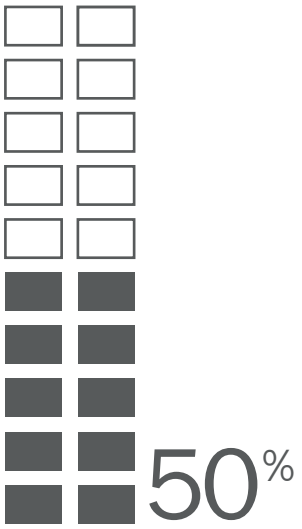
Regulation

The government sets general healthcare policy objectives and the corresponding measures as part of its administrative programme. Legislative initiatives and reforms of health regulation are promoted by the Ministry of Social Affairs and Health.

At the local level, each municipality is responsible for regulating the provision of healthcare services within its own territory.

For social care Finland has a much lighter regulatory regime than other European countries. Responsibility lies with the Ministry of Social Affairs and Health, but they are primarily a steering body that issues guidance to regional and municipal bodies. Valvira (the National Supervisory Authority for Welfare Health) was established to perform this function. They provide licences for private providers and workers with protected occupational titles, and investigate user complaints.





Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Finland is mostly public, with public funds accounting for about 75% of the total expenditure. There are two sources of public healthcare revenue. The main source is municipal taxes, levied at local level and complemented by central government subsidies. In addition, individuals are required to contribute towards National Health Insurance (NHI) via payroll contributions. Private healthcare spending comes mostly in the form of charges. In 2016 total healthcare expenditure was €20bn (9.3% of GDP). Expenditure has grown annually since 2005.

Healthcare Financing Flows

Due to there being two parallel sources of public funding, healthcare financing flows are complex. Municipalities are responsible for organising healthcare services and resources allocation decisions. Top-up central allocations vary between municipalities and are distributed according to local demographics. Approximately 50% of municipal healthcare expenditure is used for secondary (hospital) and primary care. In parallel, NHI is used to cover the cost of private healthcare services. The total NHI resource allocation and contribution fee is determined by the Finnish parliament and individuals must apply for reimbursement after they have used services. NHI makes up 5.7% of the total expenditure.

Healthcare System Structure

Services

Individuals have access to three types of healthcare services. Municipal services represent 35% of all service use, occupational services 45%; and the private system 15%. The municipal system is characterised by low user charges and comprehensive services while the occupational and private systems have short waiting lists. Occupational healthcare is only available to individuals whose employers pay for their access. The main benefit of the private system is that it allows people the opportunity to choose their provider. Only those in employment can access all three systems.

Payers

Municipalities are the main payer for healthcare services. However, public healthcare services are not free at the point of need, and user charges vary between municipalities. The government sets a maximum limit for user charges and an annual ceiling for how much an individual will pay for health services provided by the municipality.

As there is no payer/provider split, GPs are employed directly by municipalities and hospital districts. The payment system for GPs in municipal health centres varies. In recent years, there has been an increase in health centres leasing the healthcare workers from private firms. In 2016, the maximum payment for treatment in primary healthcare was €20.9. This limit was set nationally and is reviewed every two years. Municipalities can set their own user charges, as long as they are below the official maximum cost and are not above the amount it costs to provide the service. They can also provide services free of charge.

The annual ceiling for healthcare services such as physician appointments, physiotherapy, outpatient surgery and other treatments is €633. In 2007, the annual upper limit for pharmaceuticals was €630. Municipalities are responsible for adjusting charges according to the individual's ability to pay. Health institutions cannot charge interest on failed payments.

User charges for rehabilitation services, outpatient pharmaceuticals and ambulance services are reimbursed by the NHI. There are three levels of reimbursement for pharmaceuticals (42%-72%-100%). A proportion of private services can also be reimbursed by the NHI (rates of up to 60% of the official basic tariff and 75% in treatments and examinations) and occupational health services. In practice, only a third of the cost is reimbursed due to the high cost of the private services.

Municipalities can also purchase healthcare services (primary healthcare services or specialised healthcare services) from other municipalities, other hospital districts, private providers or the third sector. The provision of private health and social services is subject to licence. The most commonly-used private services in Finland are physiotherapy, physicians, dentistry consultations and occupational healthcare.

Providers

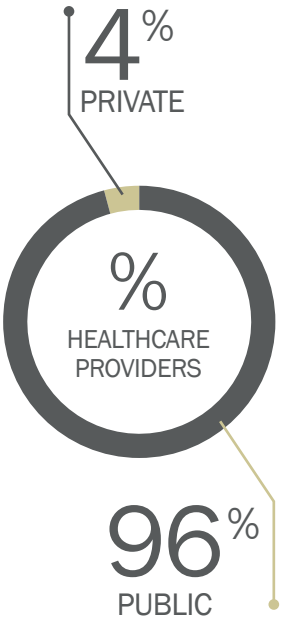
The majority of healthcare services are provided publicly and there is purchaser/provider split. The private healthcare sector is relatively small and provides about 3-4% of services.

In addition to general healthcare services, municipalities are legally responsible for providing maternal and child healthcare and school care, free immunisations, breast cancer screening, family planning and reproductive health services, and environmental health services.

Primary healthcare services are provided by municipal health centres, and specialised medical care is provided by 20 district hospitals. Municipal primary healthcare services provide preventative and curative public health services across a wide range of areas. These include maternal care, dentistry, child healthcare and care for older adults. By law, they must serve a population of at least 20,000 people. Occupational health centres provide primary health services for employees whose employers have elected to use these centres and cover the full cost.

Specialised health services and secondary care can be provided either in healthcare municipal centres or in one of the 20 hospital districts in Finland. All municipalities must be associated within one hospital district and contribute funding towards it. The coverage population per hospital varies from six to 58 municipalities. Patients cannot choose between hospitals and are referred in accordance with the treatment required.

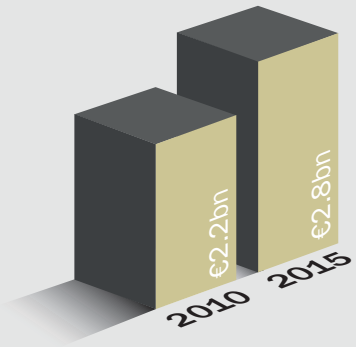
Prescribed pharmaceuticals must be acquired in private pharmacies. Patients can only obtain them in the health centres in emergency situations.



Adult Social Care Financing

Adult Social Care Financing Context

Social care expenditure is mostly public in Finland, but individuals are expected to contribute privately towards some of the costs of their care. As public resources come from the same budget as healthcare, they are mostly levied through local taxation. However, unlike healthcare, NHI does not play a major role in social care financing. In 2015, the total expenditure on long term care for older people and people with intellectual disabilities was €2.8bn, an increase from €2.2bn in 2010. This was partly due to large increases in spending on services purchased from private providers, particularly within the long-term homecare service market. In contrast, the overall annual expenditure on institutional care for older adults and people with intellectual disabilities has decreased as a result of moving patients out of hospitals.



TOTAL EXPENDITURE ON LONG TERM CARE FOR OLDER PEOPLE AND PEOPLE WITH INTELLECTUAL DISABILITIES

Adult Social Care Financing Flows

Social care financing is highly decentralised. Each municipality has a degree of discretion in resource allocation and sets its own payment system and fees. Municipalities can outsource services to private providers or authorise private care homes to accept vouchers subsidised by the municipalities.

Adult Social Care System Structure

Services

Adult social care services are not free at the point of need and are organised by municipalities. The National Supervisory Authority for Welfare and Health and the Regional State Administrative Agencies are responsible for supervising these services. Users have the right to access social services in accordance with their municipality of residence and can only access services based on their current location in emergency situations.

Social services for older adults in Finland include long-term care in health centres, 24-hour serviced accommodation, and institutional and residential services. In 2015, there were 9,494 older adult users of these services. In that year, these services were only being used by the 22% percent of the older adult population in the country but the use of services such as 24-hour accommodation increased by 7% from the previous year.

Payers

There are three mechanisms of payment for older adults' housing services.

First, municipalities establish a fee per service and charge users based on their income at the time the service is provided, in line with a municipal outsourcing agreement.

The second is a partial subsidy payment through a service voucher. The user will pay the service provider any amount that exceeds the value of the voucher. This service is provided by care homes authorised by municipalities to accept the voucher. The user can choose the care home of his or her preference among the authorised by those local authorities.

The third option is payment of the full cost of private care home services.

Providers

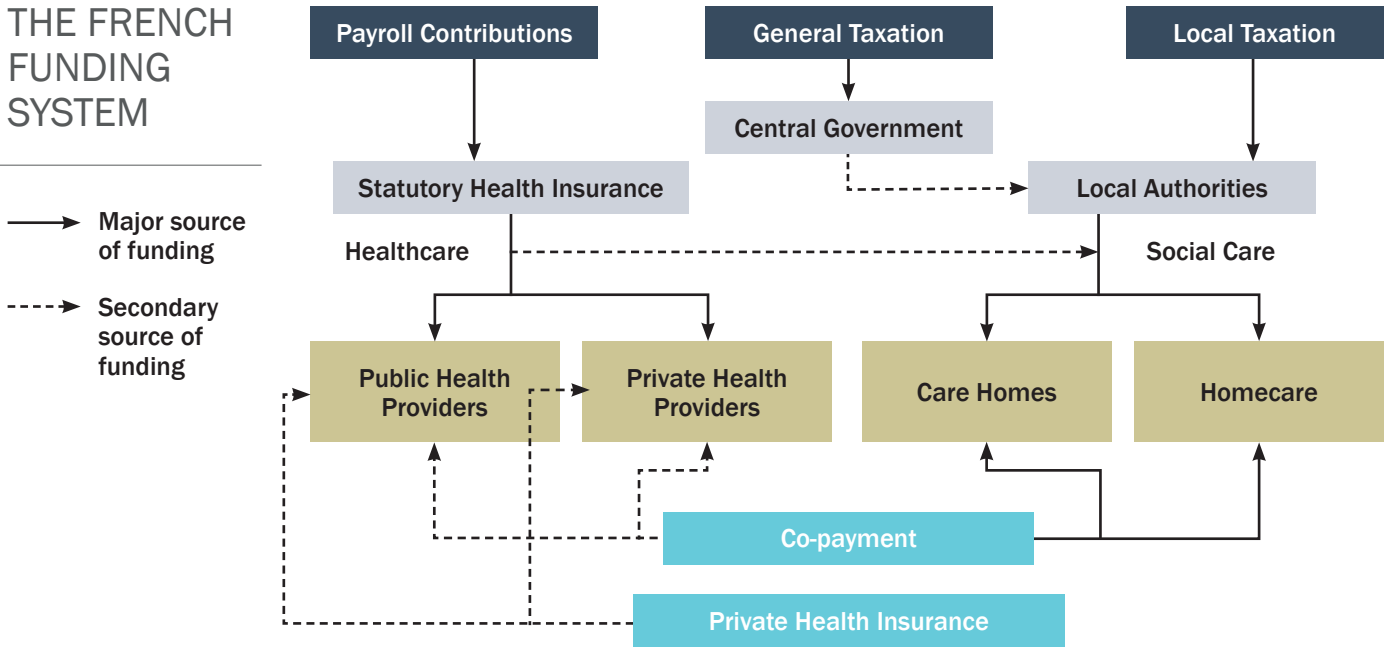
The majority of older adult social care services are owned and administered by the municipalities. However, there is increasing demand for private providers of social care services in Finland and expenditure on private providers has increased in recent years. There is far more expenditure on private provision for homecare services than on institutional services. In 2015, spending on institutional services remained primarily directed at public providers (80% of public expenditure in 2015). In order to provide social care services, providers must obtain a licence.

FRANCE

The French healthcare system is based on statutory health insurance (SHI) and is primarily funded through payroll contributions. As most healthcare services are not free at the point of need, the system is also funded by co-payments. Some co-payments may be claimed back to the SHI and/or to private health insurance (PHI), which covers nearly all the population.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
66.9m	643,801km^2	Paris	**W** 85.5 | **M** 79.2

THE FRENCH FUNDING SYSTEM

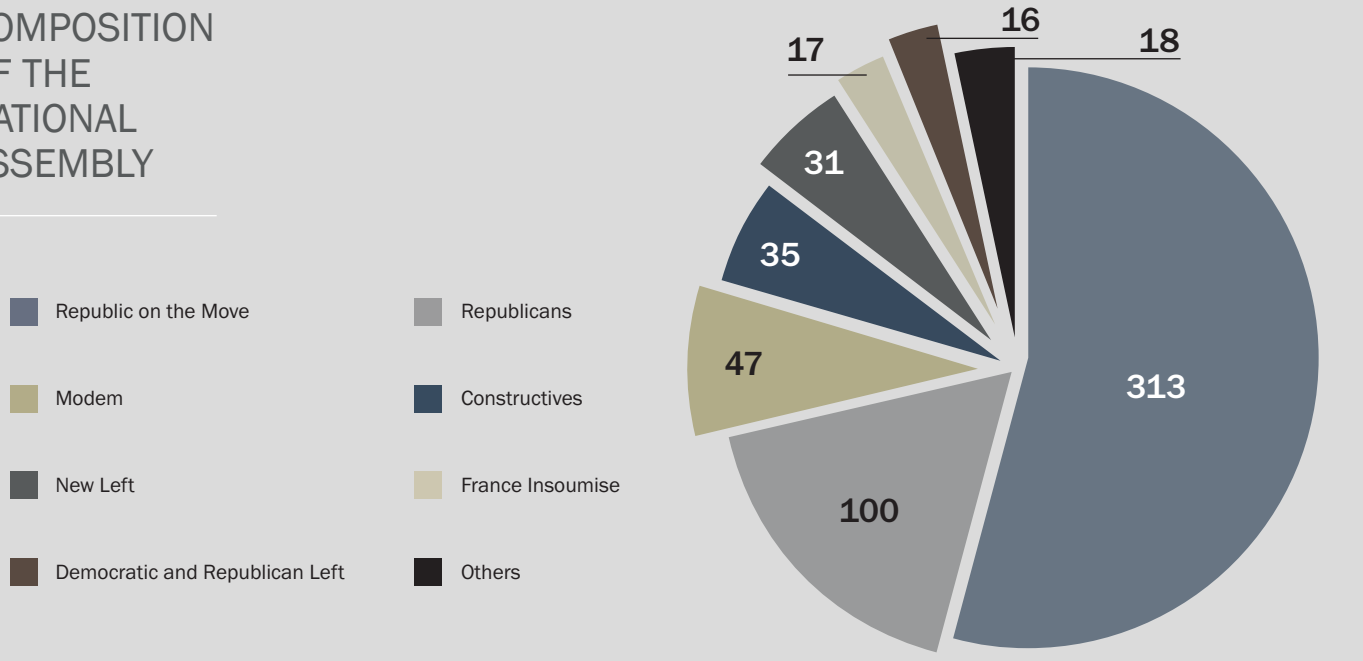


POLITICAL CONTEXT

France is a semi-presidential republic with a population of 67,024,459. A directly elected president holds most of the executive power. They appoint the prime minister and the government, who draft legislation for the approval of parliament (made up of the National Assembly and the Senate). The president must take into account the composition of the National Assembly when appointing the prime minister.

The current president is Emmanuel Macron. His party, the newly created centrist République en Marche (Republic on the Move) holds the majority of seats in the National Assembly. The traditionally dominant centre-right (Republican) and centre-left (Socialist) parties suffered major losses in the 2017 elections and currently sit in opposition. The president and members of the National Assembly are elected every five years by popular vote. The next national elections will take place in Spring 2022.

COMPOSITION OF THE NATIONAL ASSEMBLY



Governance

Health and social care decisions are shaped mainly at national level while regional and local bodies hold an executive function.

	HEALTHCARE	SOCIAL CARE
National	Ministry for Health	Ministry for Health
Regional/Local	Regional Health Agencies	Local Authorities

Healthcare

Healthcare policy and priorities are determined nationally by the Ministry of Health. The Ministry also allocates budgets to regions and services, gives final approval to tariffs and pharmaceutical prices, and defines quality standards.

Locally, the regions are responsible for planning and organising healthcare services. The Regional Health Authorities (RHAs) ensure that service provision is in line with the needs of local populations. They operate directly under the oversight of the Ministry of Health but have some autonomy in their decisions. Each RHA defines its own healthcare programme, outlining regional priorities and applying them to all providers in the region.

The latest reform of the French healthcare system took place in 2015. The Health Act 2015 addressed both health services and public health. A key measure was an attempt to abolish fees for GP visits, so ending the complex reimbursement system for service users. However, the reform was very unpopular with GPs and as a result only SHI-reimbursed fees will be phased out, leaving patients to claim back the remaining fees to their PHI. This change was due in November 2017, but the Minister for Health announced a phased withdrawal, on a timetable to be presented in 2018.

Other measures in the Act include:

- Development of primary and community services.
- Investment and strengthening of public hospitals.
- Preventative public health measures.

Social Care

The governance of social care is complex and involves several stakeholders. The Ministry of Health is responsible for most of the political decision-making. However, regional and local decision-makers are also relevant, with local authorities (LAs) playing a major role in managing social care funding and allocating resources. The RHAs play a limited role.

Regulation

The Health Authority (Haute Autorité de Santé – HAS) is the main regulator of healthcare services and products. Public and private healthcare providers must be certified by the HAS. There are different certifications procedures for hospitals and primary care services. Hospitals are re-evaluated every four to six years, while primary care professionals benefit from a more light touch certification process. There is limited quality monitoring and evaluation in France, but legislative changes in recent years have sought to improve the quality of care, patient rights and safety.

The main social care regulator is the National Agency for the Quality Assessment of Health and Social Care Organisations (ANESM).

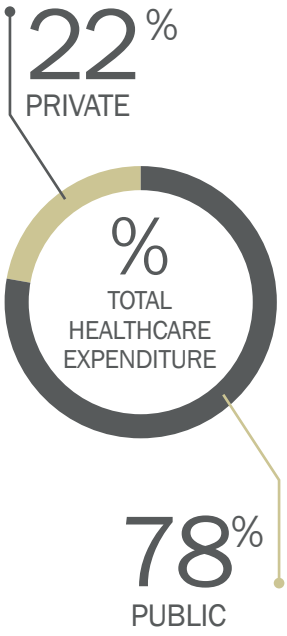
They are responsible for upholding the rights of people using services and developing preventive measures to avoid mistreatment. They also produce guidelines for the social care sector. Evaluations are carried out internally by social care providers and externally by inspection bodies that have been accredited by the ANSEM. The ANSEM works in partnership with the regions and local authorities at the departmental level. Most provider authorisations are granted for 5 years. From 2018, the ANSEM is expected to be merged into the HAS, the main healthcare regulator.

HEALTHCARE – FINANCING AND STRUCTURE

Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in France is mostly public. About 78% of this total healthcare expenditure comes from public sources and the rest comes from complementary private healthcare insurance (PHI), co-payments and out-of-pocket spending. The balance between these sources has remained stable in the past five years. Public sources of funding are derived mostly from compulsory payroll contributions towards statutory health insurance (SHI). These contributions are shared between employers and employees and collected nationally. In addition, SHI funding is complemented by a healthcare tax, the "general social contribution" levied centrally, as well as tobacco and alcohol levies. The SHI does not cover all healthcare costs and individuals are strongly encouraged to subscribe to complementary PHI which covers over 95% of the population. Total healthcare expenditure was €244.4bn (including some social care expenditure) in 2016. Over the past five years, SHI expenditure has grown by less than 2% per year on average.



Healthcare Financing Flows

The SHI expenditure limits are set annually by parliament in the Act on Social Security Financing. This Act also sets out resource allocations for the different healthcare services. Implementation of these directions is carried out by the SHI, which is a centralised single organisation, responsible for managing public healthcare financial resources.

Healthcare System Structure

Services

The French healthcare system is characterised by a strong division between hospital and primary care services. Secondary care services in hospitals are mostly free at the point of need, primary care services are not.

In 2017, there was a total of 197,859 primary care professionals, including 88,137 GPs (a slight reduction of 0.84% compared to 2016). Primary care services tend to be concentrated around urban areas meaning that some rural areas are subject to under-provision. Several governments have struggled to address this as GPs' freedom to choose where to practise is a cornerstone of primary care. Services delivered in primary care settings can include GP services, dentistry, some diagnostic procedures, and community pharmacy.

In 2014, there was a total of 3,111 hospitals. 1,416 were public hospitals, while 1,012 private for-profit and 683 non-profit. Private clinics are generally involved in short-stay surgical care (such as cataract operations), rehabilitation and mental health services. Public hospitals cover a much larger range of services. Non-profit hospitals tend to specialise in cancer treatment.

Payers

SHI is the main payer covering approximately 75% of healthcare costs. The remaining costs are mostly met by supplementary PHI, which covers about 95% of the population. Subscription is strongly encouraged and may be on an individual basis or through employer schemes. The legislative framework facilitates subscription for individuals on low incomes as well as self-employed individuals. Since January 2016, all private employers must offer PHI to their employees covering basic primary and secondary care services. Individuals can also subscribe to additional voluntary PHI to cover specific costs that are not systematically reimbursed, such as ophthalmology and dental services.

Reimbursement rates are set nationally in legislation for goods and services. In France, patients are often required to pay a fee-for-service (FFS) upfront and then claim it back to their insurers (SHI and PHI). This is common in primary care where self-employed General Practitioners (GPs) are paid on an FFS basis. Upfront payments are not required by hospitals for medical services in most cases. Some hospitals have agreements with PHI to be paid directly for non-medical costs. FFS rates are set by the Ministry of Health and the SHI in negotiation with the National Union of Health Professionals. In recent years, new payment mechanisms have been developed, including payment for performance (P4P) and activity-based payments.

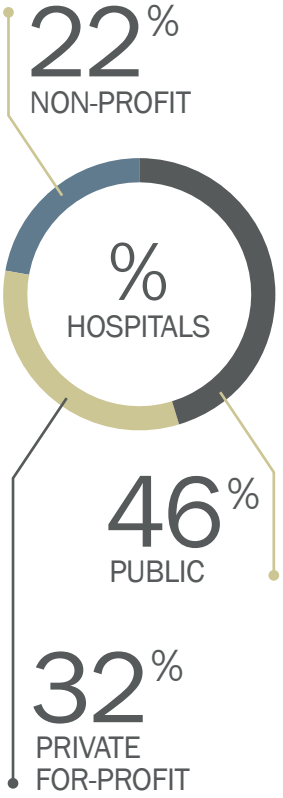
Patients must register with a GP to access full SHI reimbursement and are free to choose among specialists on referral by a GP, with some exceptions for certain specialities. Bypassing referral is permissible, but results in reduced SHI coverage.

All public hospitals are paid on activity through a diagnostic related group (DRG) system. A lump-sum tariff is set annually for each DRG. Tariffs are calculated differently for public and private hospitals. Private for-profit clinics, which are increasingly owned by large corporations, have the same funding mechanisms as public hospitals, though their DRG tariffs are calculated differently.

Providers

Healthcare services are delivered by a mix of public and private providers. Primary and specialist outpatient care is mostly provided by independent, self-employed professionals in private practice. Increasingly they work under the same roof as others in primary healthcare centres (maisons or poles de santé). Since 2013, the number of these healthcare centres has grown continuously, and it is estimated there were more than a 1,000 by 2015.

Secondary care services are primarily delivered by public hospitals and complemented by private clinics. About two-thirds of hospitals are public, a quarter are private for-profit and private non-profit (the main providers of cancer treatment) make up the remainder.



Adult Social Care Financing

Adult Social Care Financing Context
Social care expenditure is fragmented. It is made up of both public expenditure and private spending as individuals are expected to contribute towards the cost of their care. Public expenditure relies on a complex mix of local and national sources of funding. In 2015, France spent about €35.2bn on all social care services.

Adult Social Care Financing Flows
As there are several sources of funding, social care financing flows are complex. The responsibility for funding most social care services lies with local authorities (LAs, or départements). LAs must allocate social care resources within their wider budgets, alongside other local services. In 2015, the total budget of LAs was €67.7bn. 69% came from local taxation. Local taxation revenue is made up of indirect and direct taxes, including a form of Council Tax (taxe d'habitation) that the current government is looking to abolish by 2022. Other sources of LA funding include central funding (€11bn), and some SHI funding.

Adult Social Care System Structure

Services
The range of social care services in France is large. Homecare services may be support for activities of daily living, medical homecare, or a mix of both. Similarly, care homes may be residential homes or nursing homes. There are also day-care and short-term residential services, which can be used to step down from hospital care.

There are about 8,000 care home services, 7,000 homecare services (activities of daily living) and 2,000 medical homecare services.

Payers
The main public payers are the LAs but individuals are expected to contribute to the cost of their care. Payments can be made to individuals or to providers. Tariffs are negotiated between LAs and providers and must be published online. In addition, the SHI covers the costs of medical care in care homes or at home.

