Appendix A Overview of health system financing and of service provision and payment in primary or ambulatory care and hospital care in Denmark, Germany and the Netherlands

	Health system financing (2013)			Principles of healthcare provision outside hospital			*Strength of primary care system ¥*	Payment of providers	
Total population	***Main sources (% total health expenditure)***	***Health spending as % GDP***	***Per capita spending (US$ PPP)***	***Provision of primary/generalist and specialist care outside hospital***	***Choice of provider in primary care***	***GP gatekeeping***		***Payment of physicians in primary/ambulatory care***	***Payment of hospitals (year introduced)***
Denmark									
5.6 m	Taxation: 84.3% OOP: 13.7% VHI: 1.9%	10.4%	4,553	GP practices; practice structure is gradually shifting from solo to group practices; practices are increasingly employing nurses	Yes, within specified local area; registration with GP required ('Group 1') ¶	Yes; access to specialist care upon referral only except for certain specialists, e.g. ophthalmologists and dentists	*Strong*	Combination of capitation per patient (one-third) and fee-for-service (two-thirds) for consultations, home visits, out-of-hours services, minor surgery, etc. Reimbursement levels are negotiated between the Danish Regions (represents the regions at national level) and professional associations	Combination of global budget and activity-based funding using DRGs (phased in from 1999)
Germany									
80.6 m	SHI: 69.7% Taxation: 6.6% OOP: 13.5% VHI: 9.3%	11.0%	4,819	Office-based primary and specialist care physicians	Yes	Voluntary ('GP contracts')	*Medium*	Combination of capitation and fee-for service based on centrally negotiated 'uniform value scale' (EBM) by the Federal Association of SHI physicians	German diagnosis-related groups (G-DRG) (phased in from 2003)

	Health system financing (2013)			Principles of healthcare provision outside hospital			Strength of primary care system ¥	Payment of providers	
Total population	***Main sources (% total health expenditure)***	***Health spending as % GDP***	***Per capita spending (US$ PPP)***	***Provision of primary/generalist and specialist care outside hospital***	***Choice of provider in primary care***	***GP gatekeeping***		***Payment of physicians in primary/ambulatory care***	***Payment of hospitals (year introduced)***
								and the National Association of SHI Funds	
The Netherlands									
16.8 m	SHI: 78.3% Taxation: 7.2% OOP: 5.3% VHI: 5.9%	11.1%	5,131	GPs in group practices of two to seven doctors; practices are increasingly employing nurses	Yes; registration with GP required	Yes; access to specialist care upon referral only	*Strong*	Combination of capitation and fee-for-service; maximum remuneration fees for GPs negotiated between National Association of GPs, Health Insurers Netherlands and Ministry of Health, Welfare and Sport	Diagnosis and treatment combinations (DBCs) (2005)

Notes: ¶ Since 1973 residents have been able to choose between two coverage options in the statutory system, Group 1 and Group 2; Group 1 is the default and almost all residents (98%) opt for this. In Group 2, individuals are free to consult any GP and any specialist without referral; **¥** based on a scoring of seven core dimensions of strong primary care (governance, funding, workforce, access, continuity, coordination and comprehensiveness.
GDP – gross domestic product; PPP – purchasing power parity; OOP – out-of-pocket payment; SHI – statutory health insurance; VHI – voluntary health insurance; m – million

Sources: [1-4]

Appendix B Summary overview of regulatory framework and policy initiatives to strengthen coordinated care in Denmark, Germany and the Netherlands, from 2000

