OECD Health Working Papers No. 50

Health Systems Institutional Characteristics: A Survey of 29 OECD Countries

Valérie Paris,

Marion Devaux,

Lihan Wei

https://dx.doi.org/10.1787/5kmfxfq9qbnr-en

OECD

Unclassified **DELSA/HEA/WD/HWP(2010)1**

Organisation de Coopération et de Développement Économiques
Organisation for Economic Co-operation and Development **28-Apr-2010**

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DELSA/HEA/WD/HWP(2010)1
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Health Working Papers

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Valerie Paris, Marion Devaux and Lihan Wei

JEL Classification(s): I1, I10 and I18

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SUMMARY

In 2008, the OECD launched a survey to collect information on the health systems characteristics of member countries. This paper presents the informaton provided by 29 of these countries in 2009. It describes country-specific arrangements to organise the population coverage against health risks and the financing of health spending. It depicts the organisation of health care delivery, focusing on the public/private mix of health care provision, provider payment schemes, user choice and competition among providers, as well as the regulation of heallth care suppply and prices. Finally, this document provides information on governnance and resource allocation in health systems (decentralisation in decision-making, nature of budget constraints and priority setting).

RESUMÉ

En 2008, l'OCDE a lancé une enquête auprès de ses pays membres pour recueillir une information sur les caractéristiques des systèmes de santé. Ce document présente l'information fournie par 29 pays en 2009. Il décrit comment chaque pays organise la couverture de la population contre les risques liés à la santé et le financement des dépenses de santé. Il dépeint l'organisation des soins, à travers le caractère public/privé de l'offre de soins, les modes de paiement des prestataires, le choix de l'usager et la concurrence entre prestataires, ainsi que la régulation de l'offre et des prix. Finalement, il donne une information sur la gouvernance et l'allocation des ressources dans les systèmes de santé (décentralisation, nature de la contrainte budgétaire et établissement des priorités).

1 INTRODUCTION

1. This paper presents an information base on the institutional characteristics of health systems. This work serves two purposes:

- First, to better understand current institutional arrangements of the health systems of OECD Member countries. Traditionally, health systems have been described in rudimentary terms based mainly on financing arrangements. In the past, the distinction between "Public Integrated", "Public Contract" and "Private Insurance/Provider" models, adequately reflected a larger set of consistent institutions and incentives. Increasingly, these distinctions are being blurred. Systems based on social health insurance have increased the role of taxes in financing and national health systems use new contracts and payment schemes for the provision of care. As a result, health systems with similar financing mechanisms may have indeed very different incentive structures. Hence, there was a need to collect updated information on institutional arrangements and policies in a systematic way to enrich policy analyses.

- Second, to develop a limited set of quantitative indicators designed to capture the main characteristics of health systems. These indicators are being used to assess the role of health institutions and policies on health systems efficiency.

2. A survey was designed to collect qualitative information on health coverage, health care provision, resource allocation and governance. The questionnaire included about 80 questions, often with multiple items and sub-questions for further details (See Annex A). The survey was launched on-line in October 2008.

3. All OECD countries, except the United States, replied to the survey by the beginning of 2009. An intensive phase of validation and completion of missing data took place in the first months of 2009. Three main problems were identified. First, in a few cases, questions were misinterpreted by respondents and replies were not consistent with experts' knowledge and understanding. Second, in many cases, countries were reluctant to provide a single "answer" when the reality of the situation consisted of complex institutional arrangements. Third, in some cases, requested data were simply not available in the country.

4. The validation phase allowed most of these problems to be solved and ensured cross-country consistency of the information. In addition, the authors completed some sets of information, which were not satisfactorily covered by the survey.

5. This working paper presents the information collected through the survey on health systems characteristics. Efforts have been made to enrich this information on health institutions with data drawn from OECD Health Data or from the System of Health Accounts data collection. The overall objective is to provide an updated set of information describing how health systems are set up and how they work in practice.

6. All the information included in this paper comes from the Health System Characteristics Survey 2008-2009, unless otherwise sourced.

7. All tables and charts are available in Excel file via StatLink web links.

8. Following the structure of the survey, this paper is divided in three sections.

9. The first part describes ***health financing and health coverage arrangements***. It aims to characterise basic primary coverage for health and to answer the following questions. Is the population covered by a single insurance scheme or by several schemes? Is health coverage automatic, compulsory or voluntary? Do some portions of the population remain uninsured? In those countries with multiple competing schemes, what is the degree of user choice in selecting coverage and of competition in health insurance markets? How do governments intervene to guarantee health coverage for high-risk or economically disadvantaged people in countries where health coverage is not automatically provided to all residents? Then, the paper proposes a method to assess the comprehensiveness of coverage by basic primary health insurance according to three dimensions: the share of the population covered by the system; the scope of benefits and types of services covered and the level of coverage for these benefits and services. Finally, the role of private health insurance as a "secondary source" of coverage is described, as well as the breakdown of health spending by financing agents.

10. The second part of this document describes ***the organisation of health care delivery***. It depicts the type of institutions delivering services (e.g. physicians in solo practice, in group practice, clinics or health care centres), the public/private mix for physicians and acute hospital care and providers payments schemes. The degree of user choice among providers is assessed using information on the existence of gate-keeping and how primary care is co-ordinated with other levels of care for patients including incentives and/or restrictions for accessing specialised levels of care. Then, different aspects of regulation are considered: the regulation of health care supply, prices and fees and providers' activities.

11. The third part of the paper focuses on issues of ***governance and resource allocation*** in health systems. Information gathered on the degree of decentralisation of decision-making, on the stringency of budget pressures and on the role of priority setting in decision-making (role of health technology assessment, definition of the health benefit basket, and definition of public health targets) provides details on the responsibilities and authorities of health system stakeholders. A final section provides some additional material on patient's rights and representation as well as public involvement in the health system.

12. The main purpose of the data collection on health system characteristics is to provide a new set of tools for permitting a more nuanced characterisation of the institutional arrangements and the underling policy choices made by countries. Health systems across countries differ widely and the information summarised here represent key characteristics likely to impact the varying goals of health system dimensions of efficiency in health care delivery, sustainability, quality of care, equity in financing and access, financial protection and patient experiences. These policy oriented indicators of health systems are envisioned to be a source of additional information to enrich future work for health system performance analysis.

2 HEALTH FINANCING AND COVERAGE ARRANGEMENTS

13. Health coverage and financing arrangements have long been considered as fundamental features of health systems. Several models exist among OECD countries. The following paragraphs describe arrangements for health financing, population coverage, the scope of benefits covered and the depth of coverage (the share of costs covered by health insurance/health systems).

2.1 Characteristics of basic primary health care coverage

14. Basic primary health coverage is available to the vast majority of residents of OECD countries. However, countries differ in the way coverage is organised (see Table 1).

15. Automatic health coverage is provided to the entire population and financed from taxes in 13 OECD countries (Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden and the United Kingdom).

16. Ten countries rely on social health insurance, compulsory for all or almost all of the population and financed through income-related social contributions, though these are often supplemented out of general tax-financed government revenues (Austria, Belgium, France, Germany, Greece, Hungary, Japan, Korea, Luxembourg, and Poland). In these countries, coverage is often linked to occupation and is usually extended to relatives of the employed. Safety nets exist to subsidise coverage or provide services for the poorest part of the population. Germany is singular in that people earning high revenues are allowed to opt out from social health insurance to enrol in private health insurance, with 15% of the population actually doing so.

17. The Slovak and the Czech Republic have a specific arrangement where workers are covered by mandatory health insurance financed through employer and employee contributions linked to revenues while their families and other non-workers are covered via direct payments from the national government who pays premiums to health insurance companies on behalf of the beneficiaries.

18. In the Netherlands and Switzerland, health insurance is compulsory for all, but is not entirely financed through income-related contributions[1]. Instead, individuals pay community-rated premiums to competing private health insurance funds. However, health insurance markets are strongly regulated to address market failures and guarantee universal access to health insurance: health insurers are not allowed to deny coverage to applicants and mechanisms of risk-adjustment exist to manage costs and risks. Therefore, health insurance in these countries is classified as "social health insurance", rather than "private" in the international system of health accounts.

19. In Mexico, more than half of the population is covered through social security. Another 20% of the population is covered through *Seguro Popular*, a publicly-subsidised voluntary health programme targeted at the population without access to social security coverage, while approximately 1% of the

1. In the Netherlands, premiums charged by health insurance funds for adults account for 45% of expected annual costs. A national equalisation fund financed by income-related contributions covers 50% of total costs and the remaining 5% is financed through government general revenue for child coverage (Leu *et al.*, 2009).

population have voluntary private coverage. Turkey is on the way to universal coverage and currently is a mixed system dominated by mandatory coverage by social security for a part of the population while a third of the population remain uninsured (OECD and World Bank, 2008).

Table 1. Characteristics of basic primary health coverage (end 2008) (Q1) (% of population)

Country	Automatic coverage	Compulsory coverage	Voluntary coverage	Other	Not insured
Australia	100	0	0	0	0
Austria	0	98.7	0	0	1.3
Belgium	0	99	0	0	1
Canada	100	0	0	0	0
Czech Republic	0	100	0	0	0
Denmark	100	0	0	0	0
Finland	100	0	0	0	0
France	2.5	97.5	0	0	0
Germany	0.5	83.3	15.2	1	0
Greece	0	100	0	0	0
Hungary	0	100	0	0	0
Iceland	100	0	0	0	0
Ireland	100	0	0	0	0
Italy	100	0	0	0	0
Japan	0	98.8	0	1.2 [(a)]	0
Korea	0	100	0	0	0
Luxembourg	0	96.8	1.1	0	2.1
Mexico	0	59	22.5	1	17.5
Netherlands	0	100	0	0	0
New Zealand	100	0	0	0	0
Norway	100	0	0	0	0
Poland	0	99	0	0	1
Portugal	100	0	0	0	0
Slovak Republic	55.7	44.3	0	0	0
Spain	100	0	0	0	0
Sweden	100	0	0	0	0
Switzerland	0	100	0	0	0
Turkey	0[(i)]	58.6[(i)]	8.6[(i)]	0[(i)]	32.8[(i)]
United Kingdom	100	0	0	0	0

Note: (a) Public Assistance; (i) Secretariat's estimates.

Source: OECD Survey on health system characteristics 2008-2009 and OECD (2008), Review of Health Systems Turkey; OECD (2009), "Improving the performance of the public health care system" in OECD Economic Surveys: Greece.

StatLink http://dx.doi.org/10.1787/810054077181

20. Beyond financial arrangements and coverage entitlement, countries differ in the organisation of the supply of basic primary coverage. For the typical employed adult, basic health coverage is provided by (see Table 2):

- National health services in nine countries (Australia, Hungary, Iceland, Ireland, Italy, New Zealand, Portugal, Sweden and the United Kingdom);

- Local health services in five countries (Canada, Denmark, Finland, Norway and Spain);
- A common health insurance scheme (single payer) in Belgium, Korea, Luxembourg, Poland and Turkey; and by
- Multiple insurers in ten countries. In five of these countries (Austria, France, Greece, Japan and Mexico), affiliation to a specific insurer is not a matter of individual choice and is generally linked to professional status[2]. By contrast, in the five other countries – the Czech Republic, Germany, the Netherlands, the Slovak Republic and Switzerland - people can choose their insurer.

Table 2. Provision of basic primary coverage for the "typical" employed adult (Q2)

Country	Q2a. The basic primary health care coverage is supplied by:	Q2b. How is affiliation determined?
Australia	National health services	
Austria	Multiple insurers	Not a matter of choice
Belgium	Common health insurance scheme	
Canada	Local health services	
Czech Republic	Multiple insurers	Choice among several insurers
Denmark	Local health services	
Finland	Local health services	
France	Multiple insurers	Not a matter of choice
Germany	Multiple insurers	Choice among several insurers
Greece	Multiple insurers	Not a matter of choice
Hungary	National health services	
Iceland	National health services	
Ireland	National health services	
Italy	National health services	
Japan	Multiple insurers	Not a matter of choice
Korea	Common health insurance scheme	
Luxembourg	Common health insurance scheme	
Mexico	Multiple insurers	Not a matter of choice
Netherlands	Multiple insurers	Choice among several insurers
New Zealand	National health services	
Norway	Local health services	
Poland	Common health insurance scheme	
Portugal	National health services	
Slovak Republic	Multiple insurers	Choice among several insurers
Spain	Local health services	
Sweden	National health services	
Switzerland	Multiple insurers	Choice among several insurers
Turkey	Common health insurance scheme	
United Kingdom	National health services	

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810055382615

2. For example, in Japan, the self-employed are covered by the national health insurance scheme and the employed are covered by corporate-based insurance schemes. In France, three separate health insurance funds exist for salaried workers, agricultural workers and the self-employed. These schemes automatically cover family members.

2.2 Regulation of health insurance markets in countries with multiple insurance funds

21. Countries with multiple insurance funds have adopted different regulation mechanisms either to ensure uniform contribution rates and benefits to the whole population, or on the contrary, to allow insurance funds to differentiate their products (level of contribution/premium, scope of coverage or cost-sharing requirements).

22. Four countries with multiple insurance funds but no consumer choice indicated that insurers have some flexibility in one or several of those domains (Austria, Greece, Japan, Mexico; see Table 3). In Austria, insurers are required to cover 'all necessary services' but these are not explicitly defined leading to minor variations across health insurance funds. In Greece, insurers determine themselves the benefits they cover and the level of coverage, as well as contribution rates. In Mexico, social security funds in principle cover all types of services with no explicit definition but are limited by their own budget constraints. By contrast, a benefit package is explicitly defined for the *Seguro Popular*. In France, by contrast, contributions and benefits are uniform across health funds.

23. Countries with consumer choice also have different regulations. In the Slovak Republic, insurers cannot modulate premiums and are required to offer the same benefit package and same level of coverage. In the Czech Republic insurers are required to cover a uniform benefit basket "*de lege artis medicinae*"; they are allowed to extend the scope of coverage (range of benefits) but are not allowed to alter premiums or the level of coverage.

24. In Switzerland, a uniform benefit basket is defined and insurers are not allowed to modulate it. Insurers are required to collect uniform premiums from all their enrolees[3] but can offer lower premiums in exchange for "managed care plans" or higher cost-sharing (See Table 3 and Leu *et al.*, 2007).

25. In the Netherlands, insurers are allowed to modulate the benefit basket only upwards. The basic insurance package is set by the national government; insurers cannot fall below this level of coverage. Insurers can offer a lower premium (up to 10% lower) to people enrolled via a collective contract. Collective contracts can be "closed" (e.g. negotiated by an employer and reserved to his employees) or "open", i.e. negotiated for instance by a consumer group and open to everybody who wants to enroll. Premiums can also vary according to the coverage model (in-kind benefit versus reimbursement)

26. In 2007, Germany adopted an important reform which took effect in 2009. Health insurance funds now collect contributions as a uniform percentage of gross wage or income. Contributions are pooled in a central national fund, together with tax-financed subsidies paid by the federal government to cover children. The central fund then re-distributes a uniform capitation rate to health insurance funds, adjusted for age, gender and about 80 chronic conditions. Funds are given more flexibility to define benefits covered. Funds can offer plans with additional benefits in exchange for higher cost-sharing or acceptance of a set of constraints, such as restricted provider networks, or specified health care pathways (7.4% of the insured were enrolled in such plans in 2008). Funds can also offer options with lower premiums and higher cost-sharing, as well as no-claim bonuses. Health insurance funds with a financial surplus are also permitted to offer additional benefits or premium rebates while funds with a deficit may be obliged to charge their enrolees an additional premium, capped at 1% of the insured's gross wages or income (Cheng and Reinhardt, 2008).

3. In Switzerland, students and children benefit from reduced premiums.

Table 3. Regulation of health insurance markets in countries with multiple insurers (Q3 to Q5)

Country	Q3. Insurers allowed to modulate benefit basket	Q3. Insurers allowed to modulate level of coverage	Q4. Insurers allowed to modulate premiums	Q5. System of risk-equalitsation	Q5. if yes, main risk factors are:
Austria	yes	no	no	no	
Czech Republic	no	no	no	yes	age, gender, other
France	no	no	no	yes	
Germany	yes	no	yes	yes	age, gender, health status
Greece	yes	yes	yes	no	
Japan	yes	yes	yes	yes	age, other
Mexico	yes	yes	no	no	
Netherlands	yes	no	yes	yes	age, gender, other
Slovak Republic	no	no	no	n.a.	
Switzerland	no	yes	yes	yes	age, gender

Note: n.a. means Not Available

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810070653354

25. Most countries with multiple insurers have a form of a risk-equalisation scheme. Since 2006 in the Czech Republic, all health insurance contributions have been re-distributed according to age and gender with partial ex-post compensation allocated to health insurance for "outliers", i.e. insurees with costs 30 times higher than average. In the Netherlands, where 50% of expected costs are redistributed to health funds, risk-equalisation is based on age, gender, region, pharmaceutical cost groups and diagnosis cost groups. In Germany, the risk-equalisation scheme, based on age and gender until 2008, was refined in 2009 to include 80 chronic disease conditions. In Switzerland, the risk-equalisation scheme is only based on age and gender with provisions that this will be expanded to include additional factors in 2012.

2.3 Consumer choice and competition between health insurers offering basic primary health care coverage

26. Policy analysts and economists have produced a large body of literature on the respective advantages of competing health insurance markets versus single payer systems. Regulated competition in the health insurance market is credited with the potential for gains in efficiency and the quality of health care provision provided that insurers have the ability to differentiate their products and that consumers have adequate information on the price and quality of these products. On the other hand, competition in comparison with a single payer approach is linked to higher search and administration costs. The questionnaire included several questions pertaining to competition in health insurance markets.

27. Naturally, *consumer choice of insurer* is a pre-condition for real competition in health insurance markets. As mentioned earlier, only five of the surveyed countries offer consumer choice of insurer: the Czech Republic, Germany, the Netherlands, the Slovak Republic, and Switzerland. In all of these countries, health insurers are required to enrol all applicants and to accept contract renewal. The Netherlands and Switzerland have set constraints on premium increases for renewals. Such a provision is not necessary in other countries where premiums are linked to revenues; in those countries, constraints exist *de facto* (see Table 4). In the five countries, consumers are allowed to switch health plans annually.

28. *Consumer information* is another essential feature to ensure effective competition in health insurance markets. According to survey responses, information on premiums is published by health insurance funds in four of these countries. There is no information in the Slovak Republic. Information on benefits covered is published by individual funds in Germany and Switzerland. In the Netherlands,

information on premiums/contributions is published by individual insurers, public authorities (RIVM KiesBeter.nl) and private organizations (e.g. www.independer.nl); information on the benefits covered are presented by public authorities and individual funds; information on performance is published by private organizations and public authorities (RIVM KiesBeter.nl). In the Czech Republic, benefits covered and premium levels are defined in the law which is the main source of information for consumers.

29. The effective switching rate and the dispersion of premium prices could serve as indicators of the effective level of competition in health insurance markets. According to survey responses, the switching rate is of 3% in the Czech Republic, 4% in the Netherlands[4] and 7% in Switzerland. This rate is unknown for Germany and the Slovak Republic (see Table 4).

30. Studies have revealed relatively low switching rates and persistent price dispersion in the most competitive European markets. In the Swiss insurance market, Frank and Lamiraud (2008) observed that monthly premiums ranged from 47 to 140 CHF in 2004 though the number of plans available to consumers ranged from 49 to 70 across cantons. Between 1997 and 2000 – the period studied in the report -, only 15.2% of consumers switched from one health plan to another with switching rates being found to decline when the number of choices increased yet positively correlated with price dispersion. Van den Berg *et al.* (2008) observed that the Dutch reform led to strong price competition between insurers in 2006 and 2007, with unusually high switching rate in 2006 followed by a return to lower price dispersion and the usual switching rate in 2007.

Table 4. Further regulation of health insurance markets with competing providers (Q6 to Q9)

	Country				
	Czech Republic	Germany	Netherlands	Slovak Republic	Switzerland
Q6a. Insurers required to enrol any applicant?	Yes	Yes	Yes	Yes	Yes
Q6b. Insurers required to accept contract renewal for people they cover?	Yes	Yes	Yes	Yes	Yes
Q6c. Constraints on premium increases in the case of contract renewal?	Yes *de facto*	Yes *de facto*	Yes	Yes *de facto*	Yes
Q7. Restrictions on switching?	Switch at set times / frequencies	Switch at set times / frequencies	Switch at set times / frequencies	Switch at set times / frequencies	Switch at set times / frequencies
Q8a. Information on premiums / contributions published by:	Individual funds	Individual funds	Individual funds, Public authorities, Private organisations	-	Individual funds
Q8b. Information on benefits covered published by:	Public authorities	Individual funds	Individual funds, Public authorities	-	Individual funds
Q8c. Information on performance published by:	Public authorities	Individual funds	Public authorities, Private organisations	-	Private organisations
Q9. Share of total insured population that switch in a given year:	3	n.a.	4	n.a.	7

Note: n.a. means Not Available; "-" Not Applicable.
Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810107370551

4. The switching rate peaked at 20% in 2006, the year of the health insurance reform, but dropped again at its former level in 2007.

31. *Market structure* is another important feature for competition. The number of plans a consumer typically faces is greater than five in four countries, while three insurers cover the whole market in the Slovak Republic. The concentration of the primary basic health insurance market is the highest in the Czech Republic where the top insurance fund holds 60% market share (see Table 5). It is relatively high in the Netherlands and Slovak Republic, where the top three insurers account for 75% and 100% of the market, and lower in Germany and Switzerland. In Switzerland, health insurers operate at the cantonal level while in other countries insurers mainly operate nationwide.

32. In the Czech Republic, the Slovak Republic and Switzerland, basic primary health coverage is supplied by not-for-profit insurers. In Germany, private for-profit insurers supply basic health coverage to the wealthiest part of the population with the means to opt out of social insurance. In the Netherlands, plans can operate on either a for-profit or not-for-profit basis (see Table 5).

Table 5. Structure of primary health insurance market (Q22 to Q24)

	Country				
	Czech Republic	Germany	Netherlands	Slovak Republic	Switzerland
Q22. Number of choices for a typical insurance customer	more than 5	more than 5	more than 5	3-5	more than 5
Q23. Market share of the top insurer (%)	60	10	29	n.a.	12
Q23. Market share of the top 3 insurers (%)	80	28	75	100	31
Q23. Market share of the top 5 insurers (%)	89	39	94	-	43
Q23. Market share of the top 10 insurers (%)	100	56	100	-	66
Q24. Market share of not-for-profit insurers (%)	100	85	n.a.	100	100
Q24. Market share of for-profit insurers (%)	0	15	n.a.	0	0

Note: n.a. means Not Available; "-" Not Applicable.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810138662728

33. Harnessing all the potential benefits from competitive health insurance markets supposes insurers have the *ability to select and contract with providers*. Indeed, health insurers have the possibility to select providers in the Czech Republic, Germany, the Netherlands and the Slovak Republic, although not in Switzerland. Still, insurers can negotiate contracts with physicians and individual hospitals about the prices, quantity and quality of health care services in these five countries. In Germany and the Netherlands, they can also negotiate with pharmaceutical companies to obtain discounts or rebates. In the Netherlands, individual insurers can issue a call for tenders for the provision of drugs in classes of "homogeneous" products and only reimburse the product of the winning company (the "preferred drug"), unless the physician decides that the drug is not appropriate for a given patient. However, most countries indicated that negotiation opportunities were only marginally used by health insurers (see Table 6). In the Czech Republic, negotiations with providers for in-patient care account for only 7% of all contracted in-patient services. By contrast, in the Netherlands, negotiation opportunities were widely used; insurers and

hospitals negotiate prices for 20% of hospital services and this share is expected to increase in the coming years.

34. Finally, insurers need *levers to steer the demand for health care or ensure appropriate use of health services* (see Table 6). In the Czech Republic, insurers can offer non-financial rewards to enrolees who do not claim any reimbursement within a given period of time. Insurers are also able to restrict the network of providers, although in reality these restrictions are not really enforceable.

35. In the Netherlands, health insurers can offer insurance plans requiring patients to follow specific care pathways or plans with restricted networks of providers. In the latter case, patients may still choose any provider outside the network but will bear higher copayments if they do so. (See Table 6).

36. In Germany, insurers can also offer plans with restricted networks or specified care pathways; they can offer several options with higher cost-sharing in exchange for a partial refund of premiums, or plans with "no-claim" bonuses. Currently, individuals choosing such options are required to enrol for three years (Lisac *et al.*, 2009).

37. In Switzerland, insurers have all the above mentioned possibilities with the additional right to require prior authorisation for the use of certain services. About 24% of the insured are enrolled in one of the three forms of managed care plans: health maintenance organisations (HMOs), independent practice associations (IPAs) or fee-for-service plans with gate-keeping provisions. HMOs directly employ physicians (staff model) or contract with groups paid on a per capita basis. IPAs use networks of generalists acting as gatekeepers. Both HMOs and IPAs are more likely to use prior authorisation (Leu *et al.*, 2009).

Table 6. Health insurers' ability to select and contract with providers (Q25-26)

		Country				
		Czech Republic	Germany	Netherlands	Slovak Republic	Switzerland
Q25. Are insurers allowed to select health care providers?		Allowed but marginally used	Allowed and widely used	Allowed but marginally used	Allowed and widely used	No
Q25. Are insurers allowed to negotiate contracts with physicians?		Allowed but marginally used	Allowed but marginally used	Allowed and widely used	Allowed and widely used	Allowed but marginally used
Q25. Are insurers allowed to negociate with individuals hospitals?		Allowed but marginally used	Allowed but marginally used	Allowed and widely used	Allowed and widely used	Allowed but marginally used
Q25. Are insurers allowed to negociate with pharmaceuticals companies?		No	Allowed but marginally used	Allowed and widely used	n.a.	No
Q26. Relations between health insurers and insured people. Insurers allowed to:	require prior authorisation for certain services to be reimbursed	X				X
	offer insurance plans with a restricted network of providers		X	X		X
	offer insurance plans requiring patients to follow specific care pathways		X	X		X
	offer several options of cost sharing levels in exchange for higher or lower premium		X			X
	offer financial rewards to insured persons who do not claim any reimbursments within a given period of time		X			X

Note: n.a. means Not Available.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810168305364

2.4 Interventions of the public sector to ensure coverage of high-risk or low-income people in non-NHS systems

38. Where coverage is not automatically provided to all residents through national or local health systems, policies have been implemented to guarantee access to coverage or to care for people with low-income or high health risks. Questions 10 and 11 of the survey were designed to collect information on this type of measure and thus only apply to 15 countries: Austria, Belgium, the Czech Republic, France, Germany, Greece, Japan, Korea, Luxembourg, Mexico, the Netherlands, Poland, the Slovak Republic, Switzerland, and Turkey (see Table 7).

39. In the set of countries considered, health insurance contributions/premiums are either linked to revenues or regulated so as to avoid anti-selection of "bad-risks" by insurers. Therefore, there is no need for specific provisions to ensure health *coverage* of high-risk people. However, special programs often exist to improve access to health care services.

Table 7. Complementary interventions of the public sector in health coverage (Q10)

Country	Q10. Governement intervention for low-income or economically disavantaged groups?	Q10b. If yes, how?
Austria	Yes	Subsidies for purchase of insurance (Mean-tested)
Belgium	Yes	Subsidies for purchase of insurance
Czech Republic	Yes	n.a.
France	Yes	Subsidies for purchase of insurance
Germany	Yes	Subsidies for purchase of insurance (Mean-tested)
Greece	Yes	Provision of health care
Japan	Yes	Subsidies for purchase of insurance (1), Dedicated programmes
Korea	Yes	Dedicated programmes
Luxembourg	Yes	Dedicated programmes
Mexico	Yes	Dedicated programmes, Direct provision of health care
Netherlands	Yes	Subsidies for purchase of insurance (Mean-tested)
Poland	Yes	Subsidies for purchase of insurance (Mean-tested), Dedicated programmes, Direct provision of health care
Slovak Republic	n.a.	n.a.
Switzerland	Yes	Subsidies for purchase of insurance (Mean-tested)
Turkey	Yes	Subsidies for purchase of insurance (Flat)

Note (1): In Japan, there are no real "subsidies" but reduced contributions for low-income people.

Note: n.a. means Not Available.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810181655783

40. In all 14 countries[5], ***governments intervene to ensure the provision of basic health coverage or health services for low-income or disadvantaged groups***.

41. Eleven countries have implemented policies to help the disadvantaged in *obtaining health coverage at no or lower cost through subsidies or dedicated programmes*. For instance, in Austria and Belgium, low-income individuals benefit from reduced contribution rates, while in Luxembourg contributions rates are subject to a ceiling (Immervoll, 2009).

42. In France, individuals with income below €8,774 (in 2008) are entitled to free health coverage through the universal coverage scheme (CMU). In 2008, about 2.3% of the population was covered by the free CMU. In Germany, means-tested subsidies are provided to about 2% of the population. In Korea, individuals whose income does not reach the minimum standard of living are entitled to the Medical Aid Programme, providing free health insurance for about 4% of the population.

43. In Mexico, individuals not entitled to social security can purchase voluntary health insurance through the *Seguro Popular* scheme. The scheme, subsidising the coverage of 17% of the population, is financed by Federal and State contributions and income-related family contributions (OECD, 2005). In Turkey, 8.6% of the population is entitled to the Green Card, i.e. a flat subsidy for the purchase of health insurance coverage (OECD and World Bank, 2008).

44. In the Netherlands and Switzerland, large shares of the population receive means-tested subsidies for the purchase of health coverage (40% and 30% respectively) (Leu *et al.*, 2009; Survey 2008). In Poland, for some insured groups covered by universal health insurance (e.g. registered unemployed people who do not receive social benefits) health insurance contributions are paid by state budget.

45. Three countries offer *in-kind benefits* through the direct provision of free health care services. In Greece, health care centres and NHS hospitals' outpatient units dispense free care to the uninsured (Economou and Giorno, 2009). In Mexico, the Ministry of Health and State Health Services provides medical care for uninsured people -generally subject to copayments- and several programmes provide free health care services to specific population groups -small communities, rural and indigenous populations and individuals in extreme poverty (OECD, 2005). In Poland, uninsured people and refugees are entitled to free health care (Immervoll, 2009).

