OECD Health Committee Survey on Health System Characteristics

2023 ROUND

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PART I. HEALTHCARE FINANCING AND COVERAGE ARRANGEMENTS

Section 1. Characterisation of basic healthcare coverage

*This section aims to capture information on healthcare coverage. The following questions only pertain to **population coverage and financing of healthcare 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) healthcare 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 healthcare 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 healthcare 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 healthcare 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 or an independent regulator?

- ☐ 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 (please 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? (please 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 (please 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 (please 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 health coverage for low-income or economically disadvantaged groups?

- ☐ No
- ☐ Yes

If yes, how does the government intervene? (please 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 healthcare coverage through dedicated public insurance programmes

  If so, what is the share of the population eligible for such dedicated insurance programmes? ____%

Comments/clarifications (if any):

10. Does the government intervene to ensure access to basic coverage or healthcare 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? (please 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 healthcare services to high-risk groups

Comments/clarifications (if any):

Section 4. Comprehensiveness of basic healthcare coverage

This section aims to assess the level of basic healthcare 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.*

11. Is there a general deductible that must be met before basic health coverage pays a share 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? (in 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 healthcare goods and services?

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 (see here) to obtain more information about the content of each category in the table below based on the SHA classification of functions.

If eligibility and co-payment criteria vary between jurisdictions, please fill out one table for each of the three largest jurisdictions.

	Types and level of cost-sharing requirements for an adult not subject to any specific exemption rule

Acute inpatient care	*Examples:* *- Free at the point of care* *- €15/day, capped to €X or Y days* *- max (20% cost-sharing; co-payment per day)* *- 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* *- Not reimbursed if private hospital*
Outpatient primary care physician contacts	*Examples:* *- Free at the point of care* *- Co-payment of €2 per visit* *- Co-payment of €10 for the first of each semester* *- Co-insurance of 20%* *- Not reimbursed if not referred*
Outpatient specialist contacts	*Examples:* *- Free at the point of care* *- Co-insurance of: 30% if referred by a primary care doctor, otherwise: 50% + potential extra-billing* *- Co-payment of €10 if not referred by a primary care doctor*
Clinical laboratory tests	*Examples:* *- Free at the point of care* *- Co-insurance of 20% capped at €X*
Diagnostic imaging	*Examples:* *- Free at the point of care* *- Co-insurance of 20% capped €X* *- Co-payment of €18 for any test exceeding €91 + co-insurance of 30%*
Medicines	*Examples:* *- Co-payment per prescription item ($5 for generics and $20-25 for originators drugs)* *- Cost-sharing: 10% of cost with a min of €5 and a max of € 10 per item* *- Cost-sharing of 0%, 35%, 65% or 85% depending on drug category + €0.50 per item* *- Deductible of SEK 900 beyond which cost-sharing diminishes by step as spending increases (from 50%, 25%, 10% and 0%)* *- Any difference between actual price and reference price for medicines subject to reference price*
Dental care	*Examples:* *- Not covered* *- Cost-sharing: 65% of costs*
Dental prostheses	*Examples:* *- Not covered* *- Cost-sharing: 65% of costs* *- Any difference between price and reference price*

Comments/clarifications (if any):

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

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

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

Comments/clarifications (if any):

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

TOTAL EXEMPTION

	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	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For those whose incomes are under designated thresholds	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For beneficiaries of social benefits	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For seniors (people aged 65 years and above)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For children (people aged 0-17 years)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For pregnant women	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For those who have reached an upper limit (or cap) for out-of-pocket payments	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Others (please specify in comments/ clarifications)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

PARTIAL EXEMPTION

	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	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For those whose income are under designated thresholds	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For beneficiaries of social benefits	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For seniors	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For children	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For pregnant women	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For those who have reached an upper limit (or cap) for out-of-pocket payments	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Others (please specify in comments/ clarifications)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Comments/clarifications (if any):

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

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

<u>**Section 6. Private health insurance acting as a secondary source of coverage**</u>

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

16.a. Is private health insurance a secondary source of coverage for some subgroups of the population?