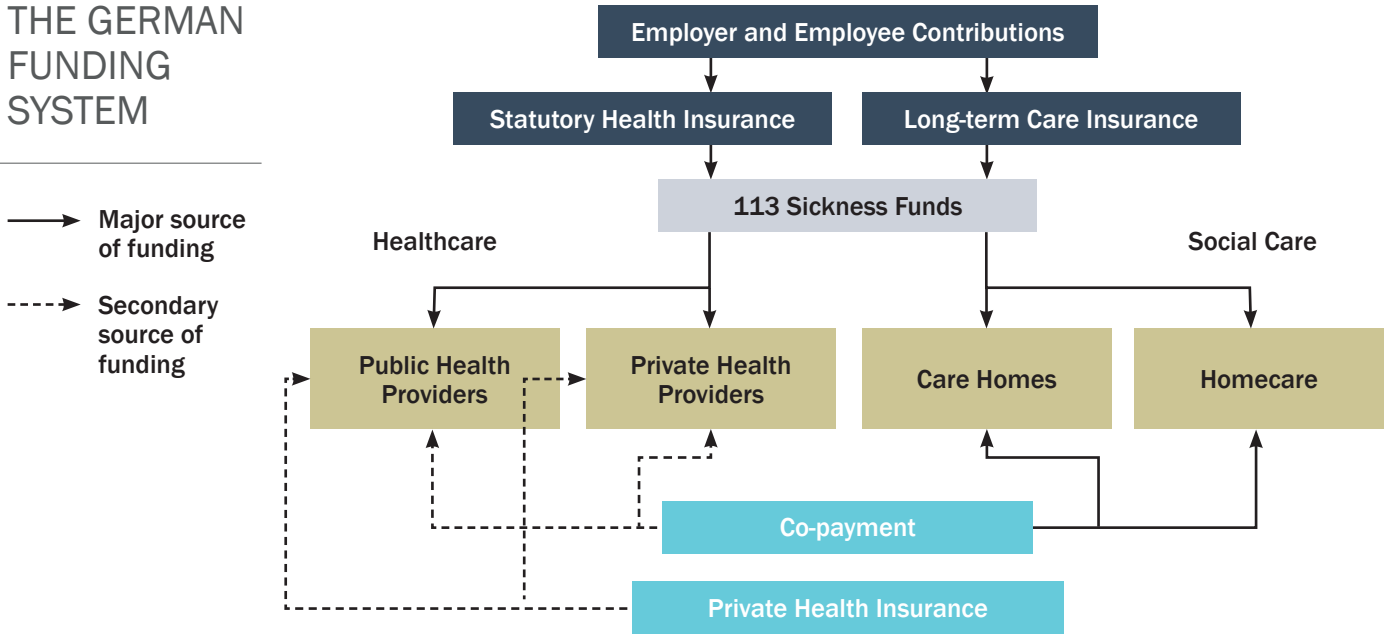
Providers
Social care services are offered by a mix of public and private providers. Historically, providers were mostly public. While the public sector continues to provide the majority of services, legislative changes in 2005 have enabled more private provision and the number of private providers is increasing. They are mainly involved in residential care (25% of the total provision).

GERMANY

The German healthcare system is based on a multi-payer statutory health insurance (SHI) system, providing a standard basket of services to the population. SHI is financed through payroll taxes and is provided by competing, not-for-profit, health insurance funds (sickness funds). The social care system is based on Long-term care insurance (LTCI) administered by the sickness funds. Subscription to both insurances is mandatory. However, those earning more than €53,100 per year may opt-out from the statutory system if they prefer to subscribe to private insurance.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
82.3m	357,376km^2	Berlin	**W** 83.1 | **M** 78.3

THE GERMAN FUNDING SYSTEM



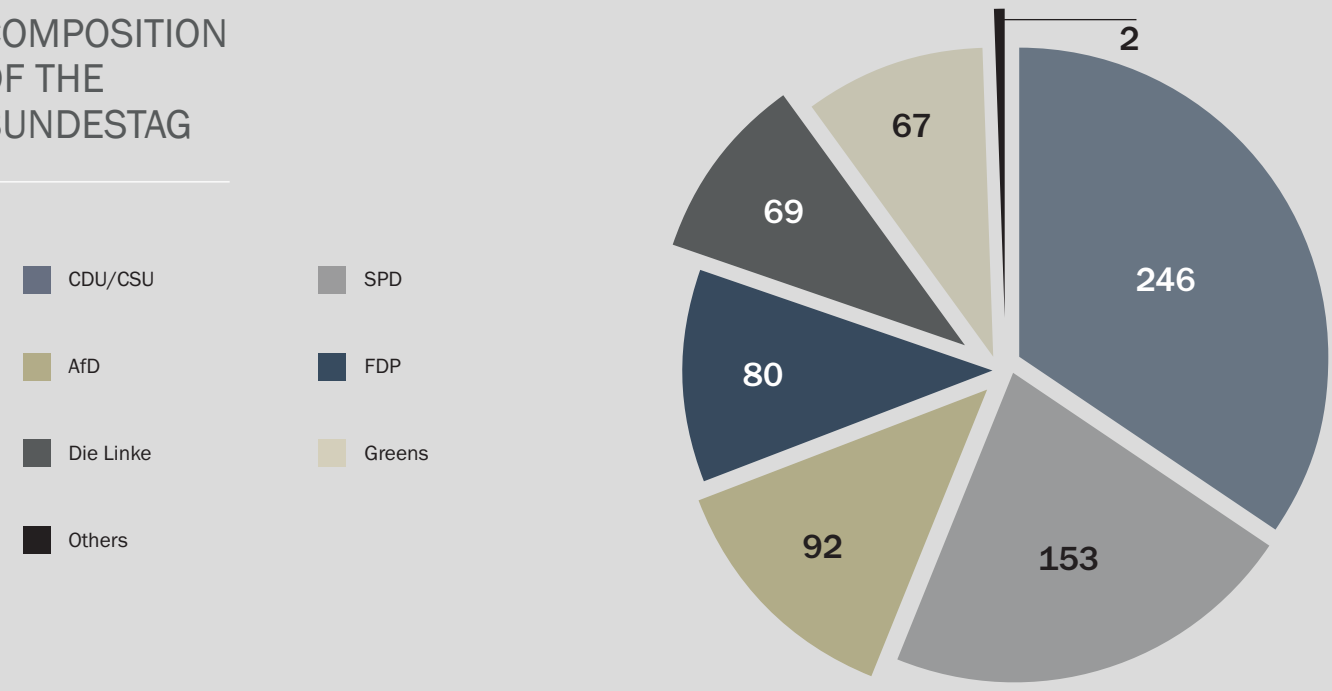
POLITICAL CONTEXT

Germany is a federal republic with a population of 82,800,000. It is made up of 16 Länder (regional) governments and the federal government in Berlin. The federal government is led by the chancellor, who is appointed by members of the Bundestag, the lower house of parliament.

A general election on 23 September 2017 led to one of the most fragmented results since the end of the Second World War.

Six parties are currently represented in the Bundestag, with the traditional centre-right (CDU/CSU) and centre-left (SPD) losing several seats. Although the CDU/CSU remained the largest party, their initial attempt at forming a coalition with the Greens and the liberals (FDP) failed. The CDU/CSU are currently exploring renewing the Grand Coalition (GroKo) with the SPD. Should an agreement not be reached, a second election will take place in 2018.*

COMPOSITION OF THE BUNDESTAG



*A coalition agreement between the CDU/CSU and the SPD was approved by both parties at the beginning of March 2018.

Governance

Health and social care decisions in Germany are shaped by decision makers at the national and local levels. While health and social care are not integrated, the decision makers are similar.

	HEALTHCARE	SOCIAL CARE
National	- Ministry for Health - Joint Federal Committee (GBA) - Federal Association of the Sickness Funds (GKV)	- Ministry for Health - Joint Federal Committee (GBA) - Federal Association of the Sickness Funds (GKV)
Regional	- 16 Länder (regional) governments - 16 Länder (regional) association of the sickness funds	- 16 Länder (regional) governments - 16 Länder (regional) association of the long-term care funds

Healthcare

At national level, the federal government, through the federal Ministry of Health, is responsible for the general direction of health and social care and proposes legislation that sets out the framework for it.

At regional level, the Länder are responsible for implementing national legislation. In addition, they define their own health and social care policies and pass their own legislation. Negotiations between payers and providers also take place at Länder level.

Social Care

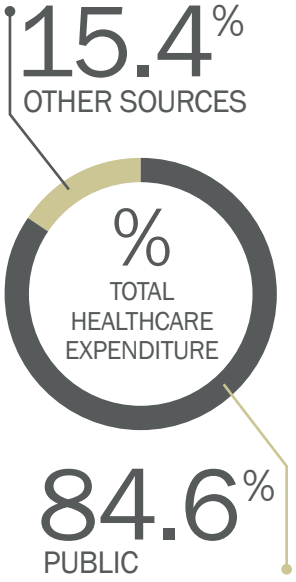
The governance of social care is similar to that of healthcare. The Ministry of Health sets out the legislative framework for funding and access to services while the Länder implement national directions and pass their own legislation. In addition, German social care has recently seen legislative changes. Three Acts to Strengthen Long Term Care within the reform of long term care introduced the most significant changes to social care in over 20 years. The main objective was to expand access to services and address the needs of an ageing population.

Regulation

Regulation of health and social care is the responsibility of the GBA, which is made up of representatives from the GKV, and provider associations.

The GBA has the regulatory power to determine the services covered by sickness funds and to set quality measures for providers. It is supported by the Institute for Quality and Efficiency (IQWiG) and the Institute for Quality and Transparency (IQTiG).

The quality of social care services is overseen by the Medical Service of the SHI/LTCI (MdK). The MdK is funded by sickness and long-term care funds and carries out medical and needs assessments of individuals, as well as inspections of social care services on their behalf. The methodology for evaluating service quality is currently being redesigned. It was due to be introduced in 2018 for residential services and 2019 for homecare, but has been postponed to 2019 and 2020 respectively.



Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Germany is mostly public. In 2016, 84.6% of healthcare expenditure came from public sources. The remainder was made up of small individual co-payments for certain services and (to a lesser extent) private health insurance (PHI). The German healthcare system is based on mandatory statutory health insurance (SHI) and is mostly funded through employer and employee contributions. The general SHI contribution is currently set at 14.6% of gross wages, shared equally between employers and employees. Individuals earning more than €53,100 in annual income may opt out of the SHI but they must subscribe to PHI. PHI must offer a similar level of healthcare coverage to SHI and covers about 11% of the population. In 2016, total healthcare expenditure was about €353.1bn. Total SHI expenditure amounted to €298.6bn.

Healthcare Financing Flows

Germany relies on a multi-payer structure. Individuals are required to enrol with one the of 113 statutory sickness funds. The sickness funds collect their members' contributions and pool them in the Central Reallocation Pool. The Central Reallocation Pool is administered by the Federal Insurance Authority, which allocates funding to each sickness fund on the basis of a morbidity-based risk-adjustment scheme. Between 2011 and 2016, SHI expenditure has grown by an average of 3.57% per year. Sickness funds are not allowed to register deficits. In the past few years, they have been encouraged to build reserves which were estimated to total €15.9bn in 2016.

Healthcare System Structure

Services

A wide range of healthcare services is included in the minimum basket of services, which are mostly free at the point of need.

Primary and ambulatory care services include care from family doctors (general practitioners), dentistry, pharmaceutical care, physiotherapy, speech and language therapy, occupational therapy and psychotherapy. As of 2014, there were approximately 109,600 self-employed SHI-accredited physicians in ambulatory care, of which 52,800 (48%) practiced as family physicians, and 56,800 (52%) as specialists. There were also about 2,000 multi-specialty clinics with more than 13,000 physicians (10% of ambulatory care physicians). Patients have free choice of GPs.

Secondary care offers both outpatient and inpatient services, covering low acuity to highly specialised medical procedures.

Payers

The SHI relies on multiple payers. Mergers have led to a decline in the total number of sickness funds, but there are currently 113 funds. These funds compete against each other on quality, as they are not allowed to compete on price. There is a minimum basket of services and products that all funds must offer, but since 2013 they have been allowed to offer additional services. For example, some sickness funds offer better coverage of assisted reproduction services, which normally require a 50% co-payment for eligible individuals.

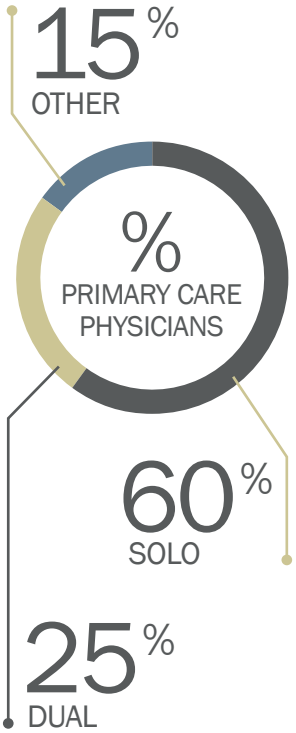
Sickness funds collectively negotiate payments to providers. The overall framework is set nationally through the Federal Framework Contract (Bundesmantelvertrag), which serves as the basis for negotiations at Länder level. The majority of contracts and payments are agreed collectively between all sickness funds and providers at Länder level. In addition, sickness funds may agree selective contracts directly with individual providers. Generally, hospitals are paid on a diagnostic-related group (DRG) basis. Primary care providers are paid on a fee-for-service (FFS) basis for services listed in a reimbursement catalogue.

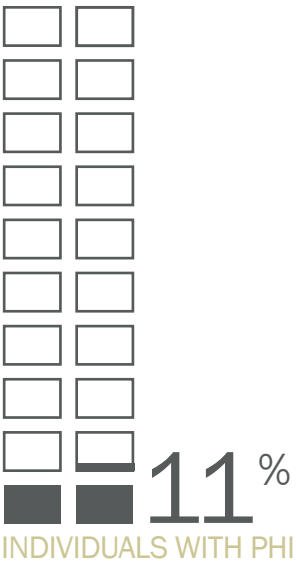
About 11% of the population subscribes to PHI instead of the SHI. Individuals earning over €53,100 in annual income are allowed to opt-out of the SHI but must contribute to PHI instead. The use of complementary PHI by SHI subscribers is limited.

Providers

Primary care physicians usually work in private practice, with 60% working in solo practices and 25% in dual practices. Most physicians employ doctor's assistants. Non-physicians such as physiotherapists typically have their own offices.

As of 2012, there were 2017 hospitals in Germany, of which 48% were publicly owned, 34% were private non-profit, and 18% were private for-profit hospitals. The three types have an equal share of the SHI market. Notably, the number of private for-profit hospitals has been growing and currently constitutes around one-sixth of all beds. Hospitals are staffed by salaried doctors. Typically, doctors in hospitals are not permitted to treat outpatients. Senior doctors may treat privately insured patients on a FFS basis. Hospital specialists provide some specialised care in outpatient care settings. Patients are free to choose between hospital providers.



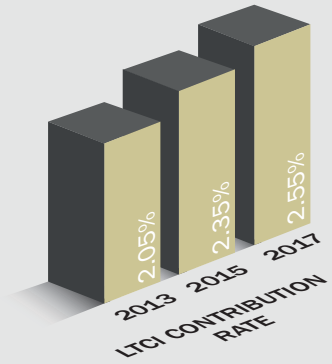


Adult Social Care Financing

Adult Social Care Financing Context

Social care expenditure is mostly public but individuals are expected to contribute towards the cost of their care as LTCI does not cover the full cost. Individuals are required to pay a top-up. This is mostly out-of-pocket or through welfare payment support. Public sources of funding come from compulsory employer and employee contributions towards LTCI. The current contribution rate is 2.55% of gross salary, rising to 2.8% for individuals with no children. In 2016, LTCI funds spent €31bn on social care services. In addition, it is estimated that about €12bn was spent privately by individuals.

LTCI funding has increased over the past 5 years. This is due to changes to the contribution rate, which rose from 2.05% to 2.35% in 2015. In addition, the low unemployment rate in Germany has been favourable to LTCI funding. The contribution rate increased again in 2017 to 2.55%. In addition, out-of-pocket payments also grew between 2011 and 2016.



Adult Social Care Financing Flows

LTCI is separate from the SHI and its funding is raised separately. LTCI is administered by the sickness funds and, similarly to healthcare, money is pooled nationally and redistributed among the funds. The MdK assesses the need of individuals and determines their eligibility for funding. There are five grades to which different levels of funding are attached. Support may be received as cash benefits, services or a mix of both.

Adult Social Care System Structure

Services

Services are not completely free at the point of need. LTCI covers care costs up-to a certain level, but individuals are expected to pay for care costs not covered by the LTCI and for non-care costs.

Services include a wide range of homecare and care home services for the elderly. In addition there are short term and respite care services, day care services, and services for adults with learning disabilities.

Payers

There is a complex mix of payers in social care. There are 113 LTCI funds covering certain care costs for individuals who have been assessed as needing care. However, as remaining costs are not covered individuals must contribute towards the cost of their care. Those who cannot afford to pay privately may be eligible for financial support from the social welfare fund. The cost of care and the balance between different payers varies between Länder.

Providers

Long-term care services are provided by a mixture of public and private providers. The federal law is set up to bias service provision towards private sector providers, in order to stimulate market development.

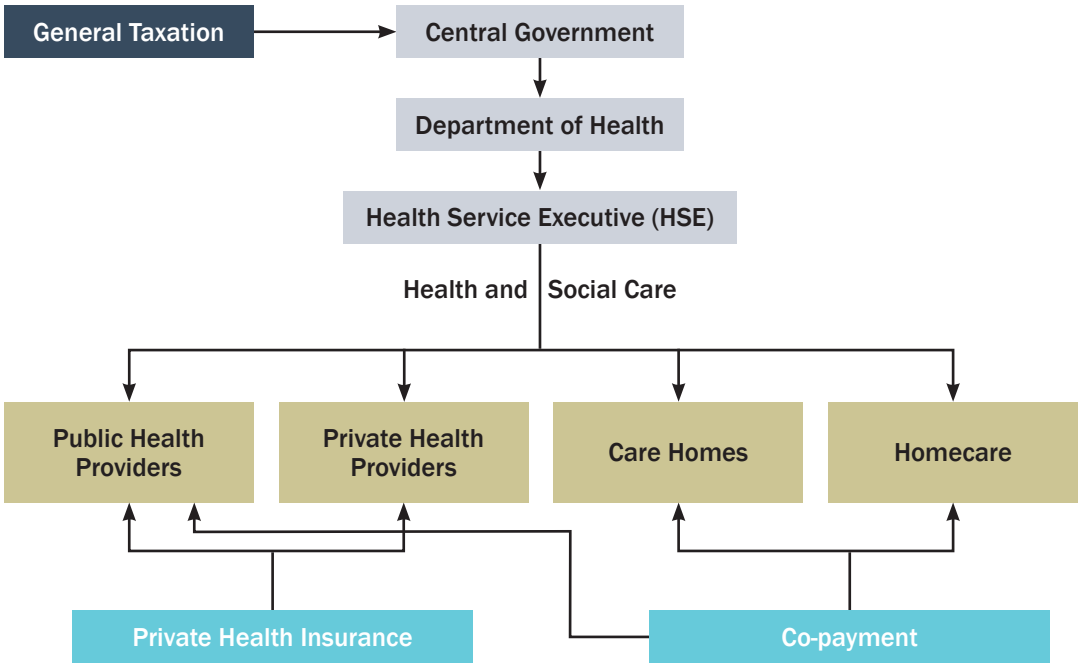
Similar to healthcare, the principle of ‘dual financing’ applies to social and long-term care. Länder pay for investment expenditure and the LTCI and private insurance pay for recurrent costs. Homecare services are paid for on a FFS basis, while residential and institutional care are paid on a per-diem basis. They are negotiated at the Länder level between LTCI funds and associations of providers.

IRELAND

The Irish health and social care system is a mixed system combining public and private provision. It is funded through a mix of general taxation, co-payments and private health insurance. Access to free services at the point of need depends on a complex mix of income, age and family situation. About 60% of the population contributes some sort of co-payment for care, capped to certain thresholds for hospital services.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
4.7m	70,273km^2	Dublin	**W** 83.4 | **M** 79.6

THE IRISH FUNDING SYSTEM



Major source of funding

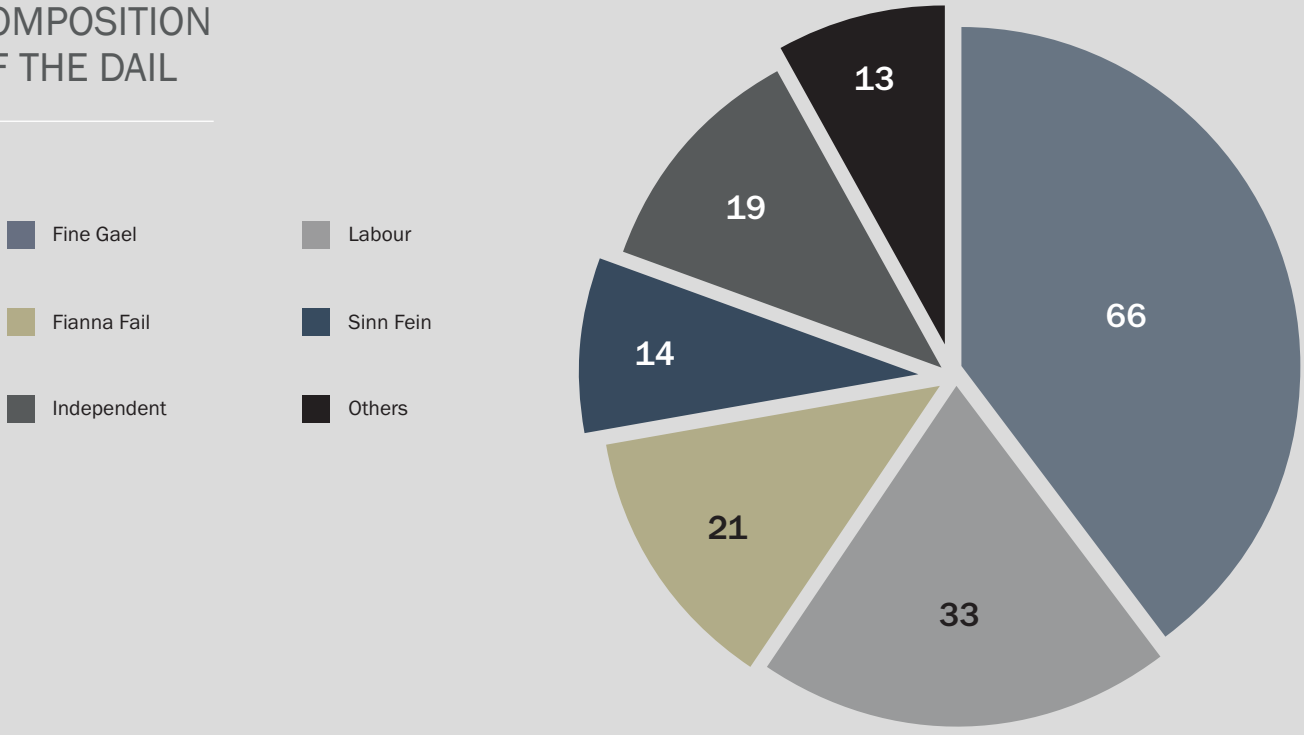
Secondary source of funding

POLITICAL CONTEXT

Ireland is a parliamentary republic with a population of 4,774,833. The president is directly elected but has a primarily ceremonial role. Political power lies with the Taoiseach (prime minister) who leads the government. The Irish parliament consists of the directly elected Dail (House of Representatives) and the indirectly elected Seanad (Senate).

The last general election took place on 26 February 2016 and resulted in the previous Fine Gael Labour coalition falling short of securing a majority. After several weeks of negotiations, Fianna Fail (the largest opposition party) agreed to a minority government led by Fine Gael. Leo Varadkar is the current Taoiseach, and has been in post since June 2017.

COMPOSITION OF THE DAIL



Governance

Health and social care governance in Ireland is integrated and mostly centralised.

	HEALTHCARE	SOCIAL CARE
Central	- Department of Health - Health Service Executive	
Regional	- Seven Hospital Group Organisations - Nine Community Healthcare Organisations	

The government is responsible for the strategic direction of the health and social care system. The Department of Health, led by the Minister of Health, has primary responsibility for the strategic development and overall organisation of the health service, including setting statutory regulations.

The Irish healthcare system is currently undergoing a series of policy reforms aimed at simplifying the system and expanding access to public services. A major reform programme was launched in 2012 and there has been some progress towards its implementation. Progress includes a move towards activity-based payments for hospitals, expansion of access to primary care services, and reform of the coordination and delivery of health and social care services regionally.

The Health Service Executive (HSE, the equivalent of the NHS in England) is responsible for the budget, organisation and delivery of health and social care services as a single national entity. The HSE prepares an annual National Health Service plan, which is approved by the Department of Health.

