



## **OECD Health Committee Survey on Health Systems Characteristics**

### **2016 ROUND**

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## PART I. HEALTH CARE FINANCING

### Section 1. Characterisation of basic health care coverage

*This section aims to capture information on health care coverage. The following questions only pertain to **population coverage and financing of health care services** and do **not** cover the provision of services, which is addressed in Part II of the questionnaire.*

#### 1. What share of the population obtains basic primary health care coverage through:

- |   | (%) population |
|---|----------------|
| ▪ Automatic coverage (e.g. based on residence)  | _____%         |
| ▪ Compulsory/mandatory coverage, linked to the payment of a specific contribution/premium (by individuals, households or on their behalf)           | _____%         |
| ▪ Voluntary coverage, obtained through individual or household premiums (which may benefit from tax-financed public subsidies, means-tested or not) | _____%         |
| ▪ Not insured   | _____%         |

Comments/clarifications (if any):

#### 2.a. What is the main source of basic health care coverage in your country? (i.e. which covers the largest share of the population)

- A national health system covering the country as a whole
- Local health systems that serve distinct geographic regions
- A single health insurance fund (single-payer model)
- Multiple insurance funds or companies

#### 2.b. For multiple insurance funds (see 2.a above), how is affiliation with a particular insurer determined?

- Affiliation to a specific insurance/fund is not a matter of choice; it is linked to professional status, geographic situation, or employer.
- Affiliation is a matter of choice; people can choose among several insurers/funds.

Comments/clarifications (if any):

→ Countries without a health insurance market should go directly to section 4, Question 11.

### Section 2. Regulation of health insurance markets for basic health care coverage

The following questions apply **only to those countries featuring multiple insurers/funds**. For questions 3-8.b below: if a system has multiple coverage schemes (e.g., both social insurance and voluntary insurance provide basic health care coverage), the response should refer to the scheme under which the greatest number of people are covered.

**3. Are insurers/funds required to offer the same coverage?**

- They are required to offer the same benefit package with the same level of coverage / co-payment.
- They are required to offer the same benefit package but can differentiate the level of coverage (level and/or type of cost sharing).
- They are allowed to differentiate the benefit package but a “minimum benefit” is defined.
- They freely determine the benefits they cover and the level of coverage.

Comments/clarifications (if any):

**4. Are premiums/contributions regulated by the government or the parliament?**

- Contributions/ premiums are fully defined by regulation.
- Contributions/ premiums are mostly defined by regulation but funds/insurers can adjust them at the margin .
- Schemes/funds can define contributions/premiums within regulatory constraints.  
*If yes, insurers are allowed to modulate premiums according to (check all that apply):*
  - age
  - gender
  - health status
  - benefit design
  - geographic area (e.g. region, canton)
  - income
  - other, explain
- Schemes/funds can define contributions/premiums without any regulatory constraint.

Comments/clarifications (if any):

**5. Is there any system of risk-equalisation between health insurers/funds?**

- Yes  
*If yes, what are the main risk factors used in adjustment? (Check all that apply.)*
  - age
  - gender
  - health status (e.g. prevalence of specific diseases generating higher costs in the insured population)
  - prior utilisation of services
  - other (please specify)

- No

Comments/clarifications (if any):

*The following questions only apply to those systems with multiple insurers/funds and choice of affiliation.*

**6. Restrictions and constraints on enrolment and contract renewal**

**6.a. Are health insurers/funds required to enrol any applicant?**

- Yes  
 No

**6.b. Are health insurers/funds required to accept contract renewal for people they cover?**

- Yes  
 No

**6.c. Are there limits to premium increases in the case of contract renewal?**

- Yes  
 No

Comments/clarifications (if any):

**7. Are there restrictions on switching?**

- People are allowed to switch insurers at any time.  
 People are allowed to switch at set times/frequencies (annually, quarterly)

Comments/clarifications (if any):

**8.a. What kind of information is available to individuals who are choosing among alternative health insurers/funds (check all that apply)?**

- Information on premiums/ contributions  
 Information on benefits covered  
 Information on performance (e.g. claim processing time, client responsiveness)

Comments/clarifications (if any):

**8.b. Is this information disclosed by (check all that apply):**

- Individual funds
- Private organisations that publish comparative standardised information on health insurance funds
- Public authorities that publish comparative standardised information on health insurance funds

Comments/clarifications (if any):

**Section 3. Other interventions of the public sector in the health insurance market**

*The following questions only apply to systems in which coverage is not automatic.*

**9. Does the government intervene to ensure access to basic primary health coverage or health care services for low-income or economically disadvantaged groups?**

- No
- Yes

*If yes, how does the government intervene? (Check all that apply.)*

- There are public subsidies (direct subsidy, tax credit or other tax incentives) for the purchase of basic health insurance.  
If so, is the level of the subsidy:
  - Flat (the same for all beneficiaries)
  - Means-tested

What is the share of the population eligible for such subsidies? \_\_\_\_\_%

What is the share of the population with effective take-up of subsidies? \_\_\_\_\_%

- People are entitled to health coverage through dedicated public insurance programmes.  
If so, what is the share of the population entitled to such health care coverage through dedicated insurance programmes? \_\_\_\_\_%

Comments/clarifications (if any):

**10. Does the government intervene to ensure access to basic primary coverage or health care services to high-risk groups (seniors, disabled, people with chronic disease, etc.) ?**

- No
- Yes

If yes, how does the government intervene in the provision of services to high-risk groups?  
(Check all that apply)

- The government regulates premiums to promote access to insurance for high-risk groups (e.g., community rating)
- The government subsidises (via direct subsidy, tax credit or other tax incentive) the purchase of basic health insurance
- High-risk groups are entitled to public coverage through dedicated programmes
- The public sector directly provides free health care services to high-risk groups

Comments/clarifications (if any):

#### Section 4. Comprehensiveness of basic health care coverage

*This section aims to assess the level of basic health care coverage to which “typical” working-age adults are entitled to. Responses should **not consider** children, seniors and other categories of population which may be entitled to higher levels of benefits (e.g. people with serious illnesses). In countries with multiple insurers allowed to offer different levels of benefits, responses should refer to the most frequent or most typical situation (see examples below).*

**11. Is there a general deductible that must be met before basic health coverage pays a share of the cost or the full cost of covered services?**

- Yes  
If so, what is the amount of the deductible that must be met before basic primary health coverage pays/reimburses? (national currency units) \_\_\_\_\_  
What is the period in which the deductible applies (e.g. year, lifetime, episode of illness, etc.)?
- No

Comments/clarifications (if any):

**12. Are patients required to share the costs of health care for the services and goods listed below?**

*Please indicate the type and level of cost-sharing left at the charge of users by basic primary health coverage, in the case of an adult with no specific exemption of user charge. If there is no cost-sharing, please indicate "no cost-sharing".*