- ☐ Yes
- ☐ No

16.b. What are the main areas of interventions of private health insurance acting as a secondary source of coverage?

	This represents a significant share of private health insurance activities	*This represents a more marginal share of private health insurance activities*	*Private health insurance is not allowed to cover this*	*Private health insurance is allowed to cover this, but generally does not*
It covers healthcare goods and services that are **not included** in the basic benefit package (e.g. dental care, eyeglasses, medicines)				
It covers **cost-sharing** for healthcare goods and services covered by basic (primary) coverage scheme(s)				
It covers healthcare goods and services **included** in the basic benefit package (duplicate cover): i. Only when delivered by providers whose services are <u>not</u> eligible for funding by basic (primary) coverage ii. Including when delivered by providers whose services are eligible for funding by basic (primary) health coverage (e.g.				

quicker access or choice of doctor).				

Comments/clarifications (if any):

17. If you responded that there is duplicate cover to question 16.a, what does duplicative coverage most often allow?

- ☐ Coverage for enhanced non-medical accommodation services (e.g. private rooms in hospitals)
- ☐ Expands the choice of providers
- ☐ Quicker access to healthcare
- ☐ Choice of doctor
- ☐ Lower co-payments

PART II. HEALTHCARE DELIVERY SYSTEM

Section 7. Provision and payment of healthcare services

This section aims to describe the status and types of **organisations** *delivering healthcare services as well as their mode of payment. Status and remuneration of individual health professionals are addressed in a following section.*
Since healthcare services can be financed through several channels using different payment methods, the questions below 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 care is received.*

18. Please provide information on the provision of primary care services and related payment methods used by the key purchaser.

18.a. Are primary care services provided predominantly by (*please check only one answer*):

- ☐ Solo practice (a practice that is run by a single physician or healthcare professional)
- ☐ Group practice with own patients (two or more physicians or healthcare professionals who share premises but do not share a common pool of patients)
- ☐ Group practice with shared patients (two or more physicians or healthcare professionals who share a common pool of patients)
- ☐ Multi-specialty group practice (a practice that is run by two or more physicians or healthcare professionals who have different specialisations)
- ☐ Other, please specify___________________

18.b. How does the key purchaser pay these providers? (please c*heck the predominant payment method*)

- ☐ Capitation
- ☐ Fee-for-service
- ☐ Pay-for-performance
- ☐ Bundled payments
- ☐ Global budget
- ☐ Other, please specify ___________________

18.c. If capitation is the predominant payment method, is it adjusted in any way?

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

18.d. If capitation is the predominant payment method, is it combined with other payment methods?

- ☐ Yes (please check all that apply)
  - ☐ Fee-for-service
  - ☐ Pay-for-performance
  - ☐ Other (please specify): ______________________
- ☐ No

Comments/clarifications (if any):

19. **Please provide information on the provision of outpatient specialist services in the community and related payment methods used by the key purchaser.**

19.a. Are outpatient specialists services in the community provided predominantly in:

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

19.b. How does the key purchaser pay these providers? (please check the predominant payment method)

- ☐ Fee-for-service
- ☐ Global budget
- ☐ Bundled payments
- ☐ Pay-for-performance
- ☐ Other, please specify __________________

Comments/clarifications (if any):

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

- ☐ Publicly owned hospitals
- ☐ Not-for-profit privately-owned hospitals
- ☐ For-profit privately-owned hospitals

21. Are public hospitals mainly *owned* by: *(please only check one answer)*

- ☐ Central Government
- ☐ Regional Government
- ☐ Municipal Government
- ☐ Social health insurance funds
- ☐ Others, please specify : _________________

22. What is *the main payment method* **the key purchaser use for acute care?**

22.a. Public hospitals (please check the predominant payment method)

- ☐ Prospective global budget
- ☐ Line-item budgets
- ☐ Payment per case (Diagnosis-Related Groups (DRG)-like)
- ☐ Payment based on procedure or service (fee-for-service)
- ☐ Per diem
- ☐ Bundled payments
- ☐ Retrospective payments of all costs

