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Person-centred care in Europe: a cross-country comparison of health system performance, strategies and structures

Policy briefing

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Note on terminology

Throughout this document we use the term “person-centred care” as opposed to “patient-centred care”, which is sometimes used to describe similar ideas. We prefer the term “person-centred” because it covers a wider range of care settings, recognises people as individuals rather than as ‘patients’, and is more able to reflect the important role of people’s families, friends, and carers in their health and wellbeing. Whilst there may be differences in terminology, it is reasonable to hold that these are mostly superficial and that use of the term ‘patient-centred’ elsewhere seeks to reflect similar ideals: we thus cite work on ‘patient-centred care’ throughout, treating it as functionally interchangeable.

Introduction

The concept of 'person-centred care' has been with us in one form or another for many decades: indeed, many of the characteristics of good person-centred care are visible in Florence Nightingale's seminal 'Notes on Nursing', published in 1860¹. In recent years, it has taken on heightened prominence, with many health services and providers explicitly aspiring to provide person-centred care. Internationally, this is reflected in developments such as the World Health Organisation's forthcoming global strategy on people-centred and integrated health services².

Despite the international prominence of the concept of person-centred care, practice and policy in different nations is not always well publicised, and there have been few attempts to compare and contrast the way in which the principles of person-centred care are being adopted and advanced in different jurisdictions. This briefing provides an overview of health systems performance and strategies in person-centred care in Europe, with the aim of advancing understanding of the ways in which different national services:

- have chosen to focus on the needs of their users;
- have adapted to address financial pressures and efficiency challenges.

This briefing is not intended to provide an exhaustive analysis of policy in every European nation – rather, it focuses on five nations as exemplars and highlights general learning from these.

Elements of person-centred care

Person-centred care has been described as “*treating the patient as a unique individual*”³. It is a standard of practice⁴ that demonstrates a respect for patients and service users as individuals⁵, and it is about considering the patient's point of view and circumstances in the decision-making process.⁶

Person-centredness also refers to a style of doctor–patient encounter characterized by responsiveness to patient needs and preferences, using the patient's informed wishes to guide activity, interaction and information-giving, and shared decision-making.⁷ A key element of this

¹ Nightingale, Florence. *Notes On Nursing*. Philadelphia: Lippincott, 1992. Print.

² World Health Organisation, *WHO global strategy on people-centred and integrated health services*, 24 July 2015. <http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>.

³ Redman R W (2004) Patient-centered care: an unattainable ideal? *Research and Theory for Nursing Practice* 18(1): 11-14.

⁴ Binnie A, Titchen A (1999) *Freedom to practise: the development of patient-centred nursing*. Butterworth Heinemann, London.

⁵ Shaller D (2007) *Patient-centered care: what does it take?* Picker Institute, Oxford and The Commonwealth Fund.

⁶ Ponte PR, Conlin G, Conway JB et al (2003) Making patient-centered care come alive: achieving full integration of the patient's perspective. *Journal of Nursing Administration*, 33(2): 82-90.

⁷ Rogers A, Kennedy A, Nelson E, Robinson A (2005) Uncovering the limits of patient-centeredness: implementing a self-management trail for chronic illness. *Qualitative Health Research* 125(2): 224-39.

approach is empathy – the professional’s willingness to suspend judgement and appreciate the service user’s perspective.

Person-centred care is also a way of viewing health and illness that affects a person’s general well-being and an attempt to empower the patient by expanding his or her role in their health care. Making the patient more informed, and providing reassurance, support, comfort, acceptance, legitimacy and confidence are the basic functions of this approach.⁸ Person-centred care assumes that patients are qualified to decide their own needs and expectations, and that they are able to make decisions and choices about what they need and want: the role of healthcare providers is therefore to support patients with appropriate health advice so that they can make informed decisions about their own treatment.⁹

Early definitions of person-centred care helped shape the vision of a new approach, providing the basic concepts for building a quality healthcare system.¹⁰ However, such definitions did not apply to people who lacked health literacy or capacity. Further on, people’s needs, welfare, rights and personhood were gradually put at the centre of person-centred care, regardless of whether people had capacity or not. The shift from the agency based idea of person-centred care to a more inclusive model of research and practice has been pioneered for many years in areas such as mental health and dementia, for example.¹¹ Patient priorities for care have included the following characteristics: respect, courtesy, competence, efficiency, patient involvement in decisions, time for care, availability and accessibility, information, and communication.¹² A survey of patient preferences in the primary care setting determined that communication, partnership, and health promotion were the most important patient needs, particularly among patients with psychosocial issues or who were symptomatic.^{13 14}

Similarly, the key components of person-centredness are set out in the Picker Institute’s principles of patient-centred care¹⁵:

- Fast access to reliable health advice
- Effective treatment delivered by trusted professionals
- Continuity of care and smooth transitions

⁸ Fulford KWM, Ersser S, Hope T (1996) *Essential practice in Patient-centred care*. Blackwell Science Ltd, UK.

⁹ Lutz BJ, Bowers B J (2000) Patient-centered care: understanding its interpretation and implementation in health care. *Scholarly Inquiry for Nursing Practice* 14(2): 165-82.

¹⁰ Coulter A (2002) *The autonomous patient: ending paternalism in medical care*. Nuffield Trust, London. Coulter defines patient-centred care as: ‘Health care that meets and responds to patients’ wants, needs and preferences and where patients are autonomous and able to decide for themselves.’

¹¹ Nolan, M. et al. "Towards A More Inclusive Vision Of Dementia Care Practice And Research". *Dementia* 1.2 (2002): 193-211. Web.

¹² Robinson, Janice H. et al. "Patient-Centered Care And Adherence: Definitions And Applications To Improve Outcomes". *Journal of the American Academy of Nurse Practitioners* 20.12 (2008): 600-607. Web.

¹³ Robinson, Janice H. et al., *ibidem*.

¹⁴ Duncan E, Best C, Hagen S. Shared decision making interventions for people with mental health conditions. *Cochrane Database of Systematic Reviews* 2010, Issue 1. Art. No.: CD007297. DOI: 10.1002/14651858.CD007297.pub2.

¹⁵ *Principles of patient centred care*, Picker Institute Europe. <http://www.pickereurope.org/about-us/principles-of-patient-centred-care/>.

- Involvement of, and support for, family and carers
- Clear, comprehensible information and support for self-care
- Involvement in decisions and respect for preferences
- Emotional support, empathy and respect
- Attention to physical and environmental needs

These principles are not the only framework but seek to conceptualise the different elements of person-centred care, but they retain enduring popularity and highlight the range of considerations that are important. In reviewing international practice around person-centred care, we consider these principles an accepted reference point.

Cost-effectiveness of person-centred health systems: the value-based approach

Economic constraints may be one driver of person-centred care: if the promises of person-centred approaches can be realised, then these may include economic as well as individual benefits¹⁶. Some research indicates that person-centred approaches are associated with better clinical outcomes and improved cost effectiveness^{17,18,19}. The evidence on the cost effectiveness of person centred care is not conclusive, however: one controversial study, for example, reported that greater levels of patient satisfaction were associated with significantly increased mortality and greater healthcare expenditure²⁰.

Educating and recruiting a satisfactory number of health professionals remains a crucial requirement for implementing person-centred care in healthcare systems. This represents an economic challenge for many countries where additional training and recruitment would add further pressure on national budgets, which are already under severe strain because of several factors like ageing population, a rise of people affected by chronic and long-term conditions, and the acceleration of medical innovations that have increased demand for state-of-the-art treatment.

Internationally, governments are looking to use their money in a more efficient way. Although efficiency in healthcare has traditionally been interpreted in terms of cost reduction, more

¹⁶ Stone S (2008) 'A Retrospective Evaluation of the Impact of the Planetree Patient Centered Model of Care Program on Inpatient Quality outcomes.' *Health Environments Research and Design Journal* 1(4): 55-69.

¹⁷ Bezold C (2005) The future of patient-centered care: scenarios, visions, and audacious goals. *Journal of Alternative and Complementary Medicine*. 11(Supplement 1): s77-84.

¹⁸ Olsson LE, Hansson E, Ekman I, Karlsson J (2009) A cost-effectiveness study of a patient-centered integrated care pathway. *Journal of Advanced Nursing*, 65(8): 1626-35.

¹⁹ Reid RJ, Fishman PA, Yu O et al (2009) Patient-centered Medical Home demonstration: A prospective, quasi-experimental, before and after evaluation. *American Journal of Managed Care*, 15(9): e71-e87.

²⁰ Fenton JJ, Jerant AF, Bertakis KD, & Franks P. (2012). The cost of satisfaction: A national study of patient satisfaction, health care utilization, expenditures, and mortality. *Archives of Internal Medicine*, 172(5), 405–411. <http://doi.org/10.1001/archinternmed.2011.1662>

recently healthcare policymakers have reframed the notion of value according to the willingness of health systems to follow best clinical practice. As a result, practitioners are promoting a more holistic, person-centred understanding of value - one championed by the academics Michael Porter and Elizabeth Olmsted Teisberg, who first coined the term “value-based healthcare” (VBH) to describe outcomes of health treatment relative to cost.²¹

At the core of value-based healthcare is maximizing value for patients: that is, achieving the best outcomes at the lowest cost. According to Michael Porter and Thomas Lee, the healthcare system should move away from a supply-driven health care system organized around what physicians do and toward a person-centred system organized around what patients need. Therefore, a conceptual shift - from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved – is needed. In addition to that, integration is key in the value-based approach: a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations are essential to deliver high-value care.²²

The strategic agenda for moving to a high-value health care delivery system is comprised of six components. They are interdependent and mutually reinforcing: as integrated practice units; cost and outcomes measurement; bundled payments; integrated care delivery across facilities; expanded services across geography; and an information technology platform to enable those processes.