*Please refer to the glossary for standard terminology relating to cost-sharing requirements (deductible, co-insurance and co-payments). You may wish to refer to the System of Health Accounts Manual to obtain more information about the content of each category (see SHA classification of functions):*

[http://www.oecd.org/document/8/0,3746,en\\_2649\\_37407\\_2742536\\_1\\_1\\_1\\_37407.00.html](http://www.oecd.org/document/8/0,3746,en_2649_37407_2742536_1_1_1_37407.00.html)

	<i>Types and level of cost-sharing requirements for an adult not subject to any specific exemption rule</i>
Acute inpatient care	<i>Examples: - Free at the point of care</i>

	<ul style="list-style-type: none"> <li>- €15/day, capped to €X or Y days</li> <li>- max (20% cost-sharing; co-payment per day)</li> <li>- Free at the point of care for patients treated as public patients in public hospitals but cost-sharing of x% + potential extra-billing for “private patients” in public or private hospitals</li> <li>- Not reimbursed if private hospital</li> </ul>
Outpatient primary care contacts	<p>Examples:</p> <ul style="list-style-type: none"> <li>- Free at the point of care</li> <li>- Co-payment of €2 per visit</li> <li>- Co-payment of €10 for the first of each semester</li> <li>- Co-insurance of 20%</li> <li>- Not reimbursed if not referred</li> </ul>
Outpatient specialist contacts	<p>Examples:</p> <ul style="list-style-type: none"> <li>- Free at the point of care</li> <li>- Co-insurance of: 30% if referred by a primary care doctor, otherwise: 50% + potential extra-billing</li> <li>- Co-payment of €10 if not referred by a primary care doctor</li> </ul>
Clinical laboratory tests	<p>Examples:</p> <ul style="list-style-type: none"> <li>- Free at the point of care</li> <li>- Co-insurance of 20% capped at €X</li> </ul>
Diagnostic imaging	<p>Examples:</p> <ul style="list-style-type: none"> <li>- Free at the point of care</li> <li>- Co-insurance of 20% capped €X</li> <li>- Co-payment of €18 for any test exceeding €91 + co-insurance of 30%</li> </ul>
Pharmaceuticals	<p>Examples:</p> <ul style="list-style-type: none"> <li>- Co-payment per prescription item (\$5 for generics and \$20-25 for brand name drugs)</li> <li>- Cost-sharing: 10% of cost with a min of €5 and a max of € 10 per item</li> <li>- Cost-sharing of 0%, 35%, 65% or 85% depending on drug category + €0.50 per item</li> <li>- Deductible of SEK 900 beyond which cost-sharing diminishes by step as spending increases (from 50%, 25%, 10% and 0%)</li> <li>- Any difference between actual price and reference price for medicines subject to reference price</li> </ul>
Dental care	<p>Examples:</p> <ul style="list-style-type: none"> <li>- Not covered</li> <li>- Cost-sharing: 65% of costs</li> </ul>
Dental prostheses	<p>Examples:</p> <ul style="list-style-type: none"> <li>- Not covered</li> <li>- Cost-sharing: 65% of costs</li> <li>- Any difference between price and reference price</li> </ul>

Comments/clarifications (if any):

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**Section 5. Protection against excessive out-of-pocket expenditures**

**13. For outpatient primary care physician contacts, do people usually:**

*Please indicate the most frequent situation*

- Receive free services at the point of care
- Pay only user fees or co-payments (where applicable).
- Pay the full cost of health services and get reimbursed for covered services afterwards.

Comments/clarifications (if any):

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**14. Are there partial or total exemptions from co-payments for some segments of the population?**

*If there is any type of exemption, please specify by type of service*

	ARE THERE EXEMPTIONS ?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
For those with certain medical conditions or disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No								
For those whose income are under designated thresholds	<input type="checkbox"/> Yes <input type="checkbox"/> No								
For beneficiaries of social benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No								
For seniors	<input type="checkbox"/> Yes <input type="checkbox"/> No								
For children	<input type="checkbox"/> Yes <input type="checkbox"/> No								
For pregnant women	<input type="checkbox"/> Yes <input type="checkbox"/> No								
For those who have reached an upper limit (or cap) for out-of-	<input type="checkbox"/> Yes <input type="checkbox"/> No								

pocket payments									
Others (please specify in comments/clarifications)									

Comments/clarifications (if any):

**15. Are there special tax treatments (e.g., credits, deductions) for households' qualified health or medical expenditures (e.g., insurance premiums, out-of-pocket expenditures)?**

- Yes
- No

Comments/clarifications (if any):

**16. What was the share of households exposed to catastrophic health expenditures in 2014 or last available year? \_\_\_\_\_(%)**

Comments/clarifications (if any):

**17. Do exemption mechanisms most often:**

- Prevent people from paying co-payments at the point of service?
- Reimburse or refund co-payments afterwards (e.g., through tax credits)?

Comments/clarifications (if any):

**[Section 6. Competition between health insurers offering basic health care coverage and consumer choice](#)**

*The following questions apply **only to those countries featuring competing insurers/funds.***

**18. A typical insurance customer has how many choices of health insurance plans?**

- 1-2
- 3-5
- more than 5

Comments/clarifications (if any):

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**19. What is the share of the basic health insurance market covered by:**

	% market	% population
the top insurance company/fund?		
the top 3 insurance companies/funds?		
the top 5 insurance companies/funds?		
the top 10 insurance companies/funds?		

Comments/clarifications (if any):

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**20. What share of the market (% of covered population) is insured by:**

	% market	% pop covered
Not-for-profit insurers (public or private)		
Private for-profit insurers		

Comments/clarifications (if any):

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**21. Relations between health insurers and insured people. Are health insurers allowed to: (check all that apply)**

- Require prior authorisation for certain services in order for them to be reimbursed
- Offer insurance plans with a restricted network of providers
- Offer insurance plans requiring patients to follow specific care pathways (gatekeeping, disease management, etc...)
- Offer several options of cost-sharing levels in exchange for higher or lower premiums
- Offer financial rewards (bonuses) to insured persons who do not claim any reimbursements within a given period of time?