☐ Payment per case combined with global budget

Is capital funding included in those payments?
- ☐ Yes
- ☐ No

Is expenditure on “Research and development in health” funded separately?
- ☐ Yes
- ☐ No
- ☐ N/A (there isn’t any)

Is expenditure on “Education and training of health personnel” funded separately?
- ☐ Yes
- ☐ No
- ☐ N/A (there isn’t any)

22.b. Not-for-profit hospitals (please check the predominant payment method)
- ☐ Prospective global budget
- ☐ Line-item budgets
- ☐ Payment per case (DRG-like)
- ☐ Payment based on procedure or service (fee-for-service)
- ☐ Per diem
- ☐ Bundled payments
- ☐ Retrospective payments of all costs
- ☐ Payment per case combined with global budget

Is capital funding included in those payments?
- ☐ Yes
- ☐ No

Is expenditure on “Research and development in health” funded separately?
- ☐ Yes
- ☐ No
- ☐ N/A (there isn’t any)

Is expenditure on “Education and training of health personnel” funded separately?
- ☐ Yes
- ☐ No
- ☐ N/A (there isn’t any)

22.c. Private hospitals (please check the predominant payment method)
- ☐ Prospective global budget
- ☐ Line-item budgets
- ☐ Payment per case (DRG-like)
- ☐ Payment based on procedure or service (fee-for-service)
- ☐ Per diem
- ☐ Bundled payments
- ☐ Retrospective payments of all costs
- ☐ Payment per case combined with global budget

Is capital funding included in those payments?

- ☐ Yes
- ☐ No

Is expenditure on "Research and development in health" funded separately?
- ☐ Yes
- ☐ No
- ☐ N/A (there isn't any)

Is expenditure on "Education and training of health personnel" funded separately?
- ☐ Yes
- ☐ No
- ☐ N/A (there isn't any)

23. Are there models that foster payment integration?
- ☐ Yes, integration of organisations with the same type of healthcare providers such as networks of primary care physicians/clinics and networks of hospitals (horizontal integration)
- ☐ Yes, integration of organisations with complementary type of care such as outpatient and inpatient care (verical integration)
- ☐ Yes, integration between providers and payers (e.g. Health Maintenance Organisations in the US, health insurers being the main shareholders in big private hospitals such as in Portugal)
- ☐ No

Comments/clarifications (if any):

Section 8. Price regulation for healthcare services

This section aims to understand how prices paid by key third party payers are set as well as the use of balance billing by providers.

24. Do price negotiations take place between purchasers and various providers (e.g. hospitals, long-term care, community care) or providers' organisations?

- ☐ Yes
- ☐ No

25. 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:

25.a. Are fees based on a relative value scale (e.g. Resource-Based Relative Value Scale, RBRVS)?
- ☐ No
- ☐ Yes, there is only one relative value scale for the whole country
- ☐ Yes, there are several relative value scales set at local level or by different payers

25.b. Are fees or point values of the relative value scale:
- ☐ Unilaterally set by the key purchaser or government at central level

☐ Negotiated at central level between the key purchaser and providers' associations/networks
☐ Negotiated at local level between the key purchaser and providers' associations/networks
☐ Negotiated between individual purchaser and provider
☐ 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 the key purchaser or government at central level
☐ Negotiated between the key purchaser and providers' associations at central level
☐ Negotiated between the key purchaser and providers' associations at local level
☐ Negotiated between individual purchaser and provider
☐ 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
☐ A combination of allocation principles and negotiations
☐ 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 the key purchaser or government at the central level
☐
☐ Negotiated at central level between the key purchaser and providers' associations
☐ Negotiated at local level between the key purchaser and providers' associations
☐ Negotiated between individual purchasers and providers
☐ Other, please specify ___________________________________

Comments/clarifications (if any):

26. 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 **in the community:**

26.a. Are fees based on a relative value scale (e.g. Resource-Based Relative Value Scale, RBRVS)?
☐ No
☐ Yes, there is only one relative value scale for the whole country
☐ Yes, there are several relative value scales set at local level or by different payers

