# COMPARING HEALTHCARE SYSTEMS: USING THE EXAMPLE OF LUXEMBOURG AND THE UNITED STATES

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## ABSTRACT

The Grand Duchy of Luxembourg is a land-locked country in Europe, bordered by Germany, Brussels, and France, and belongs to the shared economy of EU. Luxembourg is a democratic monarchy. The country has strong economy, high gross GDP ($98,110 USD), and low healthcare spending. Since Luxembourg is a wealthy nation, it appears to spend a lower amount of GDP on healthcare than the EU; although in reality, the country's national health expenditures are the highest in EU region. Luxembourg's health system is distinctive on several dimensions, such as state-level financing, comprehensive healthcare coverage, right to healthcare, long-term care, free choice of providers (both physician & hospital), and health status compared to the U.S. market health system. Comparing and contrasting the health-system of these two countries will provide a better real world illustration of factors that have the most substantial impact/ influence and their outcomes/ consequences on these health-systems.

### Organization, Financing, Service Delivery, and Customer Satisfaction

The implications of the healthcare-systems design of Luxembourg are significant, as this small country (998$m^2$ size), as a land locked country with less population density (rural areas) and health expenditures, has high rating for most quality and health status indicators. Luxembourg has a population of half a million (OECD, n.d.). National health expenditures are €3,926.7/$USD 6,341 per capita (6.6% of GDP)), as of 2012. In contrast, the U.S. spends a whopping 17.5% of GDP on healthcare – $ 9,523 USD per capita (CMS, 2015).The country has a GINI index of 34.8 (2006-2010), indicating modest income inequality (World Bank, n.d.). Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality (World Bank Group, 2016). The organization of the country's healthcare system is relatively centralized. Since Luxembourg is a small country, it becomes efficient to organize healthcare system. Luxembourg recently passed legislation to reorganize their healthcare system, in 2010 to 2015, and address inefficiencies. The regulation of the healthcare system is synchronized between the Ministry of Health and Ministry of Social Security (WHO, 2015). The ministry of health is in charge of national level health planning, enacting and implementing health policy, hospital investments, and is involved in the financing of healthcare and public health; Luxembourg Health Portal, n.d.); and further delegates implementation to the Directorate of Health. The ministry of health is headed by the minister of health, while the directorate of health is supported by 2 deputy directors (Health Portal, n.d.). The Directorate of Health further subdivides itself into administrative departments, and medical/technical health departments. The medical/technical components of Directorate of health include 11 business divisions, including the divisions of sanitary inspection, Preventive Medicine, School Medicine and division of health of children and adolescents, curative medication and health quality, pharmacy and medicines, radiation protection, occupation health and environment, social medicine division of addition and mental health, food safety, service of orthoptics and audiological service. The ministry of social security, akin to the ministry of health, is involved with enacting and implementing social policy; in addition, this organization is involved in managing the health