Comments/clarifications (if any):

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**Section 7. Private health insurance acting as a secondary source of coverage**

*This section aims to collect information on the role and scope of private health insurance acting as a secondary source of coverage (complementary, supplementary or duplicative).*

**22.a. Is private health insurance a secondary source of coverage for some of the population?**

- Yes
- No

**22.b. What are the main areas of interventions of secondary private health insurance (PHI) in your country?**

	<i>This represents a significant share of secondary PHI activities</i>	<i>This represents a more marginal share of secondary PHI activities</i>	<i>PHI is not allowed to cover this</i>	<i>PHI is allowed to cover this but generally does not</i>
It covers health goods and services that are <b>not included</b> in the basic benefit package (e.g. dental care, eyeglasses, pharmaceuticals)				
It covers <b>cost-sharing</b> for health goods and services covered by basic primary coverage scheme(s)				
It covers health goods and services <b>included</b> in the basic benefit package (duplicate cover): <ul style="list-style-type: none"> <li>i. Only when delivered by providers whose services are <u>not</u> eligible for funding by basic primary coverage</li> <li>ii. Including when delivered by providers whose services are eligible for funding by basic primary health coverage (e.g. to jump the queue or choose your doctor).</li> </ul>				

Comments/clarifications (if any):

**23. If you responded that there is any duplicate cover in question 22.a, what does duplicative coverage most often allow?**

- Coverage for enhanced non-medical accommodation services (e.g. private rooms in hospitals, a television etc.)
- Expands the choice of providers
- Quicker access to health care

- Choice of doctor
- Lower co-payments
- Financial benefits through the tax system

## PART II. HEALTH CARE DELIVERY

### Section 8. Provision of health care and payment of health services

*This section aims to describe the status and types of **organisations** delivering health care services as well as their mode of payments. Status and remuneration of individual health professionals are addressed in the following section.*

*Since health care services can be financed through several routes and with different payment methods, the questionnaire will focus on payment methods employed **by the key “purchaser”**. “Purchaser” refers to financing agents as defined in the System of Health Account, i.e. the “final payer”. Depending on the country and type of service, purchasers either pay the provider directly or reimburse the patient after he/she receives care.*

#### **24. Please provide information on the provision of primary care services and payment methods used by key purchasers.**

##### **24.a. Are primary care services provided predominantly in (please check only one answer):**

- Public primary care clinics staffed by physicians only
- Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)
- Outpatient departments of public hospitals
- Private solo practices
- Private group practices staffed by physicians only
- Private group practices staffed by physicians and other health professionals (e.g., nurses)
- Outpatient departments of private hospitals
- Other, please specify \_\_\_\_\_

##### **24.b. How do key purchasers pay these providers for primary care services? (Check *all* that apply)**

- Capitation
- Fee-for-service
- Pay-for-performance
- Global budget
- Other, please specify \_\_\_\_\_

##### **24.c. If capitation is one component of payment, is it adjusted in any way?**

- Yes
  - If yes, what are the main risk factors used for adjustment? (check all that apply)*
  - Age
  - Gender
  - Health status (e.g. measured by prevalence of specific conditions)
  - Prior use of services
  - Other (please specify): \_\_\_\_\_
- No

##### **24.d. Is there a second significant form of service provision?**

- No
- Yes

If yes, please indicate the second significant form of service provision (check only one answer):

- Public primary care clinics staffed by physicians only
- Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)
- Outpatient departments of public hospitals
- Private solo practices
- Private group practices staffed by physicians only
- Private group practices staffed by physicians and other health professionals (e.g., nurses)
- Outpatient departments of private hospitals
- Other, please specify \_\_\_\_\_

**24.e. How do key purchasers pay these providers? (check all that apply)**

- Capitation
- Fee-for-service
- Pay-for-performance
- Global budget
- Other, please specify \_\_\_\_\_

**24.f. If capitation is one component of the payment, is it adjusted in any way?**

Yes

If so, what are the main risk factors used for adjustment? (check all that apply)

- Age
- Gender
- Health status (e.g. measured by prevalence of specific conditions)
- Prior use of services
- Other (please specify) \_\_\_\_\_

No

Comments/clarifications (if any):

**25. Please provide information on the provision of outpatient specialist services and payment methods used by key purchasers.**

**25.a. Are outpatient specialists' services provided predominantly in:**

- Public multi-specialty clinics
- Outpatient departments of public hospitals
- Private solo practices
- Private group practices
- Outpatient departments of private hospitals

**25.b. How do key purchasers pay these providers? (check all that apply)**

- Fee-for-service
- Global budget
- Pay-for-performance
- Other, please specify \_\_\_\_\_

**25.c. Is there a second significant form of service provision?**

- No
- Yes

*If yes, please indicate the second significant form of service provision:*

- Public multi-specialty clinics
- Outpatient departments of public hospitals
- Private solo specialists
- Private group practices
- Outpatient departments of private hospitals

How do key purchasers pay these providers:

- Fee-for-service
- Global budget
- Pay-for-performance
- Other, please specify

Comments/clarifications (if any):

**26. What is the possible status of hospitals delivering acute inpatient care? (check all that apply)**

- Publically owned hospitals
- Not-for-profit privately owned hospitals
- For-profit privately owned hospitals

**27. Are public hospitals mainly owned by: (Please only check one answer)**

- Central Government
- Regional Government
- Municipal Government
- Social health insurance funds
- Others, please specify : \_\_\_\_\_

**28. What is the main payment method key purchasers of care use to pay for acute care in each relevant category ?**

*Please only check one answer per category*

**28.a. Public hospitals**

- Prospective global budget
- Line-item budgets
- Payment per case (DRG-like)
- Payment based on procedure or service
- Per diem
- Retrospective payments of all costs

Is capital funding included in those payments?

- Yes

- No

Are teaching, training and research funded separately?

- Yes
- No

**28.b. Private not-for-profit hospitals**

- Prospective global budget
- Line-item budgets
- Payment per case (DRG-like)
- Payment based on procedure or service
- Per diem
- Retrospective payments of all costs

Is capital funding included in those payments?

- Yes
- No

Are teaching, training and research funded separately?

- Yes
- No

**28.c. Private for profit hospitals**

- Prospective global budget
- Line-item budgets
- Payment per case (DRG-like)
- Payment based on procedure or service
- Per diem
- Retrospective payments of all costs

Is capital funding included in those payments?

- Yes
- No

Are teaching, training and research funded separately?