26.b. Are fees or point values of the relative value scale:
☐ Unilaterally set by the key purchaser or government at central level
☐ Negotiated at central level between the key purchaser and providers' associations

- ☐ Negotiated at local level between the key purchaser and providers
- ☐ Negotiated between individual purchasers and providers
- ☐ Other, please specify_____________________________

If a **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_______________________________

Comments/clarifications (if any):

27. How are prices *paid to hospitals by the key purchaser* established for acute inpatient services?

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

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

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

Comments/clarifications (if any):

28. Is balance billing permitted?

A key question for pricing policy is whether prices are binding for providers or whether the providers are permitted to charge patients more than the regulated price for covered services. In the case of balance billing, healthcare providers can charge patients for amounts higher than the amount reimbursed based on a fixed or negotiated prices. In this case, the patient should pay the difference.

- ☐ Yes
- ☐ No

  If yes, is it permitted:

  - ☐To all providers
  - ☐ To hospitals
  - ☐ To specialists providing services in the community
  - ☐ To specialists providing services within hospitals
  - ☐ To primary care physicians

Comments/clarifications (if any):

Section 9. Employment status and remuneration of healthcare professionals

This section aims to collect information on the status and remuneration of healthcare professionals, with a focus on physicians. In most countries, physicians can choose among several status and payment methods. Therefore, this section aims to collect information on the predominant status and payment method 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
- ☐ Publicly employed
- ☐ Privately employed

29.b. Are *these* physicians remunerated by? (please check the predominant payment method)

- ☐ 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* in the community:

30.a. Are physicians supplying outpatient specialist services in the community predominantly:

- ☐ Self-employed
- ☐ Publicly employed
- ☐ Privately employed

30.b. Are *these* physicians remunerated by: (please check the predominant payment method)

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

30.c. Is dual practice allowed for physicians supplying outpatient specialist services in the community (e.g. as self-employed and publicly 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? _____

Comments/clarifications (if any):

31. Please provide information on the employment status and payment method of physicians supplying specialist services associated with hospitals:

31.a. Are physicians supplying specialist services associated with hospitals predominantly:

- ☐ Self-employed
- ☐ Publicly employed
- ☐ Privately employed

31.b. Are these physicians remunerated by: (please check the predominant payment method)

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

31.c. Is dual practice allowed for physicians supplying specialists services associated with hospitals (e.g. as self-employed and publicly 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? _____

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. Is there a pay-for-performance model that provides incentives for bundling payments across providers?

- ☐ Yes
- ☐ No

34. Pay-for-performance payments for primary care providers:

34.a. Are primary care physicians or practices eligible for bonus payments 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 that cover different states, regions or different therapeutic areas have been implemented. 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 questions 34.b-34.e

34.b. For those providers participating in the programme(s), do targets typically relate to:
(please c*heck all that apply*)

- ☐ Population risk factors (e.g., smoking rate in the community)
- ☐ Preventive care
  - Primary prevention activities (e.g., targets for vaccination rate)
  - Secondary prevention activities (e.g., targets for screening)
  - Tertiary prevention activities (e.g., reducing impact of an established chronic condition)
- ☐ Management of chronic diseases by
  - adhering to clinical guidelines
  - reaching targets for clinical outcomes
- ☐ Uptake of IT services (e.g., electronic medical records or electronic prescribing)
- ☐ Patient satisfaction and patient reported experience measures
- ☐ Data quality and linkage to co-ordinate care across settings
- ☐ Efficiency (e.g. share of generics in pharmaceutical prescriptions)
- ☐ Quality indicators (e.g. readmissions)
- ☐ Other, please specify : ____________________

34.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)

34.d. Is performance against quality objectives defined in terms of:
(please c*heck 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, practice or network)
- ☐ Directly to individual physicians

Comments/clarifications (if any):

35. Pay-for-performance payments for <u>specialists providing outpatient services in the community</u>

35.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 that cover different states or regions, different specialties or different therapeutic areas have been implemented. 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 questions 35.b-35.e

