EUROPEAN FACT FILES

HEALTH AND SOCIAL CARE REPORT

2019

- Belgium
- Denmark
- Finland
- France
- Germany
- Ireland
- Italy
- Netherlands
- Norway
- Spain
- Sweden
- Switzerland
- England
- Northern Ireland
- Scotland
- Wales

MARWOOD GROUP

Contents

Introduction

With voters heading to the polls in several countries later this year, the European political map may have shifted substantially by the end of 2019. Alongside this the European Parliament elections in May will also act as a key marker to the extent to which populist parties are gaining ground. Meanwhile, Brexit continues to cast a long shadow over the UK's relationship with the European Union.

It is vital that investors stay abreast of these developments and modulate their strategies accordingly, as the shifting political landscape has the potential to deeply impact on health and care policy, regulation, and reimbursement. Despite sharing common features, Europe cannot be viewed as a homogeneous entity, with a one-size-fits-all solution. Instead investors must get to grips with the specific challenges within individual territories.

Health and care systems are tied to their national historical context and cultural preferences. They will shape users' attitudes and expectations, including their willingness to pay to access services or products. These are essential considerations to keep in mind for companies looking to enter the European market or expand a business model from one country to another.

Overall, the European health and care market is an attractive one for investors. The fundamental drivers are common across markets, with people living not just longer, but often with multiple conditions that require long-term care and support. Publicly funded healthcare systems must find ways to fund rising demand, whilst investing in new technology and infrastructure, and improve care quality. This can provide opportunities for investors who are able to offer cost-effective alternatives to traditional delivery models, or offer new solutions that improve efficiency and quality.

To support our clients, Marwood Group produces an annual European Fact File. It provides readers with easy access to essential knowledge about the health and care systems across Europe. This year's edition covers 16 different countries. In light of important regulatory changes coming into force, we have included a section on European Union medical device and pharmaceutical regulation.

Throughout our research, we have found similar policy themes emerging across Europe, as countries tackle system challenges, from demographic change to increased pressure on public services.

1. Social care reform is coming up the policy agenda. It has often been a secondary priority to healthcare, but as countries get to grips with the societal costs of failing to address the ageing population challenge, this is beginning to change. Germany has led the way, with reforms that have expanded access to publicly-funded social care services.

2. Across Europe, policy makers are attempting to lay the foundations for 21st century healthcare systems. Several governments have outlined how data can be leveraged to improve system efficiency and better tailor care to patients' needs. Denmark is a leader in this area, and their 2018 Digital Health Strategy aims to expand digital solutions across the health and care system.

3. Moving service provision outside of traditional inpatient settings is a common objective. This has the advantage of delivering care where it is most convenient for the individual, whilst potentially reducing system spend on more costly locations. In turn, this frees up resources to reinvest in providing support for the most acute, high-cost care needs.

We hope you enjoy reading our European Fact Files Health and Social Care Report 2019, and would be more than happy to discuss further any countries and topics we have covered.

Jyoti Mehan
Director, Business Development
+44 (0)20 3178 2504 / jmehan@marwoodgroup.com

Healthcare System Snapshot

	HEALTHCARE			
	Public Healthcare System: Access Criteria	Public Healthcare System: Sources of Funding	Primary Payers	Healthcare Providers
Belgium	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions, National Taxation	Seven Sickness Funds	Majority Public and Non-Profit, Small Private Sector
Denmark	National Health Service Universal Access	National Taxation	Five Regions	Majority Public, Small Private Sector
Finland	National Health Service Universal Access	National and Local Taxation	311 Municipalities	Majority Public, Small Private Sector
France	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions, National Taxation	Central Statutory Health Insurance	Public and Private Mix
Germany	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions	110 Sickness Funds	Public and Private Mix
Ireland	National Health Service Access Means Tested	National Taxation	Health Service Executive, Individuals	Public and Private Mix
Italy	National Health Service Universal Access	National Taxation	21 Regions, 103 Local Health Authorities	Majority Public, Small Private Sector
Netherlands	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions	Sickness Funds	Majority Public and Non-Profit
Norway	National Health Service Universal Access	National and Local Taxation	Four Regional Health Authorities	Majority Public, Small Private Sector
Spain	National Health Service Universal Access	Local Taxation	19 Regional Health Services	Public and Private Mix
Sweden	National Health Service Universal Access	Local Taxation	21 County Councils	Majority Public and Non-Profit
Switzerland	Statutory Health Insurance Universal Access	Statutory Health Insurance Premiums, National and Local Taxation	Sickness Funds, 26 Cantonal Health Authorities	Public and Private Mix
England	National Health Service Universal Access	National Taxation	195 Clinical Commissioning Groups	Majority Public, Small Private Sector
Northern Ireland	National Health Service Universal Access	National Taxation	Health and Social Care Board	Majority Public, Small Private Sector
Scotland	National Health Service Universal Access	National Taxation	14 NHS Boards	Majority Public, Small Private Sector
Wales	National Health Service Universal Access	National Taxation	Seven Local Health Boards	Majority Public, Small Private Sector

Social Care System Snapshot

SOCIAL CARE				
Public Social Care System: Access Criteria	Public Social Care System: Sources of Funding	Primary Payers	Social Care Providers	
Need and Means-Test	National and Local Taxation	Seven Sickness Funds, Regions, Individuals	Public and Private Mix	Belgium
Need-Test	Local Taxation	98 Municipalities, Individuals	Majority Public, Small Private Sector	Denmark
Need and Means-Test	National and Local Taxation	311 Municipalities, Individuals	Majority Public, Small Private Sector	Finland
Need and Means-Test	National and Local Taxation	101 Local Authorities, Statutory Health Insurance, Individuals	Public and Private Mix	France
Need-Test	Employee/Employer Payroll Contributions to Long-Term Care Insurance	110 Long-Term Care Funds, Individuals	Majority Private	Germany
Need and Means-Test	National Taxation	Health Service Executive, Individuals	Public and Private Mix	Ireland
Need and Means-Test	National and Local Taxation	7,000+ Municipalities, 103 Local Health Authorities, Individuals	Majority Public, Small Private Sector	Italy
Need and Means-Test	Employee/Employer Payroll Contributions to Long-Term Care Insurance	380 Municipalities, Sickness Funds, Individuals	Majority Non-Profit	Netherlands
Need and Means-Test	National and Local Taxation	422 Municipalities, Individuals	Majority Public, Small Private Sector	Norway
Need and Means-Test	National and Local Taxation	19 Regions, Individuals	Majority Private	Spain
Need-Test	Local Taxation	290 Municipalities	Public and Private Mix	Sweden
Need and Means-Test	Statutory Health Insurance Premiums, National and Local Taxation	Sickness Funds, 26 Cantons, Municipalities	Public and Private Mix	Switzerland
Need and Means-Test	National and Local Taxation	152 Local Authorities, Individuals	Majority Private	England
Age, Need and Means-Test	National Taxation	Health and Social Care Board, Individuals	Majority Private	Northern Ireland
Age, Need and Means-Test	National Taxation	32 Local Authorities, Individuals	Majority Private	Scotland
Need and Means-Test	National and Local Taxation	22 Local Authorities, Individuals	Majority Private	Wales

European Union Regulation

Key Messages

- The European pharmaceutical and medical device markets are estimated to be worth over €300bn
- Legislation and regulation of pharmaceutical products and medical devices are established by the European Union (EU). It is a dynamic environment, with changes planned over the next five years
- Manufacturers of medical devices will need to adapt to new regulations strengthening the regulatory framework for medical devices authorisation and post-market safety surveillance
- There will be changes looking to further harmonise pharmaceutical development and health technology assessment, which intend to support developers of innovative and value-added medicines
- Developers and manufacturers selling their products primarily to publicly funded European healthcare systems are subject to separate pricing and reimbursement decisions in each territory. These decisions are influenced by the state of public healthcare funding and national policy priorities

Key Facts and Figures

Top Five Largest Markets in Value

Source: MedTech Europe, EPFIA

No.	Pharmaceuticals	Medical Devices	In-vitro Diagnostic Medical Devices
1	Germany	Germany	Germany
2	France	France	Italy
3	Italy	United Kingdom	France
4	United Kingdom	Italy	Spain
5	Spain	Spain	United Kingdom

Medical Devices in the EU

Source: MedTech Europe

Market Value (EU) (2016)

€110bn

Number of Companies (EU)

27,000

Number of Medical Devices on the Market (EU)

500K+

Pharmaceuticals in the EU

Source: EPFIA

Market Value (EU) (2017)

€193.7bn

Number of live clinical trials as of 2018 (EU)

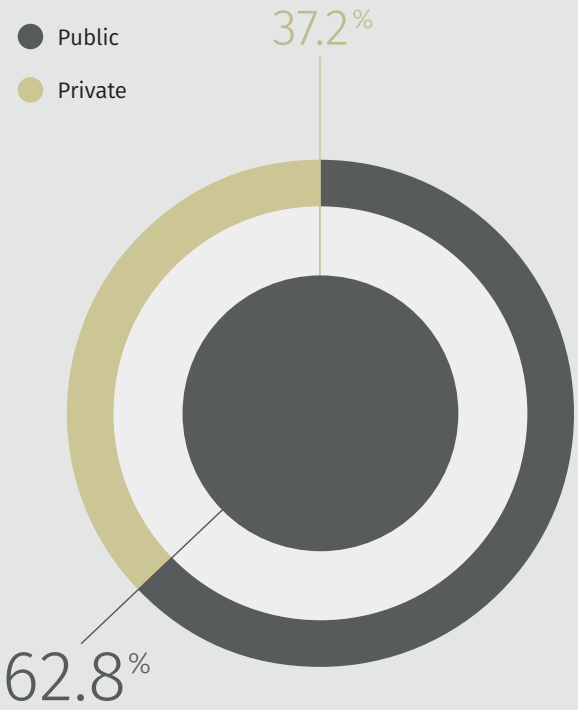
33,557

Number of new medicines approved by the European Medicines Agency in 2017

92

Expenditure on Pharmaceuticals in the EU

On average, public expenditure contributes to 62.8% of the total expenditure on pharmaceutical products in Europe (16 countries)



European Union Regulation

The European Union's Role in Healthcare

The role of the EU in healthcare is most relevant to pharmaceutical and medical device regulation. In addition, the EU acts as a platform for cooperation on public health issues, particularly when cross-border threats have been identified, and also provides funding for research and development.

The EU has very limited additional powers when it comes to healthcare services. Individual member states are responsible for funding and organising healthcare services and defining their own policy objectives. In this area, the role of the EU is limited to overseeing and setting the legal framework for cross-border healthcare services. This framework has recently been used by British hospitals located in Kent to outsource elective care operations to Normandy hospitals in France to reduce waiting lists. Although these arrangements remain unusual, EU legislation has harmonised the rules governing them, and provides mechanisms to settle reimbursement disputes between countries.

Policy, Legislative and Regulatory Changes

Incoming Medical Device and In-vitro Diagnostic Medical Device Regulations

Regulatory changes impacting on medical device's pre- and post-market surveillance are coming into force over the next five years.

Manufacturers will need to take steps to ensure compliance with the new regulations. The main impact on medical devices currently on the market is that they will have to re-certify under the new Regulations.

The table below summarises the key changes.

Overview of MDR & IVMRD Changes
Creation of a new European database ("EUDAMED") will collate and process information relating to medical devices
All medical devices to display a Unique Device Identifier (UDI) system to improve post-market vigilance and traceability of devices
Greater supervision of notified bodies by competent authorities. Notified bodies will be re-accredited and will be expected to meet a higher standard of expertise
Pre-market assessment procedure will be mandatory for high-risk products (e.g. implantable Class III devices and certain Class IIb active devices).
Introduction of a new risk classification system for in-vitro diagnostic medical devices in line with international guidance
Scope of Regulations extended to certain aesthetic devices presenting the same characteristics and risk profile as analogous medical devices (e.g. aesthetic contact lenses)

The Medical Device Regulation (MDR) and the In-vitro Diagnostic Medical Device Regulation (IVDR) replace three previous directives; the Medical Device Directive (MDD), the In-vitro Diagnostic Medical Device Directive (IVDD) and the Active Implantable Medical Devices Directive (AIMDD).

These directives, adopted in the early 90's, were shown to have serious limitations following a series of safety issues with medical devices across Europe, culminating in the failure to prevent the 2009 PIP breast implant scandal.

The key objective of the new regulations is to strengthen safety requirements for devices before placing them on the market and to improve device monitoring after being placed on the market. In doing so, European regulation is catching-up with international best practice. Many manufacturers will already be operating in compliance with some of the new requirements, such as assigning a Unique Device Identifier (UDI) to each medical device. However, all medical devices will have to be re-evaluated under the new regulations in order to continue to be sold on the European market.

Incoming Clinical Trial Regulation

Overview of the Clinical Trial Regulation Changes
Harmonised electronic submission and assessment processes for clinical trials conducted in multiple member states
Improved collaboration between member states
Information sharing and decision making between and within member states
Higher safety standards for patients
Increased transparency of information on clinical trials

There are regulatory changes to pharmaceutical development associated with the implementation of the Clinical Trial Regulation.

The objective of the Clinical Trial Regulation is to make it easier to obtain trial authorisation and carry out trials across several member states. This could be particularly beneficial to those developing rare diseases treatments and needing access to a large enough number of patients to validate their trials.

The creation of an EU online portal and database is essential to the full implementation of the Regulation. There have been some delays in setting this up. The most recent update of June 2018 indicated that the portal would go live in Q2 2019. But the lack of further updates suggests that this may be delayed to late 2019 or early 2020.

Developments in Pharmaceutical Pricing

Whilst the EU has no direct powers on pharmaceutical and medical device pricing, the European Commission has made a proposal to harmonise health technology assessments (HTA). HTA measures the added value of a new health technology compared to existing ones and are used to inform national reimbursement decisions. If adopted, the European Commission proposal for a Regulation on HTA will formalise pan-EU HTA cooperation and make it mandatory for:

- Pharmaceutical products subject to the central authorisation procedure (e.g. orphan drugs, cell and gene therapies)
- High-risk medical devices and in-vitro medical devices, subject to expert panel recommendation

Formal HTA cooperation will be limited to performing joint clinical assessments. Non-clinical aspects of the HTA (economic, ethical and legal matters) will continue to be performed at national level. The proposal intends to limit duplication of health technology clinical assessments by national bodies and harmonise data and evidence requests to developers. Pricing and reimbursement decisions will continue to be made by national authorities. However, since HTA form part of the evidence informing these national decisions, harmonising the assessment of clinical aspects may speed-up pricing and reimbursement agreement.

The proposal is currently being considered by the European Parliament and Council of the EU. Adoption is expected in 2019 but may be delayed due to the May 2019 European Parliament elections and the appointment of a new European Commission in the second half of 2019. Once adopted, it is currently envisaged that there will be a three-year transition period before the Regulation becomes fully applicable.

Medical Devices

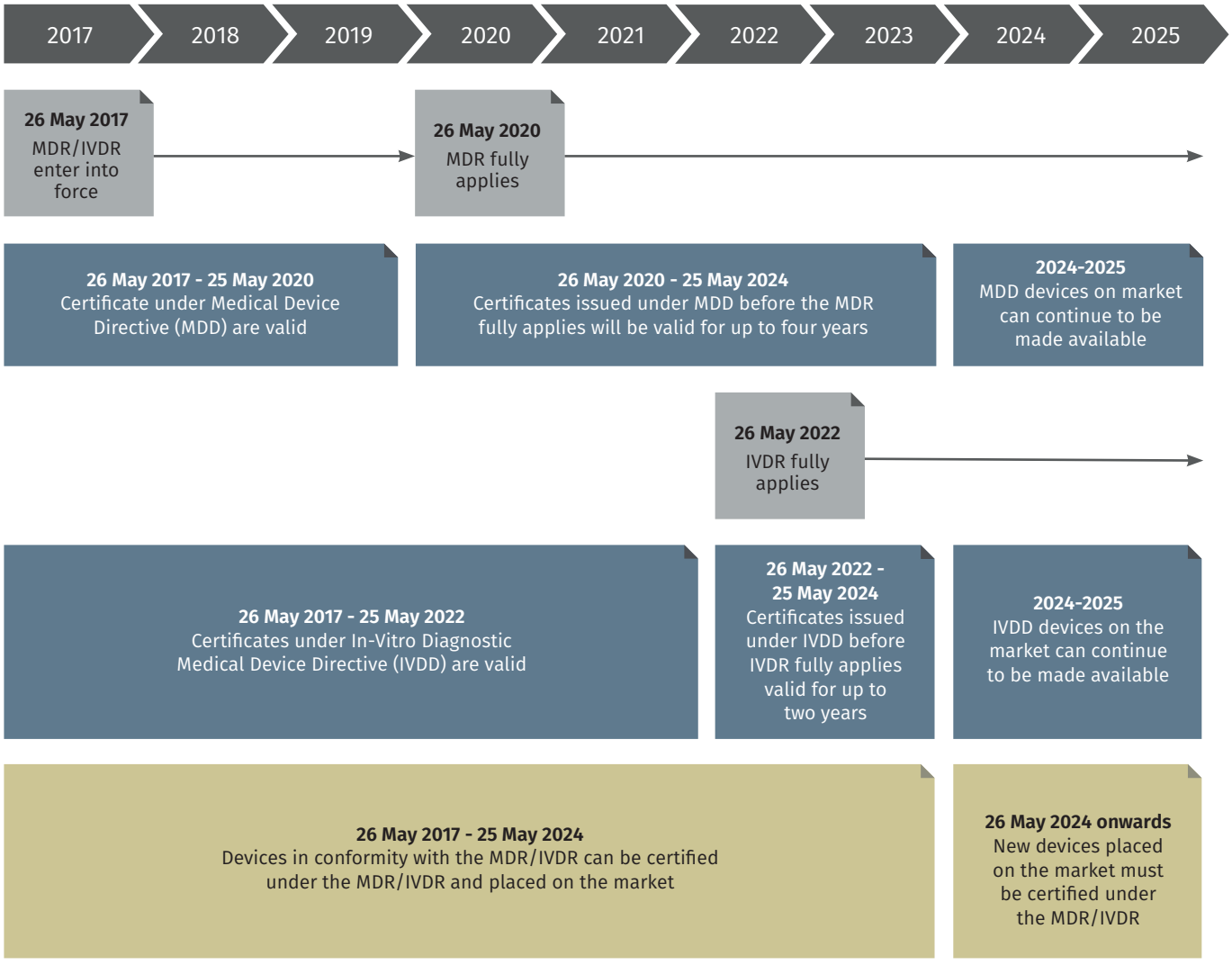
Regulation

Medical technology regulation is primarily set at EU level but is implemented by national regulators (competent authorities) and their Notified Bodies.

To be placed on the market, a medical device must bear a CE mark, granted by one of the competent Notified Bodies. Notified Bodies are private companies that have been entitled by a national competent authority to assess whether manufacturers and their medical devices meet regulatory requirements. When requirements have been satisfied, the Notified Body authorise manufacturers to put a CE mark to their device. There are currently 57 Notified Bodies entitled to deliver CE marks.

The Medical Devices Regulation is due to apply in full by 25 May 2020 and the In-vitro Diagnostic Medical Device Regulation is due to apply in full by 25 May 2022. Devices will need to be re-certified under the new regulations. However, for this to become possible, Notified Bodies need to be re-accredited. Due to the increased requirements on Notified Bodies under the MDR, it is expected that some of them will cease their operations. Their number is due decrease from just under 60 to approximately 35. As a result, MDR re-certification workload will fall on a smaller number of Notified Bodies, which may cause delays in issuing the new certificates.

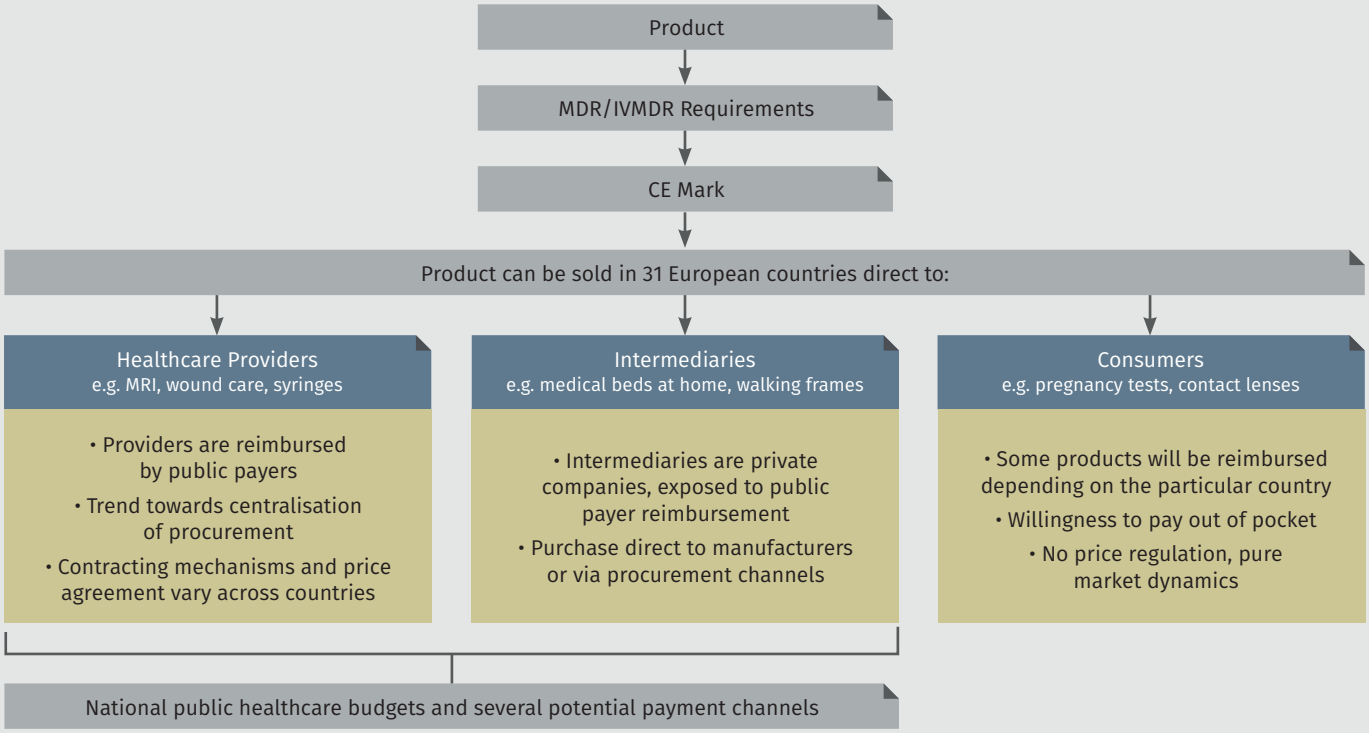
Medical Device Regulation Implementation Timeline



Payment Mechanism

Once a CE mark has been granted, medical devices companies may sell their product in 31 European countries. This includes the 28 EU member states (inclusive of the UK) and the three European Economic Area (EEA) countries; Norway, Iceland and Liechtenstein.

Depending on the type of product and how it will be used, there are three main payers. These are healthcare providers, intermediaries, and consumers. The chart below provides an overview of their key features.



Market

The European medical devices market is estimated to be worth €110bn across the 28 EU countries, Norway and Switzerland. Approximately 27,000 companies employing 650,000 people in Europe are engaged in medical device manufacture. They are located in greater numbers in Germany, the UK, France and Sweden.

Overall, European countries export more medical devices than they import, although at a country level, Italy, the UK, Spain and France import more medical devices than they export. The majority of imports come from other European countries and are facilitated by the EU's single market, an area of free trade. Outside of the single market, Europe's main trade partners are the US, China and Japan. Imports from developing countries are low overall. However, the Confederation of British Industry reports that they grew by 12% on average each year between 2011 and 2015. Germany was the largest importer of medical devices from developing countries, with imports worth €2.3bn, or nearly 15% of total imports.

Merger, acquisition, separation, inversion, in-licensing and alliance activity in the sector are driven mostly by the general instruments segment. The ageing population will sustain the demand for medical devices but budgetary pressures on public health systems will likely drive the consolidatory trends and offshoring to cheaper countries for manufacturing.

Pharmaceutical Products

Regulation

Pharmaceutical regulation is primarily set at EU level. The European Medicines Agency (EMA) plays a key role in evaluating and monitoring medicines, with the support of national competent authorities.

The EMA evaluates medicines that are subject to the centralised authorisation procedure. In 2017, 92 new medicines were approved. Central authorisation is mandatory for certain products, including orphan drugs, advanced therapies medicinal products such as cell and gene therapies, and medicines containing a new active substance to treat certain diseases like cancer or diabetes. EMA approval allows a medicine to be sold in 31 European countries. Once a medicine has been placed on the market, it remains subject to the EMA's pharmacovigilance guidelines.

Medicines that do not require EMA approval can still seek central authorisation or apply for authorisation at the national level. There are two available routes for companies that want to sell their products in several EU/European Economic Area countries:

- Mutual recognition procedure: a product approved in one EU country is mutually recognised in a number of other EU countries. Regulatory approval is first submitted to a reference member state (i.e. the developer's chosen national competent agency). This approval is followed by a bilateral phase during which other concerned national competent authorities assess the application, on the basis of the reference member state's decision

- Decentralised procedure: the regulatory assessment is carried out by one national competent authority and discussed and agreed with a number of other national competent authorities

National competent authorities support the EMA's work. They evaluate some medicines and applications for clinical trials. National competent authorities are EMA members' regulatory agencies. They are primarily responsible for the authorisation of medicines that do not require evaluation under the centralised authorisation procedure. They are responsible for reviewing and authorising applications for clinical trials, in accordance with the EMA's good clinical practices standards. National competent authorities staff often serve as experts in the EMA's scientific committees, working parties or in assessment teams. There are currently 34 national competent authorities – Germany and Poland have two competent authorities.

National market regulators can hold statutory powers that can take action if pharmaceutical companies are taking part in uncompetitive practices, such abusing a dominant market position.

Top five EU markets' national competent authorities

UK	Germany		France	Italy	Spain
Medicines and Human products Regulatory Agency	Federal Institute for Drugs and Medical Devices	Paul Ehrlich Institute (regulates innovative medicines)	Medicines and Healthcare Products Safety National Agency	Italian Medicines Agency	Spanish Medicine and Healthcare Products Agency
MHRA Regulating Medicines and Medical Devices	Bundesinstitut für Arzneimittel und Medizinprodukte	Paul-Ehrlich-Institut	ansm Agence nationale de sécurité du médicament et des produits de santé	Agenzia Italiana del Farmaco AIFA	agencia española de medicamentos y productos sanitarios

Payment Systems

The processes governing application for pricing and reimbursement vary from country to country. National pricing and reimbursement authorities create their own methodologies to determine the cost/benefit of a new pharmaceutical product and its eligibility for reimbursement.

European public healthcare systems generally offer generous coverage of prescription medicines. On average, public funding contributes to 62.8% of total pharmaceutical spend. Germany's statutory health insurance is the most generous public scheme in Europe, covering 84% of the country's pharmaceutical spend.

In recent years, European countries have been trying to contain the growth of public pharmaceutical spending. Individual countries have approached this differently. For products already on the market, this includes introducing or increasing co-payments (Spain), removing drugs with a low medical benefit from reimbursement lists (UK, France), mandated targeted price cuts (Italy, France), or encouraging market penetration of competing cheaper generic or biosimilar drugs (UK, Germany, France).

Prices for new medicines (originators) are generally set in negotiations, following a cost-efficiency test, such as the one set by the UK's National Institute for Health and Care Excellence (NICE). A key element of this appraisal is the measurement of a medicine's cost per Quality-Adjusted Life Years (QALY) resulting from using the treatment. Among originators, the cost of emerging innovative products, often cell or gene-based therapies, has proved challenging for national payers. Some countries, like Italy, have developed flexible performance-based payments to address this challenge by sharing the financial risk between payers and manufactures.

Market

The pharmaceutical sector, including the research and development R&D segment, is a major industry in Europe, directly employing 750,000 people.

In 2017, this market was estimated to be worth €193.7bn. Investment in R&D was estimated to have reached €35.2bn, Switzerland, Germany and the UK attracting just over half of investment value. In the same year, IQVIA estimated that the European pharmaceutical market constituted 22.2% of the global pharmaceutical sales, making it the second largest market after North America.

According to IQVIA, the European pharmaceutical market is expected to growth at an annual average of 3.6% between 2016 and 2021.

Top five EU markets' national pricing and reimbursement authorities

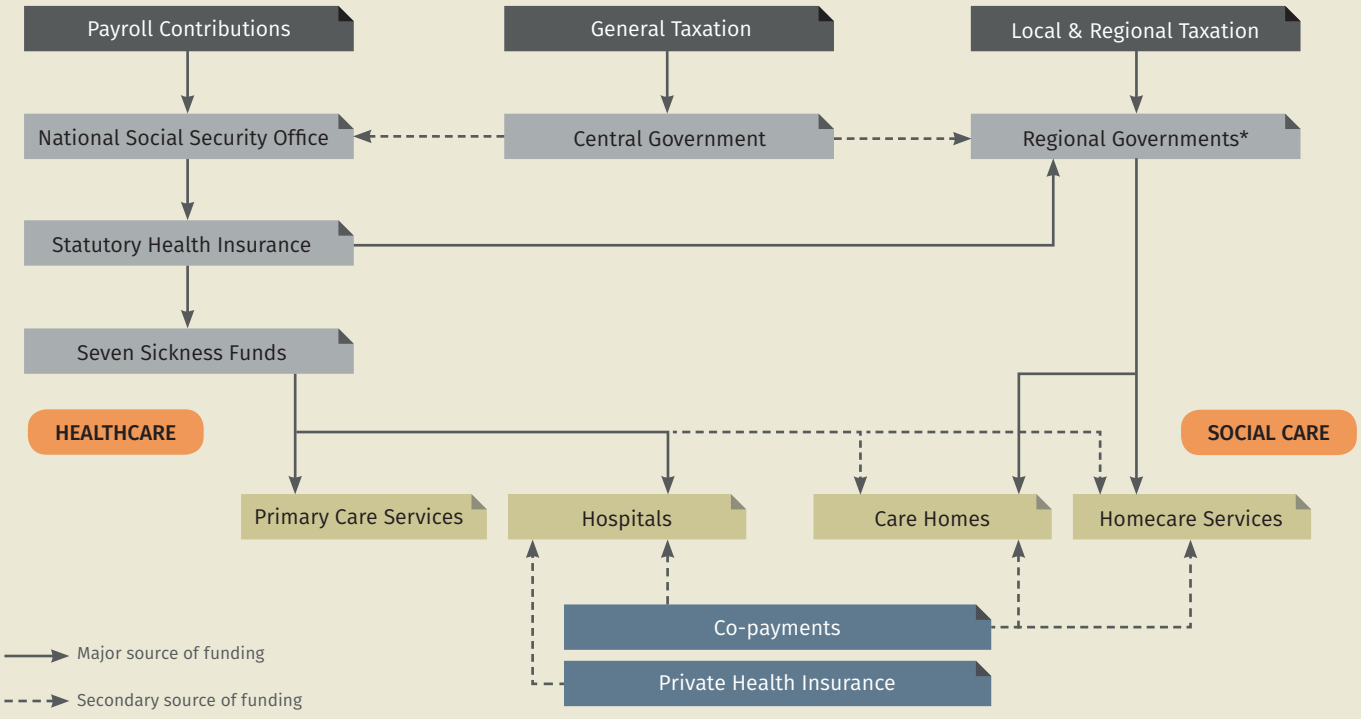
UK	Germany	France	Italy	Spain
Department of Health and Social Care	Joint Federal Committee	Economic Committee for Health Products	Italian Medicines Agency	Inter-ministerial Price Commission of Medicines

Belgium

Key Messages

- The health and social care systems are changing as a result of central government transferring more decision-making powers to the three regional governments
- The latest transfer of powers will reshape relationships between social care providers and payers, with the onus for payments and price negotiations shifting from national statutory health insurance bodies to regional payer organisations
- The process of health and social care devolution is continuing. Ongoing regional separatist tensions could lead to even more devolution of powers to the regions depending upon the outcome of the general election in May 2019
- In the long-term, all health and social care funding and organisation decisions impacting on providers could be devolved to the regional level

Funding Flows



* The devolution of competencies and funding responsibility to regional governments is ongoing. Regional governments have or will set-up regional payer organisations to manage payments to providers

Population

Total

11.4m

Source: Federal Institute for Stats

Life Expectancy

81.5 years

Source: OECD

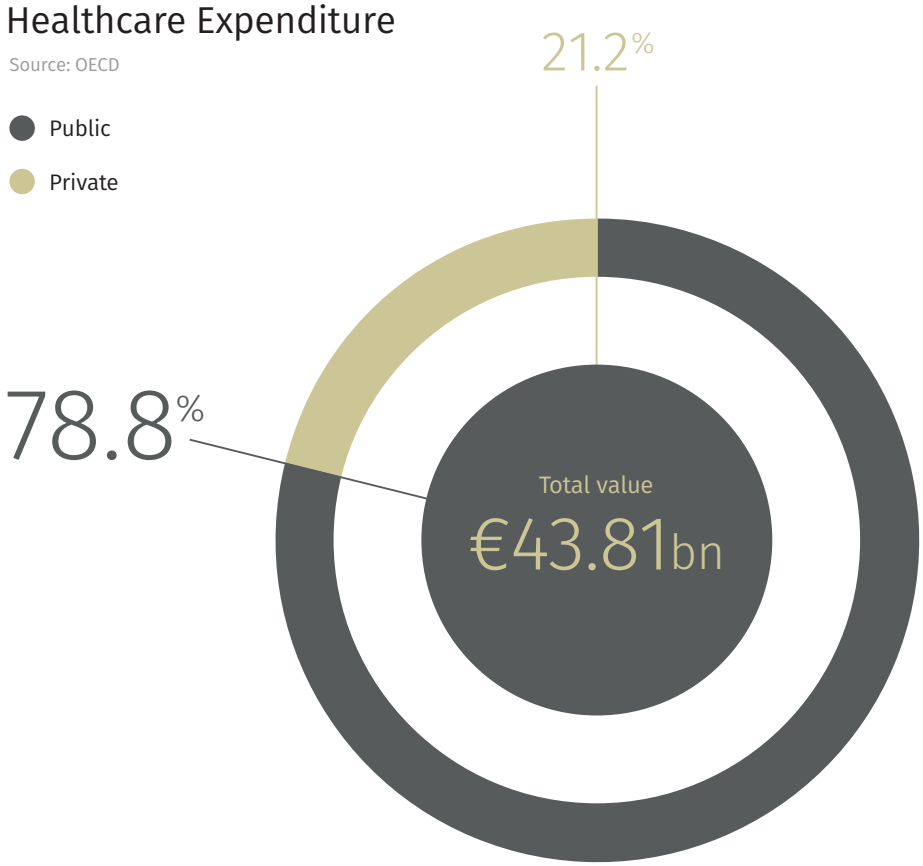
Population Distribution (%)

- 28.6% are aged between 0 and 24
- 53% are aged between 25 and 64
- 18.4% are aged over 65

Source: OECD, Eurostat (2018)

Healthcare Expenditure

Source: OECD



Policy Snapshot: Devolution

There is an increasing shift of funding, regulatory and organisational powers and responsibilities to the regional governments

Belgium started a process of devolution in the 90's to address growing separatist tensions in Flanders. A wide range of responsibilities for public services have progressively been handed over by central to regional governments. The latest reforms were adopted in 2014 and transferred several health and social care funding, regulatory and organisational responsibilities to the regions including:

- Hospital equipment funding
- Hospital accreditation regulation
- Mental health inpatient services organisation and funding
- Social care services for older people organisation and funding, including homecare and care homes
- Prevention services organisation and funding
- Primary care services organisation

These services are worth €5.09bn in public funding. This funding is distributed by the National Institute for Health and Disability Insurance to the three regions (61% for Flanders, 31% Wallonia, and 8% Brussels).

As the transition is still ongoing, some of the services that have officially been devolved continue to be funded by the Statutory Health Insurance. This includes social care services in Wallonia and Brussels. In Flanders, a new social security fund and a healthcare fund took over responsibility for funding all devolved services.

Healthcare

Funding

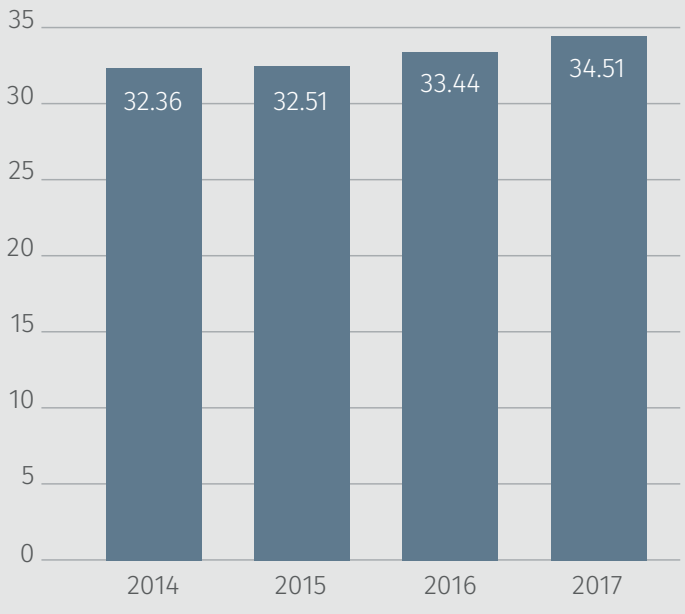
Healthcare funding is primarily public. The healthcare system relies on mandatory Statutory Health Insurance (SHI) funded primarily from employee and employer payroll contributions. In addition, central government tops-up the budget with revenue from general taxation and other levies. A reform adopted in March 2017 intends to re-balance healthcare funding from payroll contributions to other forms of taxation, such as value-added tax.

The healthcare budget is set on an annual basis. In the past few years, real-term annual growth has been progressively reduced and is currently capped at 1.5%, after a gradual decrease from 4.5% in 2012.

Regional governments are responsible for funding hospital equipment, such as radiotherapy equipment. They receive their funding from local and regional taxation, allocations from the SHI, and central government.

Public Healthcare Expenditure (€, bn)

Source: OECD



Payment System

SHI expenditure is managed by seven non-profit sickness funds. Individuals are free to choose between any of these seven funds, which enable access to a nationally-agreed level of healthcare services.

Tariffs and fees for healthcare services are fixed at national level and updated annually. They are negotiated and agreed between the sickness funds and the associations of health professionals under the umbrella of the SHI.

Payments to primary care providers are based on a fee-for-service. This is either paid directly by sickness funds or by patients, who then claim full or partial reimbursement from their sickness fund.

In secondary care, hospitals receive two types of payments: fixed and variable. The fixed part is paid by sickness funds as a monthly advance determined by the previous year's activity. The variable part is paid according to the number of admissions and bed days. These payments cover the cost of medical services. Patients are expected to make co-payments, including a daily fee for accommodation and board costs. They also pay out of pocket for supplementary services and medicines that are not covered. These costs may be covered by supplementary voluntary private health insurance.

The role of voluntary private health insurance in Belgium

The use of voluntary private health insurance in Belgium has been limited and decreased further in 2012, when it became mandatory for all members of the sickness funds to pay an additional flat-rate contribution covering the cost of orthodontics, homoeopathy and osteopathy.

Today, voluntary private health insurance plays mostly a supplementary role. It is primarily used to cover the additional cost of a single room in hospital.

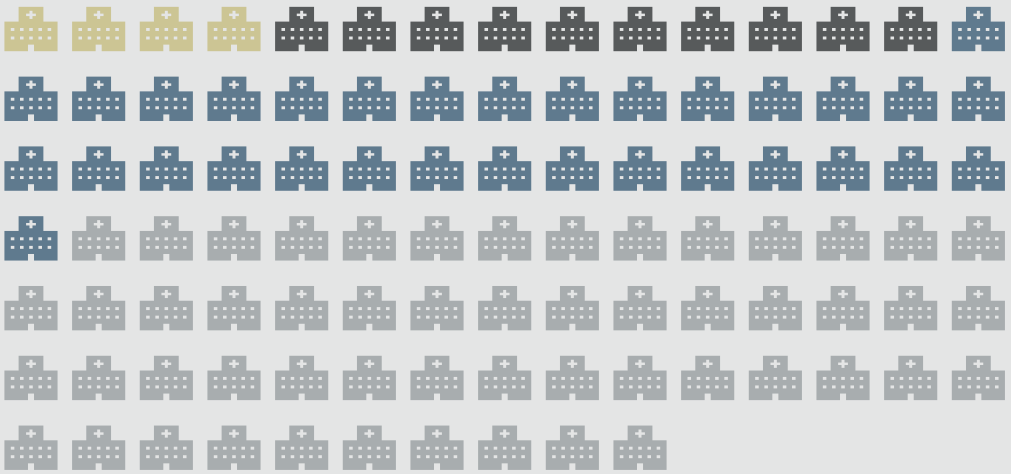
Voluntary private health insurance is provided by the sickness funds and for-profit insurance companies. However, private companies are increasingly gaining dominance in this market.

Provider Landscape

In 2017, primary care services were delivered by 15,989 general practitioners (GPs). GPs are often the first point of contact with the health system. Though, as there is no mandatory gatekeeping referral system, patients may visit a specialist directly. GPs are mostly private, self-employed professionals.

Hospital care is dominated by non-profit provision. There is a very small for-profit hospital sector, providing 3,000 of the total 49,464 hospital beds. For-profit operators provide a wide range of services, including acute inpatient mental health, elective care, and rehabilitation services.

Overall, the number of doctors per capita practicing in primary and secondary care has remained stable over the past twenty years, whilst the number of nurses has increased. In 2015, there were three doctors and 10.5 nurse per 1,000 population.



Source: European Commission

Regulation

The Federal Public Service (Ministry of Health) is responsible for regulating the compulsory health insurance. They also set minimum standards for hospitals and professional qualifications through the SHI.

In order to operate, hospitals need to obtain accreditation from the regional public health authorities. The practice of medical professions is regulated by the Practice of Health Care Professions Act. Among others, this Act regulates access to the various professions such as physicians, dentists, and nurses.

Quality of care is monitored and evaluated by the Evaluation and Medical Control Service of SHI. It works with providers by providing guidance and evaluates their adherence to standards. Evaluation is based on a wide range of indicators informing inspectors on access to care, quality of care and outcomes.

The most recent evaluation of the Belgian healthcare system was performed in 2015. It found that the majority of patients were satisfied with the quality of care they received. Based on findings from 106 indicators, the healthcare system was deemed to perform well overall. However, mental health services were seen as an area for improvement. There are also regional variations in terms of access, quality of care and outcomes.

The three regions are responsible for health promotion and prevention, providing maternity and children care, social services, community care. They are also responsible for coordination and collaboration in primary and palliative care, and also for financing hospital investment.

Social Care

Funding

Historically, social care funding comes from the wider healthcare budget. This budget is primarily funded through mandatory employee and employer payroll contributions and topped-up by central government's general taxation revenue. It finances care home services for older people, and adults with a physical or learning disability. It also finances homecare medical costs, whilst the costs of activities of daily living support are funded by regional governments.

The latest devolution reforms have transferred the responsibility for funding all social care services to the regions. Fiscal powers have been transferred to regional governments to give them more fiscal autonomy. Central government funding is expected to continue but will play a top-up role. In Flanders, residents pay a €51 annual contribution towards the cost of their social insurance to regional government.

Payment System

Payments to social care providers include a mix of public and private payments. Everyone in Belgium is entitled to publicly-funded social care services. However, individuals are subject to needs and means tests which determine the level of costs covered by public funding.

Historically, providers have been paid by the sickness funds or directly by patients who may choose to receive cash benefits to spend on their care. Co-payments are required to top-up the difference if there is a gap in cost coverage. With devolution reforms, the role of sickness funds as payers is decreasing. In Flanders, they have been replaced by the new social security fund and a healthcare fund.

Before devolution, prices for social care services were set at the federal level, by sickness funds and the associations of health professionals under the umbrella of the SHI. In the future, price setting is expected to continue to be negotiated between payers and providers, but will take place at the regional level.

Provider Landscape

Older people's care services include short- and long-term residential care, homecare and community services. In recent years, policy has strongly focused on enabling older people to remain in their own home as long as feasible. As a result, Belgium has developed a wide range of home assistance and personal care services to help older people live independently.

Residential and nursing homes in Belgium can be public, private non-profit, or private for-profit organisations. In 2016, there were 143,761 beds available, including 46,926 in the private sector.

Care Home Beds (2016)

- 54,537 are non-profit
- 46,926 are for-profit
- 42,298 are public

Source: National Institute for Health and Disability Insurance

Regulation

The Federal Public Services (Ministry of Health) is responsible for sickness and disability insurance and planning and accreditation criteria for the nursing homes.

In order to operate, care homes and homecare agencies need to obtain accreditation from the regional public health authorities. Nurses delivering homecare services are regulated by the Practice of Health Care Professions Act.