46. In Japan, contributions rates are reduced for low income people[6]. In addition, persons who still live in poverty even after utilising his/her asset and ability to work can receive public assistance. Public assistance recipients can receive the same health services available under other basic health insurance systems from medical institutions as an in-kind benefit without any out-of-pocket payment. Comprehensiveness of basic primary health care coverage

47. Assessing the level of basic primary coverage of the population against health risks is a challenge. It requires taking into account three important dimensions: the share of the population covered, the scope of the benefit basket (services and goods covered by health insurance) and the depth of coverage (share of services costs covered).

5. Information on the Slovak Republic is not available.

6. In Japan, contributions to health insurance depend on income, property assets and the size of the household. The later part is reduced for low income people.

48. The OECD survey on health systems characteristics included two questions pertaining to the coverage of ten types of services by basic health insurance (Q13a and Q13b)[7]:

- The first question related to the scope of benefits covered. Countries were asked to indicate whether each service was "typically" covered, with or without copayments.

- The second question related to the depth of coverage (share of costs covered by basic primary health insurance). Countries were asked, for each type of service to indicate the "typical" range of costs covered: below 50%, 51%-75%, 76%-99%, 100%.

49. In both questions, countries were invited to describe the "typical" or "the most frequent" situation. Indeed, in many countries, including those with single and "uniform" coverage schemes, the scope and the level of coverage vary across population groups (according to age, employment, health status, etc.). Collecting and analysing information on every specific situation was just not possible for the scope of this study, a *fortiori* in countries with pluralistic systems of coverage. Therefore, the questionnaire focused on the "typical situation".

50. The information collected through the survey is summarised in Table 8. The Mexican and Irish situations deserve a few comments. In Mexico, more than half of the population is covered through mandatory social security and 23% through *Seguro Popular*. However, since social security schemes do not define explicitly the benefit package they cover, replies from Mexico reflect the situation of people insured by *Seguro Popular*, i.e. not the most frequent situation. That being said, the social security scheme in Mexico generally provides coverage for the same types of services.

51. In Ireland, one third of the population is eligible for a means-tested Category I coverage, with free access to hospital and medical services, while the remaining two-thirds are eligible for Category II coverage and must share the costs of health care services. Information presented in Table 8 reflects the situation of those eligible for Category II and therefore underestimates the level of coverage of the whole population.

7. The survey included a question (Q12) on the existence of a general deductible. Due to a lack of specificity of the question, replies were not usable.

Table 8. Coverage of ten functions of care by basic primary health coverage (Q13) (typical range of costs covered)

Country	Acute inpatient care	Outpatient primary care physicians contacts	Outpatient specialists contacts	Clinical laboratory tests	Diagnostic imaging
Australia	Covered (100%)	Covered (76-99%)	Covered (76-99%)	Covered (51-75%)	Covered (51-75%)
Austria	Covered (76-99%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Belgium	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Canada	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Czech Republic	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (100%)	Covered (100%)
Denmark	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Finland	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (100%)
France	Covered (76-99%)	Covered (51-75%)	Covered (51-75%)	Covered (51-75%)	Covered (76-99%)
Germany	Covered (100%)	Covered (76-99%)	Covered (76-99%)	Covered (100%)	Covered (100%)
Greece	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Hungary	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Iceland	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Ireland	Covered (100%)	Not covered	Covered (100%)(1)	Covered (100%)	Covered (100%)
Italy	Covered (100%)	Covered (100%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Japan	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Korea	Covered (76-99%)	Covered (51-75%)	Covered (51-75%)	Covered (76-99%)	Covered (76-99%)
Luxembourg	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Mexico	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Netherlands	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
New Zealand	Covered (100%)	Covered (51-75%)	Covered (100%)	Covered (100%)	Covered (76-99%)
Norway	Covered (100%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Poland	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Portugal	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Slovak Republic	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Spain	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)
Sweden	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (100%)	Covered (76-99%)
Switzerland	Covered (100%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Turkey	Covered (100%)	Covered (76-99%)	Covered (76-99%)	Covered (100%)	Covered (100%)
United Kingdom	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)	Covered (100%)

Note: (1) Category II patients have 100% coverage for public specialist outpatient services but are not covered for private specialist care.

Source: OECD Survey on health system characteristics 2008-2009 and OECD estimates.

StatLink http://dx.doi.org/10.1787/810267523105

Table 8. Coverage of ten functions of care by basic primary health coverage (Q13) (typical range of costs covered) (cont.)

Country	Physiotherapist services	Pharmaceuticals	Eyeglasses and/or contact lenses	Dental care	Dental prostheses
Australia	Covered (1-99%)	Covered (76-99%)	Not covered	Not covered	Not covered
Austria	Covered (100%)	Covered (76-99%)	Covered (1-50%)	Covered (100%)	Covered (51-75%)
Belgium	Covered (1-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Canada	Not covered	Covered (51-75%)	Not covered	Not covered	Not covered
Czech Republic	Covered (100%)	Covered (51-75%)	Covered (1-50%)	Covered (1-50%)	Covered (1-50%)
Denmark	Covered (1-99%)	Covered (51-75%)	Not covered	Covered (1-50%)	Not covered
Finland	Covered (1-99%)	Covered (51-75%)	Not covered	Covered (76-99%)	Covered (76-99%)
France	Covered (1-99%)	Covered (51-75%)	Covered (1-50%)	Covered (1-50%)	Covered (1-50%)
Germany	Covered (1-99%)	Covered (76-99%)	Covered (1-50%)	Covered (76-99%)	Covered (1-50%)
Greece	Covered (1-99%)	Covered (76-99%)	Covered (1-50%)	Covered (1-50%)	Covered (1-50%)
Hungary	Covered (100%)	Covered (76-99%)	Covered (1-50%)	Covered (1-50%)	Covered (1-50%)
Iceland	Covered (1-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)	Covered (76-99%)
Ireland	Covered (100%)(2)	n.a.	Not covered	Not covered	Not covered
Italy	Covered (1-99%)	Covered (100%)	Not covered	Covered (1-50%)	Not covered
Japan	Covered (1-99%)	Covered (76-99%)	Not covered	Covered (76-99%)	Covered (76-99%)
Korea	Covered (1-99%)	Covered (51-75%)	Not covered	Covered (51-75%)	Not covered
Luxembourg	Covered (1-99%)	Covered (76-99%)	Covered (1-50%)	Covered (51-75%)	Covered (51-75%)
Mexico	Covered (100%)	Covered (100%)	Not covered	Covered (100%)	Not covered
Netherlands	Covered (1-99%)	Covered (100%)	Not covered	Covered (1-50%)	Not covered
New Zealand	Covered (1-99%)	Covered (76-99%)	Not covered	Not covered	Not covered
Norway	Covered (1-99%)	Covered (76-99%)	Not covered	Not covered	Not covered
Poland	Covered (100%)	Covered (51-75%)	Covered (1-50%)	Covered (100%)	Covered (100%)
Portugal	Covered (100%)	Covered (1-50%)	Covered (1-50%)	Covered (1-50%)	Covered (1-50%)
Slovak Republic	Not covered	Covered (76-99%)	Covered (51-75%)	Covered (51-75%)	Covered (51-75%)
Spain	Covered (100%)	Covered (76-99%)	Not covered	Covered (100%)	Not covered
Sweden	Not covered	Covered (51-75%)	Not covered	Covered (1-50%)	Covered (1-50%)
Switzerland	Covered (1-99%)	Covered (76-99%)	Covered (1-50%)	Not covered	Not covered
Turkey	Covered (100%)	Covered (76-99%)	Covered (51-75%)	Covered (100%)	Covered (51-75%)
United Kingdom	Covered (100%)	Covered (100%)	Not covered	Covered (76-99%)	Covered (76-99%)

Note (2): Category II people have 100% coverage in the acute inpatient/outpatient setting while they have no specific eligibility for this service when provided in the non-acute setting.

Note: Countries did not have the possibility to answer to the question on the level of coverage for physiotherapists' services, since the question was not in the questionnaire. However, we were able to identify countries which have a 100% coverage because they answered to Q13a that physiotherapists' services are covered without cost-sharing. Although we received complementary answers afterwards, we chose to keep the same answer "covered (1-99%)" for homogeneity reasons.

Note: n.a. means Not Available

Source: OECD Survey on health system characteristics 2008-2009 and OECD estimates.

StatLink http://dx.doi.org/10.1787/810267523105

52. Most OECD countries guarantee a high level of coverage for acute inpatient care and medical services, as well as for laboratory tests and diagnostic imaging. For primary care services, four countries indicated a level of coverage below 75%: France, Ireland, Korea and New Zealand. In France, the typical share of costs covered for outpatient physicians' services is 60%, however complementary health insurance, held by 92% of the population, covers virtually all cost-sharing. In Ireland, basic primary health insurance does not cover primary care services for people eligible for Category II.

53. Pharmaceuticals are typically covered at lower levels than other health services. Only four countries reported coverage of pharmaceuticals up to 100% of costs: Italy, Mexico, the Netherlands and the United Kingdom. In fact, in Italy, some regions impose low prescription fees (€1-€2 per prescription) and people may have to pay the difference between the actual price and the reimbursement price for products subject to reference prices. However, these co-payments can be considered negligible in comparison with other cost-sharing arrangements (Martini *et al.*, 2007). In the United Kingdom, prescription fees in principle do exist but more than ¾ of NHS prescriptions are exempt from these fees.

54. In Canada, pharmaceuticals are not included in the basic benefit package defined by the Canadian Health Act. However, the federal and provincial governments provide coverage to some segments of the population (30%), including seniors, with different cost-sharing mechanisms. Additionally, most employers provide drug coverage as part of employment benefits.

55. Dental care and eye products are typically covered at a lower level than other types of care or are not covered at all for adults in OECD countries.

56. The information presented in Table 8 corresponds to institutional arrangements for health care coverage of adults. In some countries, however, there is a discrepancy between what is theoretically covered by basic health coverage and constraints faced in practice as individuals actually access care. For instance, people may be entitled to health services "free at the point of care" but nevertheless be obliged or tempted to turn to private providers with copayments or to lay out informal payments for different reasons (lack of supply, long waiting times). For instance, in Hungary, hospital and primary care are in principle fully covered by basic health insurance. In reality, patients' out-of pocket payments account for 7.3% of hospital expenditures and 14.1% of expenditures for basic medical services (see Table 9). In Australia, inpatient care is free of charge for public patients treated in public hospitals but patients can also choose to be treated as private patients in public or private hospitals, in which case they usually face copayments after coverage by private health insurance. Hence, the share of private funding in expenditures for acute inpatient care (18.5%) is well beyond the level of cost-sharing suggested by Table 8 (0%). In Belgium, patients pay extra-billing and supplemental fees for inpatient care leading to high levels of private payments (23.8%), exceeding "official" copayments (Lecluysea *et al.*, 2009).

57. On the other hand, in many countries the actual level of private funding is below the level predicted by cost-sharing arrangements. This reflects the fact that some population groups benefit from partial or total exemption of cost-sharing requirements.

Table 9. Share of out-of-pocket and private health insurance payments in current health expenditure for inpatient care and basic medical services .

Country	Share of OOP in inpatient curative care	Share of PHI in inpatient curative care	Share of OOP in basic medical and diagnostic services	Share of PHI in basic medical and diagnostic services
Australia	4.1%	14.4%	4.0%	0.0%
Austria	2.5%	8.9%	13.7%	3.9%
Belgium	17.9%	5.9%	39.1%	2.6%
Canada	2.1%	2.3%	1.3%	0.0%
Czech Republic	0.6%	0.7%	9.3%	0.1%
Denmark	6.5%	0.8%	2.2%	0.0%
Finland	4.8%	5.5%	8.2%	1.8%
France	2.6%	5.3%	9.2%	17.9%
Germany	1.9%	9.8%	10.1%	9.5%
Greece	9.0%	0.0%	53.0%	0.0%
Hungary	7.3%	0.1%	14.1%	0.4%
Iceland	1.0%	0.0%	8.2%	0.0%
Ireland	n.a.	n.a.	n.a.	n.a.
Italy	n.a.	n.a.	n.a.	n.a.
Japan	6.5%	11.5%	15.9%	0.5%
Korea	25.7%	9.5%	36.1%	4.0%
Luxembourg	2.2%	4.0%	4.6%	0.9%
Mexico	24.5%	0.0%	49.6%	0.0%
Netherlands	0.3%	0.0%	2.5%	1.6%
New Zealand	7.2%	9.9%	5.0%	1.1%
Norway	0.2%	0.0%	20.2%	0.0%
Poland	0.6%	0.9%	6.7%	0.4%
Portugal	0.3%	2.8%	n.a.	n.a.
Slovak Republic	15.4%	0.0%	52.6%	0.0%
Spain	3.8%	5.2%	3.0%	6.5%
Sweden	2.7%	0.0%	15.9%	0.0%
Switzerland	6.1%	14.5%	28.7%	10.9%
Turkey	8.7%	4.4%	42.8%	3.0%
United Kingdom	1.9%	n.a.	2.0%	0.0%

Note: For Canada, Denmark, Greece, Iceland, Luxembourg, Mexico, the Netherlands, Norway, Portugal, Slovak Republic, Sweden, Turkey and the UK, the share of OOP and PHI expenditures have been estimated by the Secretariat. In addition, data on health expenditures by function of care and financing agents have not been fully validated by several countries (Belgium, Iceland, Japan and Switzerland). In the Netherlands, out-of-pocket payments are not well captured in the system of health accounts and are thus underestimated.

Note: n.a. means Not Available.

Source: SHA 2009 and Secretariat's estimates.

StatLink http://dx.doi.org/10.1787/810305364753

2.5 Protection against excessive out-of-pocket payments

58. In OECD countries, patients often face copayments when seeking care, at least for some services and goods. Question 16 of the survey investigated whether population groups are entitled to partial or total exemption from copayments for certain categories of care. Countries were also invited to provide data on the share of population exempted from copayment (Q17) and the share of households exposed to catastrophic health expenditures (Q19), but only a few correspondents provided this information.

59. All countries (with the exception of Mexico and Turkey) have implemented policies to protect population groups from usual copayments or to protect the entire population from excessive out-of-pocket expenses (see Table 10). Countries protect some groups of individuals from potential excessive copayments due to their *health status or high health risks*: 24 countries exempt those with specific medical condition and disabilities, 13 countries exempt seniors, and 13 countries exempt pregnant women.

60. Another option to protect populations from excessive copayments is to set an upper-limit for these out-of-pocket payments, in general in relation to individual or household income. Seventeen countries have chosen this option, sometimes in combination with the other protection mechanisms. In the Netherlands, out-of-pocket payments for curative health care services included in the benefit package are capped (at €165 in 2010). In addition, some high risk-patient groups are entitled to partial compensation of OOP-payments. This compensation is defined by the difference between the maximum threshold for OOP-payments and the expected average OOP-payment in the Netherlands (€111 in 2010): it amounts to €54 in 2010. People entitled to this compensation scheme are paid an allowance. In the Czech Republic, children and seniors who have reached a cap of €100 per year are exempt from copayments. In Japan, the High Cost Medical Treatment system defines absolute thresholds for the total amount of OOP payments, which vary with age and income level.

61. Many countries also have measures to protect *low-income individuals* and families from excessive copayments: 15 countries exempt people whose income is below a defined threshold and 14 countries exempt beneficiaries of social benefits. Finally, 18countries exempt children from copayments to guarantee access to health services[8].

62. The share of the population at least partially exempted from copayments varies from 11% (in Austria and the Netherlands) to 62% in the United Kingdom (where copayments only apply to prescription drugs). However, one must keep in mind that copayments may not apply to the same categories of health services across countries. Exemption mechanisms are more crucial where copayments exist for all categories of care.

8. In France, children are exempt from the minor deductibles introduced in 2004 (€1 per physician consultation and €0.50 per prescription drug) but not from usual co-insurance rates (e.g. 35% of the price of a physician consultation)

Table 10. Exemptions from copayments (Q16 to Q19)

Country	Q16. Are there exemptions from copayments ?	If Q16 = Yes								Q17. Share of population at least partially exempted from copayment	Q18. Exemption mechanisms prevent from paying copayments at point of care?	Q19. Share of households exposed to catastrophic health expenditures	Q20. Special tax treatments for households qualified health or medical expenditure
		for those with certain medical conditions or disabilities	for those whose income are under designated thresholds	for beneficiaries of social benefits	for seniors	for children	for pregnant women	for those who have reached an upper limit for out-of-pocket payments	other				
Australia	Yes								X(1)	n.a.	Yes	n.a.	Yes
Austria	Yes	X	X					X		11	Yes	0	Yes
Belgium	Yes	X	X	X	X			X	X (2)	14	No	n.a.	No
Canada	Yes	X	X	X	X					n.a.	Yes	n.a.	Yes
Czech Republic	Yes	X	X	X	X	X		X	X	15	Yes	n.a.	No
Denmark	Yes	X			X	X		X		n.a.	Yes	0	Yes
Finland	Yes					X		X		24	Yes	1	No
France	Yes	X	X	X			X		X(3)	18	Yes	n.a.	Yes
Germany	Yes	X	X	X		X				n.a.	Yes	n.a.	Yes
Greece	Yes	X	X	X			X			n.a.	Yes	2	Yes
Hungary	Yes	X								n.a.	Yes	n.a.	n.a.
Iceland	Yes	X		X	X	X	X	X		37	Yes	0	No
Ireland	Yes	X	X	X		X	X	X		30	Yes	n.a.	n.a.
Italy	Yes	X	X		X	X	X			n.a.	n.a.	n.a.	Yes
Japan	Yes	X			X	X	X	X	X (4)	n.a.	Yes	n.a.	Yes
Korea	Yes	X	X	X	X	X		X		n.a.	Yes	3	Yes
Luxembourg	Yes	X					X	X		n.a.	n.a.	n.a.	Yes
Mexico	-									-	Yes	2.5	Yes
Netherlands	Yes	X				X		X	X(5)	11	No	0	Yes
New Zealand	Yes	X	X	X		X	X	X		n.a.	Yes	0	No
Norway	Yes					X	X	X		20	Yes	0	Yes
Poland	Yes	X				X			X (6)	n.a.	Yes	n.a.	Yes
Portugal	Yes	X	X	X	X	X	X			55	Yes	n.a.	n.a.
Slovak Republic	Yes	X	X	X	X	X	X			30	Yes	n.a.	No
Spain	Yes	X			X					24	Yes	0	No
Sweden	Yes	X				X		X		n.a.	Yes	0	No
Switzerland	Yes	X	X	X	X	X	X	X		1	No	n.a.	Yes
Turkey	No	-	-	-	-	-	-	-	-	-		-	No
United Kingdom	Yes	X	X	X	X	X	X	X		62	Yes	0	No

Notes: (1) In Australia, while no universal exemptions apply, full or partial exemptions and safety nets apply in various parts of the health system; (2) chronic patients; (3) accidents at work ; (4) public assistance beneficiaries;(5) GP-visits; (6) e.g. war invalids and disabled soldiers.
Note: n.a. means Not Available; "-" Not Applicable.
Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810337507076

63. Most countries reported copayment exemption mechanisms in which individuals are prevented from paying the copayment at the point of care (Table 10). However, Belgium, the Netherlands and Switzerland reported that their exemption mechanisms consist in *ex-post* refund of "excessive" copayments, for instance through tax credits. Italy and Luxembourg provided no detailed information regarding their mechanisms.

64. Only a few countries reported data on the share of population exposed to catastrophic health expenditures. Catastrophic expenditures for health are defined by out-of-pocket payments greater than or equal to 40% of a household's non-subsistence income. While 9 countries indicated that no households are exposed to such levels of out-of-pocket payments, Korea reported that 3% of households face catastrophic expenditures. This percentage amounts to 2.5% in Mexico, 2% in Greece and 1% in Finland.

65. Finally, 16 countries reported special tax treatments for qualified household health expenditures (either insurance premiums or medical care costs): Australia, Austria, Canada, Denmark, France, Germany, Greece, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, Norway, Poland, and Switzerland (Table 10). For instance, in Poland, spending for rehabilitation or long-term care qualifies for tax-credit.

2.6 "Over the basic" health care coverage

66. In many OECD countries, basic primary coverage is complemented by a secondary source of coverage. Depending on their role –complementary, supplementary or duplicative-, secondary sources of coverage are likely to impact health system performance (OECD, 2004a).

67. Secondary sources of coverage allow additional risk-pooling for benefits or costs not covered by basic health insurance (supplementary or complementary), thus offering a higher level of protection against financial risks. They are usually less redistributive than income-related health coverage but have the potential to enhance access to care, though access inequalities may remain due to unequal access to these health insurance or to plans with the highest level of coverage (Kambia-Chopin B. *et al.*, 2008; Buchmueller and Couffinhal, 2004).

68. Duplicative health insurance has the potential to increase the responsiveness of the health system, at least for the part of the population with this coverage. On the other hand, it increases inequity in access and is suspected to divert human resources from the public sector in those countries where dual practice is authorised for physicians (OECD, 2004a). According to the evidence collected by the OECD, the existence of duplicate private health insurance has often added to health expenditures and increased service utilisation, thus entailing additional costs for the public primary source of coverage in some circumstances (OECD, 2004a). Its contribution to overall efficiency has been assessed to be small.

69. OECD Health Data reports information on the share of population covered by private health insurance, with details on the type of insurance (duplicative, complementary, supplementary), as well as figures on the share of total health expenditures financed by private health insurance. Question 21 of the survey intended to explore the opportunities for secondary sources of coverage in OECD countries. Indeed, there may be a gap between the potential role for this type of coverage and actual take-up and market development, due to a lack of supply or to low demand (from either a low ability or willingness to pay).

70. In 14 countries[9], private insurers are allowed to cover cost-sharing for health goods and services partially covered by basic primary schemes (Austria, Belgium, Denmark, Finland, France, Germany, Japan, Korea, Luxembourg, New Zealand, Norway, Poland, Turkey, and the UK), thus playing the role of *complementary* health coverage. However, the share of population with complementary health insurance is greater than 50% in only three of these countries (Belgium, France and Luxembourg). It is relatively high

9. Six countries did not reply to question 21.

in two other countries (Korea: 38% and Austria: 33%) and significant in Denmark, Finland, Germany and Portugal.

Table 11. Coverage by non-primary private health insurance in 2007 or latest year available

Country	Duplicative private health insurance (% population)	Complementary private health insurance (% population)	Supplementary private health insurance (% population)	Private health insurance expenditure (% of Total current health expenditure)	Q21. Private insurers are allowed to sell coverage for :		
					Cost-sharing for health goods and services covered by basic primary coverage schemes	Goods and services included in the benefit package of basic primary coverage when provided by providers whose services are:	
						-eligible for funding by basic primary coverage	-not eligible for funding by basic primary coverage
Australia	43.5	0.0	46.3	8.0	No	No	Yes
Austria	0	33.3	33.3	4.8	Yes	No	Yes
Belgium	0.0	77.4	77.4	5.6	Yes	No	No
Canada	0.0	0.0	67.0	13.4	No	No	Yes
Czech Republic	0.0	0.0	0.0	0.2	n.a.	n.a.	n.a.
Denmark	0.0	15.5	15.5	1.7	Yes	Yes	Yes
Finland	0.0	11.5	11.4	2.2	Yes	Yes	Yes
France	0.0	92.0	92.0	13.8	Yes	Yes	Yes
Germany	0.0	17.5	17.5	9.6(1)	Yes	Yes	Yes
Greece	8.0	0.0	0.0	3.2	No	Yes	Yes
Hungary	0.0	0.0	0.0	1.1	n.a.	n.a.	n.a.
Iceland	0.0	0.0	0.0	0.0	No	No	No
Ireland	51.2	0.0	0.0	8.4	No	Yes	Yes
Italy	15.6	0.0	0.0	0.9	No	No	Yes
Japan	n.a.	n.a.	n.a.	2.6	Yes	Yes	Yes
Korea	0.0	38.0	38.0	4.4	Yes	n.a.	n.a.
Luxembourg	0.0	59.4	2.4	1.7	Yes	Yes	n.a.
Mexico	3.3	0.0	0.0	3.8	No	No	Yes
Netherlands	0.0	0.0	92.0	6.2	No	No	Yes
New Zealand	32.8	0.0	0.0	5.0	Yes	Yes	No
Norway	0.0	0.0	0.0	0.0	Yes	No	Yes
Poland	2.6	0.0	0.0	0.5	Yes	Yes	Yes
Portugal	17.9	8.7	8.7	4.3	n.a.	n.a.	n.a.
Slovak Republic	0.0	0.0	0.0	0.0	n.a.	n.a.	n.a.
Spain	10.3	0.0	0.0	6.1	n.a.	n.a.	n.a.
Sweden	0.0	0.0	2.3	0.2	n.a.	n.a.	n.a.
Switzerland	0.0	0.0	29.5	9.2	No	Yes	Yes
Turkey	0.0	0.0	0.0	0.0	Yes	Yes	Yes
United Kingdom	11.1	0.0	0.0	1.2	Yes	n.a.	Yes

Note: In several countries, private health insurance offers both complementary and supplementary coverage. This explains why the percentage of population covered for each category is the same.

(1) In Germany, PHI expenditures include spending for primary coverage of the population who opted out from the social insurance scheme.

Note: n.a. means Not Available.

Source: OECD Health data 2009 and OECD estimates.

StatLink http://dx.doi.org/10.1787/810360550570

71. Most often, private health insurance supplies both complementary and supplementary coverage (i.e., coverage of benefits not included in the basic benefit packages and of supplemental fees charged by providers). This is the case for all of the above mentioned countries. However, in a few countries, private health insurers are not allowed to cover cost-sharing but only to cover additional benefits or extra-fees. This is the case in Australia, the Netherlands and Switzerland, where 46%, 92% and 30% respectively of the population is covered by supplementary insurance. In Australia, patients can choose to be treated as a 'private patient' in public or private hospitals. This option allows them to choose their doctor. Where a

patient chooses to be a private patient, the Medicare covers 75% of a specified 'schedule fee' for the physician services. Patients with private insurance can claim additional benefits from health funds. Where someone receives care as a public patient, services are provided at no cost.

72. The potential role for "duplicative" health insurance is more challenging to describe. Private health insurers acting as a secondary source of coverage may be allowed to cover services included in the basic benefit package ("first dollar coverage"). Those services must then be provided on a private basis, either by doctors allowed to have dual practice (in both public and private sector) or by doctors who have opted out of the public system. In Canada, for example, dual practice is not allowed. Physicians who want to treat patients on a private basis must opt out from the public system, and only then, is private health insurance allowed to cover services included in the basic benefit package.

73. All things considered, secondary sources of coverage play the largest role in Canada and in France. In Canada, 67% of the population is covered by supplementary health insurance, which offers in-kind benefits not covered by the public system and pharmaceutical coverage. In France, 92% of the population has complementary health insurance, which mainly provides additional reimbursement for user charges imposed by social health insurance. In most OECD countries, private health insurance covers much less than 50% of the population and represents less than 5% of health expenditure (Table 11).

2.7 Financing health care

74. Analysing health expenditures by financing agent is another useful way to characterise financing arrangements in health systems. According to the SHA data collection (Table 12), general governments finance more than 50% of health expenditures (up to 85%) in 13 countries: Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden and the United Kingdom. In those countries, populations are entitled to health coverage through public schemes.

75. In another group of 13 countries, social security funds are the main funder, providing more than 40% of total health spending: Austria, Belgium, the Czech Republic, France, Germany, Hungary, Japan, Korea, Luxembourg, the Netherlands, Poland, the Slovak Republic and Switzerland.

76. In Greece, Mexico and Turkey, public funding is not clearly dominated by one source and is shared between governments and social security funds.

77. Greece, Korea, Mexico and Switzerland stand out because of the large share of private expenditures in total spending (40%, 45%, 55% and 41% respectively), largely dominated by out-of-pocket payments.

Table 12. Health expenditure by financing agent, 2007 or last available year

Country	Public expenditure			Private expenditure		
	Total	General government	Social security	Total	Out-of-Pocket payments	Private Health Insurance
Australia	67.7%	67.7%	0.0%	32.3%	18.2%	7.5%
Austria	76.4%	31.6%	44.8%	23.6%	15.4%	4.6%
Belgium*	75.1%	12.4%	62.7%	24.9%	19.0%	5.6%
Canada	70.0%	68.6%	1.4%	30.0%	14.9%	12.8%
Czech Republic	85.2%	8.3%	76.9%	14.8%	13.2%	0.2%
Denmark	84.5%	84.5%	0.0%	15.5%	13.8%	1.6%
Finland	74.6%	60.1%	14.5%	25.4%	18.9%	2.1%
France	79.0%	5.2%	73.8%	21.0%	6.8%	13.4%
Germany	76.9%	9.0%	67.8%	23.1%	13.1%	9.3%
Greece	60.3%	29.1%	31.2%	39.7%	-	-
Hungary	70.6%	12.4%	58.2%	29.4%	24.9%	1.1%
Iceland	82.5%	55.5%	27.0%	17.5%	16.0%	0.0%
Ireland	80.7%	80.1%	0.6%	19.3%	9.9%	8.1%
Italy	76.5%	76.4%	0.1%	23.5%	20.2%	0.9%
Japan	81.3%	15.4%	64.0%	18.7%	15.1%	2.6%
Korea	54.9%	12.3%	42.7%	45.1%	35.7%	4.1%
Luxembourg	90.9%	20.6%	70.3%	9.1%	6.5%	1.7%
Mexico	45.2%	18.6%	26.6%	54.8%	51.1%	3.7%
Netherlands*	81.4%	5.8%	75.6%	18.6%	6.0%	6.2%
New Zealand	78.0%	68.2%	11.9%	22.0%	14.0%	5.0%
Norway	84.1%	72.1%	12.0%	15.9%	15.1%	0.0%
Poland	70.8%	12.3%	58.6%	29.1%	24.3%	0.5%
Portugal	71.5%	70.7%	0.8%	28.5%	22.9%	4.1%
Slovak Republic	66.8%	6.8%	60.1%	33.2%	26.2%	0.0%
Spain	71.8%	66.7%	5.1%	28.2%	21.1%	5.9%
Sweden	81.7%	81.7%	0.0%	18.3%	15.9%	0.2%
Switzerland	59.3%	16.5%	42.8%	40.7%	30.6%	9.2%
Turkey	71.4%	33.7%	37.7%	28.6%	19.9%	0.0%
United Kingdom	81.7%	81.7%	0.0%	18.3%	11.4%	1.1%

Note: * Excludes investment expenditure.

Source: OECD Health Data 2009.

StatLink http://dx.doi.org/10.1787/810412371836

3 HEALTH CARE DELIVERY

78. The organisation of health care delivery differs widely across OECD countries. The survey investigated several institutional features of health care delivery commented on below: the organisation of health care supply, providers' payment schemes, patient choice of provider, and the regulation of supply and prices.