- Yes
- No

Comments/clarifications (if any):

**Section 9. Employment status and remuneration of health care professionals**

*This section aims to collect information on the status and payment of health care professionals with the main focus on physicians. In most countries, physicians can choose among several status and payment methods, or even have multiple exercises. Therefore, this section aims to collect information on the predominant status and payment methods for each category of service. Countries are invited to provide information on the relative size of the “predominant” category whenever possible.*

**29. Please provide information on the employment status and payment methods of physicians supplying primary care services:**

**29.a. Are physicians supplying primary care services predominantly:**

- Self-employed
- Publically employed
- Privately employed

**29.b. Are *these* physicians remunerated by?**

- Salary
- Fee-for-service
- Capitation
- Mix of salary and capitation
- Mix of fee-for-service and capitation
- Mix of fee-for-service and salary
- Mix of salary, fee-for-service and capitation

Comments/clarifications (if any):

**30. Please provide information on the employment status and payment methods of physicians supplying *outpatient specialist services*:**

**30.a. Are physicians supplying outpatient specialist services predominantly:**

- Self-employed
- Publically employed
- Privately employed

**30.b. What is the share of specialists supplying outpatient services working in this category (exclusively or not)? \_\_\_\_\_**

**30.c. Are *these* physicians remunerated by:**

- Salary
- Fee-for-service
- Mix of fee-for-service and salary

**30.d. Is dual practice allowed for specialists supplying outpatient services\*\* (e.g. as self-employed and publically employed)?**

- No
- Yes, in some circumstances only (e.g. only in some states in federal countries, or for some categories of physicians)
- Yes, always

If dual practice is allowed, what is the share of specialists with dual practice? \_\_\_\_\_

*\*\* In some countries, it may not be possible to distinguish specialists supplying outpatient services from specialists providing inpatient services for this question. If this is the case, please describe this situation in the comments below.*

Comments/clarifications (if any):

**31. Please provide information on the employment status and payment method of physicians supplying inpatient specialist services:**

**31.a. Are physicians supplying inpatient specialist services predominantly:**

- Self-employed
- Publically employed
- Privately employed

**31.b. What is the share of specialists supplying inpatient services working in this category (exclusively or not)? \_\_\_\_\_**

**31.c. Are these physicians remunerated by:**

- Salary
- Fee-for-service
- Mix of fee-for-service and salary

**31.d. Is dual practice allowed for specialists supplying inpatient services\*\* (e.g. as self-employed and publically employed)?**

- No
- Yes, in some circumstances only (e.g. only in some states in federal countries, only in underserved areas, or for some categories of physicians)
- Yes, always

If dual practice is allowed, what is the share of specialists with dual practice? \_\_\_\_\_

*\*\* In some countries, it may not be possible to distinguish specialists supplying outpatient services from specialists providing inpatient services for this question. If this is the case, please describe this situation in the comments below.*

Comments/clarifications (if any):

**32. Please provide information on the regulation of recruitment and remuneration of medical staff in public hospitals.**

a) Recruitment of *medical staff*

- Hospital managers have complete autonomy
- Hospitals must negotiate with local authorities

- Central or local level of government decides
- Not applicable (physicians are always or most often self-employed and therefore not recruited or appointed)

b) Remuneration level of *medical staff*

- Hospital managers have complete autonomy
- A pay scale is set or negotiated at the central level
- A pay scale is set or negotiated at a local level (e.g. province, region, canton, etc.)
- Not applicable (physicians are not salaried)

c) Are work contracts of the *salaried medical staff* officially with:

- The hospital
- Local government
- Central government
- Not applicable (self-employed physicians)

Comments/clarifications (if any):

### Section 10. Pay-for-performance and other financial incentives for providers

#### **33. Pay-for-performance payments for primary care providers**

##### **33.a. Can primary care providers (physicians or practices) get a bonus payment for achieving targets related to the quality of care (pay-for-performance)?**

- No
- Yes

*If yes, please answer the questions below:*

*In some countries, several programmes have been implemented that cover different states, regions or different therapeutic areas. The following questions aim to get an overall picture of the types of incentives used in the country as a whole. So, please refer to the most significant programmes or combination of significant programmes when answering the questions below.*

*Please provide information for the largest pay-for-performance scheme for items b-e*

##### **33.b. For those providers participating in the programme(s), do targets typically relate to:**

*(Check all that apply)*

- Preventive care (e.g., targets for screening or vaccination rate)
- Management of chronic diseases
- Referral rates below a certain level
- Uptake of IT services (e.g., electronic medical records or electronic prescribing)
- Patient satisfaction
- Efficiency (e.g. share of generics in pharmaceutical prescriptions)
- Other, please specify : \_\_\_\_\_

**33.c. Is participation:**

- Mandatory for all primary care providers nationwide
- Mandatory for all primary care providers in a target category (e.g., a region)
- Voluntary and open to all primary care providers
- Voluntary but subject to some conditions (e.g., accreditation, practice size, geography etc.)

**33.d. Is performance against quality objectives defined in terms of:**

*(Check all that apply)*

- Absolute measure (e.g., screening rate of 80%)
- Change over time (e.g., increase in screening rate by 10%)
- relative ranking (e.g., 10% highest performers earn bonuses)

**33.e. Is the bonus payment normally paid to:**

- The organisation (e.g., physician group)
- Directly to individual physicians

Comments/clarifications (if any):

**34. Pay-for-performance payments for specialists**

**34.a. Can specialists get a bonus payment for achieving targets related to the quality of care (pay-for-performance)?**

- No
- Yes

*If yes, please answer the questions below:*

*In some countries, several programmes have been implemented that cover different states or regions, different specialties or different therapeutic areas. The following questions aim to get an overall picture of the types of incentives used in the country as a whole. So, please refer to the most significant programmes or combination of significant programmes when answering the questions below.*

*Please provide information for the largest pay-for- performance scheme for items b-e*

**34.b. For those providers participating in the programme(s), do targets typically relate to:**

*(Check all that apply)*

- Preventive care (e.g., vaccination rate)
- Management of chronic diseases
- Uptake of IT services (e.g., electronic medical records or electronic prescribing)
- Patient satisfaction
- Other, please specify : \_\_\_\_\_

**34.c. Is participation:**

- Mandatory for all specialists nationwide
- Mandatory for all specialists in a target category (e.g., a region)

- Voluntary and open to all specialists
- Voluntary but subject to some conditions (e.g., specialists in a certain network of physicians)

**34.d. Is performance against quality objectives defined in terms of:**

*(Check all that apply)*

- Absolute measure (e.g., screening rate of 80%)
- Change over time (e.g., increase in screening rate by 10%)
- relative ranking (e.g., 10% highest performers earn bonuses)

**34.e. Is the bonus payment normally paid to:**

- The organisation (e.g., physician group)
- Directly to individual physicians

Comments/clarifications (if any):

**35. Pay-for-performance payments for acute care hospitals**

**35.a. Do some acute care hospitals get a bonus payment for achieving targets related to the quality of care (pay-for-performance)?**

- No
- Yes,

*If yes, please answer the questions below:*

*In some countries, several programmes have been implemented that cover different regions, different types of hospitals or different therapeutic areas. The following questions aim to get an overall picture of the types of incentives used in the country as a whole. So, please refer to the most significant programmes or combination of significant programmes when answering questions below.*

*Please provide information for the largest pay-for-performance scheme for items b-e*

**35.b. For those hospitals that participate in the programmes, do targets typically relate to** *(check all that apply):*

- Clinical outcomes of care (e.g., acute myocardial infarction 30-day mortality)
- The use of appropriate processes (e.g., thrombolytic agent received within 30 minutes of hospital arrival for patients with heart attack)
- Patient satisfaction (subjective appreciation on the quality of care and accommodation)
- Patient experience (waiting times, information given by medical staff, etc.)