Following the adoption of the value agenda, there would be many positive implications for organizations: As integrated practice units’ outcomes improve, so will their reputations and, therefore, their patient volumes. With the tools to manage and reduce costs, providers will be able to maintain economic viability even as reimbursements plateau and eventually decline. Providers that concentrate volume will drive a virtuous cycle, in which teams with more experience and better data improve value more rapidly - attracting still more volume.

Although all stakeholders in healthcare have important roles to play, providers are key. Their boards and senior leadership teams should commit to the value agenda, and the discipline to progress through the inevitable resistance and disruptions that will result. Likewise, clinicians will be called to prioritize patients’ needs and patient value over the desire to maintain their traditional autonomy and practice patterns. According to Porter and Lee, trusts and organizations – either large or small, community or academic – that will be able to adopt effectively the value agenda will be rewarded with financial viability and the public reputation gained by excellence in outcomes and value delivered.²³

²¹ Porter, M. E., “What is Value in Health Care?” *The New England Journal of Medicine*, 363:2477-2481, 23 December 2010.

²² Porter, M., Lee, T. (2013, October). The Strategy That Will Fix Health Care. *Harvard Business Review*, available at <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

²³ Porter, M., Lee, T. (2013, October). The Strategy That Will Fix Health Care. *Harvard Business Review*, available at <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

International relevance of person-centred care

In their forthcoming “*Global strategy on integrated people-centred health services 2016-2026*”, the World Health Organisation (WHO) called for a paradigm shift in the way health services are funded, managed and delivered. In order to achieve this, the document set out a global strategy on integrated people-centred health services. The adoption of a person-centred care strategy at international scale has been required to address some of the most urgent challenges being faced by health systems around the world, such as:²⁴

- Ageing populations, urbanization and the globalization of unhealthy lifestyles;
- Spreading of non-communicable diseases, mental illness and injuries;
- Poor access to and fragmented health systems, factors that contributed to the spread of the Ebola crisis in West Africa;
- Lack of accountability by service providers, which have limited incentive to provide the responsive care that matches the needs and preferences of their users.

Additionally, a global people-centred strategy would help to achieve universal health coverage (UHC), improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction, improved efficiency of services, and reduced overall costs.

Individual countries are key stakeholders for the implementation of this ambitious strategy: moves towards people-centred and integrated health services need to be country-led in a process of co-production between governments, providers and the people that they serve. Countries committed to this path should be sure to develop and communicate a clear vision and strategy for what they wish to achieve. They also need to secure adequate funding for reform and implementation research. Academics and researchers also are going to play a crucial role in this, as they need to provide analytical, educational and implementation skills.

Achieving person-centred care globally is, of course, a challenging and ambitious goal, especially after the latest OECD report of health systems around the world²⁵. The analysis, which is based on a cross-country comparisons of the health status of populations and the performance of health systems in 34 OECD countries, as well as of candidate countries and emerging economies (Brazil, China, Colombia, Costa Rica, India, Indonesia, Latvia, Lithuania, the Russian Federation and South Africa), highlighted a slight improvement of the quality of care, alongside increasing evidence of inequities and inefficiencies within health systems.

In particular, although improving quality of care is a high priority in most OECD countries, based on the available data, no country consistently performs in the top group on all indicators

²⁴ World Health Organisation, *WHO global strategy on people-centred and integrated health services*, 24 July 2015. <http://www.who.int/service-delivery/safety/areas/people-centred-care/en/>.

²⁵ OECD, *Health at a Glance 2015*, 4 November 2015. <http://www.oecd.org/els/health-systems/health-at-a-glance-19991312.htm>.

of quality of care²⁶, even those that spend much more on health. This suggests that a lot still needs to be done in all countries to improve health care quality and the prevention, early diagnosis and treatment of different health problems.

In conclusion, the performance of health systems in achieving universal access and high quality and person-centred care depends not only on allocating more resources to health care, but also on making a more effective use of the existing assets and providing the right incentives to ensure the best value for money spent.

In the following sections, this briefing will provide a more focused review of the approach to person-centred care in five different national health systems. In each case, we look at policy and practice around areas linked to person-centred care – including patient choice, patient information, patient involvement, and public satisfaction with the health system. By analysing the type of healthcare systems, their funding model and data on national spending, existing measures of person-centred care, key priorities in person-centred care, and the different adoptions of a value-based approach to healthcare, this cross-country comparison intends to highlight various approaches to person-centred care in Europe and to provide an international perspective that may inform the future development of person-centred approaches.

Limitations of the analysis

There are numerous challenges in carrying out international comparisons of health system performance, strategies and structures. However, international comparisons also provide vast potential for both within and cross-country learning. Through comparative assessments, policy-makers are provided with an instrument to understand what is driving reported strategies to improve person-centred care, as well as guidance on where to look for potential solutions and ideas. The major benefit of international comparisons is their potential to provide a snapshot comparison of different experiences. These comparisons offer the possibility of exploring new and different options; the potential for mutual learning and the opportunity to reconsider national policy.

However, it is important to note the specific limitations of the current review. They can be summarised below:

- Firstly, the review focuses only on five countries as exemplars of the breadth of policy and practice in the more developed nations of Europe. Evidence from these is not intended to, nor should it be assumed to be, generalizable to a wider set of countries: instead of being representative, they are intended to be illustrative only.
- Even when comparing five countries with relatively similar economic profiles, there is limited data available to support quantitative comparisons of performance. This reflects

²⁶ Asthma and COPD hospital admission; Diabetes hospital admission; Case-fatality for AMI; Cervical cancer survival; Case-fatality for ischemic stroke; Breast cancer survival; Colorectal cancer survival.

a need for more evidence, particularly on people experiences of using health services internationally, to supplement the currently limited evidence base.

- Finally, other countries may face different sets of challenges, which are not considered in the analysis (for instance, demographic change, limited resources and rising costs), therefore potential for policy transfer at national level would not be recommended on the basis of this study.

International comparison of person-centred care systems



England

The structure of the healthcare system

Responsibility for health legislation and general policy rests with Parliament, the Secretary of State for Health, and the Department of Health. The Secretary of State has a legal duty to promote a comprehensive health service, providing services free of charge, except for charges already in place. Rights for those eligible for National Health Service (NHS) care are summarized in the NHS Constitution, and include access to care without discrimination and within certain time frames for some categories, such as emergency and planned hospital care. Under the NHS Health and Social Care Act 2012, day-to-day responsibility for running the NHS rests with NHS England.

NHS England is responsible for managing the NHS budget, overseeing local Clinical Commissioning Groups, and ensuring that the objectives set out in a mandate by the Secretary of State for Health are met, including both efficiency and health goals. Budgets for public health are now held by local government authorities; the 2012 Act requires them to establish “health and wellbeing boards” to improve coordination of local services and reduce health disparities.

Currently, the NHS workforce is comprised of more than 1.2 million staff (HSCIC, October 2015). Publicly owned hospitals are organized either as NHS trusts directly accountable to the Department of Health or as foundation trusts regulated by Monitor, the economic regulator of public and private providers. Foundation trusts enjoy greater freedom from central control, have easier access to capital funding, and are able to accumulate surpluses or run (temporary) deficits.

Funding model and national spending

In 2012, the U.K. spent about 9.3% of GDP on health care, of which public expenditure, mainly on the NHS, accounted for about 84%.²⁷ The majority of funding comes from general taxation, and notionally from national insurance (a payroll tax); in 2006/07 (the latest year for which data are available in this form), 76% came from general taxation and 18 percent from national insurance.²⁸ The NHS also receives income from co-payments, those using NHS services as private patients, and some other minor sources.²⁹

²⁷ OECD. *OECD Health Statistics 2014 - Country Notes*. Available at <http://www.oecd.org/els/health-systems/oecd-health-statistics-2014-country-notes.htm>.

²⁸ Boyle, S. (2011). *United Kingdom (England): Health system review. Health Systems in Transition*; 13(1):1–486.

²⁹ The Commonwealth Fund (2015, January). *International Profiles of Health Care Systems, 2014*. Retrieved from <http://www.commonwealthfund.org/publications/fund-reports/2015/jan/international-profiles-2014>.

NHS budgets are set at the national level, usually on a three-year cycle. The clinical commissioning groups are allocated funds by NHS England, which closely monitors their financial performance to avoid overspending. They are expected to achieve financial balance each year.