3.1 Organisation of health care supply

79. The organisation of health care supply potentially influences the accessibility to health services, their effectiveness, efficiency and quality, as well as provider and patient satisfaction. This section of the survey was designed to collect information on the organisation of the health care supply for primary and specialised outpatient services (collective versus solo practice) and on the public/private mix in health care delivery.

80. Generally, group practice is deemed to increase patient accessibility and professional working conditions, as well as the effectiveness and efficiency of health care delivery as several health professionals work together in collaboration (Tollen, 2008).

81. The public/private mix of institutions delivering health care is often considered to be an important feature of health care systems, for several reasons. First, public and private institutions are intended to respond to different motivations and face distinct constraints (i.e. management autonomy), leading to variations in efficiency in the delivery of health care. Secondly, integrated public health services may be more receptive to command-and-control regulation from public authorities.

82. Privatisation takes many different forms in health care provision ranging from private ownership of hospitals to private practice in public hospitals, both responding to the constraints of the policy and regulatory environment which may significantly limit in some cases the free play of markets (Maarse, 2006). Though such a varied landscape makes it difficult to find appropriate descriptors of the public/private mix of health care institutions, the survey tried to collect information for both outpatient physician services and acute hospital care.

3.1.1 The provision of outpatient physician services: organisation and public/private mix

83. Countries were invited to indicate in questions 27 and 28 the predominant mode of provision for primary care services and for outpatient specialist services, as well as the secondary mode of provision if it accounted for more than 20% of services delivered.

84. ***Primary care services*** are predominantly provided in private settings in 21 OECD countries. Almost all countries with social health insurance systems rely on private practice and 7 countries with national health systems do so as well including: Australia, Canada, Denmark, Ireland, New Zealand, Norway and the United Kingdom. By contrast, primary care services are mainly provided in public health centres in Finland, Iceland, Italy, Mexico, Portugal, Spain, Sweden and Turkey (see Table 13).

85. Private providers of primary care services most often run solo practice (12 countries) but group practice is the predominant mode of provision in 9 countries.

86. ***Outpatient specialists' services*** are provided in public hospitals in 10 countries and public centres in 4 countries. However, 15 countries rely on private practices for outpatient specialist services, among which 10 countries report that this takes place largely in private solo practice. Countries with national health systems predominantly supply outpatient specialist' services in public hospitals, except Australia, Denmark, and Norway. Countries with social health insurance systems typically rely on private settings, except Hungary, Mexico and Turkey (see Table 13). In Poland, outpatient specialists' services are delivered equally by private and public health care providers.

Table 13. Predominant modes for the provision of primary care services and outpatient specialists' services (Q27 & Q28)

Country	Q27 Predominant mode of provision for primary care services	Q27 Second mode of provision for primary care services	Q28 Predominant mode of provision for specialists' services	Q28 Second mode of provision for specialists' services
Australia	private group practices		private group practices	public hospital
Austria	private solo practices		private solo practices	public hospital
Belgium	private solo practices	private group practices	private solo practices	private group practices
Canada	private group practices	private solo practices	public hospital	private group practices
Czech Republic	private solo practices		public hospital	private group practices
Denmark	private group practices		private solo practices	
Finland	public centres	private group practices	public hospital	private group practices
France	private solo practices		private solo practices	private clinic
Germany	private solo practices		private solo practices	
Greece	private solo practices		private solo practices	public hospital
Hungary	private solo practices		public centres	public hospital
Iceland	public centres		private group practices	
Ireland	private solo practices		public hospital	
Italy	public centres		public hospital	
Japan	private clinics		private clinic	
Korea	private solo practices		private solo practices	
Luxembourg	private solo practices		private solo practices	private clinic
Mexico	public centres	private solo practices	public centres	private group practices
Netherlands	private group practices	private solo practices	private group practices	private solo practices
New Zealand	private group practices		public hospital	
Norway	private solo practices		private solo practices	
Poland	private clinics	private solo practices	public centres	private solo practices
Portugal	public centres		public hospital	public centres
Slovak Republic	private group practices		private group practices	public hospital
Spain	public centres		public centres	
Sweden	public centres		public hospital	
Switzerland	private solo practices		private solo practices	
Turkey	public centres		public hospital	
United Kingdom	private group practices		public hospital	

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810426777114

3.1.2 The public/private mix in the provision of acute hospital care

87. In several OECD countries, the public/private mix in the provision of hospital services vary according to the type of care (acute, rehabilitation, long-term). As it was not possible to collect information for all types of services, the survey focused on acute in-patient care to gain an overall understanding.

Hospital acute care beds account for on average ¾ of all hospital beds in OECD countries, ranging from 51% in Ireland to 93% in Turkey (OECD Health Data 2009).

88. Countries were first asked to indicate the respective shares of acute care beds located in "publicly owned hospitals", "not-for-profit privately owned hospitals" and "for-profit privately owned hospitals" (Q30). Then, they had to indicate whether private practice was allowed in public hospitals, for self-employed doctors and/or for salaried doctors (Q31).

89. In a few OECD countries, organisations providing covered health services cannot earn profits. This is the case for instance in Japan. In Canada, though health services covered through the Canadian Health Act must be provided on a not-for-profit basis, a small number of for-profit hospitals exist and provide covered health services. However, most hospitals are public or not-for-profit entities.

90. Acute hospital care is mainly provided by the public sector in all OECD countries, except Belgium, Japan, Korea and the Netherlands, where the private not-for-profit sector is the predominant provider. The private for-profit sector plays an important role in the Slovak Republic (40% of acute beds), in Mexico (35%), in Greece (28%), as well as in France and Korea (25% each).

91. Private practice in public hospitals is authorised in 16 out of 29 countries. Indeed, physicians working in public hospitals are not always salaried staff. For instance, in Belgium and some Canadian provinces, the vast majority of doctors working in public hospitals are self-employed and paid on a fee-for service basis. In some countries (e.g. France, the United Kingdom), salaried doctors of public hospitals are permitted in some circumstances to treat patients on a private basis. In France, this privilege was granted as a concession to attract and keep experienced doctors in public hospitals where salaries are in general lower than in the private sector. In both countries, private practice in public hospitals is however limited.

Table 14. Public/private mix in the provision of hospital acute care (Q30 & Q31)

Country	Q30. Percentage of total acute care beds in:			Q31. Is private practice in the public hospital setting allowed?		
	Publically owned hospitals	Not-for-profit privately owned hospitals	For-profit privately owned hospitals	For self-employed doctors	For salaried doctors	No
Australia	69.59	14.38	16.03		X	
Austria	72.5	18.8	8.7		X	
Belgium	34	66	0	X	X	
Canada	100	0	0	X		
Czech Republic	91	0	9			X
Denmark	96.7	2.5	0.8			X
Finland	89	0	11			X
France	66	9	25		X	
Germany	49	36	15	X		
Greece	69	3	28		X	
Hungary	n.a.	n.a.	n.a.			X
Iceland	100	0	0			X
Ireland	88	0	12		X	
Italy	81.5	16.7	1.8			X
Japan	26.3	73.7	0	X	X	
Korea	10	65	25			X
Luxembourg	68	29	3	X	X	
Mexico	65	0	35			X
Netherlands	0	100	0	X(2)	X(2)	
New Zealand	81	9.5(1)	9.5(1)			X
Norway	99	1	0			X
Poland	95	0	5	X		X
Portugal	85.7	6.6	7.7		X	
Slovak Republic	59.6	0	40.4	n.a.	n.a.	n.a.
Spain	74.23	17	8.77			X
Sweden	98	0	2	X		
Switzerland	82.7	4.8	12.5	X	X	
Turkey	89.5	0	10.5		X	
United Kingdom	96	4	0		X	

Note: (1) OECD imputation; (2) Private practice is allowed for both salaried and self-employed doctors of private not-for-profit hospitals.

Note: n.a. means Not Available.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810452174667

3.2 Payment of health care providers

92. Provider payments arrangements are certainly one of the most determinant characteristics of health systems, affecting the quantity, quality and efficiency of health services supply. Each payment scheme provides specific incentives. While fee-for-service is credited for favouring both quantity and quality in the provision of health services, it may lead to supplier-induced demand in case of high supply. On the other hand, prospective payments and capitation may lead providers to reduce their effort, cherry-pick healthier patients and over-refer patients to other sectors of care (Rochaix, 1998; Simoens and Hurst, 2006; Grignon *et al.*, 2002).

93. Two recent OECD studies have described physician payment schemes in several but not all OECD countries (Simoens and Hurst, 2006, Fujisawa and Lafortune, 2008). Information on hospital payment methods was not systematically available. Therefore, the survey included several questions to update and complete the information on provider payments (Q33 to Q38). However, many countries were not able to provide information with the level of details initially requested in question 33. Complementary research was used to build two sets of information: one for physicians (Table 15) and one for hospitals (Table 16). It is worth noting that information presented below reflects only the predominant mode of payment for physicians. In some countries, providers or institutions with different status provide health care services under different payment schemes.

3.2.1 Predominant modes of physician payment

94. Fee-for-service is the predominant mode of payments for ***primary care doctors*** in Australia, Belgium, Canada, France, Germany, Ireland, Japan, Korea, Luxembourg and Switzerland. Primary care physicians are predominantly remunerated by salary in Greece, Iceland, Mexico, Portugal, and Sweden and by capitation in Hungary, Italy, Poland and the Slovak Republic. The other 10 countries use a mix of these modes of payment.

95. In Austria, "contracted" primary care doctors working in private practice are paid by a capitation, for "basic services", and by fee-for-service. Capitation accounts for almost 70% of their income (Hofmarcher and Rack, 2006). In Czech Republic, 91% of primary care doctors are self-employed. They are paid through a mix of capitation (adjusted by age) and fee-for-service. Capitation rates are adjusted by age and decline beyond a certain limit in the number of registered patients. Some services, such as preventive examinations and home visits are paid by fee-for-service, which accounted for 30% of physicians' income in 2008 (Bryndová *et al.*, 2009). In Denmark, GPs are paid through a mix of capitation (30% of their income) and fee-for-service (Strandberg-Larsen *et al.*, 2007). In the Netherlands, since 2006, general practitioners have been paid through a mix of capitation (€52 per patient) and fee-for-service for each additional contact (€9 for a consultation, lower fees for e-mail contacts) (Knotterus and ten Velden, 2007). In Norway, generalists receive a capitation fee (30% of their income) as well as fees for individual services paid by patients and National Insurance (Grytten J. and R.J. Sørensen, 2009). In the United Kingdom, 87% of GPs are independent contractors grouped in primary practices paid through a mixture of capitation payments and fee-for-service payments for the provision of enhanced services and bonuses.

96. In Finland, most doctors working in municipal services are salaried employees. In some centres, patients are assigned to a specific doctor ("personal doctor system"). In those cases, doctors are paid through a mix of salary (60%), capitation (20%), fee-for-service (15%) and other allowances (5%), in order to encourage the provision of timely care to patients (Järvelin, 2002).

97. Australia, Austria, Belgium, Canada, France, Germany, Iceland, Japan, Luxembourg, and Switzerland employ a fee-for-services system as the predominant mode of payment for ***out-patient specialists services***, whereas Denmark, Finland, Hungary, Ireland, Italy, Mexico, Portugal, Spain, Sweden

and the UK use salary and another 7 countries use a combination of these two modes of payments. In Poland, where out-patient services are provided equally by the public and private sector, doctors working in public settings are paid on a salary basis, while doctors in private practices are paid by fee-for-service. In the Czech Republic, outpatient services are provided in public hospitals or in private settings and are paid on a fee-for-service basis. However, physicians delivering these services may be employed by the hospital and salaried.

Table 15. Predominant modes of physician payment

Country	Primary care physicians payment	Out-patient specialists payment	In-patient specialists payment
Australia	FFS	FFS	Salary
Austria	FFS/Cap	FFS	Salary
Belgium	FFS	FFS	
Canada	FFS	FFS	FFS
Czech Republic	FFS/Cap	FFS/Salary	Salary
Denmark	FFS/Cap	Salary	Salary
Finland	Salary/Cap/FFS	Salary	Salary
France	FFS	FFS	Salary
Germany	FFS	FFS	Salary
Greece	Salary	FFS/Salary	Salary
Hungary	Cap	Salary	
Iceland	Salary	FFS	Salary
Ireland	FFS	Salary	Salary
Italy	Cap	Salary	Salary
Japan	FFS	FFS	FFS
Korea	FFS	FFS/Salary	FFS/Salary
Luxembourg	FFS	FFS	
Mexico	Salary	Salary	Salary
Netherlands	FFS/Cap		FFS
New Zealand	FFS/Salary	FFS/Salary	FFS/Salary
Norway	FFS/Cap	FFS/Salary	Salary
Poland(*)	Cap	FFS/Salary	Salary
Portugal	Salary	Salary	
Slovak Republic	Cap		Salary
Spain	Salary/Cap	Salary	Salary
Sweden	Salary	Salary	
Switzerland	FFS	FFS	
Turkey	FFS/Salary	FFS/Salary	FFS/Salary
United Kingdom	Salary/Cap/FFS	Salary	Salary

Note: Cap means capitation, FFS fee-for-service.(*) In Poland, around half of physicians who work in hospitals receive salary; second half is self-employed and is remunerated according to contracts.

Source: OECD Survey on health system characteristics 2008-2009 and OECD estimates.

StatLink http://dx.doi.org/10.1787/810485838853

98. Canada, Japan, and the Netherlands have a fee-for-services system as the predominant mode of payment for ***specialists providing inpatient services***. Salary is the predominant mode of payment in Australia, Austria, the Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Mexico, Norway, Poland[10], the Slovak Republic, Spain and the United Kingdom. Korea, New Zealand, and Turkey use a combination of these two modes of payments.

99. In fact, in several countries, specialists can be employed by public or private hospitals, be self-employed or have a dual practice. Generally, doctors receive salaries from the establishment which employs them and fee-for-service when they are self-employed. In France, for example, 49% of specialists are exclusively salaried while 51% work as full-time or part-time self-employed. Most salaried specialists work in public hospitals. Typically, private-for-profit hospitals do not employ physicians, who rather intervene as self-employed. The proportion of exclusively-salaried doctors varies according to the specialty and is higher for specialists providing mainly inpatient services. In 2009, 75% of neurosurgeons were exclusively salaried while only 14% of ophthalmologists were (Eco-santé France, 2009).

100. In Australia and the United Kingdom –and France to a lesser extent-, where patients can be treated privately in public hospitals, specialists are paid by salary for treating public patients in public hospitals and by fee-for-service for treating private patients in either public and private hospitals.

3.2.2 Payment of hospitals for acute inpatient care

101. Most OECD countries use a mix of payment arrangements to finance hospital acute care, each of which provide specific incentives for the quantity, quality and productive efficiency of hospital services.

102. Line-item budgets consist of block grants earmarked to cover specific cost categories of hospitals. They may be based on historic costs and/or expected volumes, but are usually prospective. This type of payment does not favour efficient reallocation of resources between different inputs. Only two countries fund hospital acute services with line-item budgets: Spain and Turkey.

103. Prospective global budgets allow hospitals more flexibility in resource allocation between cost categories. Three countries fund exclusively acute hospital care through global budgets: Iceland, Luxembourg and Portugal. Both line-item and global budgets do not give incentives to produce more services, at least in the short run. In some situations, i.e. when the budget constraint is tight, hospital supply of services can even be insufficient to satisfy the demand for care, generating waiting lists.

104. A retrospective payment of costs covers all hospital incurred costs. OECD countries never use this mode of payment in isolation but a few ones combine it with activity-related payments. Several countries indicated that public/social security funding ultimately covers all hospital costs - be it only by covering deficits, but it was not possible to take such information into account.

105. Payments per case/diagnosis related groups, payments per procedure/service and *per diem* all directly relate to actual levels of activity. They correspond to fees established prospectively for a single "product" delivered by the hospital. However, they differ in the definition of the "product". *Per diem* payments are widely defined for part or all services provided during one hospital "day". Though payments per diem are generally adjusted for the "nature" of the hospital stay (surgery, obstetric, etc.), they do not directly depend on the quantity of clinical services delivered. Payments per case or per procedure both refer to more specific product categories, defined in national classifications as including hundreds of "products" (diagnosis related groups – DRG or procedures). While *payments per case/DRG* typically cover

10. In Poland, half of physicians working in hospitals receive salaries, while the second half is self-employed and remunerated according to contracts.

all clinical and non-clinical services provided in hospitals (accommodation, nursing), *payments per procedure* usually cover only the provision of clinical services. Those three modes of payment provide incentives to produce additional "products" (days, stays or procedures) as long as the prospective fee/price equals or exceeds the actual production cost.

106. If the impact of a switch from a global budget to payment per case has been shown to increase hospital activity (Biørn *et al*., 2003), the respective impacts of DRG payments, payment per procedure and payment per diem on volumes are more difficult to identify. Norton *et al*. (2002) studied the impact of a switch from per diem to per case payment on the length of hospital stay in a sample of more than 8 500 patients with severe mental illness. They concluded that the length of stay was more sensitive to a change in average price (price per episode) than to a change in marginal price of an additional day (which equals 0 in payment per DRG).

Table 16. Hospital payment schemes

Country	Hospital payment scheme
Australia	Prospective global budget + Payment per case/DRG
Austria	Payment per case/DRG (47%)/ Retrospective reimbursement of costs (48%)
Belgium	Payment per case (45%) + Payment per procedure (41%) + payments for drugs (14%)
Canada	Prospective global budget (79%) + per case (9%) + per diem (9%)
Czech Republic	Prospective global budget (75%) + per case (15%) + per procedure (8%)
Denmark	Prospective global budget (80%) + Payment per case/DRG (20%)
Finland	Payment per case/DRG
France	Payment per case/DRG
Germany	Payment per case/DRG
Greece	Per diem and retrospective payment of costs
Hungary	Payment per case/DRG
Iceland	Prospective global budget
Ireland	Prospective global budget (60%) + Payment per case/DRG (20%) + per diem (20%)
Italy	Payment per case/DRG
Japan	Payment per procedure/service + diagnosis-adjusted per diem
Korea	Payment per procedure/service + DRG
Luxembourg	Prospective global budget
Mexico	Prospective global budget (60%) + line-item (30%) + payment per procedure (10%)
Netherlands	Adjusted global budget (80%) + Payment per case/DRG (20%)
New Zealand	Prospective global budget + Payment per case/DRG
Norway	Prospective global budget (60%) + payment per procedure (40%)
Poland	Payment per case/DRG
Portugal	Prospective global budget
Slovak Republic	Payment per case/DRG
Spain	Line-item budget
Sweden	Payment per case/DRG (55%) + global budget
Switzerland	Payment per case/DRG (2/3 cantons) + global budget
Turkey	Line-item budget
United Kingdom	Payment per case/DRG (70%) + global budget (30%)

Source: OECD Survey on health system characteristics 2008-2009 and OECD estimates.

StatLink http://dx.doi.org/10.1787/810575060416

107. Many countries combine global budgets with activity-related payments to finance hospital acute services. Global budgets account for more than 50% of funding in nine countries (Australia, Canada, the Czech Republic, Denmark, Ireland, Mexico, the Netherlands, Norway and New Zealand). By contrast, in the United Kingdom and Sweden, payments per case account for more than half of funding.

108. In seven countries, hospital acute care is paid exclusively through payment per case: Finland, France, Germany, Hungary, Italy, Poland and the Slovak Republic.

109. In three countries, hospital payments for inpatient acute care combine several types of activity-based payments (i.e. payment per diem/procedure/case): Belgium, Japan, and Korea.

110. Austria and Greece combine activity-related payments with retrospective funding of all costs. In Switzerland, cantons determine how they pay hospitals. Two-third of cantons use payment per case and the others use global budgets.

3.2.3 Bonuses or penalties in relation to performance targets

111. *Pay-for perfo*rm*ance schemes (P4P)* have been introduced in several OECD countries. In such schemes, third-party payers offer financial incentives (bonuses) to providers in exchange for the achievement of agreed quality-of-care targets. These targets generally pertain to preventive care (i.e. percentage of patients vaccinated or screened for defined programmes) or to the management of chronic diseases, such as asthma and diabetes (Maynard, 2008; Bras and Duhamel, 2008; Rosenthal *et al.*, 2006).

112. A set of question (Q34, Q35, Q36 and Q38) investigated the existence and scope of bonuses paid to physicians and hospitals for quality outcomes, as well as positive or negative incentives for complying with good practice guidelines. Countries were invited to provide data on the percentage of physicians receiving bonuses and the share of bonuses in physicians' revenues, but only a few countries provided the requested information (see Table 17).

113. Twelve countries reported the existence of bonuses for primary care physicians without systematically providing further information on the type of performance targets. Bonuses are linked to quality targets in preventive care and in the management of chronic diseases in seven countries. For instance, 80% of primary care physicians in Poland and in the Czech Republic receive bonuses, which represent 5% of their revenue. In Belgium, 90% of primary care physicians receive bonuses representing 2% of their revenues for the management of chronic diseases. In the United Kingdom, 99% of primary care physicians receive bonuses, which total 15% of their revenue for quality targets linked to prevention, chronic disease management and patient satisfaction. Some countries (New Zealand, Portugal) mentioned that primary care organisations (and not individual providers) are eligible to receive bonuses. In Australia, the Practice Incentives Program (PIP) provides general practitioners with incentives relating to specific activities such as immunisation of children and pap smears for women between the ages of 20 and 69 years who have not had a cervical smear in the previous four years[11].

11. For more details about the Practice Incentive scheme, see http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp.

Table 17. Performance-related payment incentives (Q34, Q35, Q36 &Q38)

Country	Q34. Bonus for primary care physicians	Q34. If so, targets related to:	Q35. Bonus for specialists	Q35. If so, targets related to:	Q38. Bonus for hospitals	Q38. If so, targets related to:	Q36. Penalties if volume targets exceeded
Australia	Yes	Preventive care, Chronic disease	No		No		Yes, reduction in physicians' fees(1)
Austria	No		No		No		Yes, reduction in physicians' fees
Belgium	Yes	Chronic disease	Yes	Chronic disease	Yes		No
Canada	No		No		No		Yes, reduction in physicians' fees
Czech Republic	Yes	Preventive care	Yes		No		Yes, refund to health insurance funds
Denmark	No		No		No		Yes, reduction in physicians' fees
Finland	No		No		No		Yes, refund to health insurance funds
France	No		No		No		No
Germany	No		No		No		No
Greece	No		No		No		No
Hungary	Yes		No		No		No
Iceland	No		No		No		No
Ireland	No		No		No		No
Italy	Yes	Preventive care, Chronic disease	No		No		Yes, refund to health insurance funds
Japan	Yes	Preventive care, Chronic disease	Yes	Preventive care, Chronic disease	Yes	Clinical outcome	No
Korea	No		No		No		Yes, reduction in physicians' fees
Luxembourg	No		No		Yes		No
Mexico	No		No		No		No
Netherlands	No		No		No		No
New Zealand	Yes	Preventive care, Chronic disease	No		No		No
Norway	No		No		No		No
Poland	Yes	Preventive care, Chronic disease	Yes	Preventive care, Chronic disease	No		No
Portugal	Yes	Preventive care, Chronic disease	No		No		No
Slovak Republic	No		Yes		Yes	Clinical outcome, Process, Patient satisfaction, Patient experience	No
Spain	Yes	Preventive care, Chronic disease	Yes		No		No
Sweden	n.a.		n.a.		n.a.		No
Switzerland	No		No		No		Yes, reduction in physicians' fees
Turkey	Yes	Preventive care	Yes	Preventive care	Yes	Process	No
United Kingdom	Yes	Preventive care, Chronic disease, Patient satisfaction	Yes	Preventive care, Chronic disease	Yes	Clinical outcome, Process, Patient satisfaction, Patient experience	Yes, reduction in physicians' fees

Note: (1) In some jurisdictions (e.g. Victoria)
Note: n.a. means Not Available.
Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810601762533

114. In France, a pay-for-performance scheme was introduced in 2009: generalist can sign, on a voluntary basis, individual contracts with the health insurance fund (*Contrats d'amélioration des pratiques* – CAPI). These contracts provide additional payments for the achievement of targets related to the quality of care (preventive activities, compliance with evidence-based guidelines) and to the efficiency of drug prescription (share of generics in some therapeutic classes). At the end of 2009, about one-third of all generalists had signed such agreements.

115. Eight countries reported the existence of bonuses for specialists. For instance, the United Kingdom mentioned that NHS consultants (68% of specialists) receive bonuses for targets in preventive care and the management of chronic diseases. In Poland, 5% of the specialists receive bonuses amounting to 5% of their revenues.

116. Six countries reported the existence of bonuses for hospitals. In Luxembourg, 9% of hospitals earn bonuses, which represent 1.4% of their revenues. In Belgium, the share of bonuses in revenues of hospitals is 0.5%. Only the Slovak Republic and the United Kingdom reported bonuses linked to all types of quality targets, i.e. clinical outcomes, appropriate processes, patient satisfaction and patient experience.

117. Ten countries indicated that physicians can incur penalties when volume targets are exceeded. In seven countries, penalties would take the form of reduction in physicians' fees. In three countries, the Czech Republic, Finland and Italy, penalties would consist of partial refunds to health insurance funds.

3.3 User choice and competition among providers

118. Health systems vary according to the extent to which they feature competition among providers (hospitals, physicians) and the grounds on which any such competition occurs. Providers may compete to attract patients – provided that patients can choose their provider – or to contract with health insurance funds/plan – provided that the latter are allowed to contract selectively. Beyond these drivers of competition, the intensity of competition depends on the density of supply in geographic areas or "local markets". This latter characteristic would be ideally measured by an index of market concentration, such as the Herfindahl-Hirschman Index (HHI)[12]. However, such data are not available in all OECD countries and were not possible to collect. Consequently, the degree of competition among providers was approached by three characteristics: patient choice, the existence of gate-keeping, and information available to users on providers' performance.

3.3.1 Patient choice among providers

119. Patient choice among providers is a characteristic of competitive health care markets, usually considered to put downward pressure on prices and/or increase the quality of services supplied. In some circumstances, however, restrictions on patient choice or incentives to favour one provider over another one have been used to steer the demand for health care services. Two types of incentives/restrictions exist. In national health systems with local services, patient choice is often restricted to a geographic area. This allows local authorities to keep control of resources invested in health care, including rationing. The second way to influence demand is to restrict choice to a network of providers, selected by third party payers, or to create financial incentives (e.g. higher reimbursement) to favour the choice of network

12. The Herfindahl-Hirschman Index is a commonly accepted measure of market concentration. It is calculated by squaring the market share of each "firm" competing in the market and then summing the resulting numbers. In our context," market shares" would not be available and could be approximated by shares in total activity.

members over competing providers. In this case, restrictions or incentives are designed to steer the demand towards more appropriate health services.

Table 18. Patient choice among provider (Q39, Q43, Q44)

Country	Q39: Choice of a primary care physician	Q43: Choice of a specialist	Q44: Choice of a hospital
Australia	free	free	incentives
Austria	incentives	incentives	limited with exceptions
Belgium	incentives	free	free
Canada	free	free	limited with exceptions
Czech Republic	free	free	free
Denmark	limited	limited	free
Finland	limited	limited	limited
France	free	free	free
Germany	free	free	incentives
Greece	incentives	incentives	incentives
Hungary	free	free	free
Iceland	free	free	free
Ireland	free	free	free
Italy	free	free	free
Japan	free	free	free
Korea	free	incentives	free
Luxembourg	free	free	free
Mexico	limited	limited	limited
Netherlands	free	incentives	free
New Zealand	free	limited	limited
Norway	free	free	free
Poland	free	free	free
Portugal	limited	limited	limited with exceptions
Slovak Republic	free	free	free
Spain	limited	limited	limited with exceptions
Sweden	free	free	free
Switzerland	free	free	limited with exceptions
Turkey	free	free	free
United Kingdom	limited	free	free

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810643243422

120. Patient choice is on the political agenda of several OECD countries. Countries where patient choice was rather limited have taken steps to extend it, while countries historically with unlimited choice have been trying to promote rational health care pathways, notably by implementing gate-keeping.

119. Questions 39, 43 and 44 explored patient choice of provider in OECD countries for primary care, outpatient specialists' services and acute inpatient care.

120. In almost half of the OECD countries, patients do not face any constraint or financial incentive when choosing health care providers.

121. In a few countries, patients face incentives to choose one provider over another. For instance, in Austria, patients are free to visit generalists and specialists who have not contracted with health insurance funds but will face higher copayments if they do so. In Belgium, patients can elect a primary care doctor to manage their medical record and thus benefit from lower copayments when they visit this doctor. In Australia, patients can be treated at no cost if they choose to be treated as public patients in public hospitals; in other circumstances, they face copayments (partially or fully covered by their private insurance).

122. Patient choice is rather limited in several countries. In the Netherlands, patients are free to choose any GP and switch without restriction. However, GPs have the the right to refuse a patient, either because that person lives more than 15 minutes away from the practice, or because the GP already has too many patients on his list. In Denmark, the vast majority of patients (Group 1 coverage option) must choose a primary care doctor within 10 km of their home (5 km in Copenhagen). By contrast, the choice of physician is more open for the 2% people covered by the Group 2 option (Strandberg-Larsen *et al.*, 2007). In Switzerland, where hospital costs are shared between health insurance and cantonal authorities, patient choice for hospital care is in principle limited to hospitals of their canton, except in case of emergency or referral for specialised care not available in their own canton. In Finland, patient choice is limited to municipal health care centres which offer a range of health and social services and to hospitals within the patient's geographic home area. In the public sector in Mexico, patient choice is limited to the physicians available in the primary care unit where they are registered. In the United Kingdom, patients are obligated to choose their general practitioner within a geographical area. Since 2009, patients can now choose with their GP the hospital they will be referred to should they require inpatient treatment. Patient choice is also very limited in Spain and Portugal, where exceptions for hospital care can be made in the event of long waiting times.

123. It is worth noting that the survey only explored incentives for patients in their choice of provider. Some countries have indicated incentives that target providers, a situation not reflected in our data. For instance, in Hungary, patients are in principle referred to providers within a catchment area and hospitals face disincentives to attract patients from other areas.

3.3.2 Gate-keeping

124. To encourage appropriate use of health services, more and more countries have been relying on primary care doctors to guarantee good follow-up of patients and serve as gate-keepers. Dranove and Satterthwaite (2000) put it: "the concept of the primary care physician as a chief agent and coordinator has been the non-market, professional response to […] the increasing complexity [of medical knowledge and specialisation]". Gate-keeping is intended to reduce consumers' search costs, to steer demand for specialised services in such a way as to ensure the appropriate use of different levels of care. The effectiveness of gate-keeping depends however on the ability of primary care doctors to act as good agents managing and co-ordinating the follow-up of patient care, as well as on the information available on the quality and prices of services supplied by providers of secondary care.