**35.c. Is participation:**

- Mandatory for all providers nationwide

- Mandatory for all providers in a target category (e.g. a region)
- Voluntary

**35.d. Is performance against quality objectives defined in terms of:**

*(Check all that apply)*

- Absolute measure (e.g., screening rate of 80%)
- Change over time (e.g., increase in screening rate by 10%)
- Relative ranking (e.g., 10% highest performers earn bonuses)

**35.e. What is the share of participating hospitals?**

% of total hospitals providing acute inpatient care: \_\_\_\_\_

% of hospitals providing acute inpatient care and eligible for the programme \_\_\_\_\_

Comments/clarifications (if any):

**Section 11. Patients' choice and competition among providers**

*Please describe the usual or most common situation for health care covered by basic health care coverage.*

**36. Are patients required or encouraged to register with a primary care physician or practice (i.e., required/encouraged to consult this primary care provider in case of need)?**

- Patients are obliged to register
- Patients are not obliged to register with a primary care physician (or practice) but have financial incentives to do so (e.g., reduced co-payments)
- There is no incentive and no obligation to register with a primary care physician (or practice)

**37. Do primary care physicians control access to specialist care?**

- Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
- Patients have financial incentives to obtain a primary care physicians' referral (e.g., reduced co-payments), but direct access is always possible
- There is no need and no incentive to obtain primary care physician referral

**38.a. Are patients generally free to choose a primary care practice for primary care services?**

- The patient is assigned to a specific provider (e.g. a health centre serving a geographical area)
- The patient's choice is limited (e.g., to a small geographical area, or to a specific network of providers)
- Patients can choose any primary care provider but have financial incentives (e.g., reduced co-payments) to choose certain providers
- Patients are not given any incentive to choose one provider over another

**38.b. Can the patient choose his/her individual doctor within the practice he/she has chosen or he/she is assigned to?**

- Yes
- No
- Not relevant (primary care services are predominantly provided by physicians in solo practice)

Comments/clarifications (if any):

**39.a. Are patients usually free to choose providers for outpatient specialist services?**

- The patient is assigned to a specific provider (e.g. a health centre serving a geographical area)
- The patient's choice is limited (e.g., to a small geographical area, or to a network of providers)
- Patients can choose any physician providing outpatient specialist services but have financial incentives (e.g., reduced co-payments) to choose certain providers
- Patients do not face any incentives to choose one provider over another

**39.b. If facilities providing outpatient specialist services are not solo practices, can the patient choose his/her individual doctor within the institution he/she has chosen or he/she is assigned to?**

- Yes
- No
- Not relevant (outpatient specialist services are predominantly provided by physicians in solo practice)

Comments/clarifications (if any):

**40.a. Are patients usually free to choose hospitals for inpatient care?**

- Patients can choose any hospital without any consequence for the level of coverage
- Patients are free to choose any hospital but they have financial incentives to choose some providers (e.g., the closest hospital, or hospitals that have signed specific contracts with their insurer, etc.), please specify: \_\_\_\_\_
- The patient's choice is theoretically limited (e.g., to a geographical area or to publicly financed hospitals only) but may be expanded in certain circumstances (for instance, if waiting times are too long). Please indicate in which circumstances: \_\_\_\_\_
- The patient's choice is strictly limited with no exception (e.g., to a geographical area or publicly funded hospitals). Please specify limitations: \_\_\_\_\_

**40.b. Can patients choose their individual doctor within the hospital?**

- Always
- Under certain circumstances only (e.g.: if they have a certain type of health insurance, if they are prepared to pay extra fees...). Please specify \_\_\_\_\_
- Usually not

Comments/clarifications (if any):

*The following two questions below seek to understand whether health care service prices are a concern to patients when selecting a provider, and whether information on prices is available to them.*

**41.a. Are prices of primary care services the same or different between providers?**

- Health care services are free at the point of care
- All providers charge the same price to patients (partly or fully refunded by coverage schemes)
- Prices charged to patients can vary across providers (e.g. according to the physician's status) with possible consequences for the patient's own expenses

**41.b. How is information on prices of physicians' consultations/visits made available?**

- Information on prices charged by providers is required to be readily available (posted, communicated in advance)
- Information on prices charged by providers is in practice most often readily available (posted, communicated in advance)
- Patients generally do not know the price they will pay before the encounter

Comments/clarifications (if any):

**42.a. Are prices of outpatient specialist services the same or different between providers?**

- Outpatient specialist services are free at the point of care
- All providers charge the same price to patients (partly or fully refunded by coverage schemes)
- Prices charged to patients can vary across providers (e.g. according to the physician's status) with possible consequences for the patient's own expenses

**42.b. How is information on prices of outpatient specialists' consultations/visits made available?**

- Information on prices charged by providers is required to be readily available (posted, communicated in advance)
- Information for prices charged by providers is in practice most often readily available (posted, communicated in advance)
- Patients generally do not know the price they will pay before the encounter

Comments/clarifications (if any):

**[Section 12. Workforce training and regulation](#)**

**43.a. Are limits set for the number of students accessing medical education?**

- Yes, there are limits only in the form of quotas on the number of students admitted
- Yes, there are limits only in the form of budget or capacity constraints

- Yes, there are limits in the form of quotas on the number of students admitted and of budget or capacity constraints
- No, there are no limits

**43.b. If you answered “Yes” to question 43.a., please indicate who sets these limits:**

- Central government
- Local levels of government
- Universities
- Other(s), please specify: \_\_\_\_\_

**43.c. Are limits set for the number of students accessing medical post-graduate training (i.e. medical specialisation)?**

- Yes, there are limits only in the form of quotas on the number of students admitted
- Yes, there are limits only in the form of budget or capacity constraints
- Yes, there are limits in the form of quotas on the number of students admitted and of budget or capacity constraints
- No, there are no limits

**43.d. If you answered “Yes” to question 43.c., please indicate who sets these limits:**

- Central government
- Local levels of government
- Universities
- Other(s), please specify: \_\_\_\_\_

**43.e. Have any major changes occurred during the past 4 years in the number of students accessing initial medical education?**

- Yes
  - If yes, please indicate if they:*
    - Increased
    - Decreased
- No

**43.f. Have any major changes occurred during the past 4 years in the number of students accessing specialty training in general medicine?**

- Yes
  - If yes, please indicate if they:*
    - Increased
    - Decreased
- No

Comments/clarifications (if any):

**44. Is a formal system of continuous medical education (CME) in place for physicians?**

- No
- Yes
  - If yes, does it apply to all specialities?*
    - Yes

- No

If yes, is the system mandatory for all physicians?