Access

The aim of the NHS as established was to provide access to healthcare to all residents, irrespective of how much, or whether, the individual had contributed to its financing. This remains the case today. All those “ordinarily resident” in England are automatically entitled to health care, largely free at the point of use, through the NHS. Non-residents with a European Health Insurance Card are also entitled to free care. Only treatment in an emergency department and for certain infectious diseases is free to other people, such as non-European visitors (Department of Health, 2013). Most private hospital care is financed through supplementary private voluntary health insurance, which covered 10.9 percent of the U.K. population in 2012. The bulk of this was provided through companies (3.97 million policies) versus individual policies (0.97 million).³⁰

The NHS provides or pays for a wide range of services, including: preventive services, including screening, immunization, and vaccination programs; inpatient and outpatient hospital care; physician services; inpatient and outpatient drugs; clinically necessary dental care; some eye care; mental health care, including some care for those with learning disabilities; palliative care; some long-term care; rehabilitation, including physiotherapy (e.g., after-stroke care); and home visits by community-based nurses. The volume and scope of these services are generally a matter for local decision-making, but the NHS Constitution also states that patients have a right to drugs or treatment approved in technology appraisals carried out by the National Institute of Health and Clinical Excellence (NICE), where recommended by their clinician.³¹

State of person-centred care

Patient choice: with the publication of the NHS Constitution in 2010, the government established a set of rights for patients, the public and staff with respect to the NHS. Citizens hold three rights regarding choice:

³⁰ Nuffield Trust (2013). *Public payment and private provision: The changing landscape of health care in the 2000s*. Available at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130522_public-payment-and-private-provision.pdf.

³¹ Department of Health (2013). *The NHS Constitution for England*. Available at: <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf>.

- The right to choose their GP practice. They must be accepted by that practice unless there are reasonable grounds for refusal, in which case they must be informed of the reasons for this.
- The right to express a preference for a particular doctor within their GP practice, and for the practice to try to comply.
- The right to make choices about their NHS health care and to information to support these choices, with options available depending on individual need.

However, evidence shows that patients' rights around choice are not always fully advertised or used. In 2010, just under half of patients recalled being offered a choice by their GP even though GPs claimed they always offered choice to their patients.³²

Patient information: the range of information available for patients to consult about their own health and health care has developed substantially in recent years. The key source is now the NHS Choices web site (<http://www.nhs.uk>), which was launched in 2007. This provides patients with a wide range of information about health and health services in general, ranging from the structure and organization of the NHS to information on costs and exemptions of services, performance indicators, waiting times, complaints procedures, access to medical advice and contact details of local providers. It also includes the facility for patients to check and compare hospitals (both NHS and private-sector), doctor profiles and performance online. Patients can access information about their conditions and treatment, and the site also provides information that may help them to decide, for example, in which hospital they want to be treated.

As well as accessing information about their own health and health care, people are able to obtain detailed information about how the NHS is working. For example, the Department of Health web site provides information on health and social care and public health policy, as well as guidance, publications and various sets of statistics. The key source for NHS statistics and analysis is the Health and Social Care Information Centre (<http://www.hscic.gov.uk/>). Statistical analysis relating to health and health care can also be found on the Office for National Statistics (ONS) web site (<http://www.statistics.gov.uk>). Information on best clinical practice and standards within the NHS is available through the NICE web site (www.nice.org.uk). Finally, the CQC provides information on its web site (www.cqc.org.uk) about the performance of NHS and private sector providers as well as reports of special investigations and consultations that it carries out.

Patient involvement: the NHS Constitution sets two right for patient involvement. First, citizens needs to be involved in discussions and decisions about their health care, and to be given information to enable them to do so; second, they are to be involved in the planning, development and operation of NHS services. Despite these rights, the 2014 NHS Inpatient Survey found out that one in 10 (10%) respondents were not involved as much as they wanted

³² The King's Fund (2010). *Patient Choice. How patients choose and how providers respond*. Available at: http://www.kingsfund.org.uk/sites/files/kf/Patient-choice-final-report-Kings-Fund-Anna_Dixon-Ruth-Robertson-John-Appleby-Peter-Purge-Nancy-Devlin-Helen-Magee-June-2010.pdf.

to be in decisions about their care and treatment, and 20% said that ‘not enough’ information about their condition or treatment was given to them.³³

Public satisfaction with the health system: according to the latest available data, the 2016 British Social Attitudes survey suggested that overall public satisfaction with the NHS fell by 5 percentage points in 2015 to 60%. At the same time, dissatisfaction with the service rose by 8 percentage points to 23%, taking dissatisfaction back to the levels reported between 2011 and 2013. The survey was carried out between July and October 2015 and asked a nationally representative sample of more than 2,000 people about their satisfaction with the NHS overall, and of more than 1,000 people about their satisfaction with individual NHS services.³⁴ Further findings from the survey on specific services showed that:

- satisfaction with GP services remained higher than with other NHS services. However, satisfaction of 69% in 2015 was the lowest rate recorded since the survey began in 1983;
- satisfaction with inpatient services was 58%, having remained statistically unchanged for the past three years;
- satisfaction with accident and emergency (A&E) services was lower than satisfaction with other hospital-based services at 53%;
- satisfaction with social care services provided by local authorities was 26%, 5 percentage points lower than in 2014 and far lower than satisfaction with health care services.

Responsibilities for improving person-centred care

The Care Quality Commission has responsibility for the regulation of all health and adult social care in England, including care provided by the NHS, local authorities, the private sector, and the voluntary sector. All providers, including institutions, individual partnerships, and sole practitioners, must be registered with the Care Quality Commission, which monitors performance using nationally set quality standards, and investigates individual providers when concerns have been raised (e.g., by patients). It can close down poorly performing services. The monitoring process includes results of national patient experience surveys conducted for inpatient, outpatient, and general practice services. The regime of inspections by the Care Quality Commission has been intensified since 2013, partly in response to failures in care at Mid Staffordshire NHS trust, and has been extended to social care and general practice. Hospitals are rated on inspection results.

In order to improve person-centred co-ordinated care, the Health and Social Care Act 2012 charged NHS England, Monitor, and clinical commissioning groups with promoting integrated care—closer links between hospital- and community-based health services, including primary and social care. The health and wellbeing boards within local authorities are intended to

³³ Care Quality Commission (2015). *National results from the 2014 Inpatient Survey*. Available at: <http://www.cqc.org.uk/content/inpatient-survey-2014>.

³⁴ The King's Fund (2016, February). *Public satisfaction with the NHS in 2015. Results and trends from the British Social Attitudes survey*. Available at: <http://www.kingsfund.org.uk/sites/files/kf/media/BSA-public-satisfaction-NHS-Kings-Fund-2015.pdf>

promote integration between NHS and local authority services, particularly at the interface between hospital and social care.

The National Institute for Health and Clinical Excellence develops quality standards covering the most common conditions occurring in primary, secondary, and social care. National strategies have been published for a range of conditions including cancer, trauma, and stroke – and there are published sets of best practice guidance for patient experience in general adult care and in mental health settings.³⁵

Finally, all doctors practicing in the UK are required by law to have a license to practice from the General Medical Council. Similar requirements apply to all professions working in the health sector. A process of revalidation every five years is being introduced for doctors.

The recent inquiry on the failings at Mid Staffordshire NHS Foundation Trust and the Freedom to Speak Up review, both conducted by Sir Robert Francis, highlighted examples of failures in person-centred care culture and led to a national focus on improving care. Part of the criticism included in these reports was that in parts of the service the focus had been on reputation, money, and targets rather than the needs of patients (Department of Health, 2015). These inquiries have created a greater emphasis on delivering high-quality, safe and compassionate care, and they have been followed by the launch of a number of national initiatives (including, for example, the 6Cs) designed to focus on the creation of person-centred care cultures.³⁶

The value based approach in England

In England, one notable example of quality incentive scheme being introduced in hospitals is the Commissioning for Quality and Innovation (CQUIN) tariff system, which was set up by the UK's Department of Health in 2009. The CQUIN system allows health commissioners to hold back 2.5% of the cost of hospital treatment contingent on outcomes; one-fifth of the outcome is assessed according to four national metrics, with locally defined ones making up the rest. However, one major concern is how to fund and assess value for chronic - as opposed to acute - conditions. While England has focused on primary care based on nurse-led clinics and case management, Germany has promoted an effort to introduce greater co-ordination between different health professionals and the introduction of disease management plans (DMPs) for certain conditions.³⁷

While payment reforms have introduced a level of value measure into European health systems, targeting the areas that have the greatest impact on patients - including survival

³⁵ National Institute for Health and Clinical Excellence (2012). *Patient experience in adult NHS services*. Available at: <https://www.nice.org.uk/guidance/gs15>.

³⁶ NHS England (2012). *Compassion in Practice – our culture of compassionate care*. Available at: <https://www.england.nhs.uk/nursingvision/compassion/>.

³⁷ Nolte, E., Knai, C. and McKee, M., *Managing Chronic Conditions: Experience in eight countries*, European Observatory on Health Systems and Policies, 2008.

rates and short-term quality of life - remains a key policymaking objective for both countries.³⁸ At the same time, the lack of sufficient levels of coordinated care and the scarcity of data to support pilot programmes make it harder to assess value in outcomes effectively.

One way in which the UK has sought to bridge this gap is through the creation of the National Institute for Health and Clinical Excellence (NICE): the agency's remit includes deciding whether new treatments are cost-effective. NICE uses quality-adjusted life years (QALYs) to assess the cost-effectiveness of treatments.

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³⁸ Fleurbaey, RL et al, *The Rise of Value Based Health Care: A Report of the ISPOR Health Policy Special Interest Group, Value Based Health Care Working Group*, International Society for Pharmacoeconomics and Outcomes Research, Draft Manuscript, 30 January 2012.