125. Questions 40 and 41 aimed to collect information about obligation or incentives to register with a primary care physician and obtain referral to access specialised care.

126. In seven countries, patients are required to ***register with a primary care doctor*** (see Table 19). This feature is more frequent in national health systems (Denmark, Italy, Norway, Portugal and Spain) than in health insurance systems (the Netherlands and the Slovak Republic). In Ireland, the majority of patients (Category II) do not have to register while Category I patients must register. In another group of seven countries, patients have financial incentives to register with a primary care doctors (Belgium, France, Germany, Hungary, New Zealand, Switzerland and the United Kingdom).

127. ***Gate-keeping*** is generally more prevalent in countries with national health systems – except in the case of Sweden, but also exists in the Netherlands.

Table 19. Gate-keeping (Q40 & Q41)

Country	Q40. Registration with a primary care physician	Q41. Referral to access secondary care
Australia	No obligation and no incentive	Financially encouraged
Austria	No obligation and no incentive	No obligation and no incentive
Belgium	Financially encouraged	Financially encouraged
Canada	No obligation and no incentive	Compulsory
Czech Republic	No obligation and no incentive	No obligation and no incentive
Denmark	Compulsory	Compulsory
Finland	No obligation and no incentive	Compulsory
France	Financially encouraged	Financially encouraged
Germany	Financially encouraged	Financially encouraged
Greece	No obligation and no incentive	No obligation and no incentive
Hungary	Financially encouraged	Compulsory
Iceland	No obligation and no incentive	No obligation and no incentive
Ireland	No obligation and no incentive	Financially encouraged
Italy	Compulsory	Compulsory
Japan	No obligation and no incentive	No obligation and no incentive
Korea	No obligation and no incentive	No obligation and no incentive
Luxembourg	No obligation and no incentive	No obligation and no incentive
Mexico	No obligation and no incentive	Compulsory
Netherlands	Compulsory	Compulsory
New Zealand	Financially encouraged	Compulsory
Norway	Compulsory	Compulsory
Poland	No obligation and no incentive	Compulsory
Portugal	Compulsory	Compulsory
Slovak Republic	Compulsory	Compulsory
Spain	Compulsory	Compulsory
Sweden	No obligation and no incentive	No obligation and no incentive
Switzerland	Financially encouraged	Financially encouraged
Turkey	No obligation and no incentive	No obligation and no incentive
United Kingdom	Financially encouraged	Compulsory

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810665718628

128. In four countries, financial incentives exist for both registering with a primary care doctor and obtaining referral to access secondary or specialised care. In Belgium, patients benefit from reduced cost-sharing for doctors' consultations if they choose to open a "global medical file" with a GP. The Global Medical File includes all information on health and health care interventions. Cost-sharing reductions vary with age and health status and can reach up to 30%[13]. In France, the 2004 reform introduced incentives for patients over the age of 16 to register with a primary care physician and seek referral to access specialised care. Patients pay higher cost-sharing for physician consultations if they do not register with a GP or if they consult a specialist without referral. In addition, specialists consulted without referral are allowed to charge

13. See https://www.socialsecurity.be/CMS/fr/citizen/displayThema/health/SANTH_4/SANTH_4_2.xml, consulted on December 22, 2009.

extra-billing fees, even if they are not registered in "Secteur 2[14]". Initially, the reimbursement rate for doctors' consultation out of the "coordinated care pathway" was 60% instead of 70% (Com-Ruelle *et al.*, 2006) but has been progressively reduced to reach 30% in 2009[15]. Direct access to specialists is still possible without penalty for gynaecologists, ophthalmologists and psychiatrists (for young people 16-25). Following the reform, direct access to other specialties fell from 22% of consultations to 15% between 2004 and 2006 (Le Fur and Yilmaz, 2008).

129. In Germany, the 2004 reform introduced a €10 copayment per calendar quarter for the first appointment at a doctor's office and for each subsequent physician visit without a referral from the physician seen first (Lisac *et al.*, 2009). In addition, since 2004, health insurers have been required to offer GP-centred plans to their members with financial incentives to consult GPs first and obtain referral for specialised care. In 2007, half of the health insurance funds were offering such programmes and 19% of eligible individuals were enrolled (Lisac *et al.*, 2009). In Switzerland, people can select health insurance plans with managed care options which provide financial incentives for registration with a generalist and referral to access secondary care. In 2007, 24% of those insured had chosen such plans.

130. In some countries, referral is compulsory for the public sector but not for the private sector. For instance, in Mexico, where patients pay out-of-pocket for direct access to physicians in the private sector, 20% of specialist visits occur without referral.

131. In Australia, patients can access to private specialised care without referral at the cost of lower reimbursement by Medicare.

132. The extent to which gate-keeping ensures appropriate use of health care resources cannot easily be assessed. For instance, in Portugal, the gate-keeping system and localised shortages in specialised care causing waiting times resulted in large and inappropriate number of visits to emergency departments of hospitals where 25% of patients in emergency rooms do not in fact need immediate or urgent care (Bentes *et al.*, 2004). Spain faces a similar problem: more than one third of the population believe that emergency departments are better equipped than specialists to address their needs or do not want to wait for referral to access specialists (Duran *et al.*, 2006). Likewise, in the Netherlands approximately 60% of patients arriving in emergency departments have no GP referral and 21% do not need emergency care.

3.3.3 Information on quality and prices of providers services

133. The availability of information on quality and prices for users or purchasers has the potential to enhance the quality and efficiency of services. Studies suggest that information on quality is seldom used by consumers but nevertheless impacts the quality of care and has the power to influence providers' performances (see Canadian Health Services Research Foundation, 2006 for a review).

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14. In France, some physicians, registered in "Secteur 2", are allowed to charge extra-billing fees to patients in all circumstances (except for patients with free-CMU coverage). By contrast, physicians registered in "Secteur 1" are not allowed to do it, except when patients consult them out of the "coordinated care pathway".

15. See http://www.ameli.fr/assures/soins-et-remboursements/combien-serez-vous-rembourse/consultations/les-consultations-en-metropole/hors-du-parcours-de-soins-coordonnes.php, consulted on December 22, 2009.

User information on prices

134. In the vast majority of OECD countries, health services are free of charge for patients or have uniform prices (and copayments) set at the national level (see Table 20). In both of these circumstances, information on prices is not really needed by or useful to users.

135. In other countries, prices may differ across providers. This is the case for instance in Belgium, where information on prices is readily available for doctors consultations but not for medical procedures.

136. France, Greece and the Slovak Republic reported that information on prices is readily available for both types of services (consultations and procedures). In France, the national insurance fund for salaried workers (CNAMTS) publishes on its website the average price of current medical procedures for individual doctors. The situation of Greece is more complicated since informal payments are frequent.

137. In Australia, whilst the Medical Benefits Schedule (MBS) fee and the patient rebates are publicly available, the actual fee that the practitioner charges for the services may be more difficult to obtain. Under the Australian Constitution, the Australian Government cannot control the price that practitioners can charge for their services. Patients are required to do their own research regarding the fees that are charged by individual practitioners.

Information on quality

138. Fifteen countries reported that information on quality of services supplied by individual providers is available (Table 21).

139. Five countries provided details about information published on ***services provided by physicians*** (Table 21). In Belgium, the government publishes information on individual providers. In Germany, media and NGO's publish information on patient experience and patient satisfaction. In Korea, insurers publish information on clinical outcomes and the use of appropriate processes. In the Netherlands, insurers and the media publish information on clinical outcomes, use of appropriate processes, patient satisfaction and patient experience. Health care providers also present quality information about themselves, often on their websites. In the Slovak Republic, the government and insurers publish information on all aspects of quality (clinical outcomes and processes, patient satisfaction and experience).

140. Seventeen countries provided details regarding available ***information on the quality of hospital services*** (Table 21 cont.). In Denmark, Germany, New Zealand, Norway, the Slovak Republic and the United Kingdom, four types of information are available: clinical outcomes, appropriate processes, patient satisfaction and patient experience. This information is published by the government in Denmark, New Zealand, and Norway; by the government and health insurers in the Slovak Republic; and by the government and "other NGOs" in the United Kingdom. In Germany, insurers, media and other NGOs publish such information.

141. In Belgium, France, Ireland, Korea, Mexico and Switzerland, published information is limited to clinical matters (outcomes measures and/or processes of care). The information is published by the government in Ireland and Mexico, by the government and insurers in Belgium, by insurers and NGOs in Korea, by the government and NGOs in Switzerland. In France, the government publishes information on the use of appropriate processes in terms of safety, as well as information about the equipment and volume of activity performed in each hospital[16]. The media publishes hospital rankings based on different

16. http://www.platines.sante.gouv.fr, accessed on March 23, 2010.

indicators of performance (including attractiveness, use of advanced technologies and degree of specialisation, etc.[17]).

142. In Hungary and the Netherlands, the focus is on patient satisfaction and experience. Information is published by insurers and media in Hungary, while in the Netherlands, the government, insurers and NGOs release this information.

143. In Australia, different levels of government publish information on clinical outcomes and processes, as well as information on patient experience. Some state governments publish information in a form that facilitates comparisons across providers. In the Czech Republic, insurers, the media and NGOs publish information on clinical outcomes and patient satisfaction.

Table 20. Information on prices of providers' services (Q45)

Country	Q45a. May prices differ prices across providers?	Q45b. Information on prices of physicians' consultations	Q45c. Information on prices of medical exams
Australia	Prices may differ	No information	No information
Austria	No price or unique price	-	-
Belgium	Prices may differ	Readily available	No information
Canada	No price or unique price	-	-
Czech Republic	No price or unique price	-	-
Denmark	No price or unique price	-	-
Finland	No price or unique price	-	-
France	Prices may differ	Readily available	Readily available
Germany	No price or unique price		
Greece	Prices may differ	Readily available	Readily available
Hungary	n.a.	n.a.	n.a.
Iceland	No price or unique price	-	-
Ireland	Prices may differ	No information	No information
Italy	No price or unique price	-	-
Japan	No price or unique price	-	-
Korea	No price or unique price	-	-
Luxembourg	No price or unique price	-	-
Mexico	No price or unique price(1)	-	-
Netherlands	Prices may differ(2)	No information	No information
New Zealand	Prices may differ	Readily available	No information
Norway	No price or unique price	-	-
Poland	No price or unique price	-	-
Portugal	No price or unique price	-	-
Slovak Republic	Prices may differ	Readily available	Readily available
Spain	No price or unique price	-	-
Sweden	No price or unique price	-	-
Switzerland	No price or unique price	-	-
Turkey	Prices may differ	Readily available	No information
United Kingdom	No price or unique price	-	-

Note: (1) In Mexico, prices may differ for services which are not covered by voluntary or compulsory health insurance; (2) In the Netherlands, prices may differ but only for the so-called B-segment which accounts for 34% of all DRGs.
Note: n.a. means Not Available; "-"Not Applicable.
Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810673316135

17. http://www.lepoint.fr/html/palmares/hopitaux/methodologie.jsp accessed on March 23, 2010.

Table 21. Information on quality of providers and hospitals services (Q46)

		About physicians							
Country	Q46. Is there any comparable information published on the quality of services supplied by individuals providers?	Data on clinical outcomes	Data on the use of appropriate processes	Data on patient satisfaction	Data on patient experiences	Is the information in a form that facilitates cross-provider comparisons?	Who develops and/or publishes such information:	Is there evidence that such information is used by prospective patients in selecting providers?	Is there evidence that such information is used by providers in informing referrals?
Australia	yes								
Austria	no								
Belgium	yes						Government		
Canada	no								
Czech Republic	yes								
Denmark	yes								
Finland	no								
France	yes								
Germany	yes			X	X	no	Media, other NGOs	no	no
Greece	no								
Hungary	yes								
Iceland	no								
Ireland	yes								
Italy	no								
Japan	no								
Korea	yes	X	X			no	Insurers	n.a.	n.a.
Luxembourg	no								
Mexico	no								
Netherlands	yes	X	X	X	X	n.a.	Insurers, Media (*)	n.a.	n.a.
New Zealand	yes								
Norway	yes								
Poland	no								
Portugal	no								
Slovak Republic	yes	X	X	X	X	yes	Government, Insurers	n.a.	n.a.
Spain	no								
Sweden	no								
Switzerland	yes								
Turkey	no								
United Kingdom	yes								

Note: (*) Health care providers themselves.
Note: n.a. means Not Available.
Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810682886826

Table 21. Information on quality of providers and hospitals services (Q46)(cont.)

	About hospitals							
Country	Data on clinical outcomes	Data on the use of appropriate processes	Data on patient satisfaction	Data on patient experiences	Is the information in a form that facilitates cross-provider comparisons?	Who develops and/or publishes such information:	Is there evidence that such information is used by prospective patients in selecting providers?	Is there evidence that such information is used by providers in informing referrals?
Australia	X	X	X	X	yes	Government(1)	n.a.	n.a.
Austria								
Belgium	X				yes	Government, Insurers	n.a.	n.a.
Canada								
Czech Republic	X		X		yes	Insurers, Media, other NGOs	n.a.	n.a.
Denmark	X	X	X	X	yes	Government	no	yes
Finland								
France		X			yes	Government, Media		
Germany	X	X	X	X	yes	Insurers, Media, other NGOs	no	no
Greece								
Hungary			X	X	n.a.	Insurers, Media	n.a.	n.a.
Iceland								
Ireland		X			no	Government	no	yes
Italy								
Japan								
Korea	X	X			no	Insurers, other NGOs	n.a.	n.a.
Luxembourg								
Mexico	X				no	Government	no	no
Netherlands	X	X	X	X	yes	Government, Insurers, other NGOs (*)	n.a.	n.a.
New Zealand	X	X	X	X	yes	Government	yes	yes
Norway	X	X	X	X	yes	Government	n.a.	n.a.
Poland								
Portugal								
Slovak Republic	X	X	X	X	yes	Government, Insurers	n.a.	n.a.
Spain								
Sweden								
Switzerland	X	X			yes	Government, other NGOs	n.a.	n.a.
Turkey								
United Kingdom	X	X	X	X	yes	Government, other NGOs	n.a.	n.a.

Note: (1) State government; (*) health care providers themselves.
Note: n.a. means Not Available.
Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810682886826

3.4 Regulation of health care supply

144. Conway and Nicoletti (2006) proposed a set of indicators to measure anticompetitive regulation in nonmanufacturing sectors, including the health sector. The approach adopted here is quite different; assuming that health services are subject to some degree of regulation in all countries (e.g. requirement of a tertiary degree of education to exercise the profession of physician or pharmacist), the survey did not seek to identify all types of regulatory tools employed in health care markets but rather focused on those regulatory instruments which are known to vary across countries.

145. The regulation of health care supply is a common feature in OECD health systems. Most countries have introduced entry barriers (quotas for initial education and for establishment of health professionals) or direct control (mainly for hospital facilities) of health care supply. When regulation is not directly enforced by governments, health insurance funds or other purchasers are sometimes allowed to contract with providers on a selective basis.

3.4.1 Regulation of the supply of physicians

146. The *regulation of physicians supply* was essentially approached via questions on market entry regulation. This refers to the existence of quotas for initial education, quotas for the establishment and the possibility for purchasers to select (or exclude) providers by contracting, as well as the existence of policies to address perceived shortages or uneven distribution of physicians.

147. Many OECD countries face inequalities in the geographical distribution of physicians, which are likely to impact on the efficiency in health systems. Over-supply is suspected to induce demand for health services, while under-supply may impair access. *Regions at a Glance* (OECD, 2008a) includes indicators of regional variations in physicians' density within countries and correlations between physicians' density and the distribution of population by type of region (urban, intermediate, rural). The impact of institutions and regulation on these inequalities is not well-understood.

Regulation of physician workforce

146. The regulation of physician workforce is described through the information on quotas for medical students, regulations for the location of physician practice and the existence of policies to address perceived shortages or uneven distribution of physicians.

147. Only four countries indicated that they do not **regulate the number of medical students** (the Czech Republic, Germany, Japan and Luxembourg). In the Czech Republic, the number of medical students is determined by the seven medical schools and not by the government (HIT, 2009). In Germany, the number of medical students is determined by *Länder*, which are responsible for the financing of universities (Sénat, 2008). In Japan, each university determines the number of students. The limit is set by taking into account several factors, such as resources of the medical school and the capacity of healthcare delivery of its region, as well as the overall forecasted demand for medical professionals.

148. In some countries, the number of medical students is limited by regulation with the objective of meeting future needs. In Australia, the government determines the number of medical school places – known as Commonwealth supported places. Universities can modulate the number of places within "education clusters" and can offer training to international students paying tuition fees. In France, the Ministers of Health and Education determine both the *numerus clausus*, i.e. the number of students admitted in medical schools, and the number of students per specialty, as well as their distribution in

university hospitals. In Italy, the Ministry of Universities and Research determines the number of students (OECD, 2008b).

149. In Austria, Belgium, Canada, Mexico, Spain and Switzerland, the number of student is limited more so by university capacities and financial means. In Canada, provinces and territories, which are responsible for education, determine the number of training opportunities (Sénat, 2008).

150. The vast majority of OECD countries (20 among 29) do not ***restrict physicians in the location of their practice***. In Belgium, the government determines annually the total number of contracted physicians (both generalists and specialists), but does not regulate practice location (Sénat, 2008).

Table 22. Regulation of the supply of physicians (Q47 to Q50)

Country	Q47a. Quotas for medical students	Q47b. Quotas for students by speciality	Q48. Regulation of practice location	Q49. Any policy to address perceived shortages	Q50. Any policy to address perceived mal-distribution
Australia	yes	no	no	yes	yes
Austria	yes	no	yes	no	yes
Belgium	yes	yes	no	yes	yes
Canada	yes	no	no	yes	yes
Czech Republic	no	no	no	yes	yes
Denmark	yes	yes	yes	no	yes
Finland	yes	yes	no	yes	no
France	yes	yes	no	yes	yes
Germany	no	yes	yes	no	yes
Greece	yes	no	no	no	yes
Hungary	yes	no	yes	yes	yes
Iceland	yes	no	no	no	yes
Ireland	yes	no	no	yes	no
Italy	yes	yes	yes	yes	no
Japan	no	no	no	yes	yes
Korea	yes	no	no	no	yes
Luxembourg	no	no	no	no	no
Mexico	yes	yes	yes	yes	yes
Netherlands	yes	yes	no	yes	yes
New Zealand	yes	no	no	yes	yes
Norway	yes	no	yes	yes	yes
Poland	yes	no	no	yes	yes
Portugal	yes	yes	no	yes	no
Slovak Republic	yes	no	no	yes	yes
Spain	yes	yes	no	yes	no
Sweden	yes	no	no	yes	no
Switzerland	yes	no	yes	no	no
Turkey	yes	yes	yes	yes	yes
United Kingdom	yes	no	no	yes	yes

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810750676135

151. Nine countries regulate practice location for "contracted" or "publicly funded" physicians. For instance in Austria, health insurance funds and the Chamber of physicians sign agreements on the number and distribution of "contracted" physicians. Physicians then apply for such positions with sickness funds to offer services reimbursed by social health insurance. Non-contracted physicians are free to establish their

practice where they want (Sénat, 2008). In Germany, a Federal Joint Commission of physician and sickness fund representatives determines quotas for 400 territories and 15 specialities. Then regional joint committees deliver authorisations to practice within those quotas (Sénat, 2008). In Italy, the total number of NHS doctors is limited by a ratio of one physician for every 1,500 patients. In Mexico, practice location is regulated for doctors working in the public sector but is completely open for private doctors. In Norway, there are restrictions on the number of doctors seeking public funding. In Switzerland, until 2009, cantons could limit the number of "contracted" physicians in certain areas and thus influence practice location of physicians. In Turkey, since 2005, new graduates of medical education and medical specialty education have been obliged to accomplish "compulsory public service" for a period ranging from 300 to 600 days in areas in which they are appointed by the Ministry of Health (Mollahaliloglu, 2008).

152. Luxembourg is the only country which does not use any type of regulation.

153. Twenty-one countries indicated that ***policies to address a perceived shortage in physicians' supply*** have been implemented. The main tool reported is increasing medical student quotas (Finland, France, New Zealand, Spain, and Sweden). In Canada, Premiers of the Provinces and Territories agreed in 2003 to implement a strategy of health human resource management in order to ensure appropriate population access to health providers. The strategy includes measures to make health professions more attractive, to reduce entry barriers for foreign-trained health professionals, as well as investments in medical schools. The number of first-year trainees has increased by 63% over the last decade. As an incentive to address physician and nursing shortages, the Czech ministry of health subsidises the practical training in identified and specialised fields.

154. A majority of countries (21 of 29) have adopted ***regulations to correct the geographical misdistribution of physicians***. For instance, Canada has implemented policies to address shortages of physicians in rural and remote areas since the 80's. Recently, provinces put in place initiatives to ensure access to remote areas. In addition, a specific programme of Health Canada is focused at addressing the needs of Indian and Inuit minority populations by promoting health careers among Aboriginal students. In France, financial and fiscal incentives exist to encourage practice in underserved or rural areas through compensation for medical students doing their internship in underserved areas and subsidies for initial establishment or maintain of practice in such zones, fiscal exemptions, as well as a 20% bonus over official fees in underserved areas. In Belgium and Greece, GPs receive financial incentives to establish their practice in underserved and/or poor areas. In the Netherlands, financial incentives aim to encourage an adequate availability of emergency care.

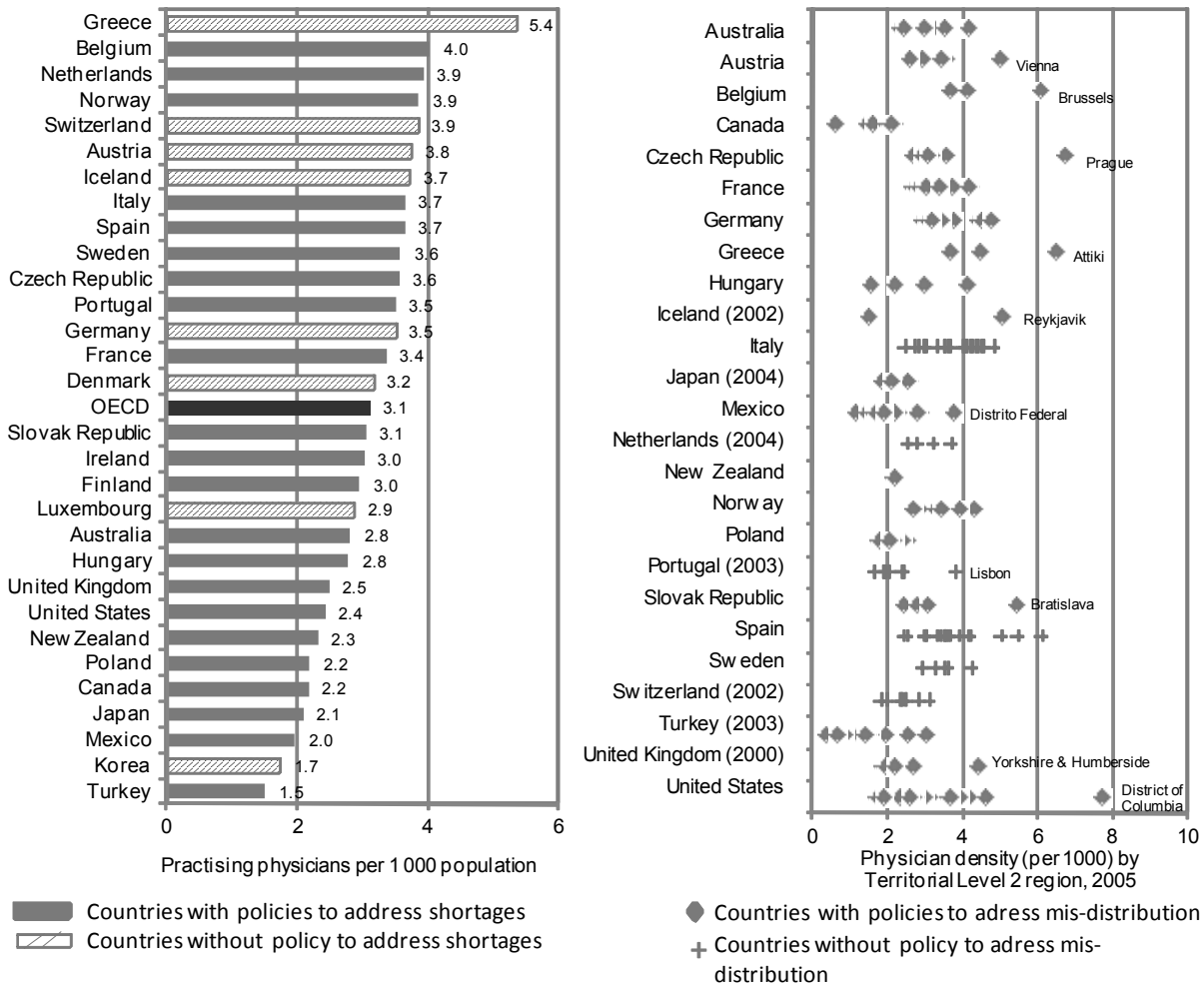
155. Sweden indicated that while there is no national policy, county councils, mostly in the northern part of Sweden, employs local measures to correct the misdistribution of physicians.

3.4.2 Regulation and density and distribution of physicians in OECD countries

156. Figure 1 shows that the existence of entry regulation for medical schools cannot be used as a predictor of low levels of supply. Almost all countries reported some form of quota for medical students, although the number of students (per 1,000 population) varies widely across countries. Similarly, many countries reported having implemented policies to address shortages in spite of high densities of practicing doctors.

157. Those results suggest that information on institutional characteristics or policy instruments must always be interpreted with caution. One must keep in mind for instance that countries with entry regulation of supply do not necessarily have lower levels of supply than countries without such regulation.

Figure 1. Regulation, policies and actual levels of the supply of physicians



Source: OECD Health at a Glance 2009.

StatLink http://dx.doi.org/10.1787/810004712838

3.4.3 Regulation of hospital supply and of the diffusion of high-cost medical technologies

158. The *regulation of hospital supply and of the diffusion of high-cost medical technologies* is common in OECD countries though not systematic. Previously, this was the preferred tool of regulators in many countries in the 1970's and 1980's to contain expenditure growth and (almost) all countries resorted to it at one point to varying degrees.

159. The questionnaire sought to identify stakeholders involved in the decision making-process for the financing of new buildings, the installation of new facilities and the purchase of high-cost equipments, and to determine the type of regulation employed. Question 52 focused on regulation applying to four types of investments: opening new hospitals, increasing the number of hospital beds, providing specific types of hospital services and investing in high-cost diagnostic equipment (Table 23).

160. In several countries, the rules of the game differ according to hospital status. Regulations described in Table 23 only apply to public facilities in Denmark, Finland, New Zealand, Spain and the United Kingdom (Ettelt et al., 2009). In these countries, private providers are in principle free to establish and expand their capacity, provided that they comply with quality and safety requirements. In addition, five countries mentioned that not-for-profit and for-profit private hospitals respond to different sets of regulations (Austria, Finland, Greece, Turkey and the UK). By contrast, capacity planning includes both public and private providers in France, Canada, Germany and Italy.

161. In some decentralised countries, regulation may vary across regions and differ according to the type of health services. In Switzerland, each canton determines regulations in areas such as the degree of public hospital autonomy in making capital investments; cantons do not regulate private hospital investments for high-cost equipments. In Sweden, hospitals must obtain authorisation from central authorities to provide services related to specialised medical care but the provision of other types of services is determined by agreements between providers and regional authorities.

Table 23. Regulation of hospital activities and high-tech equipment (Q52)

	Open new hospitals or other institutions					Increase/decrease supply of hospital beds				
Country	No regulation	quotas established at the regional level	quotas established at the central level	Regional government authorities plan capacities	Central government authorities plan capacities	No regulation	quotas established at the regional level	quotas established at the central level	Regional government authorities plan capacities	Central government authorities plan capacities
Australia		X		X			X		X	
Austria			X	X				X	X	
Belgium			X	X				X		X
Canada		X		X			X		X	
Czech Republic	X					X				
Denmark				X					X	
Finland	X					X				
France				X					X	
Germany				X					X	
Greece	X					X				
Hungary					X		X	X	X	
Iceland	X					X				
Ireland(*)					X					X
Italy		X		X			X		X	
Japan		X					X		X	
Korea	X					X				
Luxembourg					X			X		
Mexico			X	X	X				X	X
Netherlands					X			X		
New Zealand					X	X				
Norway			X						X	
Poland	X					X				
Portugal					X				X	X
Slovak Republic	X					X				
Spain				X					X	
Sweden				X		X				
Switzerland				X					X	
Turkey					X					X
United Kingdom					X	X				

Note: (*) OECD estimates.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810765116702

Table 23. Regulation of hospital activities and high-tech equipment (Q52) (cont.)

	Provision of specific types of hospital services					Supply of high cost medical equipment				
Country	No regulation	quotas established at the regional level	quotas established at the central level	Regional government authorities plan capacities	Central government authorities plan capacities	No regulation	quotas established at the regional level	quotas established at the central level	Regional government authorities plan capacities	Central government authorities plan capacities
Australia		X		X			X		X	
Austria			X	X				X	X	
Belgium			X	X	X			X	X	X
Canada		X		X			X		X	
Czech Republic	X							X		
Denmark					X				X	
Finland	X					X				
France				X					X	
Germany				X					X	
Greece	X					X				
Hungary				X	X				X	
Iceland	X					X				
Ireland(*)					X					X
Italy		X		X			X		X	
Japan	X					X				
Korea	X					X				
Luxembourg					X					X
Mexico			X	X	X				X	X
Netherlands	X					X				
New Zealand	X					X				
Norway				X					X	
Poland	X					X				
Portugal					X				X	X
Slovak Republic		X	X			X				
Spain				X					X	
Sweden				X	X	X			X	
Switzerland				X		X				
Turkey					X					X
United Kingdom	X					X				

Note: (*) OECD estimates.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810765116702

162. Mexico and Poland mentioned that providers are in principle free to expand capacity but face budget constraints. In Japan, the government subsidises the purchase of high-cost equipment in specific cases to encourage investment that providers would not otherwise make (e.g. in areas where there is a small population or where equipment is used for public health services).