At a regional level, seven Hospital Group Organisations (HGOs) and nine Community Healthcare Organisations (CHOs) have been created.

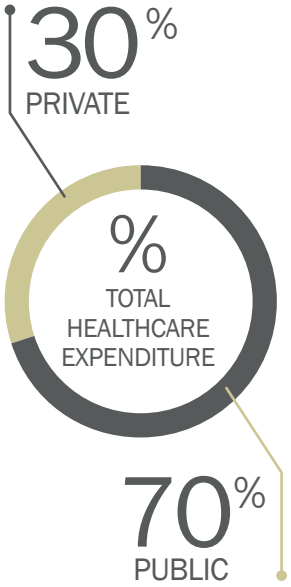
Regulation

The Health Information and Quality Authority (HIQA) is the independent quality regulator. Its regulatory functions include developing standards and registering and inspecting a range of health and social care services. In social care, the HIQA only regulates care home providers, with homecare services are outside its regulatory remit.

Healthcare Financing

Healthcare Financing Context

Healthcare expenditure is mostly public in Ireland. However, compared to other European countries there is a significant amount of private, individual spending, coming from co-payments, out-of-pocket payments and subscription to private health insurance (PHI). About 70% of expenditure is public and 30% private. Public expenditure is funded through general taxation, mostly through the Universal Social Charge levied on wages.



The economic crisis resulted in deep cuts to the public healthcare budget. However, since 2014, public funding is on a more positive trajectory. In 2018, the healthcare budget is due to increase by 5% to a total of €15.3bn. The Irish government has committed to increasing healthcare funding by at least 3% annually. Private expenditure also contracted in the aftermath of the economic crisis and there was a slight decrease in PHI take-up.

Healthcare Financing Flows

Public funding is allocated by the Department of Finance to the HSE via the Department of Health. The HSE then allocates it to public services. The HSE's National Service Plan outlines the services provided by the HSE and their volumes, and allocates funding accordingly.

Healthcare System Structure

Services

Healthcare services are not free at the point of need in Ireland. Around 40% of the population has a medical card, which means they can receive public services (acute and primary care) for free. Eligibility for a medical card is subject to income thresholds. For example, a single person under the age of 66 living alone who earns less than €184 (net) per week is eligible.

In addition, around 10% of the population has a GP Visit Card, which allows them to receive free primary care but not hospital care. Eligibility for GP cards is also subject to income thresholds. A single person under the age of 65 living alone who earns less than €276 (net) per week is eligible.

Those who do not have GP or medical cards can still receive care from public providers, but they must pay towards those services through a co-payment. For example, attending A&E will cost them €100.

Primary care is typically provided by GPs, and there are approximately 3,000 GPs in Ireland. They provide a broad range of services and are typically a patient's first point of contact for healthcare. Other primary care services include community mental health services,

	MEDICAL CARD	GP VISIT CARD	PHI	OTHERS
Public Hospitals	Covered	Not covered – co-payment with cap on maximum amount spent annually	Covered – patient treated as a private patient, at a higher rate	Not covered – co-payment with cap on maximum amount spent annually
Private Hospitals	Not covered	Not covered	Covered in accordance with PHI contract	Not covered
GP/Primary Care	Covered – GP is reimbursed through a voluntary contract with the HSE	Covered – GP is reimbursed through a voluntary contract with the HSE	Covered in accordance with PHI contract	Not covered – payment of full fee by individual (GP free to set their own fees)

disability services, dental treatment, public health nursing, and preventative services such as immunisation.

Secondary care is provided by specialist physicians, typically in a hospital setting. There are 52 public hospitals, organised under seven HGOs, and 19 private hospitals providing a range of services, including acute, diagnostic and mental health services.

Payers
The HSE is the main payer of public services. Hospitals are increasingly paid on an activity basis. GPs are free to decide whether they want to contract with the HSE to provide a proportion of public services for medical and GP visit card holders. Payments for publicly-funded primary care services are made on a capitation basis.

In addition to the publicly funded system, individuals are entitled to purchase PHI, which funds services through public and private providers. An individual cannot opt out of the public healthcare system, but they can get PHI in addition. There are three major private insurers: Vhi (partially owned by the state), Irish Life Health (a merger of Aviva and GloHealth) and Laya Healthcare.

Individuals who do not qualify for public funding support and do not hold PHI must pay a co-payment towards public healthcare services or pay out-of-pocket to access private services.

Providers
There is a mix of public and private providers in Ireland, delivering both public and private services.

GPs are self-employed and often work in individual practices. Some GPs work exclusively in the public or private sector, but the majority treat a mixture of patients. GPs can decide whether to provide services for publicly-funded medical and GP Visit Card holders or to treat private patients only (who may be covered by PHI or not). Dentists, opticians and pharmacists also have independent practices. Multidisciplinary primary care teams are currently in development.

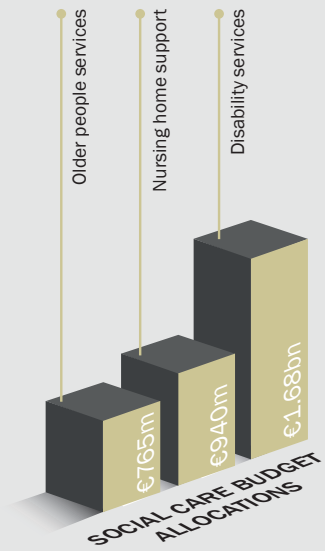
In secondary care, the HSE provides many hospital services directly. However, there are several public hospitals that provide services for private patients (i.e. patients paying privately out-of-pocket or through PHI), and private hospitals may provide services for both private patients and public patients. Waiting times to access hospital services are among the highest in Europe and the HSE regularly outsources the provision of services to the private sector to reduce backlogs.

ADULT SOCIAL CARE - FINANCING AND STRUCTURE

Adult Social Care Financing

Adult Social Care Financing Context
Expenditure on adult social care comes from a mix of public and private sources. Public sources of funding come from the same budget as healthcare, which relies mostly on general taxation. In addition there are means-tested user contributions. There is limited available information about social care expenditure in Ireland, which is partly due to its integration with healthcare. However, it is estimated that spending on social care in Ireland has remained relatively flat over the years, while demand has increased due to an ageing population.

Adult Social Care Financing Flows
Similarly to healthcare, funding decisions on social care are made annually in the HSE's National Service Plan. The 2017 social care allocation within the HSE's financial envelope



was about €3.4bn. €1.68bn was allocated to disability services, €940m to nursing home support and €765m to services for older people.

Adult Social Care System Structure

Services

Access to social care services is means-tested and not free at the point of need. The range of services available includes care homes (nursing and residential), homecare, learning disability services and services for people with sensory or physical disabilities.

Disability services include basic health services, assessments, rehabilitation, income maintenance, community care, residential respite care, homecare and day care.

Homecare Packages are a set of services older people can receive in their own home. They include nursing services, home help hours, therapy services, physiotherapy, speech and language therapy, day care services and respite care.

Payers

There is a mix of public and private payments in social care. Individuals are assessed through a needs-test and means-test, with varying thresholds applying to different services.

For care home services, the financial assessment analyses an individual's income and assets to calculate how much they will contribute to their care. Individuals will contribute up to 80% of their assessable income and 7.5% of the value of any assets per annum. However, the first €36,000 of their assets (€72,000 for a couple) are not counted in the financial assessment. The HSE pays the remaining balance of the cost of care through a payment called State Support.

The Nursing Home Support Scheme (Fair Deal) helps financially support individuals in need of long-term nursing homecare. Through the scheme, an individual will make a contribution to the cost of their care at an approved nursing home (public, private, or voluntary) and the HSE will pay the balance, regardless of which centre the individual chooses.

Homecare providers are generally paid on a hourly rate basis, either by the HSE's Homecare Packages or directly by individuals.

Providers

Care home and homecare services are increasingly provided by private operators.

Homecare Packages are provided by 32 for-profit and not-for-profit providers approved by the HSE. Individuals eligible for a Homecare Package can choose their service provider from the list of approved providers in their respective area. In 2017 there were 16,750 people receiving a Homecare Package.

Care home services are mainly provided by the private sector. In 2016, there were about 577 nursing homes for older people registered with the HIQA, with a capacity of 30,106 beds. Three-quarters of the capacity was provided by private for-profit operators.

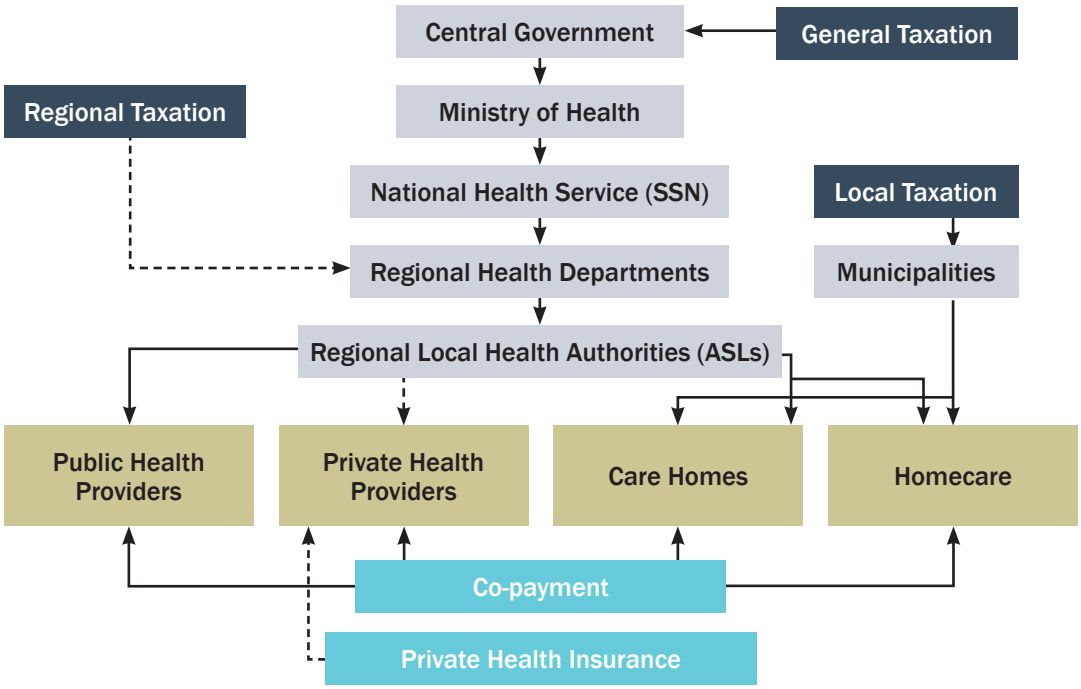
Learning disability services continue to be mainly provided by not-for profit operators.

ITALY

Italy's healthcare system is tax-funded, and mostly free at the point of need. It is characterised by tensions between the central administration and the 21 regions that have some discretion in healthcare decision making. The social care system is not free at the point of need and requires out-of-pocket payments.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
60.6m	301,338km^2	Rome	**W** 84.9 | **M** 80.3

THE ITALIAN FUNDING SYSTEM

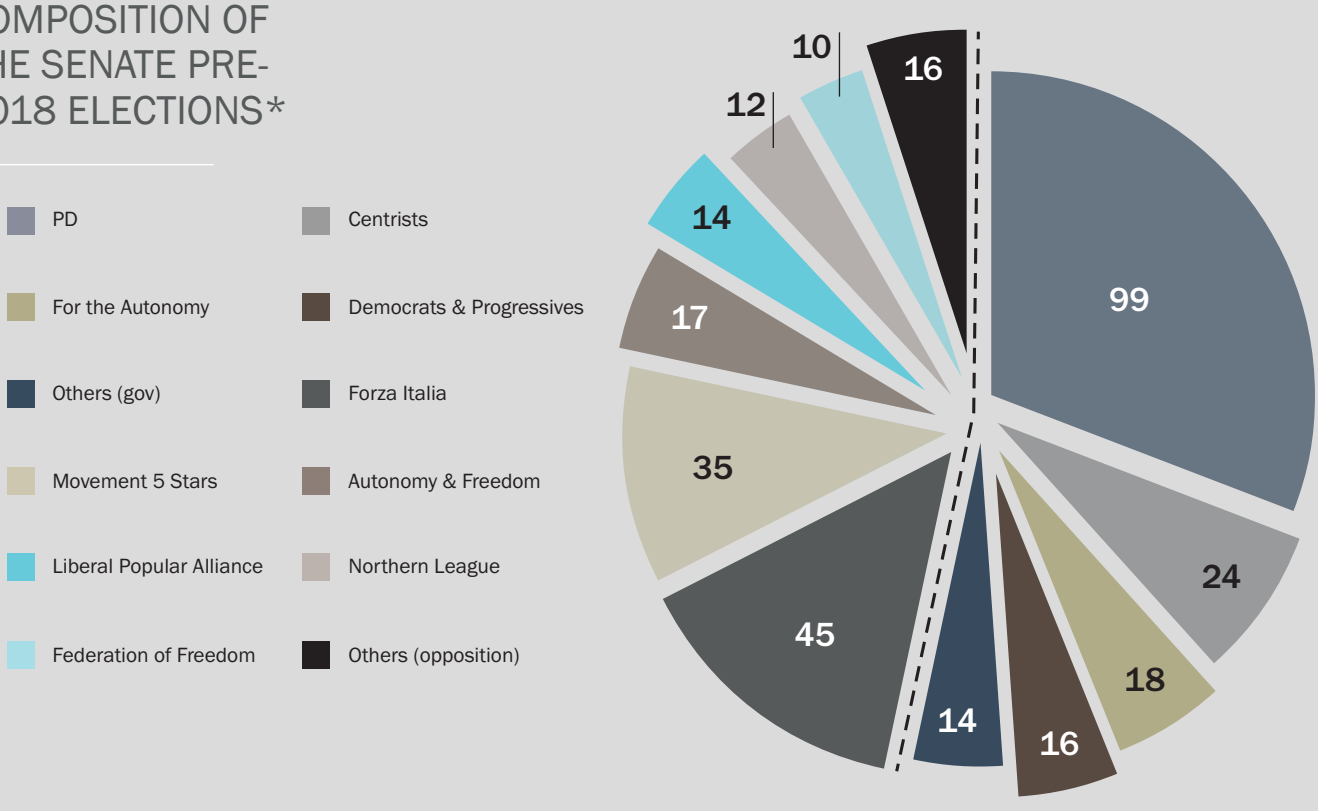


POLITICAL CONTEXT

Italy is a parliamentary republic. Its parliament is made up of two houses: the Chamber of Deputies and the Senate. The country has a population of 60,589,445. Both houses fulfil similar functions, mainly adopting legislative proposals. The parliament also elects the president of Italy, who is the head of state.

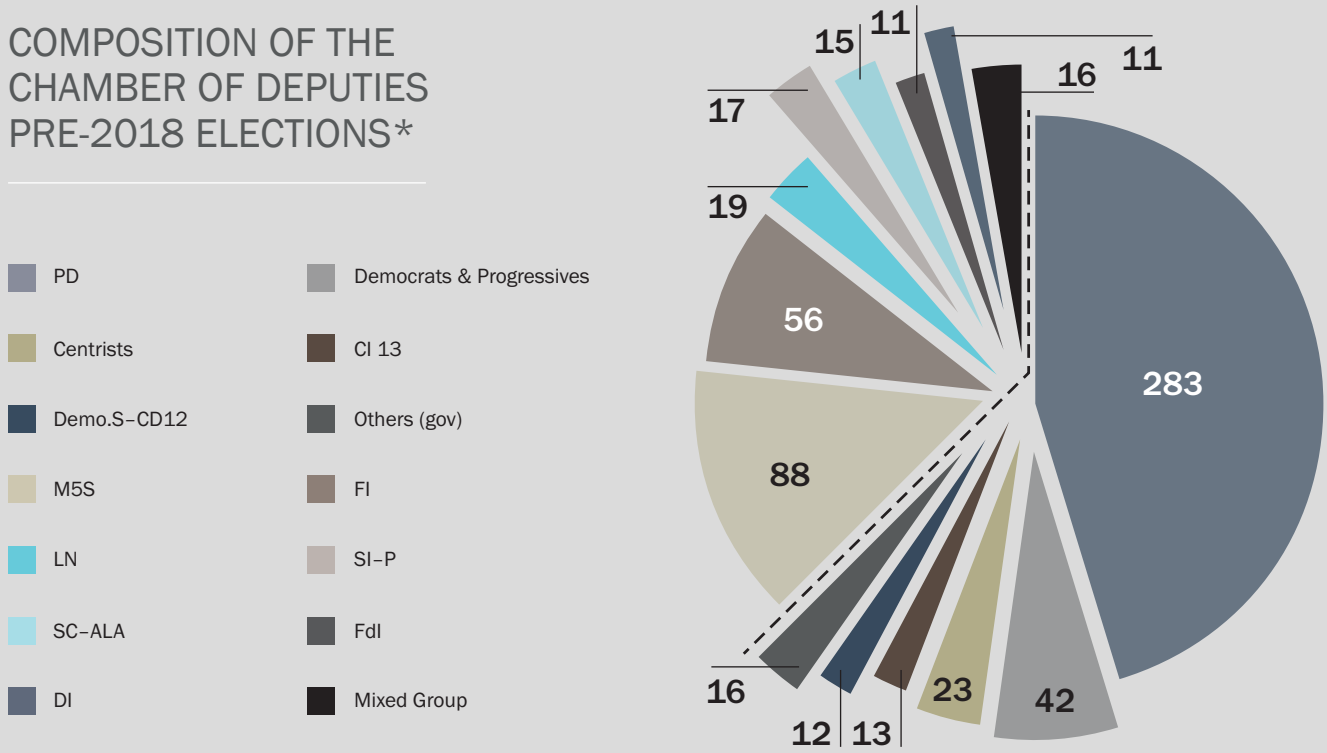
However, executive power mostly lies with the prime minister. The prime minister is generally the leader of the party that has most seats in parliament. This function is currently held by Paolo Gentiloni from the Democratic Party (PD, centre-left). The next parliamentary elections will take place in the first half of 2018.

COMPOSITION OF THE SENATE PRE-2018 ELECTIONS*



*Composition at the time of printing. Italy's general election took place on 4 March 2018 and led to fragmented results and a hung parliament .

COMPOSITION OF THE CHAMBER OF DEPUTIES PRE-2018 ELECTIONS*



HEALTH AND SOCIAL CARE – GOVERNANCE AND REGULATION

Governance

The Italian political system is subject to tensions between the central level of government and the 21 regions. Several attempts to clarify central and regional level responsibility have taken place in recent years. However, the status-quo remains, which has resulted in a multi-level governance system for health and social care.

	HEALTHCARE	SOCIAL CARE
Central	Ministry of Health	National Institute for Social Security
Regional	21 Regions	21 Regions
Local	103 Local Health Authorities	- 103 Local Health Authorities (ASL) - 7,999 Municipalities

Healthcare

Italy's healthcare system, the National Health Service (Servizio Sanitario Nazionale, SSN), has three levels of governance: national, regional and local. Nationally, the Ministry of Health is responsible for setting the general objectives and fundamental principles of the SSN, and defines what is covered by the health benefits package. Regional governments, through their regional health departments, are responsible for ensuring delivery of the national benefit package. They do this through a network of population-based local health authorities (aziende sanitaria locali, ASL).

*Composition at the time of printing. Italy's general election took place on 4 March 2018 and led to fragmented results and a hung parliament .

Social Care

The governance of the social care system is complex and highly fragmented. Several levels of governance are involved in defining key priorities, and planning, managing and delivering services. The main decision makers are the municipalities, ASLs, regions and the National Institute for Social Security. The responsibilities of each level of governance and their interactions with the SSN are not well defined. Some social care services may be accessed under the SSN benefit package and are mostly free of charge. However, many services require a co-payment. The lack of national coordination has led to significant variation between regions, especially around individual eligibility for services.

Regulation

The Ministry of Health (MoH) is the main national regulator. The MoH sets out general policies regarding prevention, diagnosis and treatment of diseases. Providers need to be accredited (licensed) by the SSN for providing healthcare services on behalf of the SSN. This accreditation focuses on quality standards, management of human and technical resources, and the provider's activity in regional health planning. The accreditation standards were set by the National Accreditation Act 1997, before constitutional reform in 2001 gave autonomy to the regions to set their own accreditation criteria. This has contributed to the significant variance.

Healthcare is governed by a combination of state laws, regulations, administrative actions and formal Acts. These are implemented by provincial medical associations, which carry out regulatory and administrative functions at a regional level. As Italy has a decentralised system, there are more than 100 such medical associations.

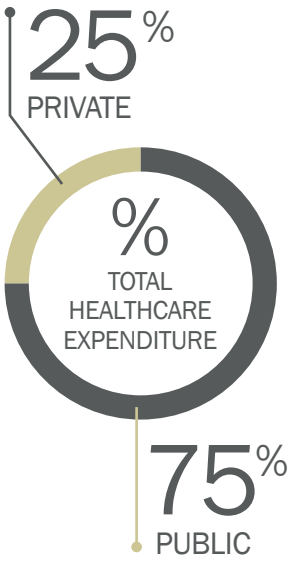
Responsibility for the regulation of social care and the interactions between primary care and community/social care is held by the regions.

HEALTHCARE – FINANCING AND STRUCTURE

Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Italy is mostly public, through the SSN. Public sources made up about 75% of the total healthcare spending in 2016 and come from national and regional taxes. Private spending is mostly made up of co-payments and some out-of-pocket payments, which represent about 22% of the total expenditure. Subscriptions to Private Health Insurance (PHI) are limited and make up a very small proportion of total health expenditure. The total healthcare expenditure in 2016 was €149.5bn, amounting to 8.9% of GDP. Reflecting the pressure on public finances, overall healthcare expenditure was flat in Italy between 2011 and 2016. Italy's public finances are under pressure and healthcare funding has been subject to a number of cuts.



Healthcare Financing Flows

The Italian central government uses a weighted capitation-based method to allocate funding to the regions. This considers a region's demographics and geographical distribution. 97% of a region's funding comes through this mechanism. The remaining 3% is generated from each region's own source of funding. While the MoH gives recommendations to the regions on how they should spend their budgets, regions are ultimately responsible for their spending decisions.

Healthcare System Structure

Services

Healthcare services are mostly free at the point of need under the SSN. The national benefits package gives access to a wide range of primary and secondary care services. Primary care services are delivered locally by about 46,000 general practitioners (GPs). For specialist care, patients can choose either public or private providers, depending on their willingness to pay. Acute inpatient care is delivered by a network of hospitals. In 2015, there were about 194,000 hospital beds across 1,115 hospitals in Italy. Patients requiring long-term rehabilitation following a hospital stay fall at the margins of health and social care services, and services are delivered through integrated homecare or rehabilitative local residential care.

Payers

Healthcare payers are mostly public.

In primary care, GP contracts are negotiated nationally and reviewed every three to five years. GPs are paid by the ASLs on the basis of capitation payments and fee-for-service provision.

In most regions the ASLs are the main payers of secondary care services. However, some of the smaller regions in northern and central Italy have adopted a region-centred template, in which most purchasing is delivered regionally and ASLs act mostly as providers. These regions directly control most public providers and only accredit a limited number of private providers. Lombardy is the only region that has carried out a complete purchaser/provider split.

Payment rates for hospital and outpatient care are determined by each region, using national rates set by the MoH as a reference. Payments for hospital care are based on diagnostic-related group (DRG) tariffs that define a set payment depending on the patients' diagnosis and treatment. DRG tariffs are also complemented by other payment methods, while outpatient care is reimbursed using a tariff per unit of care. There are considerable inter-regional variations in the payment system adopted by each region, such as how the fees are set, which services are included, and the tools employed to influence patterns of care.

Providers

There is a mixture of private and public providers, with regional variation across Italy.

GPs are normally independent and provide services on behalf of health districts, which are the operative branches of ASLs. Reconfiguration over the last 15 years has seen a move from the traditional single practice GP model to integrated care models connecting all services and providers.
In 1992, a reform aimed to introduce a quasi-market system with patients free to choose any provider. In practice these arrangements vary across regions. Private accredited providers sign an annual contractual agreement that states the volume, price and quality of services to be delivered. The highest levels of private provision are found in the regions of Lazio, Campania, Molise and Lombardy with around 30% of total hospital beds supplied by private providers.

ADULT SOCIAL CARE - FINANCING AND STRUCTURE

Adult Social Care Financing

Adult Social Care Financing Context

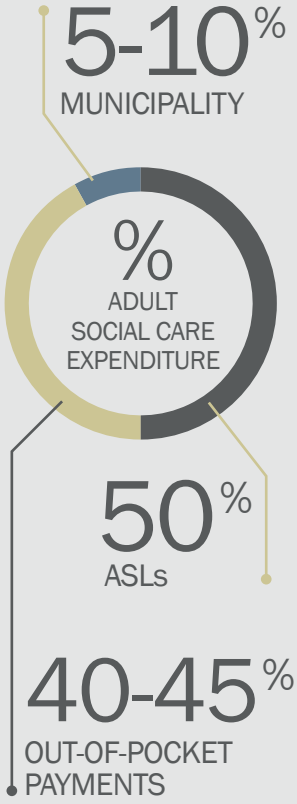
Social care expenditure relies on a mix of public and private expenditure. There are significant co-payments for individuals, which vary across regions.

