Delegation and Control in Health Care Systems

Volume 1:

Delegation and Control in 22 OECD Health Care Systems. A Data Handbook

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Abstract

Health care systems are set up to fulfill the same functions but differ largely in their organizational design. Moreover, in recent years health care systems are confronted with a range of similar problems to which they respond in different ways. It turns out that they are able to cope with these problems with different degrees of success. This put much focus on how institutional structures in health care systems affect the system's performance, adaptability and resource consumption. Comparative research is the appropriate research design to obtain answers on these questions. But in practice, empirical comparative research on the effects of institutional structures of health care systems is limited by the lack of comparable, detailed institutional information on the organization of health care systems. This data handbook is intended as a contribution to close this gap.

Health care systems are layered networks of delegation relationships: the citizens, in their role as patients as well as voters, delegate the provision of health services, the administration and the overall control of the health care system to agents: medical providers, health insurance funds, health authorities and the state. These agents usually have interests, which diverge from those of the citizen and also have substantial leeway to pursue these interests, at expense of the citizen as the principal. On the conceptual level, the delegation-approach proved to be able to explain differences in performance and achievement at the system level by rational individual behavior. Further, the delegation-approach offers a template on which a comparative analysis and the description of complex systems, like health systems, can be based.

This data handbook describes the health care systems of 22 OECD countries for two points in time, 1995 and 2004, on the basis of the institutional economics perspective. In particular from the perspective of the delegation of medical as well as administrative tasks and the control mechanisms implemented in these delegation relationships, which shall avoid opportunistic behavior. The data compiled in this data handbook shall enable researchers to study the impact of institutional structures on aspects of health system performance, like achievements in health levels, responsiveness and productive efficiency.

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A. Motivation of the Data-Handbook

1. Introduction

Health care systems, henceforth abbreviated HCS, are set up to fulfill the same functions but differ largely in their organizational design. While they are confronted with a range of similar problems, they respond to these in different ways and are able to cope with them with different degrees of success; see Saltman et al. (1998), OECD (2002) and Johnston (2004).

Among the most discussed problems in health policy and health system research is the issue of increasing costs and the financial sustainability of the HCS in the long run. Expenditure levels are perceived to be driven by an aging population[1], increasing levels of expectations and demands, see Blendon et al. (1990), Kersnik (2001), Murray et al. (2001), and Kohl/Wendt (2004), as well as technological developments, see Newhouse/Friedlander (1980); Weisbrod (1991), Okunade/Murthy (2002), and Moise (2003), which make more treatment options available for more medical conditions, but do so at high costs; see Gerdtham/Jönsson (2000) for estimations of the impact on health expenditure. Projecting the trajectories of resource demand into the future seriously poses the question, how the demand of financial resources can be met; Kanavos/McKee (1998), and Bains (2003).

But even in the short run, HCS seem to respond to these drivers with levels of resource consumption, which are colliding with other political aims; Guillén (1999), Freeman/Moran (2000), Docteur/Oxley (2003), and OECD (2002).

A second issue which is debated is how the quality of the medical services provided can be measured and assured. Preliminary evaluations of quality indicators seem to show that quality of treatment differs substantially, even among industrialized countries; Evans (2002), Sharma (1998), Shapiro et al. (1999), Sari (2002), Simonet (2003), Harteloh (2003), Wild/Gibis (2003), Walshe (2003) and Mattke (2004).

A third and more recent issue is how the HCS can be made responsive to the patients. Patients do no longer want to be the passive object of medical attention, but want to be informed and want a say, Murray et al. (2001). They also expect higher standards in the way health care is delivered, ranging from access to care to accommodation standards in hospitals. The terms "responsiveness" and "customer orientation" are referring to the process by which health is produced and medical decisions are made. They also refer to intangible aspects like patient

[1] See Zweifel et al. (1999), Seshamani/Gray (2004), Bains/Oxley (2004), Brigitte Dormont et al. (2006), and Werblow et al. (2007) for critical discussions of the existence and magnitude of demographic effects on health expenditure.

autonomy, and dignity; see for approaches and experiences in this area the issue of Eurohealth; autumn 2003 and the discussions of the meaning of "responsiveness" and its role for satisfaction in Darby et al. (2000), Schoen et al. (2004) and Kohl/Wendt (2004).

To summarize the background, the debate in health politics puts much focus on the issue of how to improve the HCS' performance. More specifically: how to redesign and to change the institutional setup of the HCS in order to make it producing health more efficient, providing better quality of care and to make it more responsive to the citizens? Comparative health policy and health system research can contribute to answering these questions.