163. Several countries found it quite difficult to answer question 52 on the regulation of hospital activities, since none of the types of regulation proposed in the questionnaire reflected their specific arrangements. For instance, France mentioned that many competencies have been devolved to regional hospital agencies (ARHs). ARHs negotiate multi-year contracts with individual hospitals, which include provisions for bed capacity and services to be provided. These contracts have to be in line with regional strategic health plans (SROS). ARHs deliver specific authorisations for some high-cost equipment (e.g. MRIs, scanners and PET-scans) but not for other types of medical equipment. In 2009, ARH have been replaced by "regional health agencies" with a broader mandate.

3.4.4 Hospital autonomy for staff recruitment and remuneration

164. This part of the questionnaire sought to assess the level of autonomy of hospital managers hold in the recruitment and remuneration of medical and non medical staff (Question 53).

165. In a majority of OECD countries (20 out of 29), hospital managers have complete autonomy in recruiting medical staff. By contrast, in Canada, France, Greece, Italy, Ireland, Mexico, Norway, Spain and Turkey, central or local governments make decisions about medical staff recruitment. Physicians' remuneration in hospitals is most often constrained by a pay scale negotiated at the national level (in 17 out of 29 countries). In 11 countries, hospital managers have complete autonomy for both the recruitment and pay of medical staff. In the Netherlands, however, managers have in practice little influence on the recruitment and remuneration of specialists since decisions are often made by specialists already present in the group-practices.

166. More frequently, hospitals retain a complete autonomy for recruiting other health professionals (in 21 out of 29 countries). Central or local level governments make decisions in seven countries (Canada, Greece, Italy, Ireland, Mexico, Spain and Turkey) and hospitals must negotiate with local authorities in Luxembourg. Hospitals can most often determine autonomously the remuneration level (11 countries) but national pay scales are defined in 18 countries. In 11 countries, hospital managers have a complete autonomy in both the recruitment and remuneration setting for non-medical health staff.

Table 24. Regulation of hospital staff (Q53)

Country	Recruitment of medical staff			Remuneration level of medical staff		Recruitment of other health professionals			Remuneration level of other health professionals	
	Hospital managers have complete autonomy	Hospitals must negotiate with local authorities	Central or sub-national level of government decides	Hospital managers have complete autonomy	A pay scale is set or negotiated at national level	Hospital managers have complete autonomy	Hospitals must negotiate with local authorities	Central or sub-national level of government decides	Hospital managers have complete autonomy	A pay scale is set or negotiated at national level
Australia	X			X		X			X	
Austria	X				X	X				X
Belgium	X				X	X				X
Canada		X			X			X		X
Czech Republic	X				X	X				X
Denmark	X				X	X			X	
Finland	X				X	X				X
France			X		X	X				X
Germany	X			X		X				X
Greece			X		X			X		X
Hungary	X				X	X			X	
Iceland	X			X		X			X	
Ireland			X		X			X		X
Italy			X		X			X		X
Japan	X			X		X			X	
Korea	X			X		X			X	
Luxembourg	X			X			X			X
Mexico			X		X			X		X
Netherlands	X			X		X				X
New Zealand	X				X	X				X
Norway			X	X		X			X	
Poland	X			X		X			X	
Portugal	X				X	X				X
Slovak Republic	X			X		X			X	
Spain			X		X			X		X
Sweden	X			X		X			X	
Switzerland	X			X		X			X	
Turkey			X		X			X		X
United Kingdom	X				X	X				X

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810781307207

3.5 Price/fee regulation

167. Initial questions pertaining to price regulation of health care services (Q54 to Q58) have generated a lot of confusion and survey responses were not able to be used to address the issue of price setting / regulation. Instead, additional research was undertaken to identify how prices and fees are set in OECD countries. In particular, it appeared necessary to make the distinction between "prices paid by third-party payers" and "prices billed to providers", whose regulation differs in a couple of countries.

Regulation of prices/fees for physicians' services

168. "Unit prices" for physicians' services do not always exist. When physicians are salaried or paid by capitation and services are provided free at the point of care, unit prices for specific services are not always defined. This does not mean that physicians' services have no price and that remuneration is not regulated. However, this section focuses on the determination of prices/fees for specific services (consultation, exam, procedure). Table 25 summarises how prices are set, for both prices paid by third-party payers and prices billed by providers.

169. When ***primary care services*** are paid through capitation or salary, providers are directly paid by third-party payers, though patients may have to pay "statutory copayments" at the point of care. Capitations rates or salaries are set by negotiations between interested parties at the central level in Finland Greece, Iceland, Ireland, Italy, Portugal, Mexico, Spain, Turkey and the United Kingdom. They are unilaterally determined by third-party payers or the government in Hungary, Poland and the Slovak Republic. In Sweden, salaries are determined by negotiations at the local level.

170. In a few countries, where capitation or salary is the predominant mode of payment for primary care doctors, providers can charge patients in some circumstances. In Ireland, for instance, GPs are free to set any price for "category 2" patients, who pay the full price for primary care consultations on a fee-for-service basis (but can be partly reimbursed by private health insurance afterwards). In Finland, about one third of doctors have dual practice and can charge any fee to private patients. In Mexico, doctors can set any price for private patients. In Hungary and Greece, doctors are not supposed to charge patients but informal payments are common practice.

171. In several countries with fee-for-service payments –most of which have social insurance systems-, fees are negotiated at the central level by interested parties (social health insurance and/or government and physician representatives): the Czech Republic, Denmark, Japan, Korea, Luxembourg, the Netherlands, Norway, Austria, Belgium, and France. In the three last countries, however, a significant proportion of physicians are allowed to charge prices higher than "official fees". In Denmark, physicians can charge any price to Group 2 patients (i.e. 2% of the population). In the Netherlands, a "maximum fee" is set at the central level but insurers can negotiate lower prices with providers.

172. In Switzerland and Germany, a resource-based relative value scale is negotiated at the central level and the point-value used to determine the fee for each service is set at the local level. In Switzerland, cantons negotiate with physician representatives. In Germany, the point-value is determined *ex-post* by dividing the regional budget for physician services by the number of "points" earned by doctors.

173. In Canada and New Zealand, the mode of payment of primary care services is determined at the local level, as well as the amounts paid by third party payers. In Canada, physicians are not allowed to charge any supplemental fees to patients. In New Zealand, physicians set freely the level of copayments charged to patients.

Table 25. Regulation of prices/fees of physician services

	Fees/prices billed by providers (to private health insurance or to patients)					
	Primary care services			Specialist services		
Fees/prices paid by third-party payers (basic primary health coverage)	Must be equal to prices/fees paid by third-party payers + "statuory copayments" if any	Can exceed prices/fees paid by third-party payers and statutory copayments only in some circumstances	Can always exceed prices/fees paid by third-party payers and statutory copayments	Must be equal to prices/fees paid by third-party payers + "statuory copayments"	Can exceed prices/fees paid by third-party payers and statutory copayments in some circumstances	Can always exceed prices/fees paid by third-party payers and statutory copayments
Fees/prices(1) set unilateraly by third-party payers at central level			Australia	Poland(2)		Australia
Fees/prices negotiated at central level between third-party payers and/or government and providers	Czech Republic, Japan, Korea, Luxembourg, Netherlands, Norway	Austria, Belgium, France, Denmark		Czech Republic, Iceland, Japan, Korea, Luxembourg, Netherlands, Norway	Austria, Belgium, France, Greece(4)	
RBRVS established at central level and local negotiation on point value	Switzerland(2), Germany			Switzerland, Germany		
Fees/prices negotiated at local level	Canada		New-Zealand	Canada	New-Zealand	
Fees/prices are negotiated with each insurer				Slovak Republic(2,6)		
Capitation or salary unilatteraly set by third-party payer or government at central level	Poland(2), Slovak Republic(2)	Hungary(4)			Hungary(4)	
Capitation or salary negotiated by interested parties at central level	Iceland, Italy, Portugal, Spain, United Kingdom, Turkey	Finland, Greece(4), Ireland(5), Mexico(3)		Denmark, Italy, Portugal, Spain, Turkey	Finland(3), Ireland(3), Mexico(3), United Kingdom(3)	
Capitation or salary negotiated by interested parties at local level	Sweden			Sweden		

Note: (1) Fees/prices can include or not "statutory copayments"
(2) Physicians can charge any price if they do not participate to the national or health insurance systems or provide not-covered services, but those circumstances are considered to be of marginal importance
(3) For private services paid on a fee-for-service basis, physicians are most often free to charge any price they will.
(4) Physicians are not allowed to charge extra-fee in principle, but informal payments are common practice.
(5) For 2/3 of the population, GPs set freely their prices.
(6) A RBRVS is set at central level, health insurers negotiate volume caps and point values.
Source: OECD Survey on health system characteristics 2008-2009 and indicated references in annex

StatLink http://dx.doi.org/10.1787/810813134182

174. Price regulation for ***outpatient specialist services*** differs from that of primary care services only in a few countries. Most often, the type of remuneration is different but the process for price-setting is the same. A notable exception is the Slovak Republic, where a resource-based relative value scale (RBRVS) is built for specialist services at the central level and insurers can negotiate volumes and value points with providers.

175. In the Netherlands, independent specialists (75% of specialists) are paid through the DBC system, which defines standard time and hourly tariffs for physicians services. Based on an assessment of time and resources required by an independent commission, fees are negotiated between the government and specialists. Hospitals and specialists can negotiate further, within a range of €6.

Regulation of prices for hospital services

176. ***Prices paid by third-party payers*** are most often set or negotiated at the central level (Table 26). In three countries, individual insurers are allowed to negotiate lower prices with hospitals for all or part of covered services (the Czech Republic, the Netherlands and the Slovak Republic). For instance, in the Netherlands, individual insurers and providers can negotiate the prices of 34% of DBCs (Dutch diagnostic-related groups). In four countries (Denmark, Germany, Italy, and Poland), DRG weights are defined at the central level and rates are set at the local level. In Poland, the value of services is defined in points and the value of points is negotiated between third-party payers and health care providers.

177. Payments modes and/or levels are negotiated at the local level in Canada, Finland, Spain, Sweden and Switzerland. They are negotiated between third party payers and individual hospitals in Mexico (for private hospitals only).

178. ***Prices billed by providers*** cannot exceed prices paid by "basic primary" third-party payers (and existing statutory copayments) in many OECD countries (see column 1 of table 26). In some countries, however, hospitals can charge patients beyond any "statutory copayments" left by basic health insurance. In Austria, Canada, Korea and Switzerland, hospitals can charge patients for superior accommodation, such as private rooms. In addition to such charges, patients may be required to pay supplemental fees to the physician who treats them. This can happen in Australia, Ireland and the United Kingdom, when patients are treated on a private basis; in Ireland, Belgium and France, when patients are treated in private-for-profit hospitals or by a doctor with a private practice in public hospitals; in Turkey and Mexico (in private hospitals); and in Germany.

179. In Mexico, hospitals can charge any price to patients treated as private patients in private hospitals. Likewise, in Australia, hospitals can theoretically charge any price to patients treated as private patients in public or private hospitals. In practice however, there are arrangements in the public sector between the Australian central government and the states and territories that limit charges for bed accommodation. In the case of private hospitals, limits to charges are often agreed to in contracting arrangements between hospitals and funders, such as private health insurers. Where there is no agreement, hospitals determine charges for bed accommodation.

Table 26. Regulation of prices for covered hospital services

	Prices billed by providers		
Price paid by third-party payers (basic primary health coverage)	**Must be equal to prices/fees paid by third-party payers + "statuory copayments" if any**	**Patients may pay supplements for superior accomodation**	**Patients may pay supplements for superior accomodation AND supplemental fees charges by physicians**
Determined by central government	Norway		Ireland, United Kingdom (private practice)
Negotiated by interested parties at central leval	Australia (public patients in public hospitals[(1)]) France ("public" hospitals[(2)]) Greece, Hungary, Japan,	Austria, Korea	Australia (private patients in public or private hospitals), Belgium, France (private hospitals, or private practice in public hospitals), Turkey
DRG weights defined at central level with negotiation of rates at local level or with insurers	Denmark, Italy, Poland		Germany
Negotiated by interested parties at local level	Finland, Spain, Sweden	Canada, Switzerland	
Negotiated at central level with possible further negotiations between individual providers and insurers	Czech Republic[(3)], Netherlands, Slovak Republic[(3)]		
Negotiated between individual third-party payers and providers			Mexico (private hospitals)
Payment by global budget	Iceland, Luxembourg, Mexico (public hospitals), New-Zealand, Portugal		

Note: (1) Public patients are not charged for treatment
(2) Include most not-for-profit private hospitals
(3) Informal payments are common

Sources: OECD Survey on health system characteristics 2008-2009 and indicated references in annex

StatLink http://dx.doi.org/10.1787/810813718634

Regulation of pharmaceutical prices

180. The vast majority of countries regulate the prices of medicines covered by basic primary coverage schemes at market entry (Table 27). They use a variety of instruments to do so: international benchmarking, therapeutic referencing, pharmaco-economic evaluation and different types of risk-sharing agreements (OECD, 2008c).

181. There are a few notable exceptions. In Germany, prices of new entrants are not regulated. However, maximum reimbursement prices (known as "reference prices") are set by health insurance funds for clusters of products with similar indications and pharmacological properties, which cover a significant part of the market (75% of prescriptions in 2008). This policy puts pressure on the prices of new entrants which can be clustered with existing products. In the United Kingdom, prices are not directly regulated but the profits companies can earn from sales to the NHS are capped. In addition, a few products are assessed by the National Institute for Health and Clinical Excellence (NICE), which makes decisions on the basis of a cost-effectiveness threshold set at around 30,000£ per QALY. This obviously reduces companies' freedom in setting prices.

182. Many countries set maximum reimbursement prices (MRPs) for clusters of products with similar indications and pharmacological properties. Most often, clusters only include products with the same active ingredients or combination of active ingredients ("generic groups"). In a few countries, clusters include products with different active substances (e.g. Germany, the Netherlands). Consequently, the market share affected by MRPs differs widely across countries. In the Netherlands, insurers can issue calls for tender for the supply of products within a MRP cluster and limit their reimbursement to the product of the winning company.

183. In general, companies freely set the prices of over-the-counter drugs that are not reimbursed by public or social basic coverage. Canada, however, controls the prices of all patented drugs at the Federal level, reimbursed or not, with the aim of protecting consumers from companies' abuse of monopoly power.

Table 27. Regulation of prices for pharmaceuticals

Country	Price regulation	(Further) Reimbursement price regulation
Australia	All covered medicines	MRPs for some clusters of products
Austria	All covered medicines	
Belgium	All Medecines	MRPs for some clusters of products
Canada	All patented medicines capped at Federal level. Price regulation for drugs covered by public schemes.	MRPs in some public schemes
Czech Republic	All covered medicines	MRPs for all products
Denmark	No	MRPs for some clusters of products
Finland	All covered medicines	
France	All covered medicines	MRPs for some clusters of off-patent products
Germany	No	MRPs for some clusters of products
Greece	All covered medicines	
Hungary	All covered medicines	MRPs for some clusters of products
Iceland	All Medecines	MRPs for some clusters of products
Ireland	All covered medicines	
Italy	All covered medicines	MRPs for some clusters of products
Japan	All covered medicines	
Korea	All covered medicines	
Luxembourg	(drugs imported at prices set in other countries)	-
Mexico	All patented medicines	
Netherlands	Prescription-only medicines	MRPs for some clusters of products
New Zealand	All covered medicines	MRPs for some clusters of products
Norway	Prescription-only medicines	
Poland	All covered medicines	MRPs for some clusters of products
Portugal	-	MPRs for some clusters of products
Slovak Republic	All covered medicines	MRPs for some clusters of products
Spain	All covered medicines	MRPs for some clusters of products
Sweden	All covered medicines	
Switzerland	All covered medicines	
Turkey	All medicines	MRPs for some clusters of products
United Kingdom	Prices of new entrants indirectly regulated by caps on companies' profits on NHS sales	

Note: Generally, health authorities regulating prices of reimbursed pharmaceuticals, also regulate rates and reimbursement and thus reimbursement prices. However, some countries only regulate reimbursement prices for clusters of products through Maximum Reimbursement Price (MRP).

Source: OECD Survey on health system characteristics 2008-2009, OECD (2008) and PPRI project http://ppri.oebig.at.

StatLink http://dx.doi.org/10.1787/810815430667

3.6 Regulation and monitoring of health provider activity

184. Several countries with modes of payment that provide incentives to generate volumes of care have introduced measures to avoid excessive supply of services, such as physicians' activity monitoring, volume targets and the ban of direct-to-consumer advertising for pharmaceuticals.

185. In addition, in many OECD countries, practice guidelines and care protocols have been developed by different types of institutions (professional-led quality circles, third-party payers or specialised agencies). These guidelines aim to help providers deliver high-quality and, in some countries, cost-effective care. In several countries, physicians face incentives or obligations to comply with these guidelines. Questions 59, 60 and 61 collected information on those measures.

186. Sixteen countries reported that health insurance funds or the national / local health service usually monitor the volume of physicians' activity. Thirteen countries reported that physicians usually receive feedback about their activity or prescriptions. For 7 countries prescription targets or budgets are defined and for 8 countries compliance with guidelines is monitored.

187. The Czech Republic for instance implemented decreasing rates for both GP per capita payments (above a certain number of patients) and specialists fee-for-service payments (above a certain activity-threshold) to contain volume growth (Bryndova *et al.*, 2009).

188. In fourteen countries, physicians have no incentive and no obligation to comply with established treatment guidelines or practice protocols. In four countries (Australia, Denmark, France and the United Kingdom), physicians have financial incentives to comply with guidelines. In Australia, while compliance with some evidence-based guidelines is monitored at the national level, there is no national-level financial incentive reward scheme for acute care physicians to follow clinical guidelines. However, individual states and territories may provide such incentives. In relation to the management of chronic conditions, the Practice Incentives Program (PIP) encourage general practices to improve the quality of care provided to patients. In 11 countries, physicians are in principle obliged to comply with guidelines and protocols. However, effective monitoring and control of this obligation is in force only in five of them (Belgium, Ireland, Japan, the Netherlands and Portugal).

189. In most OECD countries, direct-to-consumer advertising is possible for over-the-counter (OTC) and not-reimbursed medicines. In two countries, direct-to-consumer advertising is prohibited for all categories of medicines: Portugal and Turkey. By contrast, it is allowed for all pharmaceuticals in New Zealand.

Table 28. Control on health care providers' activity and direct-to-consumer advertising of pharmaceuticals (Q59 to 61)

Country	Q59 Are there any incentives or obligations to comply with treatment guidelines or practice protocols established	Q60. Health insurance funds or the national or local health service usually monitors the volume of physicians activity	Q60. Physicians usually receive feedback about their activity or prescription	Q60. Prescription targets or budgets are defined	Q60. Compliance with guidelines is monitored	Q61. Is direct-to-consumer advertising of pharmaceuticals allowed?
Australia	Financial incentives				X	Yes, for some medicines
Austria	No	X	X	X		Yes, for some medicines
Belgium	Compliance compulsory with monitoring	X	X	X	X	Yes, for some medicines
Canada	Compliance compulsory without monitoring	X				Yes, for some medicines
Czech Republic	Compliance compulsory without monitoring	X	X	X		Yes, for some medicines
Denmark	Financial incentives	X				Yes, for some medicines
Finland	No		X			Yes, for some medicines
France	Financial incentives		X			Yes, for some medicines
Germany	No					Yes, for some medicines
Greece	Compliance compulsory without monitoring					Yes, for some medicines
Hungary	No	X	X			Yes, for some medicines
Iceland	No	X			X	Yes, for some medicines
Ireland	Compliance compulsory with monitoring					Yes, for some medicines
Italy	No	X	X		X	Yes, for some medicines
Japan	Compliance compulsory with monitoring					Yes, for some medicines
Korea	No	X	X			Yes, for some medicines
Luxembourg	No		X			Yes, for some medicines
Mexico	Compliance compulsory without monitoring					Yes, for some medicines
Netherlands	Compliance compulsory with monitoring					Yes, for some medicines
New Zealand	No					Yes, for all medicines
Norway	Compliance compulsory without monitoring	X				Yes, for some medicines
Poland	Compliance compulsory without monitoring	X				Yes, for some medicines
Portugal	Compliance compulsory with monitoring			X	X	No
Slovak Republic	No	X				Yes, for some medicines
Spain	No	X	X	X	X	Yes, for some medicines
Sweden	No		X	X	X	Yes, for some medicines
Switzerland	No	X	X			Yes, for some medicines
Turkey	No	X		X		No
United Kingdom	Financial incentives	X	X		X	Yes, for some medicines

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/810873323602

3.7 Co-ordination of care

190. Questions 63 to 67 collected information on different aspect of care co-ordination: the use of disease or case management programmes, the use of electronic health records and co-ordination between the acute and rehabilitative/long-term sectors care.

191. Fourteen countries reported the use of disease management programmes and 10 the use of case management programmes for patients with complex conditions requiring chronic care. For instance, in Germany, health insurance funds offer Disease Management Programmes for six chronic conditions (diabetes type 1 and 2, coronary heart disease, breast cancer, asthma and chronic obstructive pulmonary disease). More than 5 million people were enrolled in such programmes in 2008 (Lisac *et al.*, 2009).

192. Four countries regularly use electronic exchange of information for diagnosis or treatment purposes between physicians and other health care providers (Finland, Germany, Spain and Sweden) while 13 countries regularly use it but only in limited settings (e.g. hospitals, labs) (Australia, Austria, Belgium, the Czech Republic, Denmark, Hungary, Ireland, Luxembourg, the Netherlands, New Zealand, Norway, Portugal and the UK).

193. Perceived shortages of non-acute care beds and the existence of "bedblockers" (patients experiencing extended acute hospital stays awaiting appropriate follow-up care) were used as indicators of failure in efficient care co-ordination. Seventeen countries reported shortages in non-acute hospitals beds (Australia, Austria, Canada, the Czech Republic, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Mexico, Norway, Poland, Portugal, Spain, and Sweden). In four countries, patients frequently experience extended acute care hospital stays awaiting appropriate follow-up care (Germany, Greece, Ireland, and Korea) whereas this never happens in Belgium, Hungary, and Mexico.

Table 29. Co-ordination of care (Q63 to Q67)

Country	Q63. Are disease management programs commonly used?	Q.64 Are case management programs commonly used for patients with complex conditions requiring chronic care?	Q.65 Do physicians transfer or exchange information electronically for diagnosis or treatment purposes with other health care providers?	Q66. Are there shortages of non-acute hospital beds?	Q67. Do patients experience extended acute care hospital stays awaiting appropriate follow-up care?
Australia	yes	yes	regularly in some settings only	yes	yes, occasionally
Austria	no	no	regularly in some settings only	yes	yes, occasionally
Belgium	yes	yes	regularly in some settings only	no	no
Canada	yes	yes	occasionally	yes	yes, occasionally
Czech Republic	yes	no	regularly in some settings only	yes	yes, occasionally
Denmark	yes	yes	regularly in some settings only	no	yes, occasionally
Finland	no	no	regularly	yes	yes, occasionally
France	no	no	occasionally	yes	yes, occasionally
Germany	yes	no	regularly	yes	yes, frequently
Greece	no	no	occasionally	yes	yes, frequently
Hungary	yes	n.a.	regularly in some settings only	no	no
Iceland	yes	yes	occasionally	yes	yes, occasionally
Ireland	no	no	regularly in some settings only	yes	yes, frequently
Italy	n.a.	n.a.	occasionally	yes	n.a.
Japan	n.a.	n.a.	n.a.	n.a.	n.a.
Korea	no	no	rarely	no	yes, frequently
Luxembourg	no	no	regularly in some settings only	no	yes, occasionally
Mexico	yes	no	rarely	yes	no
Netherlands	yes	no	regularly in some settings only	no	yes, rarely
New Zealand	yes	yes	regularly in some settings only	no	yes, rarely
Norway	no	no	regularly in some settings only	yes	yes, occasionally
Poland	yes	yes	rarely	yes	yes, rarely
Portugal	yes	yes	regularly in some settings only	yes	yes, occasionally
Slovak Republic	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	no	yes	regularly	yes	yes, occasionally
Sweden	no	no	regularly	yes	yes, occasionally
Switzerland	no	no	rarely	no	yes, occasionally
Turkey	no	no	rarely	no	n.a.
United Kingdom	yes	yes	regularly in some settings only	no	yes, occasionally

Note: n.a. means Not Available.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811023368185

4 GOVERNANCE AND RESOURCE ALLOCATION

194. This last section of the questionnaire investigated three aspects of health systems governance: the degree of decentralisation of decision-making; the definition of health care budgets constraints, and methods employed for priority setting.

4.1 Degree of decentralisation of decision-making

195. Decentralisation has been employed in public and health policy analyses with very different meanings. According to one definition, the word “decentralisation” covers three types of transfers of responsibility or authority from central governments to different sub-levels: "delegation" is a transfer of responsibility to a lower organisational level; "de-concentration" a transfer of responsibility to a lower administrative level; and “devolution”, a transfer of authority to a lower political level. Furthermore, "financial decentralisation" is defined by the division of taxing and expenditure functions among different levels of governments and can be observed in federations as well as in unitary parliamentary states (Bankauskaite and Saltman, 2007).

196. Comparing and measuring decentralisation across OECD countries is not an easy task. Countries differ in the number of sub-central government units (including administrative health structures), type (elected or appointed, raising taxes or not) and size. Bankauskaite *et al.* (2007) described the situation in 15 European countries and Canada, showing a high diversity in decentralisation patterns. In addition, countries differ in the number and types of "functions" allocated to sub-levels of governments.

197. Hence, the approach adopted here did not seek to apprehend all the dimensions of decentralisation but to measure a level of "decentralisation" of decision-making or financing for fourteen health-related functions. Three levels of government were considered: central/federal; state/province/region; and local/municipality. In addition, the survey attempted to identify other stakeholders involved in decision-making and financing, including non-governmental ones: health insurance funds and health professionals. In the literature, the involvement of non-governmental stakeholders in decision making is often referred to as “delegation” (Kotzian, 2007).

198. In most OECD countries, the legislature is involved in decisions related to the amount of resources to be collected and/or allocated to health systems. Only a handful of countries do not involve the legislature in those decisions: the Czech Republic, Greece, Japan, Luxembourg, the Netherlands, Spain and Switzerland. Several countries have indicated that both the Parliament and the central/federal government are involved in ***decisions pertaining to taxes and/or social contributions to be collected for health care***. This generally indicates that governments make proposals which must be approved by the legislature. In four countries, regional/provincial levels of governments participate in decisions about the amount to be collected: Canada, Italy, Sweden and the United Kingdom. In two countries (Finland and Sweden), municipalities take part in the decision process.

199. Health insurance funds collectively, negotiate with the government for the basis and level of social contributions to be collected for health in Japan and Korea. In Luxembourg, health insurance funds decide autonomously. In Greece, the Netherlands and Switzerland, individual funds set the level of contributions for their enrolees.

200. OECD countries generally ***set a budget for public funds allocated to health***. Budget setting is a prerogative of central government in 14 countries. By contrast, in Australia, Canada, Italy and the United Kingdom, both central and regional/provincial governments intervene. In Austria, Poland and Sweden

three levels of government are involved. In Spain, regions make this decision while this is the role of municipalities in Finland.

201. ***Resource allocation between regions and sectors of care*** does not always result from a decision-making process. In several countries, especially those with health insurance systems, resource allocation between sectors of care is observed *ex-post* rather than determined *ex-ante*. A majority of countries, however, indicated that resources are *distributed among regions* by the Parliament or the central government. In a few countries (Mexico, the Netherlands, the Slovak Republic), health insurance funds are involved in decision-making. Decisions for resource allocation between *sectors of care* is more often decentralised and shared with health insurance funds.

202. The responsibility for ***setting remuneration methods for physicians and hospitals*** is often shared between different types of stakeholders, including health insurance funds (collective or individual) and health professionals (collective or individual). The definition of payment methods for hospitals is typically more centralised than the definition of physician payments.

203. The legislature and/or central governments are most often involved in decisions pertaining to physicians payment methods. This responsibility is shared with regional/provincial governments in the United Kingdom. In Canada and Spain, the decision belongs to provincial/regional authorities.

204. The definition of physician payment methods is the subject of negotiations between governments and physician representatives in Canada, Finland and Greece. It results from negotiations between the government and social insurance in France. In other countries, health insurance funds' representatives negotiate with physicians' representatives, with (Korea, Mexico) or without (Belgium) the government. In the Slovak Republic, health insurance funds determine the mode of payment.

205. The government is always involved in decisions pertaining to hospital payment methods, except in Poland and the Slovak Republic, where health insurance funds make decisions on their own, and in the Czech Republic, where a negotiation between health insurance and providers takes place. However, in the Czech Republic, the Ministry of Health intervenes if the partners cannot reach an agreement. Korea is the only country with three-party negotiations on hospital payment methods.

206. Multiple stakeholders are involved in ***financing hospital building and maintenance***, new equipment, physician services and hospital care. Hospital building is financed by two or three levels of governments in 13 countries, by central government alone in Greece, Hungary, Iceland, Ireland, Luxembourg, Portugal and Turkey, by regional governments alone in Austria, Germany, Norway and Spain and by municipalities in Finland. A wider range of stakeholders are involved in financing maintenance of existing hospitals, including hospitals themselves, which probably means that maintenance costs are included in payments for hospital care. Similarly, providers often finance high-cost equipment upfront, which means that their investments are taken into account through fee-schedules.

207. The ***financing of medical services and hospital care*** naturally comes from health insurance funds in health insurance systems and from governments in national health systems. Municipalities (the lower level of government) are involved in financing all types of services in Denmark and Finland, in financing physician services in Hungary, in financing primary care services only in Iceland and Norway, and in financing hospital care in Austria and Switzerland. In other NHS countries, medical services are financed by the central government and/or the region. In many countries, patients contribute to the financing of those services, though this is not reflected in the table.