Public funding for social care comes from multiple sources. They include:

- SSN funding, which comes mainly from general taxation allocated by central government to the regions.

- ASL and municipality funding, which comes from general and local taxation.
- Funding from the National Institute for Social Security (INPS), a separate fund financed from general taxation that provides funding allowances directly to individuals.

On average, in each municipality, 50% of social care expenditure comes from the region's ASLs, 40-45% comes from out-of-pocket payments and 5-10% is covered by the municipality.



Adult Social Care Financing Flows

The structure and allocation of financial resources for social care is subject to considerable regional variation. Financial support for social care varies considerably across regions. The average public expenditure per person to support long-term care was estimated to be €5,198 in 2012. However, this hides significant regional differences.

Adult Social Care System Structure

Services

ASLs are in charge of delivering or purchasing health-related services at home (including nursing, physiotherapy, specialist and GP visits), as well as residential healthcare and other long-term care services for the elderly. Health community services are managed by health districts in most regions and are a local articulation of ASLs.

Long-term care is built around residential and community care homes. In 2011, there were 333,091 elderly (84%) and disabled (16%) patients living within residential facilities. Most of these services were located in the north of Italy.

Payers

There is a significant proportion of private payments for social care. The payers for homecare services and residential homes are the ASLs and out-of-pocket payments. In 2016, there were 13.4 million Italians over the age of 65 and almost 2 million Italians over the age of 85. By 2030, it is estimated that over-80s will account for 9% of the total population.

Public long-term care for older people includes three forms of assistance: community care, residential care and cash benefits. The SSN plans and manages, through ASLs, home healthcare services (integrated domiciliary care or assistenza domiciliare integrate or ADI) and other health services provided in residential settings. Personal social services, including domestic and personal care tasks provided at home (by the servizi di assistenza domiciliare or SAD) and institutional social care are managed at a local level by municipalities.

Local municipalities are responsible for providing social care services. This has resulted in regional variation in the structure of the adult social care system across Italy. GPs act as guides to help individuals navigate between the different services available to eligible patients.

Historically, Italy has depended on the cultural ethos of family members taking care of their own elderly population within their own home. This has resulted in a high prevalence of informal and familial homecare provided by caregivers and relatives.

Providers

Services are provided by a mix of public and private providers. Although the overall provision remains mostly public, the number of private operators is estimated to have been growing in recent years. Their distribution and involvement in service delivery varies significantly across regions.

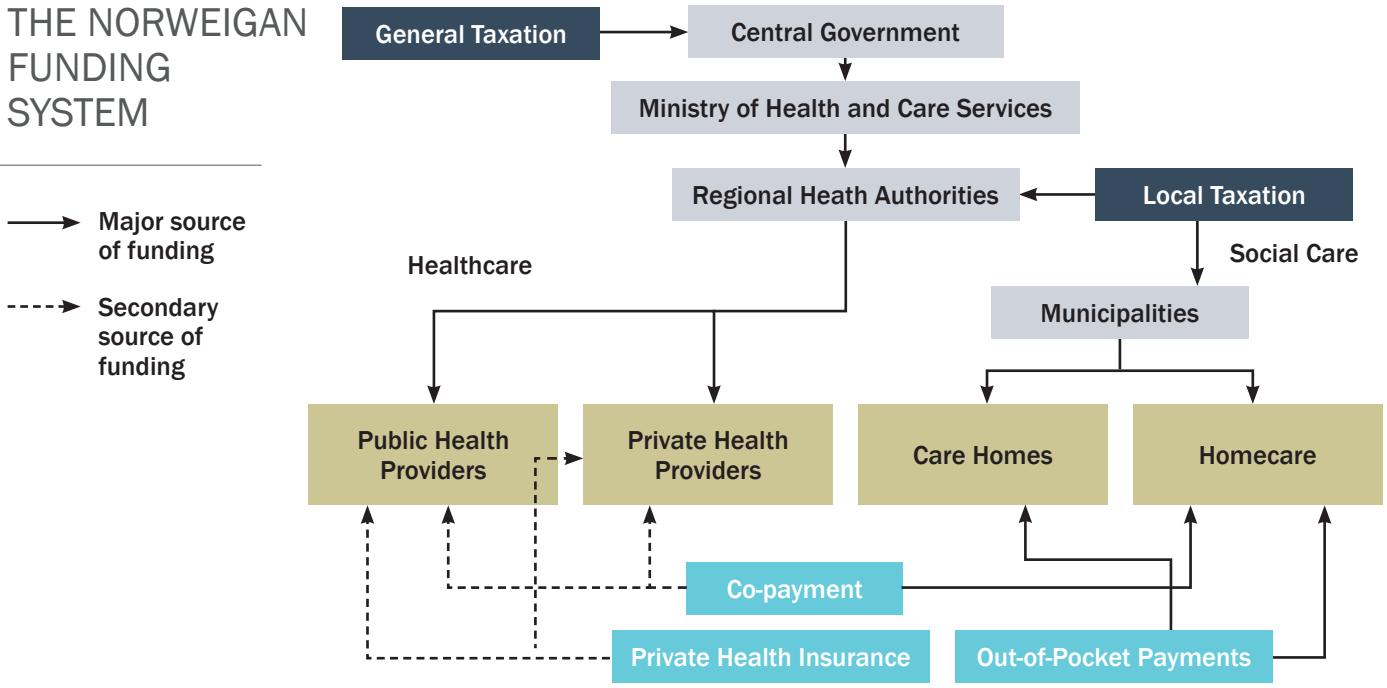
In tandem with the numerous public hospitals in Italy, there are also many private non-profit hospitals (case di cura or nursing homes), many of which are controlled by religious organisations. The majority of these are linked to the Catholic Church. A considerable number of these nursing homes have undersigned conventions with the SSN and make some beds and specialist services available for the SSN.

NORWAY

The Norwegian healthcare system provides universal coverage primarily funded through national and local taxation. A number of services are subject to capped co-payments, including GPs, specialist outpatient services and same-day surgery. Maternity services, hospital admissions and inpatient services are excluded from co-payments. Long-term care services are subject to an income assessment and supported through a national fund. Service delivery is organised at the local level.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
5.2m	385,203km^2	Oslo	**W** 84.2 | **M** 80.5

THE NORWEIGAN FUNDING SYSTEM

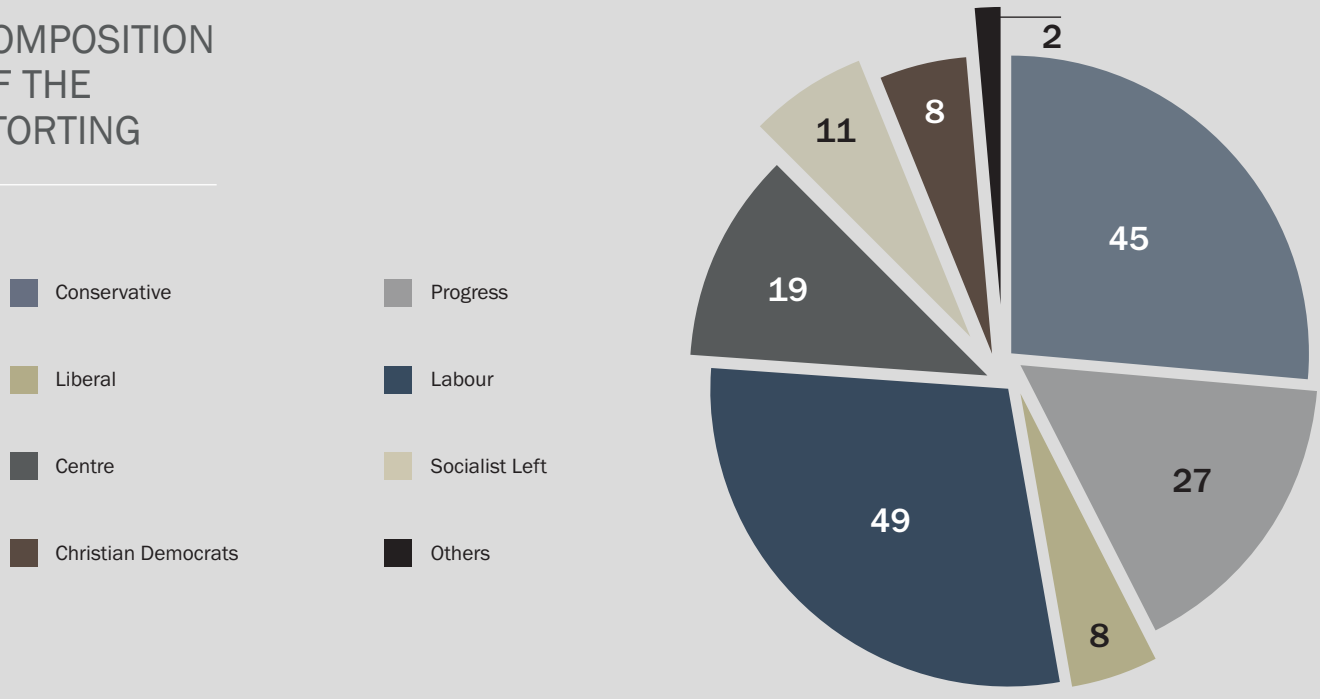


POLITICAL CONTEXT

Norway is a constitutional monarchy with a population of 5,258,317. The king, as the head of state has a largely ceremonial function, while executive and legislative powers rest with the government and parliament respectively. The Norwegian parliament (the Storting) has 169 members. The government, which must have the support of parliament, is conducted by the Council of the State, consisting of a prime minister and at least seven ministers.

Currently nine parties are represented in the parliament. No party has an absolute majority of the seats. The Labour Party is the largest party (49 seats), but a two-party minority government was formed from the Conservative Party (45 seats) and the Progress Party (27) after the last election. Elections are held every four years, with the next one due to take place in 2021.

COMPOSITION OF THE STORTING



Governance

There are four levels of health and social care governance in Norway.

	HEALTHCARE	SOCIAL CARE
National	Ministry of Health and Care Services	Ministry of Health and Care Services
Regional	Four Regional Health Authorities	Limited role
County	19 counties	Limited role
Local	426 municipalities	426 municipalities

Healthcare

The four levels of healthcare governance are: national, regional, county and municipal. Norway is divided into 19 counties and 426 municipalities, and grouped into four Regional Health Authorities (RHA).

At the national level, the government, through the Ministry of Health and Care Services, is responsible for setting national health policy and the regulation, coordination and oversight of healthcare service provision and municipal services for older adults. GP financing is subject to national negotiation, but municipalities are responsible for directly contracting services.

At the regional level, the RHAs are responsible for specialist healthcare and the wider education of medical staff and research. Among the services they cover are hospitals, psychiatry and hospital-based pharmacies, with performance covered through subsidiary health trusts. The health trusts consist of one or more hospitals.

At the county level, health authorities are responsible for the provision of dental care and general public health. At the municipality level, authorities are responsible for the organisation, funding and provision of primary care services, rehabilitation and preventive care.

Social Care

The governance of social care is primarily the responsibility of 426 municipalities. The role of the Ministry of Health and Care Services is limited to setting legislation. The 2014 Local Government Reform granted new responsibilities for the municipalities including the provision of rehabilitation and substance abuse programs, as well as involvement in financial reforms of nursing care.

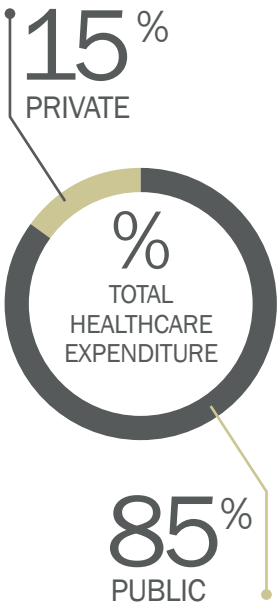
Regulation

Central government, through the Ministry of Health and Care Services, is responsible for the regulatory framework for both healthcare services and older adults' care services. Municipalities regulate the criteria for accessing nursing homes and institutional care.

Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Norway is mostly public. However, individuals are expected to pay small co-payments for using most services. On balance, about 85% of healthcare expenditure comes from public sources and 15% from private sources. This ratio has been stable for over 30 years. Public funding comes from general income taxation raised at the national and municipal level. In 2014, total healthcare expenditure was €35bn, representing 9.9% of GDP. Since 2013, expenditure has been growing slowly.



Healthcare Financing Flows

Responsibility for financing healthcare services lie mostly with the regions. However, regions levy very little in taxes themselves and rely principally on central government allocations and, to a lesser extent, municipalities. The Ministry of Health sets healthcare budgets and regions allocate resources to a wide range of services within this envelope.

Healthcare System Structure

Services

There is not a defined package of services, but there are exceptional services excluded from public coverage. These include cosmetic surgery, prescription pharmaceuticals not on the national approved list, and regular glasses for not very limited vision.

Nursing care and primary care services are organised by the municipalities and 99.6% of the population is registered with a GP. Access to specialised care is conditional on referral by the GP. Users can choose the hospital of their preference, for elective services and choose a specialist of their preference, subject to availability. The HRAs are responsible for the administration of the health trusts of hospitals that provide specialised and psychiatric care.

Emergency care is also provided at the municipality level. GP emergency services are paid for by a public fee and co-payments. In 2016, 70% of the population attended a consultation with a GP with a national average of 2.6 consultations during the year per person, and 17% required emergency primary healthcare services.

Payers

Healthcare services are not completely free at the point of need. Co-payments are required for primary and specialist healthcare services, hospital care, same day surgery, prescription pharmaceuticals, radiology and laboratory tests. There is a maximum ceiling set for each individual co-payment, and an annual cap for out-of-pocket expenditure, after which services are free of charge. In 2016 the cap was €21,850. Prescription drugs outside the list authorised by the government are excluded from the ceiling.

Antenatal and postnatal care, paediatrics, and sexual healthcare are excluded from co-payments. Inpatient treatment and hospital admission are also free of charge.

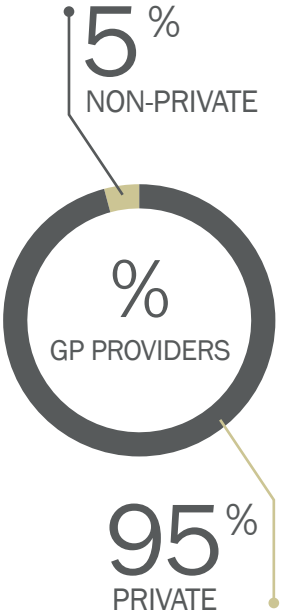
Hospital care provided by the HRAs is financed through government grants. A combination of block and activity based grants are used.

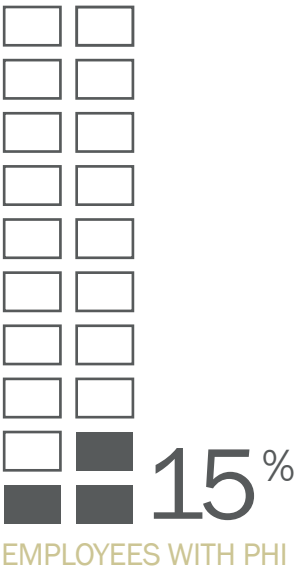
Private health insurance is used to gain faster access to healthcare services and offer a greater choice of health providers. 15% of employees have private health insurance and 91% of policies are paid by their employers.

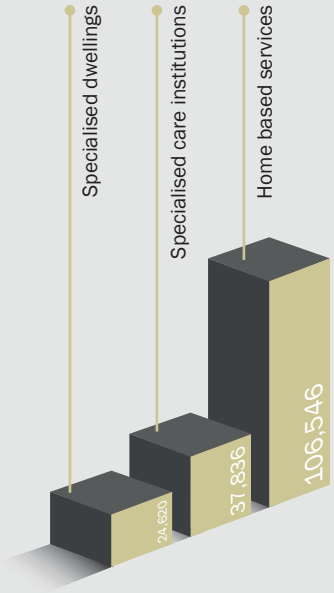
Providers

Primary care services are mainly delivered by private GPs operating under contracts with the public healthcare service. Only 5% of GPs are non-private.

Hospital services are almost exclusively provided by public sector operators. Just 0.2% of hospitals are privately owned, with some of their services publicly funded. Private specialists are contracted by an HRA and paid for through a combination of fee-for-service, patient co-payments and an annual sum based on the type of practice and number of patients. Specialists who are hired by an HRA can only charge the co-payment set by the government. There are also private providers for radiology and laboratory services and specialists who are not contracted by the HRAs and can set their own fee.







Adult Social Care Financing

Adult Social Care Financing Context

Expenditure on adult social care comes from a mix of public and private sources. There is a public safety net, funded mostly by tax revenue levied locally by municipalities, and by central allocations. However, there is a means-test and individuals may be required to contribute up to 85% of their personal income towards the cost of their care. The growth of expenditure spending on social care has slowed since 2010. In 2015, it is estimated that public expenditure on social care amounted to €1.86bn.

Adult Social Care Financing Flows

Municipalities enjoy some discretion in the allocation of social care resources among services. However, the Ministry of Health gives directions on expenditure and some of its funding is ring-fenced for specific services.

Adult Social Care System Structure

Services

Access to homecare and institutional care services is mean-tested. None of these services are specifically reserved for older adults. In 2016, 37,836 people over 67 years old were residents in specialised care institutions, 24,620 were residents in specialised dwellings and 106,546 were users of home based services, including home nursing and home help services. The total number of service users has remained stable since 2013.

Providers

Municipalities are responsible for providing adult social care services. The majority of services are public. While private services can be contracted by the government, only 3% of nursing homes are private.

Payers

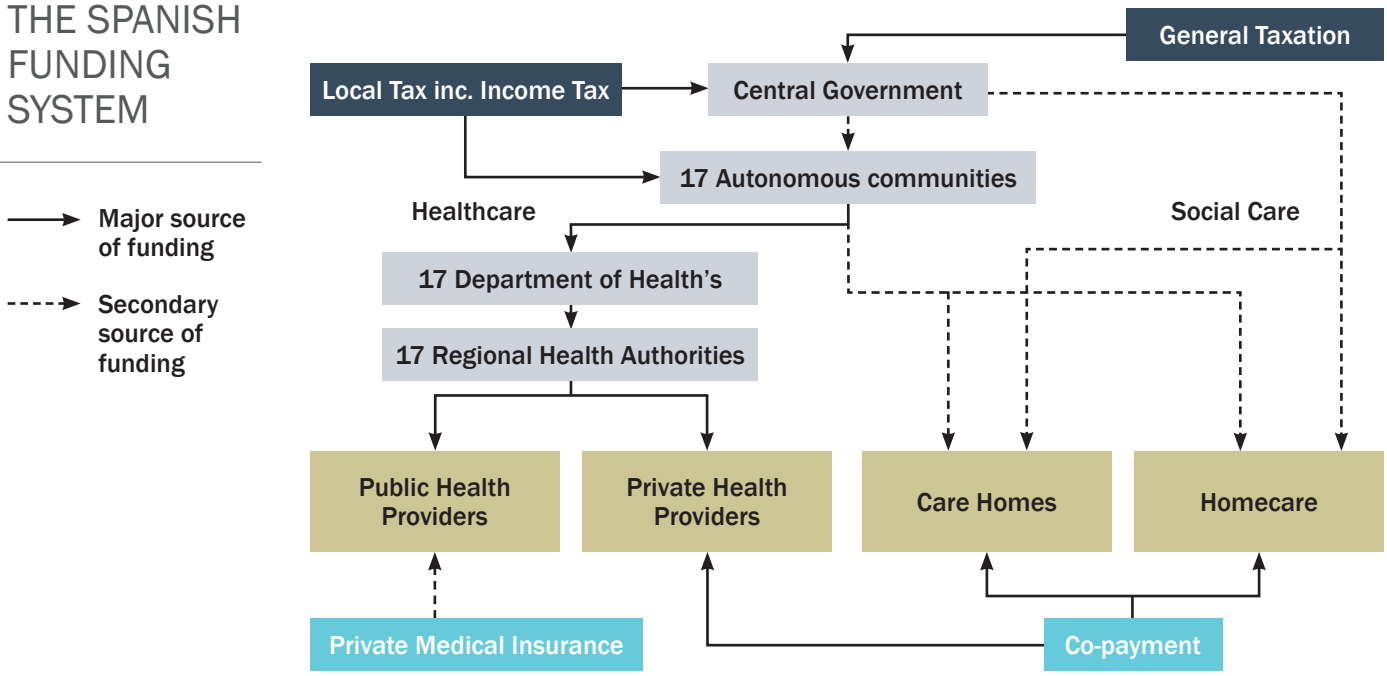
Adult social care is not free of charge. Co-payments are income based and range between 75% and 85% of personal income with the remainder funded by the municipality. This type of care is not included in the annual ceiling for out of pocket expenditure. The high level of co-payments and 100% pension coverage may explain why many older adults in Norway remain living at home on private and social pensions and receiving homecare services. Only in cases of disability are they likely to move into nursing homes.

SPAIN

The Spanish National Health System (SNS) provides universal coverage for healthcare and is primarily funded through general taxation. It remains mostly free at the point of need, although the use of required co-payments is growing. Social care services are funded through a co-payment system that varies with the type of service and the individual's ability to pay.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
46.5m	505,990km^2	Madrid	**W** 85.7 | **M** 80.1

THE SPANISH FUNDING SYSTEM



POLITICAL CONTEXT

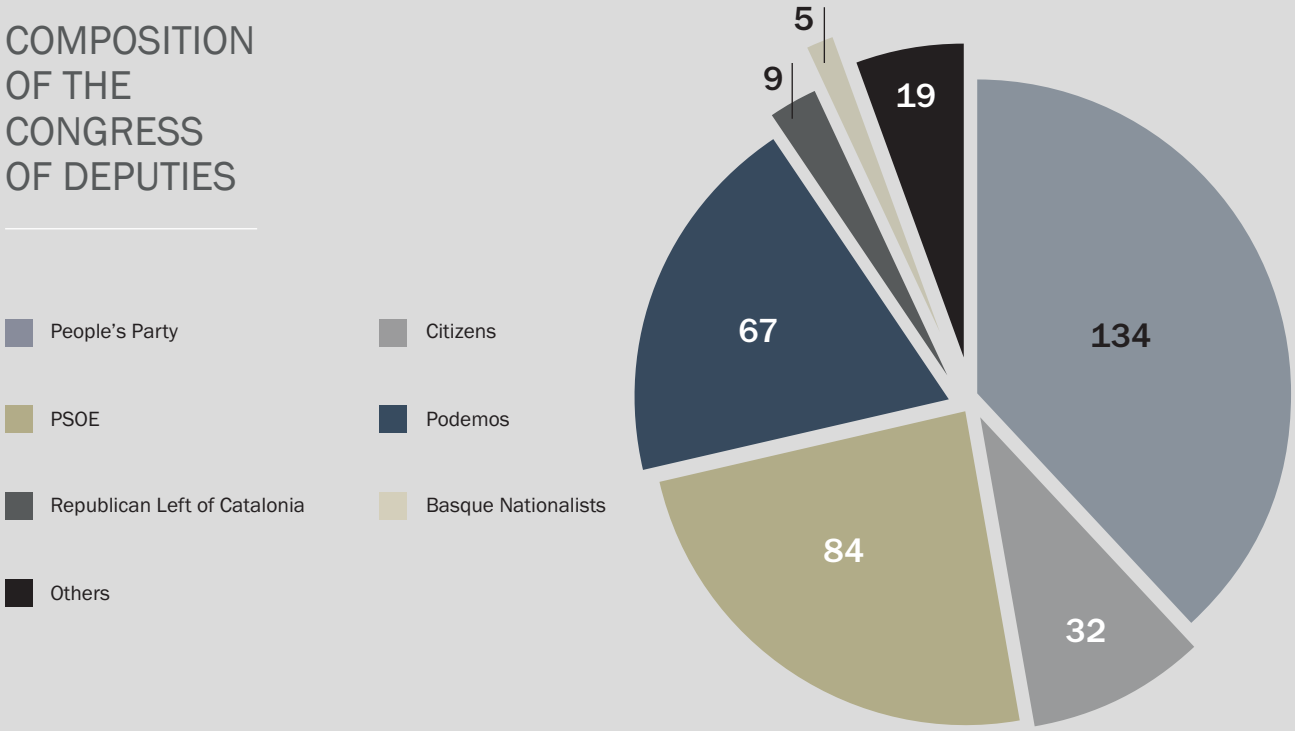
Spain is a parliamentary democracy with a population of 46,528,966. The official head of government is the prime minister. The head of state is a hereditary monarch, who is formally responsible for ratifying legislation, dissolving the legislature and proposing candidates for prime minister.