Quality of medical care is monitored and evaluated by the Evaluation and Medical Control Service of the SHI. Care homes providers are subject to three types of inspection:

- Administrative inspection, which checks financial accounts and that staff qualifications are appropriate
- Care offering evaluation, which looks at the quality of care residents receive
- Level of care, which looks to establish whether the provider has correctly evaluated the needs of their residents and is therefore billing the correct amount to sickness funds

In addition, regional inspection services evaluate that accreditation standards are met.

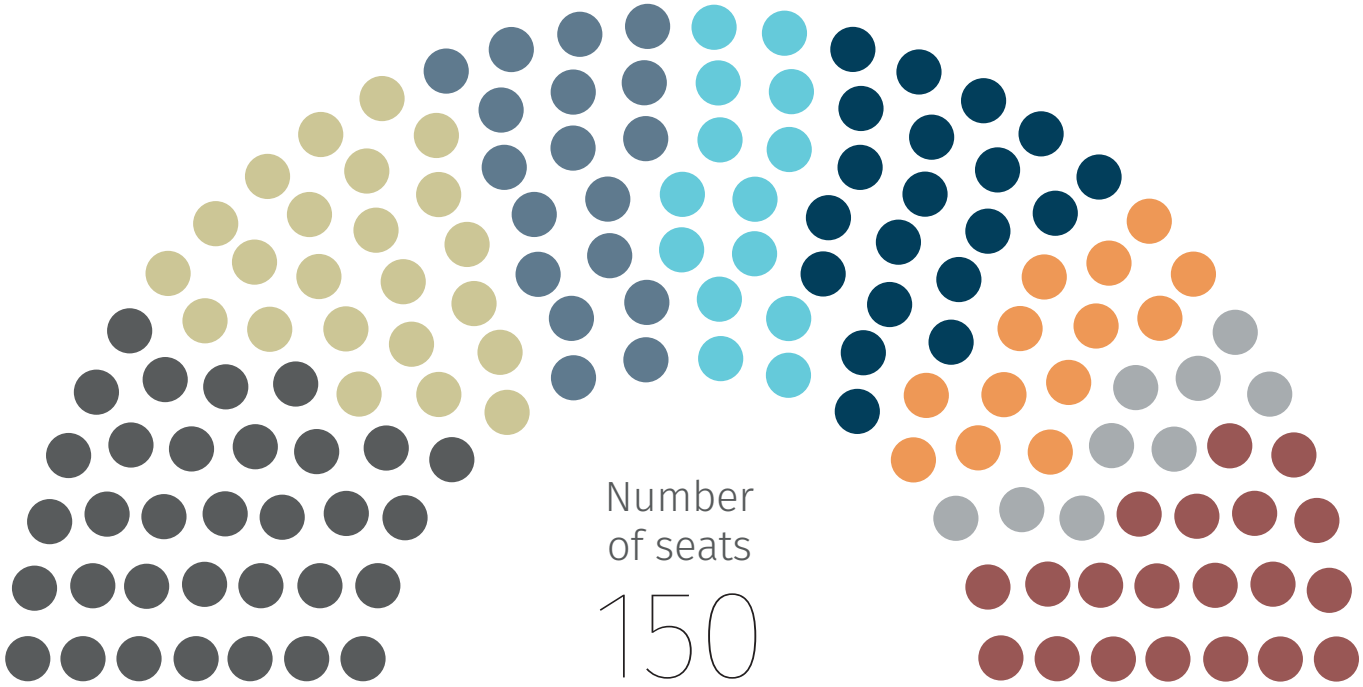
Political Environment

The fragile coalition led by centrist prime minister Charles Michel collapsed on 18 December 2018 after the Flemish nationalist party (N-VA) withdrew its support over migration issues. The next federal election is due on 26 May 2019. The prime minister is currently in post as the head of the 'care-taker' government until then. The outcome of the federal election is highly uncertain. The political divide between the northern Flanders and the southern Wallonia regions is expected to increase. The N-VA is set to keep its place as Flanders' main party, whilst Wallonia is likely to elect members of centre-left socialist and green parties. This is likely to result in difficult and long coalition building negotiations. This means that the current care-taker government could remain in place for longer.

This means that any further devolution of the health and social care competencies is unlikely in the short to medium-term. In terms of funding, the healthcare budget annual growth is secured in law and therefore, should grow by 1.5% per year in real-terms until a coalition government chooses to review it.

Composition of Parliament

- New Flemish Alliance (33)
- Socialist Party (23)
- Christian Democratic & Flemish (18)
- Open Flemish Liberals and Democrats (14)
- Reformist Movement (20)
- Socialist Party - Differently (13)
- Humanist Democratic Centre (9)
- Others (20)

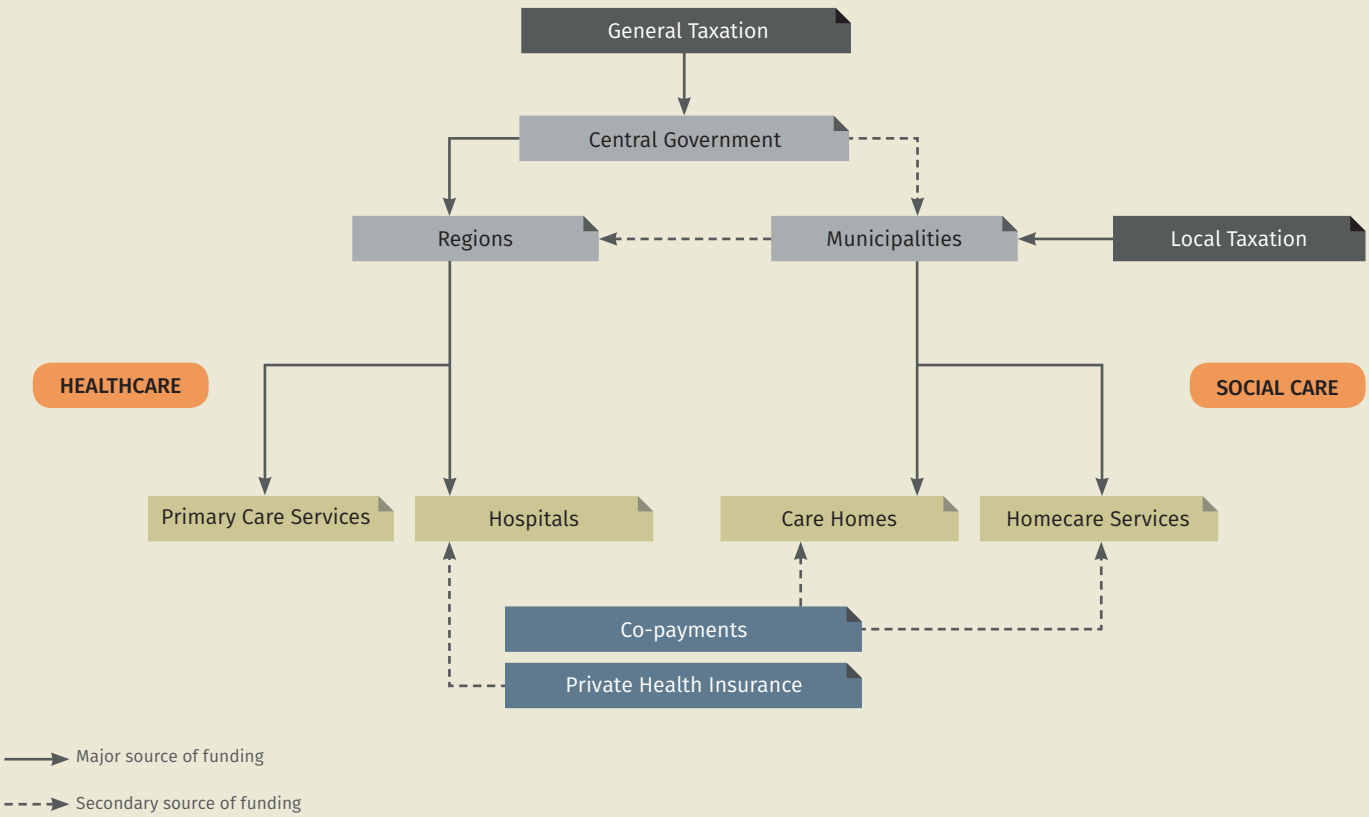


Denmark

Key Messages

- Digitisation of health and social care is among the most advanced in Western Europe and remains a key national policy priority. The ambition over the next few years is to integrate digital solutions, such as health records, to enable continuity across care settings
- Denmark is aiming to introduce routine genome sequencing services to better tailor services and treatments to individual needs, in line with the national strategy on care personalisation
- Decisions on funding allocations and service organisation of health and social care services are primarily taken at regional and municipal level. For example, the regions are currently engaged in large-scale reorganisation of hospitals, with 16 new hospitals being built, in partnership with private companies
- The delivery of health and social care services is dominated by publicly owned providers. However, there is a small private hospital sector, supporting public hospitals with waiting time objectives, and the nursing home market is open to private operators

Funding Flows



Population

Total

5.8m

Source: Federal Institute for Stats

Life Expectancy

80.9 years

Source: OECD

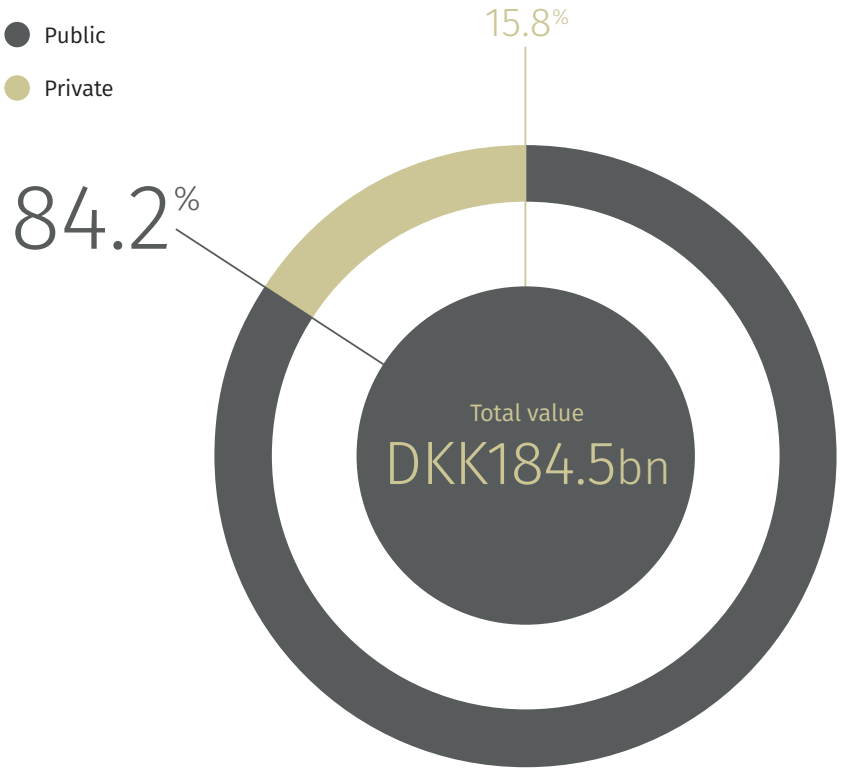
Population Distribution (%)

- 29.6% are aged between 0 and 24
- 51.3% are aged between 25 and 64
- 19.1% are aged over 65

Source: Eurostat (2018)

Healthcare Expenditure

Source: OECD
1DKK = 0.134137EURO (average 2018)



Policy Snapshot: Healthcare Change Driven By Technological Innovation

Healthcare strategies focus on digitisation to support integration of services and personalised medicine to provide tailored treatments

The Danish health and care systems is one of the most digitally advanced in Europe. For example, primary care e-consultations, are already widely available. A two-year pilot started in 2017 is trialling the expansion of e-consultation to psychological therapies for those with mild anxiety and depression.

The Digital Health Strategy 2018-2022 outlines the next priorities for health and care digitisation. The ambition is to facilitate the use of technology and system interoperability to improve collaboration between healthcare providers. Innovative solutions are also expected to support patients throughout their healthcare journey and enable them to have more control over their own care. For example, the Strategy intends to expand the National Health Record to integrate medical records from primary care and private health providers. This will complement hospital medical records, which are already available in the National Health Record.

Alongside digitisation, the National Strategy for Personalised Medicine 2017-2020 sets out the objective of placing patients at the centre of healthcare services and giving them access to treatments tailored to their needs. This will build on the large amount of patient data already collected. In addition, Denmark intends to move towards offering routine genome sequencing services to tailor treatments to patients.

Healthcare

Funding

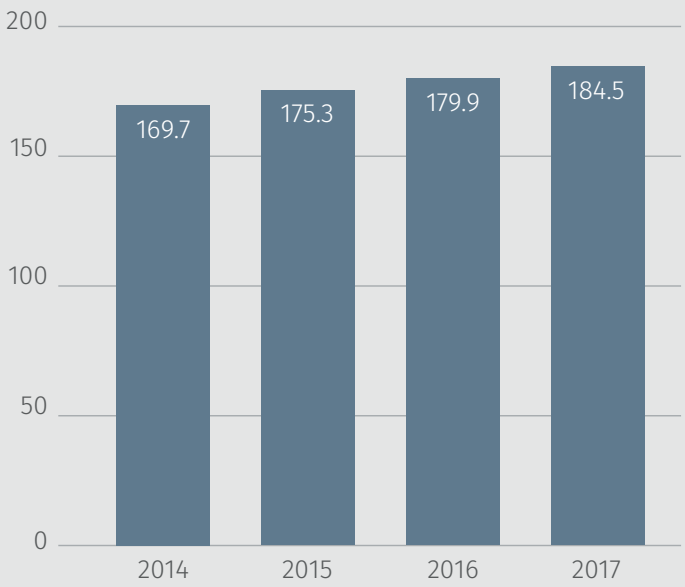
Healthcare funding is primarily public and comes from general taxation. Taxes are levied at a national level by the central government and at a local level by the 98 municipalities. Funding is then distributed among five regions, which are responsible for deciding how to allocate healthcare budgets among different services.

Hospital Modernisation Funding

Over the next ten years, the Danish regions will finance a DKK47bn hospital transformation programme. 16 projects have been selected, ranging from building new hospitals to extending and modernising existing infrastructure. The objective is to concentrate acute and specialised services into a small number of regional hospitals, while developing ambulance, outpatient and community services. DKK6.7bn of the transformation funding will be spent on purchasing new medical equipment and information technology supporting data collection.

Public Healthcare Expenditure (DKK, bn)

Source: OECD



Payment System

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. The current agreement introduced variable capitation fees, with higher rates in more deprived and rural geographical areas.

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 case-based Diagnosis-Related Group (DRG) payments. Regions also contract with private hospitals, which are used to provide additional treatment capacity when necessary.

Access to primary and secondary healthcare services is mostly free at the point of use. However, alongside public expenditure, about 16% of healthcare payments come from other sources. This mostly takes the form of user co-payments for a small number of services like dentistry and optical services. 2% of healthcare payments come from private health insurance.

Provider Landscape

The healthcare provision landscape is dominated by public providers.

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

Secondary care is mainly provided by public hospitals. They are owned and operated by one of the five Danish regions. Between 2007 and 2017 the public hospital sector experienced significant reorganisation. There are now 21 administrative organisations, down from 40, providing services across different sites at a regional level.

There is a small, fragmented private sector, operating in parallel to the dominant public hospital sector. Access to hospital treatment is subject to a maximum 30-day waiting time from the date of referral. If this deadline is breached, patients may choose to go to a private clinic to start publicly-funded treatment. The deadline applies to referrals for physical and mental illness. Private clinics may also provide experimental treatments to patients suffering from life-threatening diseases subject to the approval of the Danish Health Authority.

The role of voluntary private health insurance in Denmark

Although it makes-up just 2% of the total healthcare expenditure, subscription to voluntary private health insurance in has been growing in Denmark. Both complementary and supplementary segments of private insurance have witnessed growth.

Tax relief for supplementary insurance contributed to this growth. The insurance market is dominated by the non-profit insurer 'Danmark'.

Insurance Type	Role/Coverage	Population Covered	
		2006	2016
Supplementary	To get faster access to services in reaction to high perceived or actual waiting times	565,000	2,000,000
Complementary	To cover certain co-payments or cost of services not covered by the publicly funded package of care. This includes prescription medicines, dental, psychological and physiotherapy services, and prescription glasses	1,856,072	2,411,000

Regulation

The Danish Health Authority is responsible for defining the operational framework of the health services. It provides recommendations, guidelines and action plans to regional and municipal health authorities, which are responsible for service planning and delivery. The Danish Health Authority also develops clinical guidelines to harmonise patient pathways and improve the quality of treatments delivered by all providers.

The Danish Institute of Quality and Accreditation is the main regulator of healthcare services. Its role is to implement the Danish Health Care Quality Programme through the development of accreditation standards and the promotion continuous quality improvement. There are specific accreditation standards for private providers, which describe how day-to-day operations underpin quality. Inspections are carried out every three years. There are also plans to develop new accreditation standards for dental providers.

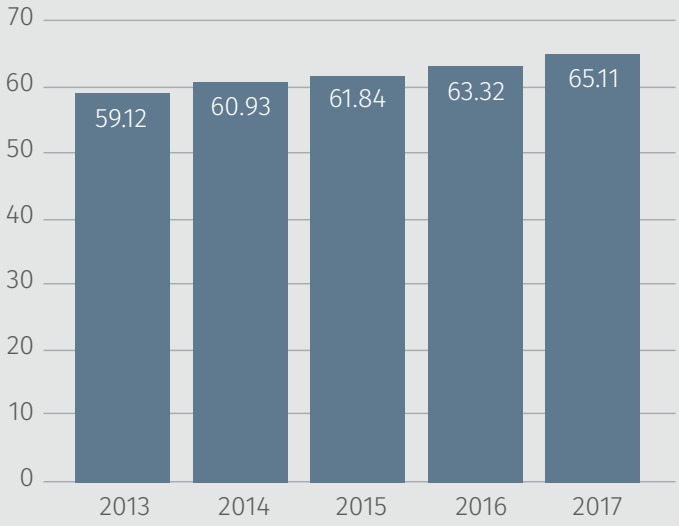
Social Care

Funding

Social care funding is primarily public and comes from local taxation, levied by municipalities. In addition, central government assigns grants through a national fund, which aims to improve living conditions for disadvantaged groups. In 2017, public funding for social care was estimated to be DKK65.11bn. It was spent on services for adults with a physical or learning disability and older people's services. In addition, in the 2016 National Budget, central government allocated nearly DKK300m to be spent between 2016 to 2019 on preventative healthcare service for older adults with complex care needs. A similar amount of funding will be available in 2020.

Public Social Care Expenditure (DKK, bn)

Source: OECD, Eurostat, Marwood Analysis



Payment System

Homecare providers are paid by municipalities. Depending on the type of services provided, individual co-payments may also be required. Municipalities cover the full cost of help with cleaning, laundering, bathing and shaving, when these services are provided on the long-term. However, there is a co-payment system for food provision and the cost varies across municipalities. In addition, individuals receiving temporary homecare services may have to contribute towards the cost of their care, depending on their income.

Care home providers are paid by both municipalities and clients. Individual contribution towards the cost of food and private expenses are means tested against their income and available savings. However, the cost of nursing and healthcare services is paid for by municipalities.

Provider Landscape

Social care services for older adults include homecare support with activities of daily living, medical homecare and nursing homes. The majority of these services are provided directly by the municipalities. However, municipalities are legally obliged to open the social care services market to private providers in order to offer alternative options to users. As a result, there is a small private nursing home market, providing 10% of the total capacity.

Most people receive services in their own home. In 2016, 67,821 people aged over 65 were residents in nursing homes and specialised accommodation for older adults and another 146,214 received homecare services.

Regulation

The Danish Institute of Quality and Accreditation is the main regulator of social care services. In addition, in 2012, the Centre for Quality Improvement developed a quality model for social services in response to the growing focus on quality improvement in this sector. The model is made of 12 standards that apply to all social care providers. They include service user involvement, development of individual care plans, medical treatment, use of force, response to unexpected events, health and wellbeing, and prevention of abuse. The model integrates staff and user feedback in quality monitoring.

Provider participation in the model and adherence to its standards is not mandatory. However, the quality model for social services has become a reference for the sector and serves as the basis for regional quality guideline development.

Political Environment

With a multi-party structure, 13 parties are currently represented in parliament. No party has an absolute majority. The current government is a coalition of the Liberal Party, the Liberal Alliance and the Conservative People's Party. The Government has the support of the right-wing Danish People's Party. General elections are held every four years. The next general election is due to take place in June 2019. Polls currently suggest that the centre-left Social Democrats are in the lead. However, it is likely they will need to form a coalition with other parties in order to govern.

Composition of Parliament

Government

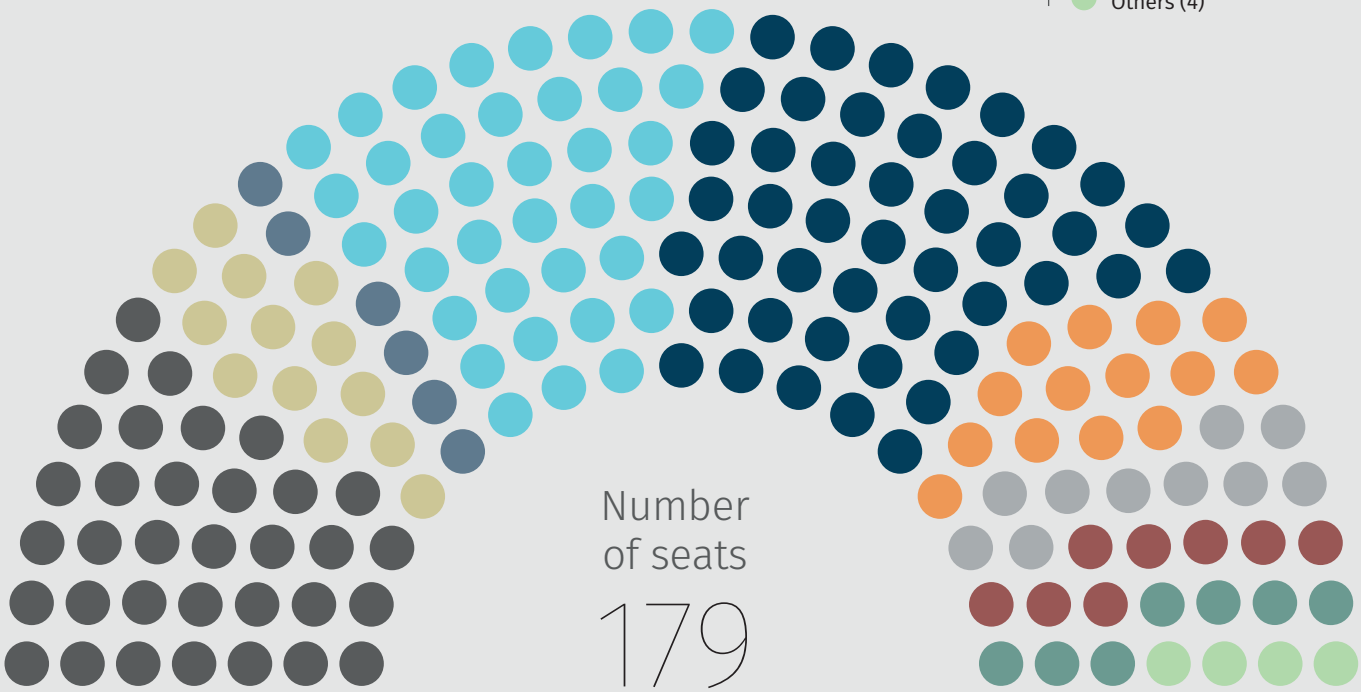
- Liberal Party (34)
- Liberal Alliance (13)
- Conservative People's Party (6)

Supporting Government

- Danish People's Party (37)

Opposition

- Social Democrats (46)
- Red-Green Alliance (14)
- Alternative (10)
- Social Liberal Party (8)
- Socialist People's Party (7)
- Others (4)

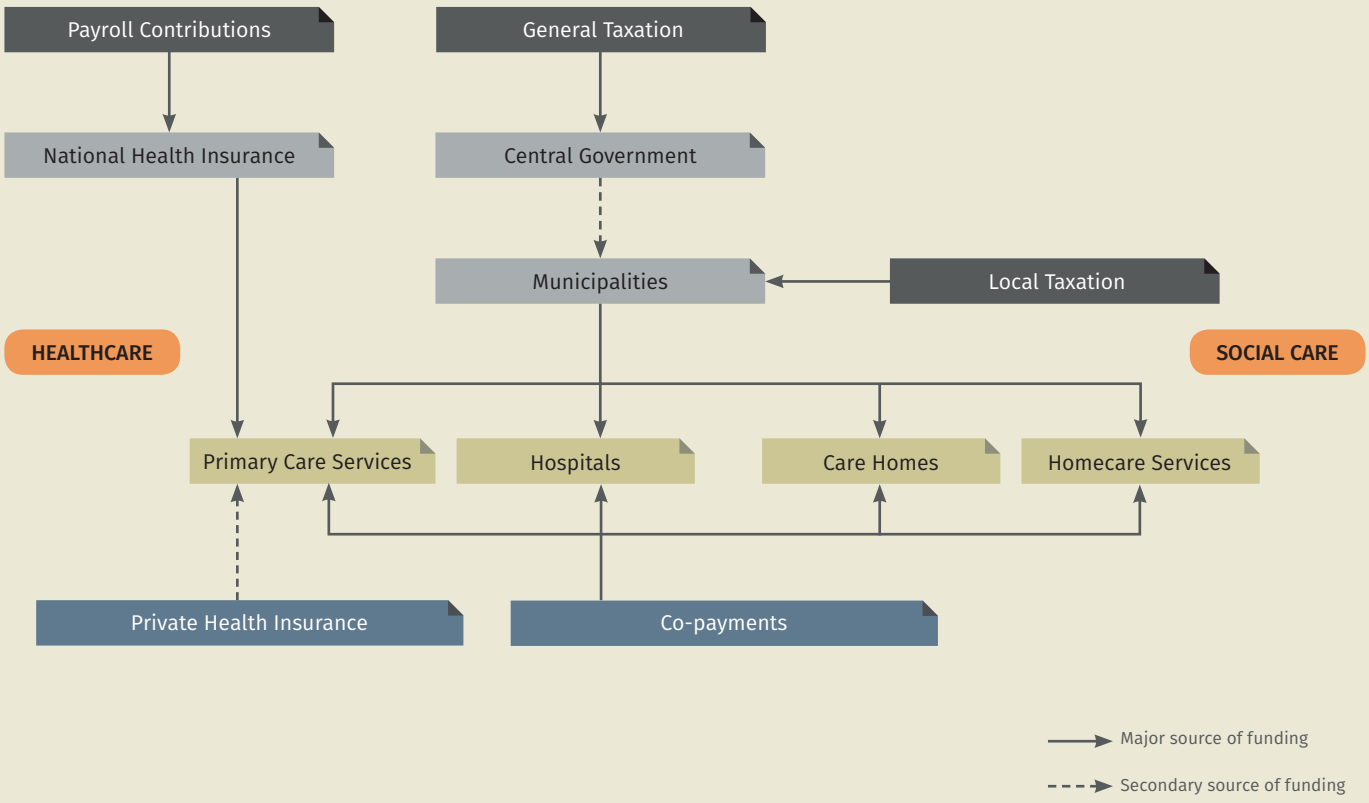


Finland

Key Messages

- Finland's health and social care system has a highly decentralised structure. Key funding and service organisation decisions affecting providers are taken by over 300 municipalities at the local level
- The Government was engaged in a comprehensive reform of the health and care system, which would address the current fragmentation in decision-making. However, the reform has failed. Its future will depend on the outcome of the April 2019 general election
- The reform currently includes opening primary care services to competition from the private sector, but these proposals have gathered significant political opposition
- Health and social care services are primarily provided by municipalities themselves. However, there is a small private sector that provides hospitals and homecare services

Funding Flows



Population

Total

5.5m

Source: Federal Institute for Stats

Life Expectancy

81.5 years

Source: OECD

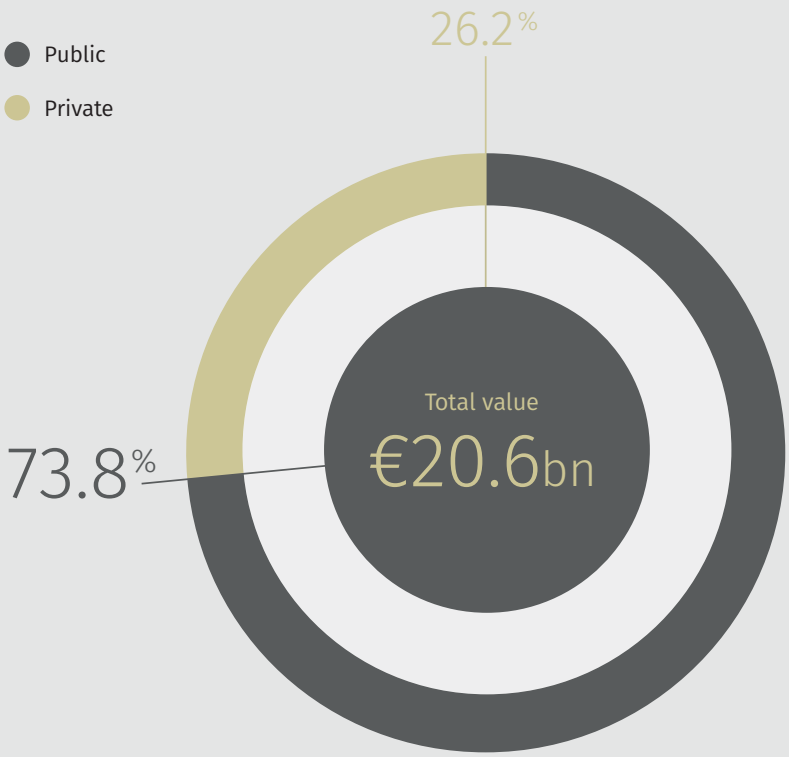
Population Distribution (%)

- 27.7% are aged between 0 and 24
- 51.4% are aged between 25 and 64
- 20.9% are aged over 65

Source: Eurostat

Healthcare Expenditure

Source: OECD



Policy Snapshot: Health and Politics

Health and social care reforms failed ahead of 2019 general election

The Government launched a comprehensive health and social care reform programme in 2015, with the objective to integrate primary, secondary and social care services. This would be funded through a single budget. Proposals included introducing competition between public and private providers in primary and social care, with users choosing freely among services offered.

Health and social care providers would operate in more centralised environment as the reform foresaw the creation of 18 new regional governance structures to replace the current fragmentation of decision-making by 311 municipalities.

However, the reform has failed and led to the collapse of the Government on 8 March 2019. Draft legislation attracted significant opposition in parliament. Despite making a number of amendments, there was no majority in favour of the proposals. However, there is an agreement among policy makers that the health and social care systems need to be reformed.

Therefore, the reform is expected to remain on the agenda of the next Government. It's scope and content will depend the outcome of the general election, which will take place on 14 April 2019.

Healthcare

Funding

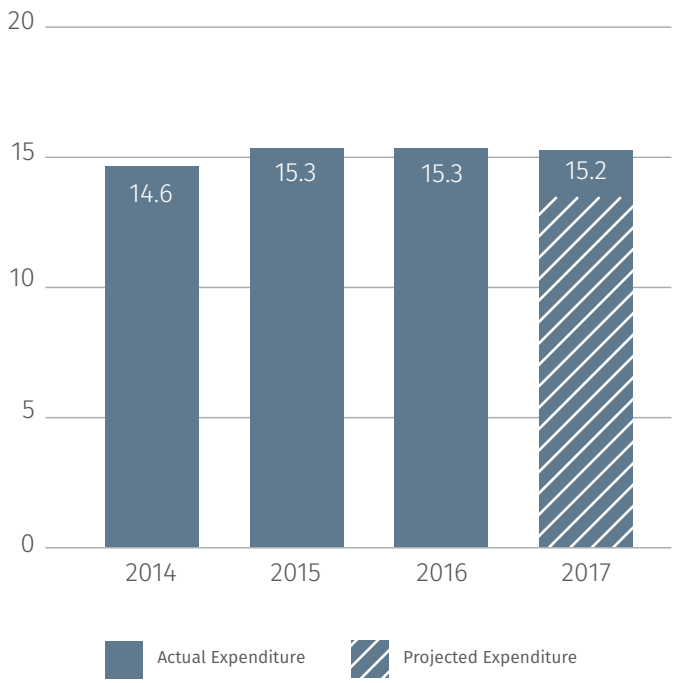
Healthcare funding is primarily public and comes from a mixture of local taxation levied by municipalities, and mandatory payroll contributions to national health insurance (NHI). In addition, central government allocates top-up funding to municipalities to level-out fiscal disparities among them. This central funding comes from general taxation revenue.

Public healthcare expenditure grew slowly between 2014 and 2017, at an average rate of 1.4% per year. In 2017, provisional figures estimate public healthcare expenditure to be €15.2bn, a 0.4% reduction on the €15.3bn spent in the previous year. The impact of this reduction has varied across service areas, with funding for primary care decreasing by 2% on average each year, whilst hospital and pharmaceutical funding increased by 3%.

The proportion of private pay as part of total healthcare expenditure has increased slightly in recent years. In 2017, it amounted to 26.2% of the total expenditure, up from 25.1% in 2014.

Public Expenditure on Healthcare (€, bn)

Source: OECD



Payment System

Healthcare services are subsidised but are not completely free at the point of use. This means that healthcare providers are exposed to payments from individuals and municipalities.

GPs are employed directly by municipalities. The payment system varies, but overall, they are paid through a combination of a basic monthly salary, user charges and capitated payments. User charges are limited to a maximum level, set by central government, which municipalities are free to lower for their local population.

Hospitals are primarily paid by municipalities via one of the 21 hospital districts. Payment mechanisms also vary, but they are generally based on price lists. Patients are required to pay co-payments for using hospital services and can reclaim some of these costs to the NHI.

The role of voluntary private health insurance in Finland

The share of voluntary private health insurance payments grew in recent years but remains marginal as it contributes to 3% of healthcare expenditure. Coverage increased by 41% between 2006 and 2016, now covering over a million people or 20% of the total population.

Given the limited growth of public healthcare funding and no planned increase of NHI reimbursement rates, demand for voluntary private health insurance is expected to continue. This could change if funding reform is agreed in the near future. However, the current government has so far failed to progress its proposed changes.

Insurance Type	Role/Coverage	Population Covered	
		2006	2016
Supplementary	To get faster access to services in reaction to high perceived or actual waiting times	819,000	1,157,000
Complementary	To cover the cost of co-payments which are not reimbursed by the NHI – e.g. prescription medicines		

Provider Landscape

The majority of healthcare service provision is public. There is a small private healthcare market, providing 3-4% of healthcare services. The most commonly-used private services in Finland include physiotherapy and dentistry. Current legislative proposals intend to increase competition between public and private providers in primary care. However, these reforms are not expected to be adopted before the next general election in April 2019.

Primary healthcare services are provided by municipal health centres. Municipal primary healthcare services offer 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 of treatment.

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. There are between six and 58 municipalities per hospital district. Patients cannot choose between hospitals and are referred in accordance with the treatment required.

Regulation

The government sets general healthcare policy objectives 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.

To operate, private providers must obtain a license from the National Supervisory Authority for Welfare and Health.

Social Care

Funding

Social care financing is highly decentralised. Financial resources come primarily from local taxation levied by municipalities. Each municipality has a degree of discretion in resource allocation. Unlike healthcare, NHI does not play a major role in social care financing.

Social care expenditure is mostly public, but individuals are expected to contribute privately towards some of the costs of their care. In 2015, the total expenditure on long term care for older people and adults with learning 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 inpatient settings.

Payment System

User access to financial support is needs and means tested, which means that providers are paid in various way by both municipalities and directly by users.

Each municipality sets its own payment system and fees to pay homecare providers. In addition, providers are also paid directly by users. This may be to cover the cost of services not covered by municipalities or because they do not qualify for public financial support under the means test.

Providers of private residential and nursing care services contracting with municipalities have some discretion in negotiating fees based on a resident's needs. Payments may come directly by municipalities, by individuals using municipality-funded care vouchers, or through out-of-pocket payments by individuals.

Provider Landscape

The majority of care home services are owned by the municipalities. However, there is increasing demand for private providers in some municipalities, which are allowed outsource service provision to private providers or authorise private care homes to accept the vouchers they subsidise. This demand is concentrated in larger, urban municipalities, whilst smaller municipalities tend to continue to provide services in-house.

Adult social care services and are organised by municipalities. 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.

Regulation

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

Municipalities are responsible for providing and organising social care services, but can outsource part or all of the provision to external providers. In order to provide social care services, these providers must obtain a licence from the municipality.

The National Supervisory Authority for Welfare and Health and the Regional State Administrative Agencies are responsible for supervising social care services. Central government has introduced initiatives to improve the quality and capacity of homecare services. In addition, there are minimum staffing requirements for residential and nursing home providers; the staff-patient ratio should be 0.5 staff per patient.

Political Environment

Nine parties are currently represented in the Finnish parliament. No party has an absolute majority. The Centre Party, which won the largest number of seats, governed in coalition with two other centre-right parties, the National Coalition Party and Blue Reform. This government is led by Prime Minister Juha Sipilä.

The government collapsed on 8 March 2019 after it failed to pass its healthcare reform. The Prime Minister remains in post as the head of a 'care-taker' government, until the next general election.

The next general election will take place on 14 April 2019. The centre-left Social Democratic party has been leading in the polls since May 2018, followed closely by the National Coalition Party. It is not expected that any party will win a majority of seats and a coalition government is likely to be set-up following a period of negotiations.

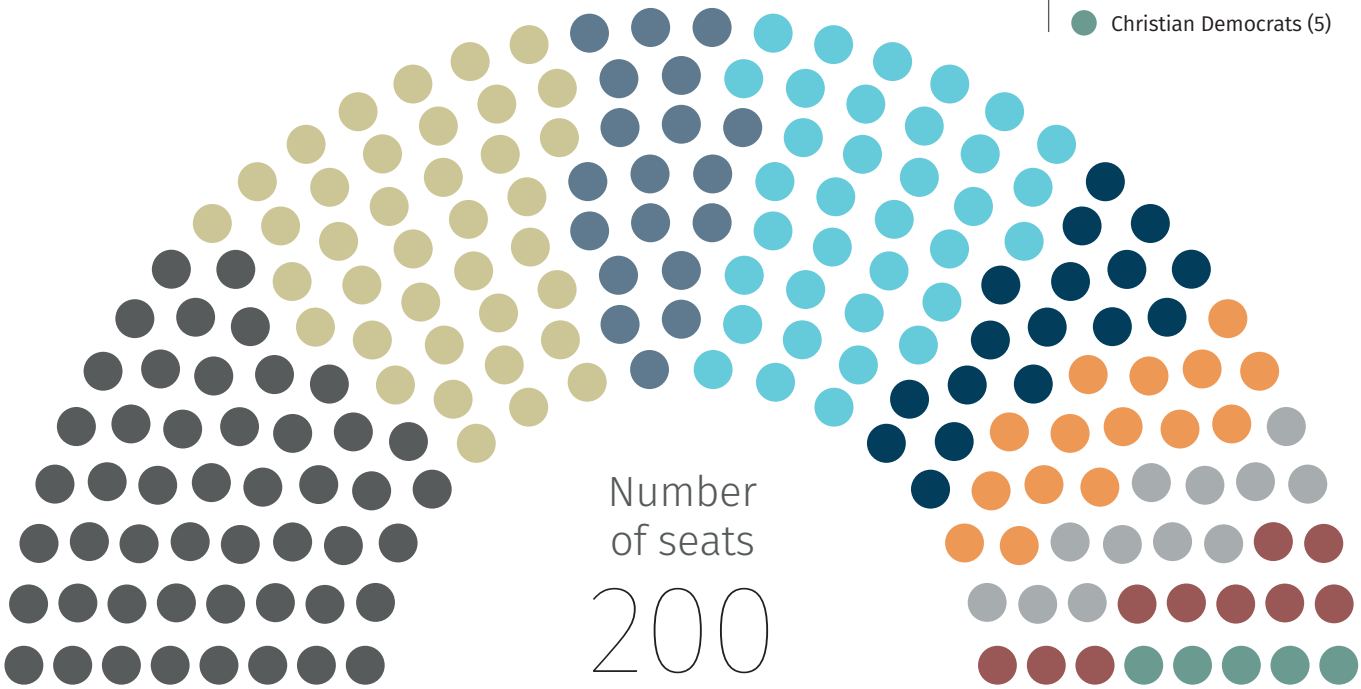
Composition of Parliament

Government

- Centre Party (49)
- National Coalition Party (38)
- Blue Reform (19)

Opposition

- Social Democratic Party (35)
- Finns Party (17)
- Green League (15)
- Left Alliance (12)
- Swedish People's Party (10)
- Christian Democrats (5)



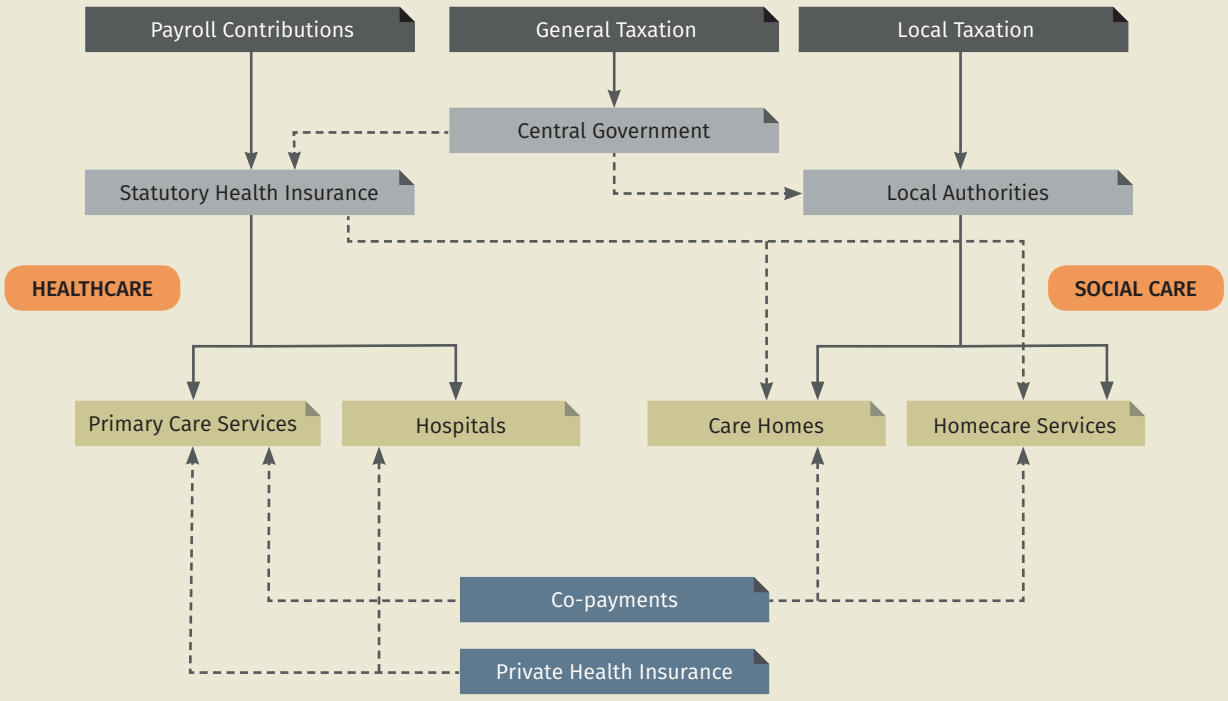
Composition of Parliament prior to the collapse of Government on 8 March 2019

France

Key Messages

- The Government launched a wide-ranging reform of the healthcare system in Autumn 2018, supported by €3.4bn additional funding between 2019 and 2022
- The reform is expected to increase demand for preventative services and shift more service provision outside of hospital. This includes mental health services, where there is substantial private inpatient provision
- Implementation will be driven at the regional level, taking account of local needs. This means that providers operating across several locations may be subject to different interpretations of national policy
- A reform of social care is expected later this year. Its scope and ambition are unclear, but the policy announcement is expected to address funding, service availability, and quality
- Additional reforms of health and social care could emerge following the outcome of a national consultation aiming to reset priorities for reform. This is an attempt to address recent protests by the general public

Funding Flows



Population

Total

67.2m

Source: Federal Institute for Stats

Life Expectancy

82.4 years

Source: OECD

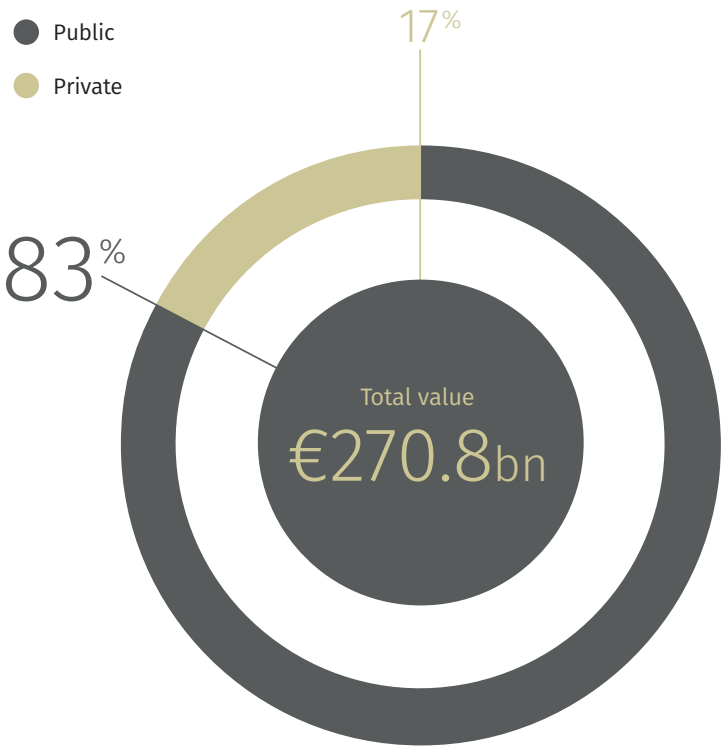
Population Distribution (%)

- 30.2% are aged between 0 and 24
- 50.6% are aged between 25 and 64
- 19.2% are aged over 65

Source: Eurostat (2018)

Healthcare Expenditure

Source: Eurostat (2018)



Social Care Expenditure (public)

Source: Ministry for Local Communities

€24.7bn

Policy Snapshot: National Health Strategy and Transformation

A comprehensive reform of the healthcare system intended to strengthen prevention, out of hospital care, and mental health services

With the publication of the national health strategy and the healthcare system transformation plan, the government presented its vision for the future of the healthcare system. The extent of the reform is comprehensive. It includes strengthening prevention services, providing more services outside of hospital, including urgent care, and creating primary care networks. The government allocated a total of €3.4bn additional funding between 2019 and 2022 to support the reform.