Table 30. Responsibilities in decision-making (Q68)

Country	Setting the level of taxes which will be earmarked to health care								Setting the basis and level of social contributions for health								Setting the total budget for public funds allocated to health					Deciding resource allocation between sectors of care									Determining resource allocation between regions							Setting remuneration methods for physicians								Defining payment methods for hospitals								
	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Other	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Other	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Other
Australia	X	X							X	X							X	X	X					X							X	X						X	X	X			X	X	X		X	X						
Austria									X	X							X	X	X	X		X	X	X	X	X					X	X	X	X									X	X	X	X	X	X	X	X				
Belgium	X	X								X								X			X		X			X	X	X				X										X	X	X			X						
Canada	X	X	X														X	X	X					X	X						X	X	X							X				X				X						
Czech Republic		X								X													X			X	X																X	X	X						X	X	X	
Denmark	X																X			X		X	X	X	X						X								X	X				X			X	X						
Finland	X			X					X											X					X			X		X											X			X	X				X						
France	X	X							X								X					X										X							X			X					X							
Germany	X								X									X					X									X												X			X							
Greece		X								X				X				X														X												X			X							
Hungary	X								X								X					X																	X									X							
Iceland	X								X									X					X									X								X								X							
Ireland	X	X							X	X							X	X					X							X(1)							X(1)		X				X				X				X			X(1)
Italy	X		X															X	X				X	X								X															X	X						
Japan										X		X	X				X																												X		X							
Korea	X									X			X		X																								X			X		X			X			X		X		
Luxembourg													X																									X								X				X				
Mexico	X								X								X						X	X			X	X		X	X	X			X	X				X	X		X	X	X			X	X			X	X		
Netherlands	X	X							X	X				X			X	X				X	X				X									X		X	X							X	X							
New Zealand	X								X								X							X							X								X										X						
Norway	X								X								X					X								X								X										X							
Poland	X								X								X	X	X	X			X		X	X					X	X						X	X						X					X					
Portugal		X							X								X						X								X	X							X						X			X							
Slovak Republic	X								X									X								X	X								X						X					X					X			
Spain																			X					X								X								X									X						
Sweden		X	X	X					X	X	X	X					X	X	X	X				X								X													X			X	X						
Switzerland			X								X			X																								X								X								
Turkey	X	X							X	X							X	X					X									X								X								X			X				
United Kingdom	X	X	X						X	X	X						X	X	X				X	X				X				X	X							X	X							X	X						

Note (1): In Ireland, the HSE is an independent statutory body set up under the Health Act 2004 to manage and deliver, or arrange to be delivered on its behalf, health and personal social services.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811047060050

Table 30. Responsibilities in decision-making (Q68) (cont.)

Country	Financing new hospital building							Financing new high-cost equipment							Financing the maintenance of existing hospitals							Financing primary care services								Financing specialists in out-patient care							Financing hospital current spending							Setting public health objectives								
	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Other	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Parliament	Central/federal gov.	Regional/state gov.	Local/municipal gov.	Collective social health ins.	Individual health ins.	Collective providers	Individual providers	Other
Australia	X	X					X	X	X					X	X	X					X	X	X							X	X						X	X			X		X		X	X							
Austria		X							X							X										X								X			X	X	X	X			X		X	X			X			
Belgium	X	X						X						X	X						X				X		X						X		X		X			X				X	X	X						
Canada		X	X			X			X	X			X	X		X				X			X			X					X				X			X				X			X	X	X			X	X	
Czech Republic	X	X	X			X	X	X	X	X				X	X	X	X		X			X			X	X			X				X	X			X					X	X		X	X	X					
Denmark	X		X					X		X					X		X					X		X					X		X						X		X						X							
Finland			X				X			X				X			X				X			X							X								X					X	X		X					
France				X							X							X							X								X							X				X								
Germany		X												X				X							X								X							X							X					
Greece	X							X						X	X						X	X				X				X				X			X				X											
Hungary	X							X								X	X					X		X	X					X		X																				
Iceland	X														X							X		X						X						X	X						X	X							X		
Ireland	X							X						X	X							X						X	X(1)							X	X															X(1)
Italy	X	X						X	X						X	X						X								X	X						X	X						X									
Japan	X	X					X	X	X					X	X	X					X				X								X							X					X		X	X					
Korea					X							X							X							X								X							X				X								
Luxembourg	X										X							X							X								X							X			X	X								
Mexico	X	X		X	X			X	X		X	X			X	X		X	X			X	X		X	X			X	X			X	X			X	X			X	X		X	X							
Netherlands							X							X							X					X								X									X	X	X							
New Zealand(*)	X	X						X	X							X						X									X							X							X								
Norway		X							X							X								X							X							X						X								
Poland	X	X	X			X	X	X	X	X			X	X	X	X	X			X	X				X								X							X					X	X	X						
Portugal	X							X	X						X	X						X	X						X	X							X	X							X								
Slovak Republic						X							X							X						X								X							X			X	X	X	X			X	X	
Spain		X							X							X							X								X							X								X						
Sweden	X	X						X	X							X							X								X							X														
Switzerland		X	X				X		X	X				X		X	X				X					X								X				X	X		X				X	X						
Turkey	X							X							X							X								X			X				X			X				X								
United Kingdom	X	X					X	X	X					X	X	X					X	X	X					X		X	X					X	X	X					X		X	X						

Note: (*) For public hospitals only.

Note (1): In Ireland, the HSE is an independent statutory body set up under the Health Act 2004 to manage and deliver, or arrange to be delivered on its behalf, health and personal social services.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811047060050

4.2 Definition of health care budget and pressure for cost-containment

208. Information on the *nature of budget constraint* (expenditure target or fixed budget) and on the *consequences of past budget constraints* were collected through question 69. A few countries set a strict budget constraint and further allocate funds to regions and to sectors of care (Norway, New Zealand, Poland, Portugal, Sweden[18] and the United Kingdom). Italy, Ireland and Hungary also set strict budget constraints, with further regional allocation for Italy and Ireland, and allocation between sectors of care for Hungary.

209. A majority of countries (15) set health expenditure targets. Most often, those targets are further divided by sector of care (ambulatory, inpatient, pharmaceuticals). In Spain, regions set their own targets, which can theoretically not be exceeded, but in practice usually are. In Mexico, the national expenditure target is divided by sector and region. In Canada, provincial and territorial governments set targets for health expenditures for their own jurisdiction. Budgets for physicians' services are generally separated from hospital and community health services budgets. In social insurance systems, health expenditure targets are defined in relation to expected revenues from social contributions. In the Czech Republic, health insurance funds' business plans have to be balanced and must be approved by the Parliament. In France, the Parliament also approves expenditure targets, which may however exceed expected resources –thus increasing deficits. For Mexico, though no overall macro-budget is defined annually, the Congress sets limits on government spending on health. Social security institutions also set prospective budgets in relation to expected contributions and federal allocations.

210. Only four countries indicated that no prospective budget or target was defined: Austria, Japan, Korea, and Switzerland. Japan nevertheless mentioned the existence of 5-year strategic plans, with projections of health expenditures and targets in relation to health policies. In Switzerland, some cantons set budget envelopes for hospital care and reduce their participation to the cost of hospitalisation beyond a certain volume of care. In addition, insurers and physician associations sign agreements on expected volumes of care, according to which overall costs of physician services are monitored and measures can be taken to limit spending growth if necessary.

18. In Sweden, budget constraints are defined by county councils and not by central government.

Table 31. Nature and stringency of the budget constraint (Q69)

Country	Q69. Budget constraint defined annually for public spending at macro-level?	Q69b. Target is further divided in sub-targets	Q69b. Which criteria?
Australia	Yes, target with possible overshooting	for different health services	
Austria	No		
Belgium	Yes, target with possible overshooting	for different health services	
Canada	Yes, target with possible overshooting	for different health services, by region/sector	
Czech Republic	Yes, target with possible overshooting	for different health services	
Denmark	Yes, target with possible overshooting	for different health services	
Finland	Yes, target with possible overshooting	for different health services	
France	Yes, target with possible overshooting	for different health services	
Germany	Yes, target with possible overshooting	for different health services	
Greece	Yes, target with possible overshooting	for different health services	
Hungary	Yes, strict health budget	for different health services	
Iceland	Yes, target with possible overshooting	for different health services	
Ireland	Yes, strict health budget	by region/sector	historic costs for the area
Italy	Yes, strict health budget	by region/sector	population adjusted for demographic characteristics
Japan	No		
Korea	No		
Luxembourg	Yes, target with possible overshooting		
Mexico	Yes, target with possible overshooting	for different health services, by region/sector	historic costs for the area
Netherlands	Yes, target with possible overshooting	for different health services	
New Zealand	Yes, strict health budget	for different health services, by region/sector	population adjusted for demographic characteristics and for morbidity/mortality data, inequalities
Norway	Yes, strict health budget	for different health services, by region/sector	population adjusted for demographic characteristics and for morbidity/mortality data Education level Degree of decentralisation
Poland	Yes, strict health budget	for different health services, by region/sector	population adjusted for demographic characteristics
Portugal	Yes, strict health budget	for different health services, by region/sector	population adjusted for demographic characteristics
Slovak Republic	Yes, target with possible overshooting	for different health services	
Spain	Yes, target with possible overshooting	by region/sector	historic costs for the area, population adjusted for demographic characteristics
Sweden	Yes, strict health budget	for different health services, by region/sector	historic costs for the area, population adjusted for demographic characteristics, for morbidity/mortality data and for consumption of health services
Switzerland	No		
Turkey	Yes, target with possible overshooting	for different health services	
United Kingdom	Yes, strict health budget	for different health services, by region/sector	historic costs for the area, population adjusted for demographic characteristics and for morbidity/mortality data

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811071238407

211. Questions 70 and 71 explored the consequences of overshooting spending targets and cost-pressures from the past five years. Eleven countries reported an increase in budget deficits and nine an increase in taxes, social contributions or insurance premiums. Eighteen countries implemented cost-containment policies over this period (Table 32).

212. In a few countries however, this period was not characterised by tight budget constraints. In New Zealand, for instance, the strong fiscal position and relatively low level of debt allowed increases in health expenditures above the historical growth trend.

213. The most frequently reported consequences of cost pressures were the increase of out-of-pocket payments and user fees (15 countries) and increases in health care institutions' deficits (11 countries). Nine countries reported delisting of goods of services from the health benefit package. Seven countries reported increased waiting times in at least one of the following categories: appointment with a GP, appointment with a specialist, diagnostic care and elective surgery. Six countries mentioned partial refunds from health care providers and/or the pharmaceutical industry to health insurance funds or the government (Belgium, France, Hungary, Italy, the Netherlands, and Portugal). The Netherlands and Ireland also reported a reduction in physician fees (table 32).

214. This question provided limited information about the stringency of budget constraint since the question was limited to changes in the past five years. For instance, the budget constraint could be very strict in a given country and patients may experience waiting times, without deterioration in the past five years.

Table 32. Consequences of reaching health expenditure targets in the past five years (Q70, Q71)

	Q70. Consquences of reaching spending target			Q71. Consequences of cost-containment pressure										
Country	Bugdet deficit created or increased	Social contributions, premiums or taxes increased	Cost-containment policies implemented	Increased waiting time for appointements with a PCP	Increased waiting time for appointements with a specialist	Increased waiting time for diagnostic care	Increased waiting time for elective surgery	Delisting of medical goods and services	Increase in patients'OOP payments or users' fees	Implementation of policies to promote purchase of private/voluntary health insurance	Increase in health care institutions' deficits	Reduction in physicians' fees	Partial refund to health insurance or the NHS from the pharmaceutical industry	Partial refund to health insurance or the NHS from health providers
Australia			X				X			X				
Austria		X			X				X		X			
Belgium			X					X	X				X	X
Canada		X						X			X			
Czech Republic	X	X			X	X	X	X	X		X			
Denmark														
Finland		X	X						X					
France	X		X					X	X		X			X
Germany			X					X	X					
Greece	X								X		X			
Hungary	X		X		X	X	X				X			X
Iceland			X	X					X		X			
Ireland			X						X	X		X		
Italy	X	X	X		X	X	X	X	X		X			X
Japan														
Korea		X						X						
Luxembourg		X	X					X	X					
Mexico	X		X											
Netherlands	X	X	X									X	X	X
New Zealand			X											
Norway			X								X			
Poland		X	X		X	X	X							
Portugal			X						X					X
Slovak Republic	X								X					
Spain	X										X			
Sweden	X		X						X					
Switzerland									X		X			
Turkey	X		X					X		X				
United Kingdom														

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811072053114

4.3 Priority setting and public health targets

215. The questions about *priority setting* collected information on three institutional characteristics: the use of health technology assessment (HTA), the definition of the health benefit basket, and the specification and monitoring of public health objectives.

4.3.1 The use of health technology assessment

216. The survey intended to collect a minimum set of information on the effective use of health technology assessment in decision-making. This information is not specific enough to obtain a sound understanding of the role of health technology assessment in health systems. However, it provides some indications on the existence of capacity for technology assessment (HTA) and the role of HTA in decisions pertaining to coverage and price setting, and as a tool to establish practice guidelines.

217. All but five countries (the Czech Republic, Greece, Luxembourg, the Slovak Republic and Turkey), reported the existence of structures or capacities for health technology assessment. However, HTA capacities vary widely across countries (Sorenson *et al.*, 2007; Velasco-Garrido *et al.*, 2008). In Canada, for instance, a national HTA agency was established in 1990, three provinces have HTA units (Alberta, Ontario and Quebec) and several national or provincial organisations conduct HTA activities. In Switzerland, by contrast, a single commission is in charge of providing advice on the coverage of new or contested medical procedures by health insurance funds.

218. All countries using HTA other than France take into account cost-effectiveness and affordability in health technology assessment.

219. Most countries reported that HTA is used to determine the coverage of medical procedures, medicines and high cost-equipments. In Iceland and Ireland, HTA is only used to determine coverage of pharmaceuticals. Many countries indicated that HTA results are also taken into account to establish reimbursement prices, especially for drugs. Finally, in a majority of countries, HTA is also used to produce clinical guidelines.

Table 33. Use of HTA (Q62)

Country	Structure and capacity for health technology assessment	Cost-effectiveness and affordability taken into account in HTA	New medicine			New procedure			New high-cost equipment		
			Coverage	Reimbursement or price	Guidelines	Coverage	Reimbursement or price	Guidelines	Coverage	Reimbursement or price	Guidelines
Australia	Yes	Yes	X	X	X	X	X	X	X	X	X
Austria	Yes	Yes	X	X							
Belgium	Yes	Yes	X	X	X	X		X	X		
Canada	Yes	Yes	X	X	X				X	X	X
Czech Republic	No	-									
Denmark	Yes	Yes	X	X	X	X	X	X	X	X	X
Finland	Yes	Yes	X	X	X			X			
France	Yes	No	X	X		X	X		X		X
Germany	Yes	n.a.									
Greece	No	-									
Hungary	Yes	Yes	X			X			X		X
Iceland	Yes	n.a.	X								
Ireland	Yes	Yes	X								
Italy	Yes	n.a.									
Japan	Yes	Yes	X	X		X	X		X	X	
Korea	Yes	Yes	X	X		X					
Luxembourg	No	-									
Mexico (1)	Yes	Yes	X	X	X	X		X	X		X
Netherlands	Yes	Yes	X	X	X	X	X	X	X	X	X
New Zealand	Yes	Yes	X	X	X	X			X	X	
Norway	Yes	Yes	X		X	X		X	X		X
Poland	Yes	Yes	X	X		X		X	X		
Portugal	Yes	Yes	X	X	X			X			X
Slovak Republic	No	-									
Spain	Yes	Yes		X		X		X	X		X
Sweden	Yes	Yes	X	X	X						
Switzerland	Yes	Yes	X			X					
Turkey	No	-									
United Kingdom	Yes	Yes	X					X			X

Note (1): In Mexico, the use of HTA is yet limited.

Note: n.a. means Not Available; "-" Not Applicable.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811076021764

4.3.2 The definition of the health benefit basket

220. The section concerning the *definition of the health benefit basket* summarises country approaches in defining the range of pharmaceuticals and medical procedures covered by basic primary health insurance. The so-called "health benefit basket" can either by implicitly defined, by vague formulas such as "all necessary medical services" or explicitly defined through positive or negative lists, including all goods and services which are respectively covered or not covered by basic primary health insurance.

221. ***For medical procedures***, 12 countries define the benefit basket covered by basic insurance by a positive list established at the central level, among which 9 are health insurance systems (Belgium, France, Japan, Korea, Luxembourg, Mexico, the Netherlands, Poland and the Slovak Republic) and three national health systems (Australia, Italy and Spain). Four countries define the benefit basket by listing procedures excluded from the benefit package at the central level (the Czech Republic, Germany, Switzerland and the United Kingdom). In Greece, health insurance funds establish their own positive lists. Finally, 13 countries do not explicitly define the benefit package (Table 34).

222. *For pharmaceuticals*, 25 countries establish positive lists at the central level. Only Germany and the United Kingdom define the benefit package for pharmaceuticals only by negative lists. The Czech Republic, the Slovak Republic and Iceland, establish both positive and negative lists at the central level. In Canada, pharmaceuticals are not included among the insured benefits guaranteed by the Canadian Health Care Act. Consequently, provincial and federal drug plans, which cover specific population groups, develop their own formularies (positive lists). Private insurers usually have "open" formularies. Greece is the only country with no positive or negative lists for pharmaceuticals (Table 34).

223. Mexico has a very specific profile due its pluralistic system of coverage. For medical procedures performed in the public system, social security funds do not define the benefit basket, which is nevertheless constrained by resource availability, while the *Seguro Popular* establishes a positive list of covered procedures. For pharmaceuticals, a positive list of products that can be purchased by public institutions is defined at the central level but public providers are not obliged to purchase all medications included in this list and usually establish their own formularies (Table 34).

Table 34. Definition of the health benefit basket (Q72)

	Q72. Definition of the benefit basket for medical procedures:						Q72. Definition of the benefit basket for pharmaceuticals:					
Country	A positive list is established at the central level	A negative list is established at the central level	Individual health insurance funds establish their own positive lists	Individual health insurance funds establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The benefit basket is not defined	A positive list is established at the central level	A negative list is established at the central level	Individual health insurance funds establish their own positive lists	Individual health insurance funds establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The benefit basket is not defined
Australia	X						X					
Austria						X	X					
Belgium	X						X					
Canada						X			X			
Czech Republic		X					X	X				
Denmark						X	X					
Finland						X	X					
France	X						X					
Germany		X						X				
Greece			X									X
Hungary						X	X					
Iceland						X	X	X				X
Ireland						X	X					
Italy	X						X					
Japan	X						X					
Korea	X						X					
Luxembourg	X						X					
Mexico	X					X	X		X			
Netherlands	X						X					
New Zealand						X	X					
Norway						X	X					
Poland	X						X					
Portugal						X	X					
Slovak Republic	X						X	X				
Spain	X						X					
Sweden						X	X					
Switzerland		X					X					
Turkey						X	X					
United Kingdom		X						X				

Source: OECD Survey on health system characteristics 2008-2009 and OECD estimates.

StatLink http://dx.doi.org/10.1787/811081306278

224. Ten countries reported the use of three proposed criteria in decisions pertaining to the coverage of both medical procedures and pharmaceuticals, clinical effectiveness, cost-effectiveness and affordability or budget impact (Table 35).

225. First of all, the meaning of each criteria needs to be clarified. "Clinical effectiveness" refers to the assessment of the risk-benefit ratio of medical procedures or medicines. In all OECD countries, pharmaceutical products have to obtain a marketing authorisation to enter markets, which is not the case of medical procedures. Traditionally, the latter have been performed on the basis of professional judgement and experience, without formal assessment of their risk-benefit ratio by HTA agencies. The development of HTA has led several countries to include the formal assessment of new medical procedures in the decision-making process for coverage decisions. However, in general, the bulk of medical procedures has not been assessed, and probably do not need to be, since long experience appears to have guaranteed favourable risk-benefit ratios. The picture for pharmaceuticals is different: the licensing process is already a guarantee of clinical effectiveness. Still, several countries include "clinical effectiveness" among the criteria to define health benefit baskets. For both procedures and pharmaceuticals, this criteria can serve two purposes: to assess whether "benefits" deserve collective funding by basic primary health insurance (for instance, drugs just improving the comfort of patients with minor ailments can be excluded from basic benefits) or to assess whether a procedure/product brings more benefits than competing alternatives (comparative effectiveness assessment).

226. Cost-effectiveness assessment puts costs and benefits in perspective and can be used to inform coverage decisions (or establish clinical guidelines). Most often, cost-effectiveness is assessed by comparison with therapeutic alternatives and the consideration of *incremental* costs and benefits. In some countries, cost-effectiveness thresholds are defined or implicitly used, beyond which procedures or products are not covered (for instance the United Kingdom and Sweden).

227. Affordability or budget impact is generally included in the economic evaluation of health care strategies. Though this criteria has certainly played an important role in many health systems in the past, its explicit and transparent consideration is quite recent. Ten countries do not explicitly consider affordability in coverage decisions: Austria, the Czech Republic, Denmark, France, Germany, Italy, Portugal, Spain, Sweden, and Switzerland although this probably does not mean that affordability is not an issue for all these countries. By contrast, affordability is mentioned as the single criteria for reimbursement decisions in Greece (where funds define the benefits they cover according to available resources), Ireland, Turkey, and New Zealand for new medical procedures.

Table 35. Criteria taken into account in the definition of the benefit basket (Q73)

Country	Criteria taken into account in the definition of the basic benefit basket	
	Medical procedures	Pharmaceuticals
Australia	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Austria		Clinical effectiveness, Cost-effectiveness,
Belgium	Clinical effectiveness Affordability or budget impact	Cost-effectiveness, Affordability or budget impact
Canada	Clinical effectiveness	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Czech Republic	Clinical effectiveness	Clinical effectiveness, Cost-effectiveness
Denmark	Clinical effectiveness	Clinical effectiveness, Cost-effectiveness
Finland		Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
France	Clinical effectiveness	Clinical effectiveness
Germany	Clinical effectiveness, Cost-effectiveness	Clinical effectiveness, Cost-effectiveness
Greece	Affordability or budget impact	Affordability or budget impact
Hungary		
Iceland	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Ireland	Affordability or budget impact	
Italy	Clinical effectiveness	Clinical effectiveness
Japan	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Korea	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Luxembourg	Clinical effectiveness Affordability or budget impact	Clinical effectiveness
Mexico	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Netherlands	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
New Zealand	Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Norway	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Poland	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Portugal	Cost-effectiveness	Cost-effectiveness,
Slovak Republic	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact
Spain	Clinical effectiveness	Clinical effectiveness
Sweden		Cost-effectiveness
Switzerland	Clinical effectiveness, Cost-effectiveness,	Clinical effectiveness, Cost-effectiveness,
Turkey	Affordability or budget impact	Affordability or budget impact
United Kingdom	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact	Clinical effectiveness, Cost-effectiveness, Affordability or budget impact

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811083816525

4.3.3 The definition of public health objectives

228. Setting public health objectives, or health targets, is another way of prioritising investments in the health sector. Health targets can be set under different forms: process (e.g. increase vaccination rate), health outcomes (e.g. reduce cancer mortality by 20%), or reduction of social or geographical health inequalities. Countries can set a reduced number of broad targets or a wide range of targets. For instance, France defined a set of 100 health targets in the 2003 Public Health Act.

229. The questions on the *definition and monitoring of public health objectives* investigated whether the objectives are set and effectively monitored by one or several institutions and whether someone is held responsible for their attainment.

230. Most countries have public health objectives with the exceptions of Belgium, Greece, Luxembourg and the Netherlands. Countries most often define several types of targets, which are in general monitored by Parliament and/or central government.

Table 36. Definition and monitoring of public health objectives (Q74)

Country	Public health objectives	Set in terms of:	Monitored by:	Anyone held responsible if objectives not met
Australia	Yes	process, outcomes, reduction of inequalities	Parliament, central government, independent agency	Yes
Austria	Yes	process, outcomes, reduction of inequalities	not monitored	No
Belgium	No	-	-	-
Canada	Yes	outcomes, reduction of inequalities	central government	Yes
Czech Republic	Yes	process	central government	Yes
Denmark	Yes	process	Parliament, central government	Yes
Finland	Yes	process, outcomes, reduction of inequalities	central government	No
France	Yes	process, outcomes, reduction of inequalities	Parliament, independent agency	Yes
Germany	Yes	outcomes	insurance funds	No
Greece	No	-	-	-
Hungary	Yes	process, outcomes, reduction of inequalities	central government	Yes
Iceland	Yes	process, outcomes, reduction of inequalities	central government	No
Ireland	Yes	process, outcomes	Parliament, central government, independent agency	Yes
Italy	Yes	process	central government	Yes
Japan	Yes	process, outcomes, reduction of inequalities	central government	Yes
Korea	Yes	process	central government, insurance funds	No
Luxembourg	No	-	-	-
Mexico	Yes	process, outcomes	Parliament, central government	Yes
Netherlands	No	-	-	-
New Zealand	Yes	process, outcomes, reduction of inequalities	Parliament, central government	Yes
Norway	Yes	process, outcomes, reduction of inequalities	Parliament, central government	Yes
Poland	Yes	process, outcomes, reduction of inequalities	central government	Yes
Portugal	Yes	process, outcomes, reduction of inequalities	central government	Yes
Slovak Republic	Yes	process, outcomes, reduction of inequalities	Parliament, central government	Yes
Spain	Yes	process	central government	No
Sweden	Yes	process	central government	No
Switzerland	Yes	process, outcomes, reduction of inequalities	central government	Yes
Turkey	Yes	process, outcomes, reduction of inequalities	central government	Yes
United Kingdom	Yes	process, outcomes, reduction of inequalities	Parliament, central government, independent agency	Yes

Note: "-" means Not Applicable

Source: OECD Survey on health system characteristics 2008-2009

StatLink http://dx.doi.org/10.1787/811135151520

4.4 Patient's rights and involvement in health care systems

231. The section on patients' rights and involvement included questions about the existence of a national definition of patients' rights (Question 75); the possibilities to seek redress in court and the types of damage awards patients can obtain (Question 78); the possibility to engage in class action suits against health providers (Question 80) and the existence of an Ombudsman for health matters (Question 80). Public participation was approached by a question (Q77) exploring the formal role of patient or public representatives in several processes (licensing of pharmaceuticals, health technology assessment, hospital planning, and definition of public health objectives). Table 37 summarises country replies.

4.4.1 Patient rights

230. The vast majority of OECD countries declared that a formal definition of patients' rights exist at the national level. Only Canada, Ireland, Sweden and Switzerland reported no such provision.

231. Hospitals are required to have a patient desk to register patients' complaints in a majority of countries (19). By contrast, Austria, Belgium, Canada, Germany, Norway, Poland, Sweden and Switzerland do not impose such obligations on hospitals.

232. The vast majority of OECD countries reported the existence of an Ombudsman in charge of investigating and resolving patients' complaints about health services. Only Denmark, Japan, Korea, the Netherlands and Turkey do not have this type of mediation.

4.4.2 The tort system and the possibility to engage class actions

233. In all countries but Finland, Iceland, New Zealand and the Slovak Republic, patients can seek redress in courts in case of medical errors. In all those countries, medical error has to be proven to obtain reparation, except in the case of Denmark, where health providers' liability does not have to be proven to grant indemnification to the victim; it can be "presumed" if there is an obvious link of causation between an event (e.g. medical act) and an effect (the injury).

234. There is a basis for "no fault compensation" in nine countries: Austria, Denmark, Finland, France, Iceland, Mexico, New Zealand, Norway and Sweden. This means that providers' liability is not a pre-condition for granting indemnification to the injured patient. Patients may obtain compensation when the adverse outcome was not predictable according to the state of medical knowledge, for instance. In all countries, both economic and non-economic losses (such as pain, discomfort) can be compensated.

235. Patients can engage in class actions against health providers or pharmaceutical companies in fourteen countries: Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Japan, Norway, Poland, Portugal, Spain, Sweden, Turkey and the United Kingdom.

4.4.3 Patients' representation and involvement in decision-making

237. Patients' representation in decision–making is still the exception in OECD countries. Patients are represented in decisions pertaining to the licensing of pharmaceuticals only in the Czech Republic, Denmark and Sweden. They are represented in decisions relating to the coverage of health services in Australia, Canada, the Czech Republic, Denmark, Korea, the Netherlands, Switzerland and Turkey and in health technology assessment bodies in Australia, Denmark, Korea, Norway and the United Kingdom. Patient representatives are involved in hospital planning in Denmark, Iceland, Norway and the United Kingdom and in the definition of public health objectives in Denmark, France (through regional consultations on public health), Hungary, Iceland, Mexico, Norway, Portugal, Turkey and the United Kingdom.

Table 37. Patient rights and involvement (Q75, Q76, Q78, Q80 and Q81)

Country	Q75. Is there any formal definition of patients' rights at the national level?	Q76. Are hospitals required to have a patient desk in charge of collecting and resolving patient complaints?	Q81. Are there any Ombudsmen in charge of investigating and resolving patients' complaints about health services?	Q.78 What is the type of the tort system in the country?			Q80. Can people engage in Class Action suits against health providers, pharmaceutical companies, etc.?
				Patient can seek redress in courts in the case of medical error	There is a basis for no fault compensation	If a tort system exists, can patients obtain damage awards for:	
Australia	yes	yes	yes	yes (medical error has to be proven)	no	economic & non-economic losses	yes
Austria	yes	no	yes	yes(medical error has to be proven)	yes	economic & non-economic losses	yes
Belgium	yes	no	yes	yes(medical error has to be proven)	no	economic & non-economic losses	yes
Canada	no	no	yes	yes(medical error has to be proven)	no	economic & non-economic losses	yes
Czech Republic	yes	yes	n.a.	yes(medical error has to be proven)	no	economic & non-economic losses	yes
Denmark	yes	yes	no	yes(medical error can be presumed)	yes	economic & non-economic losses	yes
Finland	yes	yes	yes	no	yes	economic & non-economic losses	no
France	yes	yes	yes	yes(medical error has to be proven)	yes	economic & non-economic losses	no
Germany	yes	no	yes	yes(medical error has to be proven)	no	economic & non-economic losses	n.a.
Greece	yes	n.a.	yes	yes(medical error has to be proven)	no	economic & non-economic losses	n.a.
Hungary	yes	yes	yes	yes(medical error has to be proven)	no	economic & non-economic losses	n.a.
Iceland	yes	yes	yes	no	yes	economic & non-economic losses	no
Ireland	no	yes	yes	yes(medical error has to be proven)	no	economic & non-economic losses	no
Italy	yes	yes	n.a.	yes(medical error has to be proven)	no	economic & non-economic losses	no
Japan	yes	yes	no	yes(medical error has to be proven)	no(1)	economic & non-economic losses	yes
Korea	yes	yes	no	yes(medical error has to be proven)	no	economic & non-economic losses	no
Luxembourg	yes	yes	yes	yes(medical error has to be proven)	no	economic & non-economic losses	no
Mexico	yes	yes	yes	yes(medical error has to be proven)	yes	economic & non-economic losses	no
Netherlands	yes	yes	no	yes(medical error has to be proven)	no	economic & non-economic losses	n.a.
New Zealand	yes	yes	yes	no	yes		no
Norway	yes	no	yes	yes(medical error has to be proven)	yes	economic & non-economic losses	yes
Poland	yes	no	yes	yes(medical error has to be proven)	no	economic & non-economic losses	yes
Portugal	yes	yes	yes	yes(medical error has to be proven)	no	economic & non-economic losses	yes
Slovak Republic	yes	n.a.	n.a.	no	no		n.a.
Spain	yes	yes	yes	yes(medical error has to be proven)	no	economic & non-economic losses	yes
Sweden	no	no	yes	yes(medical error has to be proven)	yes	economic & non-economic losses	yes
Switzerland	no	no	yes	yes(medical error has to be proven)	no	economic & non-economic losses	no
Turkey	yes	yes	no	yes(medical error has to be proven)	no	economic & non-economic losses	yes
United Kingdom	yes	yes	yes	yes(medical error has to be proven)	no	economic & non-economic losses	yes

Note (1): Since 2009, such compensation exists for babies that suffer from cerebral palsy following delivery.