Germany

The structure of the healthcare system

Responsibility for the health care system in Germany is shared between the Länder (states), the federal government and civil society organisations, thus combining vertical implementation of policies with strong horizontal decision-making.

At the national level, the Federal Assembly, the Federal Council (the upper house, representing the states) and the Federal Ministry of Health and Social Security are the key actors. Regionally, the ministries in each Land (state) are responsible for passing their own laws, supervising subordinate authorities, and financing investment in the hospital sector. The Länder are subdivided into administrative districts and local authorities (towns, municipalities, counties), all of which have numerous competencies in the healthcare system, from health promotion to hospital planning. The role of the central government in relation to localities in Germany has been compared to the less unitary ‘tripartite’ structure in the UK NHS prior to 1974, under which hospitals were run by Regional Hospital Boards, community health services were controlled by local councils and primary care GPs were contracted.

Responsibilities in the German health system follow the separation of powers between the federal government, the states, and the corporatist level. Federal law sets basic definitions in the Social Code Book V (SGB V) and delegates details and their implementation to various corporatist institutions. Health insurance is provided by competing, not-for-profit, nongovernmental health insurance funds called “sickness funds” (there were 154 as of July 2014) in the statutory health insurance (SHI) scheme, or by substitutive private health insurance (PHI) (Federal Association of Sickness Funds, 2014). States own most university hospitals, while municipalities play a role in public health activities and own about half of hospital beds. The various levels of government have virtually no role in the direct financing or delivery of health care. A large degree of regulation is delegated to self-governing associations of the sickness funds and the provider associations. The most important body is the Federal Joint Committee.

In 2012, there were 2,017 hospitals with 501,475 beds (6.2 beds per 1000): 601 were publicly owned, 719 were private non-profit and 697 were private for-profit hospitals, with bed shares of 48%, 34% and 18%, respectively. Among the public hospitals, 57% of beds (27% of all beds) were in 354 institutions under private law (“corporatized”) and 43% (21%) in 247 institutions under public law; the latter group can be subdivided into 108 dependent and 139 independent (“autonomous”) institutions. The 264 psychiatric hospitals had 43,101 beds (9%) and the 1,692 general (or acute) hospitals had 458,374 beds (91%); in addition, there were 61 pure day or night hospitals – officially without beds. (Statistisches Bundesamt, 2013).

Funding model and national spending

In Germany, SHI is the major source of financing health care, covering 70 million people or 85% of the population in 2012. A total of 9 million people (11%) were covered by PHI.

Although SHI dominates the German discussion on health care expenditure and reform(s), its actual contribution to overall health expenditure was only 57.4% in 2012 (Statistisches Bundesamt, 2014). The other three pillars of social insurance contributed an additional 10.7% of total health expenditure: statutory retirement insurance with 1.4% (mainly for medical rehabilitation), statutory insurance for occupational accidents and disease with 1.6%, and statutory long-term care insurance with 7.7%. Governmental sources contributed another 4.8%. Altogether, public sources accounted for 72.9% of total expenditure on health. Private sources accounted for 27.1% of total expenditure.

In 2012, total health expenditure accounted for 11.3% of GDP (OECD, 2014). According to estimates by the Economist Intelligence Unit (2013), Germany's total health care spending is expected to rise to 11.9% in 2017.

Access

Coverage is universal for all legal residents. All employed citizens (and other groups such as pensioners) earning less than €4,462.50 per month (€53,550 per year) as of 2014 are mandatorily covered by SHI, and their dependents are covered free of charge. Individuals whose gross wages exceed the threshold, civil servants, and the self-employed can choose either to remain in the publicly financed scheme voluntarily or to purchase substitutive PHI. Especially for young people with a good income, PHI is attractive, as the insurance may offer contracts with more extensive ranges of services and lower premiums. PHI is complementary as well as supplementary. About 86% of the population receives their primary coverage through SHI and 11% through substitutive PHI (Federal Ministry of Health, 2013). The remainder (eg soldiers and policemen) are covered under special programs. Health insurance is mandatory for all citizens and permanent residents of Germany, while visitors are not covered through German SHI. Finally, undocumented immigrants are covered by social security in case of acute illness and pain, as well as pregnancy and childbirth. Services are provided by the responsible authorities or physicians and hospitals.

SHI covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, physical therapy, prescription drugs, medical aids, rehabilitation, hospice and palliative care, and sick leave compensation. SHI preventive services include regular dental check-ups, well-child check-ups, basic immunizations, check-ups for chronic diseases, and cancer screening at certain ages. All prescription drugs—including newly licensed ones—are covered unless explicitly excluded by law or pending evaluation.

State of person-centred care

Patient information: there is a very large number of sources where patients can get information about various topics, although only a few of them are actually independent and evidence-based, like gesundheitsinformation.de from IQWiG³⁹ or patienten-information.de from ÄZQ (Ärztliches Zentrum für Qualität in der Medizin)⁴⁰, BÄK (Bundesärztekammer) and KBV (Kassenärztliche Bundesvereinigung). There is also the Unabhängige Patientenberatung (UPD).

Patient choice: patients in Germany generally have free choice of physicians. Individuals with private insurance or paying out of pocket have access to all licensed health providers except when this is precluded by contractual limitations. Individuals covered by SHI may choose freely among ambulatory care physicians who have been accredited by the sickness funds to treat SHI-covered patients. Amongst providers, hospitals included in the state-level hospital requirement plans are obliged by law to publish quality reports every two years and they may participate in voluntary quality inspections conducted by the Organization for Transparency and Quality in Health Care or other institutions who give out quality management certificates (eg the European Foundation for Quality Management).

Patient rights: in February 2013, the parliament passed the Patients' Rights Act (Patientenrechtegesetz). It includes several measures designed to strengthen patients' rights. The most important one is the incorporation of the treatment agreement into the Civil Code, in which the rights, duties, and forms of etiquette emerging from the relationship between provider and patient are established, as well as a statutory duty to provide information and documentation to patients on their request. This general law on patient rights states that patients in Germany have the right to:

- choose their physician and hospital freely;
- seek a second opinion;
- receive qualified and judicious medical treatment according to recognized standards of medical practice;
- determine the type of treatment they should receive and the extent of this treatment;
- use sign language or other communication aids if necessary to interact with their physician and have the cost covered by their sickness fund;
- insist that all medical procedures be performed only with their legal consent;
- obtain individual advice from their sickness funds about insurance benefits;
- be treated with pharmaceuticals or medical products that satisfy the legal quality and safety requirements;

³⁹ <https://www.informedhealth.org/>

⁴⁰ <http://www.patienten-information.de/>

- receive timely, face-to-face information about a proposed treatment;
- receive a written record of their most important diagnoses and treatments;
- view their own medical records and have copies made of them at their own expense;
- have their patient data treated with confidentiality; and
- receive compensation in the event of medical error, lack of informed consent, or injury caused by pharmaceuticals or medical devices.

There is also a Charter of Rights for People in Need of Long-term Care and Assistance, which is based on the work of the Round Table on Long-term Care (Runder Tisch Pflege) initiated in the autumn of 2003 by the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth and the Federal Ministry of Health. Some 200 representatives from different fields of geriatric care participated in the various working groups. The Charter contains eight articles on the following areas:

- Self-determination and support for self-help.
- Physical and mental integrity, freedom and security.
- Privacy.
- Care, support and treatment.
- Information, counselling and informed consent.
- Communication, esteem and participation in society.
- Religion, culture and beliefs.
- Palliative support, dying and death.

In July 2014, the Federal Cabinet passed the *Bill of the First Act to Strengthen Long-Term Care*, to be implemented in January 2015. It aims to support families that provide care at home, for example, through more day care and short-term care opportunities, and by increasing the number of additional caregivers.

Public satisfaction with the health system: according to the OECD German patients indicate a high level of satisfaction with their regular doctor. In all four dimensions – “*spending enough time with patient in consultation*”, “*providing easy-to-understand explanations*”, “*giving an opportunity to ask questions or raise concerns*”, and “*involving patient in decisions about care and treatment*” – Germany is one of the five leading countries among the 13 to 14 countries with data and ranks above the OECD average.⁴¹ However, it is worth mentioning that Germany does not run a systematic national survey of patient experience.

⁴¹ OECD (2013, June). *Public spending on health and long-term care: a new set of projections*. Retrieved from: <http://www.oecd.org/eco/growth/Health%20FINAL.pdf>.

Responsibilities for improving person-centred care

Between 2009 and 2015, the Institute for Applied Quality Improvement and Research in Health Care was charged with developing quality assurance across ambulatory and inpatient care. At the beginning of 2016, the Federal Joint Committee has established the Institute for Quality Assurance and Transparency in Health Care (IQTIG). Among the Institute's additional tasks, there is the development of indicators for quality assurance which might provide further criterion for decisions of hospital planning and payment. Overall, the Institute is responsible for evaluating and monitoring quality across the German healthcare system, with a particular focus on hospitals.⁴²

All hospitals are required to publish results on 182 selected indicators defined by the Federal Office for Quality Assurance and AQUA⁴³, enabling a comparison of hospitals. Many institutions and health service providers include complaint management systems as part of their quality management programs, which in 2013 were made obligatory for hospitals. At the state level, professional providers' organizations are urged to establish complaint systems and arbitration boards for the extrajudicial resolution of medical malpractice claims.