A new mental health roadmap reflects these priorities. Mental health has not previously been a major policy focus. The roadmap aims to address the growing demand for support from common mental health problems to severe psychiatric conditions. Regional health agencies are developing plans to ensure that the full range of mental health services can be accessed in their area. These plans should be implemented by 2020.

There is a focus on expanding services available outside of hospital and preventing inpatient admissions. There are also commitments to safeguard mental health budgets and to address regional spending variations. In 2016, a total of €19.8bn was spent on mental health services, with nearly 50% spent on inpatient services. Whilst there is no spending reduction target, the share of the inpatient sector in the total mental health spending will likely reduce over time, as more resources are invested in community-based services.

Some of these measures are directly implementable. Others, like the reorganisation of community hospitals and lifting caps on doctor training numbers, require changes to primary legislation. A Bill was introduced in February 2019. The Government's objective is to legislate by Summer 2019.

Healthcare

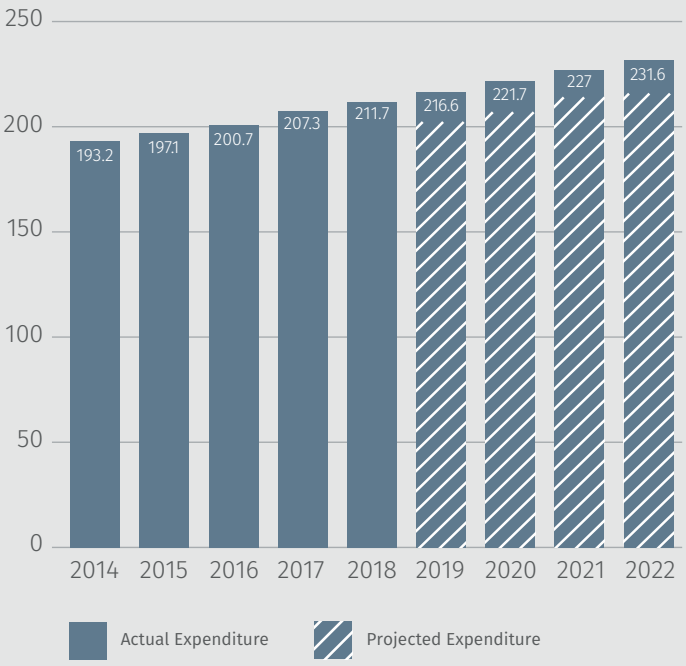
Funding

Healthcare funding is primarily public and comes from mandatory payroll contributions to the Statutory Health Insurance (SHI). Increasingly this is topped-up by general taxation revenue allocated by central government.

The SHI expenditure limits are set on an annual basis by parliament. Expenditure has been growing at an average annual rate of 2.3% between 2014 and 2018. The Social Security Funding Act 2018 stipulated that annual average growth will remain capped to a maximum of 2.3% per annum between 2018 and 2022. The announcement of an additional €3.4bn funding between 2019 and 2022 is expected come on top of baseline increases.

SHI Expenditure (€, bn)

Social Security Funding Act 2018, Ministry of Health, Marwood Analysis



Payment System

Reimbursement rates to providers are set nationally by the Ministry of Health and the SHI, in negotiation with the National Union of Health Professionals.

However, provider reimbursement is complex. Whilst the SHI ultimately covers the majority of healthcare costs, individuals may be required to pay for services before claiming these expenses back from the SHI and their complementary private health insurance (PHI). There are also differences between primary care and hospital reimbursement mechanisms.

In primary care, GPs are paid directly by patients, who then claim the expense back from the SHI and complementary PHI. The current price of a visit is €25, of which €1 cannot be claimed back. In addition, the SHI makes direct capitated payments GPs for the management of chronically-ill patients.

Hospitals are paid directly by the SHI based on a Diagnosis Related Group (DRG) system. In recent years, new payment mechanisms have been developed, including payment for performance and activity-based payments. There are limited patient co-payments for the cost of food and accommodation.

The role of voluntary private health insurance in France

As SHI does not cover all healthcare costs, individuals are strongly encouraged to subscribe to complementary private health insurance, which covers eligible remaining costs, such as GP or specialist visit. The tariffs for these costs are set nationally. Over 95% of the population is now covered. This is a result of reforms requiring all employers to purchase complementary health insurance for their employees and cover at least 50% of the costs.

Complementary insurance plans may also offer supplementary insurance, covering for example upgrading to a single hospital room. Some plans also cover services that are not covered by the SHI, like osteopathy or some vaccines. Overall, voluntary private health insurance does not provide faster access to services.

Provider Landscape

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. They increasingly work in primary health centres with other healthcare professionals. In 2018, there were 1,100 primary health centres, covering 2.8m patients. Another 300 centres are planned.

Secondary care services are primarily delivered by public hospitals complemented by private clinics. 45% of hospitals are public, 32% are for-profit and 23% non-profit (the main providers of cancer treatment) make up the remainder. Private for-profit hospitals are found in greater numbers around Paris, the Loire Valley, the South East and Corsica.

Regulation

Healthcare services and products are regulated by the Health Authority. In order to operate, public and private healthcare providers must obtain a certification from the Health Authority. There are different certifications procedures for hospitals and for primary care services. Hospitals are re-evaluated every four to six years, while primary care professionals benefit from a lighter certification process.

The Health Authority is currently reviewing its certification procedure. A new system is expected to be in place by 2020, and will increase the focus on:

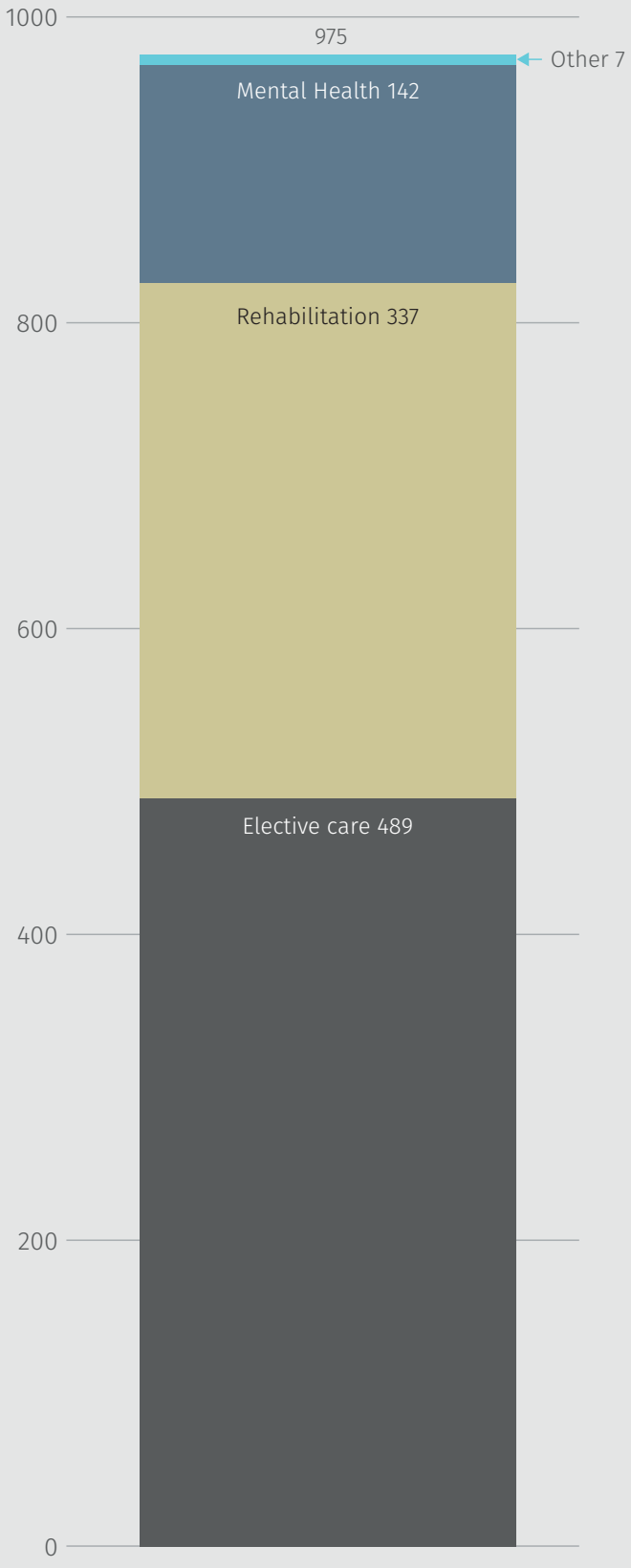
- Clinical outcomes
- Quality standards
- Patient-centred care

The new certification process will apply to both public and private hospitals.

Recent legislative changes have sought to improve the quality of care, patient rights and safety. In addition, the Healthcare Transformation Strategy opened a consultation on the development of indicators to evaluate the quality of pathways for common diseases, such as diabetes. The Health Authority is currently working on this, with introduction of indicators expected in 2019.

Private Hospital by Service Type

Source: Ministry of Health



Funding

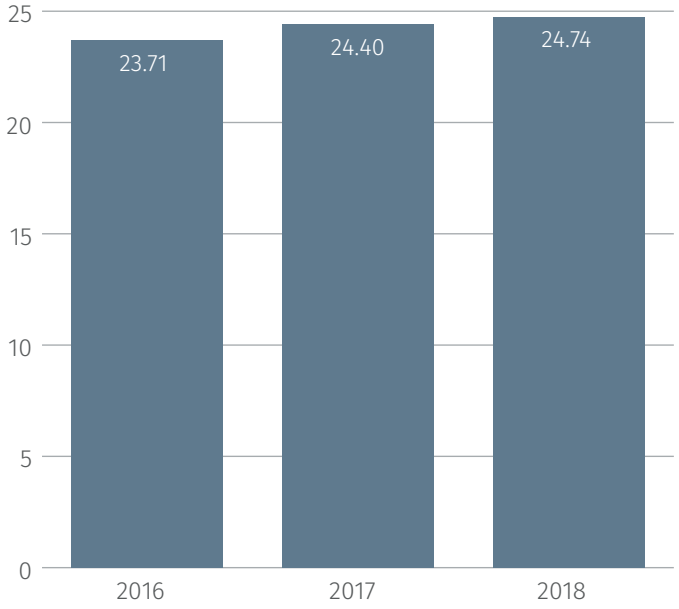
Public funding for social care services relies on a complex mix of local and national revenue sources. The responsibility for funding social care services lies with local authorities. Local authorities allocate social care resources within their wider budgets, alongside other local services.

In 2018, the total budget of local authorities was €69.1bn, of which €24.7bn was dedicated to funding social services for children, adults and older people. 65% of local authority budgets come from local taxation. Other sources of local authority funding include central funding, and some SHI funding.

In recent years, central government has allocated additional funding to social care on an ad-hoc basis. This funding is primarily directed at supporting care homes. For example, in 2019, care homes will be able to access an additional €300m, mainly to help recruit more staff. There will also be €100m per year between 2019 and 2022 to finance care home renovations. Additional measures are expected to be announced later in 2019, and should address long-term funding, prevention, expanding homecare provision, and quality improvement.

Social Care Budget (€, bn)

Source: Ministry for Local Communities



Payment System

Social care payments are split across public and private sources. Providers receive payments from both public and private sources as individuals are expected to contribute towards the cost of their care. The local authorities are the main public payer. Care home prices are calculated on the basis of two elements:

- Dependency tariff: in 2017, the median tariff varied between €5.47 and €20.35 per day. It covers the costs of support with activities of daily living in a care home. This tariff is set by local authorities and applies to all care home beds
- Accommodation and board tariff: in 2017, the median rate was €59.44 per day. This tariff is negotiated between local authorities and providers and apply to beds commissioned by local authorities. Tariffs for private beds can be set freely by providers

In addition, the SHI pays for the cost of medical care delivered in care homes.

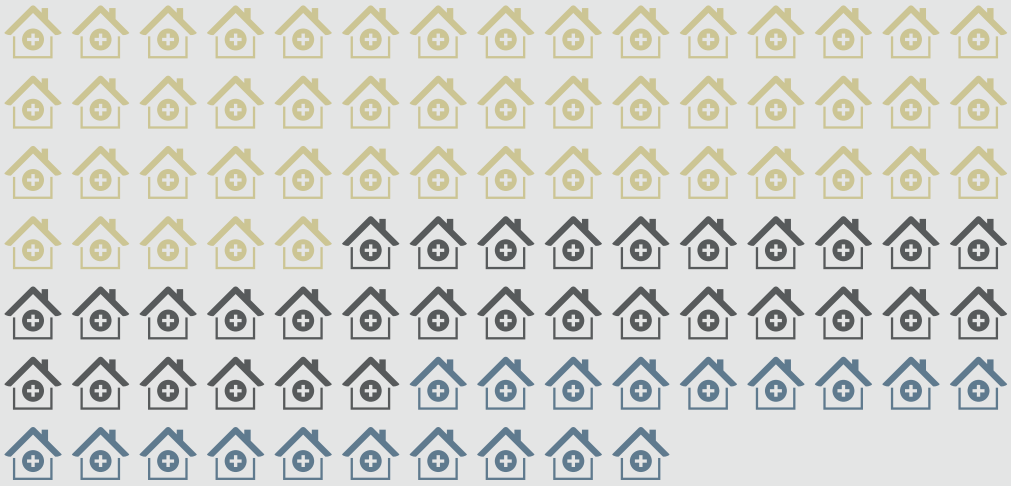
Local authority payments for support with activities of daily living services delivered at home can be made to individuals, who then purchase services from their chosen provider, or directly to providers. The amount paid by local authorities is needs and means-tested, with individuals expected to make co-payments when monthly income exceeds €810,96. For services commissioned by local authorities, tariffs are agreed with each individual provider. Nursing care services delivered at home are paid by the SHI.

Provider Landscape

Social care services are delivered by a mix of public and private providers. Historically, providers were mostly public. Legislative changes have enabled more private provision, and the number of private providers is increasing.

Homecare services include support for activities of daily living, medical homecare, or a mix of both. In 2016, there were 34,902 providers of homecare services.

Care homes include residential homes and nursing homes. There are also day-care and short-term rehabilitation services, which can be used to step down from hospital care. In 2015, there were 10,005 care homes for older people. 7,400 of them were nursing homes, providing medical services for older people who are dependent. The majority of providers are publicly owned or not for profit.



Care Home Ownership

- Public (4,958)
- Private non-profit (3,124)
- Private for profit (1,923)

Source: Ministry of Health

Regulation

Since 01 April 2018, the Health Authority is responsible for regulating social care services. Regulation has been the responsibility of the National Agency for the Quality Assessment of Health and Social Care Organisations, which has now merged with the Health Authority.

The Health Authority is currently developing a common evaluation reference document for all providers. This is intended to harmonise evaluation processes and providers will be able to use the reference document as a template instead of having to develop their own systems. The Health Authority is also working on developing new best practice guidelines and setting-up a range of indicators to measure user satisfaction with social care services.

There are currently no planned changes to the way providers that contract with local authorities are evaluated. Evaluations will continue to be carried out internally by social care providers and externally by accredited inspection bodies. Most provider authorisations are granted for five years.

Political Environment

The current president, Emmanuel Macron was elected in May 2017. His government, led by Prime Minister Edouard Philippe, has the support of his centrist party, Republic on the Move, in the National Assembly. This facilitates the passing of legislation.

However, the wave of public protests that started in November 2018 shook-up the political agenda, with draft legislation on transport and local administration re-organisation put on hold. Initially targeting the rising cost of living and fiscal policy, protests have expanded to cover nearly all policy areas. In response, the President launched a national consultation in January 2019 to identify French people's concerns and how future reforms should address them. The outcome is expected in April 2019 and will reset reform trajectory. This could include measures to promote equitable access to public services, in particular local health and social care services.

The president and members of the National Assembly are elected every five years. The next elections are due to take place in Spring 2022.

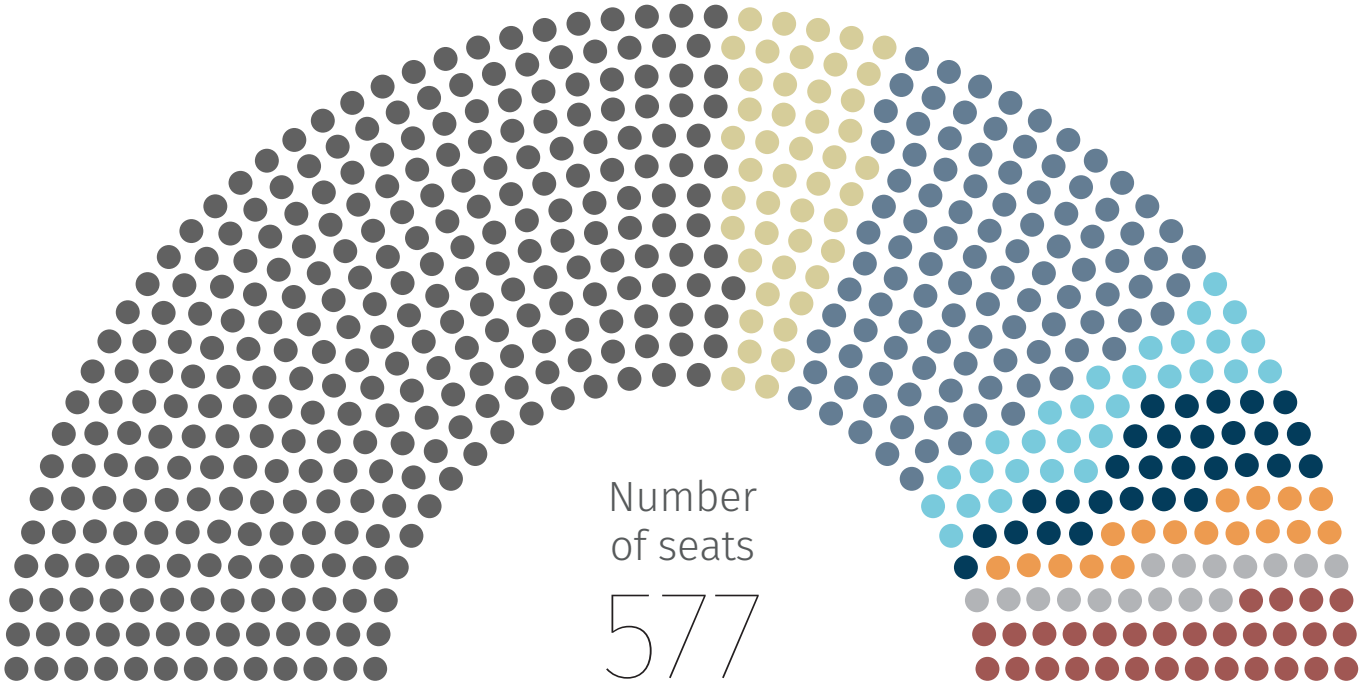
Composition of Parliament

Government

- Republic on the Move (306)
- Modem (46)

Opposition

- Republicans (104)
- Independents (29)
- Socialists (29)
- France Insoumise (17)
- Democratic and Republican Left (16)
- Others (30)

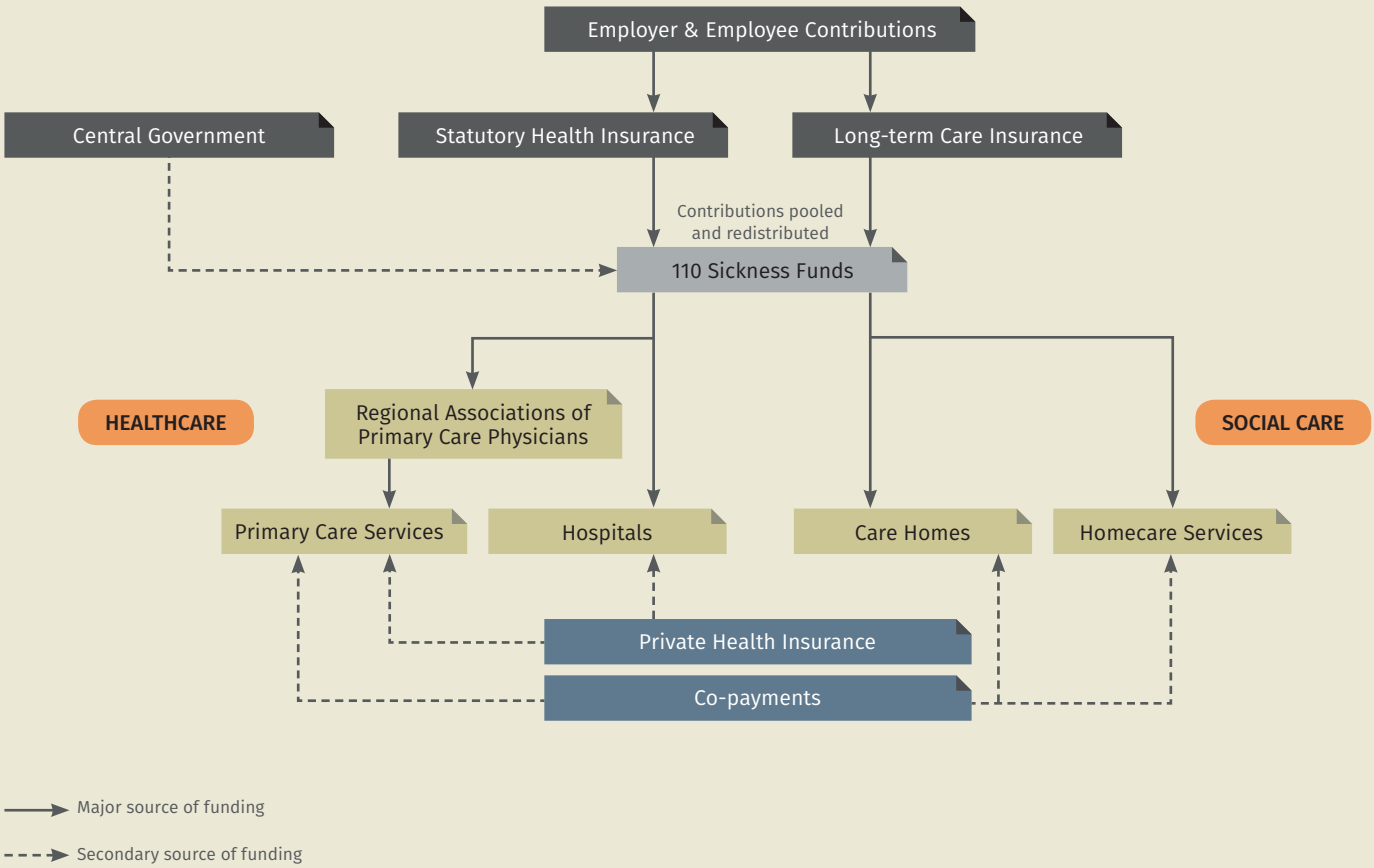


Germany

Key Messages

- Reform of social care funding and access to publicly-funded services continue to drive changes to the health and social care landscape
- The number of people accessing publicly-funded social care services is increasing, creating additional demand for homecare and care home services, two areas where private operators dominate provision
- The next stage of social care reform will focus on attracting, training and retaining health and social care staff, to address the growing demand for services
- This national policy is implemented at the regional level, with Länder having discretionary legislative and regulatory powers to introduce their own operational requirements
- Regulatory measures are being introduced to support patient choice by improving transparency and quality of information in social care

Funding Flows



Key Facts and Figures

Population

Total

82.8m

Source: Federal Institute for Stats

Life Expectancy

81.8 years

Source: OECD

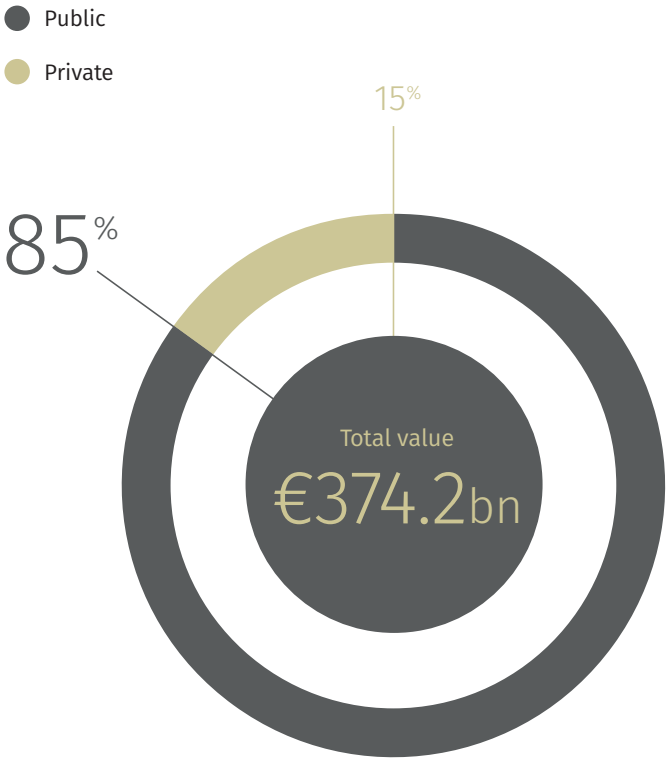
Population Distribution (%)

- 24% are aged between 0 and 24
- 55% are aged between 25 and 64
- 21% are aged over 65

Source: Eurostat

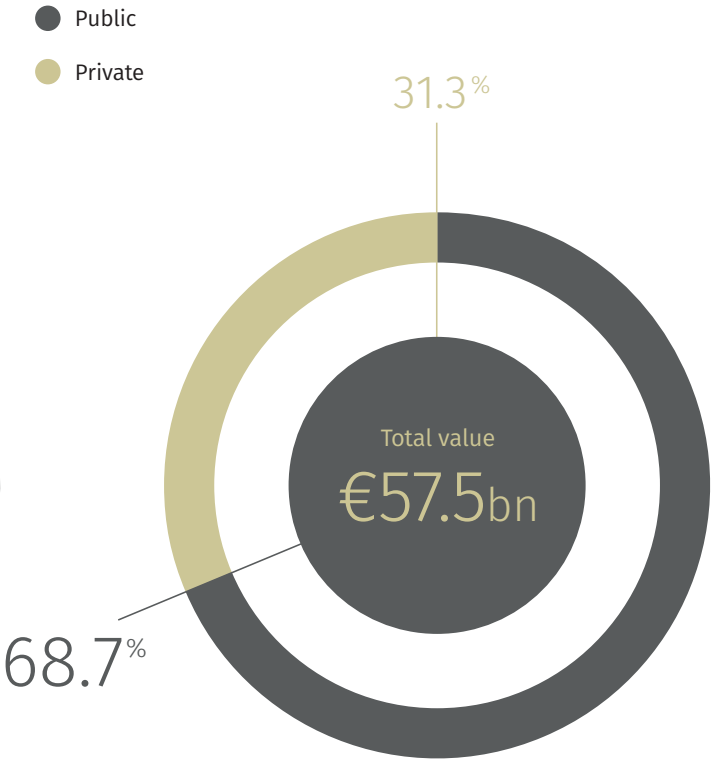
Healthcare Expenditure

Source: OECD



Social Care Expenditure

Source: Federal Office for Statistics, Federal Health Reporting Service, Marwood Analysis



Policy Snapshot: Long-term Care Insurance

Long-term care insurance reform continues to dominate the political and policy agenda

Since 2015, the German government has focused on reforming the long-term care system (i.e. services for older people) to address growing demand for services. Long-term care is expected to remain a priority over the next few years, with focus shifting from legislative changes to implementation. This will be driven by the Länder (regions).

A total of five acts addressing various aspects of long-term care were passed between 2015 and 2017 and constitute the biggest reform of the German long-term care insurance since its inception in 1995. There are three key elements to the reform:

- Funding: payroll contributions increased from 2.05% to 2.35% in 2015, and to 2.55% in 2017 (those without children pay 2.8%)
- Access to services: eligibility for LTCI funding was widened, with a new assessment system introduced from January 2017. The objective was to expand assessment criteria to take into account the needs of those affected by dementia. As a result, the number of recipients of LTCI funding increased from 2.7m to 3.3m between December 2016 and December 2017
- Workforce: as demand for long-term care services is set to grow, the current phase of the reform is focused on attracting, training and retaining the appropriate workforce. This is likely to include salary increases and a common curriculum for both health and social care nurses. From 2019, minimum staffing levels apply for certain hospital services, such as geriatrics. This could progressively be extended to other services for older people, including care homes.

Healthcare

Funding

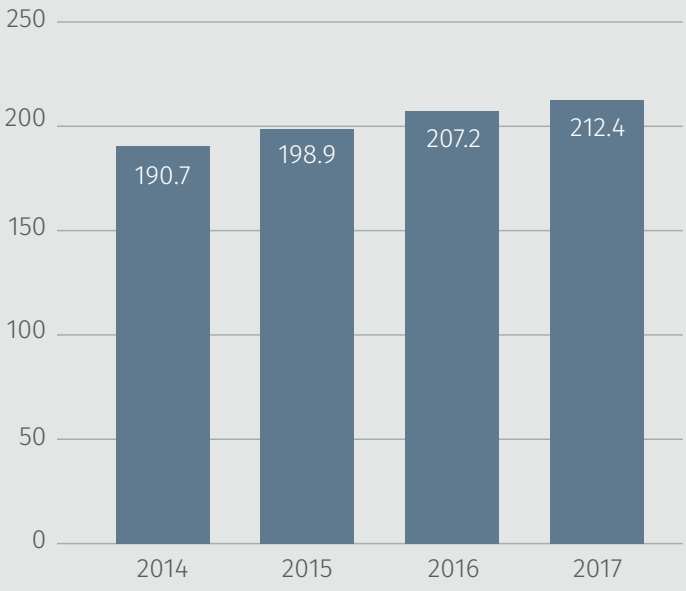
Healthcare funding is primarily public and comes from mandatory payroll contributions to the Statutory Health Insurance (SHI).

SHI expenditure grew at an average annual rate of 3.6% between 2014 and 2017, reaching €212.4bn in 2017. However, the reliance on employee and employer payroll contributions as sources of funding means that there is long-term pressure due to a shrinking working-age population relative to a growing older population. By 2030, population projections predict a ratio of two working age adults per older person. This will be a significant decrease from approximately three to one currently.

Sickness funds are not allowed to register deficits. Anticipating future funding pressure, they have built financial reserves, estimated to be worth €15.9bn across all funds at the end of 2016.

SHI Expenditure (€, bn)

Source: Federal Office for Statistics



Payment System

SHI provides generous and comprehensive coverage of healthcare services to individuals. Co-payments are only required for a few services, including dentistry or fertility treatments.

The majority of payments to providers are made by the SHI, through the sickness funds. Different payment and contracting mechanisms apply to hospital and primary care services.

In primary care, 17 regional associations of primary care physicians are responsible for contracting with and paying primary care physicians on a fee-for-service basis. Fee schedules are agreed regionally.

Hospitals are paid in two ways:

- The medical services they deliver are paid for directly by sickness funds, on the basis of a national Diagnosis-Related Group (DRG) system. There are over 1,000 DRGs updated annually. DRG payments cover all medical costs, including the cost of medicines used in hospital.
- Infrastructure costs (e.g. building refurbishment, acquisition of a MRI) are paid for by the Länder, through annual grants.

The role of voluntary private health insurance in Germany

Private health insurance is used in three ways in Germany: as a substitute to the SHI, complementary and supplementary.

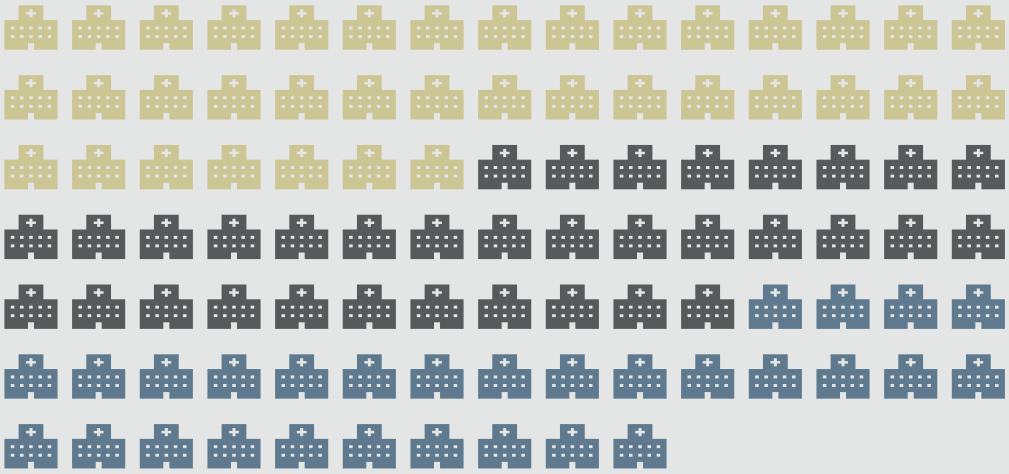
Statutory sickness funds can sell complementary and supplementary private health insurance policies to their members. The number of individuals covered by complementary and/or supplementary insurance has increased by 10.4% between 2012 and 2017, from 23.1m to 25.5m.

Insurance Type	Role/Coverage	Population Covered (2017)
Substitute	High-earners may opt-out of SHI funding and subscribe to a private health insurer of their choice. Civil servants and those who are self-employed are by default covered by private health insurance. Insurers offer a range of policies, including the option of a package of benefits that is equivalent to the SHI at a premium that may not exceed the highest contribution in the SHI.	8,753,400
Complementary	Covers co-payments for services and products that are not, or not fully covered by the SHI or substitutive insurance. This includes medical devices and some costs of hospital stay.	25,519,900
Supplementary	Covers services that are no considered as essential by the SHI. This includes tooth whitening and the majority of orthodontic treatments and the cost of upgrading to a private room in hospital.	

Provider Landscape

Primary care services are provided by independent physicians including general practitioners, dentists, pharmacies, physiotherapists, speech and language therapists, and psychotherapists. As of 2017, there were 2.2m primary care professionals, including 693,000 general practitioners. Patients are free to visit any general practitioner and can consult specialists without a referral.

Secondary care services are provided by a mix of public and private hospitals. They offer both outpatient and inpatient services, covering the whole spectrum from low acuity treatments to highly specialised medical procedures. In 2017, there were 1,942 hospitals in Germany, 720 of which were private for-profit hospitals. Doctors are generally employed and salaried by hospitals. Patients are free to choose their hospital provider.



Hospital Ownership

- 720 are for-profit
- 662 are non-profit
- 560 are public

Source: Federal Office for Statistics

Regulation

Regulation of healthcare is primarily the responsibility of the Joint Federal Committee (GBA), which is made up of representatives from the national association of sickness funds and national providers associations. The GBA determines what services are covered by sickness funds and sets quality measures for providers. It is supported by two agencies: the Institute for Quality and Transparency (IQTiG) and the Institute for Quality and Efficiency (IQWiG).

IQTiG is responsible for developing quality standards and evaluating and monitoring quality across the German healthcare system. However, in practice most oversight is focused on hospitals. Providers are expected to record a range of quality indicators and compile annual reports on their performance for the GBA. Failure to do so exposes providers to financial penalties.

IQWiG is an independent scientific institute responsible for evaluating the risks and benefits of new medical interventions, including medical procedures, drugs and medical devices. Its evaluations support the GBA's decisions to include new medical procedures to the SHI's basket of services and whether to reimburse new drugs and medical devices.

Funding

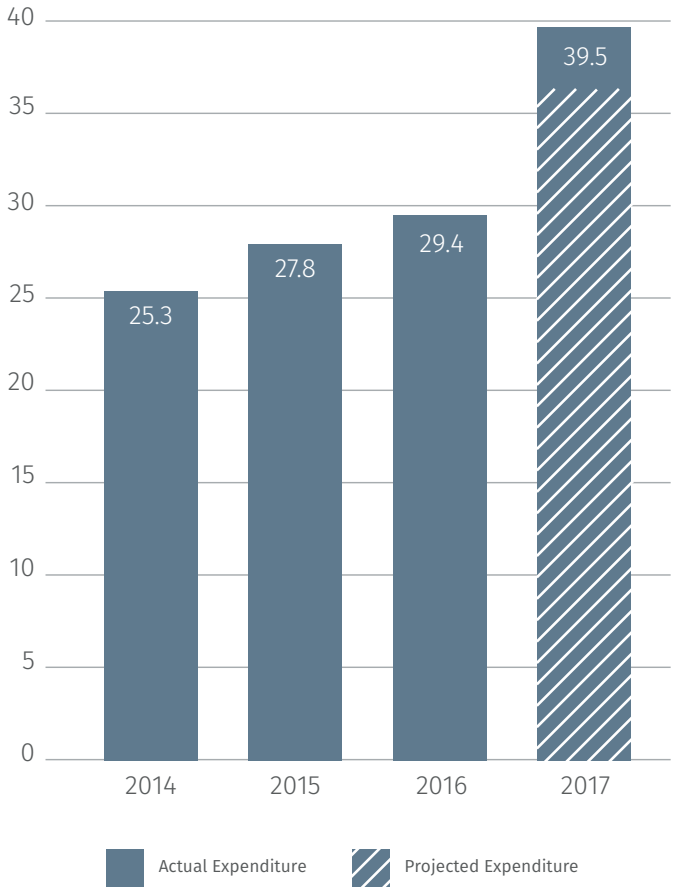
Social care funding is primarily public and comes from mandatory long-term care insurance (LTCI). However, individuals are expected to contribute towards the cost of their care as LTCI does not cover the full cost. This top-up funding comes from private co-payments or through welfare support.

LTCI funding has increased substantially since 2014. This was driven by changes to the mandatory contribution rate, which rose from 2.05% to 2.35% in 2015, and to 2.55% in 2017. Those without children pay an extra 0.25 percentage point or 2.8% since 2017. The low unemployment rate in Germany has been favourable to funding as this has increased total contributions paid by employees and employers.

LTCI is separate from the SHI and its funding is raised separately. However, LTCI is administered by the sickness funds and, similarly to healthcare, money is pooled nationally and redistributed among the funds.

LTCI Spending (€, bn)

Source: Federal Office for Statistics



Payment System

Social care providers are paid by both LTCI funds and individuals. The 110 LTCI funds pay for most care costs of individuals assessed as being in need of care by the medical service of the SHI (MdK). There are five care grades with different levels of funding. Under certain conditions, individuals may choose to receive personal budgets to purchase services directly from providers.

Homecare providers are paid on a fee for service 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.

Non-medical costs are not covered by the LTCI, which means that individuals have to pay for board and accommodation costs. Individuals may also have to contribute towards the cost of certain care services. Those who cannot afford to pay themselves may be eligible for financial support from the social welfare budget.

Provider Landscape

Social care services are provided by a mix of independent for-profit and non-profit providers operating a range of homecare and care home services. Public provision is marginal. In part, this is because federal law favours private sector providers, in order to stimulate market development.

The homecare and care home provision landscape is highly fragmented. In 2017, there were 14,050 homecare agencies and 14,480 care home locations, providing services to older people and adults with learning and physical disabilities.

Regulation

The medical service of the SHI oversees the quality of social care services and undertakes annual inspections of social care providers. Inspections of care home providers are usually unannounced, while homecare providers are normally notified the day before. Inspections intend to evaluate quality outcomes by reviewing a provider's quality records and by talking to users.

A new quality control and transparency system for care homes is due to come into force in Autumn 2019. It will integrate users' experience into inspections. Providers will continue to publish the outcome of inspections, which are expected to provide clearer quality information to users and prospective users, and support them in choosing or switching provider.

When providers care for individuals who have opted-out of the statutory LTCI, the inspection service of the Association of Private Health Insurance is responsible for overseeing the quality of services providers delivers to these individuals. Inspections are carried out in a similar way as those undertaken by the medical services of the SHI.

Political Environment

The most recent general election took place in September 2017. It saw traditional centre-right and centre-left governing parties losing several seats in Parliament to smaller and/or emerging parties. After several months of negotiations and a failed attempt at building tri-partite collation between the centre-right Christian Democratic Union/Christian Social Union (CDU/CSU), the liberal FDP and the Greens, a coalition agreement was found between the CDU/CSU and the centre-left SPD.

This coalition is fragile. Both governing parties subsequently lost seats at regional government level to the Greens and the Alternative for Germany (AfD), a right-wing, anti-immigration party. As a result, senior SPD politicians are tempted to return to the opposition, whilst the CDU is actively preparing for the post-Merkel era. This started with the election of Annegret Kramp-Karrenbauer as leader of the party. She will lead the CDU into the next general election due to take place by October 2021. Angela Merkel will remain Chancellor until then.