Spain's parliament is comprised of the 350-seat Congress of Deputies, elected by popular vote, and the 265-member Senate, of which 208 members are elected directly and the remaining 57 appointed by regional legislatures. Candidates for prime minister must be approved by the Congress of Deputies.

The last general election took place in June 2016. No party won an absolute majority. The centre-right People's Party (PP) gained the most seats in both Congress and the Senate, followed by the centre-left Spanish Socialist Workers Party (PSOE). A coalition deal was agreed between the People's Party, the Citizens Party and the Canaries Coalition, which broke a political deadlock that stretched back to September 2015.

General elections are held every four years. The next general elections are expected in early 2020.

COMPOSITION OF THE CONGRESS OF DEPUTIES



HEALTH AND SOCIAL CARE – GOVERNANCE AND REGULATION

Governance

Healthcare governance is highly decentralised. Spain is divided into 17 regions (autonomous communities or ACs) and two autonomous cities, Ceuta and Melila. Each AC has its own parliament and regional government and is responsible for its own healthcare policy. They have economic and financial autonomy with the power to determine and approve an annual budget and local taxation system.

Events surrounding Catalonian independence have highlighted the tensions that can exist between the regional and national level. It also demonstrates the limits of decentralised power and the extent to which the national government can exert authority where necessary.

	HEALTHCARE	SOCIAL CARE
National	Ministry of Health, Social Services and Equality	Ministry of Health, Social Services and Equality
Coordination	Interterritorial Council of the Spanish National Health Service	- Territorial Council for the National Long-term Care System - Territorial Council of the System for Autonomy and Care for Dependency
Regional	17 ACs and two autonomous cities	17 ACs and two autonomous cities

Healthcare
The governance of healthcare is highly decentralised.

The national government, through the Ministry of Health, Social Services and Equality retains authority over certain strategic areas and general healthcare legislation. This includes making sure that equal access to health services is maintained across the country.

To avoid decentralisation leading to major regional differences there is national coordination through the Interterritorial Council of the Spanish National Health Service (CISNS). Chaired by the Health Minister, its membership includes the ACs' departmental directors with responsibility for health affairs. They are responsible for deciding the content of the minimum common benefits package, which includes primary care, specialised care, supplemental care and pharmacy. This provides a national minimum, but ACs are free to add additional services for their own area.

In April 2012, Royal Decree Law, 16/2012 was passed in order to implement urgent measures to ensure the sustainability of the National Health System and improve the quality and security of its benefits. The measures of this Royal Decree Law were based on a coordination agreement between central government and the ACs to address the SSN debt (€16bn). Their focus was on efficiency, controlling expenditure, and increasing financial resources.

Social Care
The governance of social care is also highly decentralised.

The ACs are responsible for social care provision, and are free to design their own policies. However, since 2009 the Ministry of Health, Social Services and Equality has held overall national responsibility for social policy. Coordination between the ACs and central government takes place through the Territorial Council for the National Long-term Care System and the Territorial Council of the System for Autonomy and Care for Dependency.

There are different degrees of integration between health and social care among the ACs.

Regulation

Health regulation responsibilities are distributed among the Ministry of Health, Social Services and Equality, ACs, and local councils. Quality of care standards are set nationally by the National Agency for Quality of the SNS, whilst ACs take on responsibility for the accreditation and authorisation of services.

In social care, the Territorial Council for the National Long-term Care System and the Territorial Council of the System for Autonomy and Care for Dependency develop quality indicators for accreditation and determine the criteria used by ACs for needs threshold assessments.

Changes to adult social care have been limited over the last five years. However, there is ongoing reflection on potential improvements to the System for Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency (SAAD), which was introduced in 2006.

HEALTHCARE – FINANCING AND STRUCTURE

Healthcare Financing

Healthcare Financing Context
Healthcare expenditure in Spain is mostly public. However, successive reforms have led to an increase of individual co-payments.

Currently, 70% of Spanish healthcare expenditure comes from public sources and 30% from private. The share of private expenditure has increased since 2010,

Healthcare System Structure

and this ratio has decreased slightly. However, take-up of voluntary private health insurance (PHI) remains limited, currently covering about 13% of the population.

Healthcare in Spain is principally funded through general taxation raised at regional and national levels. In 2016, Spain spent €100,056m (9% of GDP) on healthcare. The decentralised nature of the health system means that funding trends are difficult to establish as they will vary between regions. However, despite the intention to contain the cost of pharmaceuticals through the inclusion of co-payments on pharmaceutical prescriptions in 2012, there has been a growth in the sales of existing pharmaceutical products.

Healthcare Financing Flow

Since 2009, the ACs have gained additional fiscal autonomy. As such, they retain more taxes, including a proportion of income tax, and transfer less revenue to central government. The core function of central government is to play a redistributive role through the allocation of block-grants to level out regional fiscal income differences. The ACs currently administer 89% of public health funding. The responsibility for commissioning healthcare services lies with the ACs. They are required to spend over a minimum threshold, worked out in accordance with their demographics and health needs. Healthcare expenditure varies from 22% of the total AC budget in Navarra to 38% in Valencia. It is the largest part of all ACs' budgets. Each regional Department of Health allocates resources to the Regional Health Service. They commission primary care services and specialised hospital care, and contract with a number of private providers.

Services

Services are mostly free at the point of need. Basic services provided in primary healthcare include general practice (GP), paediatrics, prevention of diseases programs, health promotion, health education and rehabilitation. Secondary healthcare services provide specialised medicine and surgery. Services Centres and Reference Units provide high technology treatments available for every person in the country.

Payers

Primary care services are funded through block grants with a capitation component. Hospitals have historically been funded through contract programs negotiated with the Regional Health Service. Increasingly, these contracts include quality and efficiency objectives.

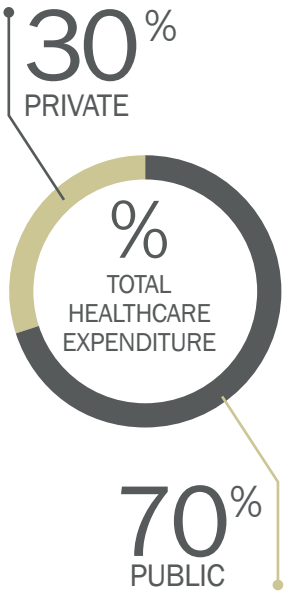
While healthcare is mostly free at the point of need, recent austerity measures and budget cuts have led to the introduction of co-payments for pharmaceuticals and some services.

Providers

The provision of services in Spain relies on a mix of public and private providers. There can be significant variation in provision between regions.

Health centres provide primary healthcare services, including family and GP services, nursing, paediatrics, social services and physiotherapy. They should be located within thirty minutes of a person's place of residence.

Spain has 788 hospitals. 355 are public and 433 private. About 7% of private hospitals are integrated into the hospital network for public use through public-private partnerships, and 40% of private hospitals have contracted some of their services to the SNS.



Adult Social Care Financing

Social Care Financing Context

Social care is not free at the point of need in Spain and has long been under-funded, with only the most dependent patients receiving some kind of support. Like healthcare, social care services are funded through general taxation. There are three levels of public funding:

- A minimum level of protection, which is funded by central government.
- Supplementary funding, which is agreed between central government and the ACs.
- Additional funding, which is provided voluntarily by the ACs through their budgets.

In 2007, Spain launched a reform of long-term care, which introduced a universal but subjective right to care for adults. This guarantees a person access to a package of care services (subject to some cost sharing), regardless of place of residence, if they are deemed eligible following an assessment of care needs, income and financial assets.

Social care funding has been cut in recent years. On average, the minimum level of funding has been cut by 13%, while there has been a decrease in the average proportion of co-payments for the use of specialist care centres. This fell from 45.31% to 43.94% between 2011 and 2015. However, in 2017, central government announced an annual increase of €102m in funding for adult social care.

Social Care Financing Flows

Central government allocates funding to 17 autonomous communities, which is used alongside co-payments to fund social care. Spanish law states that beneficiaries of social care services must contribute financially to the funding of services by means of a co-payment. The level of co-payments depends on income and is not the same for all social care services.

Adult Social Care Structure

Services

Specialised social care services for adults comprises both day and night care centres, and nursing homes. In 2014, 18% of Spain's population was over 65 (approximately 8.28m people). There were 381,333 spaces available in care centres in the country, and 212,525 of those spaces were financed with public money. Cataluña, Castilla and León and Andalucía are the regions with higher numbers of care centres. There are also 118 geriatric and long stay hospitals in Spain.

Payers

Individuals contribute significantly towards the cost of social care. Access to adult social care services is subject to co-payments that are determined by the type of service and an individual's ability to pay. It is estimated that co-payments increased by about 68% between 2009 and 2013. While there is partial public funding available for applicants who cannot pay for the full cost of services, on average, service user charges cover 43.94% of the total cost.

Providers

Social care provision is dominated by the private sector, and its share has been increasing in recent years alongside a decrease in public provision. Long-term care was traditionally delivered by informal family carers.

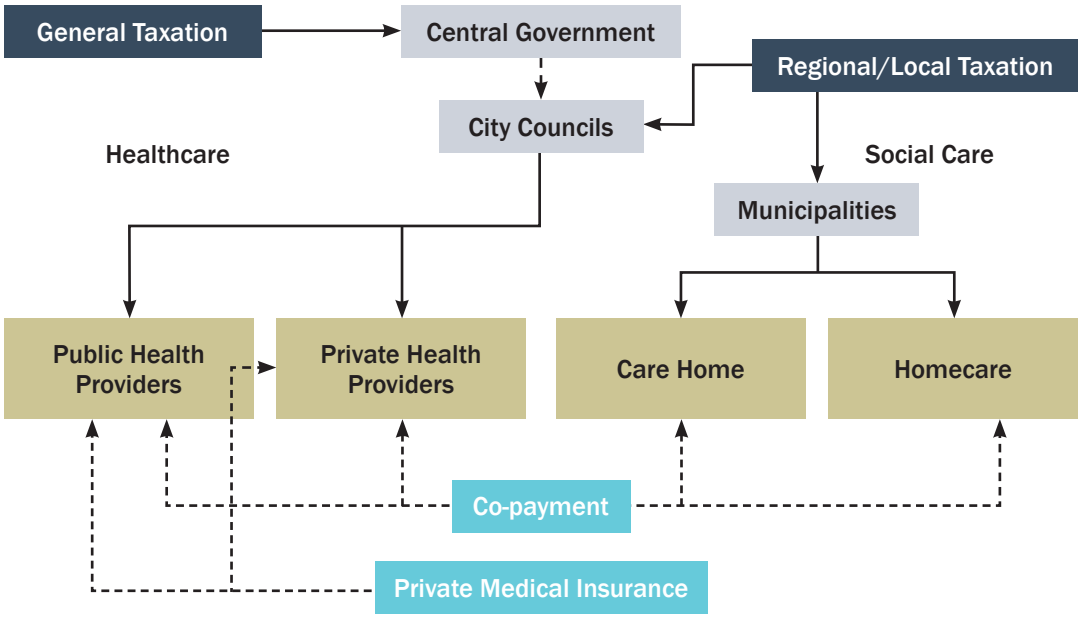
Services are delivered through a network of public and accredited private SAAD (System for Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency) centres.

SWEDEN

The Swedish healthcare system is primarily funded through local taxation, with a redistributive element coming through central government funding. Healthcare services are not free at the point of need, and the system is part-funded through co-payments, which are capped at different annual thresholds depending on the service. In contrast to most European countries, social care services are almost free at the point of need. They are mostly funded through local taxation.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
9.9m	447,435km^2	Stockholm	**W** 84.1 | **M** 80.4

THE SWEDISH FUNDING SYSTEM



Major source of funding

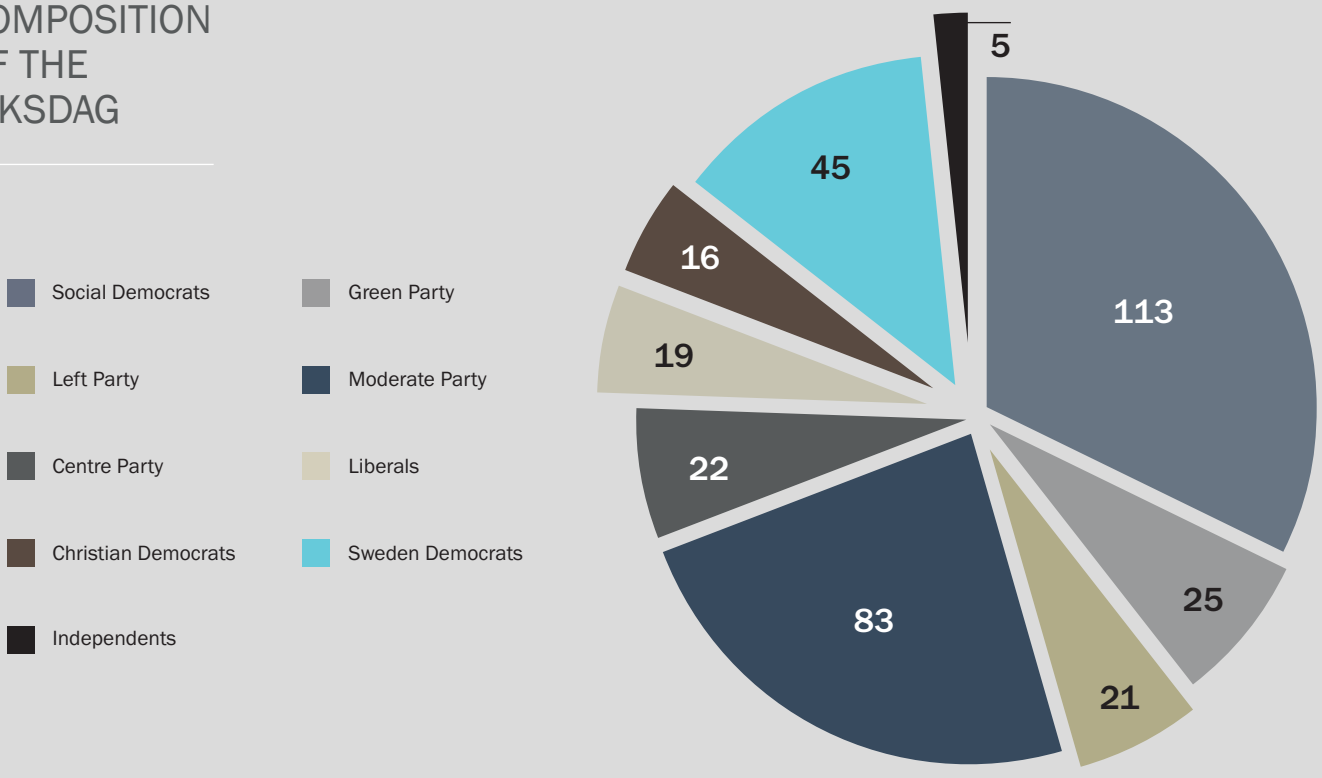
Secondary source of funding

POLITICAL CONTEXT

Sweden is a parliamentary monarchy with a population of 9,995,153. Executive power is exercised by central government. The prime minister is elected by parliament, with the monarch largely playing a symbolic role as Head of State. Legislative power is spread between the central government and parliament. Sweden's unicameral parliament, the Riksdag, has 349 directly elected members.

The highly proportionally voting system ensures that no party has an absolute majority of parliamentary seats, leading to a multi-party system. The current minority government is formed from a centre-left bloc, containing the Social Democrats, and the Green Party. General elections are held every four years. The next general election will take place on 09 September 2018.

COMPOSITION OF THE RIKSDAG



Governance

There are three levels of healthcare governance.

	HEALTHCARE	SOCIAL CARE
National	Ministry of Health and Social Affairs	Ministry of Health and Social Affairs
Regional	20 counties	20 counties
Local	290 municipalities	290 municipalities

Healthcare

Since 1982, the Swedish healthcare system has been decentralised, with county councils retaining primary responsibility for planning and provision of care. The implementation of national health policies can vary across local geographies as a result of the decentralised structure, and the introduction of reforms is usually undertaken by individual county councils. However, providers are required to adhere to national standards.

Central government is led by the prime minister who, along with 22 ministers, have legislative power, implement parliamentary decisions and is responsible for the budget. While parliament is the supreme political decision-making body, healthcare policy is the responsibility of the Ministry of Health and Social Affairs. The Ministry is supported by eight national government agencies, which carry out ancillary functions.

Sweden is divided into 20 counties and 290 municipalities. At regional level, county councils oversee tasks requiring the coordination of large regions, including healthcare. County councils are responsible for funding, organising, and planning health services.

Social Care

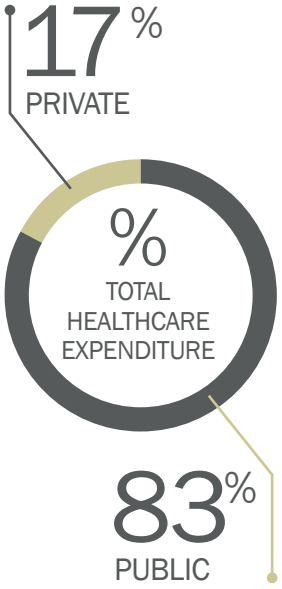
Social care governance is decentralised to local government, which is in the hands of municipal assemblies. These assemblies are responsible for the provision of basic facilities and services including schools, water and childcare. They oversee the funding, organisation, and planning of care for the elderly and disabled. They are also responsible for providing adult social care services.

Regulation

National principles and guidelines for service provision are set by central government using a combination of legislation and coordination agreements with regional and local governments.

The National Board of Health and Welfare is the central government's supervisory authority. The board supervises all healthcare personnel, provides information and guidance, develops standards for care and ensures those standards are upheld.

For social care the national Inspectorate for Healthcare and Social Services regulates social care providers through a registration system, and regular inspection activity.



Healthcare Financing

Healthcare Financing Context

The majority of healthcare expenditure in Sweden is public. Approximately 83% of healthcare expenditure is publicly financed and the remainder is privately financed, mostly through co-payments. These are capped to a maximum annual amount per person. Take-up of private health insurance (PHI) is limited. In 2016, less than 5% of the population had private insurance.

Healthcare funding is mainly the responsibility of county councils and municipalities, which levy proportional income tax on their respective populations. In total, Sweden spends about 11% of its GDP on healthcare. This amounted to just over €48bn in 2014.

Healthcare Financing Flows

The majority of public resources for healthcare are levied at county and municipal levels. About 69% of county councils' total revenue comes from local taxes. This is complemented by central government grants, funded through national income taxes and indirect taxes. Central government funding is limited, contributing to about 17% of county councils' revenue. It is distributed through grants to equalise differences in income tax revenue across county councils and municipalities. It may also be provided to finance specific initiatives. County councils spend the vast majority of their budgets (89%) on healthcare. They are responsible for allocating resources across a wide range of services.

Healthcare System Structure

Services

Primary healthcare involves services that do not require advanced medical equipment and may be administered by GPs, nurses, midwives, physiotherapists, psychologists or gynaecologists. Mental health is integrated into the wider healthcare system and usually attended to at the primary care level. Since 2010, primary care providers have had freedom of establishment.

There are about 1,100 primary care units, of which about 40% are private. Team-based primary care facilities of four to six GPs, complemented by other healthcare staff, are the most typical form of primary care practice. A few solo private practices exist. Dental care is offered by both public and private providers.

There are about 70 hospitals at the county council level and seven university/regional hospitals, providing specialised inpatient treatment and outpatient somatic and psychiatric care. Around two-thirds of county council hospitals provide acute care. There are six private hospitals in Sweden, of which three are run as for-profit enterprises, and three are non-profit and in contract with Stockholm County Council.

Payers

County councils are the main payers for healthcare. Payments to private providers are usually contract-based, following a public tendering process. Each county council sets its own payment system, but overall payments for primary care are based on capitation and performance. Hospitals are paid through global budget diagnosis-related groups, performance-based methods and, sometimes, case-based payments.

However, healthcare is not entirely free at the point of need. Patients pay a fee for service (FFS), determined at the county council level. The fee is standardised for public and private providers. In 2016, the fee for a general practitioner (GP) consultation varied from €11 to €22, and consulting a specialist costs between €25 and €35. The fee level is determined by the county council and varies across the country. People under 20 (or 18 in some counties) are exempt from fees for GP consultations and dental care. Hospital stays cost €8 per day for the first ten days and €6 thereafter. Once FFS payments reach the national annual threshold (around €122), patients are no longer required to pay for healthcare services. Less than 5% of the population has private health insurance (PHI), which is primarily used to gain quicker access to specialist services.

Providers

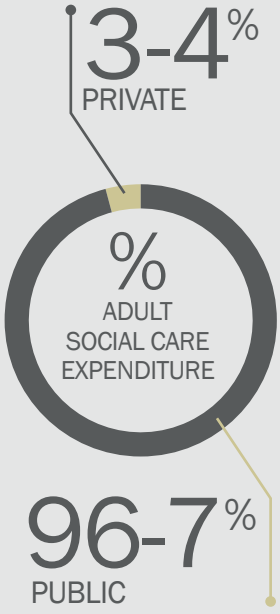
Sweden has a purchaser/provider split model. County councils buy public services from a mix of public and private providers, depending on who offers the best combination of price and quality.

Provision of health and medical care services, including dental care for residents up to the age of 21, is ensured by the county councils and, for some services, by municipal governments. This model allows the population to freely choose the service of their preference. However, the health care market is dominated by public providers. In 2013, only 12% of healthcare financed by county councils was carried out by private providers.

Adult Social Care Financing

Adult Social Care Financing Context

Expenditure on adult social care in Sweden is mostly public with limited individual co-payments. Public expenditure on social care is primarily funded through taxation (85%), levied at the local level by 209 municipalities. Central government funding levels out differences in local tax revenue through redistributive grant mechanisms. Sweden spent approximately SEK 109.2bn (€11.9bn) on social care in 2014. Co-payments make up just 3-4% of total expenditure.



Adult Social Care Financing Flows

Each municipality sets its own payment system and prices. Resources are allocated directly from municipalities to social care services. There is limited central government involvement. However, central government may finance specific objectives. For example, SEK 2bn was allocated annually between 2016 and 2018 to improve the quality of elderly care.

Adult Social Care System Structure

Services

Unlike most European countries, social care services are almost free at the point of need. Access to services is based on an individual's needs, not their ability to pay. In 2016, 317,000 older adults were receiving at least one specialised service. 32% received home help and 16% special housing. Specialist accommodation includes nursing care and hospices. Home help services include hot meal deliveries, help with bathing, dressing and cleaning, and specialised transportation.

Payers

Municipalities are the main payers for social care services. For older adults there are limits on the amount an individual should pay and the level of co-payments is determined in relation to income. There are subsidised costs for older adults who pay for themselves.

Municipalities are responsible for carrying out needs assessments to determine whether an individual requires social care. There are no national standards for assessment criteria, which are determined by each municipality. Increasingly, national policy encourages municipalities to organise care closer to home with individuals staying in their own homes as long as appropriate.

Providers

Services are provided by a mix of public and private operators. Like healthcare, the market has been opened to competition and patients are entitled to choose the service they want to use. There is a reimbursement system for informal caregivers designed to promote home assistance over institutional care. It is estimated that about 14% of all nursing home and homecare provision was privately provided in 2012.