The Robert Koch Institute, an agency subordinate to the Federal Ministry of Health and responsible for the control of infectious diseases and health reporting, conducts surveys about health status and health care utilization, and publishes epidemiological, public health, and health care data. Registries for specific diseases, such as certain cancers, are usually organized regionally. In August 2012, as part of the National Cancer Plan, the federal government introduced a draft bill that proposes the implementation of a nationwide standardized cancer registry in 2018 to improve the quality of cancer care; every hospital will be obliged to document the incidence, treatment, and course of the disease.

The value based approach in Germany

In Germany the value based agenda is pursued by the Institute for Quality and Efficiency in Healthcare (IQWiG). Germany uses value dossiers, which assess treatments as a summary of clinical, economic and patient-relevant therapeutic value.⁴⁴ The use of healthcare delivery value chain models that measure outcomes - such as symptoms, complications, sustainability of recovery - is still in its infancy, but the efficiency frontier is the approach chosen in Germany to deliver future healthcare services. In fact, the most recent set of healthcare legislation⁴⁵, which is going through its final readings in the Bundestag before coming into effect in January 2016, contains measures to carry out benefit assessments of medical devices and to evaluate

⁴² IHS (January, 2015). *IQTIG established in Germany to evaluate quality in medical care*. Available at: <https://www.ihs.com/country-industry-forecasting.html?ID=1065997751>

⁴³ <http://www.aqua-institut.de/en/home/>.

⁴⁴ Von der Schulenburg, J. M. Graf, *Value-Based Pricing: How do Approaches Vary by Health Care Context?*, Centre for Health Economics. Available at: http://www.ispor.org/congresses/Spain1111/presentations/IP2_SchulenbergMatthias.pdf

⁴⁵ Federal Ministry of Health, "Krankenhausversorgung zukunftsfest machen", 2 July 2015.

the quality of healthcare, including the introduction of discounts and surcharges depending on the quality of the services provided. The new legislation will also aim to make the quality reports of hospitals more patient-friendly.⁴⁶

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Italy

The structure of the healthcare system

The Italian National Health Service (Servizio Sanitario Nazionale or SSN) is regionally based and organized at the national, regional, and local levels. Under the Italian constitution, responsibility for health care is shared by the national government, the 19 regions, and two autonomous provinces. The central government controls the distribution of tax revenue for publicly financed health care and defines a national statutory benefits package to be offered to all residents in every region—the “essential levels of care” (livelli essenziali di assistenza). The 19 regions and two autonomous provinces have responsibility for the organization and delivery of health services through local health units. Regions enjoy significant autonomy in determining the macro structure of their health systems. Local health units are managed by a general manager appointed by the governor of the region, and deliver primary care, hospital care, outpatient specialist care, public health care, and health care related to social care.

There are 1,163 hospitals serving a population of 59.38 million people: in 2011 there were approximately 194,000 beds in public hospitals and 47,500 in private accredited hospitals (Ministero della Salute, 2014). In 2011, there were approximately 53,800 GPs and paediatricians (33.5%) and 106,800 hospital clinicians (66.5%) (Ministero della Salute, 2014). People may choose any physician whose list has not reached the maximum number of patients allowed (1,500 for GPs and 800 for paediatricians) and may switch at any time. There are 3.85 practicing physicians per 1,000 population.

Funding model and national spending

Total expenditure for the health sector stood at 9.2% of GDP (OECD, 2014). The public system is financed primarily through a corporate tax (approximately 35.6% of the overall funding in 2012) pooled nationally and allocated back to regions. Funding from this tax is typically returned to the source region, but there are large interregional gaps in the corporate tax base, leading to financing inequalities). Additionally, a fixed proportion of national value-added tax revenue (approximately 47.3% of the total health funding 2012) is collected by the central government and redistributed to regions unable to raise sufficient resources to provide the essential levels of care (Ministero dell’Economia e delle Finanze, 2012).

Regions are allowed to generate their own additional revenue, leading to further interregional financing differences. Every year the Standing Conference on Relations between the State, Regions, and Autonomous Provinces (with the presidents of the regions and representatives from central government as its members) sets the criteria (usually population size and age demographics) to allocate funding to regions. Local health units are funded mainly through capitated budgets.

The 2008 financial law established that regions would be financed through standard rates set on the basis of actual costs in the regions considered to be the most efficient. Established in legislation, this policy is not operating fully yet.

National spending levels in healthcare for the years 2014 to 2016 were established in the July 2014 Pact for Health defines funding (between €109bn and €115bn annually). In return, regions make explicit commitments to:

- Reduce hospitalizations through appropriate use of hospitals, with progress toward home care and the creation of community hospitals offering sub-acute care.
- Reorganize primary care: All regions will have to establish primary care complex units (Unità Complesse di Cure Primarie) (as described in the section on care integration) to replace all other forms of general practice networks (base group practice, network group practice, and advanced group practice).
- Revise hospital and specialist care fees in line with health inflation and with the underlying structure of health care costs.
- Revise co-payments for outpatient specialist care to promote more equitable access. Co-payments currently represent a barrier for disadvantaged sectors of the population.
- Strengthen electronic records systems.

Private health insurance plays a limited role in the health system, accounting for roughly 1% of total spending in 2009. Some private health insurance policies also cover co-payments for privately provided services, or a daily rate of compensation during hospitalization. Tax benefits favour complementary over supplementary voluntary insurance.

Access

Primary and inpatient care are free at the point of use. “Positive” and “negative” lists are defined using criteria related to medical necessity, effectiveness, human dignity, appropriateness, and efficiency in delivery. Positive lists identify services (eg pharmaceuticals,) offered to all residents, including primary care, pharmacy services, inpatient care, preventive medicine, home care, and outpatient specialist care. Outpatient optometrist visits are covered, while corrective lenses are not. Negative lists, on the other hand, identify services not offered to patients (eg cosmetic surgery), services covered only on a case-by-case basis (eg, orthodontics and laser eye surgery) and services for which hospital admissions are likely to be inappropriate (eg cataract surgery). Regions can choose to offer services not included in the essential levels of care but must finance them themselves.

Essential levels of care do not include a specific list of mental health, preventive, public health, or long-term care services. Rather, national legislation defines an organizational framework for mental health services, with local health authorities obliged to define the diagnostic, curative, and rehabilitative services available. Essential levels of care also outline general community and individual levels of preventive services to be covered by the National Health Service, including hygiene and public health, immunization, and early diagnosis tools. They

broadly state that rehabilitative and long-term inpatient care are to be delivered as part of a standard, inpatient curative care program.

State of person-centred care

During the last 20 years, national legislators have devoted increased attention to the issue of patients' rights and empowerment in the health care sector, recognizing these principles in SSN reforms and providing national legislation to ensure their actual implementation. Legislation passed during the 1990s covers three main components of quality: input (quality of infrastructure and human resources); process (appropriateness and timeliness of interventions); and outcome (health status and patient satisfaction).

Patient involvement: The first major reform of the SSN since its establishment (Legislative Decrees Nos. 502/1992 and 517/1993) dedicated a whole article (Art. 14) to citizens' rights, focusing on collective involvement of patients/citizens through voluntary and community group representatives and giving greater attention to the use of patients' satisfaction surveys to assess providers' services. At the national level, Art. 14 provided that the Ministry of Health, together with patients' and citizens' associations, needed to establish a set of indicators to systematically measure the quality of health services from the patient's point of view. The indicators covered four areas: personalizing and humanizing care, citizens' information rights, quality of hospital accommodation services and disease prevention policies. A further Ministerial Decree published on 15 October 1996 identified 79 patient satisfaction indicators in these areas. The indicators under 'personalized and humanized care' include the ability to book appointments by telephone and the percentage of general practitioners (GPs) who set up out-of-hours services. The implementation of this national framework on patients' rights and empowerment has not been homogeneous: regions such as Emilia-Romagna, Tuscany and Veneto have given systematic attention to this issue. Therefore, as each region has adopted distinctive and different solutions regarding patient involvement, there is a lack of comparability across the country about this aspect of person-centred care.

Public satisfaction with the health system: according to a Eurobarometer Survey from 2014 on public satisfaction with the health care system in the then EU28 countries, Italy remained under the EU average (56% against an EU average of 71%). At the regional level, available data on Italian citizens' satisfaction in 2012 (ISTAT) show that satisfaction differs across the north–south divide, with the northern and central regions consistently obtaining above-average results, whereas all southern regions score under the average.

Responsibilities for improving person-centred care

Legislation passed during the 1990s covers three main components of quality: input (quality of infrastructure and human resources); process (appropriateness and timeliness of interventions); and outcome (health status and patient satisfaction) (Lo Scalzo et al., 2009).

In order to guarantee full implementation of the before-mentioned Art. 14, in 2006 the Standing Conference on the Relations between the State, the Regions and the Autonomous Provinces signed the 'National Agreement for Health', approving the implementation of a National

Programme for Health Care Quality. This document contains guidelines for the systematic and periodic analysis of citizen satisfaction surveys; however such studies are not currently taking place

National legislation requires all public health care providers to issue a “health service chart” with information on service performance, quality indicators, waiting times, quality assurance strategies, and the process for patient complaints. These charts also have been adopted by the private sector for its accreditation process, and must be published annually, although dissemination methods are decided regionally. Most providers issue data through leaflets and the Internet, while nurses and other medical staff are offered financial performance incentives (linked to manager evaluations but not to publicly reported data).