Comparative Health Policy

HCS tackle the issues mentioned in different ways and are able to cope with these issues to different degrees of success; see Abel-Smith/Mossialos (1994), Saltman/Figueras (1998), Docteur/Oxley (2003), Oliver et al. (2005), and Saltman et al. (2006). So, if one is looking for answers to the above questions and strategies to cope with the problems, a straightforward strategy offers itself: Given that health care is organized in so many different ways in different countries, the method of choice for finding answers on how to improve a given HCS is to look at how other HCS tackle the problems and learn from them, be it from their success or their failure. Institutional learning is implemented either by adapting isolated institutional features, e.g. remuneration modes, or more general properties, e.g. the degree of decentralization of the decision making.

These political efforts of systematic policy learning are no longer national level undertakings, but are conducted at the international level: the WHO, the OECD and the EU are engaged in developing benchmarks for what a HCS should achieve and in providing support for national health policy making.

a) The WHO stimulated the emulation among HCS by its 2000 World Health Report, which explicitly compared achievement and efficiency of the HCS of all WHO members and yielded an explicit ranking. While methods and results are highly debated, see Navarro (2001), Williams (2001), and Gravelle et al. (2003), the impact of the study was nevertheless significant. In particular in those countries, which HCS were revealed to be underperforming.

b) The OECD engaged in several benchmarking efforts, e.g. the volumes OECD (2002), OECD (2003), OECD (2004a) and OECD (2004b). The aim is to identify common problems and challenges and to analyze the results and effects of the various approaches by which different HCS tackled these problems.

c) The EU established a process using the open method of coordination, where member states jointly formulate standards and targets and try to achieve them; see Busse (2002), Schulte (2005), and the report of the EU Health Policy Forum (2003); see also the Health Policy Monitor Network's website, which is tracking and evaluating specific health policy measures.

Such benchmarking demonstrates what different HCS can achieve and are actually achieving. Contrary to purely theoretical exercises[2], benchmarking in the form done by the OECD and the EU puts more pressure on health policy makers. The resulting rankings are often published to a wider audience, e.g. in the press, and are much more concrete. The achievement of these aims and standards is much more realistic, since there are actual HCS which meet these targets. Comparative health system research on health system efficiency, in its empirical strain as well as its theoretical strain, has spent considerable effort to provide information for an "evidence based" health-policy making; Murray/Frenk (2001). The aim is to provide empirical evidence appropriate to give health policy makers concrete hints on what features to copy under what circumstances, see Pawson et al. (2005) and Lavis et al. (2005).
However, despite an extensive body of comparative research on health systems there are several problems and open questions: The first is that while efficiency is a term often used in the public and academic debate, it is not entirely clear what HCS efficiency actually is and how can it be measured. Second, while it is clear from a theoretical point of view, what the effects of a certain regulation are, it is empirically not that easy to tell that this particular institutional feature has this particular effect, e.g. on efficiency. Moreover, the question is also, whether efficiency can be increased by copying certain institutional features, and if so, which ones? Or, is copying isolated features useless, because features only work, when combined in a certain way? I will shortly elaborate on both of these problems.

Measurements of Health System Efficiency

Before looking at results of existing research on the determinants of HCS performance and efficiency, I will shortly elaborate what HCS efficiency and performance is.
Performance is often understood as what the HCS is achieving, often but not always taking at what costs. Efficiency is always based on the ratio of inputs to outputs. Even before

[2] There is a long tradition of studies looking at the provision of health care from an industrial organization perspective, see e.g. Diamond (1992) and López-Casasnovas (1991). However, while they deliver arguments for certain institutional solutions, their impact on health policy remained limited.

comparative studies of HCS efficiency became a major field of research, the input side as well as the output side of the HCS was studied.

a) For the input side, i.e. the determinants of health expenditure in absolute as well as relative terms, an overview of the encompassing research can be found by Gerdtham/Jönsson (2000). While institutional settings are found to have an effect, the most important role is usually assigned to GDP. Here, the issue of whether there is any causality in the correlation between GDP and health expenditure is still unsolved. The mechanisms underlying this relationship are also debated. Some argue that it is purely an effect of preferences, implying that health care is a luxury for which more money is spent as people get richer; see in particular Newhouse (1977). The institutional settings in HCS are in this view mere epi-phenomena, chosen for their effects on satisfying societal preferences, which are the real determinants[3]. Other authors see health expenditure as an investment in the society's productive capacities. GDP is seen as an indicator of the financial value of a certain period of life which is produced by the HCS. It makes economically sense to spend more money for additional health, if this period of life gets more valuable in terms of produced GDP. In the frame of this argument, some countries are underinvesting in health, either by spending to little or by not covering a significant proportion of the population - with negative effects on economic development, see Hall/Jones (2004), López-Casasnovas et al. (2005), Suhrcke et al. (2005), WHO (2001), Bhargava et al. (2001) and Kotzian (2006). Expenditure is a highly visible "feature" of a HCS, and much reform activity is aiming at limiting this figure. However, health spending per se is no indicator of performance, because it is also influenced by preferences, see Evans (1985) and McGuire et al. (1993) for the usage of economic models to questions which are basically normative by nature.