35.b. For those providers participating in the programme(s), do targets typically relate to:
(please c*heck all that apply*)

- ☐ Preventive care (e.g. vaccination rate)
- ☐ Management of chronic diseases following clinical guidelines
- ☐ Uptake of IT services (e.g. electronic medical records or electronic prescribing)
- ☐ Patient satisfaction and self-reported outcomes
- ☐ Data quality and linkage to co-ordinate care across settings
- ☐ Other, please specify : ____________________

35.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)

35.d. Is performance against quality objectives defined in terms of:
(please c*heck 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. Is the bonus payment normally paid to:

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

Comments/clarifications (if any):

36. Pay-for-performance payments for <u>acute care hospitals</u>

36.a. Can 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 that cover different regions, different types of hospitals or different therapeutic areas have been implemented. 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 questions 36.b-36.e

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

- ☐ Clinical outcomes of care (e.g. acute myocardial infarction 30-day mortality; readmissions)
- ☐ The use of clinical guidelines (e.g. thrombolytic agent received within 30 minutes of hospital arrival for patients with heart attack)
- ☐ Uptake of IT services (e.g. electronic medical records or electronic prescribing)
- ☐ Patient satisfaction and self-reported outcomes
- ☐ Patient experience (e.g. waiting times, information given by medical staff)
- ☐ Data linkage to coordinate care across settings

36**.c. Is participation:**

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

36.d. Is performance against quality objectives defined in terms of:
(please c*heck 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)

36.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 healthcare covered by basic (primary) healthcare coverage.

37. Are people registered with a primary care physician or practice?

- ☐ Yes, (almost) the whole population (>99%)
- ☐ Yes, the majority (>50%)
- ☐ Yes, less than than 50%
- ☐ No

38. 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

39.a. Are patients generally free to choose a primary care physician or 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 a specific network of providers)
- ☐ Patients are not obliged to register with a primary care physician or practice but are strongly encouraged and/or have financial incentives (e.g. reduced co-payments) to do so
- ☐ There is no incentive, no encouragement and no obligation to register with a primary care physician or practice

39.b. Can the patient choose his/her individual care provider within the primary care practice chosen or assigned to?

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

Comments/clarifications (if any):

40.a. Are patients usually free to choose providers of outpatient specialist services in the community?

- ☐ 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

40.b. If facilities providing outpatient specialist services in the community are not solo practices, can the patient choose his/her individual doctor within the institution chosen or assigned to?

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

Comments/clarifications (if any):

41.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.)
- ☐ 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)
- ☐ The patient's choice is strictly limited with no exception (e.g. to a geographical area or publicly funded hospitals)

41.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 willing to pay extra fees). Please specify ___________________
- ☐ Usually not

Comments/clarifications (if any):

Section 12. Health workforce (training, scope of practice and resilience)

42.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

42.b. If you answered "Yes" to question 42.a., please indicate who sets these limits:

- ☐ Central government
- ☐ Local levels of government
- ☐ Universities
- ☐ Other(s), please specify: ______________________

42.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

42.d. If you answered "Yes" to question 42.c., please indicate who sets these limits:

- ☐ Central government
- ☐ Local levels of government
- ☐ Universities
- ☐ Other(s), please specify: ______________________

42.e. Have any major changes occurred during the past 3 years in the number of students accessing initial medical education?

☐ Yes

If yes, please indicate if they:

☐ Increased

☐ Decreased

☐ No

42.f. Have any major changes occurred during the past 3 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):

43. Is a formal system of continuous professional development (CPD) 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, CPD is mandatory but not linked to recertification or relicensing of physicians

☐ Yes, CPD is mandatory <u>and</u> linked to recertification or relicensing of physicians

☐ No, participation in CPD is voluntary

If yes, does it contain requirement for general and transferable skills (e.g. physicians providing non-acute care continuing to receive training in life saving measures)?