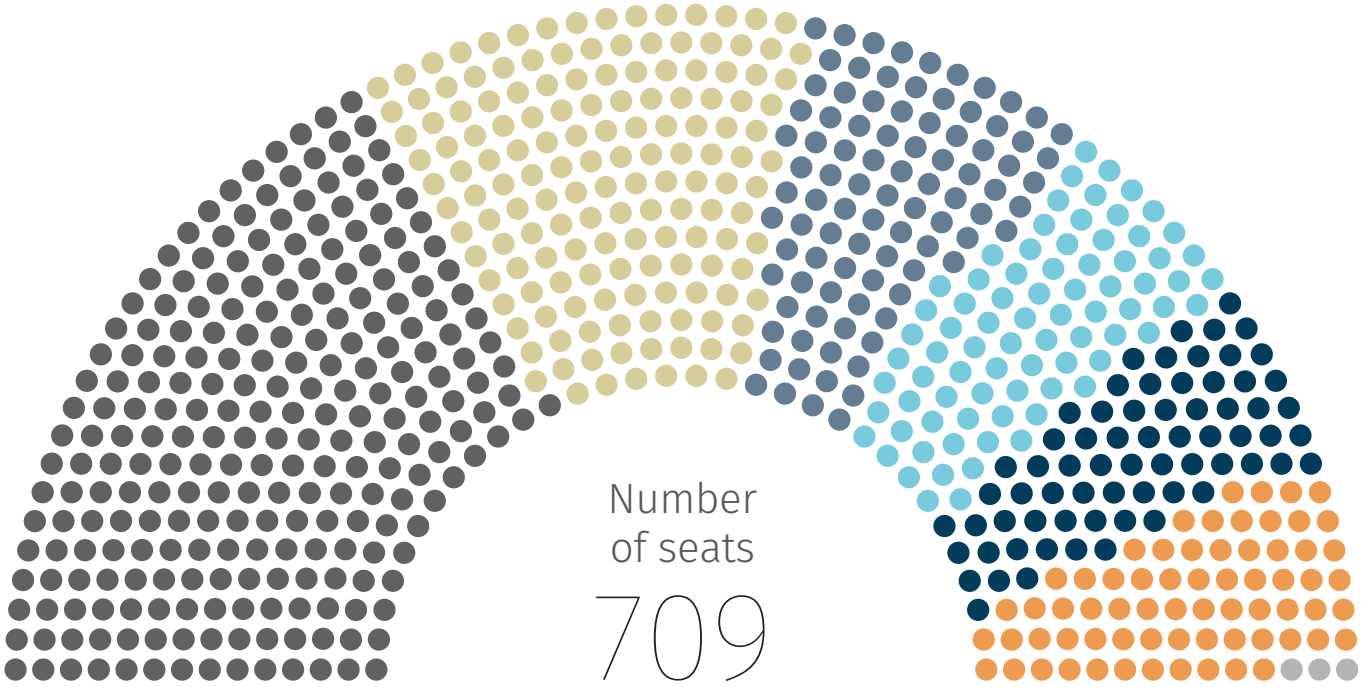
Composition of Parliament

Government

- CDU/CSU (246)
- SPD (152)

Opposition

- AfD (92)
- FDP (80)
- Die Linke (69)
- Greens (67)
- Others (3)

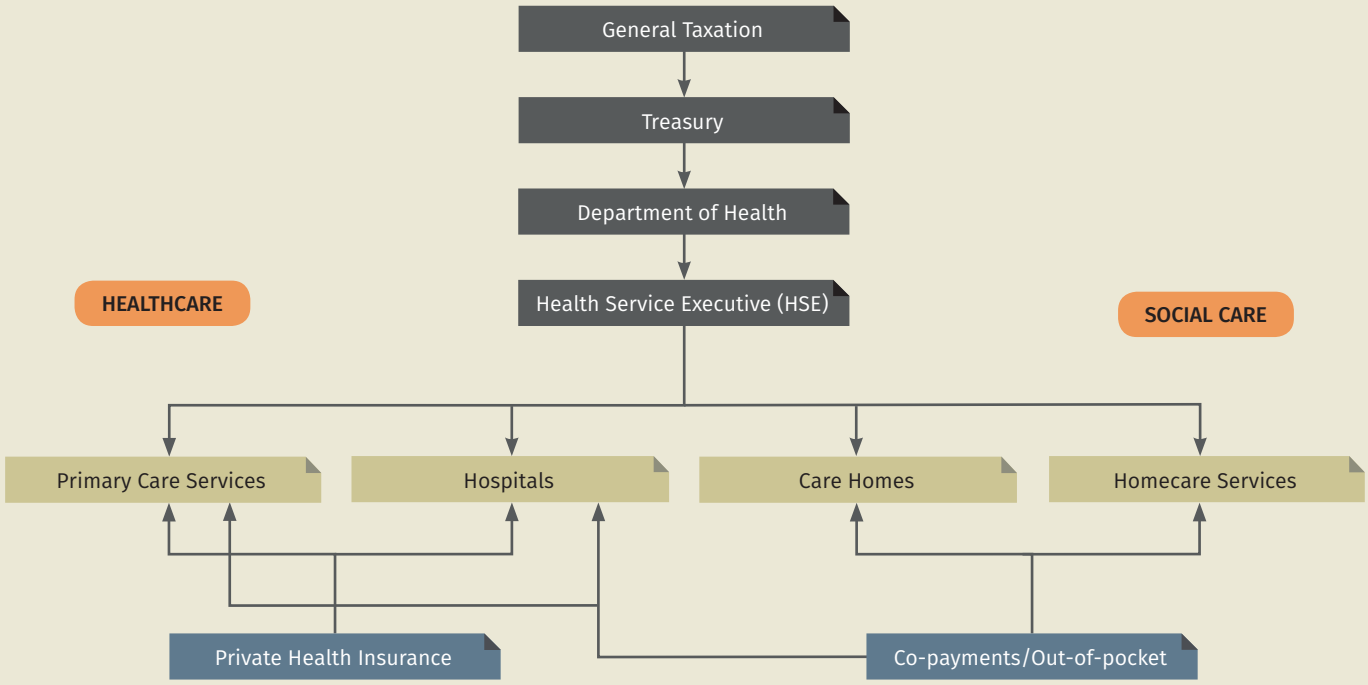


Ireland

Key Messages

- After several years of political debate, a cross-party parliamentary report was published in 2017 recommending a comprehensive reform of the health and social care systems
- The Government subsequently endorsed the recommendations, which are being implemented over the next five to ten years
- The reforms foresee significant expansion of services across all health and social care sub-sectors and are estimated to require 7% annual budget increases over the next five to ten years
- The size of expansion is particularly significant in primary care, homecare and palliative care services
- If the Treasury follows-up on funding recommendations made by the Future of Healthcare report, the health and social care budget should grow from €16.36bn in 2019 to €21.45bn in 2023

Funding Flows



→ Major source of funding

Key Facts and Figures

Population

Total

4.8m

Source: Federal Institute for Stats

Life Expectancy

81.8 years

Source: OECD

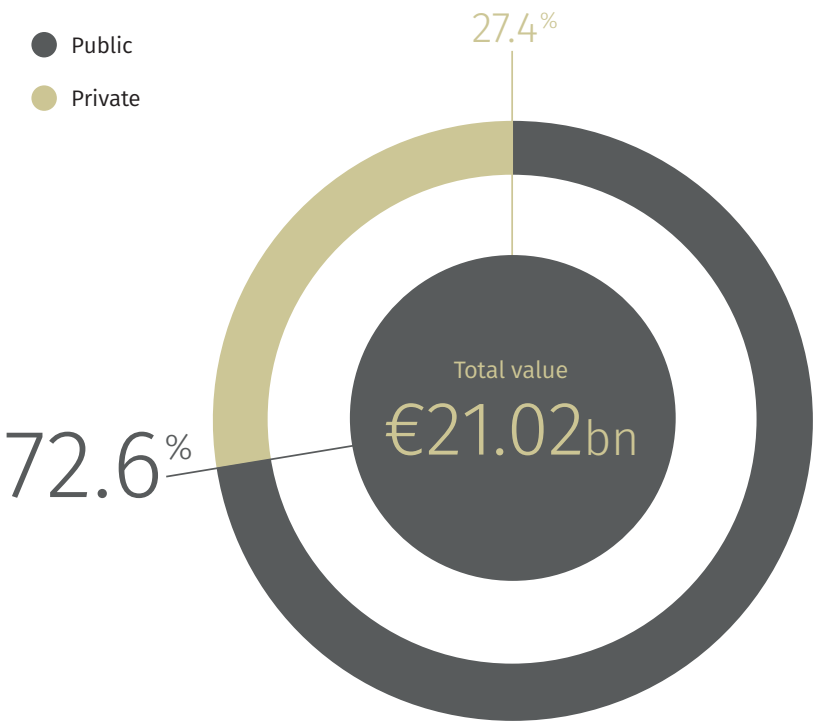
Population Distribution (%)

- 33.3% are aged between 0 and 24
- 53.2% are aged between 25 and 64
- 13.5% are aged over 65

Source: Eurostat, OECD

Healthcare Expenditure

Source: OECD



Social Care Expenditure (public)

Source: Health Service Executive, 2018

€3.54bn

Policy Snapshot: Future of Healthcare

The long march of healthcare reform in Ireland

The Irish healthcare system does not currently grant universal access to services, which is an exception in Western Europe. Attempts to change this system started in 2012. However, due to a lack of political consensus, the initially ambitious reform was halted in 2015. In 2016, a cross-party committee on the future of healthcare was formed in Parliament to overcome the deadlock and put forward consensual reforms. This led to the publication of the Future of Healthcare report in 2017. The key recommendations of the report include:

- Removing patient charges in hospitals to enable access to services that are free at the point of need
- Expanding the range of GP and primary care services, which will be free at the point of need for all
- Expanding palliative and homecare services, which will be free at the point of need for all
- Developing and improving access to mental health services

The Government accepted the recommendations of the Future of Healthcare report and has published an implementation plan. Implementation is expected to be phased over 10 years, at a cost of €2.8bn, in addition to annual baseline increases to the healthcare budget. In total, the report recommends that healthcare funding should increase by 7% annually over the next five to ten years for the reform to be fully implemented.

Healthcare

Funding

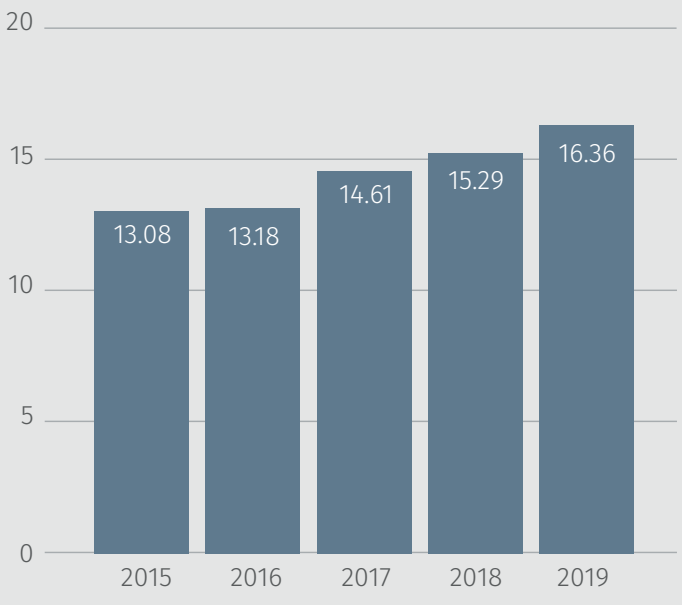
Healthcare funding is primarily public and comes from general taxation.

Since 2016, public funding for healthcare has increased significantly. This follows a period of austerity due to the impact of the global financial crisis on Ireland public finances. In 2019 alone, the healthcare budget is due to increase by 7% from €15.29bn to €16.36bn. In comparison, the healthcare budget only increased by 6.9% over four years between 2014 and 2017. Given the scale of healthcare reforms engaged, the Future of Healthcare report recommends that annual funding increases of 7% should continue over the next five to ten years. This is expected to cover the cost of the reform (€2.8bn over ten years) and growing demand for services.

The healthcare budget includes funding for social care services.

Public Healthcare Expenditure (€, bn)

Source: Irish Government



Payment System

The Health Service Executive (HSE) is the main payer of public services. However, the Irish healthcare system is unique in western Europe, as it does not provide the same basic level of service coverage to all individuals. As a result, the proportion of private expenditure is relatively high in the European context. Access to publicly-funded services is means-tested. Whilst this is being reformed, transition towards a universal system is yet to start and the expansion of access to healthcare services which are free at the point of use is expected to be phased over ten years.

The majority of hospitals are paid on an activity basis. The Future of Healthcare implementation strategy suggests that the few hospitals that have not yet moved to activity-based payments will do so by 2019. In the medium-term, the government plans to replace all payments to providers by comprehensive population-based funding models, integrating acute and primary healthcare. Hospital outpatient appointments are free of charge for all, while non-medical card holders must pay €80 per inpatient day.

GPs services are currently means-tested and only available free of charge to individuals holding medical or GP visit cards. About half of the population are eligible for either of the cards, and GPs are paid on a capitation basis for providing these services. The other half of the population has to pay the full fee-for-service. This amounts to €52 on average, as GP may set their tariff freely.

It is not possible for individuals to opt-out of the publicly-funded system. However, they are entitled to purchase private health insurance, which covers the cost of services provided by public and private providers. Individuals who do not qualify for public funding support and do not hold PHI must pay out-of-pocket to access services.

Voluntary private health insurance in Ireland

45% of the population subscribes to private health insurance, a share which has remained stable over recent years. It is primarily used to cover the cost of elective care services. It gives faster access to these services which are provided in both public and private hospitals. The healthcare reform is expected to change the role of private health insurance. As public providers will no longer be allowed to provide private health services, the use of private health insurance will be restricted to paying for private services delivered by private providers.

There are three major private insurers: Vhi (partially owned by the state), Irish Life Health (a merger of Aviva and GloHealth) and Laya Healthcare.

Provider Landscape

Currently, there is a mix of public and private providers in Ireland, delivering both public and private services. The healthcare reform intends to establish a clearer separation between providers, with public providers restricted to deliver HSE-funded services only. However, private hospitals should continue to be used for the provision of selected HSE-funded services.

GPs are self-employed and often work in individual practices. They can decide whether to provide services for HSE-funded medical and GP Visit Card holders or to treat private patients only. The majority of GPs provide a mix of public and private services. Dentists, opticians and pharmacists also work in independent practices. Multidisciplinary primary care teams are currently in development.

In secondary care, HSE provides services directly across 48 public hospitals. Several public hospitals also provide services for private patients (i.e. patients paying privately out-of-pocket or through private health insurance). However, this is expected to change in the medium-term, as a key recommendation of the Future of Healthcare cross-party report is to end the provision of private services by public hospitals. An Independent Review Group was set-up in December 2017 to provide views on how to implement this change. The final report was expected by end of 2018, but has been delayed – suggesting this might be complex to implement in practice.

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. There are 18 acute private hospitals and three psychiatric private hospitals.

Regulation

The Health Information and Quality Authority (HIQA) is the independent quality regulator for healthcare services.

HIQA is mandated by the HSE to develop quality and safety standards, and register and inspect providers which fall under its remit. This includes hospitals and community services that are provided or funded by HSE. Private providers receiving no HSE payments are currently excluded from the scope of HIQA's regulation. However, the Patient Safety Bill introduced in July 2018 will expand HIQA's remit to private providers. The private sector is already aligned on HIQA's national standards and contribute to their development. The Patient Safety Bill also seeks to make it mandatory for all providers to disclose serious patient safety incidents.

HIQA has not developed a quality rating system. However, providers are inspected regularly and inspection reports are produced following inspection to track progress and highlight areas for improvement.

Funding

Public sources of funding for social care services come from the same budget as healthcare, which relies mostly on general taxation.

Public funding allocations to social care are made annually in the HSE's National Service Plan. The 2018 social care allocation within the HSE's financial envelope was €3.55bn, of which €1.77bn was allocated to disability services, and €1.77bn to older people's services. The 2018 social care budget represents a 4.7% increase on 2017.

Payment System

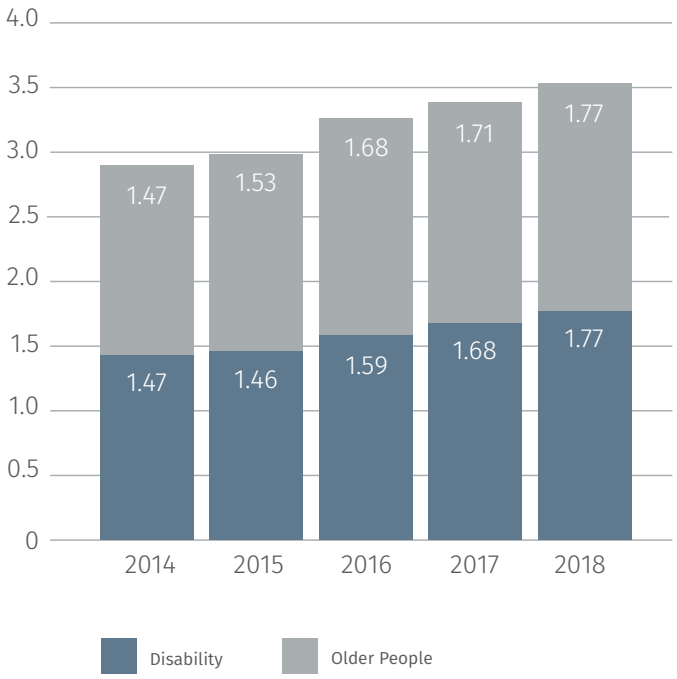
There is a mix of public and private payments in social care. Individuals are assessed through a needs-test and means-test, with varying thresholds applying to different services.

For care home services, individuals are subject to a needs-test and a means-test. The means-test takes account of an individual's income and assets to calculate how much they will contribute to their care. Individuals contribute up to 80% of their assessable income and 7.5% of the value of all assets worth over €36,000 (€72,000 for a couple). HSE pays for the remaining costs. Home and land owners may opt for a nursing home loan, to delay paying for their care until after their death, using these assets to secure the loan. Care homes that contract with HSE agree maximum weekly prices. These prices are negotiated for each provider at county level with the relevant HSE Nursing Home Office. Self-payer fees are set freely by providers and users can claim income tax relief.

Eligibility for publicly-funded homecare support is need-tested. However, unlike care home services, there is no means-test. Providers are paid on an hourly rate basis, either by HSE for eligible homecare support services or directly by individuals who may be receiving direct payments from HSE or paying out of pocket. Providers contracting with the HSE agree hourly rates as part of the tendering process.

Social Care Expenditure (€, bn)

Source: Health Service Executive



Provider Landscape

The range of social care services available in Ireland includes services for disabled working age-adults and services for older people. These services are delivered either in care homes (nursing and residential) or at home (homecare).

Care home and homecare services for older people are increasingly provided by private operators. Homecare support services are provided directly by HSE or by 32 for-profit and not-for-profit providers approved by the HSE. Services provided include nursing services, help with activities of daily living, therapy services, physiotherapy, and day and respite care. Individuals eligible for homecare support can choose any provider from the list of approved providers operating in their respective area. In 2018 there were over 50,000 people receiving homecare support.

Care home services are mainly provided by the private sector. In 2016, there were 577 nursing homes for older people registered with the HIQA, with a capacity of 30,106 beds. 75% of this capacity was provided by private for-profit operators.

Disability services are mainly provided by not-for profit operators delivering learning or physical disability services. These services include basic health services, assessments, rehabilitation, income maintenance, community care, respite care, residential care, homecare and day care.

Regulation

HIQA's mandate to regulate social care services is limited to care homes for older people and disabled people, operated by HSE or private providers. Homecare services are not currently regulated. However, as the policy focus is increasingly shifting towards supporting older people in their own home, HIQA's mandate could be expanded in the future.

Overarching national standards, apply to all care home providers. In addition, there are specific standards for care home settings for older people, as well as specific standards for care home settings for children and adults with disabilities. The type of inspections HIQA carries out on care home providers may be announced or unannounced, comprehensive or focus on a selected area.

Political Environment

The Irish government is currently led by Fine Gael (centre-right). However, Fine Gael has no majority in parliament and governs on the basis of a confidence and supply agreement with Fianna Fáil, the main centrist opposition party. The next general election has to take place before the 21 April 2021. However, there is speculation that it could be called earlier, either in 2019 or 2020.

The extensive work towards finding a cross-party agreement on healthcare reform means that a change in government is unlikely to derail the course of the reform.

Composition of Dail

Government

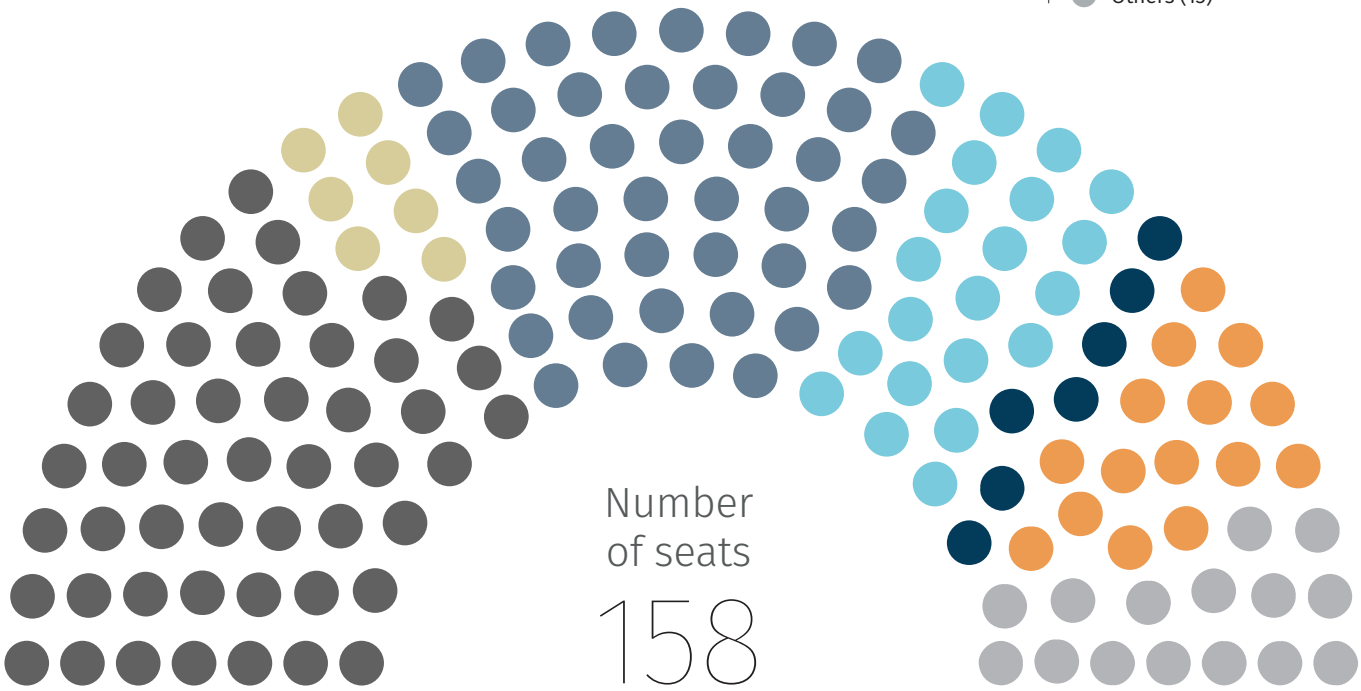
- Fine Gael (49)
- Independents (7)

Confidence and Supply Support for Government

- Fianna Fail (44)

Opposition

- Sinn Féin (21)
- Labour (7)
- Independents (15)
- Others (15)

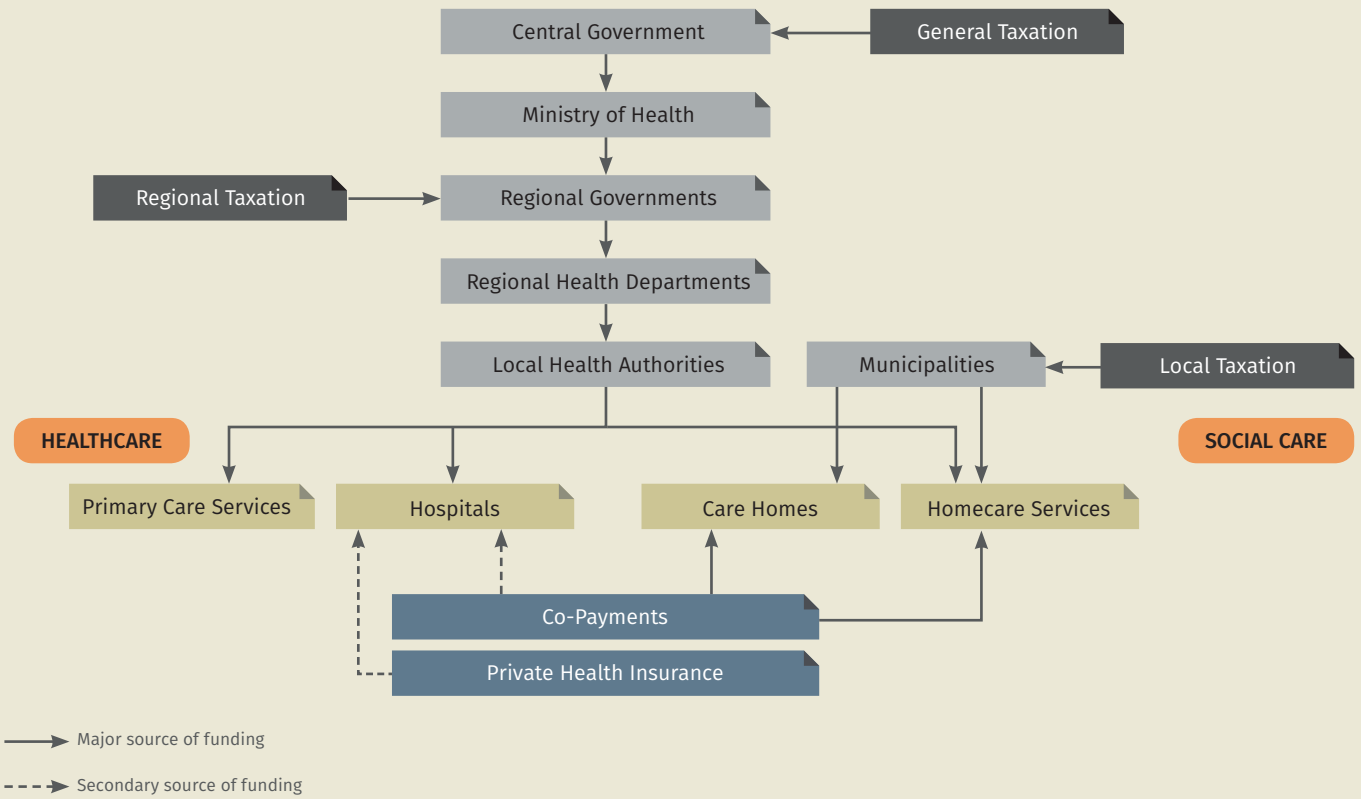


Italy

Key Messages

- The health and care systems are not expected to experience any major organisational changes, despite the appointment of a coalition Government made of non-traditional parties, which shook-up the political landscape and national policy priorities in June 2018
- Policy ambitions to shift care provision outside of hospital, increase the use of health digital solutions and technology, and integrate health and social care services have been outlined by the Government. However, budget allocations do not provide substantial additional funding to support these priorities
- The ongoing tension between centralisation and decentralisation of decision-making is reflected in healthcare organisation. Whilst central government gives overall policy directions and sets the budget, regional governments' decisions influence service organisation and providers' ability to operate
- Social care policy is decentralised to the local and regional levels, with very limited central government direction. This results in great variation in the organisation, level of public funding, and type and range of services available locally

Funding Flows



Population

Total

60.5m

Source: Federal Institute for Stats

Life Expectancy

83.3 years

Source: OECD

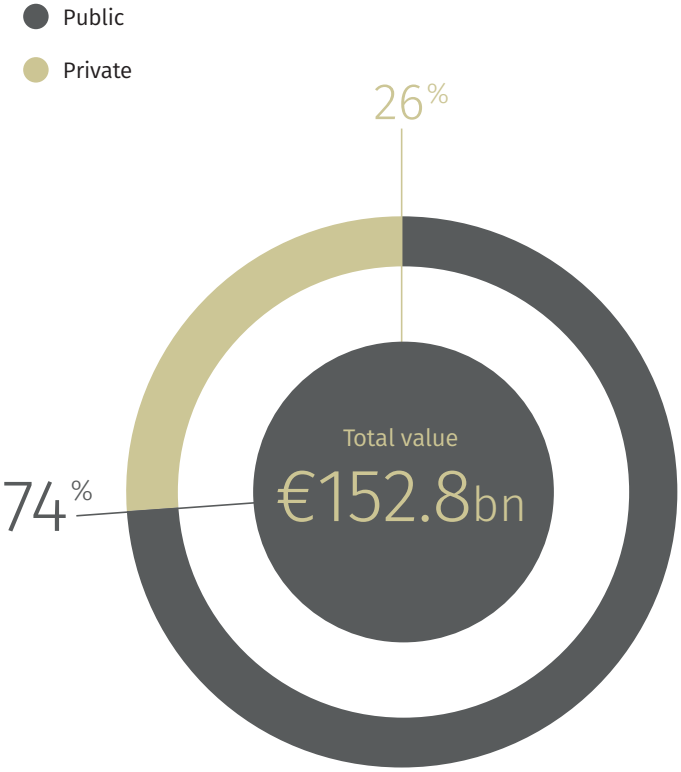
Population Distribution (%)

- 23.2% are aged between 0 and 24
- 54.5% are aged between 25 and 64
- 22.3% are aged over 65

Source: Eurostat (2018)

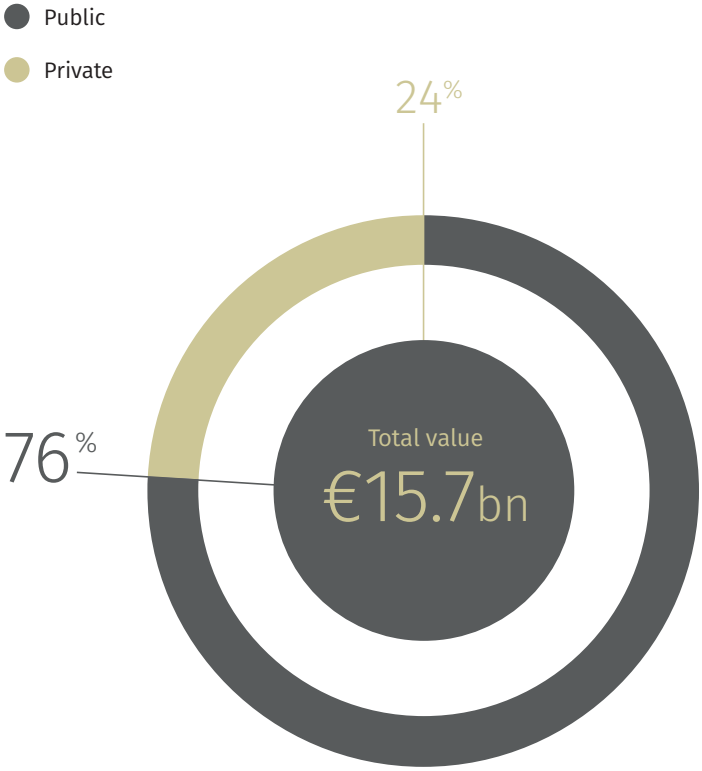
Healthcare Expenditure

Source: OCED, Eurostat, Marwood Analysis



Estimated Social Care Expenditure

Source: OCED, Eurostat, Marwood Analysis



Policy Snapshot: Populist Policies Meet Pragmatic Funding

Health and social care policy under the 5-Star Movement and League coalition: an ambitious transformation agenda but limited funding to support it

The formation of the 5-Star Movement/League coalition Government in May 2018 raised many questions on the policy trajectory these two non-traditional parties would take once in power. They were elected on the basis of potentially expensive promises, mainly the introduction of a universal revenue and a flat tax. Neither of these measures directly impact health and social care, but their introduction would impact on funding availability.

Health and social care policy priorities were clarified in the coalition agreement. It upholds the basic principles of the Italian national healthcare service (SSN). This means. a system that is publicly-funded and where services are free at the point of use. In addition, it outlines a vision for a system in which primary care is strengthened as care provision moves away from hospital settings. There are also statements around the use of digital technology in healthcare, reducing waiting times, centralisation of purchasing, reviewing pharmaceutical expenditure governance, and integration between health and social care services.

This makes for an ambitious agenda. However, the 2019 budget forecasts an increase of 0.9% to healthcare funding compared to 2018. As the government's role is limited to defining the overall trajectory of policy, implementation will fall on the regions. Whilst they may be able to find additional funding locally, they are likely to have to prioritise among their policy ambitions.

Healthcare

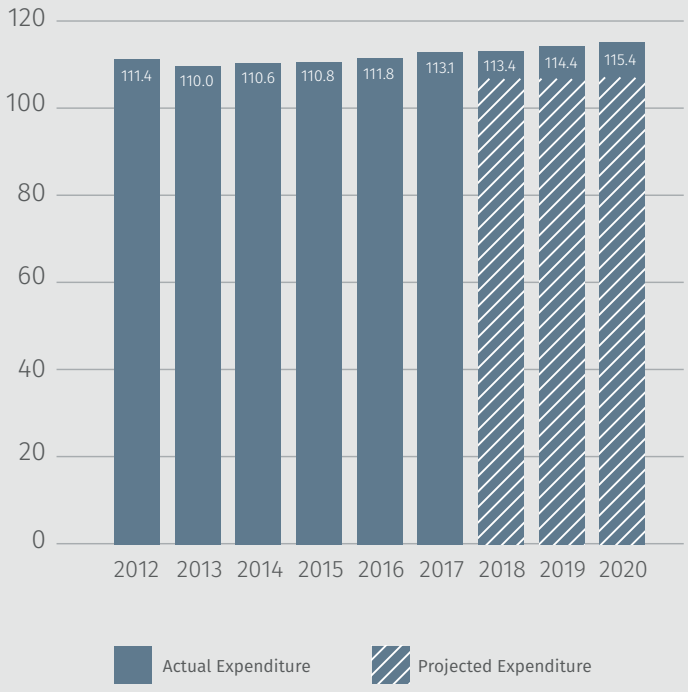
Funding

Healthcare funding is primarily public and comes from a mix of national and regional taxes. Over the last five years funding grew below the rate of inflation as Italy attempted to improve its public finances. The new government has promised to increase spending. The 2019 budget suggests a 0.9% increase this year, which is in line with increases in recent years and expected to bring total healthcare expenditure to €114.4bn.

Regions have some flexibility to increase local taxes and may raise extra funding this way. However, the ability to generate additional revenue is strongly linked to their fiscal capacity, with southern regions having overall less fiscal power than their northern neighbours.

SSN Expenditure (€, m)

Source: OECD, Budget 2019, Marwood Analysis



Payment System

103 Local Health Authorities are responsible for organising and paying for primary care services. Primary care physicians' contracts are negotiated nationally and reviewed every three to five years. Payments are made through a mix of capitation, fee-for-service and an element of performance.

In most regions, the Local Health Authorities are also the main payers of secondary care services. However, Local Health Authorities in some of the smaller northern and central regions have pooled their local commissioning capacity. Under this model the region purchases services from Local Health Authorities, which act as providers. These regions directly control public providers and only approve and use a limited number of private providers. Lombardy is the only region with a clear purchaser/provider split.

Payment rates for hospital and primary care are determined by each region, using national rates set by the Ministry of Health as a reference. Payments for hospital inpatient care are based on diagnostic-related group (DRG) tariffs. There is significant variation in the payment systems adopted by each region, such as how fees are set, which services are included, and incentives used to influence the way services are delivered.

The majority of services are free at the point of use. However, there are co-payments for laboratory and diagnostics tests and certain specialist services. In addition, patients pay out-of-pocket for services not covered by the SSN like dental care and cosmetic surgery.

The role of voluntary private health insurance in Italy

Voluntary private health insurance plays a minor role in payments to healthcare providers, accounting for 1.5% of the total expenditure in 2016, subscription to insurance schemes has been stable in recent years.

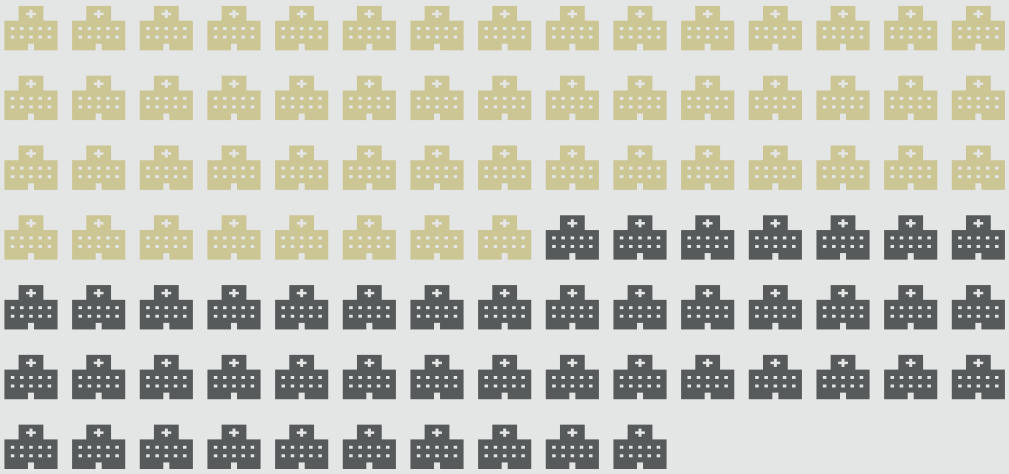
Private health insurance is used to cover co-payments for certain services, such as diagnostics, or to cover the cost of services that are not included under the SSN, like dentistry. It is also used to gain faster access to services, avoiding long waiting lists.

Provider Landscape

SSN healthcare services are delivered by a mix of public and private providers.

Primary care services are delivered locally by 46,000 independent general practitioners (GPs). For specialist care, patients can choose either public or private providers, depending on their willingness to pay out-of-pocket. 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.

Acute inpatient care is delivered by a network of hospitals. In 2016, there were 1,384 hospitals in Italy. 733 of them were publicly-owned and 651 were private. In theory, patients are free to choose any hospital provider. In practice, the ability to choose varies across regions. Private hospital providers must gain regional accreditation to operate and must agree contracts stating 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 where around 30% of total hospital beds are operated by private hospitals.



Hospital Ownership (2016)

- Public Providers (733)
- Private Providers (651)

Total number of hospitals: 1,384

Source: Ministry of Health

Regulation

Regulation of providers and healthcare services is decentralised to the regions. In order to provide services on behalf of the SSN, providers need to be accredited (or licensed) by the relevant regional authorities. Accreditation focuses on quality standards, management of human and technical resources, and the provider's activity in regional health planning. Regions are able to set their own accreditation criteria, which mean that they differ across regions. Central government oversees regional regulatory frameworks, however, it does not regulate providers directly. Its primary responsibility is to define what services are covered under the SSN.

Regions and central government also receive some advice and support from The National Agency for Regional Health Services (Agenas) on service cost-efficiency, quality and innovation. Agenas is defined as a technical and scientific body of the SSN carrying out research activities and supporting the Ministry of Health and the regions. It provides technical and operational support to the regions with regards to organisational, economic, financial aspects and efficacy of health interventions, as well as quality and safety of care. In 2017, Agenas set-up an internal quality observatory to collect data on risks, adverse events, and on the size and type of accidents. Agenas monitors the accreditation process for health providers.

Social Care

Funding

Social care funding relies on a mix of public and private sources. Public funding for social care comes from three sources:

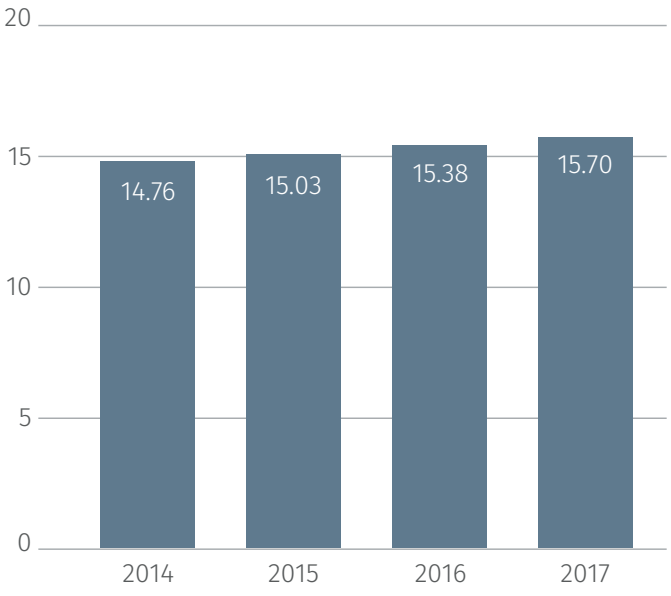
- Local health authorities and municipality funding, which comes from general and local taxation.
- SSN funding, which comes mainly from general taxation allocated by central government to the regions.
- Funding from the National Institute for Social Security (INPS), a separate fund financed from general taxation that provides cash benefits directly to individuals.

The total expenditure on social care was estimated to be €15.7bn in 2017, including public and private sources of funding. This public funding does not cover all the costs of social care services. It is complemented by private payments, which represent 24% of total expenditure on social care on average.

Social care funding covers a range of services for adults with disabilities and older people. In recent years, central government provided additional resources to finance services for severely disabled people. This funding amounts to €460m per year and is distributed across the regions. However, Italy's public-pay expenditure on social care is among the lowest per capita in Western Europe.

Total Social Care Expenditure (€, bn)

Source: OECD, Eurostat, Marwood Analysis



Payment System

The payment system is highly fragmented. Providers may be paid directly by regions, Local Health Authorities, or municipalities depending on the type of service provided. Overall, the responsibility of paying for medical costs lies with regions or Local Health Authorities, whilst municipalities pay for the costs of non-medical care, such as support with activities of daily living. Individuals may receive cash benefits, which they can use to pay for the cost of their care at home or in care homes. In addition, they are often required to top-up public payments with private co-payments.

Provider Landscape

Social care services are provided by a mix of public and private organisations. Overall, provision remains primarily public and is likely to be under developed in several regions as, historically, Italy has relied on informal, family carers to support older people living in their own home. However, the number of private operators has grown in recent years.

Local Health Authorities and municipalities are responsible for the provision of social care services, which they can outsource to external providers. Long-term care provision is built around residential and community care homes. In 2015, there were 287,685 older people living in care homes, with most of these services located in the north. In addition, 47,363 disabled people lived in residential facilities.

Regulation

Regulation of social care providers is decentralised to the regions. In order to operate services, all care home providers must be accredited by the relevant regional authorities. Criteria for authorisation and accreditation are set at regional level, reflecting various local priorities. Common criteria include continuity of care, quality of care, safety and hygiene standards.

The framework regulating homecare providers is evolving towards stronger oversight. This is due to the growing demand for formal services in an area which has historically relied on family carers. There is a variety of homecare services, including nursing homecare and support with activities of daily living. Access to these services is subject to obtaining a referral from a formal Local Health Authority. Regulation is expected to be set at regional level, on the basis of national standards.

Political Environment

A general election was held in March 2018 and resulted in a hung parliament. After several weeks of negotiations, the Five Star Movement (which is politically unclassifiable) and the League (right-wing) formed a coalition government. This coalition, built around populist parties, has broken the traditional centre-left/centre-right political parties' control over power. Whilst both parties have had experienced success at regional elections, this is the first time they have entered into a national government. As often in Italian politics, this coalition is fragile. The next general election is due to take place in May 2023.

Healthcare policy and legislation is characterised by tensions between central administration and the 21 regions and their Local Health Authorities that have some discretion in healthcare decision making. Several reforms have attempted to recentralise or fully decentralise the system, with very limited success either way.