- Yes, CME is mandatory but not linked to recertification or relicensing of physicians
- Yes, CME is mandatory and linked to recertification or relicensing of physicians
- No, participation in CME is voluntary

Comments/clarifications (if any):

**45. Do formal requirements (e.g. mandatory specialist training, specialist licensing) exist for physicians to practise primary care?**

- Yes, mandatory
- Yes, voluntary
- No

If mandatory, please briefly describe the requirements: \_\_\_\_\_

**46. Do formal requirements (e.g. accreditation, certification) exist for facilities to provide primary care?**

- Yes, mandatory
- Yes, voluntary
- No

If mandatory, please briefly describe the requirements: \_\_\_\_\_

**47. What are the policies in place to address the identified physician supply problems? *Check all that apply***

- Increase in training capacity
- Prolong working time for physicians (e.g., incentives for postponing retirement)
- Targeted immigration policy
- Incentives to foster the take-up of general practice (financial and non-financial)
- Incentives to foster the take-up of specialties where shortages exist or are expected (financial and non-financial)
- Introduction or expansion of non-physician practitioner roles (e.g., nurse practitioner)
- Financial incentives to correct perceived geographic maldistribution
- Other, please specify : \_\_\_\_\_
- No particular policy

Comments/clarifications (if any):

**48. Is there any regulation concerning physicians choosing the location of their practices?**

- Yes, relating to density
- Yes, relating to geographical proximity
- Yes, relating to other factors
- No

Comments/clarifications (if any):

**49.a. Is there any limit for entry into nursing education? (check all that apply)**

- Yes, there are limits only in the form of quotas on the number of students admitted
- Yes, there are limits only in the form of budget or capacity constraints
- Yes, there are limits in the form of quotas on the number of students admitted and of budget or capacity constraints
- No, there are no limits

**49.b. If you answered “Yes” to question 49.a, please indicate who sets these limits:**

- Central government
- Local levels of government
- Universities
- Others, please specify: \_\_\_\_\_

**49.c. Have any major changes in nursing student intake occurred during the past 4 years?**

- Yes  
*If yes, please indicate if they:*
  - Increased
  - Decreased
- No

Comments/clarifications (if any):

**Section 13. Infrastructure and service delivery planning**

*This section aims to understand whether regulatory mechanisms are in place to adapt health service delivery and infrastructure to the needs of the population.*

**50.a. Is there any regulation regarding the capacity and service mix provided by hospitals?**

- No, there is no regulation: providers are free to establish and expand capacities
- Yes  
*If yes, does it apply:*
  - To all hospitals that operate on the territory
  - To all hospitals that aspire to contract with the main purchaser(s) of services
  - Only to some categories of hospitals,  
*If so, which one(s) (check all that apply):*
    - Public hospitals
    - Private non-for-profit hospitals
    - Private for profit hospitals
    - Service delivery streams (e.g. obstetrics; cancer). Please specify:  
\_\_\_\_\_

**50.b. What is the main regulatory tool used?**

- Certificate of needs

- Formal hospital and infrastructure master plan, if so (several answers possible):
  - It is designed at the central level
  - It is designed at the local level
  - It is limited to specific service delivery streams (e.g. obstetrics, cancer). Please specify \_\_\_\_\_
- Formal health services plan
  - It is designed at the central level
  - It is designed at the local level
  - It is limited to specific service delivery streams (e.g. obstetrics, cancer, ...). Please specify \_\_\_\_\_
  - Other tool

**50.c. Is the implementation of the regulation on capacity driven by:**

- Administrative and regulatory procedures (authorisation, closures, mergers)
- Economic incentives (e.g. grants for investments, selective contracting)
- Negotiations and agreements between stakeholders (specify which stakeholders)

Comments/clarifications (if any):

**Section 14. Price regulation for health care services**

*This section aims to understand how prices paid by key third party payers are set, as well as the extent to which prices billed to patients can exceed these prices.*

**51. How are fees paid by third-party payers for primary care services determined?**

A combination of different payment methods may be used. If so, please provide a response for each relevant component.

If **fee-for-service** is a component or the main payment method of primary care services:

**51.a. Are fees based on a common Resource-Based Relative Value Scale (RBRVS) (or equivalent)?**

- No
- Yes, there is only one RBRVS for the whole country
- Yes, there are several RBRVSs set at local level or by different payers

**51.b. Are fees (or point values of the RBRVS):**

- Unilaterally set by central governments
- Unilaterally set by key purchasers
- Negotiated at central level between key purchasers' and providers' associations
- Negotiated at local level between key purchasers' and providers' associations
- Negotiated between individual purchasers and providers
- Other, please specify \_\_\_\_\_

If **capitation** is a component or the main payment method of primary care services, how is the capitation determined?

- Unilaterally set by key purchasers or government at central level

- Negotiated between key purchasers' and providers' associations at central level
- Negotiated between key purchasers' and providers' associations at local level
- Negotiated between purchasers and providers
- Other, please specify

If **global budget** is a component or the main payment method of primary care services, how is the budget determined?

- By allocation principles defined at central level
- By allocation principles defined at local level
- Negotiated with key purchasers
- Other, please specify

If **salary** is a component or the main payment method of primary care services, how is the salary determined?

- Unilaterally set by central governments
- Unilaterally set by key purchasers
- Negotiated at central level between key purchasers' and providers' associations
- Negotiated at local level between key purchasers' and providers' associations
- Negotiated between individual purchasers and providers
- Other, please specify \_\_\_\_\_

Comments/clarifications (if any):

**52. Who defines the price billed to patients for primary care services (if any)?**

*The price billed to patients may be partially or fully covered by any type of health insurance*

- Not applicable, health care services are free at the point of care
- Providers cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments);
- Providers can charge any price in some circumstances (depending on their status, or on patients' status), please specify: \_\_\_\_\_
- Providers can charge any price but receive guidance (e.g. from the medical association)
- Providers can charge any price without any guidance

Comments/clarifications (if any):

**53. How are fees paid by third-party payers for outpatient physicians services' determined?**

A combination of different payment methods may be used. If so, please provide a response for each relevant component.

If **fee-for-service** is a component or the main payment method for outpatient specialist services

**53.a. Are fees based on a common RBRVS (or equivalent)?**

- No
- Yes, there is only one RBRVS for the whole country

- Yes, there are several RBRVSs set at local level or by different payers

**53.b. Are fees (or point values of RBRVS):**

- Unilaterally set by central governments
- Unilaterally set by key purchasers
- Negotiated at central level between key purchasers' and providers' associations
- Negotiated at local level between key purchasers and providers
- Negotiated between individual third-party payers and providers
- Other, please specify

If **global budget** is a component or the main payment method for outpatient specialist services, how is the budget determined?