b) For the output side the relative importance of the HCS compared to other factors influencing health status is limited. Good overviews on the impact of non-HCS factors on health status can be found in Auster et al. (1969), Babazono/Hillman (1994), Cutler/Deaton/Lleras-Muney (2006) or Nixon/Ulmann (2006). The most important finding is that the overall development – economical as well as societal – is a major factor for health status. If overall living conditions improve, health status improves too, since people get ill

[3] For instance one might argue that a NHS is chosen by a society as organizational form of the HCS because it is the best method to ration health services. This rationing is an expression of the societal preferences, and the real reason why expenditure is lower in this country is this societal preference. This HCS remains in place as long as the societal preferences and the societal acceptance of rationing remain unchanged. The implication is first, that certain models of HCS cannot be transplanted from one country to another one because they will not be accepted. The second implication is that a society always has the HCS it wants and spends as much money for it as it wants.

less often and are living longer by default. Health expenditure increases parallel to societal development but seems to have no direct impact on the bulk of life years gained. In particular in developed countries, there is no longer a relationship between health expenditure and health status. The role of lifestyles for differences in health status, e.g. life expectancy, gets more important as the overall development proceeds and other causes for illness become less relevant. After having created a functioning HCS delivering basic care, the relationship between increases in health expenditure and increases health status seems to dissolve, see WHO (2000) and Self/Grabowski (2003).

The empirical research on HCS performance usually measures "performance" in terms of input-output-ratios, i.e. combines information on input (expenditure) and output (health status). The concept of HCS performance is approximated by measuring productive efficiency of the HCS: how much input is used to produce a certain level of output?
Empirical analyses looking at HCS performance – understood as productive efficiency and proxied by the ratio of resource consumption to output levels – are using the econometric techniques of Data Envelop Analysis or Productivity Frontier Analyses developed in econometrics for productivity measurement, see Farrell (1957), Charnes/Cooper/Lewin (1994), and Kumbhakar/Lovell (2000) for the methodological foundations of efficiency measurement. As such, they require quantitative data on the HCS' input, output and other outcome relevant factors. Such quantitative data is nowadays available for the analysis of some research questions, in particular since the OECD Health Database is recently providing a wide range of variables, which were collected and compiled in a way which is usable for quantitative analyses.

The empirical results of measurements show that HCS differ substantially with regard to their performance; see the performance / productive efficiency evaluations in WHO (2000), Evans et al. (2000b), Bhat (2005), Grubaugh/Santerre (1994), Greene (2004), and Retzlaff-Roberts et al. (2004). This not only concerns output in the sense of life years, but also other aspects of health production. Some HCS produce high quality care, leading to high levels of health status even after controlling for other health-relevant factors like lifestyle. Other HCS don't. Either the less efficient HCS require – ceteris paribus – more resources to produce the same health status, or they produce – again ceteris paribus – a lower health status while consuming the same resources than other, more efficient HCS.

Table 1 gives a short impression on how the estimated efficiency and performance of the HCS differs within a group of comparable countries, but also how the efficiency evaluation as such differs among studies.

Table 1: Efficiency and Performance Indicators for Health Systems in OECD Countries

	WHO1	WHO2	Bhat	Kotzian	AM1	AM2
Australia	0,844	0,876	,75	0,21	60,81	88,36
Austria	0,914	0,959	,98	0,31	72,8	106,85
Belgium	0,878	0,915	,70	0,25	n.a.	n.a.
Canada	0,849	0,881	,87	0,26	62,17	91,8
Denmark	0,785	0,862	1,00	0,30	69,35	97,21
Finland	0,829	0,881	,93	0,25	66,45	109,64
France	0,974	0,994	,81	0,34	62,69	75,08
Germany	0,836	0,902	,84	0,43	64,15	95,9
Greece	0,936	0,933	,98	n.a.	72,34	98,53
Ireland	0,859	0,924	,87	0,20	81,87	129,34
Italy	0,976	0,991	,81	0,29	68,92	88,13
Japan	0,945	0,957	1,00	n.a.	72,48	81,41
Luxembourg	0,864	0,928	,78	0,18	n.a.	n.a.
Netherlands	0,893	0,928	1,00	0,29	71,19	97,26
New Zealand	0,766	0,827	,87	0,25	74,29	109,03
Norway	0,897	0,955	1,00	0,22	56,92	87,51
Portugal	0,929	0,945	1,00	0,23	113,02	132,07
Spain	0,968	0,972	,999	0,22	66,14	84,11
Sweden	0,89	0,908	1,00	0,32	50,55	79,6
Switzerland	0,879	0,916	,86	0,40	n.a.	n.a.
United Kingdom	0,883	0,925	1,00	0,14	91,1	113,62
USA	0,774	0,838	,83	0,25	80,66	114,65

Remark:

WHO1: Efficiency Score based on production of DALEs, i.e. health outcomes only.