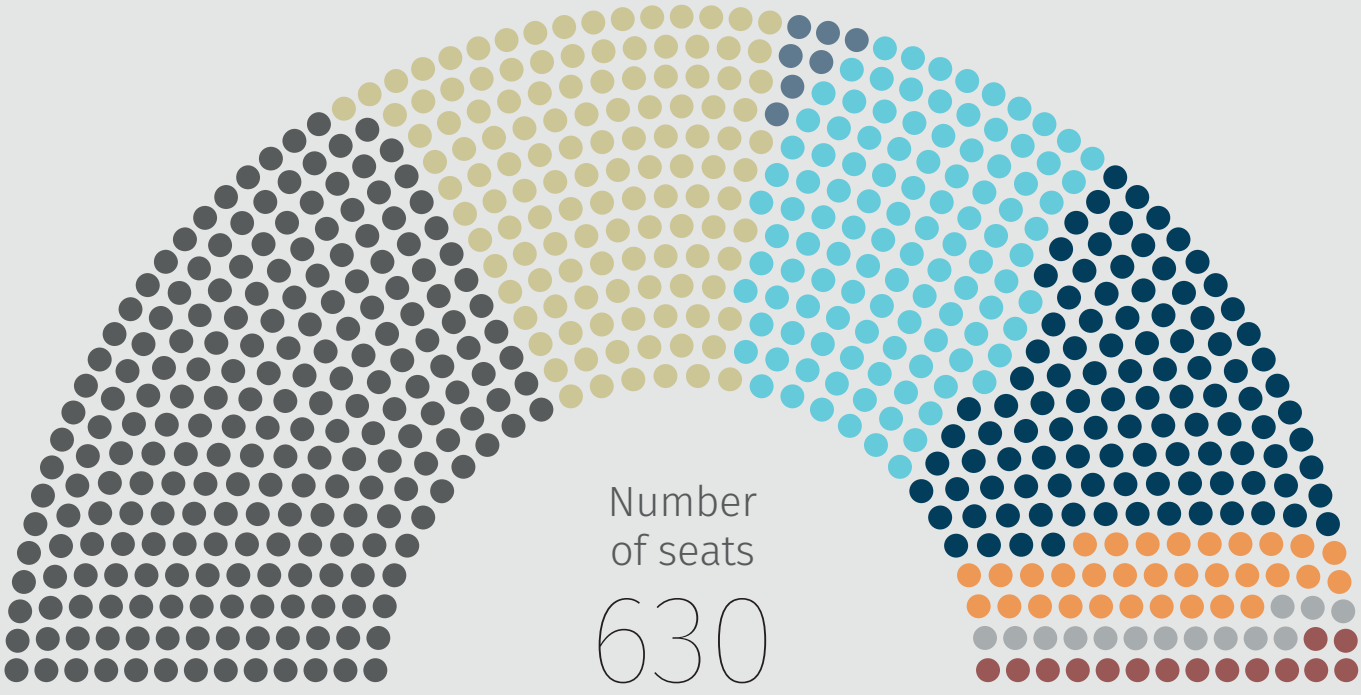
Composition of Parliament

Government

- Movement 5 Stars (220)
- Northern League (125)
- Others - Supporting Government (7)

Opposition

- PD (111)
- Forza Italia (105)
- Fdi (32)
- Free and Equal (14)
- Others - Opposition (15)

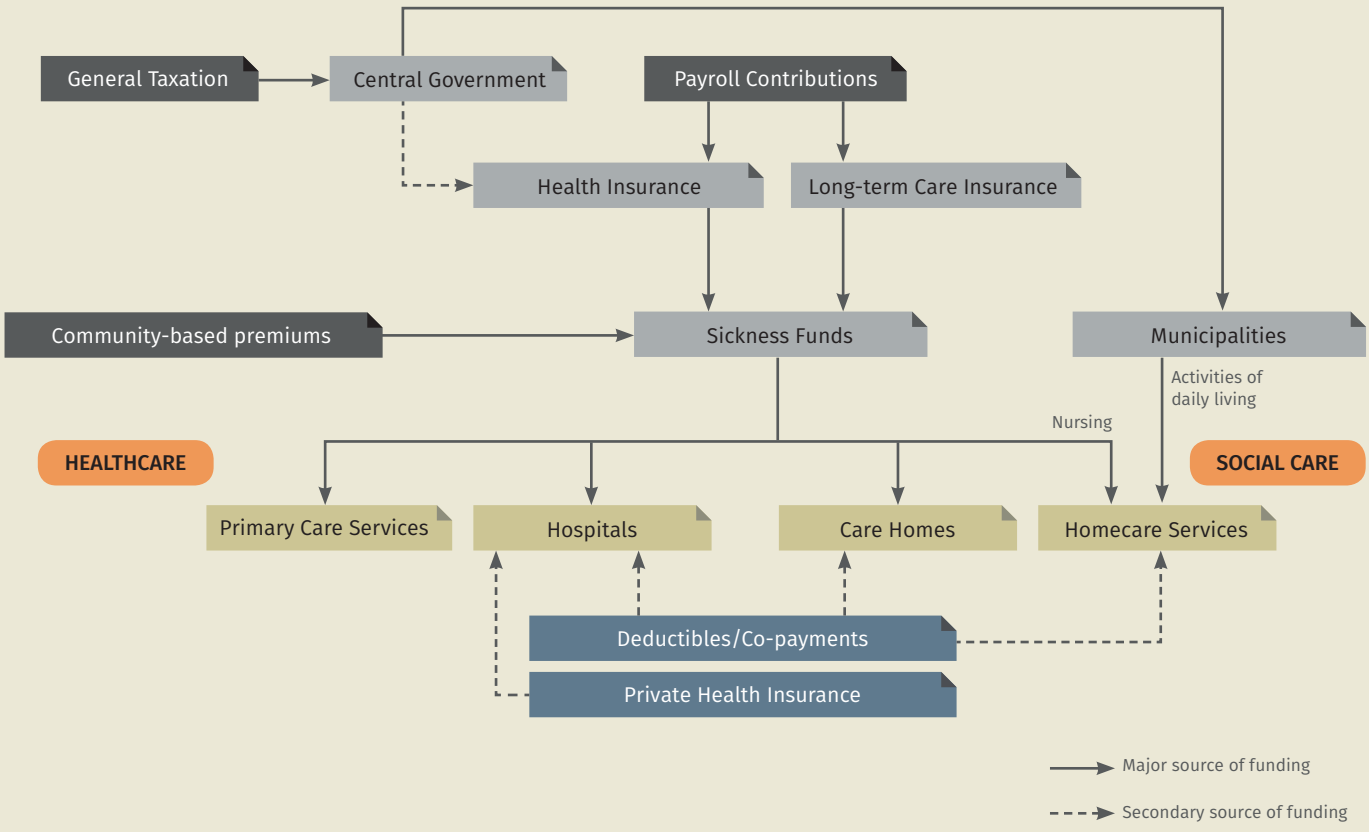


Netherlands

Key Messages

- The Government is discussing introducing legislation that would relax rules around hospital profits in 2019. Currently, hospitals delivering services on behalf of the statutory health insurance (SHI) are not allowed to make profits
- Relaxing the rules could allow for-profit hospital providers to compete for SHI contracts to deliver public services
- Allowing flexibility around profits could also increase public service hospitals' financial capacity to invest in infrastructure projects
- An attempt to relax rules around hospital profits was introduced in 2012, but a lack of political consensus stopped the adoption of the draft legislation. This suggest that passing any changes is likely to be contentious

Funding Flows



Population

Total

17.2m

Source: Federal Institute for Stats

Life Expectancy

81.6 years

Source: OECD

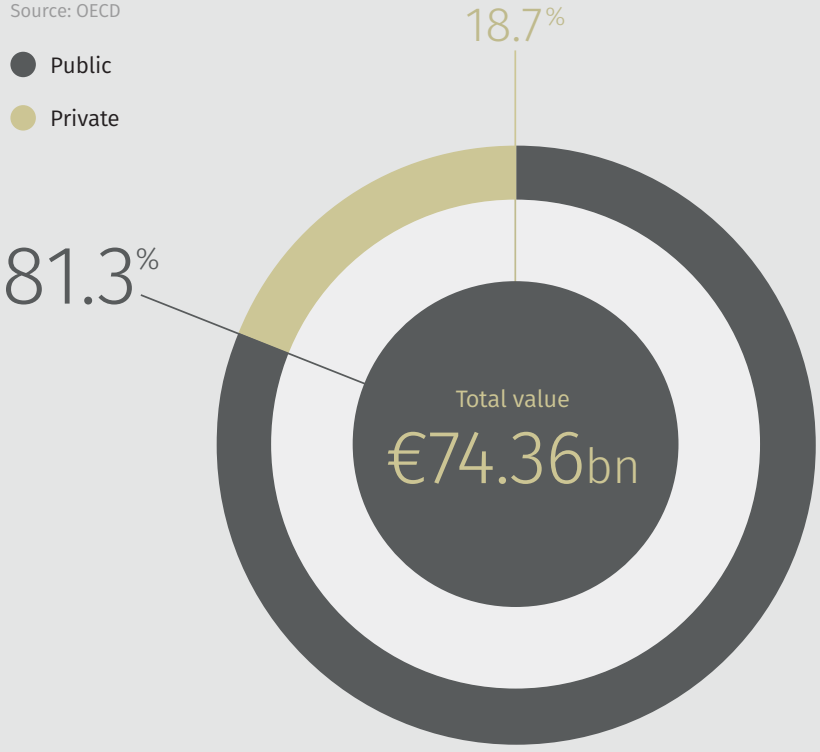
Population Distribution (%)

- 28.6% are aged between 0 and 24
- 52.9% are aged between 25 and 64
- 18.5% are aged over 65

Source: OECD, Eurostat (2018)

Healthcare Expenditure

Source: OECD



Estimated Social Care Expenditure

Source: OECD, Eurostat, Marwood Analysis

€21.74bn

Policy Snapshot: Regulation of Hospital Profits

The possible relaxation in the law prohibiting hospital profit making could create opportunities for the small for-profit sector to grow and increase the availability of capital funding

Healthcare inpatient service providers are not currently allowed to make profits. This means that for-profit providers cannot contract directly with sickness funds to deliver publicly paid services. In practice, non-profit hospitals already outsource some services to the for-profit sector.

The Government is planning to review this in 2019. A change in the law could introduce more competition, with both for-profit and non-profit hospitals bidding for sickness fund contracts. However, it is likely to be a long and sensitive political debate. In 2012 a Bill on Enlargement of Investment Options in Medical Specialist Care was introduced in Parliament. It was adopted by the lower chamber in 2014, but the upper chamber blocked it. The Bill has been on hold since. The Government is expected to address concerns around the impact of profit making on care quality, SHI financial sustainability and providers incentives to achieve healthcare policy objectives.

The motivation behind the possible relaxation of the rules stems from legislative changes introduced in 2008, which meant that central government no longer finances hospital capital costs. Instead, hospitals must find these resources within their wider budgets. This opened a political discussion around the need to give hospitals, which are primarily independent organisations more income flexibility. Therefore, changes could also lead to more capital expenditure.

Healthcare

Funding

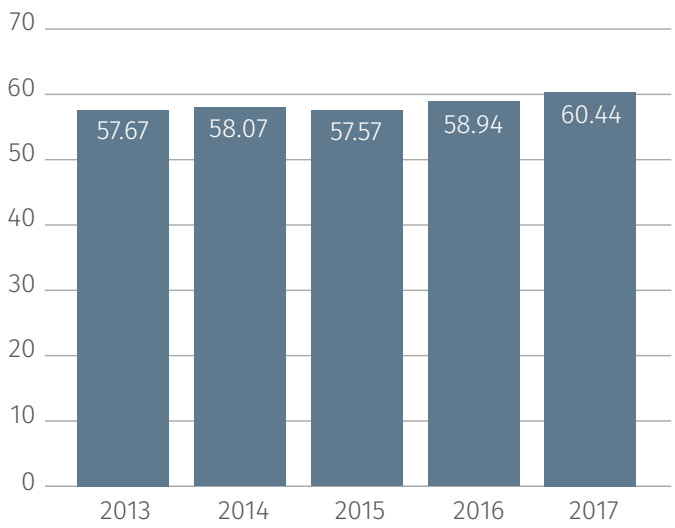
Healthcare funding is primarily public and based on mandatory statutory health insurance (SHI). Individuals pay a community-based premium to the sickness fund of their choice. Sickness funds can set their own premiums, which must be the same for all members. In addition, employees and employers pay payroll contributions to the Health Insurance Fund. This money is pooled nationally and redistributed among the sickness funds to level-out differences in revenue between sickness funds. Finally, central government tops-up healthcare funding with a grant funded through general taxation.

SHI spending grew slowly between 2013 and 2017. Provisional figures estimate that spending increased by 2.5% between 2016 and 2017, from €58.94bn to €60.44bn.

The Sickness Fund market in the Netherlands
In 2016, four sickness fund groups controlled 90% of the insurance market. Their plans must offer a nationally-defined universal package for everyone over the age of 18, regardless of age or state of health. They are not allowed to reject applications or impose special terms and conditions based on the individual's medical history.

SHI Expenditure (€, bn)

Source: OECD



Payment System

Sickness funds are responsible for provider selection and contracting in primary and secondary care.

In primary care, general practitioners (GPs) are primarily paid through a mix of fee-for-service and capitation. This makes up 75% of payments to GPs, with fees set centrally by the Dutch Health Care Authority. In addition, GPs negotiate with sickness funds for bundled payments for integrated care and pay-for-performance payments.

In secondary care, hospitals are paid through a type of diagnosis-related group (DRG) system. DRGs cover the costs of medical specialist care, nursing care and the use of medical equipment and diagnostic procedures. Each sickness fund negotiates the terms of payment with each hospital. This leads to some variation in the nature of payments hospitals receive, with some agreeing lump-sum budgets, whilst others set-up price-volume agreements. There are a few services for which individual contract negotiation is not possible and is determined nationally. This includes high-cost, low volume care, such as trauma and transplantation services.

GP and maternity care services are always free at the point of use. All other healthcare services are free at the point of use once patients have fully paid an annual deductible of €385.

Provider Landscape

Provision of healthcare services is delivered by private general practitioners (GPs) and independent non-profit hospitals.

In 2015, there were over 11,600 GPs. 84% of them worked independently or in partnership on a self-employed basis and 16% were employed in a practice owned by another GP. Many GPs employ nurses and primary care psychologists on a salary.

The introduction of bundled payments for integrated care has incentivised the creation of care groups, based on a network of GP practises. They provide services to chronically ill patients and are responsible for purchasing services from various healthcare providers.

In 2015, there were 89 non-profit hospitals delivering SHI services. Hospitals contracting with the sickness funds are not allowed to make profits or pay out profits to third parties or shareholders. Patient access to hospital and specialist care services requires a GP referral.

Regulation

The National Health Care Institute oversees the functioning of the SHI. Its role is to ensure that healthcare services covered under the SHI are accessible and of high quality. Access is ensured by regular review and expansion (or exclusion) of services from the basic SHI package. The National Health Care Institute advises the Government on the content of the package and can arbitrate reimbursement disputes when they arise between sickness funds and healthcare providers.

The regulation of care quality in the Netherlands has become an important focus of policy in recent years. Regulatory structures are relatively young. The National Health Care Institute is responsible for drafting good practice and overseeing progress towards achieving the Government's objective to improve quality of care. This is based on three pillars: effectiveness, safety and care that is patient-centred. The Dutch Health Care Inspectorate is responsible for monitoring implementation of these objectives. However, there are few indicators, and quality assurance is mostly carried out by providers, in agreement with the sickness funds. Therefore, care quality regulation is currently decentralised and remains fragmented.

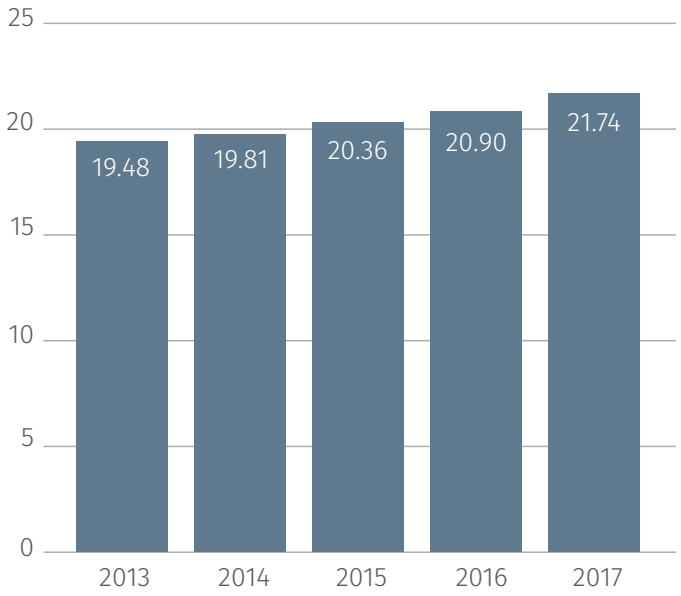
Sickness funds are regulated by the Dutch Healthcare Authority, which is responsible for ensuring that there is fair competition between insurers and providers.

Funding

Funding for social care comes primarily from the compulsory long-term social insurance scheme and social support budgets. Long-term social insurance is financed by employer and employee payroll contributions and managed by sickness funds. This funding is used to cover the cost of long-term residential care for older and disabled people, nursing care at home, and the cost of care for those with chronic mental health problems. Activities of daily living services, which are mostly provided in people's home, and community social services are funded by municipalities through their social support budgets. These budgets come from general taxation and are allocated by the Government in the form of non-ringfenced block grants. The global social support budget is set by the Dutch Healthcare Authority.

Social Care Expenditure (€, bn)

Source: OECD, Eurostat, Marwood Analysis



Payment System

Public payments to social care providers come from sickness funds and/or municipalities and are often topped-up by individuals co-payments.

Payments to residential care providers are primarily made directly by sickness funds. The amount paid by sickness funds for each individual depends on need and mean-tests carried out by the Care Needs Assessment Centre. The assessment evaluates the intensity and complexity of the care needed to determine the care intensity package. There are 10 packages for nursing care, 14 packages for mental health and 30 for care for physical and learning disability. There are national prices associated with each package, set by the Dutch Health Authority. Individual co-payments are determined on the basis of income and assets. In 2015, co-payments covered 8.7% of total spending in the compulsory long-term care scheme.

The responsibility for paying homecare providers depends on the nature of service. Activities of daily living are primarily paid for by municipalities on the basis of local hourly rates. Nursing homecare services are covered by sickness funds under long-term social insurance. Providers are also paid on the basis of hourly rates, set nationally by the Dutch Healthcare Authority. In both cases, individuals may opt to receive personal budgets, which they can spend on the provider of their choice. Finally, individuals also contribute co-payments depending on income.

Provider Landscape

Social care is primarily provided by non-profit organisations. This includes homecare agencies, residential homes, and nursing homes. The services they provide include residential care, personal care, supervision, and nursing, medical aids, medical treatment, and transport services. In recent years, policy has focused on homecare and the number of people receiving homecare services has increased. Meanwhile, the numbers in residential and nursing homes has been declining.

Regulation

Residential and nursing home providers are regulated by the Dutch Health Care Inspectorate, which is responsible for monitoring implementation of the national care quality objectives. However, there are few indicators, and quality assurance is mostly carried out by providers, in agreement with the sickness funds. Nursing homecare providers are subject to a different, lighter-touch regulatory regime.

Providers of activity of daily living services are primarily regulated by municipalities. Since 2015, they are focusing on ensuring that individuals receive services that support their independence and maintain their participation in the community. Providers are often required to monitor and keep track of progress towards achieving these two goals for their clients.

Political Environment

The Dutch government is currently led by liberal Prime Minister Mark Rutte from the centrist People's Party for Freedom and Democracy, in coalition with three other centre-right and liberal parties: the Christian Democratic Appeal, Democrats 66 and the Christian Union. The next general election is due to take place in March 2021.

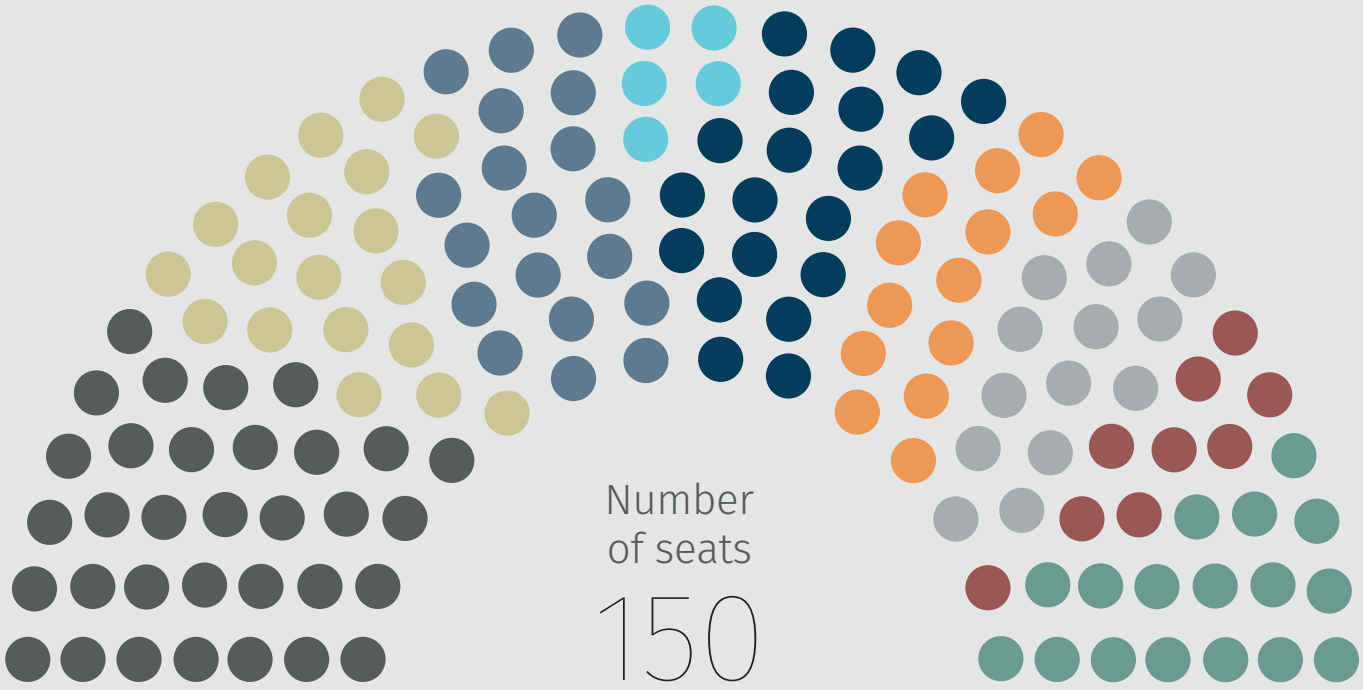
Composition of Parliament

Government

- People's Party for Freedom and Democracy (33)
- Christian Democratic Appeal (19)
- Democrats 66 (19)
- Christian Union (5)

Opposition

- Party for Freedom (20)
- Green Left (14)
- Socialist Party (14)
- Labour Party (9)
- Others (17)

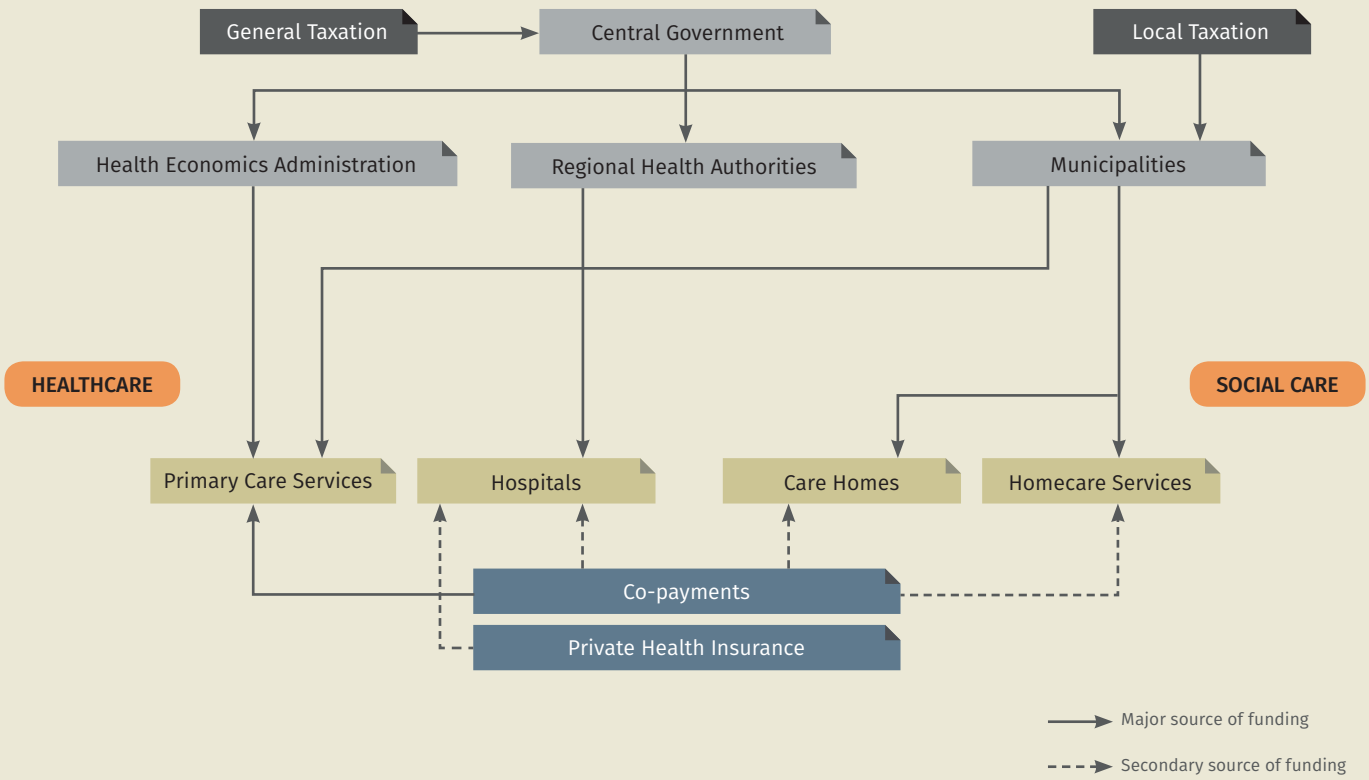


Norway

Key Messages

- The structure of the health and social care system is highly decentralised, with key decisions on funding allocation and service organisation taken by four regions and over 400 municipalities
- Overall, health and care policy is focusing on quality improvement, with new indicators being introduced to monitor the quality and safety of social care services
- Mental health policy has become a priority, with municipalities expanding the number of community mental health services available locally and working on patient pathways redesign with the regions
- Next steps in healthcare digitisation are expected to address fragmentation across geographies and enable interoperability
- Health and social care services are primarily delivered by public organisations. However, some municipalities choose to contract with private care home providers, and regions may outsource some hospital services to private hospitals on an ad-hoc basis

Funding Flows



Population

Total

5.3m

Source: Federal Institute for Stats

Life Expectancy

82.5 years

Source: OECD

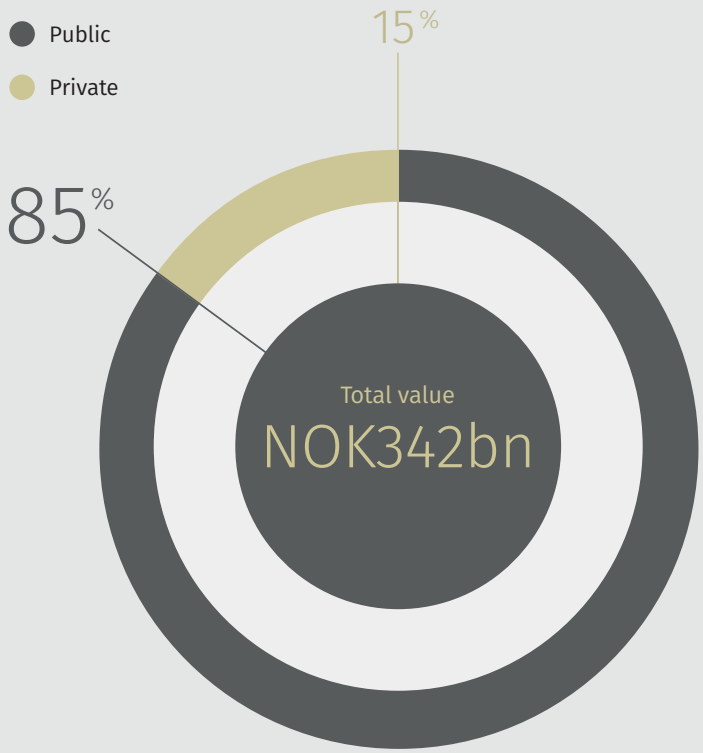
Population Distribution (%)

- 30.5% are aged between 0 and 24
- 52.8% are aged between 25 and 64
- 16.7% are aged over 65

Source: Eurostat

Healthcare Expenditure

Source: OECD
1NOK = 0.104102EURO (average 2018)



Social Care Expenditure

Source: Norwegian Government
1NOK = 0.104102EURO (average 2018)

NOK114bn

Policy Snapshot: Health and Care Policy Stability

Ongoing focus on mental health, improving social care services and digitisation

Defining the health and social care policy framework is the responsibility of the Minister of Health. This position is currently held by Bent Høie. In post since 2013, he has become the longest-serving Minister of Health in Norway.

This has led to a stable policy environment, focusing on two key elements:

- Centring delivery of health and social care around the patient's needs
- Improving care services in line with the Care Plan 2020

Changes resulting from these priorities include:

- Expanding the provision of mental health services. Municipalities are now required to contract psychotherapists as part of their primary care service offering
- The development of integrated pathways for cancer will be extended to mental health and substance abuse. This will require regions and municipalities to work together
- Introduction of new quality indicators to monitor the safety and quality of social care services
- Continuing the digitisation of health and social care. This is expected to focus on interoperability across geographies and settings of care. Municipalities have also been asked to provide guidance to patients on how to use e-health tools available to them

Healthcare

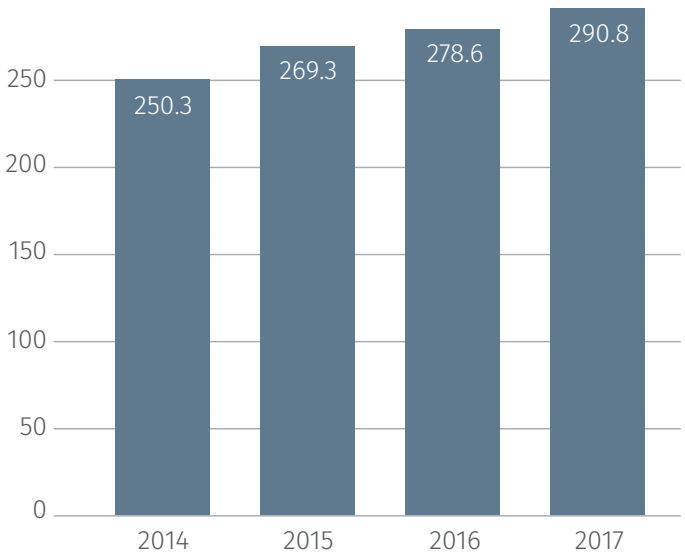
Funding

Healthcare funding is primarily public. It comes from general taxation levied at national and municipal level. The responsibility for funding healthcare services lies with the regions. However, regions levy little taxes directly and rely principally on central government allocations and, to a lesser extent, municipalities. Each region's healthcare budget is set by the Treasury. Regions allocate resources to a wide range of services within this envelope.

Public funding for healthcare has been growing in the past few years, underpinned by sustained economic growth. The 2019 budget suggests that this will continue and places healthcare as a key funding priority. Hospitals are expected to be the main beneficiaries of additional funding with an extra NOK1.4bn to finance growing demand. The Government is also expected to provide new investment loans for several large projects in the hospital sector.

Public Healthcare Expenditure (NOK, bn)

Source: OECD



Payment System

Municipalities are responsible for contracting with independent general practitioners (GPs) and other primary care providers. However, they only pay for 35% of their total costs. Remaining costs are paid by the Norwegian Health Economics Administration, an administrative division operating under the supervision of the Ministry of Health and Care Services, and patients.

The fee-for-service and co-payment tariffs are set nationally. Specialists working in hospital outpatient care are paid in the same way as primary care providers, although they contract with Regional Health Authorities.

Payer	Type of payment	% of GP/primary care provider revenue
Municipalities	Capitated payments	35%
Health Economics Administration	Fee-for-service	35%
Patients	Co-payments, up to €220 per year	30%

The four Regional Health Authorities are the main payers and providers of hospital acute services. These services are not subject to individual co-payment and are fully paid through a combination of block grants and activity payments based on Diagnosis-Related Groups (DRG).

Private hospitals may be used to outsource some elective treatments, outpatient consultations and for the provision of inpatient mental health services. This is done on a case-by-case basis, with Regional Health Authorities contracting primarily with non-profit providers, rather than for-profit ones. The contribution of public payments to for-profit hospitals' revenue varies greatly and can make up to 85% of provider revenue.

The role of voluntary private health insurance in Norway

In Norway, private voluntary health insurance plays a marginal role in healthcare payments. As of 2016, it contributed to less than 1% of total healthcare payments. However, the number of individuals covered has increased substantially between 2006 and 2016. The growth primarily comes from employers, purchasing private health insurance policies for their employees.

Voluntary private health insurance is used as a supplement to the public national healthcare system. It gives quick access to specialist services and elective surgery provided by private clinics. This mostly allows private health insurance holders to access services faster than under the publicly-funded system.

Insurance Type	Role/Coverage	Population Covered	
		2006	2016
Supplementary	To get faster access to services in reaction to high perceived or actual waiting times	84,000	482,000

Healthcare

Provider Landscape

Primary care services are mainly delivered by private GPs operating under contracts with municipalities. 95% of GPs are self-employed. They generally work in small group practices of up to six GPs and employ nurses and other healthcare professionals.

Hospital services are almost exclusively provided by public sector operators. There are 54 public hospitals delivering a full range of services, from outpatient surgery to acute and emergency care, to mental health services.

There are eight for-profit hospitals. They are primarily involved in the delivery of radiology and laboratory services, outpatient clinics and inpatient mental health services. However, they play a limited role in the total delivery of services. This includes 7% of outpatient elective surgery provision and 0.2% of inpatient mental health stays.

Regulation

Central government, through the Ministry of Health and Care Services, is responsible for the overall regulatory framework for healthcare services. In practice, individual licensing is granted to healthcare practitioners by the Directorate for Health, on the basis of their professional qualifications. It also oversees the implementation of health policy objectives. The Directorate for Health operates under the supervision of the Ministry of Health and Care Services.

Primary care providers and hospitals are required to have internal quality control systems in place. This includes appointing a quality assurance committee whose role is to define how quality is achieved, on the basis of national care quality indicators and support improvement. Ultimately, hospital management, and primary and secondary care staff are responsible for ensuring that quality standards are met. This is monitored by the National Board of Health Supervision, supported by 19 County Medical Offices.

Social Care

Funding

Funding for adult social care comes from a mix of public and private sources. There is a public safety net, funded primarily by tax revenue levied locally by municipalities, and in part by central allocations. The Ministry of Health gives directions on expenditure and ring-fences some of its funding for specific services. In the 2019 budget, the Treasury announced that it would provide specific grants to finance 1,500 full-time care packages and 450 day-activity places for people living at home with dementia. Municipalities enjoy some discretion in the allocation of social care resources among services.

In 2017, municipalities spent NOK114bn on all social care services, a 5% increase on 2016. As eligibility for publicly-funded services is mean-tested, individuals may be required to contribute up to 85% of their personal income towards the cost of their care.

Payment System

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 re people likely to move into nursing homes.

Provider Landscape

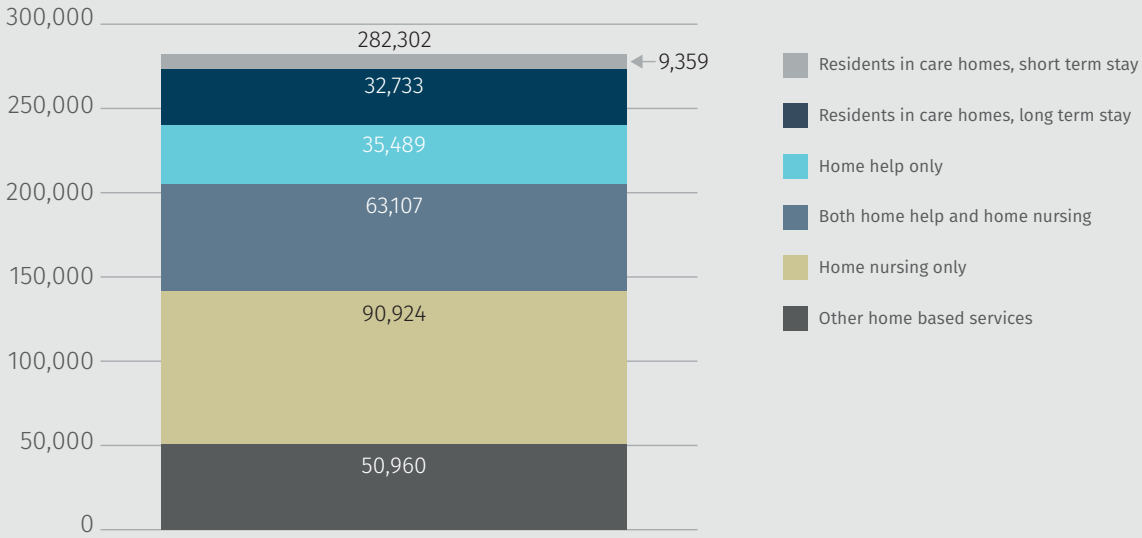
The majority of social care services are provided directly by municipalities. Services include home-based nursing care and support with activities of daily living, residential care and nursing homes. These services can be provided to older people, as well as adults.

Municipalities may choose to contract with private providers for the delivery of certain services. The private sector's involvement in delivering social care services is limited to providing 10.7% of the 40,401 total bed capacity in nursing and care homes. Due to the focus on delivering services at home, the number of nursing and care home beds has been decreasing slightly in recent years, including across private provision.

In 2017, there were 282,302 users of social care services, a 1.5% increase on 2016.

Social Care Users by Type of Service (2017)

Source: Norwegian Statistics



Regulation

The Ministry of Health and Care Services is responsible for the regulatory framework for older adults' care services. Municipalities set out eligibility criteria regulating access to nursing homes and institutional care. These criteria are based on needs and allow municipalities to carry out individual assessments on service eligibility.

Like healthcare providers, social care providers are expected to have quality assurance controls in place. In recent years, more expectations have been placed on providers to demonstrate the quality of their service. New quality indicators have been developed and their application is ongoing. The Health Supervision Board is also working towards introducing a system of learning from experience to improve the quality of social care services.

Political Environment

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 Parliament

Government

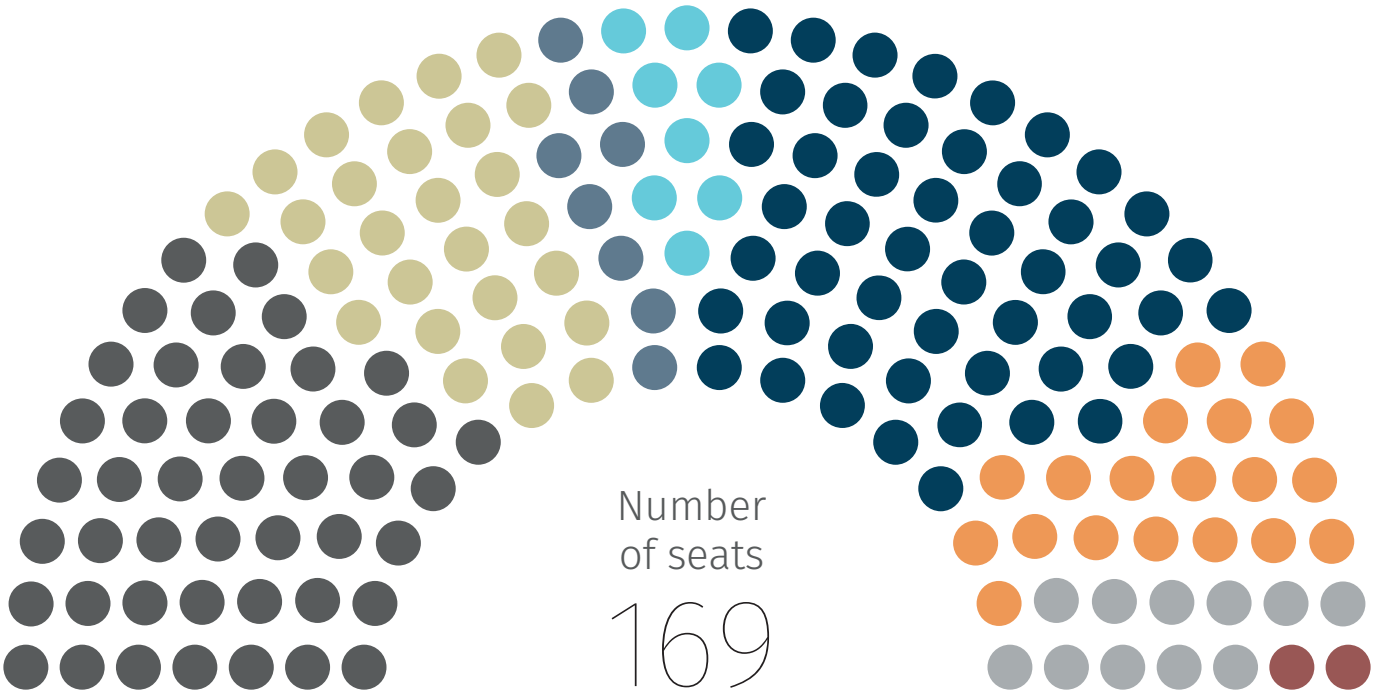
- Conservative (45)
- Progress (27)

Supporting Government

- Liberal (8)
- Christian Democrats (8)

Opposition

- Labour (49)
- Centre (19)
- Socialist Left (11)
- Others (2)

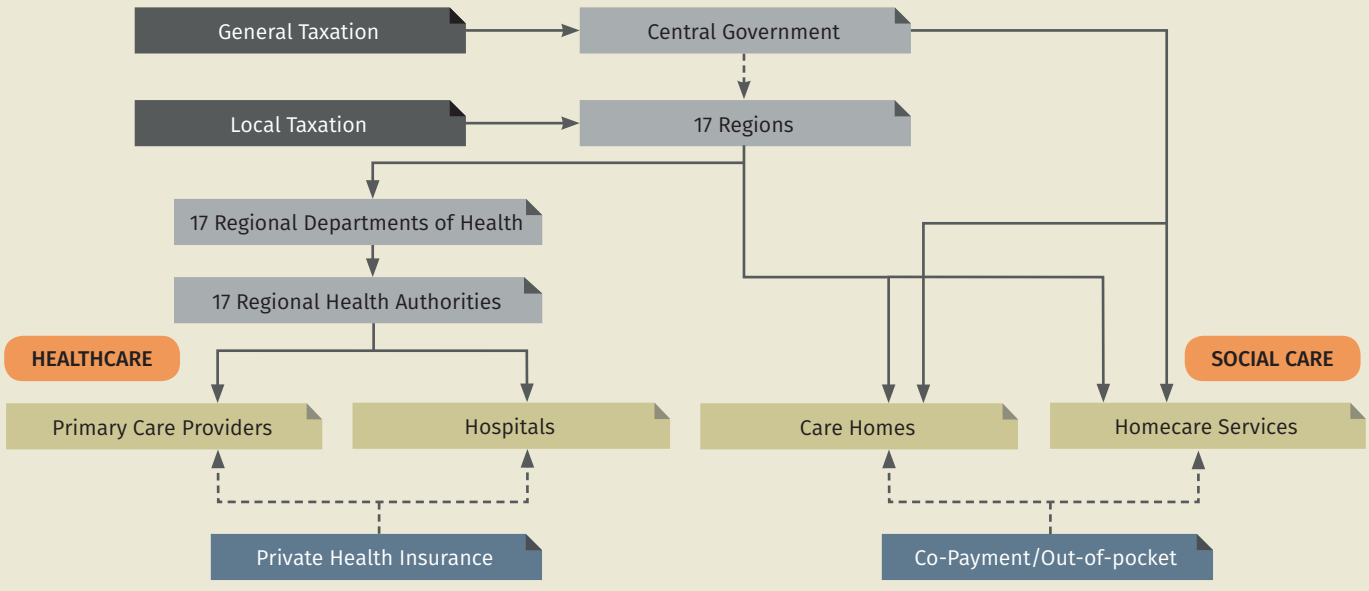


Spain

Key Messages

- Public spending has been growing year-on-year since 2015. This follows deep cuts to public healthcare funding following in the aftermath of the 2008 global financial crisis
- Healthcare expenditure is primarily through taxation. However, the proportion of healthcare expenditure that comes from private spend has increased. This has been driven in part by increased co-payments for medicines and cost-containment policies within public-pay healthcare
- Government changes at regional level have led the Valencia region to end a flagship public-private partnership model, known as Alzira. However, it remains possible for private providers to deliver publicly-funded health and social care services
- The social care provision landscape has changed following reforms in 2007, which introduced a right to access publicly funded services for all and formalised access to these services. However, spending on social care is among the lowest in Western Europe, and there is significant regional variation in public funding and the range of services available

Funding Flows



Population

Total

46.7m

Source: OECD

Life Expectancy

83.4 years

Source: OECD

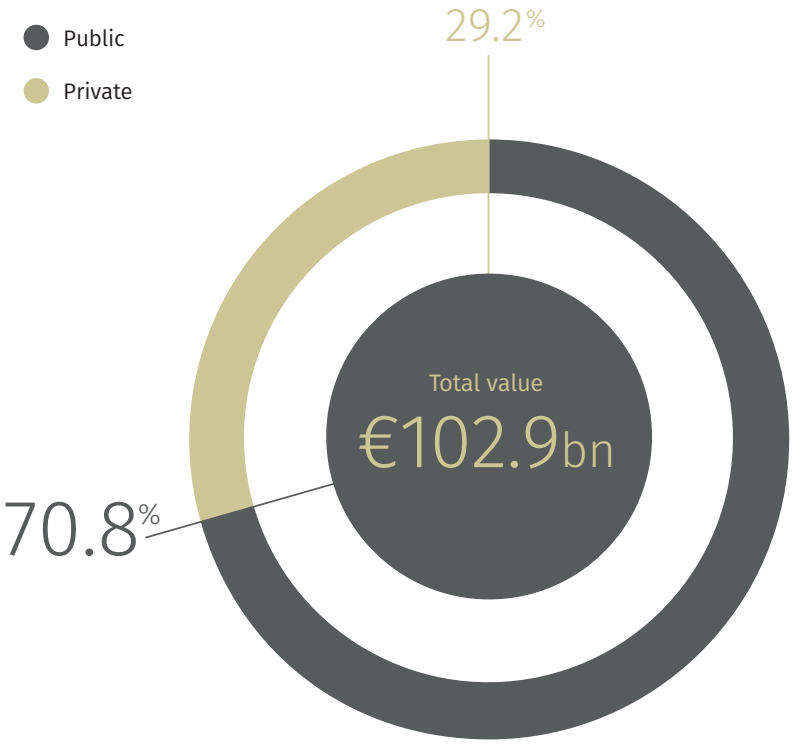
Population Distribution (%)

- 24.7% are aged between 0 and 24
- 56.3% are aged between 25 and 64
- 19% are aged over 65

Source: Eurostat

Healthcare Expenditure

Source: OECD



Social Care Expenditure

Estimation, Sources: OCED, Eurostat, Marwood Analysis

€9.8bn

Policy Snapshot: Political Landscape Changes Impacting on Health and Care

National and regional political leadership changes are shaping health and care systems' financing and structure

Cost containment has been a major national policy and legislative driver since 2010. This has led to the introduction of new co-payment mechanisms for prescription medicines. The idea of extending co-payments to public healthcare services has been raised.

The change of Government in Summer 2018 – leading to a coalition led by the centre-left, PSOE – has paused any further move towards co-payments. Overall, services are expected to remain free at the point of use. However, the coalition collapsed in February 2019. This means the future of healthcare policy and the potential expansion of co-payments may be dependent on the outcome of the April 2019 general election.

However, the highly decentralised nature of Spanish politics means regions are free to organise provision of services as they see fit. In the late 1990's and throughout the 2000's, several public-private partnerships (PPPs) were created. The most advanced one was the Alzira model in Valencia, an accountable care organisation led by a private corporation.

Following the 2015 change in regional government, the centre-left government took over the administration of the Alzira model. Other PPPs remain across Spain. However, they are smaller and the appetite for creating PPPs largely depends on political factors at the regional level.