National and regional governments remain responsible for upholding quality, and ensuring that services included in the essential levels of care are provided and waiting times are monitored. Several regions have introduced programmes for prioritizing delivery of care on the basis of clinical appropriateness of services prescribed and patient severity (France et al., 2005). All doctors under contract with the SSN must be certified, and all SSN staff participate in compulsory continuing education. The National Commission for Accreditation and Quality of Care is responsible for outlining the criteria used to select providers and for evaluating regional accreditation models (including private hospitals), which vary considerably across the system. These models do not usually include periodic reaccreditation.

Finally, national legislation requires all public health care providers to issue a “health service chart” with information on service performance, quality indicators, waiting times, quality assurance strategies, and the process for patient complaints. These charts also have been adopted by the private sector for its accreditation process, and must be published annually, although dissemination methods are decided regionally. Most providers issue data through leaflets and the internet, while nurses and other medical staff are offered financial performance incentives linked to manager evaluations but not to publicly reported data.

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Netherlands

The structure of the healthcare system

Following the introduction of a comprehensive reform package in 2006, universal medical care coverage in the Netherlands has been achieved through an insurance market that aims to be patient-focused and competitive. The care reform has brought completely new regulatory mechanisms and structures to the Dutch health care system, by introducing a single compulsory insurance scheme in which multiple private health insurers compete for insured persons.

Thus, although the government acts as regulator of the system, monitoring quality and ensuring universality of care, it no longer manages the majority of funds and nor does it control volumes, prices or productive capacity. Instead of central command therefore, it is patient demand that is intended to drive quality of care.

Traditionally, self-regulation has been an important characteristic of the Dutch health care system. Professional associations are responsible for re-registration schemes and are involved in quality improvement, for instance by developing professional guidelines. In addition to a well-developed advisory structure the Dutch health care sector can rely on an extensive infrastructure for research and development, covering medical research, health technology assessment and health services research. According to the 2006 reform, the Dutch healthcare system is divided into three “compartments”:⁴⁷

- Long-term care for chronic conditions;
- Basic and essential medical care from GP visits to short-term hospital stays and specialist appointments or procedures;
- Supplementary care e.g. dental work, physiotherapy, cosmetic procedures.

About 7% of the population works in the health care sector and, since the early 2000s, the total number of employees has grown by about one-fifth. Compared to other countries the relative number of nurses is particularly high. In 2013, there were over 40,000 registered doctors, including 12,195 primary care doctors and more than 20,000 specialists. The general practitioner (GP) is the central figure in primary care; other primary care providers include dentists, midwives, and physiotherapists.⁴⁸

⁴⁷ Civitas (2013). *Healthcare System: The Netherlands*. Based on the Civitas Report by Claire Daley and James Gubb. Updated by Emily Clarke (2011) and Elliot Bidgood (January 2013). Available at <http://www.civitas.org.uk/nhs/download/netherlands.pdf>.

⁴⁸ Schäfer W, Kroneman M, Boerma W, van den Berg M, Westert G, Devillé W and van Ginneken E. *The Netherlands: Health system review*. *Health Systems in Transition*, 2010; 12(1):1–229.

Funding model and national spending

The statutory health insurance system is financed under the Health Insurance Act through a nationally defined, income-related contribution, a government grant for the insured below age 18, and community-rated premiums set by each insurer (everyone with the same insurer pays the same premium, regardless of age or health status).

Employers must reimburse employees for this contribution, and employees pay tax on the reimbursement. For those without an employer who do not receive unemployment benefits, such as the self-employed, the income-related contribution is currently 5.4 percent.⁴⁹ Contributions are collected centrally and distributed among insurers in accordance with a risk-adjusted capitation formula that considers age, gender, labour force status, region, and health risk (based on past drug and hospital utilization). In 2011, total health care spending accounted for 12.1 percent of GDP.⁵⁰

A large part of long-term care is financed through the Exceptional Medical Expenses Act, a statutory social insurance scheme for those whose chronic conditions require continuous care and have considerable financial consequences.⁵¹ It is a largely contribution-based scheme and operates nationally. The remainder is financed through the Social Support Act, from general taxation.

Access

Since 2006, all residents are mandated to purchase statutory health insurance from private insurers. People who conscientiously object to insurance and active members of the armed forces (who are covered by the Ministry of Defence) are exempt. Insurers are required to accept all applicants, and enrollees have the right to change insurer each year. In 2013, 30,000 people (less than 0.2% of the Dutch population) were uninsured. Asylum seekers are covered by government, and several mechanisms are in place to reimburse the healthcare costs of illegal immigrants unable to pay. Permanent residents (less than three months) are obliged to purchase private insurance coverage. Visitors are required to purchase insurance for the duration of their visit if this is not covered through their home country. In addition to statutory coverage, most of the population (85%) purchases a mixture of complementary and supplementary voluntary insurance.

In defining the statutory benefits package, government relies on advice from the National Health Care Institute. Health insurers are legally required to provide a standard benefits package covering medical care, including care provided by general practitioners, hospitals, specialists, and midwives; dental care through age 18 (coverage after age 18 is confined to

⁴⁹ The Commonwealth Fund (2015, January). *International Profiles of Health Care Systems, 2014*. Available at <http://www.commonwealthfund.org/publications/fund-reports/2015/jan/international-profiles-2014>.

⁵⁰ OECD. *OECD Health Statistics 2014 - Country Notes*. Available at <http://www.oecd.org/els/health-systems/oecd-health-statistics-2014-country-notes.htm>.

⁵¹ Schäfer et al., 2010, *ibidem*.

specialist dental care and dentures); medical aids and devices; prescription drugs; maternity care; ambulance and patient transport services; paramedical care (limited physical/ remedial therapy, speech therapy, occupational therapy, and dietary advice); basic ambulatory mental health care for mild to moderate mental disorders, including a maximum of five sessions with a primary care psychologist); and specialized outpatient and inpatient mental care for complicated and severe mental disorders.

Long-term disability protection is organized separately from health insurance. People residing legally in the Netherlands and non-residents who pay Dutch payroll tax are compulsorily insured for long-term care under the Exceptional Medical Expenses Act.

State of person-centred care

At the health system level, quality of care is ensured through legislation regarding professional performance, quality in healthcare institutions, patient rights, and health technologies. Most quality assurance is carried out by healthcare providers in close cooperation with patient and consumer organisations and insurers. This may involve re-registration/re-validation for specialists based on compulsory continuous medical education or regular peer review amongst other mechanisms.

Patient choice: patients are free to choose a health insurance policy with the health insurer of their choice. Health insurers are obliged to accept any person applying for basic health insurance and are not allowed to differentiate tariffs on grounds of the age or health status of the applicant. Patients can switch health insurers on 1 January of each year. The rationale behind this freedom of choice is that health insurers may compete on quality of care and price. In the area of health care services, patients can choose between different (types of) health care providers. They can choose which physicians, therapists or institutions they want to go to. For long-term home care, patients can choose whether they want to receive care in kind or a personal budget. With the personal budget, patients can buy and organize their own care. They may buy care from professional organizations, but also from non-professionals such as neighbours, friends, and family members.

Patient information: health care providers have obligations concerning information for patients at the individual level. Physicians are obliged to inform their patients about the planned examination and treatment and about developments regarding the examination, their medical condition and the treatment. This is regulated by the Medical Treatment Agreement Act. Matters on which patients have to be informed are the nature and aim of the examination or treatment; the impact and risks; other possible methods of examination and treatment; and the state of the patient's health status and health expectancies. When a patient is under the age of 11, the physician has to take into account the comprehension of the child.

Patient involvement: individual patients are seen as actors participating in the health insurance and health care provision markets. Their involvement consists of making individual choices with regard to health insurers and providers. Since 1996, collectively

financed organizations in the fields of social care and health care are obliged to have a representative client council to safeguard the interests of the patient. This formal right for patients to be involved with health care has been laid down in the Client Representation Act. The Act gives clients the possibility to make recommendations with regard to several topics, such as the budget, annual accounts and important changes in the organization. The objectives of formal participation are the reinforcement of the clients' legal position and the harmonization between supply and demand. With regard to purchasing decisions in health care, health insurers are obliged to involve patients in these decisions. According to the Health Insurance Act, patients should be enabled to influence the policy of insurers to a reasonable extent. This influence can be realized in different ways. Examples include health insurers conducting satisfaction surveys among insured persons or health insurers setting up a Members Council. The councils consist of elected insured persons and may be given the authority to determine the annual accounts or to advise the board of directors. The Health Care Authority (NZa) supervises the obligation for health insurers to involve patients.⁵²

Public satisfaction with the health system: satisfaction with health care in the Netherlands is high – 86% – compared to 71% across the OECD. Responsiveness of the health care system to patient needs compares well internationally as expressed by the involvement of patients in care and treatment.⁵³

Responsibilities for improving person-centred care

The *Dutch Health Care Performance Report 2010* provided evidence that the quality and price of Dutch health services vary substantially among providers, and that more needs to be done to address the variation in quality.⁵⁴

At the system level, quality is ensured through legislation and via central bodies. Health care institutions have to provide “responsible” care on the basis of a quality system according to the Quality of Health Facilities Act (Ministry of Health, Welfare and Sport 1997). In this Act, responsible care is defined as “*care of a good quality, which is provided effective, efficient and patient oriented and which is responsive to the actual need of the patient*”. The concept of responsible care can also be found in other pieces of legislation, including the Individual Health Care Professions Act (BIG), the Medical Treatment Agreement Act (WGBO) and the Health Insurance Act (Zvw).