WHO2: Efficiency Score based on the Overall Achievement, health and beyond health outcomes, and fairness of the HCS. Both from the 2000 World Health Report, high scores imply high efficiency of the HCS.

Bhat: Efficiency Scores based on Constant Returns to Scale Efficiency; Bhat (2005: 219, Table 3); high scores imply high efficiency of the HCS.

Kotzian: Average production cost per life year attributably produced by the HCS; see Kotzian (2006); high values imply higher production costs of life years in the HCS, and thus lower efficiency.

Performance Indicators

AM1: Amenable Mortality; standardized death rates per 100.000 ages 0-74; excluding ischaemic heat disease .

AM2: Amenable Mortality; standardized death rates per 100.000 ages 0-74; including ischaemic heart disease; AM1 and AM2 scores are from Nolte/McKee (2003: 3); high values imply an underperforming HCS, in which many life years are lost due to causes the HCS should avoid.

When comparing the evaluations of individual HCS presented by different studies one has to keep in mind that efficiency is measured by each study in a slightly different way.

A first difference is that the share of health status attributed to the HCS differs. Some studies assume that the HCS is more important for health status than other studies, differing in the share of health status, which is actually attributable to the HCS. For instance the study of Nolte/McKee (2003) focuses on the HCS' reduction in the mortality, which can be avoided by the HCS instead of using life expectancy, as does the WHO. The argument is that while people might live long for many reasons, they should not die because of medical conditions a functioning HCS could handle. A well performing HCS should identify medical problems, treating them and avoid the loss of life years due to these illnesses. If it does not, it is underperforming. The appropriate indicator of a HCS' performance is hence the number of life years lost, which could have been avoided. The evaluations resulting from the two approaches, i.e. the WHO's life years produced vs. Nolte and McKee's avoidable mortality, are very different.

A second difference is that the studies are taking into account different types of health system output and are assuming the same societal preferences for levels and types of output. The HCS also produces services without impact on health[4]; see Newhouse (1977), Mooney (1998)

[4] Examples of these are improved diagnostic information, conveniences like the standard of accommodation in hospitals, less invasive operations, but also care which is provided in situations where it is of no measurable impact on biological health, but is more aiming at helping patients to cope with their situation.

and Donaldson/Shackley (1997) for definitions and examples of 'beyond-health-outputs' and 'process utility'. Ignoring one type of output is a potential bias in an evaluation. A good illustration are the two WHO scores. The first score is based only on health production: How good is the HCS in producing life years? Does the HCS produce as many life years as could be produced given the resource input? The implicit assumption is that all input is used to produce this one output, i.e. years of disability adjusted life expectancy; DALEs. The second score uses a composite index as output variable. This index is based on the production of health output, but also other aspects and outputs making up an 'ideal HCS', like responsiveness and fairness. The achievement of a HCS in these distinct outputs is measured. Then the different outputs are combined to a weighted composite index. Efficiency here measures, whether the input is used to produce as high a value of this composite index as possible. Again, the resulting scores differ. HCS which are highly efficient in producing health output might be not as efficient in producing other outputs. Indeed they may not produce other outputs at all, very much to the dissatisfaction of the citizens.

A third difference is, how the efficiency evaluations handle differences in preferences among societies. While the inclusion of more than one output in the evaluation makes sense, the uniform construction of the composite output variable implies the same weighting of the different outputs for all societies. Given that preferences and demands of the citizens change in particular parallel to economic development, assuming the same preferences for all WHO members is problematic. What the 'ideal HCS' is, is a question of preferences and cultural attitudes, and what the HCS produces will reflect these preferences. As an illustration one might use the US: if the citizens are demanding a very high level of responsiveness, the HCS will produce much of this output. Since responsiveness is an expensive output, much money is spent for this. While being counted as health expenditure, this money is neither spend for producing biological health nor do the citizens want it to be spend for this. In any efficiency measurement based either on the gross ratio of expenditure/health status, the US will come out inefficient. The same is true for evaluations, which – while based on a composite measure of HCS output – assume identical preferences for all societies. These evaluations ignore that Americans are willing to spend more money for this particular output than anyone else. Here too, the US will show up as inefficient.