☐ Yes

☐ No

Comments/clarifications (if any):

44. What are the policies in place to address the identified physician supply problems?

☐ Increase in training capacity

☐ Prolong working time for physicians

☐ Targeted immigration policies

☐ Incentives to foster the take-up of general practice

☐ Incentives to foster the take-up of specialties where shortages exist or are expected

☐ Introduction or expansion of non-physician practitioner roles

☐ Financial incentives to correct perceived geographic maldistribution

☐ Other_____________
☐ No particular policy

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

☐ Yes, related to density
☐ Yes, related to geographical proximity
☐ Yes, related to other factors
☐ No

Comments/clarifications (if any):

46.a. Is there any limit for entry into nursing education? (please 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

46.b. If you answered "Yes" to question 46.a, please indicate who sets these limits:

☐ Central government
☐ Local levels of government
☐ Universities
☐ Others, please specify: ______________________

46.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):

<u>*Scope of practice of nurses*</u>

The next few questions focus on nurses with advanced roles[1] in primary care. Although other non-medical professions are working in advanced roles in some countries (e.g. physician assistants, pharmacists), the focus here is only on nurses.

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[1] Definition of advanced roles: nurses performing advanced tasks beyond their traditional scope of practice. Such advanced tasks include diagnosis, treatment, prescribing (e.g. tests, pharmaceuticals), first point of contact, responsibility for panel/group of patients, and referrals. Includes: nurses working in advanced roles in primary care (for example, nurse practitioners, family health nurses, community health nurses, clinical nurse specialists, diabetes nurses). Excludes: nurses working in advanced roles in non-primary care settings (e.g. hospitals).

47. Do nurses work in advanced roles in primary care?

- ☐ Yes, nurses work in advanced roles in primary care.
- ☐ Yes partly, nurses work in advanced roles in primary care only in some states/regions and/or only in pilot/small scale projects.
- ☐ No, nurses do not work in advanced roles in primary care.

48. If you responded Yes or Yes partly to question 47, what were the main reasons for introducing or expanding the roles of nurses in your country?

Please tick each of the following reasons from 1 (less important) to 5 (more important)

	1 (less important)	2	3	4	5 (more important)
1. Address shortages of primary care doctors (current or expected)					
2. Promote greater/quicker access to primary care services					
3. Promote quality/continuity of care (e.g. for people with chronic conditions)					
4. Respond to cost-containment pressures ("do more with less spending")					
5. Promote career progression and retention of nurses					
6. Respond to increased demand for primary care during the COVID-19 pandemic					
7. Others (please specify)					

49. What are the names/titles of these nurses in primary care?

- ☐ List the main names/titles in original language, with English translation in brackets ____

50. What is the scope of the advanced roles of nurses working in primary care and has there been any recent changes in the last 3 years?

Please complete the table below

	What are nurses working in advanced roles in primary care allowed to do?			Has there been any change in last 3 years?	
	No	Yes, independently	Yes, but physician oversight is required	No	Yes, expanded

Clinical tasks	*Tick only 1 box for each row in the section below*			*Tick only 1 box for each row in the section below*	
Prescribe medicines					
Order diagnostic tests					
Decide on medical treatments					
Refer patients to other clinical professionals					
Patient groups					
Manage patients with any condition					
Manage patients with chronic conditions (for example, case manager, care coordinator)					
Service types					
Provide teleconsultations					
Provide mobile outreach services in underserved communities					
COVID-19 activities					
Administer COVID-19 test					
Administer COVID-19 vaccination					

51. Are nurses working in advanced roles in primary care in your country authorised to independently bill patients and/or their health insurer?

- ☐ Yes, they are authorised to bill for all their services.
- ☐ Partly, they can only bill in some states/regions or for only some of their services.
- ☐ No, they are not authorised to bill for their services.

52. Are there financial incentives/disincentives for primary care providers to employ nurses in advanced roles?

- ☐ Yes
  If yes, please specify – ____________
- ☐ No

Health workforce capacity/agility to respond to sudden shocks/emergencies

53. Do you have in place any plan to urgently expand and/or reallocate the workforce in case of emergencies?

- ☐ No
- ☐ Yes

If yes, please add any additional information or links

54. Do you have in place regular exercises to test the workforce capacity to respond to emergencies?

- ☐ No
- ☐ Yes

If yes, do you measure the effectiveness of these exercises?