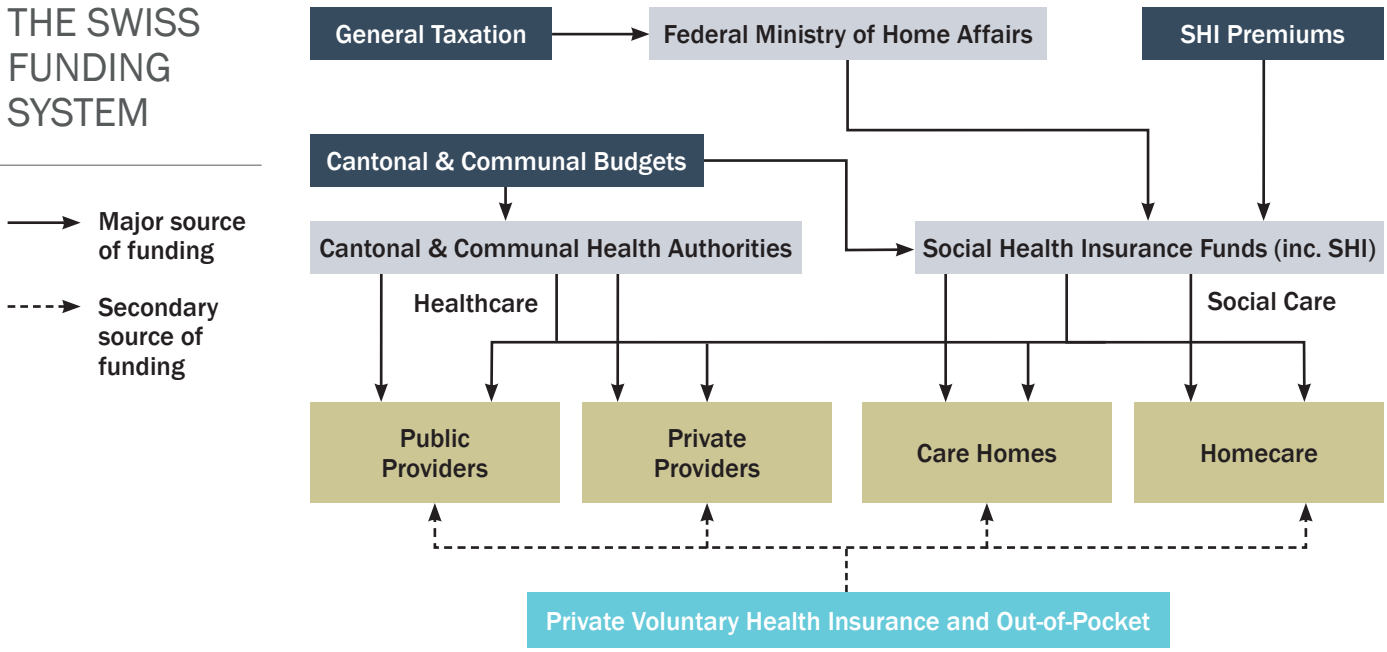
The proportion of homecare services provided privately has been increasing. Between 2013 and 2014 it increased from 24% to 30%. The growth of private provision has happened over the last 20 years, and it is estimated that between 1995 and 2005 the number of private companies in the social care services sector increased five-fold.

SWITZERLAND

Switzerland's health and social care system is complex. Funding comes from a number of public and private sources at the national and regional levels. Services are not free at the point of need and individuals are required to contribute to the costs of care in the form of insurance deductibles and co-payments. The decentralised nature of the system has led to some variation across the 26 cantons.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
8.3m	41,285km^2	Bern	**W** 85.1 | **M** 80.8

THE SWISS FUNDING SYSTEM

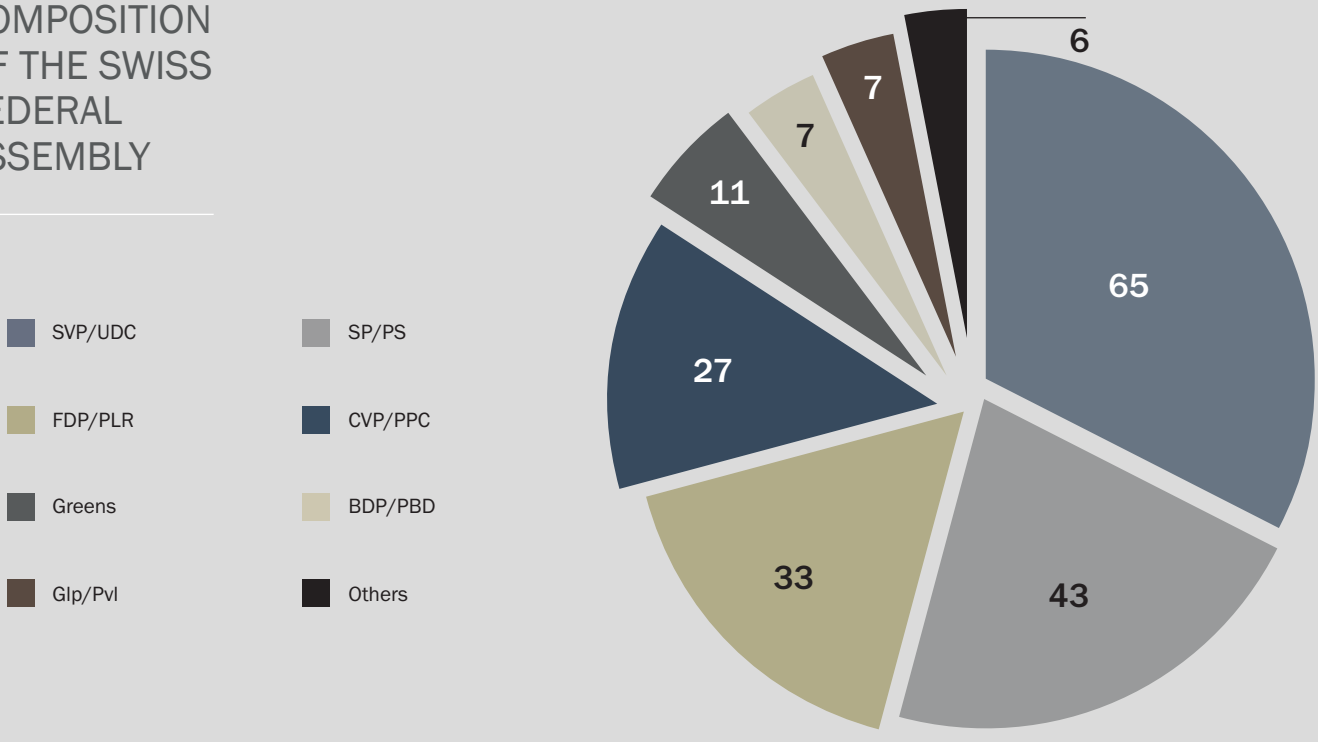


POLITICAL CONTEXT

Switzerland is a confederation of 26 cantons with a high level of decentralisation and a population of 8,417,700. Executive power is held by the Federal Council, which is made up of seven councillors. They are appointed by the Federal Assembly, made of two houses (the National Council and the Council of States), and holds legislative power.

The current seven councillors were appointed following the outcome of the 18 October 2015 elections and are made up of representatives of four parties: the Swiss People's Party (right), the Christian Democrats (centre-right), the Liberals, and the Social Democrats (centre-left). The Federal Council makes all its decisions by consensus.

COMPOSITION OF THE SWISS FEDERAL ASSEMBLY



Governance

There are three key levels of decision making in Switzerland.

	HEALTHCARE	SOCIAL CARE
National	Swiss confederation	Limited national coordination
Regional	26 cantons	26 cantons
Local	2,352 municipalities	2,352 municipalities

Civil society organisations (or corporatist bodies), including representatives of mandatory statutory health insurance (SHI) providers, and health and social care companies play a significant role in shaping governance. They engage in determining tariffs for service reimbursement and negotiate contracts at the cantonal level. In addition, the public can veto or demand reform through referenda.

Healthcare

National level responsibility is strictly defined in the constitution. The Federal Health Law (KVG/LAMal) is the most important document determining the rules of the mandatory SHI. This is regulated by the Federal Office of Public Health (FOPH), a division of the Federal Department of Home Affairs. Its most important responsibility is the financing of the healthcare system and determining the range of services included in the SHI.

Despite some centralisation, healthcare governance remains highly decentralised. At regional level, the cantons are responsible for securing healthcare provision for their populations and this is often codified in cantonal constitutions. They are also in charge of issuing and implementing a large proportion of health-related legislation. In addition, the cantons finance a significant share of inpatient care, provide subsidies to low-income households that enable them to pay for insurance, and coordinate sickness prevention and health promotion activities.

At local level, the role and influence of municipalities in providing healthcare services and other social support services varies and is dependent on decisions within each canton.

Social Care

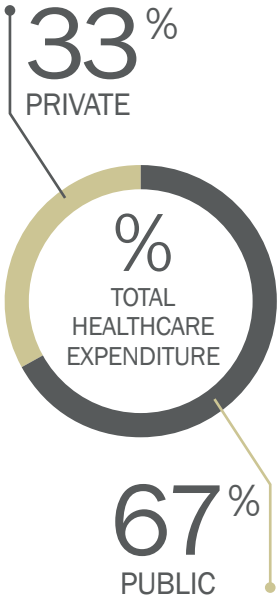
The decentralised nature of social care in Switzerland means that cantons play a major role in the organisation of long-term care. This includes the organisation of rehabilitative care, palliative care and psychiatric care. However, some aspects are delegated to municipalities at a local level. The decision to delegate varies across cantons. There is limited central government involvement, except in terms of the responsibility for the collection and disbursement of social health insurance and statutory health insurance.

Regulation

The regulation of providers is carried out jointly by the Swiss confederation and the cantons. At national level, the conditions for providing SHI services are laid out in the KVG. However, cantons are responsible for the licensing of ambulatory providers and have some discretion to determine which providers are allowed to offer secondary care services on behalf of the SHI.

To improve coordination between the highly autonomous cantons and the central government, the Confederation of Cantons Healthcare Directors (GDK/CDS) was set up as an informal government body.

The Swiss Financial Market Supervisory Authority is responsible for regulating voluntary health insurance.



Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Switzerland is split between public and private sources. Public sources of funding contribute to about 67% of healthcare expenditure, leaving a relatively high share of private expenditure in comparison to most European countries. The structure of healthcare financing is complex. Public healthcare funding comes from a mix of national, regional and local taxation as well as insurance premiums paid by individuals to the SHI provider of their choice. Individuals are mandated to subscribe to an SHI provider. Private sources include complementary private health insurance (PHI), co-payments (required for most services) and out-of-pocket payments. In 2016, total health expenditure in Switzerland as a proportion of GDP amounted to 12.4%. In real terms, total health expenditure has increased slightly over the past five years with an average annual increase of 0.3 percentage points.

Healthcare Financing Flows

SHI providers pool their resources, which are subject to risk equalisation to make sure that insurers receive sufficient resources, depending on the risk profile of their members. SHI is mandatory and applicants cannot be turned down by insurers. Premiums vary across the 26 cantons, however within a canton; they must be the same for all insured individuals. In addition, SHI expenditure is complemented by direct government expenditure.

Healthcare System Structure

Services

Services are not free at the point of need as individuals are required to pay deductibles and co-payments on their health insurance and for services used. SHI providers offer different policy types, which vary with regard to the size of deductible. This deductible is the amount that individuals have to pay themselves before the SHI coverage starts. The minimum annual deductible is 300 Swiss Francs, and the maximum 2500 Swiss Francs. In addition, a 10% co-payment rate applies to all services (this cannot be covered by voluntary insurance). In total, maximum user charges (deductible plus co-payment) are capped at 1000 Swiss Francs or 3200 Swiss Francs, depending on size of deductible chosen.

The standard SHI benefits package is defined in national legislation. The package includes services necessary to diagnose and treat diseases and their consequences, including maternity services. In practice, the SHI covers most general practitioner (GP), chiropractor, midwife and specialist services. It also covers inpatient care, an extensive list of pharmaceuticals, medical devices for home use by patients, laboratory tests, physiotherapy, speech therapy, nutritional counselling, diabetes counselling, outpatient care by nurses and occupational therapy (if prescribed by a physician). Benefits not part of the SHI include routine dental care, monetary sick pay, long-term care costs beyond a list of defined services, psychotherapy, vision aids, in-vitro fertilisation and plastic surgery not related to accidents.

Access to all levels of care, including inpatient care, without the need for a referral is a key characteristic of the Swiss healthcare system.

Payers

There is a complex multi-payer system for healthcare services.

National insurance legislation regulates the role of cantons as payers in the healthcare system. It determines hospital planning rules and the financing of inpatient care. However, cantons have autonomy on how to spend their resources. The cantons are responsible for ensuring all of their citizens purchase insurance, and for subsidising insurance premiums.

There is a payer/purchaser split where the allocated funds from the federal budget and social health insurance are paid to providers through different methods. Fee for Service (FFS, also known as TARMED) is the dominant method of provider payment for primary and outpatient secondary care. For inpatient care, diagnosis related group payments (DRG) have replaced per-diems as the most important payment mechanism. They exist mainly for acute care hospitals. Public health activities are mostly paid for on the basis of lump sum contracts or FFS.

Providers

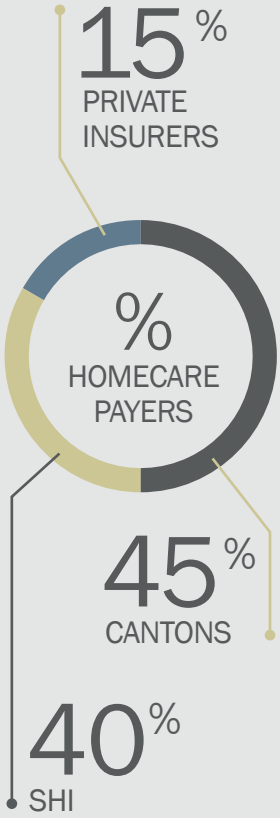
Inpatient services are provided by a mix of public and private hospitals. Patients are free to choose between these services.

Outpatient services are mainly provided by self-employed physicians working in independent single practices. They offer both primary and specialised care. Many physicians are now forming physician networks (or health maintenance organisations) and contract with insurers.

Adult Social Care Financing

Adult Social Care Financing Context

Expenditure on adult social care is made up of a mix of public and private sources. Public funding provides a safety net but individuals are required to contribute towards the costs of their care. Overall social care and long-term care are funded in a similar way to healthcare. This is through a mixture of public (social health insurance and general taxation) and private (voluntary health insurance and out-of-pocket payments) sources. More specifically, private financing is the main source of funding for long-term institutional care, along with outpatient care. Statutory health insurance (SHI) pays a contribution towards long-term care, depending on the care needs of the patient. The patient pays a co-payment that is capped at 20% of the SHI contribution and the canton covers the remaining costs.



Adult Social Care Financing Flows

It is estimated that long-term care institutions received about 13.3% of total healthcare expenditure and there is no dominant source of finance. Only one-sixth of this expenditure comes from SHI and one-sixth directly from the government and municipalities. Other social insurance contributions paid for about a quarter of expenditure, while private households contributed the largest share. The share of healthcare expenditure on long-term residential facilities in Switzerland has increased steadily over the past 10 years. In monetary terms, this is an increase from 10,768 million Swiss Francs (2010) to 12,640 million Swiss Francs (2015).

Adult Social Care System Structure

Services

Services are not free at the point of need. Individuals are either covered by the SHI (under which they are responsible for paying premiums, deductibles and co-payments), have private health insurance or pay independently out-of-pocket.

Long-term care services include basic long-term homecare, sub-acute and intermediate care, and household and social support. Complementary services such as meal deliveries, palliative care and chiropody are also included.

Payers

The payers for the social care system in Switzerland are the cantons/municipalities, SHI, individuals and private health insurance. Cantons and municipalities cover about 45% (2014) of total costs for Spitex services. SHI cover about 30% (2014), households carry 15% (2014) and private insurers cover the rest.

For long-term care, there is a per-diem payment. Providers are paid each day they house an individual. The level of care is determined by the long-term care providers and cantons on the basis of assessment instruments that vary across Switzerland. The most important ones are the Resident Assessment Instrument - Resource Utilisation Group (RAI-RUB), the BESA (Bedarfsklärungs- und Abrechnungs-System) in the German speaking part and the PLAISIR (Planification Informatisée des Soins Infirmiers Requis) instrument in the French speaking part.

Providers

Most homecare services are provided by the non-profit Spitex organisations. Most are independent, although some are directly operated by municipalities. In 2016, Spitex organisations provided 75% of homecare hours. Private for-profit provision is relatively limited.

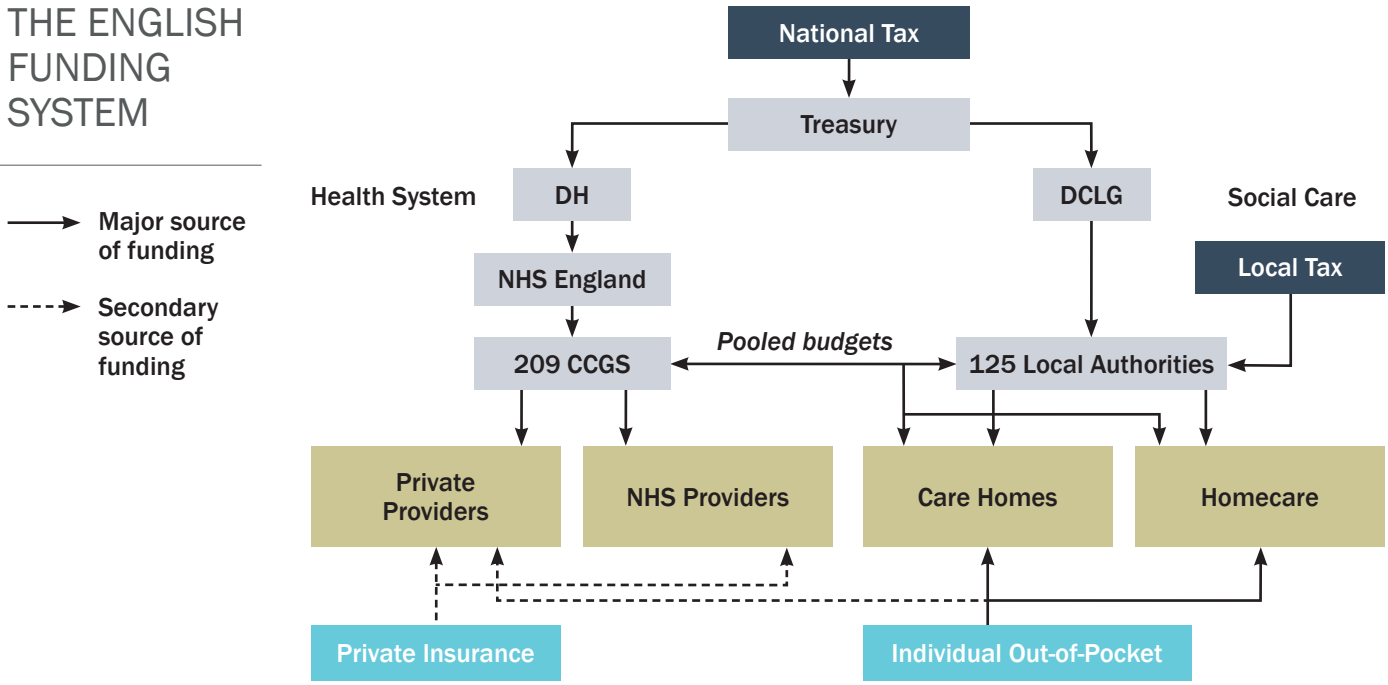
Residential long-term care is provided by medical nursing homes or the nursing departments of old-age or disability homes. It is estimated that 30% of institutions are owned directly by cantons or municipalities, 30% are independent non-profit institutions and 40% are private for-profit (2014).

ENGLAND

The English healthcare system is a tax-funded system, mostly free at the point of need. Co-payments are required for a small number of services, including dentistry and medicines. A minority of the population holds private health insurance. By contrast, the social care system is not free at the point of need and many individuals must pay privately to access services.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
53.0m	130,279km^2	London	**W** 83.1 | **M** 79.5

THE ENGLISH FUNDING SYSTEM

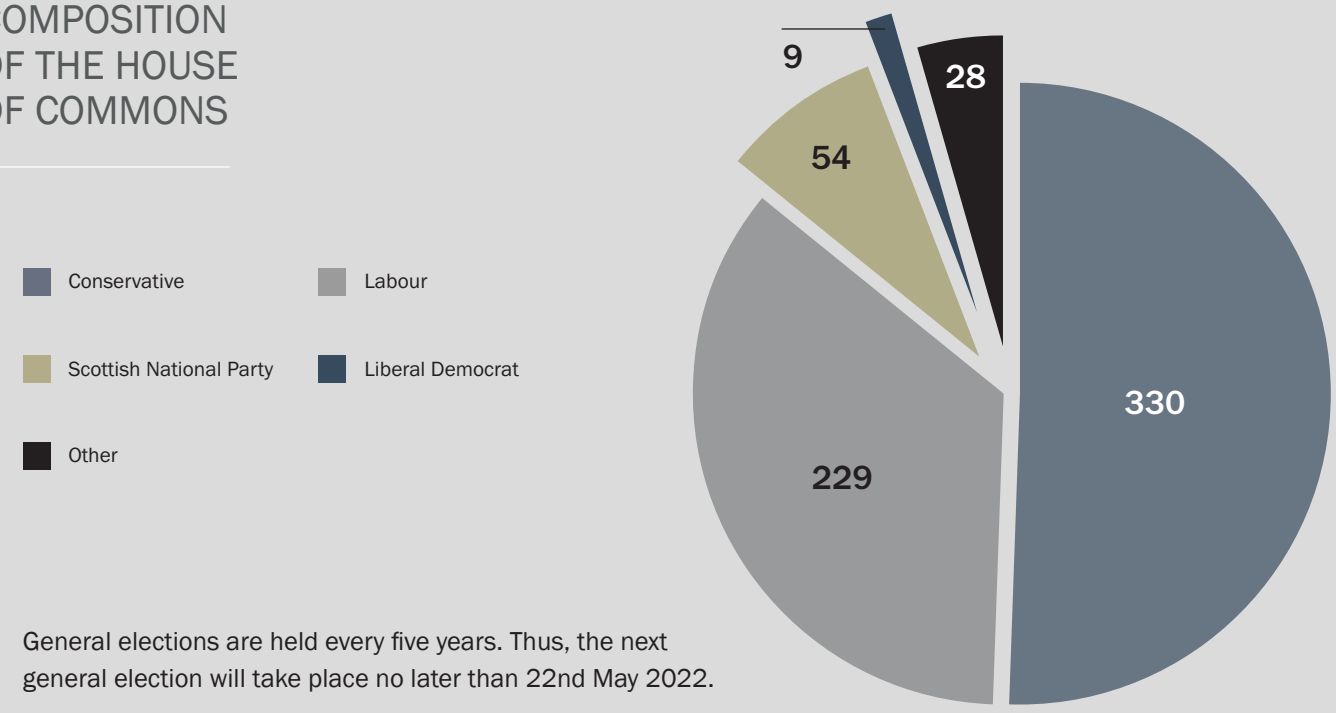


POLITICAL CONTEXT

The UK is a constitutional monarchy with a population of 66,573,504. It is governed by a bicameral parliament, formed of the House of Lords and the House of Commons. 650 members of parliament (MPs) sit in the House of Commons and are elected every five years. The leader of the party that has the most MPs becomes prime minister (PM) and appoints the government. The last general election took place on 8 June 2017 and resulted in a hung parliament in which none of the parties have a majority of seats. However, the Conservative party remained the largest party and its leader, Theresa May, has been PM since 2016.

Ten parties are currently represented in parliament. The two largest parties are the Conservative and Labour parties, which make up almost 90% of the House of Commons.

COMPOSITION OF THE HOUSE OF COMMONS



General elections are held every five years. Thus, the next general election will take place no later than 22nd May 2022.

Governance

Health and social care in England are shaped by different decision makers at the national and local levels.

	HEALTHCARE	SOCIAL CARE
National	- Department of Health - NHS England	Department of Health and Department for Communities and Local Government
Local	209 Clinical Commissioning Groups (CCGs)	152 local authorities (LAs)

Health and social care policy is devolved in the UK. This means that the devolved administrations of Wales, Scotland and Northern Ireland are responsible for health and social care policy in their respective jurisdictions. In England, the Secretary of State for Health is in charge of the Department of Health, and provides strategic leadership for health and social care policy.

Healthcare

The Health and Social Care Act 2012 provided the legislative basis for the reorganisation of the NHS in England. The main changes included:

- Shifting many of the responsibilities historically located in the Department of Health to NHS England.
- Replacing former Primary Care Trusts (PCTs) by Clinical Commissioning Groups (CCGs), formed of general practitioners (GPs) and clinicians, responsible for planning and commissioning healthcare services at local level.
- The creation of Public Health England (PHE) whose aim is to protect and improve the nation's health.
- Allowing healthcare market competition in the best interests of patients.

The national direction of healthcare policy is driven by the Secretary of State for Health, supported by the Department of Health. The Secretary of State is also responsible for negotiating the overall healthcare budget with the Treasury. The operational direction and priorities of the National Health Service (NHS) are delegated to NHS England, a public body. At local level, 209 Clinical Commissioning Groups (CCGs) implement the Department of Health and NHS England's policies. However, through their commissioning decisions and varying local priorities they have a degree of discretion and play an important role in shaping the healthcare landscape in England.

Social Care

The Care Act 2014, formed the basis of the biggest changes to the social care sector since its establishment in the 1940s. The Act introduced legal duties to Local Authorities (LAs) to signpost individuals towards appropriate care and support. The main changes include:

- Introduction of deferred payments.
- Extension of the government safety net.
- Introduction of a capped cost model of care.
- Introduction of LA information duties.

152 LAs are responsible for organising social care services and have a significant influence on shaping policies and determining priorities locally. The overall direction of social care policy is determined at national level by the Department of Health and the Department for Communities and local government.

Historically, the governance of healthcare policy has been mostly centralised and separate to that of social care. However,

this is changing. Areas such as Greater Manchester and London have obtained 'devolution deals' from central government. This means that they have been given greater responsibility for health and social care, including budgets.