Healthcare

Funding

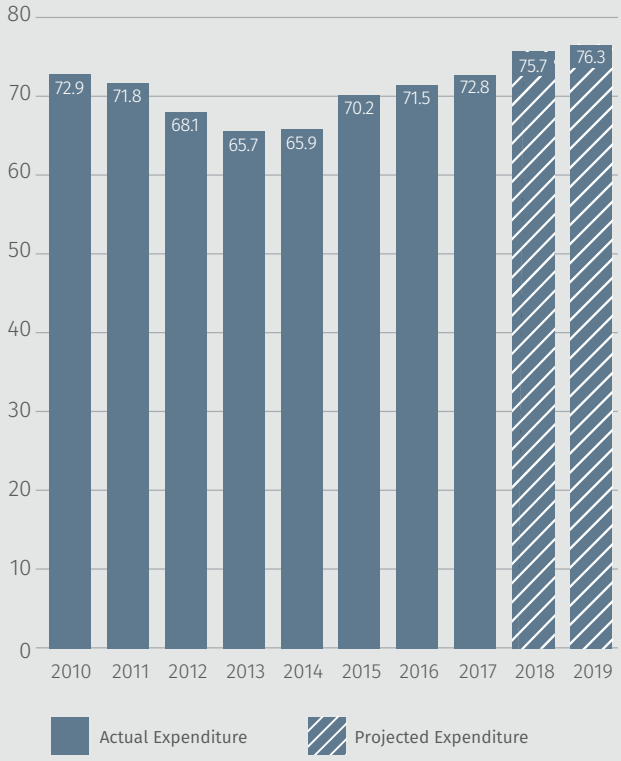
Healthcare funding is primarily public and comes from general taxation raised at regional and national levels. Since 2009 the regions have been granted additional fiscal autonomy and retain more of the taxes they raise, including a percentage of income tax. Therefore, central government's role in healthcare funding has been reduced to redistribution in order to level-out regional fiscal income variations.

After experiencing significant financial pressure between 2010 and 2014, the Spanish national health service (SNS) spending has been growing since 2014, and in 2017 spending reached €72.8bn, returning to levels seen in 2010, when austerity started. Provisional figures show that spending increased by 3.9% in 2018, but this growth is expected to slow down to 0.9% in 2019.

The actual level of public healthcare spending varies across Spanish regions as they allocate resources from their wider regional budget. Therefore, healthcare spending as a share of total regional budgets ranges from 22% in Navarra to 38% in Valencia.

SNS Expenditure (€, bn)

Source: OECD, Ministry of Health, Marwood Analysis



Payment System

Due to the decentralised nature of the system, regional health authorities are responsible for purchasing SNS services, which are free at the point of need. Some services such as dentistry are not covered and paid for out-of-pocket.

Primary care services are funded through global payments, with a capitation element. A proportion of payments to providers is dependent on achieving specific regional objectives, such as reducing waiting lists.

Public hospitals are generally paid through global payments, calculated on the basis of episode-based Diagnostic Related Groups (DRG) tariffs, determined by the regions. However, some procedures are paid on a fee-for-service basis.

Private hospitals are paid in a similar way to public ones for the provision of acute services, and on a per-diem fee for the provision of non-acute services.

Overall, healthcare providers are primarily paid by public payers. However, in recent years, the share of private payments in total healthcare expenditure has increased. This is partly due to the introduction of co-payments for pharmaceuticals products, one of the key cost-containment measures of the previous government. In addition, there are out-of-pocket payments, and private health insurance payments for non-SNS services

The role of voluntary private health insurance

In 2015, voluntary private health insurance contributed to 5% of the total healthcare expenditure.

Over 20% of the Spanish population subscribes to voluntary private health insurance, mostly to access services faster. There has been an increasing trend in subscribing to private health insurance.

Between 2013 and 2017 the number of individuals covered increased by 10.3%, from 10.43m to 11.5m. Coverage varies by region. 40% of the population has private health insurance in Extremadura, the Balearic Islands and the Community of Madrid, compared to 13% in Galicia, Navarra and Valencia.

57% of insurance policies are purchased through employer group plans. The remaining 43% are purchased directly by individuals.

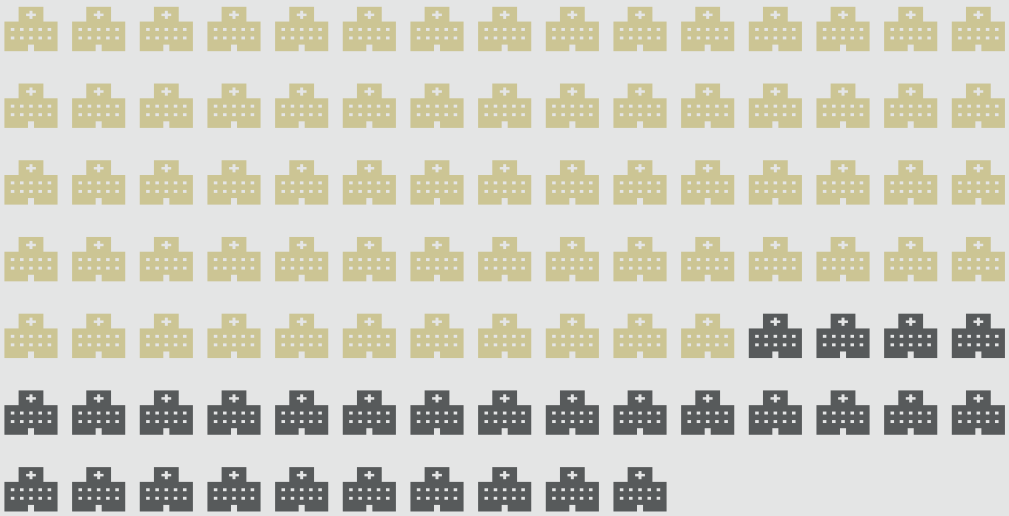
Insurance Type	Role/Coverage	Population Covered	
		2013	2017
Substitute	The majority of policies provide faster access to outpatient and inpatient services, particularly in elective care. Some policies may also include coverage of medical home visits post-hospital discharge, and/or coverage of dental care	10,430,000	11,500,000

Provider Landscape

Healthcare services are delivered by a mix of public and private providers. There can be significant variation in provision between regions.

There are 451 hospitals. The majority of them are publicly-owned.

There are 13,094 health centres providing primary healthcare services, including family and GP services, nursing, paediatrics, social services and physiotherapy. Every person should be able to access a health centre within a 30-minute drive.



Hospitals Provision Landscape

- Public Providers (324)
- Private Providers (127)

Total number of hospitals: 451

Source: Ministry of Health

Regulation

Quality of care standards are set nationally by the National Agency for Quality of the SNS. It was established in 2003 and is part of the Spanish Ministry of Health. Its main role is to oversee the implementation of the National Quality Plan by developing decision-making tools, information, and evaluation systems, as well as quality standards. Working closely with Regional Health Authorities, the Agency is responsible for ensuring that the decentralised SNS provides equal access to basic services across the 19 regions.

Regional Health Authorities take on responsibility for direct regulation of healthcare services, including accreditation and authorisation of providers. They are responsible for organising and planning health services and for ensuring that these services meet the national quality standards. Given the level of discretion they enjoy, each Regional Health Authority may approach quality regulation differently.

Funding

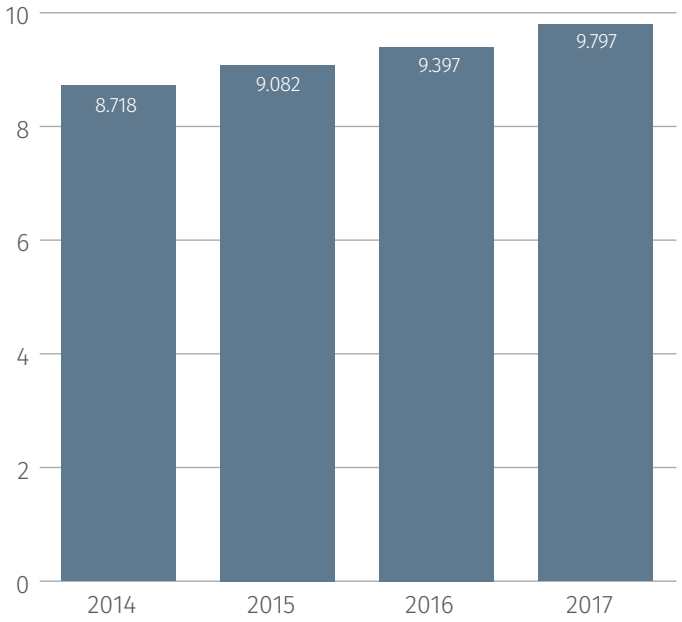
Social care services are primarily funded through general taxation. Funding allocations are made by central government and the regions.

Central government sets out annual social care budgets, which are allocated to the regions. In 2017, the total expenditure is estimated to be €9.8bn, including an additional €102m in central funding for adult social care. This national funding is complemented by regional funding. A minimum amount is agreed between central government and the regions, with each region allowed to provide additional funding on a voluntary basis. The level of expenditure on social care services is among the lowest in Western Europe.

Public funding does not cover the entire cost of social care services and individuals often have to contribute towards the cost of their care. In addition, social care has historically been under-funded and despite the introduction of a comprehensive reform in 2006, funding has been hit by austerity policies implemented from 2010.

Total Social Care Expenditure (€, bn)

Source: OCED, Eurostat, Marwood Analysis



Background to the Spanish social care system

The Spanish social care system has changed significantly over the past ten years. This is due to the 2007 reform, which aimed to formalise the social care system and to address the growing demand for professional services. It introduced a right to social care services, guaranteeing access to a package of care for anyone who needs care support, subject to some cost sharing.

Historically, social care services for disabled or older people were primarily provided informally by family carers. Whilst informal care provision continues to exist, the regions have increasingly organised formal care services, delivered by paid carers working in homecare and in care homes.

Payment System

Payments to social care providers are made by both public and private payers.

Regions are responsible for contracting with care home and homecare providers and paying them directly. Whilst they currently remain the main payers, there is a growing trend towards allocating cash benefits to individuals to purchase services from providers, primarily homecare services. These cash benefits may also be used to purchase equipment such as telecare, supporting elderly people to remain in their own home.

Individuals receiving publicly funded social care services are expected to contribute to their cost. These co-payments are estimated to represent 16% of the total payments to providers.

Provider Landscape

Social care services include a range of telecare, homecare, personal care help, residential care and day care services. These services are provided by a mix of public and private operators.

Residential and nursing care services are primarily delivered by private sector organisations, which must be licensed by regional authorities. There is a requirement to meet minimum ratios of workers per care recipient. There are significant differences in the level of provision across the regions.

In homecare, the private sector is used as a second option when public provision is unavailable or cannot provide the type of services required.

Regulation

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 regions for needs threshold assessments.

Political Environment

Healthcare governance is highly decentralised. Spain is divided into 19 regions, including the cities of Ceuta and Melila. Each region 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.

Spain's parliament is comprised of the 350-seat Congress, elected by popular vote, and the 265-member Senate, of which 208 members are elected directly and the remaining 57 are appointed by regional legislatures. A new government, led by Pedro Sánchez (PSOE, centre-left) took office in June 2018, following a vote of non-confidence against the former Prime Minister Mariano Rajoy (People's Party, centre-right).

The fragile Sánchez government collapsed on 13 February 2019, after losing a vote on the 2019 budget. An early general election will take place on 28 April 2019. The PSOE is currently leading in the polls but is not expected to win a majority of seats. This suggests that forming a government could prove difficult.

Composition of Parliament

Government

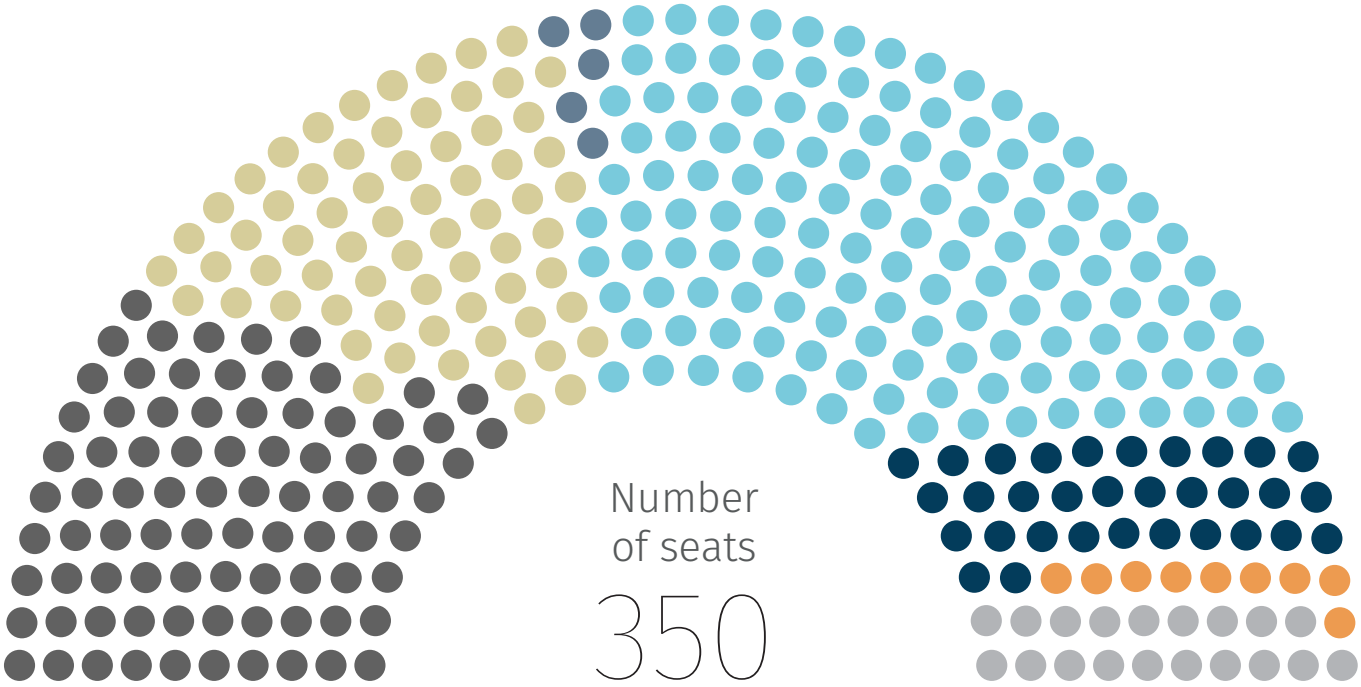
- PSOE (84)

Confidence and Supply Support

- Podemos (67)
- Basque Nationalists (5)

Opposition

- People's Party (134)
- Citizens (32)
- Republican Left of Catalonia (9)
- Others (19)

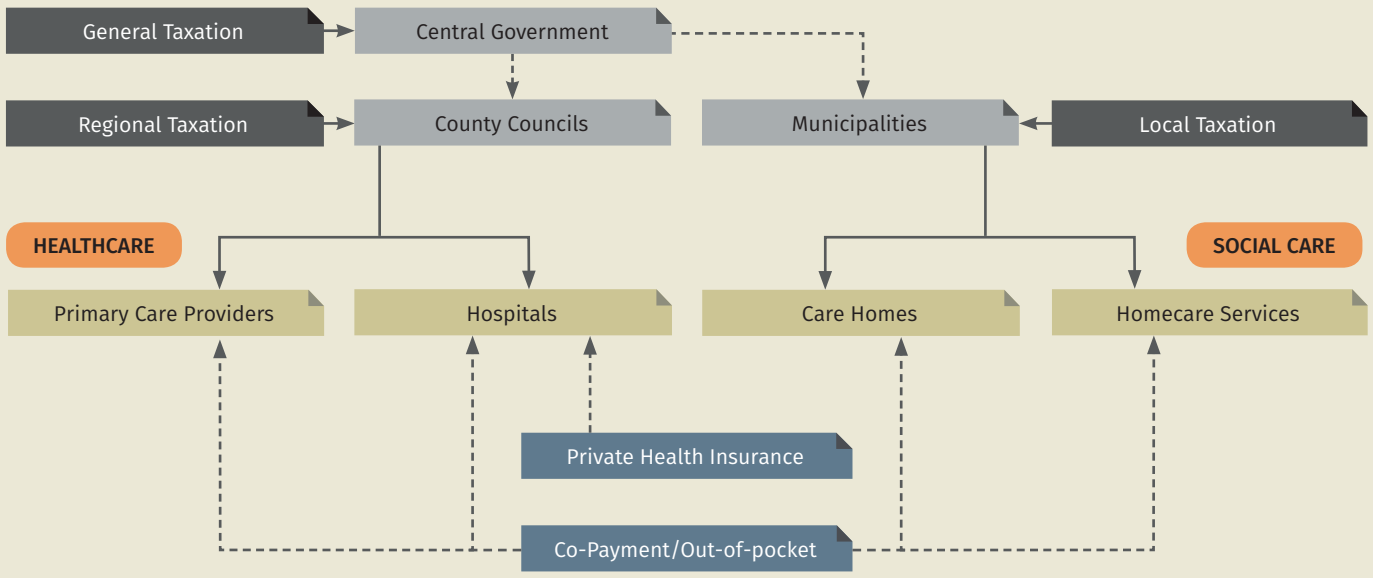


Sweden

Key Messages

- Sweden's health and social care system has a highly decentralised structure. Key funding and organisation decisions are taken at the regional level by 21 county councils and at the local level by 290 municipalities
- Healthcare policy is primarily focused on expanding primary care services, and intends to increase service provision outside hospitals
- The new Government has made reducing waiting times a priority, and is expected to outline plans to address this issue
- Provision of health and social care services continues to be dominated by public organisations. However, county councils and municipalities have increasingly opened provision of primary care services, care home and homecare services to competition from the private sector

Funding Flows



Key Facts and Figures

Population

Total

10.1m

Source: OECD

Life Expectancy

82.4 years

Source: OECD

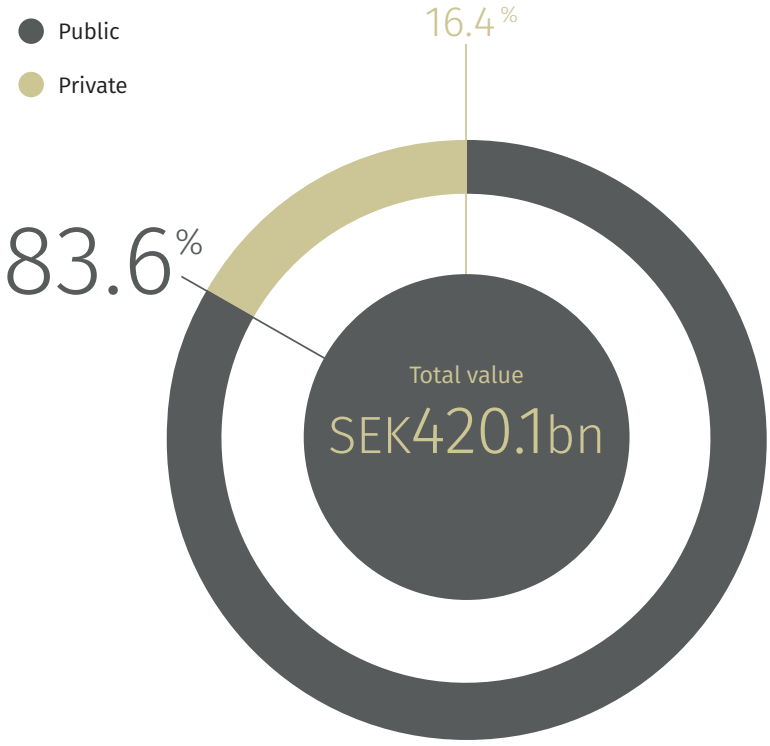
Population Distribution (%)

- 29.3% are aged between 0 and 24
- 50.9% are aged between 25 and 64
- 29.8% are aged over 65

Source: Eurostat (2018)

Healthcare Expenditure

Source: Eurostat (2018)
1SEK = 0.0975EURO (2018 average)



Social Care Expenditure

Source: OECD, Marwood Analysis
1SEK = 0.0975EURO (2018 average)

SEK132.2bn

Policy Snapshot: A Bigger Role for Primary Care

Healthcare reform driven by expanding primary care provision

The Government has commissioned an independent review of the healthcare system, with a focus on primary care services. The review, due to be published in 2019, will investigate and provide recommendations on:

- Increasing the provision of services outside of hospital
- A new national mission statement for primary care, including clarifying its role in emergency care provision
- Expansion of primary care opening hours
- Transferring funds from hospital budgets to primary care

General elections were held in September 2018, resulting in a hung parliament. On 17 January, Stefan Löfven the leader of the centre-left Social Democratic Party, secured a second term as the head of a minority centre-left government. He indicated that his Government would implement the recommendations of the review on primary care.

In addition, the Government is expected to draft a plan to address waiting lists. New waiting time standards would also apply to mental health. Psychiatric care services may be expanded, with a focus on community provision most likely

Healthcare

Funding

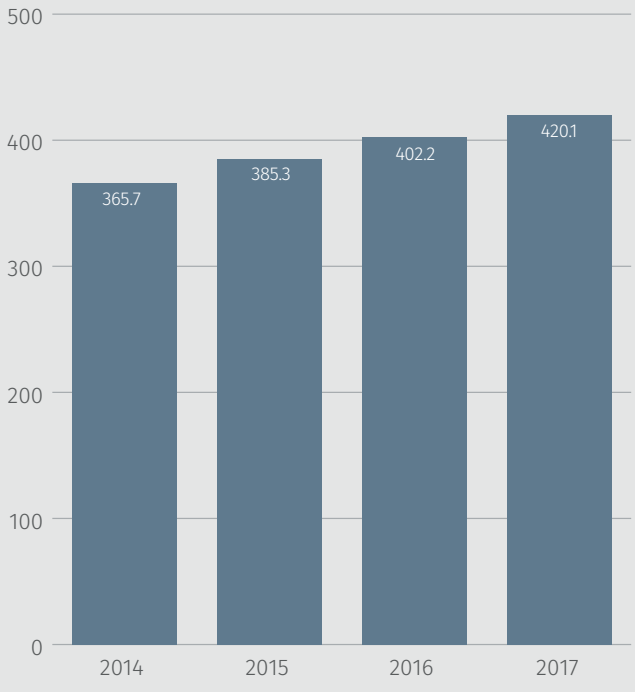
Healthcare services are primarily financed by public sources of funding, coming from regional taxation, levied by 21 county councils. This funding is complemented by central government grants, funded through national income taxes and indirect taxes. Central government funding is distributed among county councils to level out differences in income tax revenue. It may also be ring-fenced to finance specific national policy priorities. In 2018-2020, three sub-sectors are expected to benefit from central ring-fenced funding:

- Primary care – SEK1bn per year
- Maternity care – SEK1bn per year
- Mental health services – SEK0.65bn in 2018, SEK1bn in 2019 and 2020 respectively

In recent years, public expenditure on healthcare services grew substantially, from SEK365.7bn in 2014 to SEK420.1bn in 2017. This represents an annual average of 4.7% between 2014 and 2017, well above the level of inflation.

Public Healthcare Expenditure (SEK, bn)

Source: OECD



Payment System

Healthcare providers are primarily paid by county councils. Private and public providers are treated in a similar way and can compete for contracts in public tendering processes. Each of the 21 county council designs its own payment system. Notwithstanding regional variations, primary care providers are paid on the basis of capitation and performance, while hospitals are paid through a mix of global budget Diagnosis Related Groups (DRG), performance-based methods and, sometimes, case-based payments.

Healthcare services are not entirely free at the point of use. Patients pay a fee-for-service, determined at county council level. In 2016, the fee for a general practitioner (GP) consultation varied from SEK150 to SEK300 and consulting a specialist costs up to SEK400. People under 20 (or 18 in some counties) are exempt from fees for GP consultations and dental care. Hospital stays cost up to SEK100 per day. Once co-payments reach the national annual threshold (SEK1,100), patients are no longer required to pay for healthcare services. All fees apply to both public and private providers delivering public healthcare services.

The role of voluntary private health insurance

Although subscription to voluntary private health insurance has tripled between 2006 and 2016, it only covers 6% of the total population and contributes to just 1% of total healthcare payments. 70% of policies are purchased by employees and provided as employee benefits.

The content of private health insurance plans varies but tends to cover the following services: access to telephone counselling, health checks, certain treatment plans and surgery delivered by private providers, and rehabilitation such as physiotherapy and chiropractor services.

Until July 2018, private health insurance subscription was treated as a tax-free benefit. However, the growth in subscriptions led the social-democrat government to remove the tax exemption. This may slow-down subscription growth in the future.

Insurance Type	Role/Coverage	Population Covered	
		2006	2016
Supplementary	To get faster access to services in reaction to high perceived or actual waiting times	218,000	611,000

Provider Landscape

Primary care services are provided by over 1,100 health centres made of GPs, nurses, physiotherapists, psychologists, and gynaecologists. 42% of health centres are privately-owned. Any provider has the right to establish a health centre and deliver publicly-funded services, as long as they meet the county council's criteria.

County councils own the majority of hospital services. There are 70 hospitals in Sweden. Six of these hospitals are private. Three are run as for-profit enterprises, and three are non-profit, in contract with Stockholm County Council. Hospitals provide specialised inpatient acute services, elective care, and outpatient mental health care. They are subject to achieving waiting time targets which state that patients should see a specialist within 90 days of referral and then commence treatment within 90 days of specialist diagnostic. Adherence to these targets varies widely across county councils. If waiting times are exceeded, patients can choose any other provider.

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. It does that by evaluating providers on the basis of an extensive ranking system. The outcome of evaluations is used by county councils in awarding contracts and allocating resources to hospitals.

Funding

Funding for social care is primarily public and comes from local taxation, levied at the local level by 290 municipalities. Central government funding levels out differences in local tax revenue through redistributive grant mechanisms, and allocates ring-fenced funding for specific projects.

Social care budgets are used to finance services for older people as well as services for adults with learning or physical disabilities. In 2017, total social care expenditure is estimated to be SEK132.2bn.

Payment System

Unlike most European countries, social care services are almost free at point of need. Co-payments make up just 5-6% of total payments to social care providers. Each municipality designed its own payment system and prices. Payments are made directly from municipalities to social care providers.

Private providers can compete for contracts through public tendering processes, which are managed by municipalities. The number of private companies in the social care services sector is estimated to have increased five-fold between 1995 and 2005.

Provider Landscape

Social care provision continues to be dominated by public providers, but the market has been opened to competition and patients are entitled to choose the service they want to use. This has enabled private providers to enter the market and private provision increased over the past 20 years.

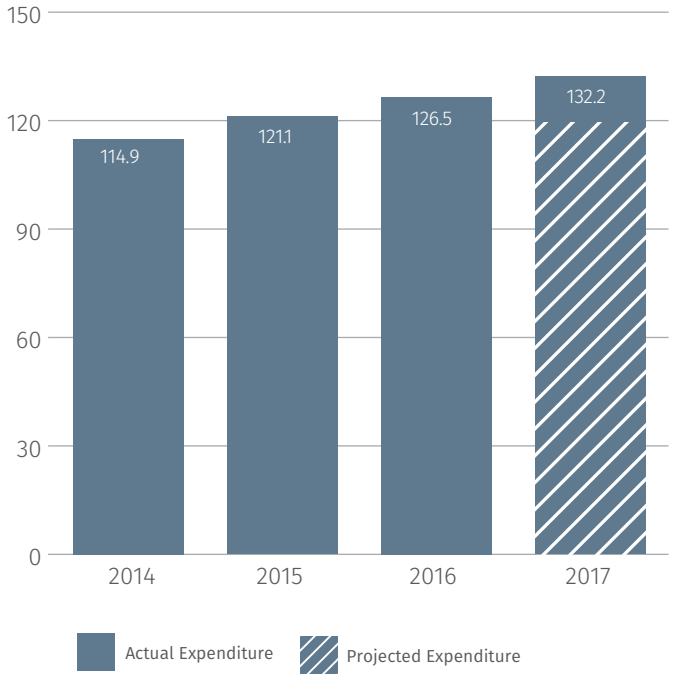
The private care home landscape is dominated by two companies, Attendo and Vardaga. Private provision penetration varies across municipalities. In 2018, care homes services were exclusively provided by private organisations in five municipalities. In 165 municipalities, they were exclusively provided by public operators and 120 municipalities relied on a mix of public and private provision.

Homecare services provided by private agencies make up 24% of the total homecare hours for older people and 34% of the total homecare hours for adults with physical or learning disabilities.

In 2017, 313,000 older people were receiving social care services.

Total Social Care Expenditure (SEK, bn)

Source: OECD, Marwood Analysis



Regulation

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

There is limited central government involvement. However, central government may finance specific objectives. For example, €190m was allocated annually between 2016 and 2018 to improve the quality of elderly care.

Political Environment

The 09 September 2018 general election resulted in a hung parliament, and saw the far-right Sweden Democrats win 17.5% of the vote. After four months of complex negotiations, on 17 January 2019, Stefan Löfven, the leader of the centre-left Social Democratic Party, secured a second term as the head of a minority coalition with the Green Party. His government, which has a confidence and supply agreement with the Centre Party, the Liberals and the Left Party, is nonetheless fragile and will need to trade carefully.

General elections are held every four years, with the next election due to take place in September 2022.

Composition of Parliament

Government

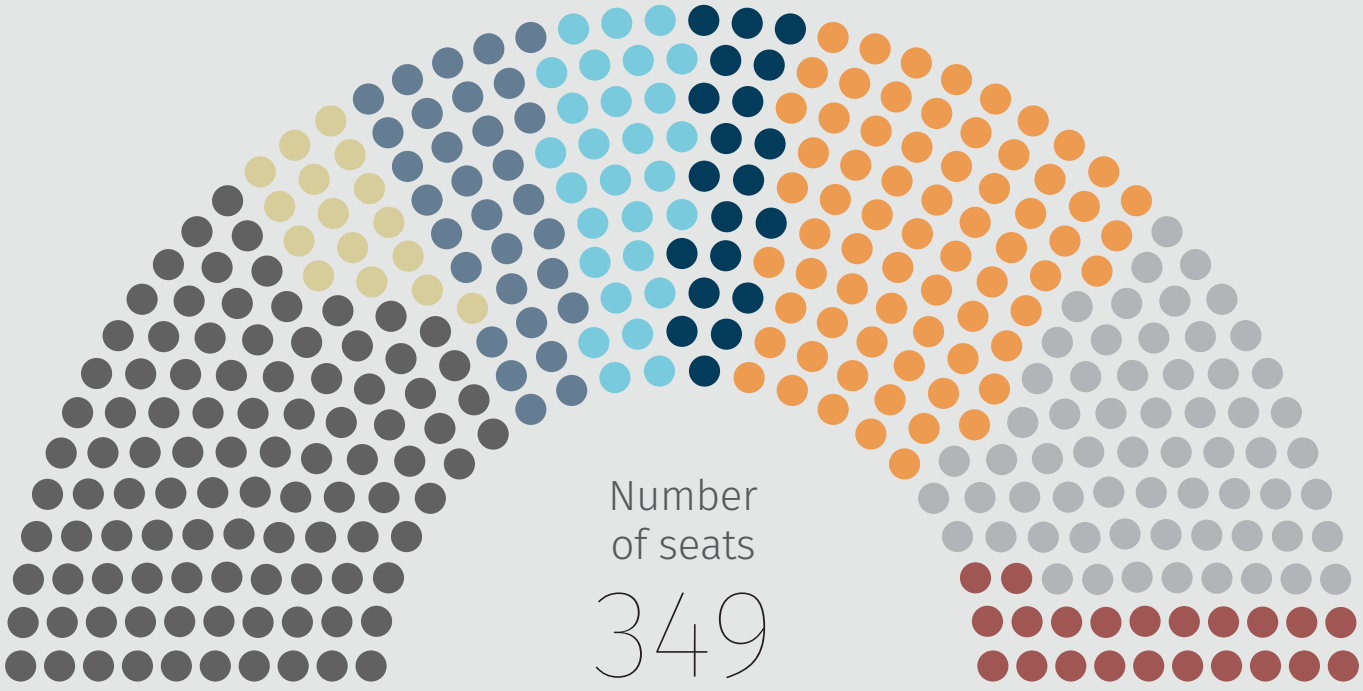
- Social Democrats (100)
- Green Party (16)

Supporting Government

- Centre Party (31)
- Left Party (28)
- Liberals (20)

Opposition

- Moderate Party (70)
- Sweden Democrats (62)
- Christian Democrats (22)

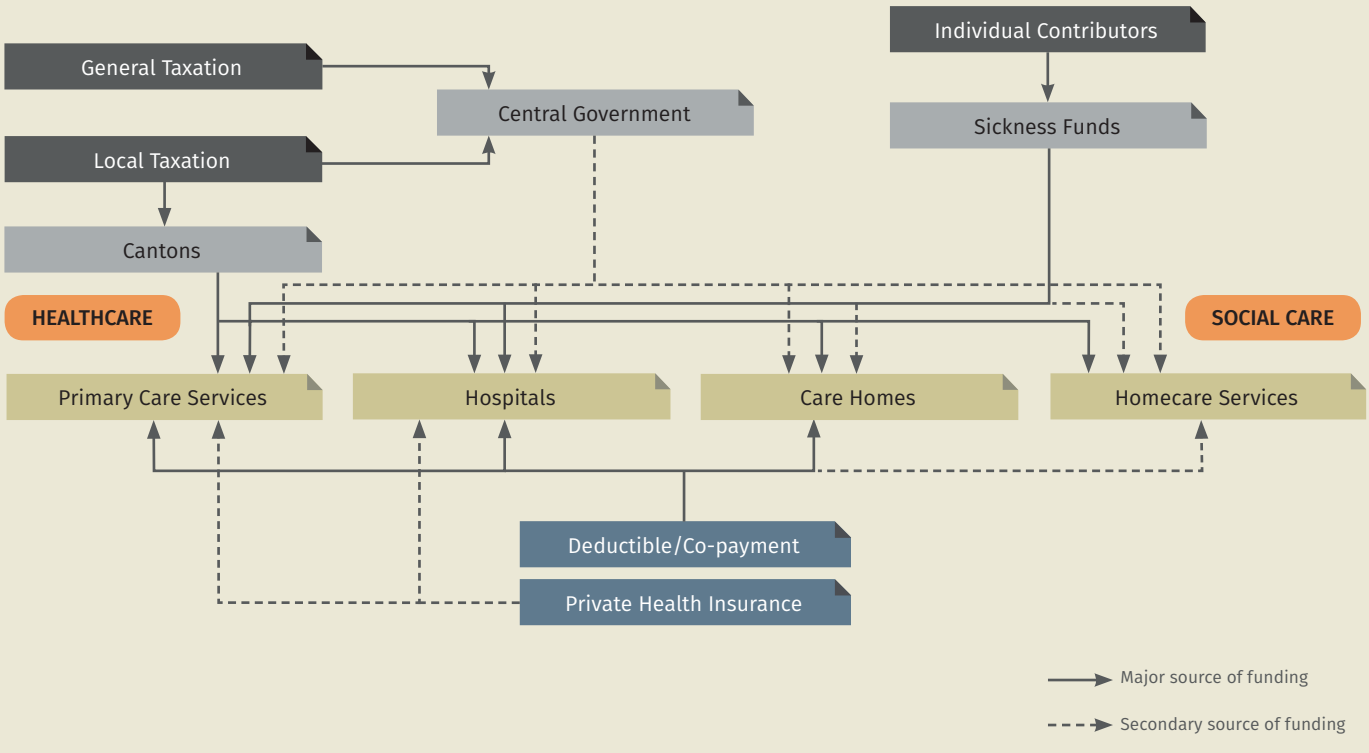


Switzerland

Key Messages

- Policy reforms are driven by cost-containment measures to control the growth of public spending on health and social care services
- Central government strengthened its role in overseeing the negotiation of fees that traditionally took place between providers and payers (sickness funds), with minimal central intervention
- Going forward, it is expected that there will be more oversight of health and social care provider payments, to address over-billing by certain providers
- The roll out of the patient electronic record system over the next few years is expected to simplify collaboration between providers and across care settings in a highly fragmented system
- National policy direction follows the principles of quality, transparency and equal access to services outlined in the Health 2020 vision. This is complemented by decisions taken locally by the 26 cantons, which have discretionary powers on the funding, planning and organisation of care services

Funding Flows



Key Facts and Figures

Population

Total

8.5m

Source: OECD

Life Expectancy

83.7 years

Source: OECD

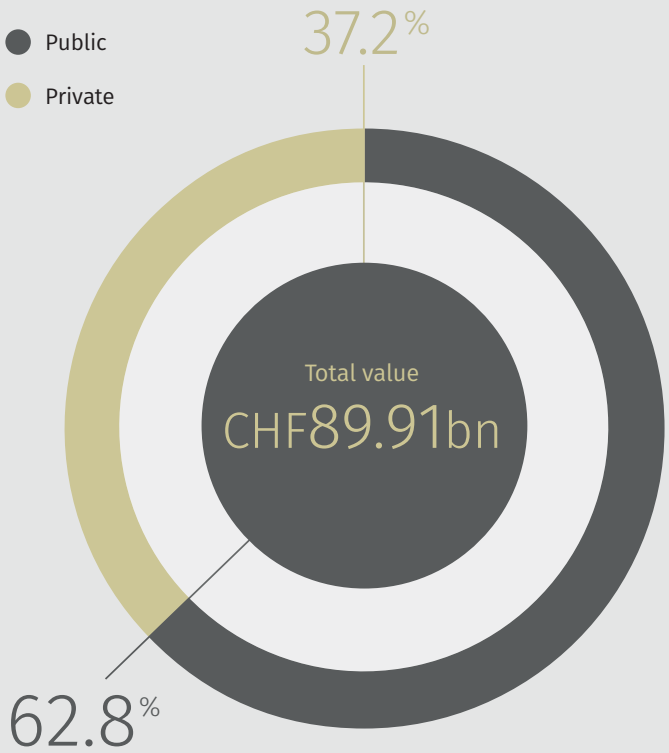
Population Distribution (%)

- 26% are aged between 0 and 24
- 55.9% are aged between 25 and 64
- 18.1% are aged over 65

Source: Eurostat (2018)

Healthcare Expenditure

Source: OECD
1CHF = 0.866EURO (2018 average)



Estimated Total Social Care Expenditure

Sources: Federal Office for Statistics, OECD, Marwood Analysis (2017)
1CHF = 0.866EURO (2018 average)

CHF15.38bn

Policy Snapshot: Cost-Containment and Patient Electronic Records

Cost-containment measures and implementation of the patient electronic record are the key policy drivers

Cost-containment measures aim to address over-prescription by healthcare providers to ensure the financial sustainability of the system. A first stage of the reform covers the fee schedule, which is used to pay primary care physicians and outpatient care specialists. From 2019, national control over fee negotiations between providers and sickness funds will be strengthen, which will enable more central oversight.

The second stage of the cost-containment reform will be put to consultation by the end of 2019 at the latest. It is expected to address medicine prescription and price, measures to increase control over provider billing, and increase transparency in the billing system. This could lead to the introduction of cost growth targets for providers and possibly sanctions for those exceeding these targets.

Health and care providers are expected to gradually introduce patient electronic records to facilitate information sharing across the system. The new e-Health strategy adopted at the end of 2018 outlines implementation steps leading to the full introduction of patient electronic records by 2022. Providers will work towards this goal with cantons, central government and the e-Health Swiss agency. To successfully implement the new system all key organisations will need to ensure staff receive adequate training on patient electronic records and the governance of private data.

The Swiss health and care system is highly fragmented, exposed to several levels of decision-making, multiple payers and limited coordination between settings of care. The implementation of the patient electronic record is intended to support integration and transparency between health and care services.

These measures support the objectives outlined in Health 2020. Launched in 2013, it is an important policy document describing the vision for the Swiss health and care system. This vision is based on improving life quality, increasing payer and provider transparency, improving care quality, and equal access to services.

Healthcare

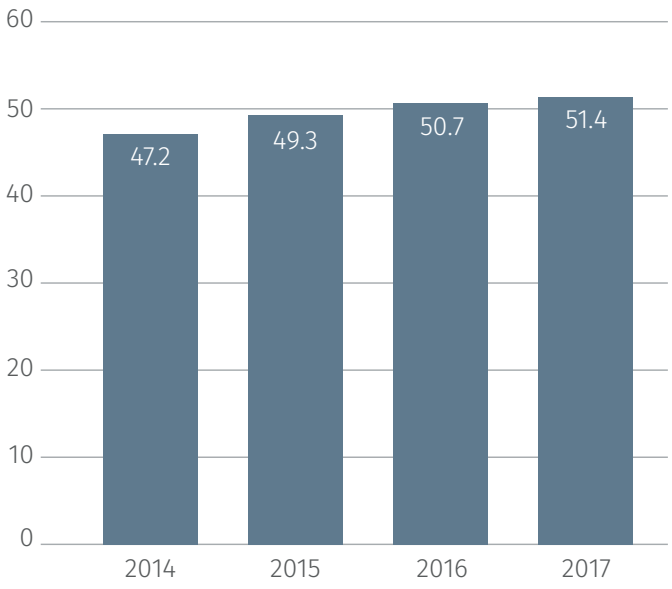
Funding

The structure of healthcare financing is in Switzerland is complex and relies on mandatory statutory health insurance (SHI). The majority of the total healthcare funding comes from public sources and covers a nationally-defined basket of health services. However, it is heavily complemented by private sources of finance.

Public healthcare funding comes from mandatory contributions, sickness funds, and deductibles, paid by individuals to the sickness fund of their choice. This funding is complemented by direct government and cantonal funding, which comes from national, regional and local taxation revenues.

Public Healthcare Expenditure (CHF, bn)

Source: OECD



The functioning of the SHI in Switzerland

57 sickness funds manage and implement the SHI. They get their revenue from monthly mandatory contributions (premiums). Individuals pay these contributions directly to their sickness funds.

Individuals are free to register with the sickness fund of their choice. The contribution amount they pay to sickness funds depends on their canton of residence. This is because cantons subsidise the cost of contributions to different extents. Within a canton, the cost of contributions must be the same for all insured individuals. The contribution may also be reduced if individuals accept a higher deductible. Deductibles set out the amount of money someone will have to pay out-of-pocket for using healthcare services before SHI financial coverage starts.

Sickness funds revenues are pooled and redistributed among them to make sure that they all have sufficient resources, depending on the risk profile of their members. As statutory health insurance is mandatory, applications cannot be turned down.

Payment System

Healthcare providers operate in a complex, multi-payer system.

Services are not free at the point of use. Individuals are required to pay user charges through deductibles and co-payments to use SHI services. Deductibles determine the amount that individuals have to pay themselves before SHI coverage starts. In total, maximum user charges, are capped between CHF1000 and CHF3200, depending on the type of insurance plan chosen.

Primary care physicians contracting with the SHI are paid on the basis of a fee schedule, which is set at national level.

Fees are generally billed directly to the patient. If they have reached the top deductible limit, patients can claim the cost back to their sickness fund to get reimbursement.

Hospitals are paid in a similar way as primary care physicians for outpatient services. For inpatient services they are primarily paid by the cantons and sickness funds, on the basis of a diagnosis-related groups (DRG) system. Hospitals invoice the cantons and the sickness funds separately. Hospitals also receive direct payments from patients, including a daily fee of CHF15. Supplementary services may be paid by voluntary private health insurers.

The role of voluntary private health insurance in Switzerland

Payments from voluntary private health insurance contribute to 6.6% of the total spending on healthcare in Switzerland. Voluntary private health insurance schemes are used both as a complement and as a supplement to the SHI.

	Complementary Insurance	Supplementary Insurance
Coverage	Dentistry and orthodontist services, glasses and contact lenses	Cost of a private room in hospital, greater provider choice

Provider Landscape

Primary care physicians are private providers, who may contract with the SHI for the provision of primary care services. In 2017, there were 11,892 primary care physicians. Around half worked in physician networks. Most of these networks contract with sickness funds.

Inpatient hospitals services are provided by a mix of public and private hospitals. In 2016, there were 283 hospitals. The private sector dominates the provision of specialist hospital and rehabilitation clinic services. Private hospitals can contract with cantons and the sickness funds to deliver SHI services. All hospitals may also treat private-pay patients. In both primary and secondary care, patients have free choice among providers and do not need a referral to access specialist consultations.

Type of services	Ownership	
	Private	Public and Non-Profit
General acute hospital	49	53
Specialist hospital	56	18
Mental health hospital	20	31
Rehabilitation clinic	37	19
Total	**162**	**121**

Source: Federal Office for Statistics

Regulation

The regulation of providers is carried out jointly by the government through the Federal Office of Public Health and the cantons. The Federal Office of Public Health is responsible for determining the conditions for providing SHI services. Cantons are responsible for licensing primary care providers and can choose which hospital providers deliver secondary care services on behalf of the SHI.

The improvement of care quality has been a key policy objective in recent years. It features among the four objectives of the national Health 2020 strategy. The strategy intended, among others, to develop a quality information system to support patients in choosing among providers. It also intended to increase the ratio of staff/patient. Initiatives to improve recruitment and retention of healthcare professionals are ongoing. However, there has been limited progress towards the development of the information system.

The sickness funds regulate payments to providers. In particular, they ensure that primary physicians do not over-bill them or over-prescribe services.