Title of reform/regulation	*Stated aim/s of reform/regulation*
Denmark	
2002 Strategy 'Healthy throughout life – the targets and strategies for public health policy of the Government of Denmark 2002–2010'	Government-endorsed national strategy with a special focus on efforts to reduce the major preventable diseases and disorders. Followed by national-level project, which aimed to develop and strengthen systematic efforts to prevent the eight diseases and disease groups, while systematically integrating disease prevention and health promotion within Denmark's health care system. These efforts were followed, in 2005, by Chronic conditions – patients, health care and community which set out options for improving care for those with chronic conditions.
2005 Health Act and 2007 structural reform	Reallocated responsibilities in the health care sector to five newly established regions (replacing the previous 14 county councils) and 98 municipalities (created from the former 275) (the Act describes the changed health care sector included in the 2007 structural reform). Introduced municipal co-financing to encourage municipalities to increase preventative services so as to reduce hospitalisation. Introduced mandatory health agreements between municipalities and regions to promote coordination across municipal care services, primary care and hospital care.
2008 Introduction of mandatory clinical pathways for cancer and cardiovascular disease	Introduced integrated care pathways for 34 types of cancer and four heart diseases to ensure fast tracked care through all stages of care.
2009 Establishment of the Danish Healthcare Quality Programme (DKKM)	The DDKM is overseen by the Danish Institute for Quality and Accreditation in Healthcare (established in 2005). The programme is based on the principle of accreditation and standards (organisational standards, standards related to care coordination, and disease-specific standards, such as treatment guidelines); it further includes monitoring of quality of care in primary and secondary care. (Nb. The programme has been discontinued in the hospital sector from 2015).
Germany	
2000 Statutory Health Insurance (SHI) Reform Act	Introduced provisions for the development of integrated care structures between the ambulatory care and hospital sector; required SHI funds to set aside a defined amount per member for primary prevention or health promotion activities.
2001 Risk Structure Compensation Reform	Introduced, from 2002, structured care programmes for those with chronic disease (disease management programmes) into the German health care

Title of reform/regulation	*Stated aim/s of reform/regulation*
Act	system.
2004 SHI Modernisation Act	Established Federal Joint Committee; strengthened integrated care and GP-centred care (through GP contracts); introduced medical care centres, which provide care across several healthcare specialities within the ambulatory care sector.
2007 Act to Strengthen Competition within SHI	Made health insurance mandatory for all and introduced the morbidity-adjusted risk compensation scheme with effect from 2009.
2008 Long-term Care Reform Act	Enabled delegation of selected medical tasks to non-medical staff in the framework of pilot projects.
2008 Act on the Advancement of Organisational Structures within SHI	Further strengthened provisions for GP-centred care.
2012 SHI Care Structures Act	
2015 Act to Strengthen Care Provision within SHI	Passed in July 2015; the Act seeks to strengthen care provision in the statutory health insurance system through a range of regulatory measures, which include, among other things, the further development of provisions governing the licensing and establishment of physicians and psychotherapists to enhance access to health care across the entire country; and the promotion of innovative forms of care through the establishment of an innovation fund at the Federal Joint Committee endowed with €300 million per annum from 2016 to 2019.
The Netherlands	
2006 Health Insurance Act	Established single mandatory insurance system; introduced possibility of selective contracting with collectives to target care delivery to those with chronic conditions.
2007 Social Support Act	Introduced provisions to enable chronically ill and/or disabled people to live independently and participate in society. (Nb. Amended in 2014 [Wmo 2015], which involved a lowering of the state budget for non-residential long term care).
2009 Act for Allowances for the Chronically Ill and Handicapped Persons	Introduced entitlement for the chronically ill and disabled persons to receive a fixed allowance to compensate for excessive healthcare expenses.
2009, Amendment of the 1993 Individual Health Care Professions Act	Facilitated use of nurses in the care of chronically ill and older people, enabling clinical nurse specialists with set qualifications to autonomously perform common and minor medical procedures.

Title of reform/regulation	*Stated aim/s of reform/regulation*
2014 Long-Term Care Act (Wlz)	Replaces the Exceptional Medical Expenses Act (AWBZ) from January 2015; parts of the AWBZ shifted to the 2006 Health Insurance Act (ZVW) and the amended Social Support Act (Wmo 2015). Health insurers made responsible for home nursing (renamed 'community nursing') as a means to strengthen continuity of care with home nurses expected to combine their medical tasks with improving cohesion between prevention, care, well-being and housing. Shift away from rights-based approach under AWBZ to a needs-based (or provision-based) approach under Wmo.

Sources: [5-12]

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