insurance, accident, and long term insurance funds. The ministry of family focuses on the long term care insurance funds. The ministry of social security is involved with the operation of the social security scheme. Residents are protected from disability, illness, maternity, occupational hazards, and social risks; social security schemes also cover residents once a certain age limit is reached. The hospital sector and the primary care/physician sectors are separated in the organizational structure; these two sectors differ in planning, capacity, and payment. Both specialist and primary care services are provided in private practices (Paris et al. 2010). Patients are not restricted to "gatekeepers"/do not have to register with a primary care physician, nor do they need a referral for specialty care. The hospital sector provides the majority of specialty care, while the physician sectors focuses on primary care. There are no private hospitals in Luxembourg; hospital care is offered thru public hospitals (Doctors of the World, 2015). Patients must have a referral from a physician in order to receive care at publically run hospitals. Tertiary care access is limited in Luxembourg, and is provided by neighboring countries; Luxembourg is able to take advantage of its central location in Europe, and outsource majority of tertiary care (EHCI, 2012). The healthcare insurance scheme is organized under the national health insurance fund/scheme (Caisse de Nationale Sante-CNS/National Health Fund). The CNS is the primary source of health insurance for Luxembourgish residents, and is the centralized "point of contact"/point of entry to the healthcare system and private health insurance for all residents (Le government du grand duchy de Luxembourg); recently, Luxembourg consolidated 6 health insurance funds into the CNS, in order to centralize management of health insurance funds and improve coordination (CNS, n.d.). The CNS also works in collaboration with commercial insurances, as patients have the option to supplement their compulsory health insurance with secondary health insurances. The above description of the CNS acts as a parlay into the financing aspects of the Luxembourgish healthcare system. Luxembourg follows a compulsory social insurance scheme, funded by tax-financed contributions from the state, employers, and employees/working Luxembourgish residents to the National Health insurance fund/CNS, following the bismarkian system developed by its German neighbors. Majority of healthcare if financed by contributions from employers and employees; only 40% of contributions are from the Luxemburg state. Employees contributes 5.44% of their income towards the national health insurance, contributing a maximum of 6,225 euros. Luxembourg uses models and forecast for predicting multi- and subsequent year healthcare expenditure, and determining the budget for the national health insurance fund (CNS). Since the CNS is the single payer for all health services, it acts as an insurance plan, in terms of the types of services that are covered and allowed level of payment. The types of services that are covered are a joint decision between the Nomenclature commission, Ministry of Health, and Ministry of Social security. The commission of nomenclature classifies services provided by health professionals and devices that are covered by the CNS; each service and product covered the CNS is classified by a key and a coefficient (Social Security code, Article 65, n.d.). The key letter indicates the monetary value (reimbursement amount), while the coefficient indicates the related value of each service (Government of the Grand Duchy of Luxembourg, 2015). The "nomenclature" can be revised biannually, and is signed by the CNS and professional organizations. As a result, the classification system provides a basis for establishment of collective barging of services and price setting. The commission on nomenclature can also expand or reduce the amount of services that will be covered by the CNS. The committee must provide reason as to why a service is being added, deleted, or modified within the CNS market basket (Legilux, 2011). Prices of pharmaceuticals are also determined by the Ministry of social security. Currently, the following service categories are covered by the CNS: Medical and professional services from health provides, laboratory and

imaging tests, hospital inpatient and outpatient care, medical devices, transportation, rehabilitation, spa, recovery/convalescence, palliative care, preventive medicine, and certain pharmaceutical medications on preferred formularies/lists. Since benefits for the compulsory national health insurance are comprehensive, voluntary health insurance in Luxembourg comprises only 4.5% of financing and has not been completely "developed" (WHO, 2015). Patients must pay the healthcare costs for health services rendered, up front/in advance; the CNS will then reimburse the patient. Copayments are exempted for patients who have reached their out of pocket limit, children, pregnant women, low-income populations, and those with who have certain medical conditions. A fee for service payment system is the primary model for reimbursement for physicians, in both primary care and specialty services (OECD, 2015). Hospitals follow a global budgeting system, accounting for operating costs; the CNS negotiates global budgets for each hospital. The CNS also negotiates with the professional organizations representing primary care. Fees that are billed by Specialists must be equal to the CNS/third party fees; in other words, specialist providers cannot bill for more than the fees/prices assigned by the CNS and must follow assigned prices. This is unlike the U.S., where providers can bill for amounts larger than assigned prices (charges), resulting in balanced billing. In addition, in other OECD countries and in the EU, provides can charge any amount or require patients to pay additional amounts on top of services rendered and accommodations; this is not practiced in Luxembourg. Similarly, hospitals must follow assigned prices by the CNS, and as mentioned previously, are reimbursed by a global budget. The service delivery of Luxembourg's healthcare system can be rated in terms of customer satisfaction, responsiveness/performance, quality of care, equity, and efficiency. Luxembourg ranks 4$^{th}$ on a recent customer satisfaction survey by the Euro Consumer Health Index, scoring 791 out of a 1000 possible points (EHCI, 2012). The Euro Consumer Health Index rated the healthcare of systems of the countries in the EU, based on patient rights/information, accessibility, outcomes, prevention, and pharmaceuticals. Luxembourg received the highest score for accessibility of healthcare; with 233 out of a possible 250 points. Luxembourg still needs to work on providing healthcare information to patient, as evident in its rating; there is a lack of data on quality, performance of the healthcare system, health-plan information, and patient access to any form of health data. In addition, prevention is another discipline that the country needs to improve upon, despite its strong health outcomes. Primary care is not a priority for the country, as patients have free choice of provider and tend to receive specialty services; the country score only 132 out of 175 possible points. Healthcare patient experiences in Luxembourg is rates above OECD average measures, as shown in the below figures 1-4. Figure 1 illustrates that in Luxembourg, 95.5% of patients feel that their primary/regular doctor spends enough time with them, compared to the EOCED average of 87.1% of patients.