A further way by which preferences impact on efficiency scores is the issue of how much health is produced. The production of health has rapidly diminishing returns. At the macro level, producing health in a society where citizens are already very healthy and any further improvement is very expensive in terms of input required, makes health expenditure soar,

while the resulting improvement in health status is only marginal, see Pritchett/Summers (1996), WHO (2000), Gandjour/Lauterbach (2005) and Self/Grabowski (2003). At the micro level the costs of producing a life year using a certain medical intervention differs substantially; see Tengs et al. (1995) for the most prominent study of the costs of a life year produced by an intervention. Drawing a line on what medical interventions to pay for is again a question of preferences and a political question, see Brown (1991), Luce/Rubenfeld (2002), Devlin/Parkin (2004) or Buxton (2005) on how countries handle this problem. If the HCS produces life years up to a very high "price per piece", HCS efficiency measured as input-output-ratio declines. But again, this has nothing to do with the HCS' efficiency, but rather concerns what the HCS is used for. The HCS might produce a certain medical intervention at minimal costs, but the intervention per se is used situations, where it cannot produce many additional life years. The fact that the medical intervention is made in situations like these is a result of the societal preferences. A further aspect of preferences is the question whether a certain medical condition, e.g. missing teeth, is acceptable or whether is it perceived to be in need of treatment. This too is a question of cultural and societal preferences. So when comparing the efficiency of HCS, one must pay attention to the preferences of the society and their notion of what an ideal HCS produces.

Institutional Design and HCS Efficiency

To summarize the empirical work on this stage, the overall result of a substantial variation in HCS efficiency holds true, even if health relevant factors outside the HCS and different outputs are taken into account. Some HCS are indeed per se more efficient than others, producing more output per unit of input used than others. From the perspective of a health policy maker driven by the wish to increase HCS performance, the question arising immediately is: What are the reasons for these differences and what can be done about it?

The chosen performance criteria reflect, what types and mixture of outputs a society wants, and what the society expect it's HCS to achieve. There is no single efficiency, which is appropriate to evaluate all HCS. Efficiency concerns whether the HCS in this country is able to achieve the aims defined by the society at least possible costs. In one society, the appropriate indicator might be the WHO score based on DALEs, because the society only cares about life years. In another country, the appropriate efficiency score might be based on the production of responsiveness, because the society is concerned only with this output. Thus, given that one has chosen an efficiency indicators one can start to analyze the reasons for differences among HCS in the chosen performance indicators. In particular, one can look

at the role of institutional factors, because these are the features amenable to policy changes – contrary to life styles, which are usually beyond politically motivated changes. For instance, if the society wants only health output, one can estimate an efficiency indicator which is based only on health production and identify the HCS which is most efficient in producing health output. If one wants high levels of responsiveness, one bases the evaluation on a responsiveness indicator and looks which HCS are achieving high levels of responsiveness at least costs. The design of the benchmark HCS can then be used as a template for changing the HCS.

What are the approaches and the results of health system research in this regard? There is a body of research analyzing the role of the institutional setting, using a variety of methods and approaches:

There are studies looking at how the institutional design of relationships between actors in the HCS affects performance, e.g. the relationship between GPs and patients which is in the core of health care delivery; see Blomqvist (1991), Scott/Vick (1999), Delnoij et al. (2000), Croxon et al. (2001), Garcia Marinoso/Jelovac (2003) and Delattre/Dormont (2003). Sectorial studies compare how organizational features affect the performance of a particular sector. For instance how the regulation of pharmaceutical consumption affects usage of generics and thereby pharmaceutical expenditure; see Kamal-Bahl/Briesacher (2004) and Hassell et al. (2003). Or, how the efficiency of hospitals is influenced by features like ownership, non-profit-status or remuneration modes, see Dismuke/Sena (1999), Hofmarcher et al. (2002), Bech (2003), Kjerstad (2003) or Biorn et al. (2003). Other studies compare prototypical organizational forms of health care delivery; see for instance Feachem et al. (2002) for a comparison of a NHS with a HMO, or Danzon (1992), for a US Canada comparison.

Doing so, a fact that soon comes into view is the institutional complexity and variability of HCS: HCS differ in many regards, and it is difficult to attribute differences in performance and efficiency to how a certain institutional feature is designed. It might even be the case that features only have effects when combined with other features in a certain way.

This problem gave rise to a different approach of analyzing variation in performance and efficiency without paying heed to the question of what the exact institutional factors and mechanisms are. The basic idea of how to compare the institutional setting of HCS without dividing the settings analytically is outlined for instance by Grubaugh and Santerre. They conduct a regression analysis of performance indicators, in their case health expenditure as

input and infant mortality as output, on exogenous features of the country, treating the features of the HCS as non-observable and using country dummy variables as proxies for the country specific institutional setting of the HCS. Using the values of a country A in the independent variables obtained in the regression equation plus the country dummy for country B, which represents unknown features of B, but also country B's HCS, one can calculate the performance country A would have, if it had the HCS of country B; see Grubaugh/Santerre (1994).