⁵² Schäfer et al., 2010, *ibidem*.

⁵³ OECD. *Government at a Glance 2015. Country Fact Sheet*. Available at: <http://www.oecd.org/gov/Netherlands.pdf>.

⁵⁴ *Dutch Health Care Performance Report 2010*. Available at: <http://www.epha.org/a/4273>.

The Dutch government has developed the programme “*Seven rights for the patient in health care*” to strengthen the position of the patient. The programme addresses the rights to:

- (1) available and accessible care;
- (2) have choice and to information that supports making informed choices;
- (3) quality and safety;
- (4) information, consent, medical file keeping and privacy;
- (5) coordination between health care providers;
- (6) effective, accessible treatment of complaints and disputes; and
- (7) participation and good governance.

The Ministry of Health issued a directive to Parliament stating that, from 2014, a central body (the National Health Care Institute) needs to be established to further accelerate the process of quality improvement and to encourage evidence-based practice. In 2013, the Ministry of Health and a number of national representative organizations signed a covenant that effectively sets a limit for the annual growth rate of spending, to be realized through improvements in quality and efficiency. Most notably, the covenant included fewer referrals to hospitals, further concentration of top clinical care, more stringent compliance with guidelines, and a critical use of resources-appropriate care.

The value based approach in the Netherlands

More cost-effective payment systems have been introduced in the Netherlands in 2010, in particular for the treatment of chronic conditions like diabetes. Here, insurers pay a bundled payment to a principal contracting entity - the care group - to cover a full range of diabetes-care services for a fixed period of 365 days. The care group, a new legal entity in the Dutch health care system, comprises multiple providers, often exclusively general practitioners. By signing the bundled-payment contract, the care group assumes both clinical and financial accountability for all diabetes patients assigned to its care program. The contract is limited to general diabetes care (services to manage the underlying disease and reduce risk for complications) and does not include services to address complex complications that may arise. Therefore, the model focuses on primary care.⁵⁵

In 2013, a report from the World Economic Forum with the aim to deliver a strategy for a high quality and sustainable health care system in the Netherlands, suggested to give a mandate to the Quality Institute to create clear standards and frameworks (for example, costs per QALY) and to differentiate standards on cost-benefit analyses for specific patient groups.⁵⁶ By

⁵⁵ Struijs, J., How Bundled Health Care Payments Are Working in the Netherlands, *Harvard Business Review*, 12 October 2015. Available at: https://hbr.org/2015/10/how-bundled-health-care-payments-are-working-in-the-netherlands&cm_sp=Article-_-Links-_-End%20of%20Page%20Recirculation.

⁵⁶ World Economic Forum (2013). *A vision for the Dutch healthcare system in 2040. Towards a sustainable, high-quality care system*, p. 12. Available at: http://www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf.

following the example of NICE in UK, the report proposed to create clear package choices for cure and care.⁵⁷

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⁵⁷ WEF (2013), *ibidem*, p. 15.

Spain

The structure of the healthcare system

The Spanish State is composed of 17 autonomous communities and 2 autonomous cities, both groups being the highest or first-order administrative division in the country. Autonomous communities are themselves composed of provinces, of which there are 50 in total, and in turn, provinces consist of a number of municipalities. Since the end of 2002, responsibilities for healthcare provision were totally devolved to the regional level; this devolution resulted in 17 regional ministries or departments of health with primary jurisdiction over the organization and delivery of health services within their territory. Health expenditure is thus mainly determined by the regional administrations.

The national Ministry of Health and Social Policy (MSPS) is therefore vested with only limited powers. It has authority over legislation on pharmaceuticals and is the guarantor of the equitable functioning of health services across the country, including the definition of the basic benefits basket, the setting of minimum thresholds for services regarding expenditure and quality, and a performance monitoring function (termed “high inspection”). In essence, the Ministry has the challenging mandate of playing the core role in the coordination of the Spanish National Health System spread through 17 regional health systems, which are accountable only to the regional parliaments and thus not hierarchically linked to the national level.

The National Health System has 3,006 health centres and 10,116 local clinics where professionals from the zone’s health care centre go in order to bring basic services closer to the population. There are 790 hospitals (1.8 per 100,000 population) operating in Spain, equipped with 162,538 beds (352.5 per 100,000 population). Public healthcare health centres and hospitals employ approximately 272,000 physicians and nurses. Physicians represent just over 114,000, and the group formed by nursing staff is the most numerous with 157,000 professionals. Health centres and local clinics of the Spanish National Health System employ more than 35,000 physicians (around 29,000 family physicians and just over 6,000 paediatricians) and over 29,000 nursing professionals. Just over 79,000 physicians (ratio of 172 per 10,000 inhabitants) and more than 128,000 nurses (ratio of 279 per 10,000 inhabitants) provide their services in National Health System hospitals and specialist care centres.

Funding model and national spending

The main source of funds for the statutory SNS is public. Currently, almost all of public health care expenditure (excluding civil servants’ mutual funds) is funded through general taxation, while a residual amount is generated by patients with other types of coverage. Taxation provides 94% of public resources; payroll and employers’ contributions to the work injuries and professional diseases mutuality schemes amount to 2.5% of health funds. Mutual funds

catering for civil servants (MUFACE, MUGEJU and ISFAS) deal with 3.4% of the resources, financed from a mix of payroll contributions and taxation.

Hospitals are normally funded through a global budget, set against individual spending headings. Traditionally, hospital expenditure was retrospectively reimbursed on a routine basis, with no prior negotiation between the third party payer and providers. Since the early 1990s, however, regional health services have progressively changed the way in which hospital budgets are fixed. The Catalan government pioneered these reforms and other managerial and organizational innovations introduced during the decade, partly due to a hospital sector dominated by private non-profit-making providers, which gave higher priority to sound contracting practices.

All health professionals in the SNS are salaried workers and a large proportion of them have a special civil servant status (statutory staff), although this proportion has been decreasing over the years and most of the new contracts are more flexible. No extra billing by health care personnel to generate income within the public sector is permitted anywhere in Spain. The most common formula for family doctors (GPs) includes salary plus a capitation component (amounting to about 15% of the total), which takes into account the nature of the population registered with them, its density, and the percentage of the population over 65 years of age.

Currently Spain spends around 9.6% of its GDP in healthcare. According to the OECD (2014), the reduction in health spending in Spain in recent years is linked partly to a reduction in pharmaceutical expenditure, which fell by more 6% in real terms in 2011. Spain has introduced a series of measures to reduce spending on pharmaceuticals, including a general rebate applicable for all medicines prescribed by NHS physicians in 2010, and mandated price reductions for generics and increase in co-payments in 2012. The share of the generic market also doubled in Spain between 2008 and 2012, to reach 18% of the total pharmaceutical market in value (40% in volume). However, GlobalData's latest report (Feb 2015) states that factors such as an aging population and free healthcare service will help drive an overall expansion of the country's healthcare market over the next six years.

Access

The statutory SNS (National Health Service) provides universal coverage, is almost fully funded from taxes, and is provided predominantly within the public sector. Provision is free of charge at the point of delivery, with the exception of pharmaceuticals prescribed to people aged under 65, which entail co-payment of 40% of the retail price.

The Spanish national health system is structured into two health care levels, primary care and specialist care, in which there is an inverse relationship between accessibility and technological complexity. Primary care makes basic health care services available within a 15-minute radius from any place of residence. The main care facilities are health care centres, staffed by multidisciplinary teams comprising general practitioners, paediatricians, nurses and administrative staff, and, in some cases, social workers, midwives and physiotherapists. Since primary health care services are located within the community, they also deal with health promotion and disease prevention.

Specialist care is provided in specialist care centres and hospitals in the form of outpatient and inpatient care. Patients having received specialist care and treatment are expected to be referred back to their primary care doctor, who, based on the patient's full medical history, provides a global clinical and therapeutic vision. This ensures the provision of continuous care under equitable conditions, irrespective of the patient's place of residence and individual circumstances, with care provided even in the patient's home if necessary.

State of person-centred care

The 1986 Health Care General Act establishes the reference framework of rights for the users of the SNS:

- the right to be informed of their rights by health authorities;
- respect for human dignity and privacy, proscribing discrimination of any sort;
- information about health services available and the requirements to access them;
- the right to confidentiality;
- the provision of sustained, complete and comprehensible information, both verbal and written, for the patient and their family regarding diagnosis, prognosis and treatment;
- the obligation for health care staff to have the patient's written informed consent to undergo health interventions (with some exceptions);
- the right to refuse treatment, resulting in voluntary discharge, except in the case of public health risk;
- existence of complaints and suggestions procedures;
- the right to receive a discharge report, in writing, documenting the care process derived from their stay in hospital;
- the right to obtain the drugs and health products necessary to promote, preserve or re-establish their health status;

Patient choice: some regional services have developed these rights differentially for primary health care and specialized services using ad hoc norms. Others have developed norms only for primary health care, while some others simply cite this right in their health legislation. The development of norms and regulations within autonomous communities has been influenced by the date when health care competences were assumed in each region. In general, the possibility to choose a specialist and hospital is relatively less developed compared to this option within primary health care, where it is more common, though in most cases the range of choice is limited to the GPs available in the users' territorial unit or health zone or area.