Figure 1: Regular doctor spending enough time with patient in consultation, 2010 (or nearest year) (age standardized per 100 patients, OECD data)

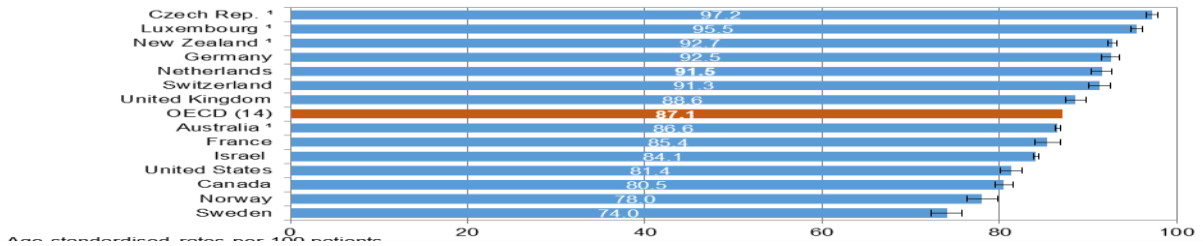
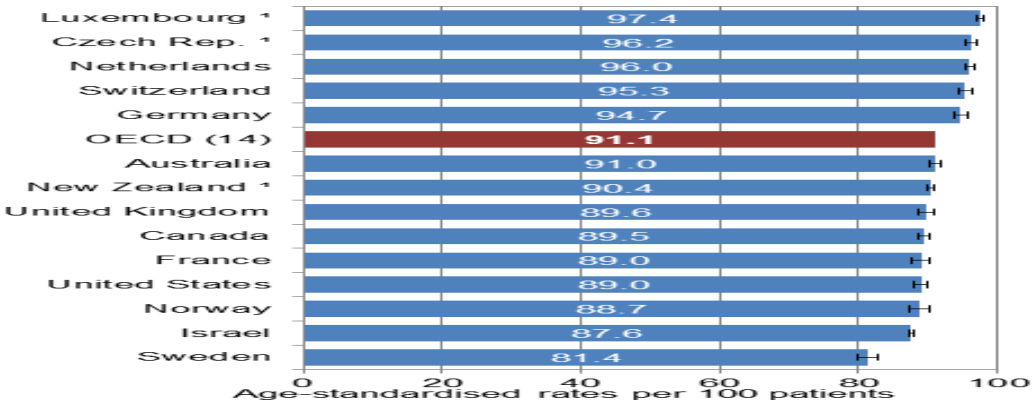
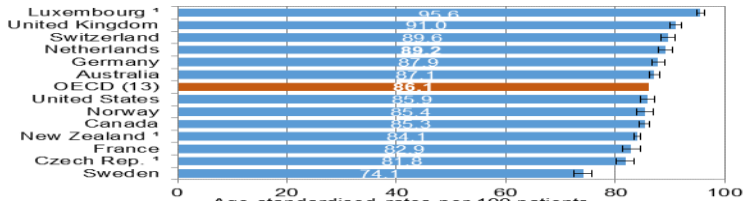


Figure 2: Regular doctor providing easy-to-understand explanations, 2010 (or nearest year) (age standardized per 100 patients, OECD data)




Luxembourg rates the highest in patient doctor communication in OECD nations, as in Figure 2 and Figure 3 . Figure 2 shows that doctors are more likely to provided explanations for medical decision and treatments, to prevent confusion. Emphasizing shared decision-making allows patients to be empowered during medical decisions and treatment options, and patient-doctor communication helps encourage health behavior modification.

Figure 3: Regular doctor involving patient in decisions about care and treatment, 2010 (or nearest year) (age standardized per 100 patients, OECD data)




Lxuembourgish patients are satisfied and self-reported that they feel open to ask their doctors questions, as illustrated in figure 4 (OECD, n.d.), increasing satisfaction, ensuring healthcare needs met and receiving appropriate care. Having the opportunity to ask questions to a doctor and receive easy to understand answers is important for disease management, adherence, changes in health behavior, and health outcomes, especially in vulnerable populations.