Regulation

In England, the regulation of health and social care services is the responsibility of several independent regulatory bodies. These bodies ensure that services are compliant with a range of standards, including quality, financial, sustainability and competition. Some of them are relevant to all health and social care services, while others focus on a particular sub-sector.

Quality regulation of both health and social care services is overseen by the Care Quality Commission (CQC). The CQC is responsible for registering, monitoring, inspecting and rating a wide range of providers. The CQC can take enforcement action when providers fail to comply with quality and safety standards.

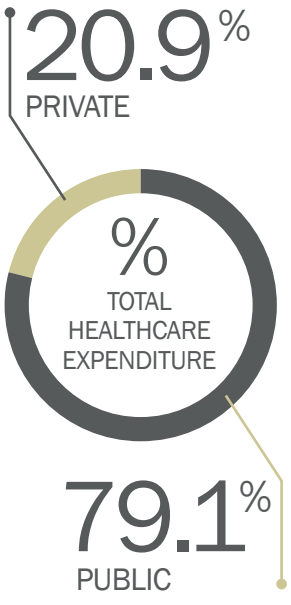
NHS Improvement (NHSI) is responsible for overseeing the financial sustainability and leadership of Foundation Trusts (FTs), NHS Trusts and independent providers who deliver NHS-funded hospital care, and ensures that competition rules are applied.

HEALTHCARE – FINANCING AND STRUCTURE

Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in England is mostly public. Although there are no specific figures for England only, in 2016, public expenditure accounted for 79.1% (or £122.5bn) of total healthcare expenditure in the UK. The remainder is made up of private spending, mostly in the form of co-payments for a small number of services and, to a lesser extent, through out-of-pocket payments and Private Health Insurance (PHI). It is estimated that 10.6% of people subscribe to PHI in the UK, a figure that has remained stable over the past five years.



Between 2009/10 and 2015/16, annual public healthcare expenditure increased by 1.4% on average. This is particularly slow in comparison to annual average increase of about 4% between the late 1940s and late 2000s. The pace of expenditure increase was particularly high under the last Labour government, from 1997-2010.

Healthcare Financing Flows

The Treasury provides funds to the Department of Health on the basis of the Spending Review, a multi-annual plan outlining how public funding will be allocated. The money filters down through NHS England (NHSE), where about a third of funding is used by NHSE directly to purchase certain services. The remaining budget is allocated to the 209 CCGs on a weighted capitation basis. The CCGs' total budget for 2017/18 is just over £72bn. CCGs are then responsible for allocating funding to a large range of local services, including secondary (hospital) care, non-specialist mental health, and, increasingly, general practice services.

Healthcare System Structure

Services

Primary and secondary healthcare services are mostly free at the point of need. In 2017 there were 7,454 general practices, 135 acute non-specialist trusts (hospitals), 17 acute specialist trusts and 54 mental health trusts.

Payers

NHSE purchases some services nationally, such as specialised services, military and veteran services, offender services, and primary care, including GP and dental services. However, in certain cases, the commissioning of specialised services and GP services has been delegated to CCGs. CCGs were created by the Health and Social Care Act 2012. They are clinically-led statutory NHS bodies composed of local GPs and other clinicians (such as nurses and secondary care consultants) and are initially responsible for commissioning local services, namely emergency care, hospital care, mental health and community health services.

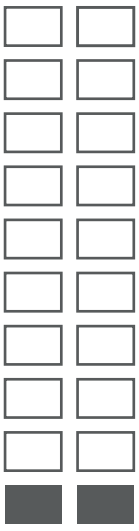
There are several user charges, mainly for dentistry, optical services and pharmaceuticals. It is estimated that 10.6% of people subscribe to private health insurance (PHI) in the UK. PHI contributed to about 3.6% of total healthcare expenditure in 2015. Specific figures for England only, though not publicly available, are estimated to be slightly higher than the UK average.

Providers

Services are provided by a mix of public and private providers.

Primary care providers include GPs, dentists, community pharmacists and opticians. GPs provide the majority of primary care and are the first point of contact for most patients. GPs increasingly work in group practices and a growing number are salaried.

The secondary care provision landscape is mainly composed of public hospitals (trusts). Services are provided by consultants (specialist doctors), nurses and other healthcare professionals, such as radiotherapists and physiotherapists employed by the trusts. There are two types of trusts: Foundation Trusts (FT), who have the freedom to invest and disinvest and are separate from the capital regime of the NHS; and NHS trusts, who have not yet been able to demonstrate the conditions to become FTs. There is also a small number of private providers, providing acute elective care as well as mental health, learning disability services and secure services.



10%

EMPLOYEES WITH PHI

ADULT SOCIAL CARE - FINANCING AND STRUCTURE

Adult Social Care Financing

Adult Social Care Financing Context

Social care services are funded primarily via public sources, through 152 Local Authorities (LAs), whose budgets are made up of a complex mix of national and local taxation. However, social care services are not free at the point of need. LA expenditure only provides a safety net and there are significant private payments. Individuals are expected to contribute towards the cost of their care if their personal wealth exceeds the thresholds set out in the means-test (see below). In 2016/17, LA expenditure on adult social care was £16.5bn. In real-terms, this equals to an 8% reduction compared to 2009/10.

Adult Social Care Financing Flows

Social care financing flows are complex. Expenditure is not ring-fenced and LAs must allocate social care expenditure from their

global budgets, alongside other local services such as transport or housing. There are two sources of revenue for LAs. Some of their funds are allocated by the Treasury to DCLG, which in turns allocates some of it to LAs on the basis of a complex formula. The rest of the funds are raised at local level directly by the LAs, mainly through council tax, levied on individual households, and business rates, levied on business activities. Since 2010, the balance between central allocations and local revenue has shifted towards the latter. The Spending Review 2015 confirmed this shift. It sought to balance revenue by giving LAs the freedom to increase council tax to fund social care (the so-called social care 'precept'). In addition, a complex reform of business rates retention is on going. The ultimate objective is to allow LAs to retain 100% of the business rates they raise, instead of pooling them nationally.

Adult Social Care System Structure

Services

Social care services are not free at the point of need. The range of services is wide, covering different levels of care.

Services in support of activities of daily living are available through homecare (or domiciliary care) services. They are delivered by carers who go to an individual's house for a certain period of time to help them with daily tasks such as cooking, cleaning, or getting dressed.

When individuals' needs increase, care home services are available. They may include nursing for those with the highest level of need.

In addition, in England, learning disability services are mostly the responsibility of LAs and fall under social care provision. These services include day centres, residential care and home support.

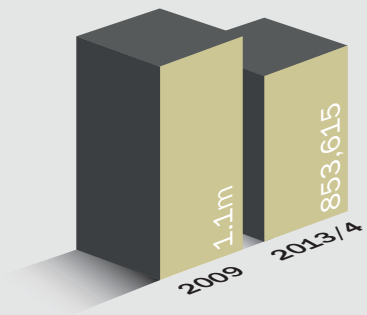
Payers

The main payer for social care services is the LAs. LA funding acts as a safety net in which individuals apply for funding and are assessed against a national set of needs and means criteria. The Care Act 2014 introduced a number of changes to the organisation and governance of social care. It placed a new responsibility on LAs to assess the needs of any individual who appears to have care needs and provide information and assistance to those who have been assessed as needing care. LAs continue to carry out financial assessments to determine whether an individual is eligible for public funding, but the Act extends the lower and upper thresholds for means-testing.

To be eligible for LA funded social care, an individual must have less than £23,250k in assets and savings. Where individuals are receiving homecare services, the value of their house is not taken into account. Where individuals are moving into a care home permanently, the value of their house will be taken into account. Individuals who do not qualify for LA support become private payers.

LAs remain the main payer for social care. They agree on contracts with local providers, which are negotiated every year. In recent years, LA prices have mostly decreased, or at best, increased by about 1% annually for care homes, but they have not kept pace with the increase in costs. This increase is due in part to the introduction of the National Living Wage from 1st April 2016. In addition, as social care is not free at the point of need, there is a substantial proportion of private payers who cover the full or partial cost of their care. Providers charge higher prices for them, and, increasingly, this revenue is used to make up for low LA prices. There has been a big reduction in the numbers of older people receiving LA-funded social care from more than 1.1 million in 2009 to 853,615 in 2013-14 – a fall of 26%.

OLDER PEOPLE RECEIVING LA-FUNDED SOCIAL CARE



Providers

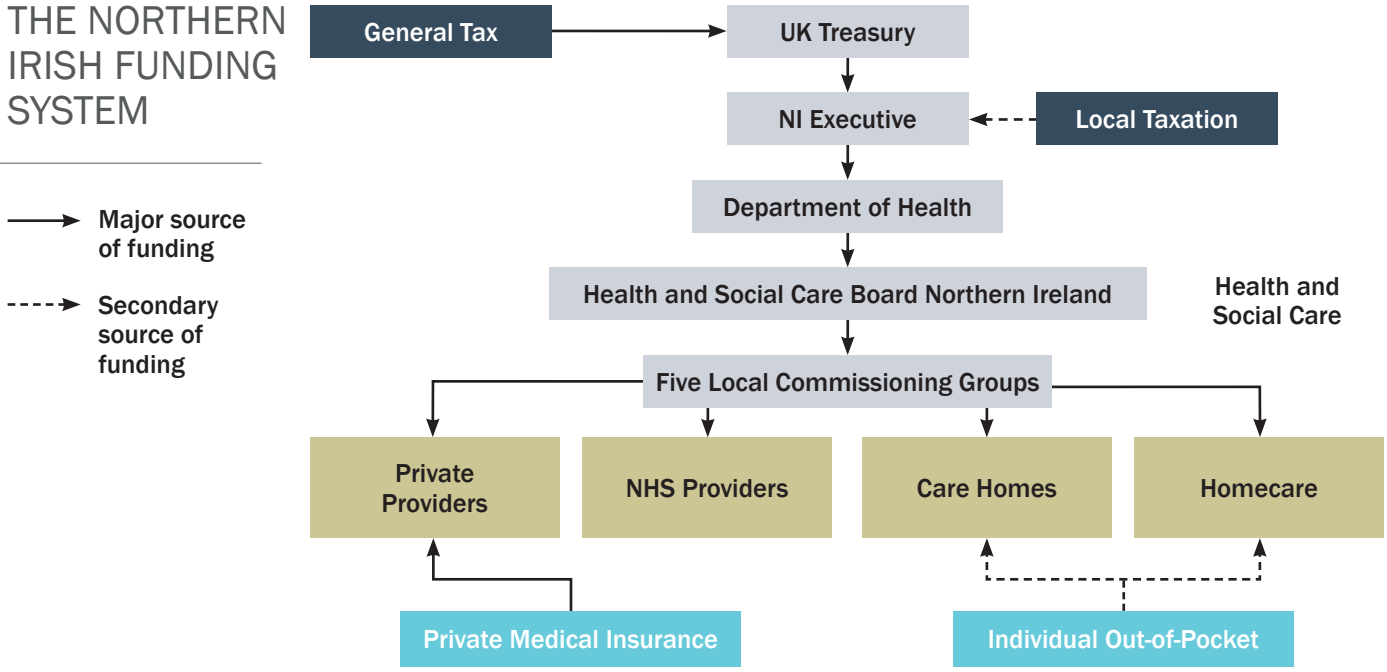
Social care services are provided mainly by private operators as LAs offer very limited direct provision. Private operators of social care services typically provide a range of care homes (nursing and residential) and homecare services. These services can vary both in the size and types of services and care provided.

NORTHERN IRELAND

Northern Ireland's health and social care system is fully integrated. It is principally funded through general taxation. Healthcare services are almost entirely free at the point of need, while social care services are not. Individuals may be required to contribute towards certain costs.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
1.8m	14,130km^2	Belfast	**W** 82.3 | **M** 78.5

THE NORTHERN IRISH FUNDING SYSTEM

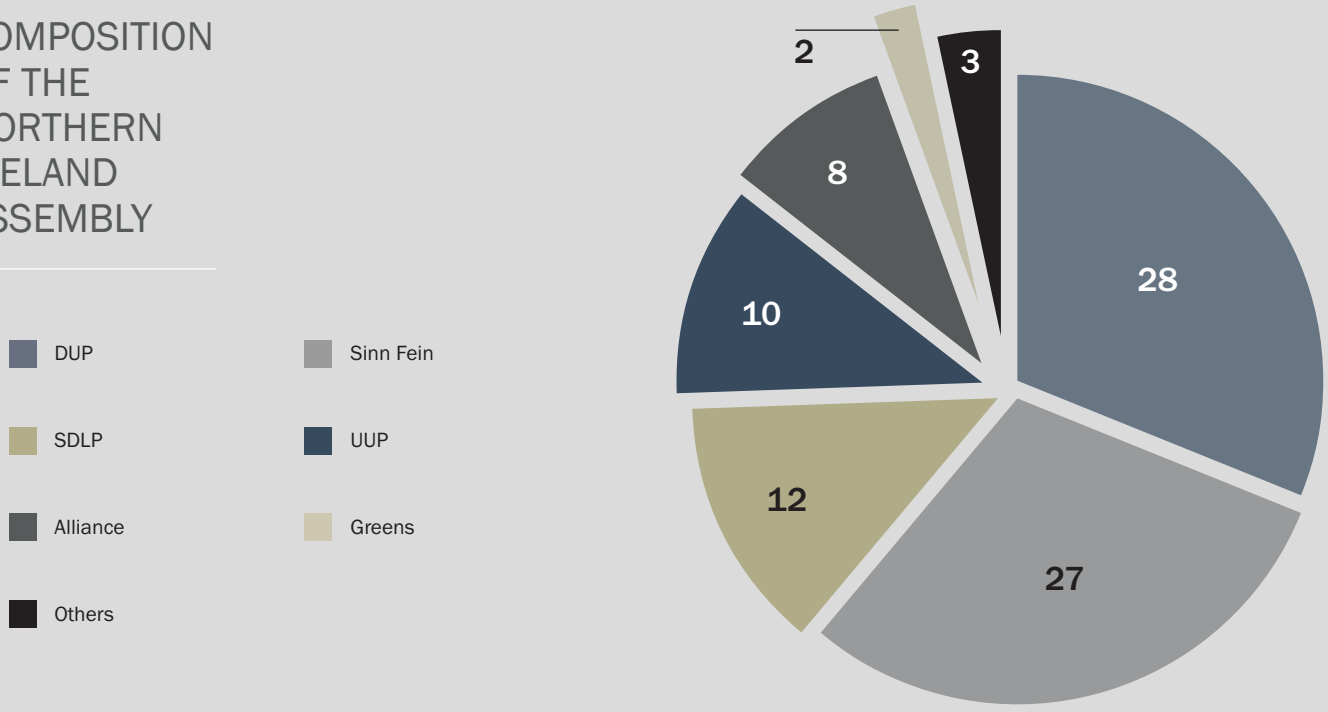


POLITICAL CONTEXT

Northern Ireland is a devolved administration in the UK, administered by the Northern Ireland Executive. The Executive is made up of 11 individuals, allocated to parties in relation to the number of seats they hold in the Northern Ireland Assembly. The First Minister and deputy First Minister are nominated by the largest and second largest parties respectively. The Northern Ireland Assembly is elected every five years and is composed of 90 members.

An election was called on 2nd March 2017 after Martin McGuinness (Sinn Fein) resigned as deputy First Minister and the Assembly was subsequently dissolved. The two main parties, the Democratic Unionist Party (DUP) and Sinn Fein, failed to reach an agreement to form a new executive. Negotiations are ongoing. In the meantime, the UK parliament has jurisdiction and can authorise executive decisions, such as making budgetary decisions.

COMPOSITION OF THE NORTHERN IRELAND ASSEMBLY



Governance

Health and social care are integrated in Northern Ireland, and governance is mostly centralised.

	HEALTHCARE	SOCIAL CARE
Central	- Minister of Health - Department of Health - Health and Social Care Board	
Local	- Local Commissioning Groups - Health and Social Care Trusts	

At central level, within the Executive, the Minister of Health is responsible for the Department of Health. The Minister, assisted by the Department of Health, sets the strategic framework and makes policy and legislation in three areas: health and social care, public health and public safety.

Health and social care services are planned and commissioned by the Health and Social Care Board in Northern Ireland (HSCB). The HSCB is organised into five professional groups:

- Medical and Allied Services.
- Social Services Inspectorate.
- Nursing and Midwifery Advisory Group.
- Dental Services.
- Pharmaceutical Advice and Services.

The HSCB is advised by five local commissioning groups (LCGs). They are responsible for determining the health and social care needs of their local areas. The LCGs work in parallel with five Health and Social Care Trusts in their respective geographic regions. The HSCB is also supported by the Business Services Organisation, which provides financial, personnel, internal audit and legal support services.

Regulation

Health and social care quality regulation is set at the Northern Irish level. Services are regulated and inspected by the Regulation Quality Improvement Authority (RQIA). The RQIA carries out inspections of public and private providers, and undertakes hygiene inspections of hospitals.

The last major health and social care reform took place in 2009. However, there have been wider policy changes, mostly driven by the Quality 2020 Strategy. The Health and Social Care (Reform) Act (Northern Ireland) 2009 led to a major reorganisation of health and social care delivery in Northern Ireland. It reduced the number of organisations involved in delivering health and social care services.

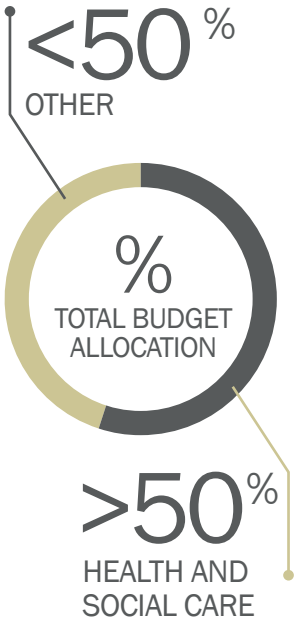
Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Northern Ireland is mostly public and financed through general taxation. There are very limited co-payments for a small number of services and take-up of private health insurance (PHI) is very low. Real-terms healthcare expenditure increased by 4.5% between 2009/10 and 2014/15. In 2016, health spending per head in Northern Ireland was higher than the UK average.

Healthcare Financing Flows

The overall Northern Ireland budget is allocated by the UK government (via the Treasury) through a block grant calculated in accordance with the Barnett formula. In 2016/17, the total budget allocated to Northern Ireland was approximately £8.6bn, of which over 50% of was allocated to health and social care. Allocation decisions are made by the Northern Ireland Executive.



Healthcare System Structure

Services

Services are split between primary, secondary and community care. All these services are managed regionally by the Health and Social Care Trusts.

Primary care services are usually the first point of contact for patients with the HSC. They include General Practitioners (GPs), dentists, pharmacies and opticians. In 2017, there were 343 GP practices with a total of 1,710 registered GPs. There is an initiative to increase GP training places to 111 places per year by 2020, this would be up from 65 places per year in 2015.

Secondary care is mainly hospital-based, and services range from emergency care to non-emergency, elective treatment. Specialist services are provided in a limited number of locations and, due to the relatively small size of Northern Ireland's healthcare system, patients are sometimes transferred to other locations in the UK to receive specialist treatment.

Payers

Services are mostly free at the point of need and the HSCB is the main payer. Primary care services are paid for directly by the HSCB, through contracts with GPs and other providers such as dentists, community pharmacists and opticians. Most GPs operate under the General Medical Services (GMS) contract and are funded on a capitation basis.

The HSCB commissions hospital services and social care services from the five Health and Social Care Trusts that provide these services. Contracts determining the volume and price of services are negotiated between the HSCB and the Trusts. Money is allocated on the basis of a programme of care capitation formula to pay for the provision of secondary care.

Private payments are limited and are mostly dental co-payments, which have a limit of £384.

Providers

Primary care providers are usually independent contractors. They are reimbursed for their services through the contracts they hold with an LCG. The five HSC Trusts provide publicly financed care through an integrated system of acute and community services at the primary, secondary and tertiary levels. This is complemented by supra-regional provision of highly specialised services within the UK. Secondary care providers are responsible for the delivery of hospital services. Mainly offering publicly provided healthcare, they may also offer some private care. There are two small private hospitals that contract with the trusts.

Adult Social Care Financing

Adult Social Care Financing Context

Social care expenditure is mostly public but, as services are not free at the point of need there is a higher level of co-payment than in healthcare. Public funding for social care comes from the same budget as healthcare. In addition some funding is raised at local level. The collection of local taxes is handled centrally by the Northern Ireland Executive's Land and Property Services Agency.

Adult Social Care Financing Flows

Social care funding comes from the wider healthcare budget. Allocations to social care are determined on the basis of a regional capitation formula. In 2016/17, the social care budget was about £982.6m. Public expenditure on social care per individual increased slightly between 2011/12 and 2014/15, by 0.4% a year on average.

Adult Social Care System Structure

Services

Social care services are not free at the point of need. Health and Social Care Trusts carry out assessments to determine whether an individual is eligible for support.

Social care services include homecare, care homes (residential and nursing) and learning disability services. Some of these services are integrated within the healthcare system. All Trusts provide a reablement service designed to promote independence for individuals who are either disabled or elderly.

Learning disability services are provided by multi-professional healthcare teams in community, residential, and inpatient settings. They support individuals to have control over their lives. Some Trusts offer supported living schemes, with independent sector providers to deliver a range of facilities and services.

Payers

There is a mix of public and private payments for social care services. The HSCB commissions social care services from five Health and Social Care trusts, which are responsible for provision, in the same way as healthcare. Public funding does not always cover the full cost of care. Services are mostly free of charge for those over 75, who have been assessed by their trust as needing homecare, while care home services are subject to an additional financial assessment for all adults. Individuals with assets of over £23,250 have to meet the full cost of their care.

From 2015, self-directed support (SDS) has been rolled out across Northern Ireland. Individuals who are eligible for SDS can choose to either take the funding as a direct payment, receive a managed budget (where the Trust holds the budget, but the individual is still in control of its use), a trust-organised service or a mixture of the three. This allows the user to decide how much funding is allocated to each of the services offered to them.

Providers

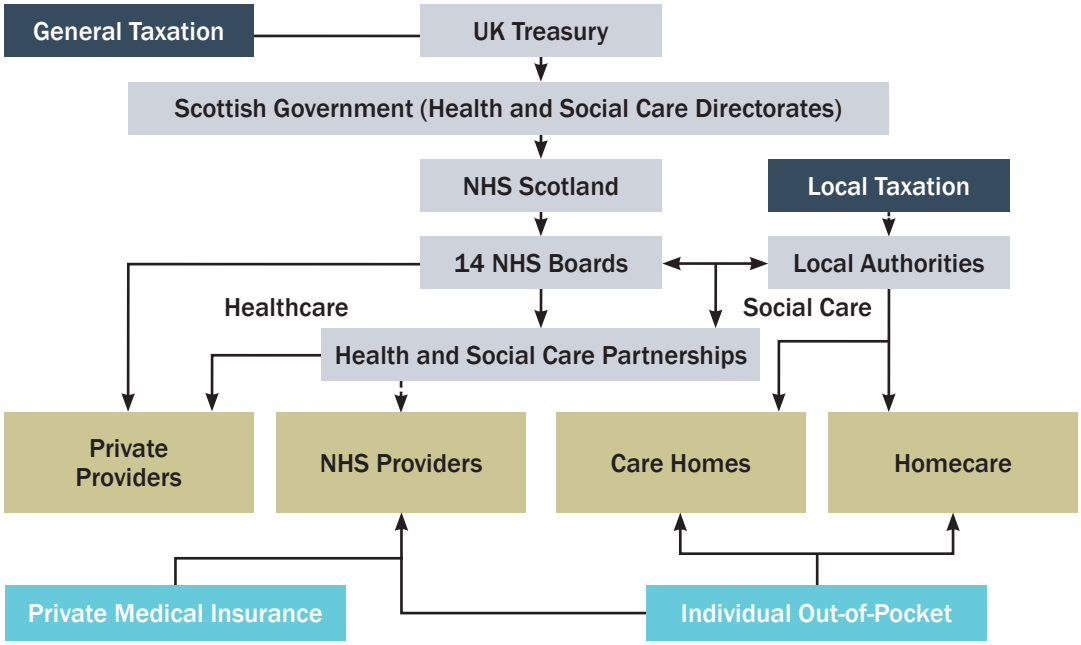
Private providers are significantly more active in delivering social care than in healthcare. The responsibility for organising social care services rests with the five Health and Social Care Trusts. In 2015, it was estimated that 68% of domiciliary care contract hours were delivered by the private sector, as were 89% of residential and nursing care packages.