Note: n.a. means Not Available.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811135567277

Table 37. Patient rights and involvement (Q77) (cont.)

Country	Q77. Is there a formal role for patient representatives in decision-making in:					
	Licensing of pharma-ceuticals?	Coverage or reimbur-sment?	Health technology assessment?	Decisions relating to hospital planning	Definitions of public health objectives?	Other?
Australia	no	yes	yes	no	no	no
Austria	no	no	no	no	no	yes
Belgium	no	no	no	no	no	no
Canada	no	yes	no	no	no	no
Czech Republic	yes	yes	no	no	no	no
Denmark	yes	yes	yes	yes	yes	no
Finland	no	no	no	no	no	no
France	no	no	no	no	yes	no
Germany	no	no	no	no	no	no
Greece	no	no	no	no	no	no
Hungary	no	no	no	no	yes	no
Iceland	no	no	no	yes	yes	no
Ireland	no	no	no	no	no	no
Italy	no	no	no	no	no	no
Japan	no	no	no	no	no	no
Korea	no	yes	yes	no	no	no
Luxembourg	no	no	no	no	no	no
Mexico	no	no	no	no	yes(*)	yes(*)
Netherlands	no	yes	no	no	no	no
New Zealand	no	no	no	no	no	no
Norway	no	no	yes	yes	yes	yes
Poland	no	no	no	no	no	no
Portugal	no	no	no	no	yes	no
Slovak Republic	no	no	no	no	no	no
Spain	no	no	no	no	no	no
Sweden	yes	no	no	no	no	no
Switzerland	no	yes	no	no	no	no
Turkey	no	yes	no	no	yes	no
United Kingdom	no	no	yes	yes	yes	no

Note (*): In Mexico, strategies promoting an active patient participation are however very limited.

Note: n.a. means Not Available.

Source: OECD Survey on health system characteristics 2008-2009.

StatLink http://dx.doi.org/10.1787/811135567277

5 CONCLUSION

238. This paper presents an important set of information on health systems characteristics as reported by 29 member countries at the beginning of 2009. To our knowledge, this set of information is unique in scope. The OECD has decided to make it available to the research and policy-making communities to draw all possible benefits from the efforts undertaken by member countries who replied to the survey.

239. Though this information does not allow all specificities of complex health systems to be addressed, it helps to identify similarities and differences in their institutional setting. It forms the basis for future analytic work.

240. The OECD has already used this information to propose a set of approximately 20 standardised "institutional indicators" aimed at characterising health systems according to an overall framework designed by its Economic Department. These indicators have been used to explore the links between health systems efficiency and institutions. The results of this piece of work will be published in 2010.

6 ANNEXES

ANNEX 1. Questionnaire

OECD Health Committee Survey on Health System Characteristics

PART I. HEALTH FINANCING

Section 1. Characteristics of basic primary health care coverage
Section 2. Regulation of health insurance for basic primary health care coverage
Section 3. Other interventions of the public sector in health insurance markets
Section 4. Comprehensiveness of basic primary health care coverage
Section 5. Protection against excessive out-of-pocket expenditures
Section 6. Competition between health insurers offering basic primary health care coverage and consumer choice

A glossary of terms is available on the introductory web page of the questionnaire http://www.oecd.org/health/HSCsurvey. Words marked with an asterisk (*) are defined in this glossary.

Section 1. Characterisation of basic primary health care coverage.

Question 1. What share of the population obtains basic, primary health care coverage* through:

(%) population

- automatic coverage (tax-financed health system) ____%
- compulsory/mandatory coverage, linked to individual or household social contributions or premiums (which may benefit from tax-financed public subsidies, means-tested or not) ____%
- voluntary, linked to individual or household premiums (which may benefit from tax-financed public subsidies, means-tested or not) ____%
- not insured ____%

Comments/clarifications (if any):

Question 2. For the "typical" employed adult, is basic primary health care coverage* supplied:

- ☐ by national health service that covers the country as a whole
- ☐ by local health services that serve distinct geographic regions/areas (one single scheme in each region/state/canton)
- ☐ by a common health insurance scheme (single-payer model)
- ☐ by health insurers that serve distinct geographical regions/areas (one single insurer in each region/state/canton)
- ☐ by multiple insurance funds

Comments/clarifications (if any):

Question 2 (continued). For multiple insurance funds, 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.

Have major changes in basic primary health care coverage* occurred in the past 5 years? If so, please describe:

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

The following questions apply only to those countries featuring multiple insurers/funds. For questions 3-9 below: if a system has multiple coverage schemes (e.g., both social insurance and voluntary insurance providing basic primary health care coverage), the response should refer to the scheme under which the greatest number of people are covered.

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

- ☐ They are required to offer the same benefit package with the same level of coverage / copayment.
- ☐ 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 define freely the benefits they cover and the level of coverage.

Comments/clarifications (if any):

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

- ☐ Contributions/ premiums are defined by regulation with no possible variations at the scheme/fund level.
- ☐ Contributions/ premiums are defined by regulation with some (rather marginal) variations permitted at the scheme/fund level.
- ☐ Schemes/funds can define contributions/premiums within regulatory constraints.

If so, 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):

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

☐ Yes

If so, what are the main risk factors used in adjustment? (Check all that apply.)

- ☐ age
- ☐ gender
- ☐ health status
- ☐ 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.

Question 6. Restrictions and constraints on enrolment and contract renewal

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

☐ Yes

☐ No

Comments/clarifications (if any):

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

☐ Yes

☐ No

Comments/clarifications (if needed):

6c. Are there constraints on premium increases in the case of contract renewal?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Question 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):

Question 8. 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 (claim processing, patient satisfaction, etc…)
- ☐ Individual funds publish information
- ☐ Private organizations publish comparative standardized information on health insurance funds
- ☐ Public authorities publish comparative standardized information on health insurance funds

Comments/clarifications (if any):

Question 9. What is the share of the total insured population that switches insurers in a given year? ___(%)

Comments/clarifications (if any):

Have major changes in the regulation of basic primary health insurance markets occurred in the past 5 years? If so, please describe:

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

The following questions do not apply to systems with a national health service model of coverage.

Question 10. Does the government intervene to ensure the provision of basic primary health coverage or health care services for low-income or economically disadvantaged groups?

- ☐ Yes
- ☐ No

Question 10 (continued). 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 primary 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 programmes that subsidise public or private provision.
  If so, what is the share of the population entitled to such health care coverage through dedicated public health programs? ____%

- ☐ The public sector directly provides health care services to the poorest part of the population.
  If so, what share of the population uses publically provided health care services? ____(%)

Question 11. Does the government intervene to ensure the provision of basic primary coverage or ensure the provision of health care services to high-risk groups (seniors, disabled, people with chronic disease, etc.)?

- ☐ Yes
- ☐ No

Question 11 (continued). 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 primary health insurance.
- ☐ High-risk people are entitled to public health coverage through dedicated programmes that subsidise public or private provision.
- ☐ The public sector directly provides free health care services to high-risk people. (Please specify.)

Have major changes in public interventions geared toward health coverage for vulnerable or high-risk people occurred during the past 5 years? If so, please describe:

Section 4. Comprehensiveness of basic primary health care coverage

Please indicate below the rules applicable to adults covered by the main scheme of the "typical" insurance type.

Question 12. Is there a general deductible* that must be met before basic health insurance reimburses 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 health insurance 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):

Question 13a. Does basic primary health coverage (typically) fully or partially finance the services described in the table below? If so, please check the type of copayment applicable (check all that apply)

Note: Respondents may wish to refer to definitions in the OECD System of Health Accounts Manual.

	Typically not covered	Typically covered without cost-sharing	Typically covered with cost-sharing with deductible*	Typically covered with cost-sharing with flat copayment*	Typically covered with cost-sharing with co-insurance*
Acute inpatient care					
Outpatient primary care physician* contacts					
Outpatient specialist contacts					
Clinical laboratory tests					
Diagnostic imaging					
Physiotherapist services					
Pharmaceuticals					
Eyeglasses and/or contact lenses					
Dental care					
Dental prostheses					

Comments/clarifications (if any):

Question 13b. For each type of service, what is the share of typical costs covered by basic primary insurance?

	less than 50%	51-75%	76-99%	100%
Acute inpatient care				
Outpatient primary care physician* contacts				
Outpatient specialist contacts				
Clinical laboratory tests				
Diagnostic imaging				
Pharmaceuticals				
Eyeglasses and/or contact lenses				
Dental care				
Dental prostheses				

Comments/clarifications (if any):

Question 14. With regards to pharmaceutical coverage, check all that apply:

- ☐ Prescription medicines approved for marketing as safe and effective are automatically covered.
- ☐ Prescription medicines approved for marketing are covered unless placed on a negative list (due to a judgement regarding relative effectiveness or cost-effectiveness, for example).
- ☐ Only those products selected for inclusion on a positive list or formulary are covered. The positive list is rather comprehensive.
- ☐ Only those products selected for inclusion on a positive list or formulary are covered. The positive list is rather selective.
- ☐ Over-the-counter medicines are usually covered when prescribed by a physician.
- ☐ Over-the-counter medicines are usually not covered.

Comments/clarifications (if any):

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

Question 15. Do people usually:

- ☐ Pay the full cost of health services and get reimbursed for covered services afterwards.
- ☐ Receive free services at the point of care and pay only user fees or copayments.

Comments/clarifications (if any):

Question 16. Are there partial or total exemptions from copayments for some segments of the population?

- ☐ Yes

  If so, check all partial or total exemptions from copayments that exist.

  - ☐ for those with certain medical conditions or disabilities
  - ☐ for those whose income are under designated thresholds

    If so, what is the income threshold for partial or total exemption from copayments? ____
  - ☐ for beneficiaries of social benefits
  - ☐ for seniors

    If so, at what age does one qualify for partial or total exemptions from copayments?
  - ☐ for children

    If so, what is the age limit for partial or total exemptions from copayments?
  - ☐ for pregnant women
  - ☐ for those who have reached an upper limit (or cap) for out-of-pocket payments

    If so, is the upper limit:

    - ☐ annual?
    - ☐ set for the lifetime?

    What is the upper limit/cap (in national currency units)? ____
  - ☐ other (specify)

- ☐ No

Question 17. What is the share (of the covered population) at least partially exempted from copayments? _____(%)

Question 18. Do exemption mechanisms most often:

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

Comments/clarifications (if any):

Question 19. What is the share of households exposed to catastrophic health expenditures* in one year? _____(%)

**Catastrophic expenditure is defined by out-of-pocket payments greater than or equal to 40% of a household's non-subsistence income, i.e. income available after basic needs (other than health care) have been met.*

Comments/clarifications (if any):

Question 20. 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):

Question 21. Are private insurers allowed to sell coverage for the following?

	Yes	No
Cost-sharing for health goods and services covered by basic primary coverage scheme(s),		
Goods and services included in the benefit package of basic primary coverage when provided by providers whose services are eligible for funding by basic primary coverage.		
Goods and services included in the benefit package of basic primary coverage when provided by providers whose services are not eligible for funding by basic primary coverage.		

Have major changes in copayment and/or exemption policies occurred in the past 5 years? If so, please explain.

Section 6. Competition between health insurers offering basic primary health care coverage and consumer choice

Question 22. A typical insurance customer has how many choices of health insurance plans?

- ☐ 1-2
- ☐ 3-5
- ☐ more than 5

Comments/clarifications (if any):

Question 23. What is the share of the basic primary health insurance market covered by:

	% market
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):

Question 24. What share of the market (% of covered population) is insured by:

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

Comments/clarifications (if any):

Question 25. Are health insurers allowed to:

	The practice is not allowed	The practice is allowed but rather marginally used by insurers/funds	The practice is allowed and widely used by insurers/funds
Select health care providers (include/exclude from coverage)			
Negotiate contracts with physicians (different from those used by other insurers) about prices, quantity and/or quality of health care services			
Negotiate with individual hospitals about prices, quantity and/or quality of health care services			
Negotiate with pharmaceutical companies to obtain discounts or rebates			

Comments/clarifications (if any):

Question 26. Relations between health insurers and insured people. Are health insurers allowed to:

- ☐ Require prior authorisation for certain services in order for them to be reimbursed
- ☐ Offer insurance plans with a restricted network of providers
  If so, what percentage of insured persons are enrolled in restricted network plans? ___ %
- ☐ Offer insurance plans requiring patients to follow specific care pathways (gatekeeping, disease management, etc…)
  If so, what percentage of insured persons are enrolled in managed care plans? _____%
- ☐ Offer several options of cost sharing levels in exchange for higher or lower premium
  If so, what percentage of insurers offer such options? (%) _____%
- ☐ Offer financial rewards (bonuses) to insured persons who do not claim any reimbursements within a given period of time?

Comments/clarifications (if any):

Have major changes in terms of health insurance market competition occurred in the past 5 years? If so, please describe.

PART II. HEALTH CARE DELIVERY

Section 1. Organisation of health care supply
Section 2. Payment of health care providers
Section 3. User choice and competition among providers
Section 4. Regulation of health care supply
Section 5. Regulation of prices/fees
Section 6. Regulation/monitoring of health providers activity
Section 7. Co-ordination of care

A glossary of terms is available on the introductory web page of the questionnaire http://www.oecd.org/health/HSCsurvey. Words marked with an asterisk (*) are defined in this glossary.

Section 1. Organisation of health care supply

Question 27. Are primary care services* provided predominately in:

- ☐ private clinics/health care centres
- ☐ private group practices
- ☐ private solo practice
- ☐ other

If there a second significant form of service provision (providing more than 20% of primary care services), please specify (using categories mentioned above). _____

Comments/clarifications (if any):

Question 28. Are ambulatory/outpatient specialists' services provided predominately in:

- ☐ private clinics/health care centres
- ☐ private group practices
- ☐ private solo practice
- ☐ hospitals
- ☐ other

If there is a second significant form of service provision (providing more than 20% of out-patient specialist services), please specify (using categories mentioned above) _____

Comments/clarifications (if any):

Question 29. Are medical doctors required to obtain a further qualification in addition to a basic medical degree in order to practice as a primary care physician*?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Question 30. What is the share of total acute-care hospital beds* that are in:

	(%)of total acute care beds
Publically owned hospitals	
Not-for-profit privately owned hospitals	
For-profit privately owned hospitals	

Comments/clarifications (if any):

Question 31. Is private practice in the public hospital setting allowed (check all that apply):

- ☐ Self-employed doctors are allowed to provide services in public hospitals.
- ☐ Salaried doctors are allowed to provide care to private patients in public hospitals.
- ☐ Public hospitals are exclusively used by publically employed doctors providing services to public patients.

Comments/clarifications (if any):

Question 32. What is the proportion of physicians of each type whose predominant employment status falls in each category below? (Total for each type of physicians should sum to 100%).

Physicians supplying primary care services*

	% of physicians
Self employed	____%
Publically employed	____%
Privately employed	____%

Physicians supplying out-patient specialist services (see below)

	% of physicians
Self employed	____%
Publically employed	____%
Privately employed	____%

Physicians supplying in-patient specialist services (see below)

	% of physicians
Self employed	____%
Publically employed	____%
Privately employed	____%

Note: If out-patient and in-patient specialist services are supplied by the same physicians in the same settings, respondents may choose to complete only one category and make a comment below.

Comments/clarifications (if any):

Have major changes in the manner of provision of health care services occurred during the past 5 years? If so, please describe.

Section 2. Payment of health care providers

Question 33. Please indicate the proportion of physicians who are remunerated by the following methods.

Physicians supplying primary care services*

	% of physicians
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	____%

Physicians supplying out-patient specialist services (see below)

	% of physicians
Salary	____%
Fee-for-service	____%
Mix of fee-for-service and salary	____%

Physicians supplying in-patient specialist services (see below)

	% of physicians
Salary	____%
Fee-for-service	____%
Mix of fee-for-service and salary	____%

Note: If out-patient and in-patient specialist services are supplied by the same physicians in the same settings, respondents may choose to complete only one category and make a comment below.

Comments/clarifications (if any):

Question 34. Can primary care physicians* get a payment bonus for the achievement of targets relating to the quality of care furnished (pay-for-performance)?

- ☐ Yes
  - If so, do targets typically relate to (check all that apply):
    - ☐ Preventive care (e.g. vaccination rate)
    - ☐ Management of chronic disease
    - ☐ Patient satisfaction
  - What is the proportion of primary care physicians who earn bonuses? _____(%)
  - For the primary care physicians that earn bonuses, what share of their revenues is represented by bonuses? _____(%)
- ☐ No

Comments/clarifications (if any):

Question 35. Can specialists get a payment bonus for the achievement of targets relating to the quality of care furnished (pay-for-performance)?

- ☐ Yes
  - If so, do targets typically relate to (check all that apply):
    - ☐ Preventive care (e.g. vaccination rate)
    - ☐ Management of chronic disease
    - ☐ Patient satisfaction
  - What is the proportion of specialists who earn bonuses? _____(%)
  - For the specialists that earn bonuses, what share of their revenues is represented by bonuses? _____(%)
- ☐ For the primary care physicians
- ☐ No

Comments/clarifications (if any):

Question 36. Will physician payments fall if they exceed established volume targets (e.g. number of prescriptions)?

- ☐ No
- ☐ Yes, physicians may have to refund expenditure excess to health insurance funds
- ☐ Yes, physician fee levels may be reduced

Comments/clarifications (if any):

Question 37. Please indicate the share in total payments to acute-care hospitals of each for the following modes of payment.

	Public or private not-for-profit hospitals (%)	Private for-profit hospitals (%)
Prospective global budget		
Line-item budgets		
Payment per case (DRG-type)		
Payment based on procedure or service		
Per diem		
Capitation		
Retrospective payments of all costs		

Comments/clarifications (if any):

Question 38. Can acute care hospitals get a payment bonus for the achievement of targets relating to the quality of care furnished (pay-for-performance)?

☐ Yes

If so, 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 (objective appreciation about waiting times, information given by medical staff, etc.)

What is the proportion of acute care hospitals which earn bonuses? _____(%)

For those hospitals earning bonuses, what is the share of their revenues represented by the bonuses? _____(%)

☐ No

Comments/clarifications (if any):

Have major changes in provider payment methods occurred during the past 5 years? If so, please describe:

Section 3. Users' choice and competition among providers

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

Question 39. Are patients generally free to choose a primary care physician*?

- ☐ Patients can choose any primary care physician and do not face incentives to choose any one over another
- ☐ Patients can choose any primary care physician but have financial incentives (e.g., reduced copayments) to choose certain providers
- ☐ The patient's choice is limited (e.g., to a geographical area, or to a network of providers)

Comments/clarifications (if any):

Question 40. Are patients required or encouraged to register with a primary care physician (i.e., committed to consult this primary care physician in case of need)?

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

Comments/clarifications (if any):

Question 41. Do primary care physicians control access to outpatient specialist care?

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

Comments/clarifications (if any):

Question 42. What is the proportion of specialists' visits that occur without primary care physician* referral? ____(%)
(Please exclude paediatricians, gynaecologists and ophthalmologists' visits from the total)

Comments/clarifications (if any):

Question 43. Are patients usually free to choose providers for out-patient specialist services?

- ☐ Patients can choose any specialist
- ☐ Patients can choose any specialist but have financial incentives (e.g. reduced copayments) to choose certain providers
- ☐ The patient's choice is limited (e.g., to a geographical area, or to a network of providers)

Comments/clarifications (if any):

Question 44. Are patients usually free to choose hospitals for in-patient care?

- ☐ Patient 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 which have signed specific contract with their insurer, etc.)
- ☐ The patient's choice is theoretically limited (e.g. to a geographical area) but may be expanded in certain circumstances (for instance, if waiting times are too long)
- ☐ The patient's choice is strictly limited (e.g. to a geographical area)

Comments/clarifications (if any):

Question 45. Are prices of specific services the same or different across providers?

- ☐ Health care services are free at the point of care or have prices that do not differ across providers, with no possible extra-billing.
- ☐ Prices paid by patients may differ from one provider to the other.

Question 45 (continued).
How available is information about the prices of physicians' consultations/visits?

- ☐ Information for price comparison is readily available (posted, communicated in advance)
- ☐ Patients generally do not know the price they will pay before meeting the doctor

How available is information about the price for medical exams, surgical procedures?

- ☐ Information for price comparison is readily available (posted, communicated in advance)
- ☐ Patients generally do not know the price they will pay before meeting the doctor

Question 46. Is there any comparable information published on the quality of services supplied by individual providers?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Have major changes in the choices available to patients and competition between providers occurred during the past 5 years? If so, please describe?

Question 46 (continued). If comparable information is published on the quality of services supplied by individual providers, please answer the following questions.

What type of information is available (check all that apply):

	physicians	hospitals
What type of information is available:		
Data on clinical outcomes (e.g. post-operative survival rates, rates of nosocomial infections)		
Data on the use of appropriate processes (e.g. % of people vaccinated, activities to prevent nosocomial infection, % of hip fractures treated within 48 hours)		
Data on patient satisfaction (subjective assessment of the quality of interpersonal interactions, the quality of care or of accommodation)		
Data on patient experiences (objective information about waiting times, information given by medical staff, etc)		
Is the information in a form that facilitates cross-provider comparisons (e.g. league tables)?		
Yes		
No		
Who develops and/or publishes such information:		
Government		
Insurers		
Media		
Other NGO's (non governmental organisations)		
Is there evidence that such information is used by prospective patients in selecting providers?		
Yes		
No		
Is there evidence that such information is used by providers in informing referrals?		
Yes		
No		

Comments/clarifications (if any):

Section 4. Regulation of health care supply

Question 47. Is there any quota for entry in initial education programmes for physicians or for the number of diplomas? (check all that apply)

- ☐ quotas for the total number of medical students
- ☐ quotas by speciality

Comments/clarifications (if any):

Question 48. Is there any regulation that restricts physicians in the location of their practices (relating to density, geographic proximity or other factors)?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Question 49. Is any policy in place to correct a perceived shortage in physician supply?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Question 50. Is any policy in place to correct a perceived misdistribution of physicians across geographic areas (e.g. rural/urban)?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Question 51. Does regulation differ for not-for-profit and for profit hospitals?

- ☐ Yes
- ☐ No

Comments/clarifications (if any):

Question 52. What kind of regulation applies to the following activities for the typical hospital (with the most common status)?

	There is no (capacity related) regulation, providers are free to establish and expand capacities	There are quotas/limits, established at the regional level	There are quotas/limits, established at the central level	Regional government authorities plan capacities (authorise each investment)	Central government authorities plan capacities (authorise each investment)
Open new hospitals or other institutions					
Increase/decrease supply of hospital beds					
The provision of specific types of hospital services (e.g. high-level cancer care, maternity)					
Supply of high-cost medical equipment (e.g. MRI, CT scanners, mammography machines)					

Question 52b. If providers are free to establish and expand capacities for high-cost medical equipments, do they face incentives to do so?

- ☐ Providers get financial incentives from national or regional authorities (e.g. subsidies)
- ☐ Providers do not get incentives from authorities, investments in such capacities is only a means to attract patients and/or physicians.
- ☐ Providers get other types of incentives from national or regional authorities, please specify:

Comments/clarifications (if any):

Question 53. What is the autonomy of hospital management with respect to recruitment and remuneration of medical staff and other professionals? *(Answer for the typical hospital - i.e. with the most common status for acute care.)*

Recruitment of medical staff

- ☐ Hospital managers have complete autonomy
- ☐ Hospitals must negotiate with local authorities
- ☐ Central or sub-national level of government decides
- ☐ Not applicable (physicians are not recruited or appointed)

Remuneration level of medical staff

- ☐ Hospital managers have complete autonomy (within rules applicable to all salaries in the country, e.g. minimum wage)
- ☐ A pay scale is set or negotiated at the national level
- ☐ Not applicable (physicians are not salaried)

Recruitment of other health professionals

- ☐ Hospital managers have complete autonomy
- ☐ Hospitals must negotiate with local authorities
- ☐ Central or sub-national level of government decides

Remuneration level of other health professional staff

- ☐ Hospital managers have complete autonomy (within rules applicable to all salaries in the country, e.g. minimum wage)
- ☐ A pay scale is set or negotiated at the national level

Comments/clarifications:

Have major changes in the regulation of supply occurred during the past 5 years? If so, please describe.

Section 5. Regulation of prices/fees

Question 54. How are the reimbursement amounts (fees or capitation levels) for physicians' services established?

- ☐ Fees for covered services are freely determined by providers.
- ☐ Reimbursement amounts are unilaterally determined by third party payers.
- ☐ Reimbursement amounts or fees for covered services are negotiated between individual third-party payers and providers.
- ☐ Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the local level.
- ☐ Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the central level.

Please specify the interested parties involved in the process (e.g. physician associations, statutory health insurance funds, etc) if relevant. _____

Comments/clarifications (if any):

Question 55. Are physicians allowed to charge any price for out-patient medical services?

- ☐ Yes, always
- ☐ Yes, if the visit or treatment is not reimbursed or paid by basic primary health insurance.
- ☐ Yes, under certain circumstances (explain below).
- ☐ No.

Comments/clarifications (if any):

Question 56. How are reimbursement amounts for hospitals' services established?

- ☐ Hospitals are funded by global budgets and determine expenditures autonomously.
- ☐ Reimbursement amounts or fees for covered services are negotiated between individual third-party payers and providers.
- ☐ Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the local level.
- ☐ Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the central level.

Please specify the interested parties involved in the process (e.g. physician associations, statutory health insurance funds, etc) if relevant: _____

Comments/clarifications (if any):

Question 57. Are hospitals allowed to charge any price for medical services?

- ☐ Yes, always
- ☐ Yes, if the visit or treatment is not reimbursed or paid by basic primary health insurance.
- ☐ Yes, under certain circumstances (explain below)
- ☐ No.
- ☐ Hospitals are funded by global budgets and provide care without formulating prices for services provided.

Comments/clarifications (if any):

Question 58. Are pharmaceutical firms free to set their own sales prices, irrespective of any reimbursement levels that might be set or negotiated?

- ☐ No
- ☐ Yes, always
- ☐ Yes, if the medicine is not reimbursed or paid by basic primary health insurance
- ☐ Yes, if the drug is off-patent
- ☐ Yes, under other circumstances (explain) _____

Comments/clarifications (if any):

Section 6. Regulation / monitoring of health providers' activity

Question 59. Are there any incentives or obligations to comply with treatment guidelines or practice protocols established (defining first-line treatment, for example)?

- ☐ No, there is no incentive or obligation
- ☐ There are financial incentives (rewards)
- ☐ Compliance is compulsory, but without effective monitoring and/or sanctions
- ☐ Compliance is compulsory, with effective monitoring or sanctions

Comments/details:

Question 60. Is there any regulation/control on health provider activity? (Check all that apply.)

- ☐ Health insurance funds or the national or local health service usually monitors the volume of physician activity.
- ☐ Physicians usually receive feedback about their activity or prescriptions.
- ☐ Prescription targets or budgets are defined.
- ☐ Compliance with guidelines is monitored.

Comments/details:

Question 61. Is direct-to-consumer advertising of pharmaceuticals permitted?

- ☐ Yes, for all medicines
- ☐ Yes, for some medicines only (e.g. OTC drugs)
- ☐ No

Comments/details:

Question 62. Is there a structure and capacity for undertaking health technology assessments (HTA)?

- ☐ Yes.
- ☐ No.

Comments/details:

Have major changes in regulation and/or monitoring of providers activity occurred during the past 5 years? If so, please describe.

Question 62 (continued). For health technology assessments (HTA), does the assessment procedure include an evaluation of the (relative) cost-effectiveness, affordability or budget impact of the use of the health technology or medicine?

- ☐ Yes
- ☐ No

How is information from HTA used? (check all that apply)

	new medicines	new medical procedures	the use of new high-cost equipment	none
In determining whether to cover:				
In determining the reimbursement level or price of:				
In developing guidelines for:				

Section 7. Coordination of care

Question 63. Are disease management programs* commonly used (specify targeted diseases in comments)?

- ☐ Yes
- ☐ No

Comments/clarifications:

Question 64. Are case management programs* commonly used for patients with complex conditions requiring chronic care?

- ☐ Yes
- ☐ No

Comments/clarifications:

Question 65. Do physicians transfer or exchange information electronically for diagnosis or treatment purposes with other health care providers?

- ☐ Regularly
- ☐ Regularly, in some settings only (e.g. hospital, labs)
- ☐ Occasionally
- ☐ Rarely

Comments/clarifications:

Question 66. Are there shortages of non-acute hospital beds (e.g., rehabilitation)?

- ☐ Yes
- ☐ No

Comments/clarifications:

Question 67. Do patients experience extended acute care hospital stays awaiting appropriate follow-up care (e.g. rehabilitation, long-term care, home care)?

- ☐ Yes, rarely.
- ☐ Yes, occasionally.
- ☐ Yes, frequently.
- ☐ No.

Comments/clarifications:

Have major changes in the coordination of care occurred during the past 5 years? If so, please describe?

PART III. GOVERNANCE AND RESOURCE ALLOCATION

Section 1. Degree of centralisation in decision making
Section 2. Definition of a health care budget and pressure for cost-containment
Section 3. Priority setting and public health targets
Section 4. Patient rights and involvement in the health care system

A glossary of terms is available on the introductory web page of the questionnaire http://www.oecd.org/health/HSCsurvey. Words marked with an asterisk (*) are defined in this glossary.