- ☐ No
- ☐ Yes

If yes, please indicate how you measure the effectiveness of these exercises

If yes, do you take any actions to address identified issues (weaknesses/vulnerabilities)?

- ☐ No
- ☐ Yes

<u>Section 13. Primary care delivery system</u>

55. Can patients access a primary care physician or nurse when the practices are closed without going to the hospital emergency room or department?

- ☐ Yes
- ☐ No

If yes, how are primary care physicians or nurses available for patients? (please check all that apply)

- ☐ Via telephone
- ☐ Via teleconsultation (video connection)
- ☐ Via e-mail or text
- ☐ The patient can attend a primary care clinic
- ☐ Primary care physicians or nurses visit patients at home

If yes, how are these out-of-hours services organised? (please check all that apply)

- ☐ Patients can contact the primary care the phsysician or nurse where they are registered
- ☐ Smaller groups of primary care providers (<10) take shifts on a rota basis
- ☐ Cooperative organisations share out of hours calls between a large number of physicians or nurses (>50)
- ☐ Commercial providers are providing out-of-hours services
- ☐ Other arrangements are available

Comments/clarifications (if any):

56. Does a large majority (>75%) of primary care physicians use health data systems/electronic health records?

- ☐ Yes
- ☐ No

If Yes, for making appointments?

- ☐ Yes
- ☐ No

For ordering and/ or receiving results of laboratory tests?

- ☐ Yes
- ☐ No

For issuing drug prescriptions?

- ☐ Yes
- ☐ No

For sending prescriptions to a pharmacy?

- ☐ Yes
- ☐ No

For recording of consultations?

- ☐ Yes
- ☐ No

For sending referral letters to medical specialists?

- ☐ Yes
- ☐ No

For ordering and/or receiving diagnostic test results?

- ☐ Yes
- ☐ No

For storing records on laboratory tests, filled drug prescriptions, consultations, referrals, and diagnostic tests?

- ☐ Yes
- ☐ No

For storing records on vaccinations?

- ☐ Yes
- ☐ No

For storing records on allergies and intolerances?

- ☐ Yes
- ☐ No

For storing records on medical procedures?

☐ Yes
☐ No

For storing records on medical devices in use?
☐ Yes
☐ No

For receiving alerts or prompts about a potential problem with drug dose or drug interaction?
☐ Yes
☐ No

For receiving alerts or results about a consultation from specialist/inpatient care that needs to be followed up by primary care physician?
☐ Yes
☐ No

For receiving alerts about a routine follow of care (e.g., screening notification) or medical history of the patient (e.g., allergy, renal insufficiency) that needs to be signalled to primary care physician?
☐ Yes
☐ No

To gain access to data from other providers to follow up on previous or inform current episode of care across settings?
☐ Yes
☐ No

57. Does a large majority (>75%) of patients have access to the option to:

Text or email their primary care provider about a medical question or concern:
☐ Yes
☐ No

View online and/or download information from their medical record:
☐ Yes
☐ No

Share or provide consent for sharing their medical records with others (specialists, family members):
☐ Yes
☐ No

58. Does a large majority (>75%) of primary care nurses or assistants independently carry out:

Immunisation:
☐ Yes
☐ No

Screening:
☐ Yes

☐ No

Health promotion activities (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. 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 14. Priority setting

59. How is the range of technologies covered by basic (primary) healthcare coverage defined *(please check all that apply)***?**

	Medical procedures	*Medicines*	*Implantable medical devices*
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):

60.a. Who performs Health Technology Assessment (HTA)[2] in your country? (please 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

60.b. Does HTA 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

60.c. Does HTA normally take into account affordability or budget impact of the use of the health technology?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

61. How is HTA used in your country? (please check all that apply)

	Medical procedures	*Medicines*	*Implantable medical devices*
HTA is *systematically* used to determine whether a technology should be covered			

[2] HTA has been developed to consider the broader impacts of health technologies and evaluate their benefits and costs. It typically involves: i) identifying the policy question, ii) systematic retrieval of scientific evidence and analysis, and iii) appraisal of evidence, including judgements about the meaning of the evidence. The evidence and its appraisal then inform the decision-making process.