SCOTLAND

The Scottish healthcare system is a tax-funded system mostly free at the point of need. Co-payments are required for a small number of services, including dentistry and eyecare. A minority of the population holds private health insurance. Social care is partially free at the point of need, however, top-up payments are required for some non-care costs.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
5.3m	80,077km^2	Edinburgh	**W** 81.2 | **M** 77.1

THE SCOTTISH FUNDING SYSTEM

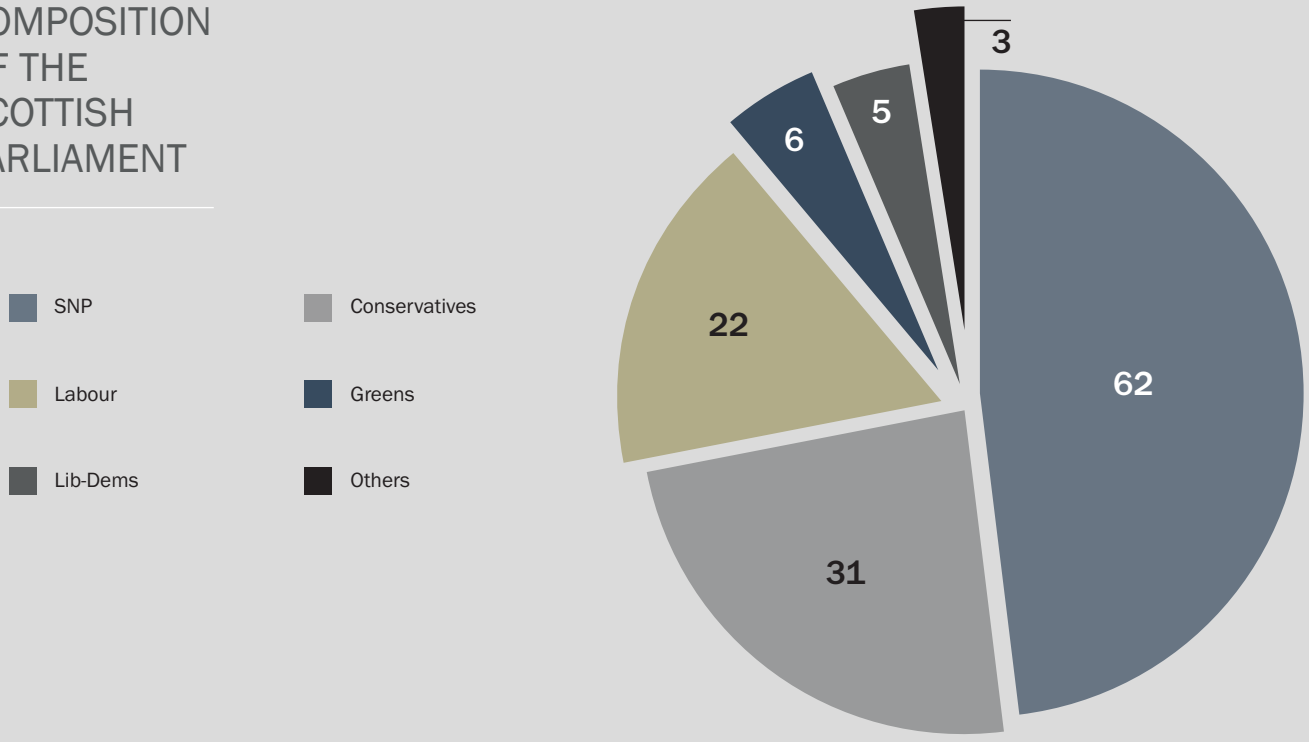


POLITICAL CONTEXT

Scotland is a devolved administration in the UK that is administered by the Scottish Government and has a population of 5,404,700. It is headed by the First Minister, who is nominated by Members of the Scottish parliament (MSPs). The First Minister appoints the Cabinet of Ministers (government). The Scottish parliament is made up of 129 elected MSPs.

Following an election on 5th May 2016, the Scottish National Party (SNP), a left-wing nationalist party, has the largest number of MSPs. SNP leader Nicola Sturgeon currently holds the position of First Minster. At present there are five different parties represented in the Scottish parliament, alongside independent and non-affiliated members. Devolved elections are held every five years. The next election is due to take place on 6th May 2021.

COMPOSITION OF THE SCOTTISH PARLIAMENT



HEALTH AND SOCIAL CARE – GOVERNANCE AND REGULATION

Governance

Scotland has two levels of health and social care governance. Some aspects of health and social care governance are integrated.

	HEALTHCARE	SOCIAL CARE
Central	Health and Social Care Directorate	Health and Social Care Directorate
Local	14 NHS Boards and 7 National Special Health Boards	32 local authorities (Councils)
Integration	NHS bodies and local authorities work together through 31 Health and Social Care Partnerships	

Healthcare Governance

Healthcare policy is the responsibility of the Cabinet Secretary for Health and Sport, supported by two junior ministers: the Minister for Public Health and Sport and the Minister for Mental Health. The Cabinet Secretary for Health and Sport leads the Health and Social Care Directorates (HSDC) and NHS Scotland.

The planning and delivery of healthcare services is organised at the local level by 14 NHS Boards, and seven National Special Health Boards that provide national services. NHS Board Chairs are appointed by the Cabinet Secretary for Health and Sport. National Special Health Board membership includes NHS Health Scotland (public health and health education), Healthcare Improvement Scotland (HIS) and the Scottish Ambulance Service.

Social Care Governance

Social care governance is primarily the responsibility of 32 Local Authorities (LAs). However, integration has led to some aspects of social care being overseen jointly by health and social care organisation.

Health and Social Care Integrated Governance

Since April 2016, the Public Bodies (Joint Working) (Scotland) Act 2014 requires LAs and NHS Boards to work in partnership to deliver integrated health and social care. 31 Health and Social Care Integration Partnerships (HSCIPs) have been created. They primarily focus on the integration of social and primary care services. Some hospital services, such as palliative care, are expected to be integrated.

Regulation

In Scotland, the regulation of health and social care services is shaped at the Scottish and UK levels.

Health quality regulation is set at Scottish level. Healthcare Improvement Scotland (HIS) supports the Scottish Government's priorities, in particular the Healthcare Quality Strategy for NHS Scotland. HIS also regulates NHS boards. It develops guidance for clinical practice, supports improvement in healthcare practice (independent and public) and provides assurance for quality and safety.

The Social Care and Social Work Improvement Scotland (SCSWIS), also known as the Care Inspectorate, regulates, inspects and supports the improvement of social care services. It works closely with the Health and Safety Executive (HSE), which is responsible for regulating health and safety in the workplace across the UK.

Both the Public Bodies (Joint Working) (Scotland) Act 2014 and the 2020 Vision strategic plan are aiming to integrate health and social care and a focus on ensuring patients are placed in community settings as quickly as possible.

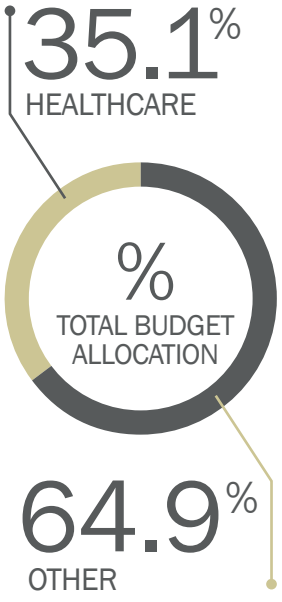
Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Scotland is mostly public. There are very limited co-payments for a small number of services and take-up of private health insurance (PHI) is very low. Healthcare expenditure in Scotland has been flat in real terms between 2009/10 and 2015/16. While healthcare expenditure per capita in Scotland remains higher than the UK national average, it has decreased in real terms.

Healthcare Financing Flows

Healthcare is mainly publicly-funded through general taxation. The overall Scottish government budget is allocated by the UK government (via the Treasury) through a block grant calculated in accordance with the Barnett formula. The Scottish government is responsible for decisions on how the overall budget is allocated. The healthcare budget for 2016/17 was approximately £13.04bn, which is equivalent to 35.1% of the overall Scottish budget of that year. Around 75% of the budget is allocated locally to regional NHS boards on a weighted capitation basis, using the NHS Scotland Resource Allocation Committee (NRAC) formula. The Scottish government ensures that no NHS Board faces a real terms reduction in its allocation in any year.



Healthcare System Structure

Services

Primary, secondary and specialist services in Scotland are mostly free at the point of need.

Primary care services are usually the first point of contact for patients with the NHS. They include general practitioners (GPs), dentists, pharmacies and opticians. There are approximately 4,900 GPs working in about 960 general practices.

Secondary care is mainly hospital-based healthcare, also referred to as ‘acute care’. Services range from emergency care to non-emergency, elective treatment. NHS boards are responsible for secondary care services within the integrated HSCPs. There are currently 274 hospitals in Scotland. Specialist services are available in a limited number of locations around the country.

Payers

In the absence of a payer/provider split, there are no contracts between NHS boards (that define strategic direction) and their operating divisions (responsible for the delivery of acute care).

In 2016/17, public payments to general practices amounted to £798.4m; an increase of 5.6% from the previous year. GP contracts are negotiated annually between the British Medical Association (BMA) and the Cabinet Secretary for Health, Wellbeing and Sport.

Providers

GPs are usually independent contractors who are reimbursed for their NHS service provision under the terms of their contract with their NHS Board.

Most hospital provision is public. There is no payer/provider split in Scotland. Hospital service provision is organised by the operational divisions of NHS Boards and staff are employed directly by the Boards. There is a very small private and non-profit healthcare sector.

Adult Social Care Financing

Adult Social Care Financing Context

Social care expenditure is mostly public but as services are not fully free at the point of need, there are also individual private co-payments. Public funding for social care services comes from LA budgets. Its estimated that LAs spent nearly £3.2bn on social care services in 2015/16. Scotland has the highest expenditure per capita on social care in the UK. However, growth has been slow and budgets are currently under some pressure.

Adult Social Care Financing Flows

The majority of LA funding comes from the Scottish government, but there is an element of local taxation through council tax and business rates. Following the introduction of the Public Bodies Acts, and the integration of health and social care, some funding comes from joint budgets. The government invested £58.8m between 2011 and 2016/17 to support the integration of health and social care and plans to invest another £9.5m in 2017/18. £3.52m has been allocated to LAs to support system and culture change.

Adult Social Care System Structure

Services

Social care services are partially free at the point of need in Scotland. In 2002, Scotland made provision to ensure that everyone can access free personal care if a needs assessment demonstrates they require it. However, individuals may be asked to pay for non-care costs on a means-tested basis.

The range of social care services includes care homes (residential and nursing), homecare and learning disability services. In 2016 there were about 960 care homes.

Payers

There is a mix of public and private payers for social care services in Scotland. Personal care and nursing care are funded by LAs for individuals who have been assessed as needing such support. LAs financial support towards non-care costs is means-tested. As a result, most individuals are required to pay a top-up to cover the full cost of their care.

An assessment is carried out by the LA to determine whether an individual is eligible to receive financial support and this is entirely dependent on need. It is followed by a financial assessment to determine how much a person can contribute towards remaining accommodation costs.

Personal care is defined as support with personal hygiene, eating, mobility and taking medication. Nursing care is medical care delivered mostly in nursing homes. Non-personal costs include hotel costs in care homes and some support with the activities of daily living in homecare.

With the introduction of the Social Care (Self-directed Support) Act 2013, the number of direct payments has increased slightly. An estimated £94.5 million was spent on direct payments in 2015/16.

For NHS-funded care services, an assessment determines whether individuals are eligible for NHS-funding. NHS long-term care includes continuing healthcare for people with long-term complex health needs, NHS-funded nursing care, and joint packages of care (which provide some funding for patient care).

Providers

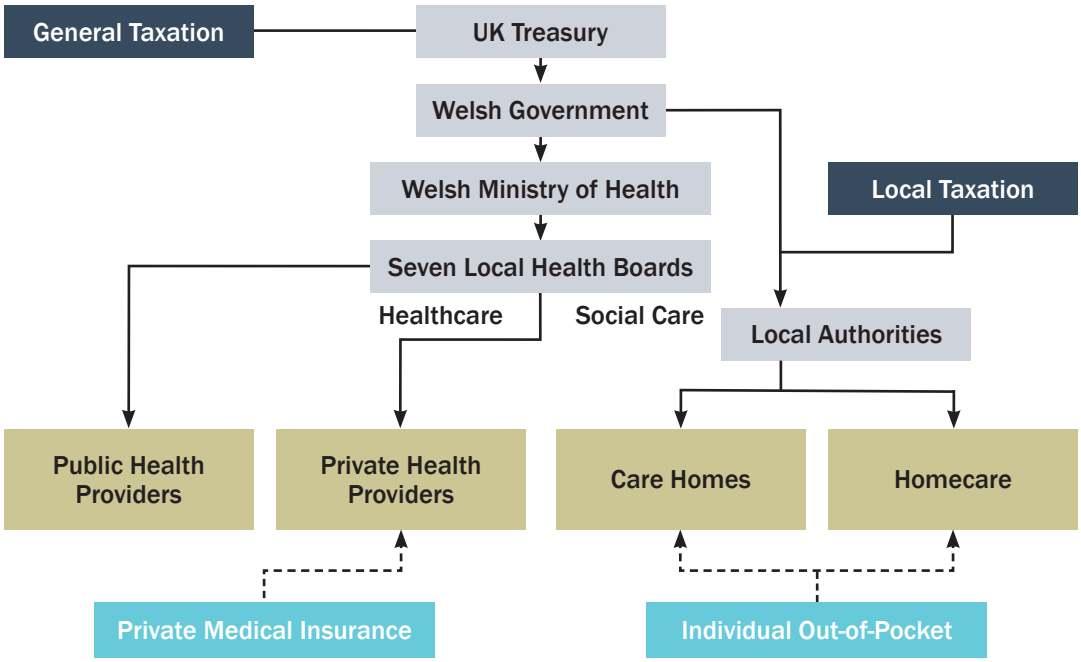
Services are provided by a mix of public and independent operators. Over the past 10 years, LAs have increasingly purchased homecare from the private and voluntary sectors, rather than providing services themselves. In 2016, the majority of care home operators were private.

WALES

The Welsh healthcare system is a tax-funded system, mostly free at the point of need. Co-payments are required for a small number of services, including dentistry and eyecare services. A very small percentage of the population holds private health insurance. The social care system is also tax-funded but is not free at the point of need.

POPULATION	AREA	CAPITAL	LIFE EXPECTANCY
3.0m	20,735km^2	Cardiff	**W** 82.4 | **M** 78.4

THE WELSH FUNDING SYSTEM



Major source of funding

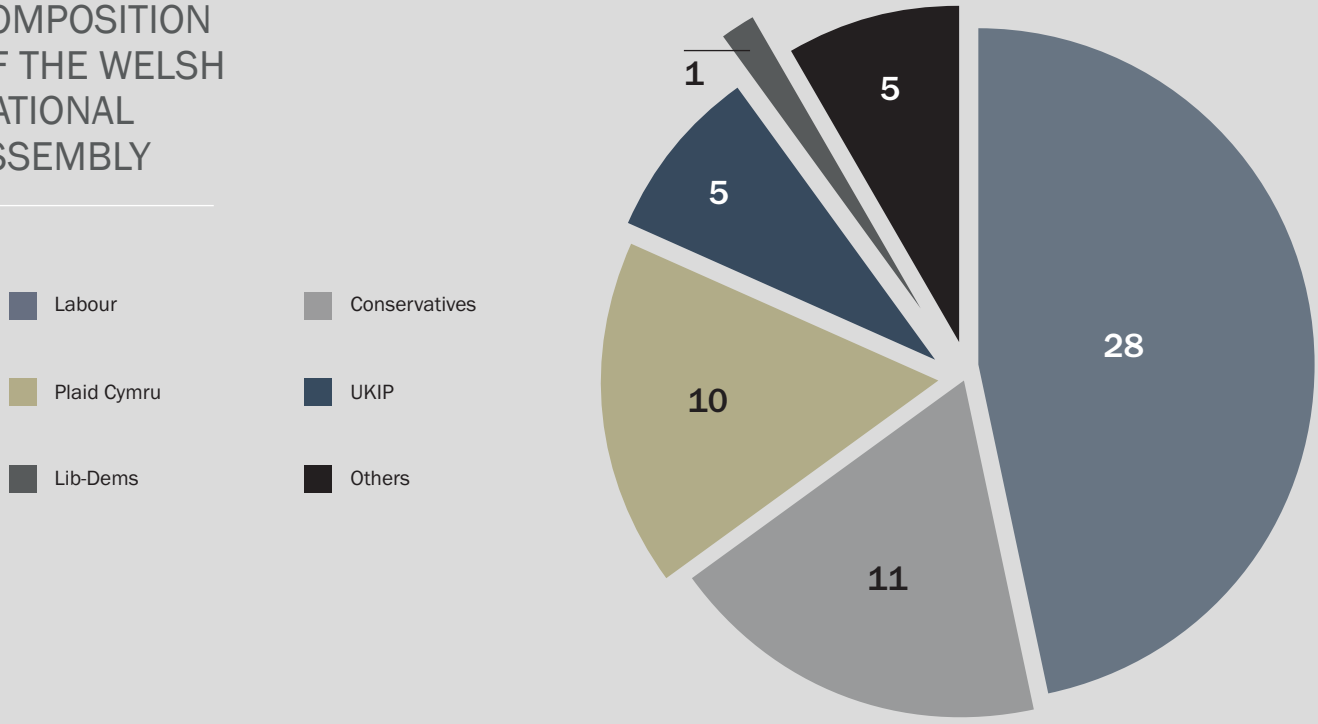
Secondary source of funding

POLITICAL CONTEXT

Wales is a devolved administration in the UK administered by the Welsh government, with a population of 3,113,150. It is headed by the first minister, who is nominated by elected assembly members (AMs). The first minister appoints the cabinet of ministers (government). 60 elected AMs form the Welsh National Assembly.

Following the election of 5th May 2016, the Labour Party is the largest party, and Carwyn Jones currently holds the position of First Minster. Five major parties are represented in the National Assembly for Wales, along with four smaller parties. One seat is currently vacant. Devolved elections are held every five years. The next election is due to be held on 6th May 2021.

COMPOSITION OF THE WELSH NATIONAL ASSEMBLY



Governance

	HEALTHCARE	SOCIAL CARE
Central	Ministry of Health and Social Services	Ministry of Health and Social Services
Local	Seven Local Health Boards	22 local authorities

Healthcare

Healthcare policy is determined by the Welsh Assembly and legislative proposals are submitted to the National Assembly for Wales for approval. The Welsh Assembly is responsible for decisions on how the overall budget is allocated to devolved services, including healthcare, education, local government, transport and housing. The Minister for Health and Social Services is responsible for the NHS in Wales. They oversee budget allocation and are accountable for the overall performance of the NHS in Wales.

Recently, the National Assembly for Wales adopted the Public Health (Wales) Act 2017 to address numerous public health concerns, such as obesity rates and the use of tobacco and nicotine products. It also provides for the licensing of special procedures (such as acupuncture and electrolysis treatments), health impact assessments and local pharmaceutical service needs assessments.

Seven local health boards (LHBs) are responsible for policy implementation across Wales, organisational planning, and healthcare service delivery, in accordance with local needs.

Social Care

The Minister for Health and Social Services also determines the overall legislative and policy framework for social care. However, social care policy is also shaped locally by 22 local authorities (LAs) that decide how services are delivered. LAs are encouraged to work together with LHBs for service planning for health and social care needs.

The Regulation and Inspection of Social Care (Wales) Act became law in January 2016. It builds on the Social Services and Well-Being Act of 2014 by creating a regulatory system focused on those providing and receiving social care services. The Act provides statutory underpinning by reforming the regulation of social care providers and the workforce, requiring registration of providers and embedding an inspection regime.

Regulation

Health quality regulation is set at the Welsh level. The Health Inspectorate Wales is an independent body that inspects NHS and independent healthcare providers and ensures compliance against quality standards. It works in partnership with the Welsh Audit Office, which assesses the efficiency of service delivery and the finances of NHS providers.

The regulation of social care services is set at the Welsh level. Standards are set by Social Care Wales. The Care and Social Services Inspectorate Wales (CSSIW) is responsible for registration and inspection of adult social care, childcare, and social services.

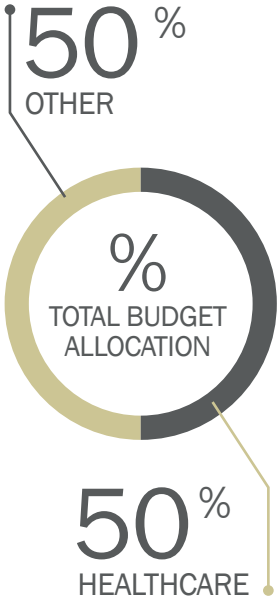
Healthcare Financing

Healthcare Financing Context

Healthcare expenditure in Wales is mostly public and financed through general taxation. There are very limited co-payments for a small number of services and take-up of private health insurance (PHI) is very small. Real per-capita health expenditure was flat between 2009/10 and 2015/16.

Healthcare Financing Flows

The overall Welsh budget is allocated by the UK government (via the Treasury) through a block grant calculated in accordance with the Barnett formula. The Welsh budget for 2017/18 allocated £7.3bn to healthcare. Healthcare is the largest budget allocation, using almost 50% of the total £15bn budget. This funding is allocated to the Welsh Ministry of Health, which in turn allocates it to the seven LHBs.



Healthcare System Structure

Services

Primary and secondary care services are mostly free at the point of need.

In 2016, there were 2,009 general practitioners (GPs) working in 441 general practices, 13 general hospitals with major Accident and Emergency (A&E) Units, and 31 community hospitals.

The seven LHBs offer dental, optical, pharmacy and mental health services. Pharmacies provide a range of services such as needle exchange facilities and emergency contraception, and pharmacists offer free expert advice regarding medicines.

There are also sexual health clinics providing services for early pregnancy, family planning, fertility and genitourinary medicine.

Payers

LHBs are responsible for commissioning and providing primary, community, and hospital care. The Welsh Assembly provides funding on a capitation basis. LHBs pay GPs through contracts that include capitation-based payments, performance-related payments, and fee-for-service payments (from additional services provided). There is a separate funding stream for LHB capital requirements.

Public Health Wales NHS Trust is funded directly by the Welsh government. The other two National NHS Trusts, Velindre Trust and the Welsh Ambulance Trust, are funded through the LHBs for their regional services.

All prescriptions are free-of-charge for patients registered with a GP who use a Welsh pharmacist.

Providers

Healthcare in Wales is delivered through a variety of providers, including LHBs, GPs, community pharmacies, and opticians. The NHS in Wales makes very little use of private providers, and the Welsh Assembly is trying to limit the proportion of NHS spend going to private providers.

Primary and community care services are provided and planned by locality networks. These are groups of GP practices working with other primary care providers, such as pharmacists. GPs are generally independent, working under a contractual relationship with LHBs. Some GPs may work within practices on a salaried basis.

Specialist services are provided in two NHS Trusts: Velindre NHS Trust and the Welsh Ambulance NHS Trust. The Velindre NHS Trust provides cancer and blood services, while the Welsh Ambulance NHS Trust provides ambulance services.

Adult Social Care Financing

Adult Social Care Financing Context

Social care expenditure is mostly public but as services are not free at the point of need there is a higher level of co-payment than in healthcare. Public expenditure comes from LAs. In 2016/17, LAs spent about £1.6bn on social care. Public expenditure on older people's services remained flat in real-terms between 2009/10 and 2015/16, while expenditure per capita decreased during this period.

Adult Social Care Financing Flows

Public funding for social care services comes from LA budgets. The majority of LA funding comes from the Welsh government, but there is an element of local taxation through council tax and business rates. Social care funding is not formally ring-fenced at LA-level, although recent Welsh government budget announcements have provided specific funding for social care. There is also some limited healthcare funding for social care services.

Adult Social Care System Structure

Services

Social care services are not free at the point of need. Services available in Wales include residential care, domiciliary or day care, equipment to help maintain independence in the home, carer support and re-settlement support following discharge from hospital.

There are around 23,000 care home beds for older people. Just over half (52%) of these beds are in nursing homes.

Payers

As services are not free at the point of need, significant private payments are made in addition to LA payments. LAs assess the long-term care needs of their population and also undertake means-testing to determine eligibility for public funding.

Individuals may be required to contribute towards the costs of homecare services, up to a maximum of £70 per week. People with less than £24,000 in savings, excluding the value of their homes, may pay less. However LA decision-making is on a case-by-case basis depending on an individual's needs. Resource pressures have meant that the threshold for support eligibility is set very high.

If an individual receives care through a residential care home, the income threshold is different. Those with assets over £30,000, including the value of their home, must pay for the full cost of residential care. The income threshold increased in 2017/18 from £24,000 to £30,000. The government is expected to raise it further to £50,000 by 2021.

Providers

The vast majority of social care services are provided by private operators. Residential care for older people includes nursing care and elderly mentally infirm care. Care homes range from small units housing several people to larger homes providing a mix of care provision and other facilities.

In recent years, there has been a significant increase in the number of people receiving direct payments that enable them to have greater choice and control over the services they receive.

Contact us

For more information on any of the content in this publication or to learn more about Marwood Group's advisory capabilities, we encourage you to please contact us.

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