- By allocation principles defined at central level
- By allocation principles defined at local level
- Negotiated with key purchasers
- Other, please specify

**54. Who defines the price billed to patients for outpatient specialist services (if any)?**

*The price billed to patients may be partially or fully covered by any type of health insurance*

- Not applicable, health care services are free at the point of care
- Providers cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments);
- Providers can charge any price in some circumstances (depending on their status, or on patients' status), please specify: \_\_\_\_\_
- Providers can charge any price but receive guidance (e.g. from the medical association)
- Providers can charge any price without any guidance

Comments/clarifications (if any):

**55. How are prices paid to hospitals by key purchasers established for acute inpatient services?**

- **Public hospitals**

A combination of different payment methods may be used. If so, please provide a response for each relevant component.

If **DRG** is a component or the main payment method of acute hospital services, DRG "point values" are:

- Set unilaterally by government or key purchasers at central level and identical for all hospitals in the country
- Negotiated between key purchasers' and providers' associations at central level
- Set unilaterally by local government or key purchasers and identical for all hospitals in the locality (e.g. region)
- Negotiated between key purchasers' and providers' associations at local level
- Set unilaterally by individual key purchasers
- Negotiated between individual key purchasers and individual hospitals
- Other, please specify

If **fee-for-service** is a component or the main payment method of acute hospital services, fees are:

- Set unilaterally by key purchasers (or government) at central level
- Set unilaterally by key purchasers (or government) at local level
- Negotiated at central level between key purchasers and providers
- Negotiated at local level between key purchasers and providers
- Negotiated between individual key purchasers and providers
- Others, please specify

If **global budget** is a component or the main payment method of acute hospital services, how is the budget determined?

- By allocation principles defined at central level
- By allocation principles defined at local level
- Negotiated with financing authorities

If **per diem payment** is a component or the main payment method of acute hospital services, how is the payment determined?

- Set unilaterally by government or key purchasers at central level and identical for all hospitals in the country
- Negotiated between key purchasers' and providers' associations at central level
- Set unilaterally by local government or key purchasers and identical for all hospitals in the locality (e.g. region)
- Negotiated between key purchasers' and providers' associations at local level
- Set unilaterally by individual key purchasers
- Negotiated between individual key purchasers and individual hospitals

- **Private hospitals**

A combination of different payment methods may be used. If so, please provide a response for each relevant component.

If **DRG** is a component or the main payment method of acute hospital services, DRG "point values" are:

- Set unilaterally by government or key purchasers at central level and identical for all hospitals in the country
- Negotiated between key purchasers' and providers' associations at central level
- Set unilaterally by local government or key purchasers and identical for all hospitals in the locality (e.g. region)
- Negotiated between key purchasers' and providers' associations at local level
- Set unilaterally by individual key purchasers
- Negotiated between individual key purchasers and individual hospitals
- Other, please specify

If **fee-for-service** is a component or the main payment method of acute hospital services, fees are:

- Set unilaterally by key purchasers (or government) at central level
- Set unilaterally by key purchasers (or government) at local level
- Negotiated at central level between key purchasers and providers
- Negotiated at local level between key purchasers and providers
- Negotiated between individual key purchasers and providers
- Others, please specify

If **global budget** is a component or the main payment method of acute hospital services, how is the budget determined?

- By allocation principles defined at central level

- By allocation principles defined at local level
- Negotiated with financing authorities

If **per diem payment** is a component or the main payment method of acute hospital services, how is the payment determined?

- Set unilaterally by government or key purchasers at central level and identical for all hospitals in the country
- Negotiated between key purchasers' and providers' associations at central level
- Set unilaterally by local government or key purchasers and identical for all hospitals in the locality (e.g. region)
- Negotiated between key purchasers' and providers' associations at local level
- Set unilaterally by individual key purchasers
- Negotiated between individual key purchasers and individual hospitals

Comments/clarifications (if any):

**56. Who defines the price billed by hospitals to patients for inpatient acute care services (if any)?**

*The price "billed to patient" may be partially or fully covered by any type of health insurance, please do not consider access to comfort accommodation services (e.g. TV, telephone...) when answering, but only prices for medical services.*

- Not applicable, services are free at the point of care (or only entail a small co-payment)
- Hospitals cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments);
- Hospitals can charge any price in some circumstances (depending on providers', physicians' or patients' status), please specify: \_\_\_\_\_
- Providers always freely determine their prices

Comments/clarifications (if any):

**Section 15. Coordination and continuity of care**

**57. What arrangements are in place for patients to see a primary care physician or nurse when the practices are closed without going to the hospital emergency room or department?**

Are there any arrangements in place?

- Yes
- No

*If Yes, are individual primary care physicians available for their own patients?*

- Yes
- No

Are group of primary care physicians available on a rota basis?

- Yes
- No

Are primary care centres (minor injury units, urgent care centres) available?

- Yes
- No

Are general practitioner cooperatives available?

- Yes
- No

Are other arrangements available (if so, please provide details)?

- Yes
- No

Comments/clarifications (if any):

**58. Do a large majority (>75%) of primary care physicians use a computer?**

- Yes
- No

*If Yes, for making appointments?*

- Yes
- No

For ordering laboratory tests?

- Yes
- No

For issuing drug prescriptions?

- Yes
- No

For keeping records of consultations?

- Yes
- No

For sending referral letters to medical specialists?

- Yes
- No

For storing diagnostic test results?

- Yes
- No

For receiving alerts or prompts about a potential problem with drug dose or drug interaction?

- Yes

No

For sending prescriptions to the pharmacy?

Yes

No

**59. Do a large majority (>75%) of primary care physicians offer patients the option to:**

Email about a medical question or concern:

Yes

No

View online, download, or transmit information from their medical record:

Yes

No

**60. Do a large majority (>75%) of nurses or assistants independently provide:**

Immunisation:

Yes

No

Health promotion (e.g. giving lifestyle or smoking cessation advice):

Yes

No

Routine checks of chronically ill patients (e.g. those with diabetes):

Yes

No

Minor procedures (e.g. ear syringing, wound treatment):

Yes

No

### PART III. GOVERNANCE AND RESOURCE ALLOCATION

*This section intentionally does not include questions on all aspects of governance and resource allocation. The OECD Secretariat already collects information through a variety of sources, especially in the Governance Directorate (e.g. Government at a Glance). In addition, the Secretariat is collecting information on Information and Communication Technology, including privacy. The OECD will seek to synthesise the diverse sources of available information in describing health system governance.*