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):

62. Generally, is HTA used in the following circumstances?

- ☐ To establish practice guidelines for health professionals for certain type of patients/diseases
- ☐ To determine objectives for pay-for-performance schemes
- ☐ To support the design of public health policies
- ☐ Other, please specify: ____

Section 15. Quality of care

63. Is there a national legislation on quality of care?

☐ Yes

☐ No

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

____

64. Is there an organisation with responsibility for national policy on healthcare quality?

☐ Yes

☐ No

If yes, please provide the name and website link:

____

65. Are there national standards for healthcare quality:

Primary Care:

- ☐ Yes
- ☐ No

Hospital Care:

- ☐ Yes
- ☐ No

Technologies:

- ☐ Yes
- ☐ No

Long-term care:

- ☐ Yes
- ☐ No

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

____

66. Do these standards apply equally to public and private providers?

- ☐ Yes
- ☐ No

If no, please explain:

____

67. How is compliance with these standards assessed?

Accreditation scheme:

- ☐ Yes
- ☐ No

Inspectorate function:

- ☐ Yes
- ☐ No

Clinical audit:

- ☐ Yes
- ☐ No

Other, please specify:

____

68. Is there a set of national metrics available to monitor compliance with standards?

☐ Yes

☐ No

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

____

69. Are these metrics publicly reported at the provider (organisational) level at least annually?

☐ Yes

☐ No

If no, please explain:

____

Section 16. Patients' rights and citizens' involvement

70. 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 patients' charter?

____

Comments/clarifications (if any):

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

Licensing of pharmaceuticals	☐ Yes ☐ No
Coverage or reimbursement	☐ Yes ☐ No
Health Technology Assessment	☐ Yes ☐ No

Decisions relating to service planning
- ☐ Yes
- ☐ No

Definitions of public health objectives
- ☐ Yes
- ☐ No

Establishing quality standards
- ☐ Yes
- ☐ No

Establishing policies for health data management and governance (e.g. privacy, access, standards)
- ☐ Yes
- ☐ No

Other (please specify)
- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Section 17. Budgeting practices for health

72. Does your country set an expenditure ceiling for publicly funded health budget?

- ☐ No
- ☐ Yes, it sets an expenditure ceiling for the total publicly funded health budget
- ☐ Yes, it sets expenditure ceilings for specific health financing agents (or schemes). Please specify for which agents:

Ministry of Health / Central government
- ☐ Yes
- ☐ No

Local government
- ☐ Yes
- ☐ No

Health insurance fund(s) or schemes
- ☐ Yes
- ☐ No

Comments/clarifications (if any):

73. If ceilings are set , they are considered:

- ☐ A fixed budget allocation (i.e. a fixed amount of funds are defined for the budget overall, and any overspending would require a special amendment/approval process)
- ☐ Only a target, objective or estimation (i.e. actual spending could be larger without need for a budget amendment)

74. If ceilings are set, please indicate which institution sets the expenditure ceiling for the health budget? (If different ceilings are set by different entities, please select the ceiling, 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 organisation, please specify:______________________________
- ☐ Other, please specify____

75. Is there an *early warning system* to provide an alert that public health expenditures may exceed the expenditure ceiling, 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*

76. Is there an overall cost containment strategy to ensure that publicly funded health expenditure stays within the expenditure ceiling?

- ☐ 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 organisation, please specify: ______________________________
  - ☐ Other, please specify: ____

77. Are the following measures likely to be regularly undertaken in response to publicly funded health expenditure exceeding expenditure ceiling? For each row, please indicate whether this option is legally possible, and whether it has occurred in the past four fiscal years.

	Legally possible	*Used in past 4 budget years*
Supplemental budget appropriations are made		
Use of reserve funds		
Budget freezes (for the overall budget or specific items/programmes)		
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):