This method of looking at institutional effects without analytically dividing them into variables can also be applied at a sub-national level. For instance the study by Hauck et al. (2003) for the UK uses multilevel random intercept model to estimate the effects of individual wards, which are nested in District Health Authorities, which in turn are nested in Regional Health Authorities. The nesting structure of the analysis allows to capture the share in several outcome variables which is due to the – unspecified – features of the administrative unit (DHA or RHA) and the variance associated with each administrative level (district or regional). A noteworthy finding is that the administrative unit's impact differ substantially among indicators of HCS performance. While relevant for some outcome variables, like mortality, the institutional setting is irrelevant for others.

There is a range of similar studies in this strain, e.g. Bhat (2005) and Retzlaff-Roberts et al. (2004), both using Data Envelop Analysis, or Evans et al. (2000), Hollingsworth/Wildman (2003) and Gravelle et al. (2003), using productivity frontiers. All have in common that they use the overall setting of the HCS without going into identifying the actual features affecting efficiency and performance.

As for the results of the studies mentioned, the role of institutional settings for health system efficiency is substantial. This holds true, even when the strong effect of societal preferences and the diminishing returns of investments in health are taken into account. But the studies do not give information about which features are influencing efficiency. They just find that the organization of the HCS affects efficiency. Obviously, this is of limited use for health policy.

So, what the empirical comparative HCS research wants to achieve, is to get insights on the institutional determinants of HCS efficiency: What institutional features increase HCS efficiency? Here, the finding that "institutions matter" is but a first step. Copying isolated features usually does not work. Thus, the question is also: Under what conditions does an institutional feature have this effect – and why does it sometimes not work, if copied? As Pawson et al. (2005) put it, the question is not simply, What works? But rather: What works

for whom in what circumstances? HCS are complex, and the interaction among the institutional features in the HCS makes it difficult to achieve an effect by changing just one feature in isolation. In pursuing these questions empirical research is restricted by the fact that little comparable institutional data is available. What is needed, is data on the institutional setting of the HCS, which can be used in the analyses of the kind described in this section.

The Lack of Comparable Institutional Data on Health Systems

Unfortunately, the lack of comparable institutional data on HCS is a persisting problem in comparative research. While there is an abundance of case-based descriptions and descriptive analyses of HCS, there is little comparable institutional data which could be used to estimate the effect of an institutional setting on HCS performance and efficiency in a quantitative setting. While some institutional data exists, it is relatively crude, e.g. leaving much variation within each category of a variable[5].

Having a look at the literature on HCS or health policy, the predominance of the case-study approach is striking. For most industrialized countries, there are many case studies, covering current issues or the development of one particular HCS in great detail. The underlying assumption seems to be that each HCS is a case sui generis, which cannot be understood unless studied with full respect to its particularities. While achieving their declared aim, most of this literature stands alone. While it captures the intricacies of a HCS and is cumulative at the level of the individual HCS, it is of limited use for comparative work. If one tries to compile a database of institutional information by excerpting information from the case studies, one is quickly stopped by the fact, that there is little overlapping in time and themes. In some HCS, e.g. Spain, decentralization is the main topic, which is no theme at all in many other HCS. To a substantial degree, overall paradigms, like decentralization or privatization, or country specific issues determine the research interests, and much of the literature then covers this main topic from various angles, leaving aside all other issues, which are currently not of interest.

Comparative research in its quantitative strain uses the rough institutional data available, e.g. dummy variables for the most important features (dummies for NHS, Fee for Service-

[5] A country may be coded as having gatekeeping, but how this is handled, and to what degree patients have a actual choice among providers is something different. Neither does gatekeeping preclude choice, nor does the absence of gatekeeping imply free choice.

remuneration or gatekeeping) in a regression analysis of cross sectional or panel data, see Newhouse (1977) or Gerdtham/Jönsson (2000) for typical examples. In its more qualitative strain, comparative research is limited in the number of HCS it can handle, since here too, the authors go in the detail, see Immergut (1992), Tuohy (1999), or Hacker (2004) as typical examples of qualitative approaches.

Given this lack of data, there are efforts to close this gap. There is a number of international level efforts to compile databases; e.g. EU reporting in the MISSOC and the Health Systems in Transition Reports, HiT, edited by the Copenhagen based European Observatory on Health Systems and Policies, which follow a common template[6]. But there is still too little comparative institutional data available on which a comparison of a larger sample of HCS can be based.