Figure 4: Regular doctor giving opportunity to ask questions or raise concerns to their doctor (age standardized per 100 patients, OECD data)

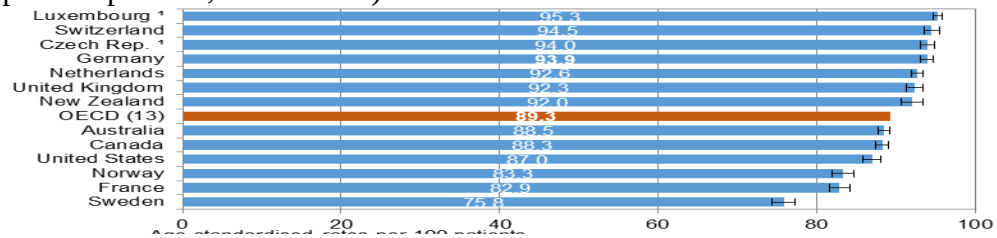


Figure 3 and 4 supplement evidence that Luxembourg's healthcare system has a strong focus on patient experience and patient's perspective of the healthcare system. Patient doctor communication and shared decision making is a vital element of quality improvement and patient safety; Luxembourg rates the highest on patient reported performance & effective communication.

**Equity and Efficiency**

Luxembourg has specific health programs that are catered to low-income and vulnerable populations. The health system in Luxembourg is effective at providing accessible preventive care services. For example, vaccination rates in Luxembourg are consistently close to 100%, over the past decade (WHO, 2015), in contrast to the U.S. Luxembourg provides specific programs for vulnerable populations, addressing access to care issues. For example, the country provides low-income populations with services through the Third party social payment - *tier payment social* (TPS). Since patients have to pay for services in advance before being reimbursed by the CNS, this poses a financial burden for low-income residents living on a restricted or limited income, patients often cannot afford to pay in advance, resulting in reduced access to services. Low-income patients might have to restrict which providers and services they access in order to accommodate their weekly, or monthly allowance/budget. The TPS aims to solve these issues associated with financial burden, providing low-income patients with a certificate and a list of covered services. Patients present this certificate when receiving services, and CNS will directly pay the provider (physician, pharmacy, hospital, etc.).The labels/list of covered services helps the patient coordinate the TPS payments to the provider; in other words, the patient must present the label to the provider, and the provider submits the label to the CNS to receive respective payment. Similarly, for prescriptions, the pharmacist needs to submit the prescription and the label to obtain payment. All Luxembourg's residents can qualify for TPS; TPS is usually granted for 3 months, 6 months, or 1-year time periods, and after 3 months residents can ask for an extension. However, the homeless have to rely on other mechanism for accessing healthcare, as social support and healthcare are linked to a resident's address, reducing the effectiveness of this social program. Refugees and asylees are provided free basic healthcare, and coverage of services is equivalent to a Luxembourgish resident. A monthly allowance, housing, and food are provided at no cost, as well. Asylees can apply for emergency care within the first 3 months of their stay. Although refugees/asylees have access to care, undocumented migrants have no right to healthcare in Luxembourg. Unaccompanied undocumented children are provided healthcare coverage; however if the child is accompanied by an adult/parent, healthcare is not provided. This results in reduced access to quality healthcare and preventive services. The Luxembourgish population with certain chronic diseases, such as HIV/AIDS infected patients. Six health centers located across Luxembourg provide free and anonymous care for HIV infected patients. Luxembourg has also recently form committee on infectious disease, to improve access to care for patients with other infectious diseases. On the other hand, like the U.S., Luxembourg needs to improve health system efficiency and performance (OECD, 2010). Luxembourg needs to start incorporating priority setting, to seek improved efficiency gains. The market baskets for health is not clearly defined in Luxembourg, let alone actually conducting economic evaluation or health technology assessment (HTA) of health services. Health technology assessment does not inform which services are covered in the market basket of Luxembourg's CNS, unlike most states in the EU. In addition, increased availability of information for patients would increase competition in the market. In addition, the implementation for gatekeeping and incentives towards primary care would increase