Social Care

Funding

Funding for adult social care services comes from a mix of public and private sources. Public funding comes from mandatory payroll contributions to social insurance and general taxation. It provides a safety net, but individuals are expected to finance some of the costs. Sickness funds may also finance medical costs for older people, if these costs are covered by the SHI. In 2017, total social care funding is estimated to be CHF15.38bn

Payment System

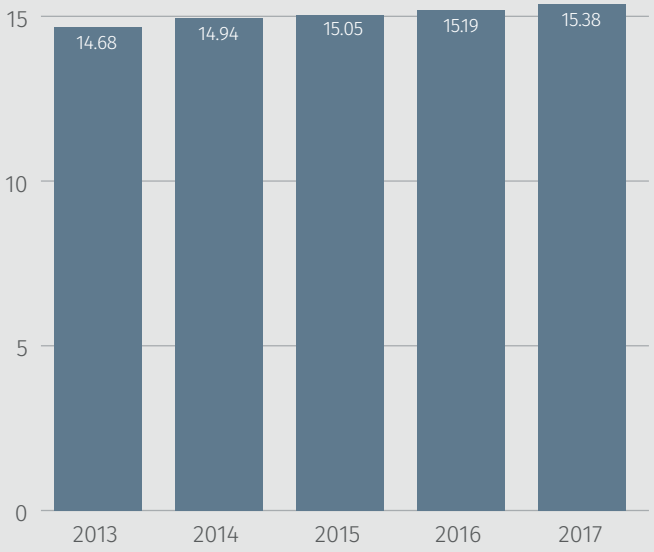
Social care services are not free at the point of need and providers are exposed to multiple payers, including cantons and municipalities, sickness funds, individuals and private health insurance.

Homecare providers receive hourly rate payments by sickness funds for the provision of nursing care services at home. The rates vary from CHF 54.60 to 79.80 per hour depending on the type of care service, but are set nationally. Tariffs applying to activities of daily living and specific tariffs for services for people living with dementia are set by the cantons. Homecare providers agree a care plan with sickness funds and/or the cantons for each patient. They bill sickness funds, cantons and patients on the basis of their employees' monthly activity reports.

Care home providers are paid on the basis of per-diem fees. Like for homecare services, care costs are paid by sickness funds. There are 12 different tariffs set nationally. However, they do not cover the full costs of services, and cantons and/or residents pay for the difference. Accommodation and board costs are billed directly by care home providers to residents. They are also calculated on the basis of a daily rate.

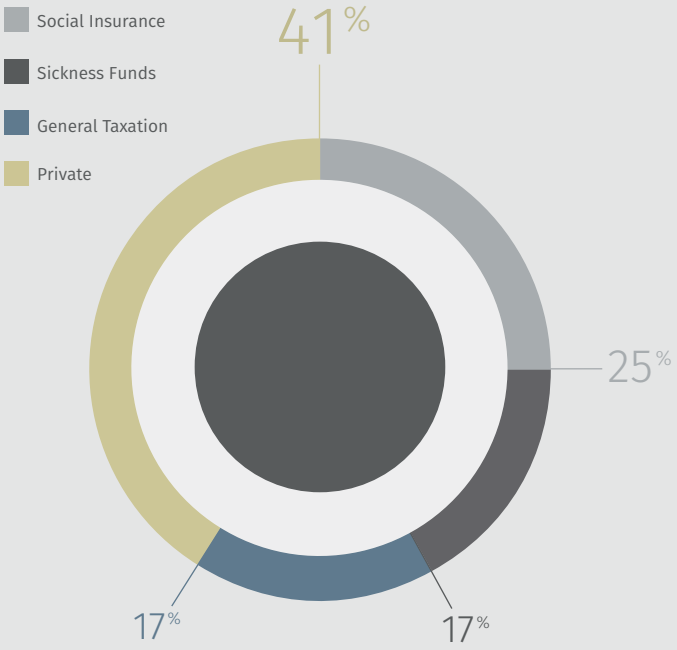
Total Social Care Expenditure (CHF, bn)

Source: Federal Office for Statistics, OECD, Marwood Analysis



Sources of Social Care Funding

Source: WHO



Provider Landscape

Homecare services are primarily provided by non-profit organisations and independent nurses. However, private for-profit provision has been growing from 293 providers in 2013 to 443 in 2017. There was a total of 2,035 homecare providers in 2017.

Residential and nursing care is provided by a mix of organisations. In 2017, there were 1,561 care homes located across the 26 cantons.

Homecare Provision

- Independent Nurses (1,015)
- Non Profit Providers (577)
- For Profit Providers (443)

Total number of homecare providers: 2,035

Source: Federal Office for Statistics

Care Home Providers (2017)

- Private Pay (688)
- Mix of Private and Public Pay (468)
- Public Pay (405)

Total number of care home providers: 1,561

Source: Federal Statistical Office

Regulation

Social care providers are primarily subject to cantonal regulation. Each canton sets out the criteria for providers to operate homecare and care home services in their geography, meaning that providers operating across multiple cantons are subject to different criteria.

Political Environment

Switzerland is a confederation of 26 cantons with a high level of decentralisation. Executive power is held by the Federal Council, which is made up of seven councillors. 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. The next federal election will take place on 20 October 2019. Opinion polls are not currently predicting that it will lead to major changes in party representation.

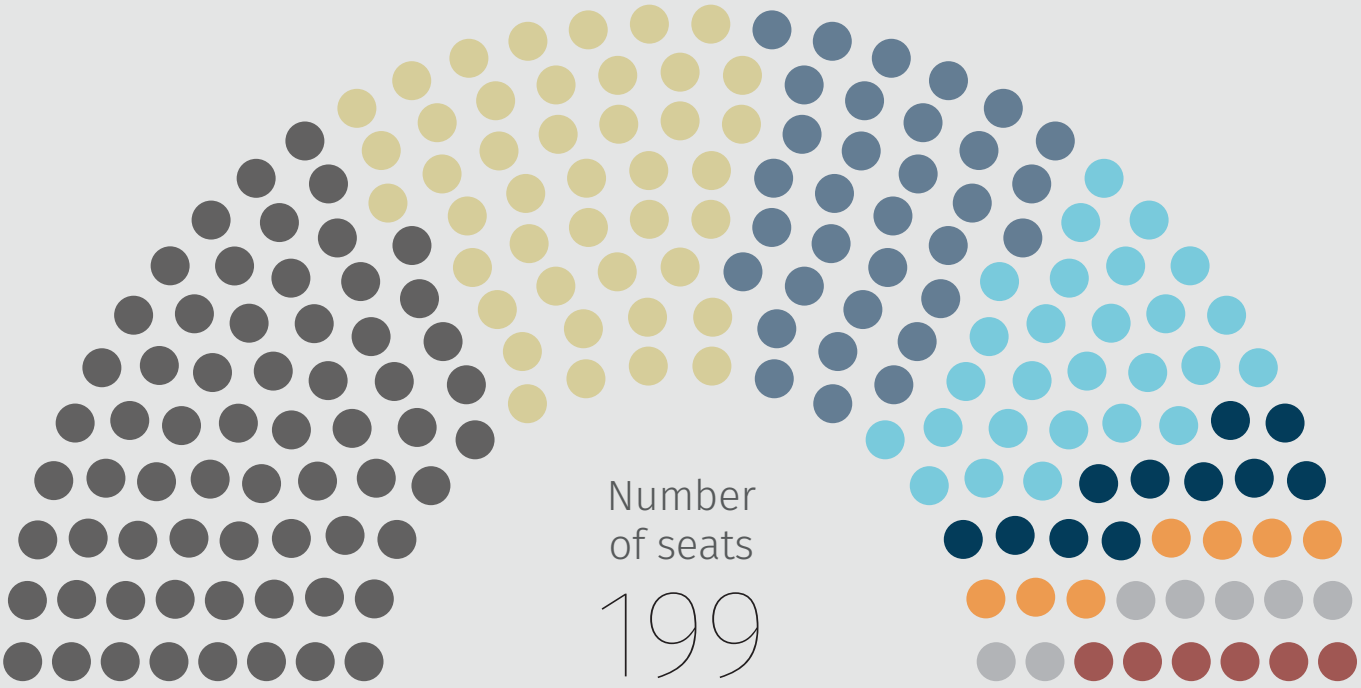
Composition of Parliament

Government

- SVP/UDC (65)
- SP/PS (43)
- FDR/PLR (33)
- CVP/PPC (27)

Opposition

- Greens (11)
- BDP/PDB (7)
- Glp/Pvl (7)
- Others (6)

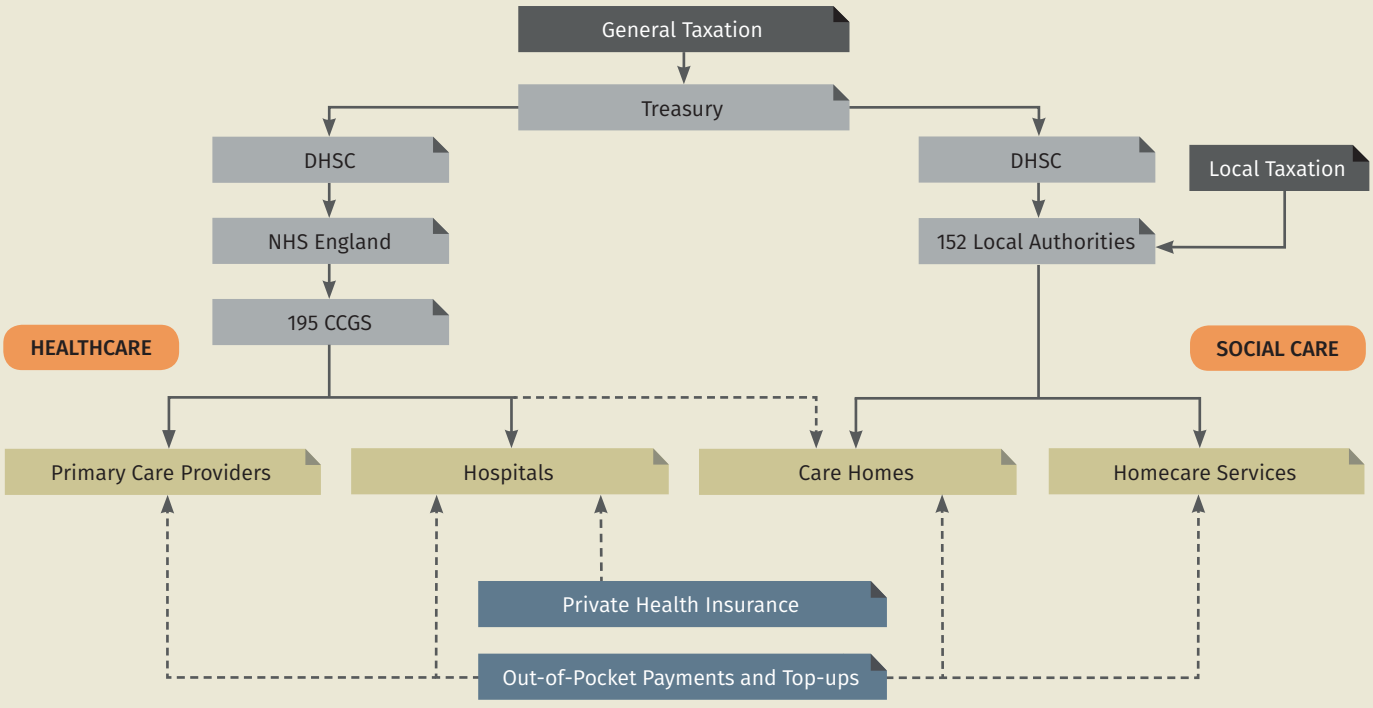


England

Key Messages

- The NHS is set to receive an additional £20.5bn funding in real-terms between 2019/20 and 2023/24, including £2.3bn for children and adult mental health services and £4.5bn for community and primary care services
- Other priority areas outlined in the NHS Long-Term Plan include cancer and maternity care, enabling and expanding the use of digital technologies in healthcare, prevention and early diagnosis of common diseases
- An expected Social Care Green Paper may not come until Summer 2019 and is expected to be published ahead of the comprehensive spending review. It is due to discuss options for funding social care in the future
- Social care services, including older people's and learning disability services, are primarily funded by local authorities whose budgets have faced reductions in central government funding
- Local authorities have sought to protect social care funding. The degree of funding pressure on providers contracting with local authorities has varied across the country

Funding Flows



Major source of funding

Secondary source of funding

DHSC: Department of Health and Social Care
MHCLG: Ministry of Housing. Communities and Local Government
CCG: Clinical Commissioning Group

Population

Total

55.6m

Source: ONS

Life Expectancy

79.5 years

83.1 years

Source: ONS

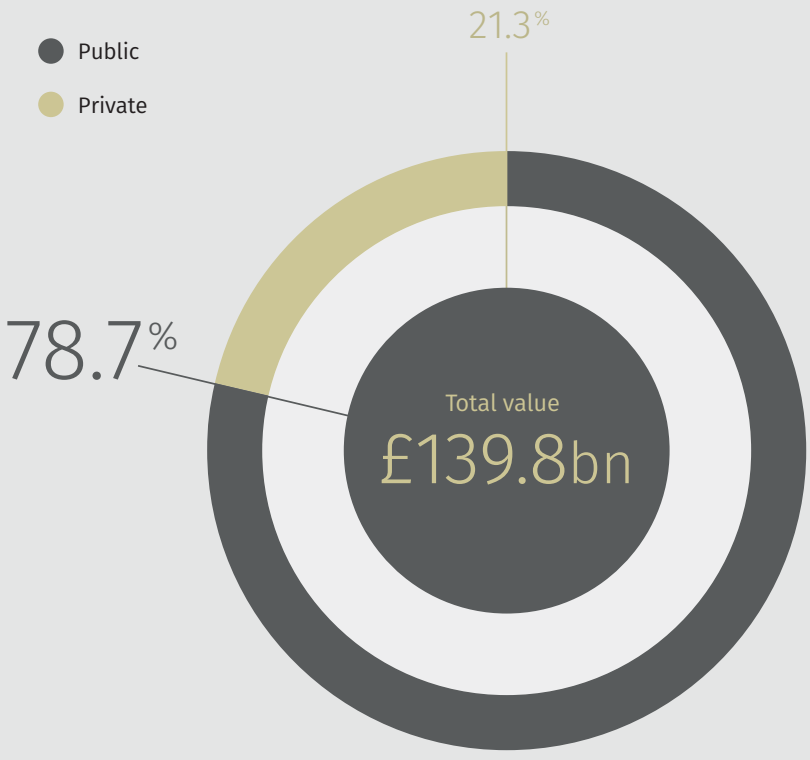
Population Distribution (%)

- 30.1% are aged between 0 and 24
- 51.9% are aged between 25 and 64
- 18% are aged over 65

Source: ONS (2017)

Public Healthcare Expenditure (NHS)

Source: OECD, Marwood Analysis



Share of expenditure is for the UK, the share of private expenditure is likely to be slightly higher in England

Policy Snapshot: The NHS Long-Term Plan

Additional funding and a Long-Term Plan for the NHS whilst social care providers still await the Green Paper

The NHS Long-Term Plan was published in January 2019. It sets out priorities for NHS services over the next five to ten years, in light of £20.5bn additional funding to be allocated between 2019/20 and 2023/24.

The Long-Term Plan outlines several areas set to benefit from this additional funding:

- Local children and adult mental health services funding will be ring-fenced and grow by an extra £2.3bn in real-terms by 2023/24. The focus remains on early interventions, eliminating out-of-area placements, and improving crisis care
- £4.5bn in additional ring-fenced funding by 2023/24 will deliver expanded community services and multidisciplinary primary care networks to support a shift in care provision outside of hospitals
- Cancer and maternity services are big winners in acute care services

There are expected changes to the way providers operate, with primary care networks set to take a leading role in healthcare provision outside of hospitals. In addition, a full chapter of the Plan is dedicated to healthcare digitisation. New initiatives are expected in this space and there may be opportunities for those developing innovative health technologies. NHS England have also proposed legislative changes that support integration but may impact on the ability of private providers to compete for NHS contracts.

The Plan indicates that workforce crisis will be addressed by increasing training places for doctors and nurses. However, specific training funding announcements must wait for the spending review later in 2019.

There are some references to social care in the Plan. However, the publication of a Social Care Green Paper which is due to make proposals on future funding for social care services, has been delayed several times. Publication is now expected by Summer 2019 This will be disappointing to providers operating in this space. Social care services are under significant funding pressure due to cuts to local authority budgets.

Healthcare

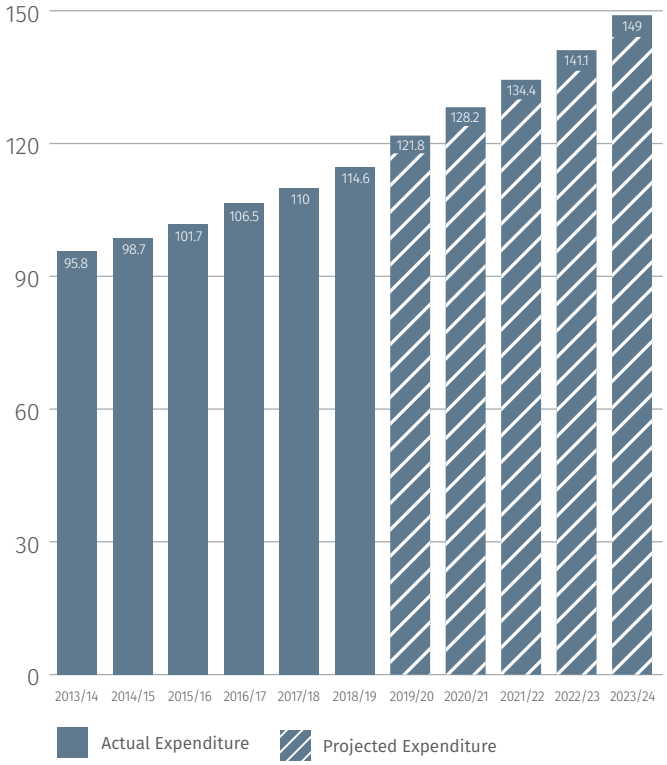
Funding

Healthcare funding in England is primarily public and comes from general taxation. Following a period of containment, public spending is set to increase above the level of inflation until 2023/24.

In July 2018, the Government announced that the NHS would receive a long-term funding boost above the rate of inflation. From 2019/20, the budget to be spent on services should increase by an average 3.4% per year and in real-terms until 2023/24.

The increased funding only applies to the NHS revenue expenditure. This is money spent on healthcare services by NHS England and Clinical Commissioning Groups (CCGs). There are currently no longer-term funding plans for capital expenditure, workforce and public health. These are expected to be announced later in the 2019 Comprehensive Spending Review.

NHS Expenditure (£, bn) Source: NHS Funding Settlement



Payment System

The NHS is the main payer in England. There are only limited additional healthcare costs to the individual under the public healthcare system, with charges for many users to part cover the cost of pharmaceutical prescriptions and dentistry.

There is relatively low usage of private medical insurance, with the majority of plans being offered as part of employer benefit packages. Out-of-pocket payments are most common in the dental sector, and there is some growth in out-of-pocket expenditure on services that provide faster, or virtual, access to GP appointments.

Private providers are able to deliver NHS services. Regulations introduced after the 2012 Health and Social Care Act created statutory requirements on CCGs that were designed to promote greater choice in healthcare providers. Discussions currently taking place are considering the possibility to repeal these regulations. Whilst this could limit private providers' ability to tender for NHS contacts, these changes would require Parliament to pass primary legislation. Given the political uncertainty around Brexit, and the limited ability for the Government to pass legislation, there may be delays before this is introduced.

Primary care services are commissioned by NHS England, usually through delegated powers given to the 195 CCGs. GP Practices are allocated a certain amount of money that will be based on number of patients, and estimated level of need.

CCGs are responsible for allocating funding to meet patient needs for local service provision across acute, secondary and the majority of mental health services. Acute care services provided by NHS providers are reimbursed according to a tariff system, which sets a fixed fee for every item of activity delivered by the NHS provider. Private providers delivering NHS services may be reimbursed in a variety of ways, including block contracts that guarantee volumes at a fixed price, and spot-purchase agreements where costs are more likely to be negotiated according to individual need.

Provider Landscape

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

Primary care providers include independent GPs, dentists, community pharmacists and opticians. GPs provide the majority of primary care services and are the first point of contact for most patients. GPs increasingly work in group practices and a growing number are employed by their practice. As of September 2018, there were 42,445 GPs, including locums.

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: NHS Foundation Trusts, and NHS Trusts. NHS Foundation Trusts have more flexibility and freedom to operate than NHS Trusts. There are a small number of private providers delivering acute elective care, as well as private provision of mental health, learning disability, and secure inpatient services.

Regulation

The healthcare system in England is subject to significant regulatory oversight, and these can lead providers to face competing priorities. There has been efforts to alight regulatory activity. The Care Quality Commission is responsible for the quality of care in health and social care services, and covers all public and private providers that carry out services defined under the regulated activities. The Care Quality Commission has inspected and rated every provider delivering healthcare services in England. This provides a comprehensive, and unique, picture into the quality of care across sectors. In the future, they intend to introduce more flexible and responsive inspections. Better performing providers are likely to be inspected less frequently, and increased use of data monitoring to inform more targeted inspections is being introduced.

Funding

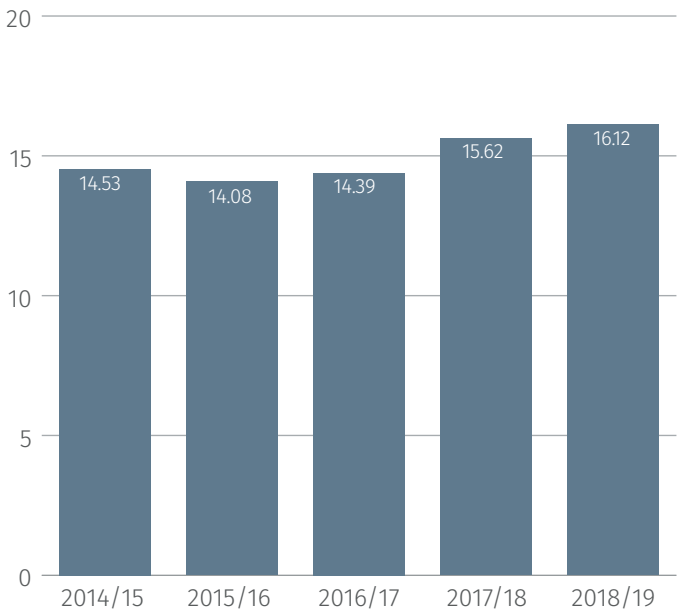
Social care services are funded primarily via public sources, through 152 local authorities, whose budgets are made up of a complex mix of national and local taxation. However, social care services are not free at the point of need. LA expenditure only provides a safety net and many people must pay for their own care privately.

Changes in local authority funding since the start of the decade have had a significant impact on the funding landscape for older people's services. Successive governments have reduced central funding for local authorities. Whilst there have been moves to offset this by giving local authorities more freedom over local revenue raising – the introduction of the social care precept, and the ability to retain a greater proportion of business rate revenue – these changes do not always meet the shortfall driven by reductions in central allocations.

These changes had a slightly negative impact on social care funding between 2014/15 and 2016/17, when average annual funding declined by 0.5%. In response, the Government announced an additional £3.5bn funding ring-fenced for social care to be allocated to local authorities between 2017/18 and 2019/20. This contributed to the increase in total local authority adult social care spending from 2017/18.

Local Authority Adult Social Care Expenditure (£, bn)

Source: Ministry of Housing, Communities and Local Government



Payment System

Social care providers are exposed to a mix of public and private payments.

Public payments come from local authorities and are due to cover the cost of care home or homecare services for older people who have been assessed as needing care and have less than £23,250 in assets and savings. For home owners applying for financial support in a care home, the value of their property is included in assets. Those who do not qualify for local authority funding pay for the cost of care home services out-of-pocket. Some people may choose to pay 'top-up' fees to stay in a care home that costs more than their local authority is willing to fund.

Local authority fees for care home services are set locally by each local authority in negotiations with care home providers. In 2017, the average weekly local authority fee was £621, while the average weekly fee charged to self-funders was £846.

Homecare services are usually paid for on an hourly rate basis. Rates are set locally by each local authority in negotiations with homecare providers. In 2018, the average hourly rate paid by local authority is £15.93. However, rates vary greatly across local authorities, and according to the complexity of the care provided.

Provider Landscape

The majority of social care service provision is delivered by private for-profit and non-profit organisations. The social care sector in England is highly fragmented. For example, no single operator provides more than 5% of the 471,463 care home beds across 16,392 locations. The 30 largest care homes supply 30% of the overall capacity.

In 2017, homecare agencies provided social care services at home across 8,614 locations, a 4.8% increase from 8,219 in 2015. Market share is difficult to assess as many of the larger providers operate older people homecare as one of a number of care revenue streams. However, estimates suggest that the top ten providers share around a quarter of the market.

Regulation

The Care Quality Commission (CQC) is the main regulator of social care services. It is responsible for the quality of care in health and social care services, and covers all public and private providers that carry out services defined under the regulated activities. CQC ratings show that the majority of homecare and care home providers' services are of good quality.

Following the 2011 Winterbourne View scandal, regulatory scrutiny of learning disability services increased significantly. The scandal, which involved serious patient abuse, highlighted the over-reliance on inpatient settings and strengthened the view that individuals would be better served in community settings of care.

CQC inspection of learning disability providers is not particularly joined up for the independent sector. Inpatient learning disability services are captured as part of CQC's mental health inspection activity, whilst learning disability services being delivered through residential, nursing or domiciliary care are inspected by CQC's adult social care directorate. This can lead to a fragmented regulatory experience for providers operating across health and adult social care.

Political Environment

The last general election took place in June 2017 after Prime Minister Theresa May called an early election. Her hopes to strengthen her conservative majority in Parliament were disappointed. The Conservative party lost seats and the vote resulted in a hung parliament, with no political party holding a majority of seats. Theresa May maintained her position and was able to form a minority conservative government, which relies on a confidence and supply agreement with the Democratic Unionist Party (DUP, representing Northern Ireland). The next general election is due to take place in May 2022.

However, the Prime Minister's leadership has been weakened by the complex Brexit negotiation process and her inability to get Parliament's approval on her withdrawal agreement with the European Union (EU). Whilst she remains in post at the time of writing, Theresa May has confirmed she will stand down ahead of the next phase of negotiations. Although her resignation would not automatically trigger an early general election, it is increasingly likely that one could be called in 2019.

Since the June 2016 referendum on Britain's membership of the EU led to a majority of voters in favour of leaving the EU, Brexit has dominated the political agenda. This leave limited parliamentary time for passing legislation in other areas.

Composition of Parliament

Government

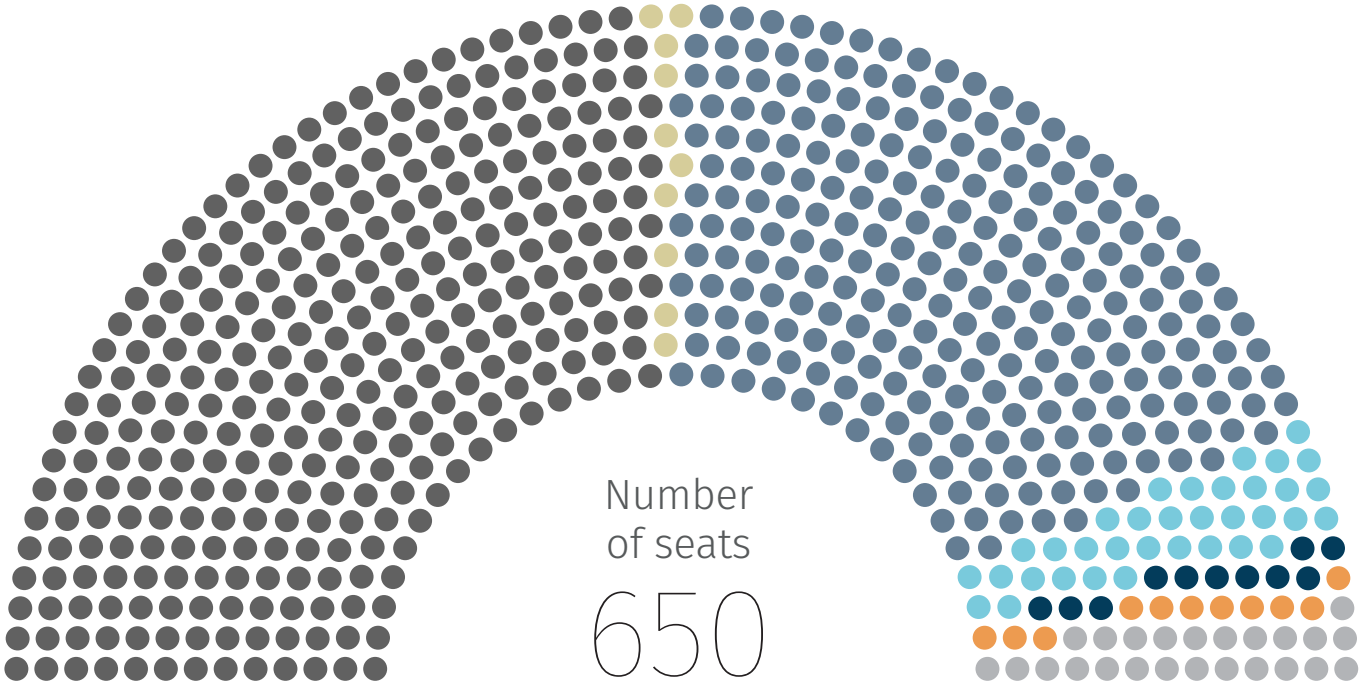
- Conservatives (314)

Confidence and Supply

- Democratic Unionist Party (10)

Opposition

- Labour (245)
- Scottish National Party (35)
- Liberal Democrats (11)
- Independent Group (11)
- Other (24)

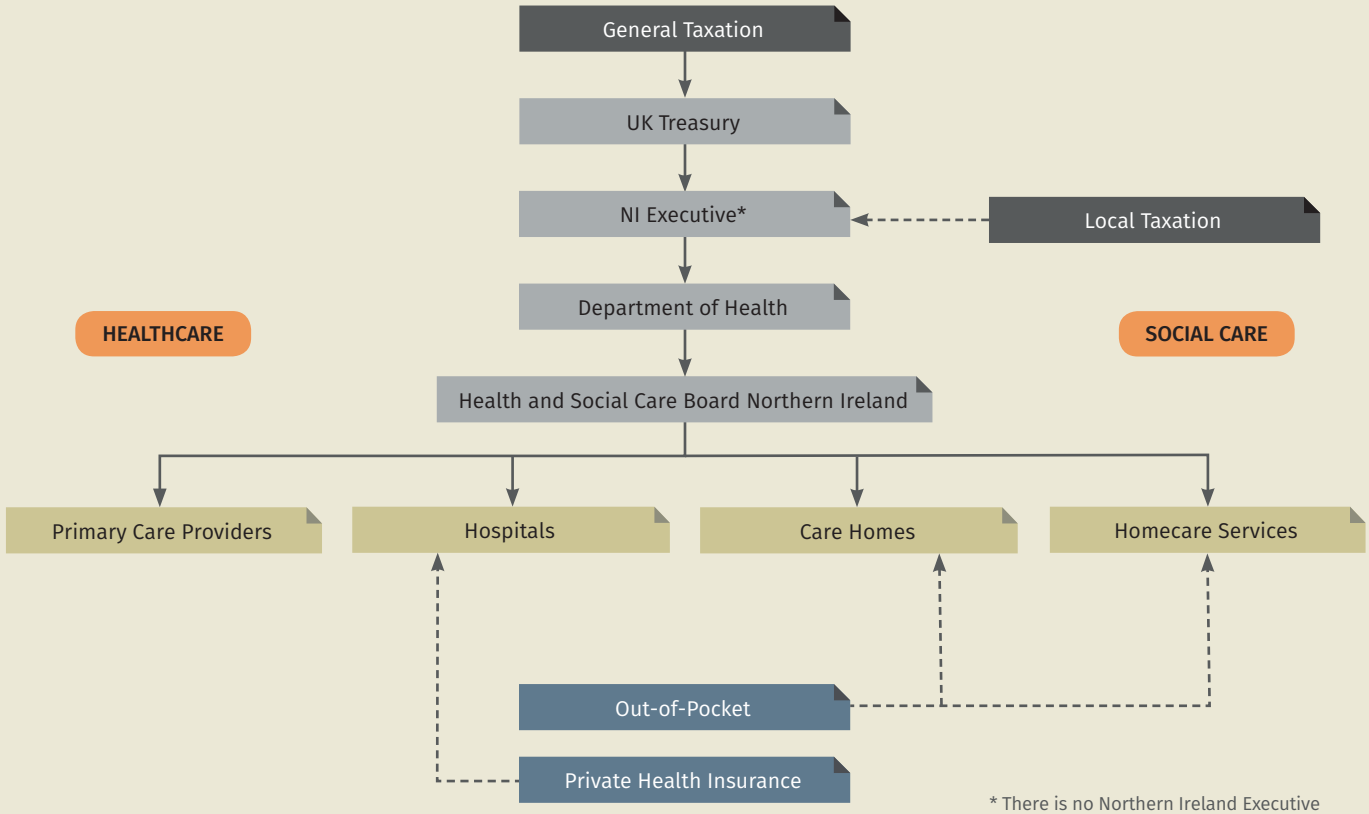


Northern Ireland

Key Messages

- Plans to reform the health and social care system, introduced in October 2016, have been placed on hold, due to the collapse of the Northern Ireland Executive in January 2017
- The reform had outlined a 10-year vision prioritising prevention and mental health policies, and expanding care services available outside of hospital
- Health and social care funding come from a single budget, held by the Health and Social Care Board
- In the absence of political leadership, the UK Government's Secretary of State for Northern Ireland is responsible for making funding decisions on the total health and social care budget
- Healthcare services are primarily delivered by public providers, whilst social care services are principally delivered by independent providers, exposed to a mix of public and private pay revenue

Funding Flows



* There is no Northern Ireland Executive leadership at present. Funding is allocated to the Health and Social Care Board by the UK Government's Northern Ireland Secretary.

Key Facts and Figures

Population

Total

1.9m

Source: ONS

Life Expectancy

78.4 years 82.3 years

Source: ONS

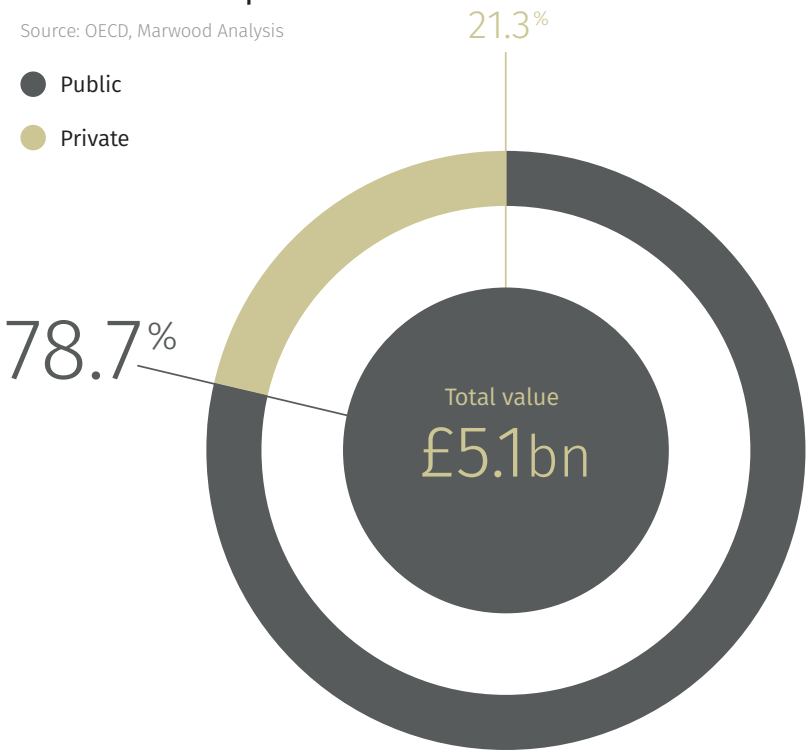
Population Distribution (%)

- 32.1% are aged between 0 and 24
- 51.7% are aged between 25 and 64
- 16.2% are aged over 65

Source: Eurostat, OECD

Healthcare Expenditure

Source: OECD, Marwood Analysis



Social Care Expenditure

Source: Northern Ireland Executive (2018/19)

£1.09bn

Share of expenditure is for the UK, the share of private expenditure is likely to be slightly lower in Northern Ireland

Policy Snapshot: Political Deadlock Stopping Health Reform

No major policy developments while the Northern Ireland Executive remains vacant

Healthcare policy direction is given by the Northern Ireland Executive, which leads Northern Ireland on all devolved matters. The Executive has been vacant since January 2017, following the resignation of deputy leader Michael McGuiness.

This situation has put plans to introduce a comprehensive reform of the health and social care system on hold. Elements of the reform were outlined in October 2016, including:

- Prioritising prevention, through investing in the development of community services
- Expanding primary care services by building multi-disciplinary teams in GP practices
- Delivering care at home where possible as an alternative to inpatient stays, especially for older people presenting chest infections, urinary tract infections or dehydration symptoms
- Improving access to mental health services, including common mental health problems, perinatal mental health, and community services

Healthcare

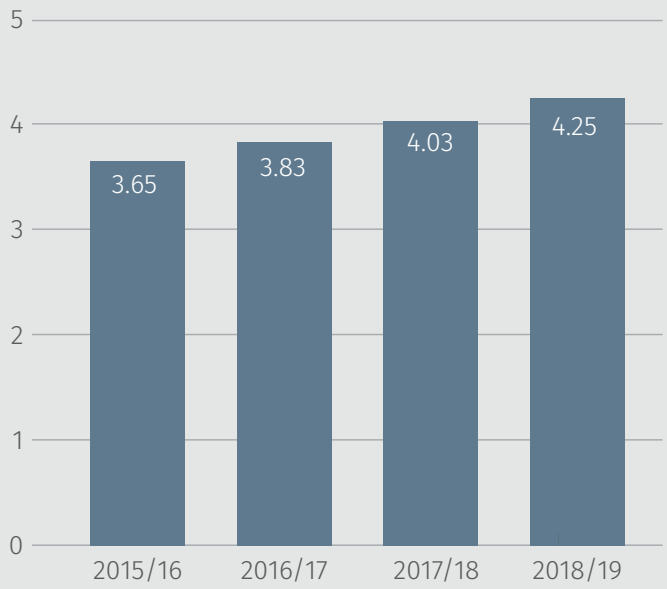
Funding

Healthcare funding in Northern Ireland is primarily public and comes from general taxation. 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. As of 2019/20, the block grant will reflect the 3.4% annual average real-term increase in NHS funding for England. As there is currently no Northern Ireland Executive to make budgetary decisions, the UK government's Secretary of State for Northern Ireland is responsible for overseeing the budget and policy proposals.

In 2018/19, the total budget allocated to Northern Ireland was £10.78bn, of which £4.25bn was allocated to healthcare. Allocation decisions are made by the Northern Ireland Executive.

Healthcare Expenditure (€, bn)

Source: Northern Ireland Executive



Payment System

Services are mainly free at the point of use and the Health and Social Care Board is the main payer.

Primary care providers are paid by the Health and Social Care Board, under the terms of their contracts. Most GPs operate under the General Medical Services contract and are paid on a capitation basis.

The Health and Social Care Board also 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 Health and Social Care Board and the Trusts. Payments are made in accordance with a capitation formula.

Provider Landscape

Primary care services are provided by independent 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.

Five Health and Social Care Trusts provide publicly financed care through an integrated system of acute and community services. There are two small private hospitals that contract with the Trusts. Specialist services are provided in a limited number of locations and, due to the relatively small population size of Northern Ireland, patients may be transferred to other locations in the UK to receive specialist treatment.

Regulation

Providers of healthcare services are regulated and inspected by the Regulation Quality Improvement Authority (RQIA). RQIA carries out inspections of public and private providers and undertakes hygiene inspections of hospitals.

Basic quality standards are developed by the Northern Ireland Department of Health. They apply to all healthcare providers, including independent providers. The latest set of standards was developed in 2006 and may be reviewed in the near future, in collaboration with RIQA.

Social Care

Funding

Social care funding is primarily public. It comes from the same budget as healthcare and is topped-up by funding raised at local level, through council tax and business rates.

Allocations of social care funding to local authorities are determined on the basis of a regional capitation formula. In 2017/18, the total social care budget allocated by the Northern Ireland Executive to local authorities was £1.09bn. As services are not free at the point of use, individuals are expected to contribute towards the cost of their care.

Payment System

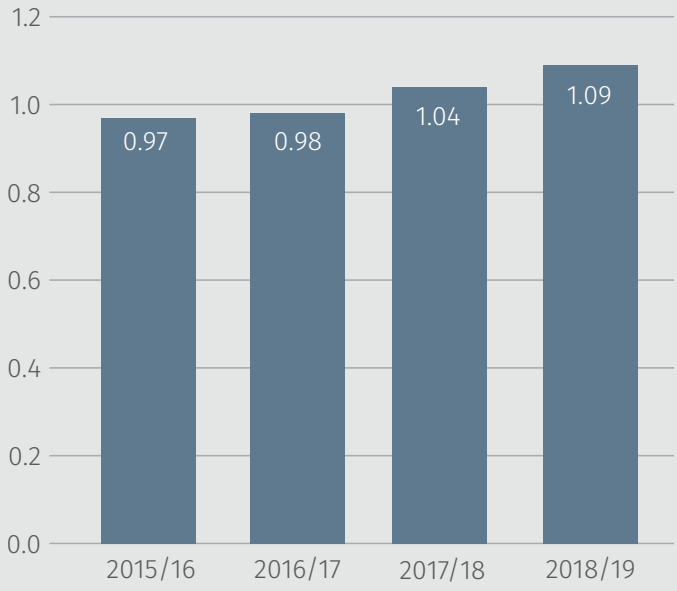
Social care providers are paid by a mix of public and private sources.

Homecare providers are paid on the basis of hourly rates, determined at local level. Individual eligibility for public funding is based on age, needs and means-tests. The Health and Social Care Trusts cover the full cost of homecare services for over-75s who have been assessed as needing support. Those under the age of 75 who have been assessed as needing care may have to contribute towards the cost of services or pay out-of-pocket if their capital exceeds the £23,250 means-test upper limit. Recipients of publicly funded social care services can request to receive direct payments, which they can use to purchase homecare services directly from providers.

Care home providers are paid on the basis of weekly fees, negotiated with their local Health and Social Care Trust. These fees have been under pressure in recent years. In its 2017 market study, the CMA recommended that Northern Ireland Department of Health strengthened its oversight of the Trusts' commissioning of care home services. Unlike homecare, there is no age-test, but the needs and means-tests apply. Those assessed as needing care, do not qualify for public funding support if their capital exceeds £23,250. Providers are free to set the level of the fees they charge private pay users.

Social Care Expenditure (£, bn)

Source: Northern Ireland Executive



Social Care

Provider Landscape

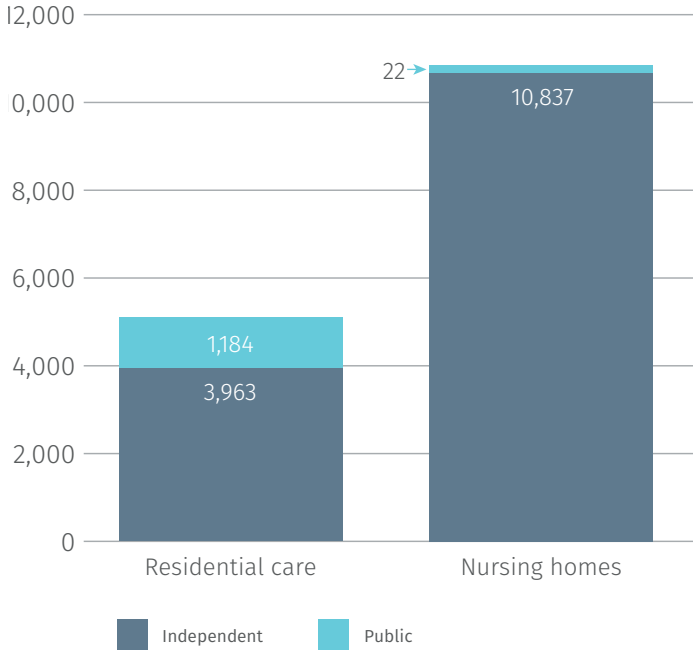
Social care services include homecare, care homes (residential and nursing) and learning disability services. Some of these services are integrated within the healthcare system and provided by the Trusts. However, the majority of provision is delivered by private operators. In 2018, 71% of the 267,083 homecare contract hours were delivered by the independent sector.

In 2018 there were 5,147 residential care homes beds and 10,859 nursing homes beds. The independent sector provided 77% of the bed capacity in residential care homes and virtually all the bed capacity in nursing homes.

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 in partnership with independent sector providers.

Care Home Beds (2018)

Source: Northern Ireland Executive



Regulation

Providers of social care services are regulated and inspected by the Regulation Quality Improvement Authority (RQIA). RQIA carries out inspections of both public and private providers.

Basic quality standards are developed by the Northern Ireland Department of Health. They apply to all healthcare providers, including independent providers. The latest set of standards was developed in 2006 and may be reviewed in the future, in collaboration with RIQA.