Section 1. Degree of decentralisation in decision-making

Question 68. Who is responsible for: (check all that apply)

	Parliament	Central/federal government	Regional/state government	Local/municipal government	Social health insurance (collective)	Individual health insurance funds	Representatives of providers/professionals	Individual providers	Other (specify)
Setting the level of taxes which will be earmarked to health care									
Setting the basis and level of social contributions for health									
Setting the total budget for public funds allocated to health									
Deciding resource allocation between sectors of care (e.g. hospital care, out patient care, long-term care)									
Determining resource allocation between regions									
Setting remuneration methods for physicians									
Defining payment methods for hospitals									
Financing new hospital buildings									
Financing new high-cost equipment									
Financing the maintenance of existing hospitals									
Financing primary care services*									
Financing specialists in out-patient care									
Financing hospital current spending									
Setting public health objectives									

Comments/details:

Have major changes in the de(centralisation) of decision-making occurred in the past 5 years? If so, please describe:

Section 2. Definition of a health care budget and pressure for cost-containment

Question 69. Is any prospective budget/ health expenditure target defined annually for public spending at the macro-level?
Note: "Public spending" refers to expenditures financed by the government or by social health insurance.

- ☐ No, there is no prospective budget/expenditure target defined a priori

- ☐ There is a "target" for health expenditures, with possible overshooting
  If so, the health expenditure target is further divided in:
  - ☐ sub-targets for different health services (silo approach)
  - ☐ sub-targets by region/sector

  If the health expenditure target is further divided into sub-targets by region /sector, which criteria are taken into account to define sub-targets (multiple responses possible):
  - ☐ historic costs for the area
  - ☐ population (number of people) adjusted for demographic characteristics (age, gender)
  - ☐ population (number of people) adjusted for morbidity/mortality data
  - ☐ population (number of people) adjusted for consumption of health services
  - ☐ other (specify)

- ☐ There is a "strict health budget" which cannot be exceeded
  If so, is the health budget further divided in:
  - ☐ budgets for different health services (silo approach)
  - ☐ budgets by region/sector/areas

  If the health budget is further divided by region /sector/areas, which criteria are taken into account to define sub-budgets
  - ☐ historic costs for the area
  - ☐ population (number of people) adjusted for demographic characteristics (age, gender)
  - ☐ population (number of people) adjusted for morbidity/mortality data
  - ☐ population (number of people) adjusted for consumption of health services
  - ☐ other (specify)

Comments/details:

Question 70. In the past 5 years, what have been the consequences of reaching the target expenditure level or budget limit (check all that apply):

- ☐ Budget deficit created or increased
- ☐ Social contributions, premiums or taxes increased
- ☐ Cost containment policies implemented

Comments/details:

Question 71. Has cost-containment pressure in the past 5 years contributed to (check all that apply):

- ☐ Increased waiting times for appointments with a primary care physician
- ☐ Increased waiting times for appointments with a specialist
- ☐ Increased waiting times for diagnostic care
- ☐ Increased waiting times for elective surgery
- ☐ Delisting of medical goods and services
- ☐ An increase in patients' out-of-pocket payments or users' fees
- ☐ Implementation of policies to promote purchase of private/voluntary health insurance
- ☐ An increase in health care institutions' (e.g., hospitals) deficits
- ☐ A reduction in physicians' fees
- ☐ A partial refund to health insurance or the NHS from health providers (physicians)
- ☐ A partial refund to health insurance or the NHS from the pharmaceutical industry

Comments/details:

Have major changes in policies to cope with budget pressure and/or cost-containment occurred during the past 5 years? If so, please describe:

Section 3. Priority setting and public health targets

Question 72. How are benefits covered by basic primary health insurance defined (check all that apply)?

a) For medical procedures:

- ☐ A positive list is established at the central level
- ☐ A negative list (of non-covered procedures) is established at the central level
- ☐ Individual health insurance funds establish their own positive lists
- ☐ Individual health insurance funds establish their own negative lists
- ☐ Providers under budget constraints establish their own positive lists at the local level
- ☐ The benefit basket is not defined, every medically appropriate procedure is covered by basic primary coverage schemes

b) For pharmaceuticals

- ☐ A positive list is established at the central level
- ☐ A negative list (of non-covered procedures) is established at the central level
- ☐ Individual health insurance funds establish their own positive lists
- ☐ Individual health insurance funds establish their own negative lists
- ☐ Providers under budget constraints establish their own positive lists at the local level
- ☐ The benefit basket is not defined; prescription drugs that are approved for marketing are systematically covered by basic primary coverage schemes

Comments/details:

Question 73. What are the criteria taken into account in the definition of the basic benefit basket (if relevant)?

	For medical procedures	For pharmaceuticals
Clinical effectiveness (risk-benefit ratio)		
Cost-effectiveness		
Affordability or budget impact		

Comments/details:

Question 74. Is there any formal specification of public health objectives? (e.g. quantitative targets for preventive screening programs, for the reduction of nosocomial infection, for the reduction in health inequalities)

- ☐ Yes
- ☐ No

Comments/details:

Question 74 (continued). For formal specifications of public health objectives,

a) Are these objectives set (check all that apply):

- ☐ In terms of process (increase screening for specific diseases, vaccination rates, reducing waiting time)?
- ☐ In terms of health outcomes (infant mortality, survival rate for a type of cancer)?
- ☐ In terms of reduction of social or geographical inequalities?

b) Are these objectives monitored (check all that apply):

- ☐ By the parliament
- ☐ By central government
- ☐ By an independent agency
- ☐ By health insurance funds
- ☐ Not monitored

c) Is anyone held responsible if objectives are not met?

- ☐ Yes
- ☐ No

Section 4. Patients' rights and involvement in health care systems

Question 75. Is there any formal definition of patients' rights at the national level (e.g. through a law, a charter)?

- ☐ Yes
- ☐ No

Comments/clarifications:

Question 76. Are hospitals required to have a patient desk in charge of collecting and resolving patient complaints?

- ☐ Yes
- ☐ No

Question 77. Is there a formal role for patient representatives in decision-making in the following areas (e.g. participation on decision-making bodies):

- ☐ Licensing of pharmaceuticals
- ☐ Coverage or reimbursement
- ☐ Health technology assessment
- ☐ Decisions relating to hospital planning (if relevant)
- ☐ Definitions of public health objectives
- ☐ Other (please specify)

Comments/clarifications:

Question 78. What is the type of the tort* system in the country?

- ☐ Patients can seek redress in courts in the case of medical error
  - o Medical error has to be proven*
  - o Medical error can be presumed*
- ☐ There is a basis for 'no fault' compensation*

Comments/clarifications:

If a tort system exists, can patients obtain damage awards for:

- ☐ economic losses only
- ☐ economic losses and non-economic losses (loss in well-being, quality of life…)

Comments/clarifications:

Question 80. Can people engage in Class Action suits against health providers, pharmaceutical companies, etc.?

- ☐ Yes
- ☐ No

Comments/clarifications:

Question 81. Are there any Ombudsmen in charge of investigating and resolving patients' complaints about health services?

- ☐ Yes
- ☐ No

Have major changes in patients' rights and involvement occurred in the past 5 years? If so, please describe?

ANNEX 2. Additional information

Table A1. Regulation of prices/fees of physician services
Table A2. Regulation of prices for acute care hospital services

Table A1. Regulation of prices/fees of physician services

Country	Is there a price for outpatient physicians services? (i.e. FFS component)		Price paid by basic primary health insurance	Prices billed by providers
	Primary care	Specialists		
Australia	Yes	Yes (out patient)	Medicare defines a fee-schedule for physicians' services and reimburses 100% of the fees for GP services and 85% for specialists' services. The Medicare Benefits Schedule (MBS) is determined by the government.	Physicians are free to set their fees if patients pay at the point of service. By contrast, when Medicare pays physicians directly ("bulk-billing"), they must comply with the Medicare fee. More than three quarters of GPs' contacts are paid through bulk-billing while the vast majority of specialists' contacts are paid by patients at the point of care (*Healy et al.* , 2006).
Austria	Yes	Yes (out patient)	Prices for contracted doctors are negotiated collectively between interested parties at local level. For "not contracted" physicians, the health insurance fund pays 80% of the cost that would have been incurred if a contracted doctor had provided the treatment. The rest has to be paid by the patients.	Physicians who have not contracted with health insurance funds can charge any price. Physicians under contract may also charge any price when treating patients on a private basis (Hofmarcher and Rack, 2006).
Belgium	Yes	Yes (out patient)	Fees are negotiated collectively at central level by interested parties	Providers usually charge the negotiated fees, with a few exceptions. Physicians who do not sign contract with insurerer have freedom to set any price. A physician can have part of his/her activity outside the agreement.
Canada	Yes	Yes	Fees are negotiated by provincial governments and physicians' associations	Physicians services are free at the point of care. Physicians can opt out in some provinces (i.e. exit the public system for private practice). Only a few physicians actually do it.
Czech Republic	Yes, but only for 30% of income (remaining is capitation)	Yes (out patient)	Fees are negotiated collectively at central level by interested parties Specialists are paid through FFS with degressive fees beyond a cap (since 2001).	Physicians are not allowed to charge extra-billing.
Denmark	Yes, for 2/3 of income (remaing is capitation)	Only in private practice (marginal)	Prices paid to Danish physicians are negotiated annually at the national level between the association of county councils (purchasers) and the association of general practitionners (Waters and Hussey, 2004)	GPs can charge any "reasonable fee" for insured patients of Group 2 (i.e. 2% of total population), for which they are not paid by capitation.
Finland	No (salary)	No (salary)	Salaries are set or negotiated collectively between interested parties at the central level.	Physicians can charge any fee for services provided in the private sector, even when reimbursed by health insurance. About 11% of Finnish doctors are full-time private practitionners and 1/3 of doctors run a private practice in addition to publis duties in public centres or hospitals (Finnish Medical Association).

Note: (1) RBRVS = Resource-Based Relative Value Scale.
Sources: OECD Survey on health system characteristics 2008-2009 and indicated references.

StatLink http://dx.doi.org/10.1787/811283148444

Table A1. Regulation of prices/fees of physician services (cont.)

Country	Is there a price for outpatient physicians services? (i.e. FFS component)		Price paid by basic primary health insurance	Prices billed by providers
	Primary care	Specialists		
France	Yes	Yes	A fee-schedule is defined at the national level, by negotiation between health insurance funds and physicians' unions. Health insurance typically covers 60% of the fee.	Physicians in "secteur 2" -13% of generalists and 40% of specialists- are allowed to charge higher fees (extra-billing). In addition, all specialists are allowed to charge higher fees when patients consult them without GP referral.
Germany	Yes	Yes (out patient)	A RBRVS[(1)] is defined at the national level and point values are set at the regional level. They depend on 1) the amount of money available (per capita contributions of health insurance funds for their insurees to regional associations of physicians); 2) the total amount of "points" generated by doctors in the region; 3) between-specialties adjustments to avoid excessive variations in remuneration.	Physicians are not allowed to charge extra-billing.
Greece	No (salary)	Yes (out patient)	Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the central level	Informal payments are common practice (Economou and Giorno, 2009)
Hungary	No (capitation)	No (salary)	Reimbursement amounts are unilaterally determined by third party payers. - Salaries of public servants regulated by law.	Patients often pay "gratitude" or "under-the-table" payments for physicians with NHI contracts though "extra-billing" is prohibited. Informal payments are more widespread in inpatient sector than in outpatient. Specialists, esp. obstetricians and surgeons, receive the bulk of copayments. Patients pay the full prices for services which are not covered or provided by physicians without contract with NHI (Gaál P., 2004).
Iceland	No (salary)	Yes (out patient)	Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the central level.	Physicians are not allowed to charge any price.
Ireland	Yes, for category II patients	Yes (out patient)	GPs services are free at the point of care and mainly paid by capitation for patients of category I. They are not covered by basic primary coverage for patients of category II. Contracts are negotiated at central level between interested parties.	GPs set freely their price for Category II patients (fee-for-service). Specialists are paid by salary, but 90% of them are allowed to have a private practice for which they are paid on a fee-for-service basis and free to set their price. In 2000, in hospitals, 30% of all elective patients were treated privately, compared with 21% of emergency patients (Mc Daid *et al.* , 2009)
Italy	No (capitation)	No (salary)	Payment levels are set by collective agreements at the national level after negotiations between the government and GPs' unions (Donati *et al.* , 2001).	

Sources: OECD Survey on health system characteristics 2008-2009 and indicated references.

StatLink http://dx.doi.org/10.1787/811283148444

Table A1. Regulation of prices/fees of physician services (cont.)

Country	Is there a price for outpatient physicians services? (i.e. FFS component)		Price paid by basic primary health insurance	Prices billed by providers
	Primary care	Specialists		
Japan	Yes	Yes (out patient)	A national fee schedule is negotiated biannually by the MHLW, the social insurance council, and representatives (public, payers, providers)	Physicians are not allowed to charge extra-fees for covered services.
Korea	Yes	Yes (out patient)	Fees are negotiated between providers and NHIC (National Health Insurance Corporation)	Fees for uninsured services are mostly unregulated market prices and can vary greatly according to the type of facility. There are reports of certain facilities levying informal or special treatment charges, although no estimates are available about their frequency and amount." (OECD, 2003)
Luxembourg	Yes	Yes (out patient)	A RBRVS is defined at the national level. Point values are negotiated each year by the Alliance of Hospitals (Entente des Hopitaux Luxembourgeouis, EHL), the Association of the Health professionals (e.g. doctors, nurses, physiotherapists, pharmacists, laboratories...), and the Health insurance fund (Caisse Nationale de Sante, CNS).	
Mexico	No (salary)	No (salary)	Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the central level	In the private sector, doctors are paid by fee-for-service, with no price regulation. Private practice represents a signifant part of medical services delivery.
Netherlands	yes (mix of capitation and fees)	yes (in patient only)	The Health care authority sets capitation rates and price ceilings for most health services. Insurers can negotiate lower prices, except for some services (Schoen *et al.*, 2009).	Physicians are bound to prices negotiated at the national level or with a specific insurer.
New Zealand	yes (FFS = 85% of physicians, rest are paid by capitation)	yes (private only) public hospital specialists are salaried	Price setting processes vary between public and private sector and according to the type of organization.	Physicians paid on a fee-for-service basis set freely their price (or patients' copayments). There have been some attempts to regulate copayments and local agreement limit them but no overall regulation (Gauld, 2008) .
Norway	Mix of capitation (30%) and fee-for-service	yes (out patient)	Capitation rates are negotiated by the Norwegian Medical Association and the municipalities' central negotiation body. GPs Unions and the State negotiate fees (and out-of-pocket payments). Fees for specialists services (paid by the National Insurance Scheme) are negotiated at the national level between the NMA and the Ministry of Health (Johnsen, 2006).	Physicians must contract with local authorities to be paid by the National Insurance Scheme (fee-for service component). Physicians without contract can charge any fee.

Sources: OECD Survey on health system characteristics 2008-2009 and indicated references.

StatLink http://dx.doi.org/10.1787/811283148444

Table A1. Regulation of prices/fees of physician services (cont.)

Country	Is there a price for outpatient physicians services? (i.e. FFS component)		Price paid by basic primary health insurance	Prices billed by providers
	Primary care	Specialists		
Poland	No (capitation)	Yes (out patient)	Prices are set in points by third-party payer and the point-value is negotiated between third-party payer and health care providers	Fees are regulated only in case of services contracted by public payers. Private providers with no contract with the National health fund and physicians providing not covered services can charge any price (Janiszewski and Bondaryk, 2007)
Portugal	No (salary)	No (salary)	Salaries are set or negotiated collectively between interested parties at the central level.	
Slovak Republic	No (capitation)	Yes (out patient & private sector)	Capitation rates are set by the MoH for PC physicians; FFS rates are based on a schedule ("points"), with a cap set by HIFs on volumes they will reimburse (Hlavčka et al., 2004). Rates for covered services are negotiated between individual thrid-party payers and providers.	Physicians who do not contract with health insurance funds can charge any price (marginal).
Spain	No (sal/cap)	No (salary)	Pay scales are negotiated at the national level	
Sweden	No (salary)	No (salary)	Salaries are set or negotiated collectively between interested parties at the local level.	
Switzerland	Yes	Yes (out patient)	A RBRVS(1) is defined at the national level (TARMED), and point values are negotiated at cantonal level	Doctors usually charge official fees. They can charge higher fees if they do not partipate to LAMal or provide services not covered by health insurance.
Turkey	No (salary)	No (salary)	Salaries are set or negotiated collectively between interested parties at the central level.	
United Kingdom	No (capitation)	No (salary)	Remuneration levels are negotiated by the MoH, NHS employers and professionnels' representatives	NHS consultants (specialists) with private practice in hospitals can determine their own fees.

Sources: OECD Survey on health system characteristics 2008-2009 and indicated references.

StatLink http://dx.doi.org/10.1787/811283148444

Table A2. Regulation of prices for acute care hospital services

Country	Is there a price ? (Fee-for-service or payment per case)	Price paid by basic primary health insurance	Prices billed by providers? (when different from the price paid by third-party payer)	Volume control
Australia	Yes, Payment per DRG in some hospitals.	Prices paid by Medicare will be: - 100% of the Medicare Fee Schedule rate for "public patients" in public hospitals; - 75% of the Medicare Fee Schedule rate for "private patients" in public or private hospitals. Prices paid by private health insurers for private patients in public or private hospitals are negotiated between individual third-party payers and providers.	Physicians do not charge anything to patients treated in public hospitals as "public patients". There are no limits on fees charged for patients treated as "private patients" in public or private hospitals. PHI usually covers the remaining 25% of the Medicare Fee (after Medicare payment). PHI can pay more when providers conclude "gap cover arrangements" with private insurers. Expenditures for private hospitals account for 21% of total hospital expenditures, and private hospitals treat 4 out of every 10 admitted hospital patients in Australia, representing 30% of all days of hospitalisation (http://www.privatehealth.com.au/ahs.htm).	In Victoria, there is a cap on activity increase, beyond which rates/ DRG are declining (Millar, 2005).
Austria	Yes (50% of costs)	Half of costs are paid through DRG payments. Activity is measured in points (national scale) and at the end of the period, the fixed budget is divided by the number of points in each Land. Another half of payments are linked to Länder-specific requirements (provision of certain types of care, hospital with specific mandates...) (Hofmarcher and Rach, 2006) DRG-weights are national but DRG-prices vary from one Land to the other. In addition, prices are adjusted to take into account specific requirements or context for some hospitals (up to x1.3) - Both Public and private hospitals are paid through DRG (HOPE, 2006) "Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the central level." Private for-profit hospitals are funded through contracts with the insurance companies. (Dexia and HOPE, 2008)	Patients pay (flat) copayments and supplements for "special class accomodation" (Hofmarcher and Rach, 2006; Dexia and HOPE, 2008)	National spending envolop, with decreasing "point value" when activity increases

Sources: OECD Survey on health system characteristics 2008-2009 and indicated references.

StatLink http://dx.doi.org/10.1787/811311268327

Table A2. Regulation of prices for acute care hospital services (cont.)

Country	Is there a price ? (Fee-for-service or payment per case)	Price paid by basic primary health insurance	Prices billed by providers? (when different from the price paid by third-party payer)	Volume control
Belgium	Yes, FFS for medical and medicotechnical procedures, exams.	Hospitals are paid through: (1) fixed prospective budgets based on activity (measured by APDRG-mix) for accomodation, emergency adminissions, nursing activities… (2) fee-for-service for medical and medicotechnical services consultations, imaging, lab, procedures- and paramedical activities -physiotherapy-. The MoH sets a national budget and allocate it to individual hospitals, health insurance funds pay hospitals (Corens, 2007; Dexia, 2009 and HOPE, 2009)	Hospitals charge copayments, charge supplements for double or private room and supplements for physicians that did not subscribe to the tariff agreement. Physicians do not have to respect fees of the national agreement when patients are treated in private rooms (Corens, 2007)	
Canada	Yes (9%)	Canadian hospitals are mainly funded through global budgets. Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the local level.	Individuals (and private insurance) pay for private rooms and other preferred accommodation, care for non-residents, chronic care and uninsured services (CIHI, 2007)	
Czech Republic	Yes, 22% of hospital revenue in 2008	Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties (hospitals and health insurance) at the central level. The State can intervene in case of persistent disagreement. For a few services, individual insurers and hospital can contract (hip replacement, implantation of defibrillator...), this represents only 1.5% of total hospital revenue but is increasing. It can represent much more in hospitals whose activity is concentrated on this list of procedures. The health insurance funds the largest part of the operating costs of hospitals. But the state and the regional and local authorities also contribute out of their budgets. (Dexia and HOPE, 2009)	Patients pay small copayments since 2008.	

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Table A2. Regulation of prices for acute care hospital services (cont.)

Country	Is there a price ? (Fee-for-service or payment per case)	Price paid by basic primary health insurance	Prices billed by providers? (when different from the price paid by third-party payer)	Volume control
Denmark	Yes, for 20% of payments	Public hospitals are funded by the regions, mainly through global budgets. Private for-profit hospitals provide services according to agreements between the hospital(s) and the region. A growing part of the budget is paid through payments/DRG. National DRG rates apply for cross-county payments to public hospitals, but counties can obtain lower prices from their own hospitals. Typically, regions negotiate lower prices/DRG with private hospitals (HOPE, 2006; Søberg and Sjuneson, 2008; Terkel, 2009).		Although the counties and municipalities are responsible for providing the majority of health services, they must do so within the targets for health care expenditure agreed at the annual budget negotiation between Ministry of Health, Ministry of Finance and the county and municipal councils with joint representatives. Hospital activity is capped, hospitals will not be paid if they exceed this cap (HOPE, 2006)
Finland	Yes	DRG rates are negotiated between municipalities and hospital districts, which are owned by the municipalitites. Purchasers and providers are free to negotiate any type of contract for the payment of services but municipalities are the residual claimants for any profits or losses generated by hospitals (Linna et al, 2006)		
France	Yes	DRG rates are set at the national level for both public and private hospitals. Public rates include all services while private rates do not include medical services, which are invoiced separately and paid on a fee-for-service basis. DRG rates are negotiated collectively between interested parties at the central level.	Private hospitals can charge supplemental fees for higher accomodation and extra-billing for physicians' services. Physicians with private practice in public hospitals can also charge extra-fees.	The Parliament votes a budget for hospital care annually. A global price-volume regulation exist: if activiy grows too much in year t, DRG rates will be lowed in t+1 as to ensure compliance with the hospital budget.
Germany	Yes	Hospitals are paid through DRG payments. DRG weights are defined at federal level but rates differ across hospitals and Länder. They are supposed to converge towards unique Land-rates. Professional fees are not included in DRG rates (HOPE, 2006;). DRG rates are set or negotiated collectively between interested parties at the local level (i.e. social health insurance funds and the German Hospital Association).	Private health insurance also use DRGs to pay hospital services; they pay supplements for private rooms and the individual services of the chief physician (Neubauer and Pfister, 2008)	DRG-budgets are capped, DRG rates may decrease if the budget target is exceeded (Neubauer and Pfister, 2008).
Greece	Yes	Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the central level. Hospitals are financed by the State (70% through global budget) and by social security funds, which pay services on a per diem basis (Dexia and HOPE, 2008).		

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Table A2. Regulation of prices for acute care hospital services (cont.)

Country	Is there a price ? (Fee-for-service or payment per case)	Price paid by basic primary health insurance	Prices billed by providers? (when different from the price paid by third-party payer)	Volume control
Hungary	Yes	National cost-weights and prices for DRG payments are uniform (Dexia, 2008) Representatives of the National Health Insurance Fund, of professional organisations, of national medical colleges and institutes, as well as the Ministry of Health are involved in the process of updating DRG "parameters" (grouping, costs...) and new prices are publised by a Minister's Decree (Nagy *et al.* , 2008)		Since early 2004, hospitals are reimbursed with "full DRG prices" for only 98% of their budget of the previous year. Beyond this volume of activity, DRG rates are declining - from 60% to 10% of full price- (Dexia and HOPE, 2008; Nagy *et al.* , 2008)
Iceland	No	Hospitals are funded by global budgets and determine expenditures autonomously.		
Ireland	Yes (20% per case, 20% per diem)	DRG payments are extending, prices are set by reference to national average costs (McDaid *et al.* , 2009)	In case of private beds (in public or private hospitals), the patients and private insurances pay for the services (Dexia and HOPE, 2008)	Funding through DRG must be budget neutral (McDaid *et al.* , 2009)
Italy	Yes	National standards are defined, but DRG prices can be modulated by region (regional prices vary from -30% to +16% according to Tedeschi, 2008) . Regions are competent for decisions and policies on DRGs and are allowed to rearrange case mix tools or tariffs and to contract price cuts or to set co-payments (HOPE, 2006).	Private hospitals can charge any price for not covered services.	Regions define annual budgets according to their priorities.
Japan	yes	Hospital payments have two components: - the DPC component or "hospital fee", which includes hotel fee, pharmaceuticals and supplies used on wards, lab tests, radiological exams and any procedure under Y10,000 ($100). For the DPC component, a per diem is set for each DPC group, decreasing with the length of stay. - the fee-for -service component for surgical procedures and anesthesia, pharmaceuticals, equipments used in operating theaters and procedures above Y10,000 (Matsuda, 2008). Reimbursement amounts are negotiated collectively at central level by interested parties (Insurers, representatives of healthcare practitioners, hospital associations and representatives of public interests such as a scholar).	Prices are not defined for services not reimbursed by health insurance.	Degressive per diem rates above a certain length of stay

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Table A2. Regulation of prices for acute care hospital services (cont.)

Country	Is there a price ? (Fee-for-service or payment per case)	Price paid by basic primary health insurance	Prices billed by providers? (when different from the price paid by third-party payer)	Volume control
Korea	Yes	Hospitals are mainly paid through fee-for-service. DRG-based financing is still marginal (7 DRGs). Hospital payments do not differ for public and private hospitals. Prices are set by annual negotiations between National Health Insurance and hospital associations.	Hospitals (both public and private) can charge supplements for superior accomodation.	
Luxembourg	No	Hospital budgets are negotiated annually between each hospital and the Union of Health Insurances UCM (Union des Caisses de Maladie) (Dexia and HOPE, 2009)		
Mexico	Yes (10%)	Public hospitals (65% of acute beds) are paid through global budgets, based on historical costs and available budgets. In IMSS hospitals, a small fraction of budget is allocated based on activity. Private hospitals are paid on fee-for-service. They set fees freely but insurers can negotiate fees for insured patients (OECD, 2005).	Private hospitals (35% of acute beds) set freely their fees, except when prices are negotiated with health insurers for private patients.	
Netherlands	Yes (20% funded through DRG payments)	Reimbursement amounts and fees are negotiated collectively by interested parties at the central level. For 20% of DBCs (Diagnose Behandelings Combinaties, the Dutch grouping for diagnostic related groups), lower rates can be negotiated by individual hospitals and insurers.		
New Zealand	No	Hospitals are funded by global budgets and determine expenditures autonomously.		
Norway	Yes (40%)	The share of activity-based (40%) funding is decided by the Parliament. Price levels are determined nationally and adjusted regionally (Survey, 2008).		
Poland	Yes	Reimbursement amounts or fees for covered services are negotiated between individual third-party payers and providers. i.e. Public payers (e.g. statutory health insurance fund, Ministry of Health) and health care providers. The National Health Fund finances healthcare services on the basis of contracts concluded with the hospitals. The public state budget funds selected services of tertiary healthcare. The National Health Fund negotiates directly all tarifs for reimbursements with doctors and hospitals (Dexia and HOPE, 2008).		

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Table A2. Regulation of prices for acute care hospital services (cont.)

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Portugal	No	Hospitals are paid through global budgets, established and allocated by the Ministry of Health and distributed by the health administration regions (ARS) (Dexia and HOPE, 2008)		
Slovak Republic	Yes	Hospitals are financed by DRG payments. The Ministry of Health sets a minimum and a maximum price for each DRG ; health insurances can purchase services within this range. Health insurances and hospitals negotiate contracts. Payment schemes are the same for public and the private hospitals under contract with the National Health Service (Dexia and HOPE, 2009).	Informal payments are common (paid by 3 patients/10 in 1999 according to Hlavčka *et al.* , 2004).	
Spain	No	Public hospitals are funded by the Autonomous Communities (ACs). For-profit and not-for-profit private hospitals are funded partly or totally by the ACs, only when they are under contract in order to compensate for insufficient healthcare provision of the National Health Service (Dexia and HOPE, 2009) ACs determine how they pay hospitals. Public hospitals (and private hospitals which are included in the usual network of providers) are usually funded on the basis of a contract-program with clearly defined targets and a funding based on healthcare treatment units. Private hospitals with contracts to deliver specific services under-supplied by public hospitals are paid on the basis of contracts (payment per service or process) (Dexia and HOPE, 2008) Autonomous Communisties (ACs) pay at least part of the activity through DRGs payments.		
Sweden	Yes (55% DRG)	Countries determine hospital payment scheme. Five large councils employ DRG payments, in combination with global budgets. Reimbursement amounts or fees for covered services are set or negotiated collectively between interested parties at the local level.	Private hospitals (marginal supply) can charge any price unless they work under contract with county councils.	In Stockholm, budget ceilings were introduced to control costs (Lindqvist, 2008)

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Table A2. Regulation of prices for acute care hospital services (cont.)

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Switzerland	Yes	Payment methods vary across cantons, but more and more cantons use DRG payments. Tariffs are negotiated between associations of hospitals and insurers in each canton. Cantons pay subsidies (investments and at least 50% of current costs), they usually set prospective budgets but cover hospitals deficits. Some cantons contract with hospitals about the amount of subsidies and services to be provided (OECD and WHO, 2006)	Patients pay copayments as well as supplements for superior accomodation or comfort services.	
Turkey	No	Hospital budgets are set or negotiated collectively between interested parties at the central level.	The Social Security Institute (ombrella for insurance schemes) must establish "appropriate" modes of payment for private hospitals. The Law allows "extra-billing" from private hospitals, up to 30% of the SSI price (OECD-World Bank, 2007)	Capped budget for MoH hospitals, nogotiated each year with the MoH. Excess volumes will not be paid.
United Kingdom	Yes	National tariffs are set at the central level by the government.	in England, NHS services not covered by the national tariff are subject to local negotiation between providers and commissioners of services.	Volume-price agreement for emergency admissions: in year t, hospitals are paid the full price for each admissions up to a threshold based on their activity in t-1 and only 50% of the above this threshold. No threshold has been imposed for elective activity and hospitals can increase activity without prior approval from PCTs (Street & Maynard, 2007).

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