efficiency, creating appropriate outpatient care utilization. As of 2010, Luxembourg implemented a healthcare reform law of its system, instituting medical expertise cell (Cellule d'expertise médicale- EMC) that is administratively under the General Inspectorate of Social Security (below the Ministry of Social Security), as an initial step towards incorporating Health technology assessments/evaluation of services in the healthcare system. The EMC addresses requests from the commission of nomenclature; Luxembourg's process of working towards HTA's is still in the initial stages. The EMC relies on literature reviews, scientific research, work with external bodies and evaluating results from other neighboring countries, rather than a formalized guidelines and process HTA, economic evaluations and cost analyses (Medical expertise cell, 2014). Costs have not been incorporated into these preliminary HTAs. This preliminary form of HTA does not directly influence the commission on nomenclature. The implementation of a HTA is especially imperative in countries such as Luxembourg, as choice is a key feature of the healthcare system. Since hospitals are operating on a prospective global reimbursement system and economic disincentives, inefficiencies and waiting lists can arise with lack of hospital supplies, due to budget constraints.

**Supply/Demand in the Luxembourgish Healthcare System**

The number of medical students is not regulated; there are no quotas for medical students to select certain specialties. Luxembourg is one of the few countries that do not regulate medical students, and the only country that does not incorporate any form of regulation (for health professionals, capacity planning, and geographic distribution of physicians). Luxembourg will be facing issues with health professional shortages soon, and is ill prepared to deal with the training capacpity needs to address shortages; the country has a below average number of practicing physicians (2.9) per 1000 individuals. The number of nurses is high (11.9 per 1,000 residents), while the number of practicing physicians is low (WHO, 2015; OECD, n.d.). The country does not have any policies in place to address medical staff shortages. Due to the small size of the country and its healthcare workforce, Luxembourg attracts cross border care and health professionals; one aspect that is attractive about working in Luxembourg is the high salary provided for health workers (Castegnaro & Claverie, 2011). In addition, Luxembourg has several trade unions that represent the healthcare section and health professionals; as per the constitution, employees have the right to collective bargaining and striking; however, by law, paramedics are prevented from going on strike, due to the healthcare capacity implications involved. There are two collective bargaining agreements in the healthcare sector, and more than 80% (approximately 20,000 individuals) of healthcare professionals are covered by at least one of the two major collective bargaining agreements. In the recent years, there have been some conflict due to providers switching collective bargaining agreements, as another trade union provided more advantageous working conditions; striking is rare in the health professional field, however there were disagreements regarding pay inequity for nurses that lead to a demonstration. At the hospital level, hospital authorities control the recruitment (supply) and pay of medical staff, while hospital authorities negotiate with local health professional authorities. The central government is in charge of setting national pay scales for other health professions. Luxembourg regulates hospitals and the increase of hospital beds, construction of new hospitals, high cost specialized technology/capital investment, and services provided, at the central level. Hospitals negotiate services and reimbursement with the central government/CNS.