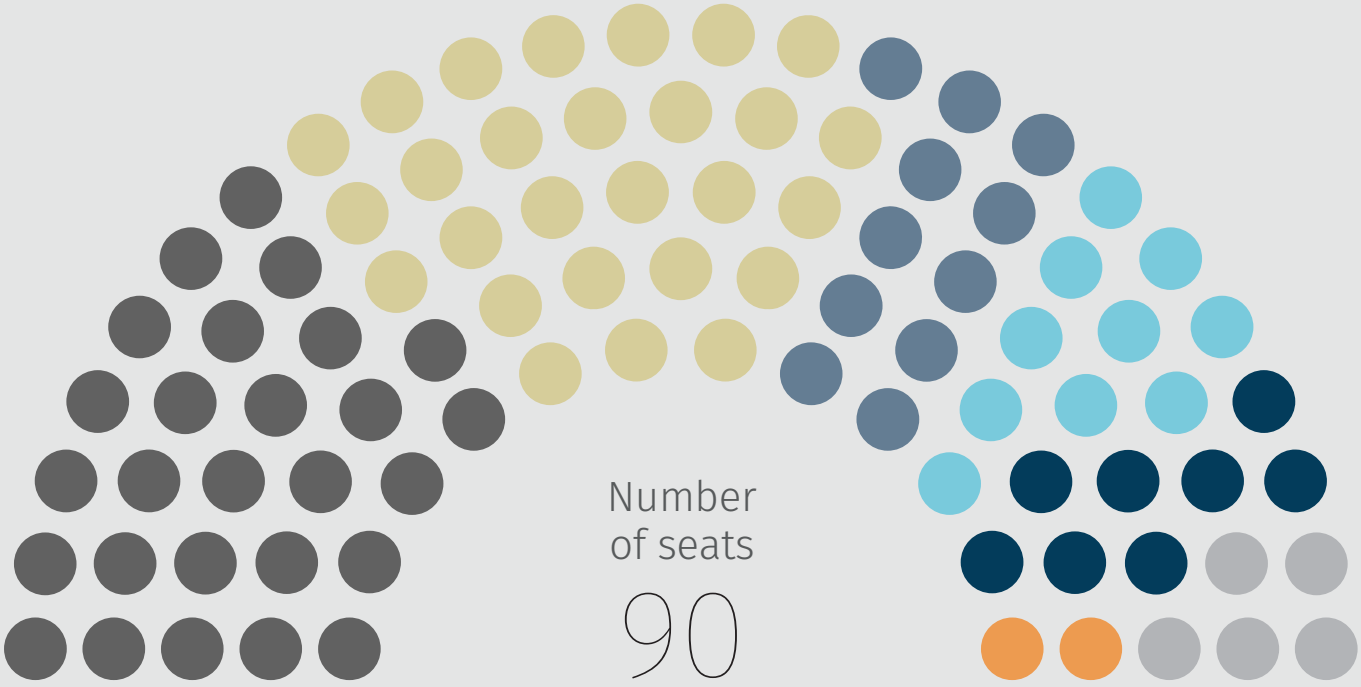
Political Environment

Northern Ireland is a devolved administration in the UK that is led by the Northern Ireland Executive. The Executive is usually led jointly by the two largest parties in Parliament. Following the resignation of Sinn Féin's Martin McGuiness as Deputy First Minister in January 2017, the Executive collapsed, and Parliament was suspended. There has been no leadership in Northern Ireland since then. Day-to-day business has been run by civil servants; however, their decision-making power is limited. This means that major policy reforms, such as the reform of the healthcare system, have stalled.

Composition of Parliament*

- DUP (27)
- Sinn Féin (27)
- SDLP (11)
- UUP (10)
- Alliance (8)
- Greens (2)
- Others (5)

* The Northern Ireland Parliament is currently suspended

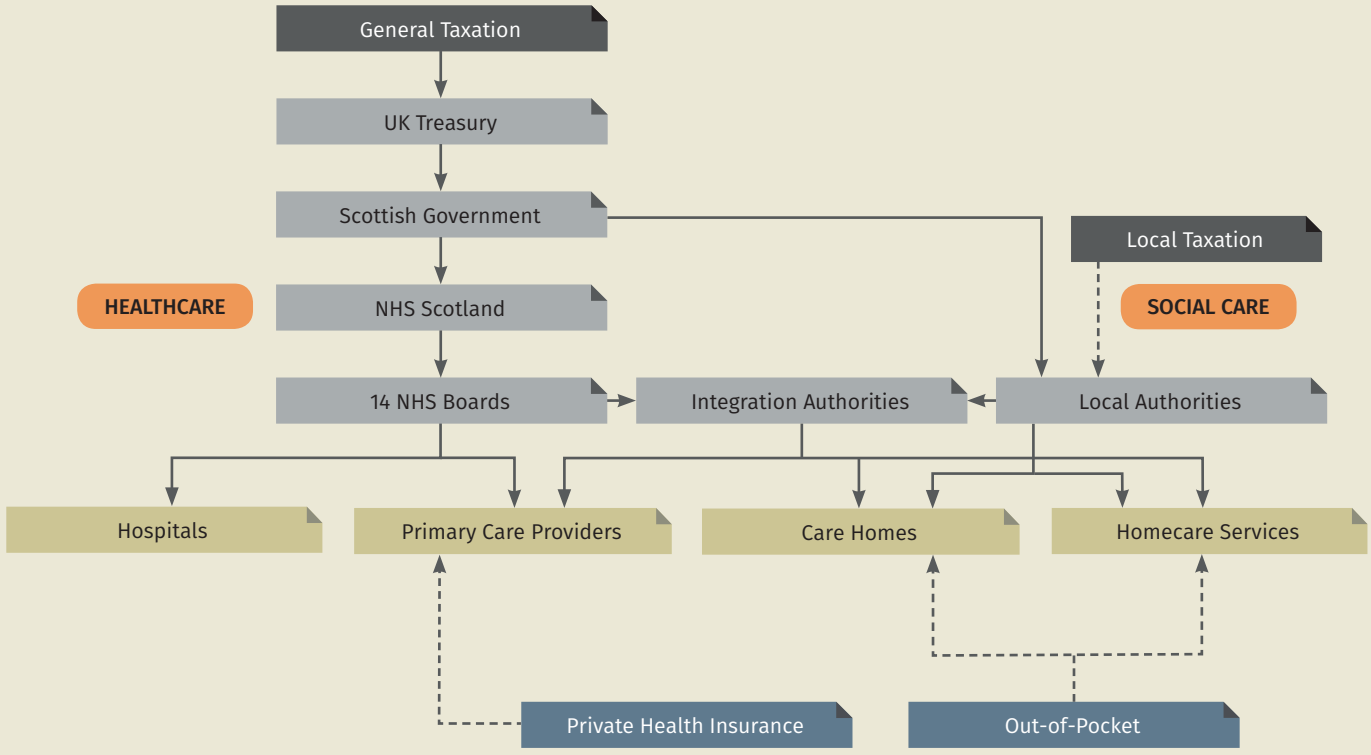


Scotland

Key Messages

- Health and social care integration is the core driver of change in Scotland, and is reshaping the landscape in which providers operate
- Increasingly, health and social care funding comes from one source. This funding is pooled locally, through Integration Authorities
- In 2019, the focus is expected to be on building relationships between providers, clarifying funding available for integration, and defining what quality and improvement of services look like
- Although the Scottish Government seeks to limit expenditure on private healthcare providers, local commissioners may use private sector capacity on an ad-hoc basis to reduce waiting times.
- Over the past ten years, local authorities have increasingly relied on independent providers for the provision of social care services

Funding Flows



Key Facts and Figures

Population

Total

5.4m

Source: ONS

Life Expectancy

77 years 81 years

Source: ONS

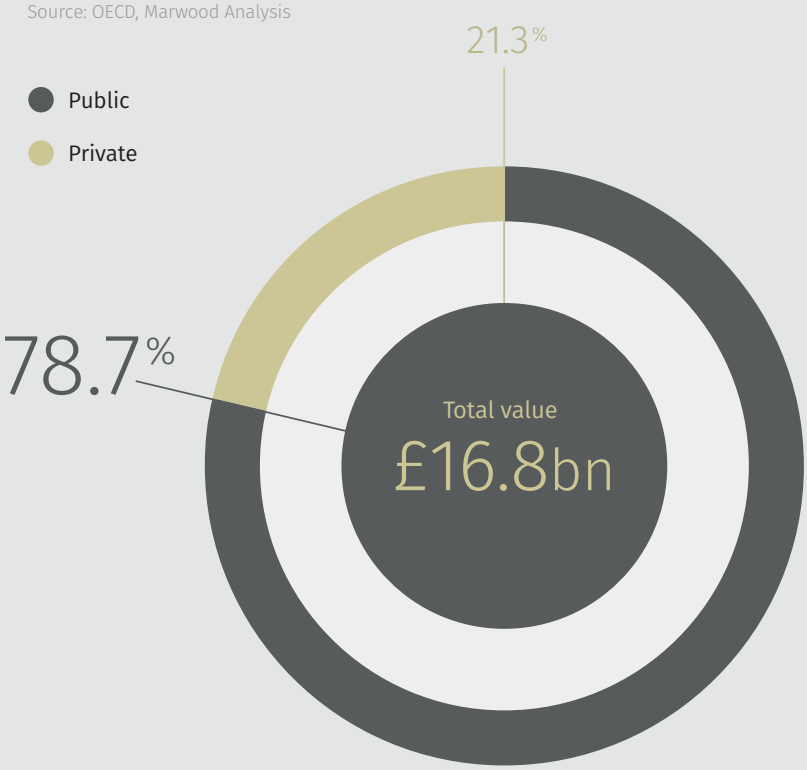
Population Distribution (%)

- 27.8% are aged between 0 and 24
- 53.5% are aged between 25 and 64
- 18.7% are aged over 65

Source: ONS (2017)

Healthcare Expenditure

Source: OECD, Marwood Analysis



Share of expenditure is for the UK, the share of private expenditure is likely to be slightly lower in Scotland

Social Care Expenditure

(est. 2019/20)
Source: Scottish Government, Local Government, Marwood Analysis

£3.73bn

Policy Snapshot: Continuing Progress Towards Greater Integration

Integrating health and social care services continues to be a major policy priority

In 2016, the Scottish government passed legislation to enable the integration of health and social care services. This led to the creation of 31 Integration Authorities. They have now been given responsibility for £8.5bn of the total £18bn health and social care budget. Previously, this funding, used for adult social care services, as well as primary and community care services, was managed separately by NHS Boards and local authorities.

This funding transfer was accompanied by the publication of the Health and Social Care Delivery Plan. The plan outlined a series of actions to realise the integration of health and social care. This included shifting service delivery outside of hospital into the community, expanding primary and community care infrastructure, workforce development and retention, and improving the quality of care.

In February 2019, a progress report pointed out that the pace of integration had been slow, and provided recommendations to accelerate integration. This includes improving local relationships between system stakeholders, including those in the independent sector.

These integration objectives build on the principles outlined in the 2020 Vision, published in 2011 and continues to be the core reference document for the underlying vision for health and social care services in Scotland. It outlined objectives for integrating health and social care in Scotland, creating a system focusing on prevention and centred around patients, with services delivered closer to home.

Healthcare

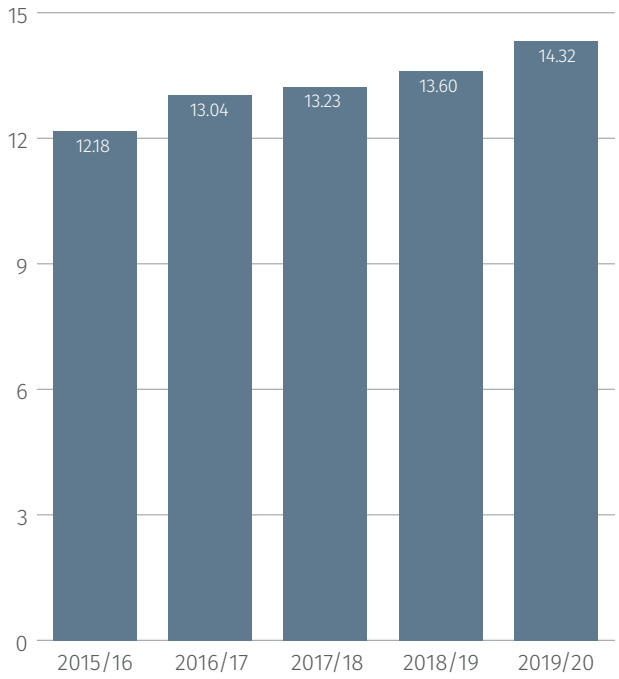
Funding

Healthcare funding is primarily public and comes from general taxation. The overall Scottish budget is allocated by the UK government, via the Treasury, through a block grant calculated in accordance with the Barnett formula. As of 2019/20, the block grant will reflect the 3.4% annual average real-term increase in NHS funding for England. However, the Scottish government has discretion for resource allocation from the block grant to the NHS in Scotland.

The 2019/20 budget allocates £14.3bn in healthcare funding, including capital spending. Around 75% of the budget is allocated locally to the 14 regional NHS boards on a weighted capitation basis, using the NHS Scotland Resource Allocation Committee formula. The Scottish government ensures that no NHS Board faces a real terms reduction in its allocation in any year.

Healthcare Budget (£, bn)

Source: Scottish Government



Payment System

In primary care, general practitioners (GPs) are paid by their local NHS board, under the terms of contracts negotiated annually between Scottish representatives of the British Medical Association and the Cabinet Secretary for Health, Wellbeing and Sport. From April 2019, the Government will introduce minimum full-time equivalent earnings of £80,430.

In the absence of a payer/provider split in secondary care, there are no contracts between NHS boards and the hospital services they provide. NHS boards have operating divisions, which are responsible for the delivery of acute care. In recent years, NHS boards have commissioned elective care services from private providers on an ad-hoc basis to reduce waiting lists. Between 2015/16 and 2017/18, the total expenditure on private hospital services is estimated to be £130.8m.

Regulation

Healthcare Improvement Scotland (HIS) regulates NHS boards. It develops guidance for clinical practice, supports improvement in healthcare independent and public services, and provides assurance for quality and safety. This work supports the Scottish Government's priorities, in particular the Healthcare Quality Strategy for NHS Scotland.

Provider Landscape

Primary, secondary and specialist services in Scotland are mainly provided free at the point of use. Primary care services are usually the first point of contact with the NHS. They include GPs, dentists, pharmacies and opticians. In 2017, there were 4,453 GPs. The majority are independent, but the number of salaried GPs increased from 394 to 631 between 2013 and 2017.

There are currently 274 hospitals in Scotland. These services are public and provided directly by the operating divisions of the NHS boards which offer the full range of acute, mental health, emergency and elective care services. Alongside public provision, there is a very small private and non-profit healthcare sector.

Funding

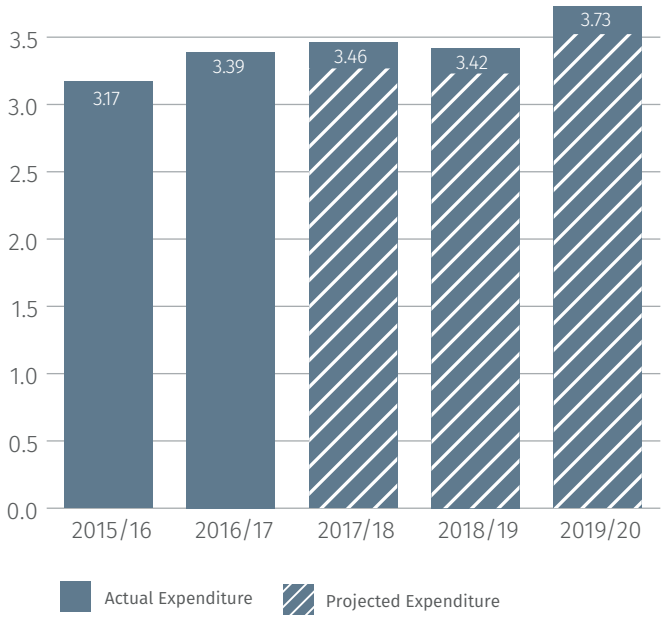
Social care funding is primarily public. As services are not fully free at the point of use, there are also individual private co-payments. However, recent policy and funding decisions aim to reduce the proportion of funding contributed by individuals.

Local authorities are primarily responsible for funding social care services from their budgets, although integration reforms are shifting some of this responsibility onto NHS boards. The majority of local authority funding comes from the Scottish government, but there is an element of local taxation through council tax and business rates. Most recent figures show that local authorities spent £3.14bn on adult social care in 2016/17. That year, the Government allocated an additional £250m to support the integration of health and social care. In 2019/20, central funding supporting integration is expected to be worth £700m, almost twice the amount allocated in 2018/19.

Following the integration of health and social care, funding comes increasingly from joint budgets managed by Integration Authorities. In 2018/19, this funding was worth £8.5bn and was used for social care services, as well as primary and community care services.

Local Authority Adult Social Care Expenditure (£, bn)

Source: Scottish Government, Local Government, Marwood Analysis



Payment System

Social care providers are paid by public and private payers. Local authorities are responsible for assessing the needs of individuals to determine their eligibility for financial support. Local authorities pay for the costs of homecare services for anyone over the age of 65 assessed as needing personal care services (i.e. support with activities of daily living). For those living in care homes, local authorities contribute up to £174 per week to pay for the cost of these services.

Homecare providers are primarily paid by local authorities on the basis of hourly rates, although some may be paid directly by individuals using direct payments. 8,290 people were receiving direct payments in 2017, accounting for £113.3m of funding. Individuals use these payments to purchase services directly from homecare providers.

Care home providers are paid by local authorities and individuals. Local authorities pay up to £79 per week towards the costs of nursing care. These fees are paid directly to providers. Other costs are mean-tested. Anyone with capital worth over £27,250 pay for the full remaining costs. Local authorities cover the full cost of care home services for those whose capital is worth less than £17,000, and partially cover costs for those in between the two thresholds.

Provider Landscape

Services are provided by a mix of public and private operators. Over the past 10 years, local authorities have increasingly purchased homecare from the private and voluntary sectors, rather than providing services themselves. As of 2017, there were nearly 60,000 people receiving local authority-funded homecare services, with local authorities directly providing just under half of homecare services.

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, the majority of which were private.

Regulation

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, which is responsible for regulating health and safety in the workplace across the UK.

Political Environment

Scotland is a devolved administration in the UK that is administered by the Scottish Government. It is headed by the First Minister, who is nominated by Members of the Scottish parliament. The First Minister appoints the Cabinet of Ministers. The Scottish parliament is made up of 129 elected MSPs. Following an election in 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 in May 2021.

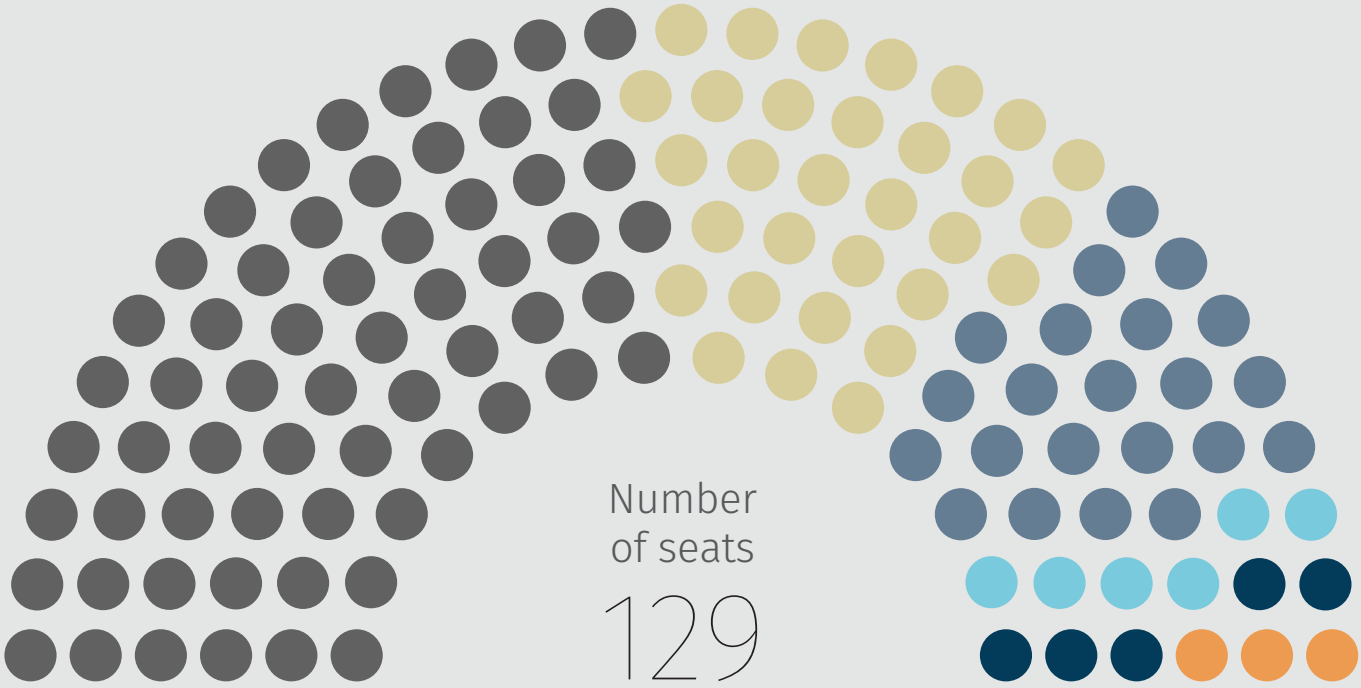
Composition of Parliament

Government

- SNP (62)

Opposition

- Conservatives (31)
- Labour (22)
- Greens (6)
- Lib-Dems (5)
- Others (3)

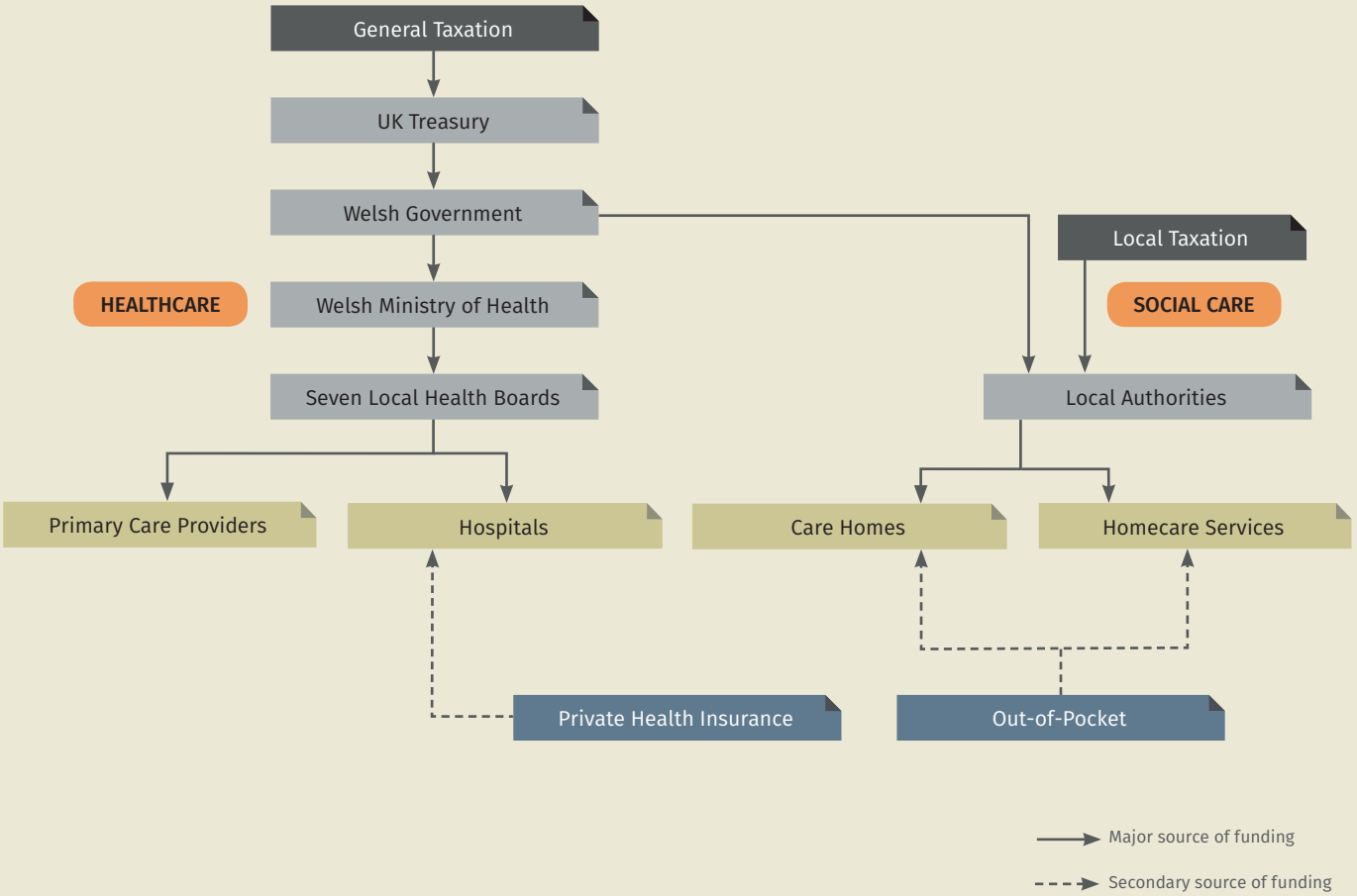


Wales

Key Messages

- In June 2018, the Welsh Government published plans outlining a ten year vision to integrate health and social care, increase prevention and give patients more control over their own care
- This vision will be developed at a local level. It could reshape the environment in which providers operate, with potential for greater partnership working across health and social car
- The Welsh NHS is dominated by public funding. In the absence of a payer/provider split in secondary care, hospital services are provided directly by NHS Local Health Boards
- Provision of social care services is outsourced by local authorities to independent organisations. These services are primarily funded by local authorities, but as they are not free at the point of use, users may be requested to contribute towards the cost of these services

Funding Flows



Population

Total

3.1m

Source: OECD

Life Expectancy

78.3 years

82.3 years

Source: OECD

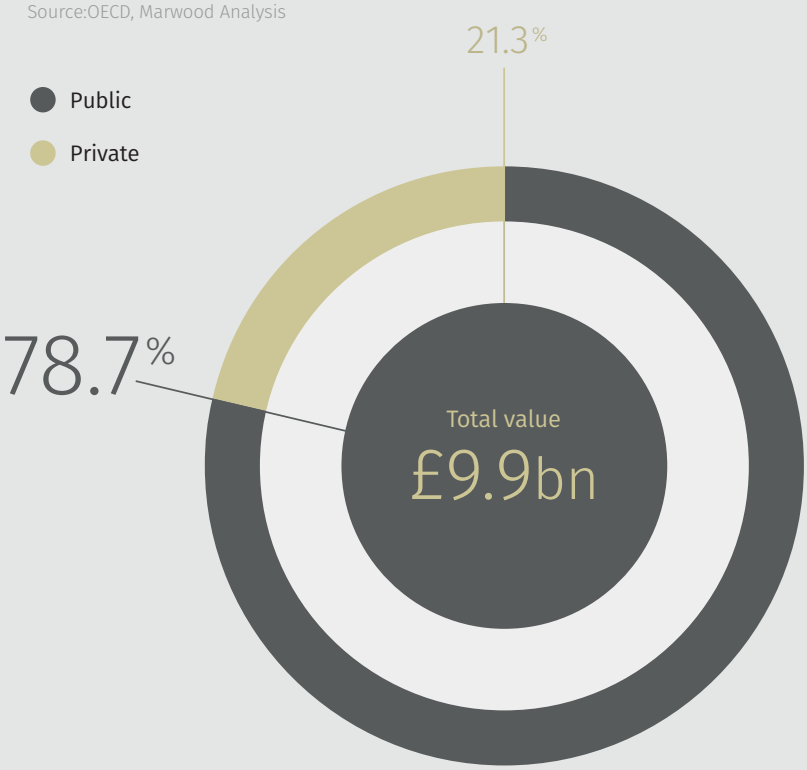
Population Distribution (%)

- 29.2% are aged between 0 and 24
- 50.2% are aged between 25 and 64
- 20.6% are aged over 65

Source: ONS (2017)

Healthcare Funding

Source:OECD, Marwood Analysis



Share of expenditure is for the UK, the share of private expenditure is likely to be slightly lower in Wales

Policy Snapshot: Long-Term Vision for the NHS in Wales

The long-term vision focuses on health and social care integration, prevention, and patient centred-care

In June 2018, the Welsh Government published A Healthier Wales, our plan for health and social care, setting out the long-term vision for the Welsh NHS over the next 10 years. The plan prioritises prevention and aims to increase integration between health and social care services. The vision is for patients to manage their own health, supported by technology, and receive services closer to home.

New models of care supporting the implementation of this vision will be rolled out. Whilst they will be shaped locally, there is an expectation that providers will work in partnership to deliver seamless care packages as patients complete their journey through the health and social care system. The introduction of the new models is supported by a £100m Transformation Fund covering the years from 2018 until 2020.

In February 2019, the Government tasked Health Education and Improvement Wales and Social Care Wales to produce a joint Health and Social Care Workforce Strategy. It is expected to be published in Autumn 2019. The strategy will look to outline how workforce training and recruitments issues are addressed, and how individuals will be supported to work across health and social care.

Healthcare

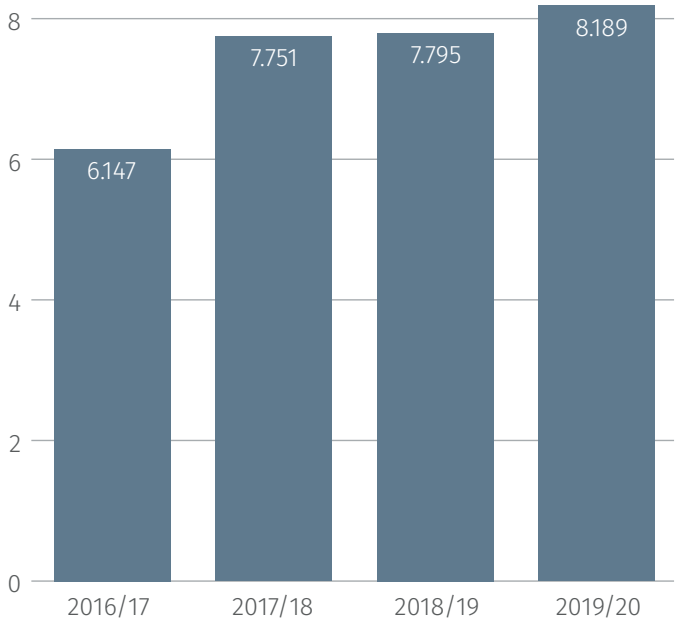
Funding

Healthcare funding is primarily public and comes from general taxation. The overall Welsh budget is allocated by the UK government, via the Treasury, through a block grant calculated in accordance with the Barnett formula. As of 2019/20, the block grant will reflect the 3.4% annual average real-term increase in NHS funding for England. However, the Welsh government has discretion for resource allocation from the block grant to the NHS in Wales.

The Welsh budget for 2019/20 allocates £8.19bn to healthcare. This includes some funding for social care services. At 43% of the total £19.1bn national budget, healthcare forms the largest expenditure by the Welsh government. Funding is allocated to the Welsh Ministry of Health, which in turn distributes it among seven local health boards.

Healthcare Budget (£, bn)

Source: Welsh Government



Payment System

In primary care, General Practitioners (GPs) are paid by their Local Health Board. The GP contract includes capitation-based payments, performance-related payments, and fee-for-service payments for additional services provided.

There is no payer/provider split in secondary care. Hospital services are provided directly by the seven Local Health Boards. Local Health Boards receive their budgets from the Welsh Government. They are allocated on a capitation basis.

Healthcare services are free at the point of use, with the exception of dental and eye services, which are subject to patient charges. Voluntary private health insurance does not normally cover these charges. Subscription to private health insurance is marginal and primarily used to access services faster in the private sector.

Provider Landscape

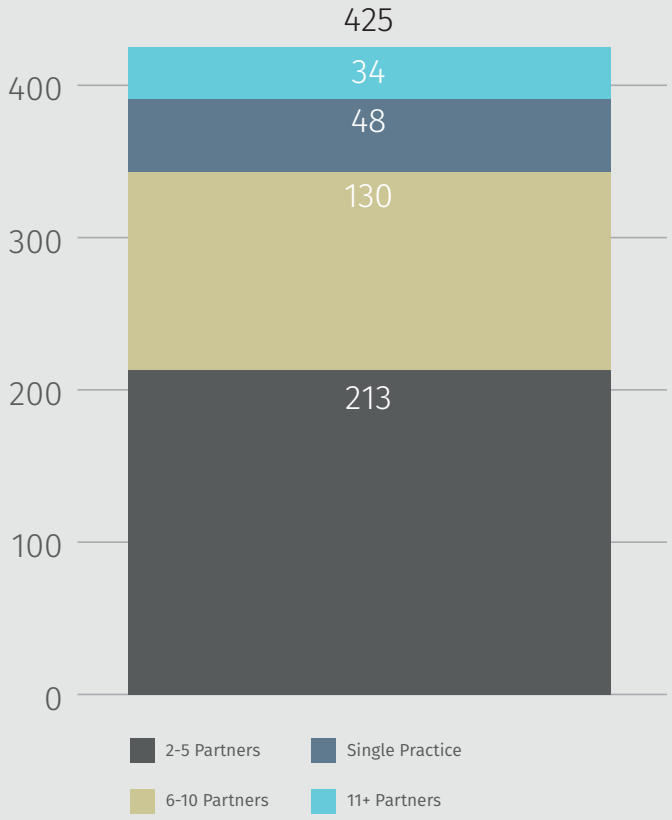
Healthcare in Wales is delivered through a variety of providers, including Local Health Boards, GPs, community pharmacies, and opticians. The NHS in Wales makes very little use of private providers, and the Welsh Assembly is trying to limit the proportion of NHS spend going to private providers. The absence of a payer/provider split in secondary care means that hospital services are provided directly by the local health boards.

In 2016, there were 13 general hospitals with major Accident and Emergency Units, and 31 community hospitals. Specialist services are provided in two NHS Trusts: Velindre NHS Trust, which provides cancer and blood services, and the Welsh Ambulance NHS Trust, which provides ambulance services.

As of September 2017, there were 1,926 GPs in Wales. This number was slightly lower than in the previous year. In the meantime, the use of locum GPs increased by 10%, reaching a total number of 754 locum GPs as of September 2017. GPs increasingly work in partnerships. In 2017, most partnerships had two to five partners, but the number of partnerships with more than 11 partners nearly tripled, reaching 34.

GP Partnerships (2017)

Source: Welsh Government Statistics



Regulation

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.

Quality standards are defined nationally by the Welsh Ministry of Health.

Social Care

Funding

Social care funding is primarily public. However, services are not completely free at the point of use and may require individuals to contribute towards the cost of their care. Public funding comes primarily from local authority budgets, which are allocated as block grants by the Welsh government. These budgets are under pressure and expected to remain flat in 2019/20 and 2020/21. Social care funding is not formally ring-fenced at local authority level, although recent Welsh government budget announcements have provided specific funding for social care. In 2019/20, there is £36m in the healthcare budget dedicated for adult social care services.

Payment System

Social care providers are paid by both local authorities and individuals. Local authorities are responsible for assessing individual needs and means to determine their eligibility for financial support.

Individuals may be required to contribute towards the costs of homecare services, up to a maximum of £80 per week. People with less than £24,000 in savings, excluding the value of their homes, may pay less. Providers are paid on the basis of hourly rates, agreed locally.

Care home providers are paid on the basis of weekly fees, negotiated with local authorities. As of 2019/20 local authorities will cover all the cost of care home services for individuals with assets below £50,000, including the value of their home. Providers are free to set weekly rates for self-payers. On average, these are 36% higher than local authority fees.

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.

Provider Landscape

The majority of social care services are provided by private operators.

In 2018, care home providers were offering 22,466 care home beds for older people across 643 locations. 52% of these beds are in nursing homes.

Homecare is provided by private agencies. In 2018, 437 homecare agencies were registered with the Care and Social Services Inspectorate Wales.

Regulation

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.

Political Environment

Wales is a devolved administration in the UK administered by the Welsh government. It is headed by the first minister, who is nominated by elected assembly members. The first minister appoints the cabinet of ministers (government). 60 elected AMs form the Welsh National Assembly. Following the May 2016 election, Labour remained the largest party, and Mark Drakeford currently holds the position of First Minster. Five major parties are represented in the National Assembly for Wales, along with four smaller parties. Devolved elections are held every five years. The next election is due to be held in May 2021.

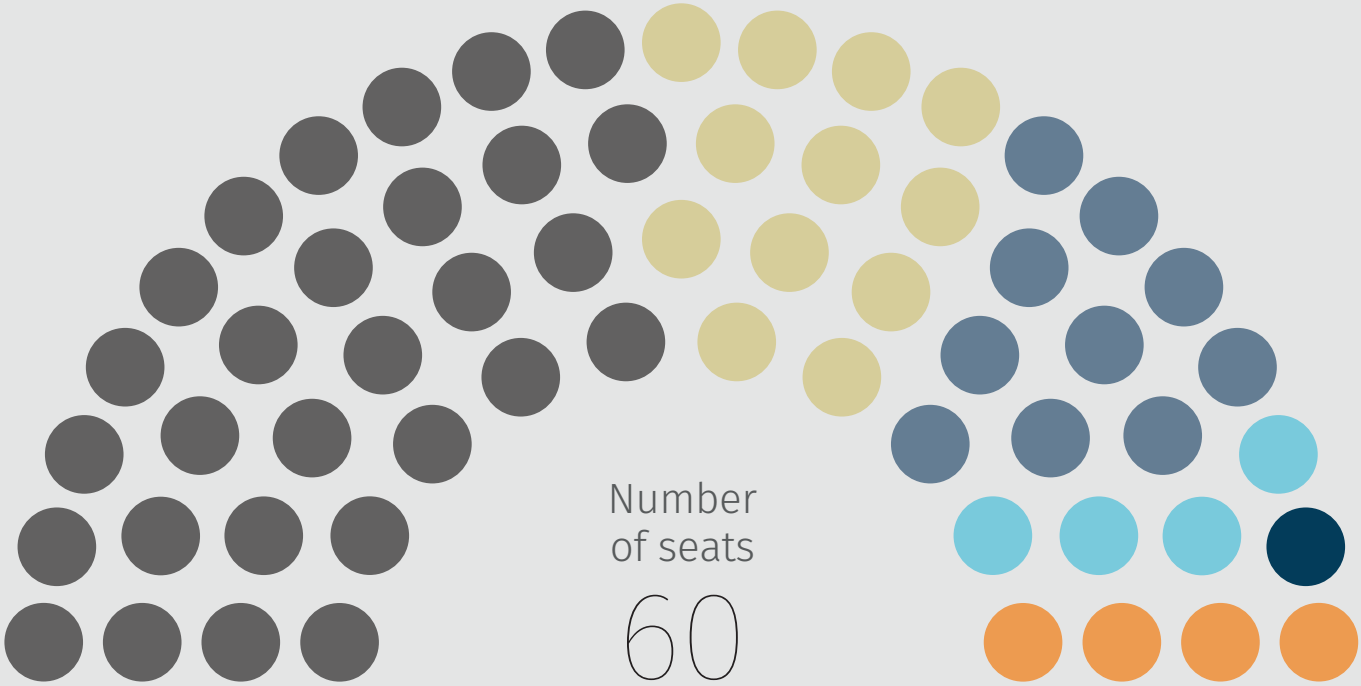
Composition of Parliament

Government

- Labour (29)

Opposition

- Conservatives (12)
- Plaid Cymru (10)
- UKIP (4)
- Lib-Dems (1)
- Others (4)



Brexit Update

The issue of Brexit has dominated the UK political agenda since the British people voted to leave the European Union (EU) in June 2016. The Government has been engaged in withdrawal negotiations since 29 March 2017. An agreement on the UK exit (Withdrawal Agreement) and the future relationship with the EU (Political Declaration) was reached in November 2018. However, this deal has been rejected twice by the House of Commons, in January and March 2019, resulting in political deadlock.

As we go to print, the UK Parliament remains deadlocked. Indicative votes on alternative Brexit options on 27 March 2019 failed to find a majority, whilst a third vote on the Government's Withdrawal Agreement saw it defeated again, albeit by a smaller margin than before.

As it stands, to avoid a no deal Brexit, the Government needs to get the Withdrawal Agreement approved by Parliament, or present the EU with an alternative Brexit option by 12 April 2019. If the EU agreed to an alternative option, it would likely mean a long Brexit delay, and require the UK to participate in the European Parliament elections of May 2019.

As a multi-dimension issue, Brexit has implications across several sectors. Health and social care are no exception. For example, the ability to trade pharmaceuticals and medical devices across the UK and the EU border may be affected by Britain leaving the single market and the customs union. The NHS also relies on approximately 63,000 staff coming from the 27 EU countries. Brexit may impact on future EU staff recruitment as their right to work in the UK could be restricted.

The following table summarises the most likely implications from various types of Brexit on four key areas relevant to health and social care providers and companies:

- Pharmaceutical and Medical Devices Regulation
- Trade across the UK/EU border
- EU citizens' right to work in the UK under the freedom of movement rules
- Recognition of professional qualifications

23 Jun 2016	The UK votes to leave the EU
29 Mar 2017	Article 50 is triggered
Jun/Jul 2018	First stage of withdrawal negotiations finalised Brexit Whitepaper published
25 Nov 2018	Withdrawal Agreement (WA) and Political Declaration (PD) agreed between UK and EU
15 Jan 2019	WA and PD rejected by UK Parliament for the first time
12 Mar 2019	WA and PD rejected by UK Parliament for the second time
21 Mar 2019	EU agrees to postpone Brexit date to 22 May 2019 if Parliament approves WA by 12 April 2019
27 Mar 2019	No alternative Brexit options emerges after UK Parliament holds indicative votes
29 Mar 2019	WA rejected by UK Parliament
Possible Next Steps	UK leaves with no deal on 12 April 2019
	UK Parliament agree to WA, UK leaves with a deal on 22 May 2019
	UK Parliament and Government agree on an alternative option, Brexit delayed
	UK revokes Article 50, Brexit cancelled

Scenario	Timeline	Pharmaceutical & Medical Device Regulation	Trade	Workers' Freedom of Movement	Recognition of Professional Qualifications
Withdrawal Agreement (WA) + Political Declaration (PD)	UK leaves the EU on 22 May 2019 Transition period starts on 23 May 2019, until at least 31 Dec 2020	Regulatory alignment maintained until 31 Dec 2020 EU & UK expected to agree framework for regulatory alignment post-transition	No tariffs and no border checks until 31 Dec 2020 Post-transition framework to be agreed in negotiations on the future relationship – PD indicates both sides would prefer no tariffs and checks	EU citizens' unconditional right to work in the UK continues until 31 Dec 2020 No freedom of movement post-transition EU citizens likely to have to go through same visa process as non-EU citizens	Mutual recognition of qualifications maintained until 31 Dec 2020 Post-transition, indication that UK and EU will seek to maintain mutual recognition, but arrangements will have to be negotiated
No Deal	UK leaves the EU on 12 Apr 2019	EU regulations stop applying to the UK MHRA's no-deal guidance provides advice on maintaining regulatory alignment Draft legislation enabling regulatory alignment yet to be approved by Parliament	No tariffs on most goods entering the UK, including pharmaceuticals and medical devices EU has not yet made a reciprocal statement on UK goods entering the EU Border checks apply from 13 Apr 2019 and may delay product entry into the UK	No freedom of movement EU citizens' unconditional right to work in the UK ends on 13 April 2019 EU citizens likely to have to go through same visa process as non-EU citizens	Mutual recognition of qualifications ends on 13 Apr 2019 Process for recognition of qualifications from 13 Apr 2019 onwards unclear at the moment Professionals qualifications recognised prior to 12 Apr 2019 unaffected
Customs Union	Brexit likely to be delayed beyond May 2019	Both sides have signalled their intent to seek regulatory alignment but the specifics would have to be agreed through separate arrangements	No border checks and no tariffs apply to goods leaving the UK for the EU and to EU goods entering the UK	No freedom of movement EU citizens' unconditional right to work in the UK would end, most likely after a transition period	Recognition of EU professional qualifications in the UK depends on separate arrangements UK could decide to recognise EU qualifications unilaterally
Norway Model (UK joins the EEA)	Brexit likely to be delayed beyond May 2019	EU Regulation continue to apply	No tariffs most likely Border checks would have to take place	Freedom of movement continues EU workers retain unconditional right to work in the UK	EU professional qualifications continue to be recognised
No Brexit	Article 50 revoked before 12 Apr 2019	Status quo maintained	Status quo maintained	Status quo maintained	Status quo maintained

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.

Jyoti Mehan
Director, Business Development
Office: +44 (0)20 3178 2504
jmehan@marwoodgroup.com

LONDON

29 Farm Street
Mayfair
London, W1J 5RL
T: +44 20 3178 2504

NEW YORK CITY

733 Third Avenue
11th Floor
New York, NY 10017
T: 212-532-3651

WASHINGTON DC

1025 Connecticut Avenue
NW Suite 610
Washington, DC 20036
T: 202-371-0012