Public satisfaction with the health system: More than 7 out of 10 adults report a favourable opinion of the public health system; this positive perception is a growing trend in recent years. About one in five think it needs changes, which is a lower figure than in previous years. The

proportion of those who state they are dissatisfied and demand that the system be completely redesigned is less than 1 in 20 (4.2%), remaining similar to previous years.⁵⁸

Responsibilities for improving person-centred care

The Quality Plan 2006-2010 mentioned the introduction of a revised version of the National Health Survey, which was presented in May of 2008 and brought about significant improvement in the detection and measurement of health inequalities (especially in relation to gender and social class, mental health and the health determinants related to the physical and social environment).⁵⁹ The survey is carried out by the Spanish Institute of Statistics, it is periodic and its latest release dates back to March 2013 (2011/2012 data). As described on the survey website, this measurement is "*directed at families. Its main objective is to obtain data on the state of health and determinant factors from the citizens' viewpoint*".⁶⁰

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⁵⁸ Ministry of Health, Social Services and Equality. *National Health System of Spain, 2012* [Internet monograph]. Madrid; 2012. P. 23.

⁵⁹ Ministry of Health and Social Policy. *Quality Plan For The National Health System of Spain 2006-2010. Review of activities to date and summary of future actions*. Madrid; 2009. Available at http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/docs/InformePlanCalidad_ENG.pdf

⁶⁰ Spanish Institute of Statistics, *The National Health Survey*, <http://www.ine.es/jaxi/menu.do?type=pcaxis&path=%2Ft15%2Fp419&file=inebase&L=1>

Discussion

This briefing, although not exhaustive, aims to offer an overview of the range of person-centred care across Europe by focusing on policy and practice in five countries. Within each of the countries reviewed, there is evidence of policy and legislative frameworks addressing, to varying extents, issues related to the quality of person centred care. However, each health system is characterized by its own peculiarities and developments, and there is evidence of differences in the way quality is approached. Whilst a lack of comparable indicators makes it difficult or even impossible to quantitatively compare person-centredness in the five nations, recent developments and performance on related indicators (for example around access and efficiency levels) may provide useful insight:

- In England, the recent inquiry on the failings at Mid Staffordshire NHS Foundation Trust and the Freedom to Speak Up review, both conducted by Sir Robert Francis, highlighted important failures in patient-centred care culture. These reports stressed a weakening of NHS values so that in parts of the service a defensive and bullying culture – concerned more with reputation, money, targets and a lack of valuing leadership – had overwhelmed the compassionate values that underpin the NHS.⁶¹ These inquiries have led to a heightened emphasis on delivering high-quality, safe and compassionate care – but this emphasis is tested by limited resources and significant pressures to make efficiency savings. Faster growth in staff numbers, as a result of the Mid Staff enquiry recommendations, may outpace growth in the numbers of patients treated or improvements in the quality of their care. If so, there will be a slowdown in productivity growth.⁶² By international standards, access to care is excellent, but - according to the latest OECD's Health at a Glance report - the quality of care is still uneven and continues to lag behind that in many other OECD countries.
- The German health care system is recognised worldwide as providing good quality care, short waiting lists and attentive service. A key component of this is the significant amount of money spent on health care: over 11% of their GDP, which is expected to increase further in the future. This means that Germany's health care system is expensive and is putting financial strain on the government. However, the German health system remains pretty efficient given the money invested: for instance, the quality of primary care, as measured by potentially avoidable hospital admissions for chronic conditions, appears lower than in many other OECD countries. Greater efforts are needed to improve the continuity of care for the growing number of people living with one or more chronic diseases to reduce unnecessary hospital use.⁶³

⁶¹ Department of Health (2015). *Culture change in the NHS Applying the lessons of the Francis Inquiries*.

⁶² Centre for Health Economics (2016, January 29). *Productivity of the English NHS: 2013/14 update*. Available at: <http://www.york.ac.uk/che/news/2016/research-paper-126/>.

⁶³ OECD (2015). *Health at a Glance 2015 How does Germany compare?* Available at: <http://www.oecd.org/germany/Health-at-a-Glance-2015-Key-Findings-GERMANY.pdf>.

- Although levels of health spending below other high-income OECD countries, in Italy access to care is automatic and universal for each citizen, and indicators of quality of care for both primary care and hospital care are above the average in many areas. However, Italy is lagging behind in some areas, like long-term care and prevention of non-communicable diseases. At the same time, the provision of long-term care for the elderly remains poorer than in most OECD countries.⁶⁴ Despite these problems, the Italian health care system has been recently considered the third most efficient globally, as judged by Bloomberg Rankings.⁶⁵
- In the Netherlands, the introduction of universal private insurance is said to have created a culture of practice innovation. This has resulted in more focus on prevention and a broader scope of practice in including more diagnostic and surgical procedures and delivery of more care for chronic conditions through primary care. Another factor for change has been the collaboration of large groups of family practices in cooperatives to contract support facilities jointly. As for quality indicators, the Netherlands spends more money on short-term admissions for mental and behavioural disorders than other OECD members. Almost one-quarter (23%) of total expenditure at Dutch hospitals including mental health (GGZ) institutions is on account of mental health care services. This is more than twice the amount spent in other OECD countries.⁶⁶
- In Spain, the existence of different regional governments has contributed to a varied set of approaches typical of decentralization. However, in order to achieve better efficiency, significant measures have been adopted nationally in the past few years: salary reduction of 7.1%; slight increase in working hours for GPs and nurses in primary care; reduction in pharmaceutical expenditure; reduction of the national health budget by 13.7% in 2012 and 22.6% in 2013.⁶⁷ As a result, when it comes to quality care, there is evidence of gaps in the continuity of care for the growing number of people living with one or more chronic diseases.⁶⁸

Comparison of developments in each of the five countries also shows that the adoption of value-based models to healthcare has taken different shapes across Europe: it is interesting therefore to see how different health systems are pursuing their own value agenda.⁶⁹

⁶⁴ OECD (2015) *Health at a Glance 2015 How does Italy compare?* Available at: <http://www.oecd.org/italy/Health-at-a-Glance-2015-Key-Findings-ITALY.pdf>.

⁶⁵ Bloomberg (2014). *Most Efficient Health Care 2014: Countries*. Available at: <http://www.bloomberg.com/visual-data/best-and-worst/most-efficient-health-care-2014-countries>.

⁶⁶ Statistics Netherlands (2015, December). Relatively high budget for mental health care services. Available at: <http://www.cbs.nl/en-GB/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2015/relatief-veel-geld-aan-zorg-voor-psychedische-en-gedragstoornissen.htm>.

⁶⁷ Civitas (2015, November). *Healthcare Reform in Italy and Spain: Do these tax-financed, decentralised systems facilitate better reform implementation than in the NHS?* Available at: http://civitas.org.uk/reports_articles/healthcare-reform-in-italy-and-spain-do-these-tax-financed-decentralised-systems-facilitate-better-reform-implementation-than-in-the-nhs/.

⁶⁸ OECD (2015) *Health at a Glance 2015 How does Spain compare?* Available at: <http://www.oecd.org/spain/Health-at-a-Glance-2015-Key-Findings-SPAIN.pdf>.

⁶⁹ The Economist Intelligence Unit (2015). *An introduction to value-based healthcare in Europe*, p. 2.

- England and Germany have been at the forefront in introducing many aspects of value based healthcare, including cost benefit assessment of health technology and evidence-based protocols for individual diseases;
- The Netherlands have also been early adopters, with the latter benefitting from its position as a smaller country - in this group of five - with a collegial community of healthcare providers;
- By contrast, in other large European economies such as Italy and Spain, implementation of value based healthcare has been more fragmented, with individual institutions often taking the initiative.

Implications for future practice

Despite the different strategies being employed by these five European countries, the general approach for the future is to make person-centred care provision and cost-effectiveness the fundamental elements of healthcare systems. As recognized by the World Health Organization's recent global strategy on integrated people-centred health services 2016-2026: *“developing more integrated people-centred care systems has the potential to generate significant benefits to the health and health care of all people, including improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction, improved efficiency of services, and reduced overall costs.”*⁷⁰

Although all the countries analyzed are committed to patient centred care, many barriers to its full implementation remain, including financial, physical, education and emotional support for individual patients. Likewise, patients' involvement needs to be in all policy making that affects patients' lives, not just restricted to healthcare but to include social and economic policies and regulatory policies. If patients' needs for better involvement, more effective communication and better coordination of care are built into each healthcare system, it will address the overall health and wellbeing of population: this in turn should result in social, health and economic gains.

⁷⁰ WHO (2015). *WHO global strategy on integrated people-centred health services 2016-2026*. Executive Summary. Available at: http://apps.who.int/iris/bitstream/10665/180984/1/WHO_HIS_SDS_2015.20_eng.pdf.

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