Gathering Institutional Data on the HCS: Accepting Limitations

Institutional data is missing not due to a lack of interest, but because gathering institutional data on HCS quickly encounters practical problems. The institutional variety of the HCS is large. HCS differ with regard to many variables, a fact which makes it impossible to compare the HCS in a way which captures all aspects and institutional differences which might be relevant. More technically put, if one focuses on OECD or EU countries, where the informational basis is quite good, these about 30 HCS are likely to differ in more than 30 aspects at any point in time. Consequentially, available comparative studies focus on selected issues:

- Degree of public vs. private provision
- Role of the state, e.g. which parameters of the HCS are set politically and at what level.
- Decentralization vs. centralization
- Issues of quality assurance
- Issues of access to care; e.g. equality of access, gatekeeping vs. factual choice
- Usage and effects of co-payments
- Issues of coverage – be it coverage of services or coverage of citizens

The question is then, how the design in a particular sector or a particular feature affects HCS performance. The results are ceteris paribus statements, based on the quasi experimental setting, in which the researcher assumes that if nothing else changes in the institutional setting

[6] See the Observatory's website for the current version of the template underlying the HiT country reports.

of the HCS, changes in the dependent variables, like expenditure, quality or responsiveness, are due to these changes.

The point to be seen is, that while case studies are most appropriate in giving the functioning of a HCS its due attention, comparative research on HCS requires compromises.
The first compromise is a selection of features of interest, with the explicit exclusion of other issues. Even focussing on institutional features leaves a wide range of issues to select from. In the following section, I will present the framework on which the selection of features for this data-handbook is based.
The second compromise is a certain superficiality. Covering several HCS implies that no HCS is treated with the attention to its particularities in organization and functioning that is usually paid to a HCS in a case study. This data handbook is thought as a source providing comparative information on a larger set of HCS by giving a list of features which in the end can be directly compared. In the most simplest case this is, whether a feature is present or not. It is intended that this information can stand alone and can be used as such, irrespective of how the overall HCS is organized[7].

2. A Framework for Comparing Health Care Systems: Delegation and Control in Health Care

Given the impossibility of a full scale comparison encompassing all potentially relevant features of HCS a selection of some issues is necessary. Such a selection in turn will be dependent on what one wants to explain – e.g. expenditure issues or quality issues. Further the selection will be based on a theoretical mechanism, assumed to be capable of explaining the variation in the variable of interest.

The framework underlying this data handbook is the following. The central question is how institutional factors affect HCS performance, which is the dependent variable to be explained. The HCS is in my view a productive system and its institutional design will determine how efficient it transforms input into output, e.g. money into outputs like life years, quality and satisfaction. Given this question, the chosen underlying theoretical framework on which an

[7] For instance, the feature "A purchaser provider split exists" is not dependent on the feature "NHS-system or non-NHS-system". There are NHS systems with and without purchaser-provider split, and also NHS-systems with a partial split, where some services are integrated, i.e. provided by the financing organization, while some services are contracted from independent providers.

explanation is based, is the institutional economics / delegation approach and this approach in turn determines the selection of the features for which the data is collected.

Institutional Economics: Delegation, Control and System Performance

When aiming at explaining the effect of the institutional design of a HCS on its performance, the institutional economics framework, especially the delegation/agency-approach, is only one of several possible options. But there are several reasons favoring this particular choice.

Firstly, the delegation of tasks is the central feature of the HCS. The patients delegated more or less every aspect of health care provision to some agent. The restoration of health is delegated to the physicians. The financing of health care is delegated to a third party, either the state or an insurance fund. The control over the HCS is delegated to the state, as the politically accountable "steward".

Secondly, this institutional economics / delegation approach is generally able to provide a micro-level based explanation of the effects of the organizational form of a system on the system's performance, be the system a political system, a private enterprise or a HCS, see for instance Le Grand (2003), Dixit (2002) or Franzese (2002). A HCS' institutional design is a macro level feature, which sets incentives for rational and hence understandable behavior of individuals at the micro level. Aggregated, this individual behavior in turn leads to effects at the macro level, e.g. HCS performance. While explaining (dependent) macro features with other, (independent) macro features, the institutional economics framework has the advantage of being "understandable", since it rests on the understandable behavior of individuals: the situation sets certain incentives and restrictions for an actor, who behaves in a certain way, because it is the rational thing to do given the opportunities and constraints of a situation.

Thirdly, with regard to comparing HCS and the construction of the HCS Inventory as the template by which the data is collected, the approach provides a list of institutional features relevant as explanatory factors for performance. It allows to look at very different HCS with the same question in mind, getting answers which are comparable, most often in a binary way. In the simplest case, the comparative description of HCS poses two questions: 1) Is a certain delegation relationship with a incentive problem present or not? 2) Is a certain control mechanism countervailing this incentive problem present or not?