**Effectiveness/Quality, Performance, Pharmaceutical, IT, Challenges, and Conclusion**

In addition, patients have access to free care. Quality of care is high, and healthcare in Luxembourg is highly ranked (WHO, 2015). Women have a higher life expectancy (83.9 years) than men (79.8 years); overall life expectancy in Luxembourg is 81.9 (OECD, n.d.). Seventy six to 100% of costs for actuate inpatient care, outpatient care/primary care, outpatient specialist, lab test, and diagnostic imaging care covered. Specialty care is indirectly incentivized, as there are no incentives or bonus for primary care physicians, and physicians earn more by providing more care; the Luxembourgish primary care system is one of the lowest ranked primary care system, in comparison with neighboring EU countries. There are 6.6 outpatient contacts in Luxembourg, which is lower than the OECD average. Thus, the lack of focus on continuity of care chronic disease management, prevention, and primary care has led to increased prevalence of chronic disease; for example, 59.6% of residents over the age of 15 are obese or overweight (OECDstat, n..d). There are no mammography equipment available at ambulatory care settings, thus patients must go to a hospital to receive screening services; however, patients need referrals to receive care at hospitals. Luxembourg is one of 3 countries with lowest number of mammography equipment availability; only 9.2 machines in hospitals/1 million residents (i.e. 4.51 machines in the entire country of 500,000 people). Hospitals receive bonus payments, although these payments are not directly dependent on outcomes and hospitals are reimbursement patient days based on patient need. The average length of stay in an acute care setting is 7 days. As mentioned previously, there is a lack of access to data or information on healthcare or healthcare system performance. Information about pricing of services are not available to patients; overall, there is a lack of data regarding health system performance. Data/evidence is not available on clinical outcomes, patient satisfaction, experiences, provider comparison, or referral selection. Pharmaceutical spending and share of GDP has not increased over the years, in Luxembourg; the country spends little on pharmaceuticals, in terms of public expenditures. In absolute terms, pharmaceutical expenditures in Luxembourg have not strongly increased in respect to GDP per capita; however, it will remain a priority to ensure that Luxembourg can maintain its position. Not surprisingly, a majority of pharmaceutical expenditures in Luxembourg are publically financed (Vogler & Habimana, 2014). Prices are set in the country where the pharmaceutical product is imported from. In term of pharmaceutical product financing, the CNS/ directly reimburses pharmaceutical products have the 3 tier system of reimbursement. Unlike other services & devices, pharmaceuticals are directly reimbursed by the CNS (WHO, 2015). Reimbursement rates are provided at 40%, 80%, and 100% of pharmaceutical costs, depending on the severity of illness, substitutes/generic availability & the resulting out of pocket costs for the patient. Currently, Luxembourg does not primarily focus on policies to address pharmaceutical pricing as part of its health agenda. Reference pricing is used to control pharmaceutical costs, although it has been applied to reimbursement of other health services as well. A reference & decision criteria is used to determine the maximum reimbursement rate (Carone et al. 2012).The country uses external reference pricing, using the lowest price from the country of originate as the basis for pricing decisions. External reference pricing is “applied for all marketed drugs” (Remuzat et al., 2015) & all countries are considered in the scope of evaluation. The reference country chosen for reference pricing varies by country in the EU, and usually is a neighboring country, or a country with similar economic characteristics. The country of origin is used as the reference for “country baskets” used in external reference pricing. However, it is not clearly established as to whether the country of origin is the manufacturing

country or marketing. Luxembourg does not incorporate internal reference pricing (evaluation against similar groups of pharmaceutical. The translation of external reference pricing & impact on the reduction of pharmaceutical prices & cost due is uncertain, it is unlikely that Luxembourg will have made an impact on tis pharmaceutical expenditures, as price comparisons between countries are affected by discounts & differences in list vs effective prices. The country is one of the few member states of the EU that allow up to 10% of pharmaceutical sales within the country direct from manufacturer (Kanavos et al., 2011). Luxembourg also uses direct price controls & international price comparison (European observatory on Healthcare systems, 2004). The country does not incorporate public tendering (bidding) mechanisms for pharmaceutical purchasing. The average margin on pharmacy retail price is 48%; pharmacy markup is linear. Wholesaler markup varies by the country of origin of the medication. Luxembourg also implements policies to encourage appropriate prescription performance; Luxembourg monitors prescriptions, encourages international-non-proprietary name (active ingredient) /generics & sets prescription guidelines targeting physicians. However these policies are not mandatory & physicians are not offered financial incentives towards appropriate prescribing or meeting prescription quotas. Generic medications substitution of brand name medications by pharmacists were banned (disallowed) in Luxembourg, a missed opportunity for pharmaceutical savings. If the prescription was written using the generic name, then pharmacists could source product that is not brand name. In 2014, the country passed anew measure that allows pharmacists to advise patients on the use of generic medications, in phases, beginning with the categories of statins & peptic ulcers/acid reflux medication (Wort, 2014, 2015). According to estimates in 2015, Luxembourg has saved approximately 2 million euros due to the substitution of generics & the use of brand name medications fell, while generic mediation usage doubled. However, Luxembourg is beginning to move towards eHealth & Heath IT, as well as big data in healthcare. Luxembourg has started hosting a national Health Summit; the topic of the Health Summit in 2016 was to focus on eHealth & big data initiatives (Health Summit, n..d). The country has made strides towards electronic health record (EHR) implementation & connectivity. Currently, healthcare organizations in Luxembourg are connected by the eHealth agency using the telematics platform known as HealthNet (eHealth Agency, n.d.); HealthNet incorporates telemedicine, databases, prescribing and patient files, and new initiatives to foster patient communication & data accesses. The governmental eHealth agency also aimed to foster interoperability, coordination of data & improve patient access to information by creating a version of an EHR for shared data, known as the shared health record (DSP). The DSP does not replace providers' records, nor is it a standalone health record; it is similar to a health record bank, where patients & providers can make withdrawals & deposits into the DSP. The DSP works in function with the telematics platforms. The economic crisis, as detailed below, was another incentive towards improving & expanding efforts in shared data & communication. As with EU countries & Bismarckian insurance systems, healthcare in Luxembourg is financed through social contributions; thus during a recession, per capita income & contributions by employees will be reduced, resulting in constraints for healthcare. Luxembourg was one of the later waves that hit by the economic crises. Since the economy was strong, the country was able to protect itself against the economic crisis by implemented fiscal sending measures at the beginning of the recession. Vulnerable populations & minorities have not faces issues with access to care, as of yet; from 2011 to 2012 there was an increase the social support/assistance provided, as well as an increase the proportions spent on health. The TPS systems is a major source of support for those who cannot afford to pay for health services in advance; as of 2013,