#### Section 16. Health Technology Assessment

##### **61. How is the range of technologies covered by basic health coverage defined (check all that apply)?**

	<i>Medical procedures</i>	<i>Pharmaceuticals</i>	<i>Implantable medical devices</i>
A positive list is established at the central level			
A negative list (of non-covered technologies) is established at the central level			
Individual third-party payers establish their own positive lists (e.g., technologies that are required to be covered)			
Individual third-party payers establish their own negative lists (e.g., technologies that are excluded from coverage)			
Providers under budget constraints establish their own positive lists at the local level			
The range of benefits covered is not defined, every technology performed by a clinician is covered by basic primary coverage schemes			

Comments/clarifications (if any):

--

**62.a. Who performs Health Technology Assessment (HTA) in your country? (check all that apply)**

- An independent body is responsible for HTA in the health sector at central level
- Main purchasers (health insurance, government) perform HTA at central level
- Main purchasers (health insurers, governments) perform HTA at local level to inform their decisions
- Several independent bodies perform HTA at the request of purchasers' or providers' groups (e.g. hospitals)
- HTAs are generally not performed

**62.b. Do HTAs generally include results of economic evaluation (original, based on literature review or conducted in other countries)?**

- No
- Yes

*If yes, what is the perspective adopted for economic evaluation?*

- (Public) payer perspective
- Health system perspective (including consequences for patients or other payers)
- Societal perspective

**62.c. Do HTAs normally take into account affordability or budget impact of the use of the health technology?**

- Yes
- No

Comments/clarifications (if any):

--

**63. How is HTA used in your country? (check all that apply)**

	<i>Medical procedures</i>	<i>Pharmaceuticals</i>	<i>Invasive medical devices</i>
HTA is systematically used to determine whether a new technology should be covered			
HTA is used in some circumstances (e.g. on request of a stakeholder) to determine whether			

a technology should be covered			
HTA is used to determine the reimbursement level or the reimbursement price of technologies			

Comments/clarifications (if any):

**64. Generally, is HTA used in the following circumstances?**

- To establish practice guidelines for health professionals
- To determine objectives for pay-for-performance schemes
- To support the design of public health policies
- Other, please specify: \_\_\_\_\_

**Section 17. Quality of care**

**65. Is there national legislation on health care quality in your country?**

- Yes
- No

*If yes, please provide the name of the legislation and website link:*

---

**66. Is there an organisation with responsibility for national policy on health care quality in your country?**

- Yes
- No

*If yes, please provide the name and website link:*

---

**67. Are there national standards for health care quality in your country:**

Primary Care:

- Yes
- No

Hospital Care:

Yes

No

Technologies:

Yes

No

*If yes, please provide the name of the organisation responsible for administering the standards and website link:*

---

**68. Do these standards apply equally to public and private providers in your country?**

Yes

No

*If no, please explain:*

---

**69. How is compliance with these standards assessed in your country?**

Accreditation scheme:

Yes

No

Inspectorate function:

Yes

No

Clinical audit:

Yes

No

Other, please specify:

---

**70. Is there a set of national metrics available to monitor compliance with the standards in your country?**

Yes

No

*If yes, please provide a list of metrics and website link to the administering organisation*

---

**71. Are these metrics publicly reported at the provider level at least annually?**

Yes

No

If no, please explain:

---

### Section 18. Patients' rights and citizens' involvement

**72. Is there a formal definition of patients' rights at the central level (e.g. a patient charter)?**

No

Yes

*If yes*

Please provide a web link to the charter (if possible in English or French):

Which institution(s) is responsible for handling reported violations against the patient's charter?

---

Comments/clarifications (if any):

**73. Is there a formal role (e.g. participation in decision-making bodies) for citizen or patient representatives in the following areas:**

- |   |                              |
|---|------------------------------|
| Licensing of pharmaceuticals            | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |
| Coverage or reimbursement               | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |
| Health Technology Assessment            | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |
| Decisions relating to service planning  | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |
| Definitions of public health objectives | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |
| Other (please specify)                  | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |

Comments/clarifications (if any):

**Section 19. Budgeting practices for health**

**74. Does your country set specific ceilings for public health expenditure?**

- No
- Yes, it sets an expenditure ceiling for overall public health expenditure
- Yes, it sets public health expenditure targets for specific health financing agents (or schemes).  
Please specify for which agents:

- |   |                              |
|---|------------------------------|
| Ministry of Health / Central government | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |
| Local government                        | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |
| Health insurance fund(s) or schemes     | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  |

Comments/clarifications (if any):

**75. If targets are set, please indicate which institution sets the budgetary ceilings for health expenditure? (If different targets are set by different entities, please select the target which corresponds to the largest set of public expenditure)**

- Ministry of Health
- Central Budget Authority (e.g. Ministry of Finance)
- Executive Cabinet or Agency (please specify) \_\_\_\_\_
- National Parliament
- Local authority (please specify) \_\_\_\_\_
- Independent body (please specify) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

**76. Is there an *early warning system* to provide an alert that public health expenditures may exceed targets or legally binding levels, i.e. health budget overruns?**

- No, there is no such a system
- Yes, there is a system that detects overruns, but an alert *does not legally require* action
- Yes, there is a system that detects overruns, and sets in motion *required action for the current year*
- Yes, there is a system that detects overruns, and sets in motion *required action for future years*

**77. Is there an overall cost containment strategy to ensure that publicly-funded health expenditure stays within the initially allocated amounts<sup>1</sup>?**

- No
- Yes

*If yes: Who has the main responsibility for proposing measures for readjustment of health expenditures in order to stay within the initially approved limit or to limit the amount of overrun/additional budgets? Please check all that apply*

- Parliament
- Cabinet of Ministers
- Ministry of Finance
- Ministry of Health
- Health insurance funds
- Local governments
- Independent institution, please specify: \_\_\_\_\_
- Other, please specify: \_\_\_\_\_

**78. Are the following measures likely to be regularly undertaken in response to budgets exceeding initially targeted levels?** For each row, please indicate whether this option is legally possible, and whether it has occurred in the past four fiscal years.

	<i>Legally possible</i>	<i>Used in past 4 budget years</i>
Supplemental budget appropriations are made		
Health insurance fund deficits increase		
Local government budget deficits increase		
Providers (e.g. hospitals) accumulate deficits		
Cuts in payment rates to hospitals		
Cuts in health personnel wage bill		
Cuts in physicians' fees		
Cuts in procurement of medicines		
Cuts in pharmaceutical prices		
Cuts in pharmaceutical reimbursement		
Cuts in the benefit package (delisting of services)		
Increase in patients fees/co-payments/deductibles		
Rationing of health services (strict budgets for providers)		
Claw-back requested from providers		
Other, please specify: _____		

Comments/clarifications (if any):

<sup>1</sup> And thus avoid the need to pass supplementary budget laws.