the European Anti-Poverty Network Lëtzebuerg help the homeless (those without an address) by covering the cost of insurance. To supplement such financial measures, Luxembourg has maintained a focus towards long term sustainability, in addition to addressing the short term issues associated with the economic crisis & preventing slipping further into the recession. For example, healthcare reform measures have been one of the long-term foci to addressing the future after the recession. Although cuts have started to emerge in Luxembourg after 2012, the economic crisis has hardly resulted in major reductions/cuts for services in Luxembourg; there still have been issues with access to care. Issues associated with mental health policy implementation were due to lack of provider experience with mental health, stigma, and the fragmentation & structure of the healthcare system, rather than the economic crisis at hand; the recession did not exacerbate issues with the implementation for mental health policies. For healthcare providers, a maximum budget has been set, with reduced payments for services above the maximum. When evaluating where public expenditures reduced the most among countries in the EU, Luxembourg was in the top quartile. There is a considering need for reducing healthcare spending, especially as expenditures are above OECD average. The country is similar to the U.S., in that both of these countries have a strong economy with a fragmented healthcare system & high expenditures. Both countries lack a focus on primary care & chronic disease management. Although Luxembourg provides a more affordable, comprehensive health benefit basket & enhanced patient experience, from the perspective of efficiency & availability of pricing information, Luxembourg is similar to the U.S.. Unlike U.S., Luxembourg is a landlocked country, nestled in the EU. Thus, Cross border care is another one of the major health system challenges the country is facing, as there are no restrictions that are currently placed on provision of cross border care. Health economics is an important consideration for the country; currently, there is no focus on efficiency or financial incentives to promote value for care. As in U. S., Luxembourg does not incorporate economic evaluation & health technology assessments in reimbursement or coverage options. Recent reforms were implemented to the nomenclature commission, to ensure that the addition, deletion, or modification of a reimbursed service was clearly justified. Health technology assessments conducted by the EMC are preliminary in nature & do not consider costs. In addition, although the EMC provides information about services covered by the CNS, there are no criteria or incentive to promote economically viable options. However, there are no requirements that the recommendations from the EMC must be implemented in the CNS. The country has made better strides that the U.S. in EHRs, shared health data, and telemedicine technologies. As the country only operates public hospitals, it seems to be considerably easier to link and connect government based healthcare organizations than fragmented, public, & private organizations, with multiple technologies & platforms, health systems & organizational needs, as is the case in the U.S. Similar to the U.S., reference-pricing need to be applied to other health services, other than pharmaceuticals. In addition, there is a dearth of information available on healthcare system performance, as well. Residents, if opting to choose a voluntary, supplementary insurance have means to compare health plans, let alone providers. Thus, it is hard to evaluate health system effectiveness, without data on appropriate metrics. No patient information is provided & health needs assessments or evaluations are not conducted. Capitalization on available data & eHealth infrastructure is the next major goal, and for the country has been trying to foray into personalized medicine & big data ventures (CRP-Sante, n.d.). The yearly countrywide Health Summit conferences provide a venue for enabling conversation & sharing tools on healthcare system performance. The country is engaging in conversations towards the state of the healthcare system and its future. **References** on request.