In this section, I will briefly outline the concepts of delegation, incentive problems and control mechanisms first in a general way, then with reference to health care.

Delegation Relationships, Incentive Problems and Control

Basis of a delegation- or agency-relationship is an actor, the principal, who cannot perform a task himself, e.g. because he lacks the necessary knowledge. Therefore, the principal delegates the task to another actor, the agent, by way of an explicit or implicit contract. Both sides realize advantages due to economies of scale and specialization; see Arrow (1986), Eisenhardt (1989), Dixit (2002) and Furubotn/Richter (1998).

However, as a self-interested actor the agent may not have an incentive to perform the task in a way, which is optimal for the principal. Their interest may diverge. The agent can be tempted to engage in opportunistic behavior, maximizing his own utility at the expense of the principal. This can take the form of extracting additional income, "rents" in addition to his official payment, or by reducing his effort and workload. This is particular the case if the principal cannot observe the agent's skill or effort, and – as it is typically the case in health production – outcomes cannot be attributed deterministically to the agent's skill and effort.

Given that this problem is known, the principal might implement control mechanisms, which bring the agent back into line with the preferences of the principal. Depending on the properties of the delegated task and the nature of the incentive problem, the possibilities to do so differ. Often, they have to be tailored to the situation at hand. Either, the mechanisms implemented make rent extraction impossible or create incentives for the agents to abstain from opportunistic behavior. Institutional economics and the economic theory of contracts have developed a range of possible control mechanisms; see for instance Varian (1990), Gibbons (1998), Prendergast (1999), Sinclair-Desgagné (1999), and Schweizer (1999).

Looking at health care various control mechanisms are available for the delegation relationships in the HCS. While the behavioral mechanisms and the expected effect of control mechanisms in health care has been discussed extensively, see Zweifel/Breyer (1997), De Alessi (1989), López-Casasnovas (1991), Ma (1994) or Scott/Farrar (2003), most of the literature remains at a theoretical level and is mostly concerned with the financial aspects. The quality side is often ignored, but is equally affected by incentives; see for quality related aspects Chalkley/Malcomson (1998), Garcia Marinoso/Jelovac (2003), and Faulkner et al. (2003).

Comparing Systems with Regard to the Organization of Delegation

This simple concept can be used to compare complex systems by conceptualizing them as networks of delegation relationships and looking at what delegation relationships exist and

how they are controlled; see Meurs (1993), Smith et al. (1997) and (Dixit 2002) for the usage of the delegation framework in comparative systems analysis.

HCS can be seen as a network of delegation relationships, see figure 1 below, which not only encompass the delegation of the restoration of health, but also various organizational tasks as well. In health insurance systems the patient delegates the task of organizing the collection of individual contributions, the negotiation of the prices for medical services as well as the payment of medical providers to the Health Insurance Fund; HIF. The HIF as the patient's agent should do this at low administrative costs and in a way, which is not too yielding vis-à-vis the providers. However, the HIF's interests diverge from the interests of its principals. First, standard bureaucratic theory predicts that the HIF has no incentive to act strictly in line with the principal's preferences for an efficient administration at least possible costs; see Moe (1997) for the behavior of bureaucracies as agents pursuing their own interests. Second, the HIF can shirk from its task to negotiate reasonable prices by colluding with the providers, allowing them to charge higher prices and in turn raise the principal's contributions to the HIF and thereby the overall volume of financial resources consumed by the HCS constantly. Part of this increase can be used by the HIFs for 'on the job consumption' or to cover high administrative overhead costs.

In addition to tasks relating directly to the provision and organization of health care, the patient in his role as a voter delegates the control of the HCS to the government, which acts as a political agent. Either the government is directly in charge of organizing health, e.g. in National Health Services, where all parameters of the HCS, like budgets, waiting lists and coverage, are explicit political decisions. Or, the government is in charge of exerting an overall control, i.e. to bring the HCS – that is, the societal actors running the system – back into line with the preferences of the electorate. Either by making decisions, which set a frame for the societal actors, e.g. limiting the contributions going into health care, or by fundamental structural reforms, e.g. taking away competencies from the societal actors or abolishing certain actors altogether by integrating their function into the public administration.

However, the government may shirk from these tasks because it doesn't want to risk opposition by the influential and well-organized interests in the HCS and therefore constantly allows for HCE growth rates that are not accepted by the voters ('collusion' of controller and controlled). The mechanism by which the government, or rather the governing parties, itself is forced to do the job, is the electoral competition; see for control exerted by elections and its effects of subsystems in different settings; Feld/Kirchgässner (2000), Bartolini (1999), Bartolini (2000) and Lake/Baum (2001).

Delegation, Control and System Performance

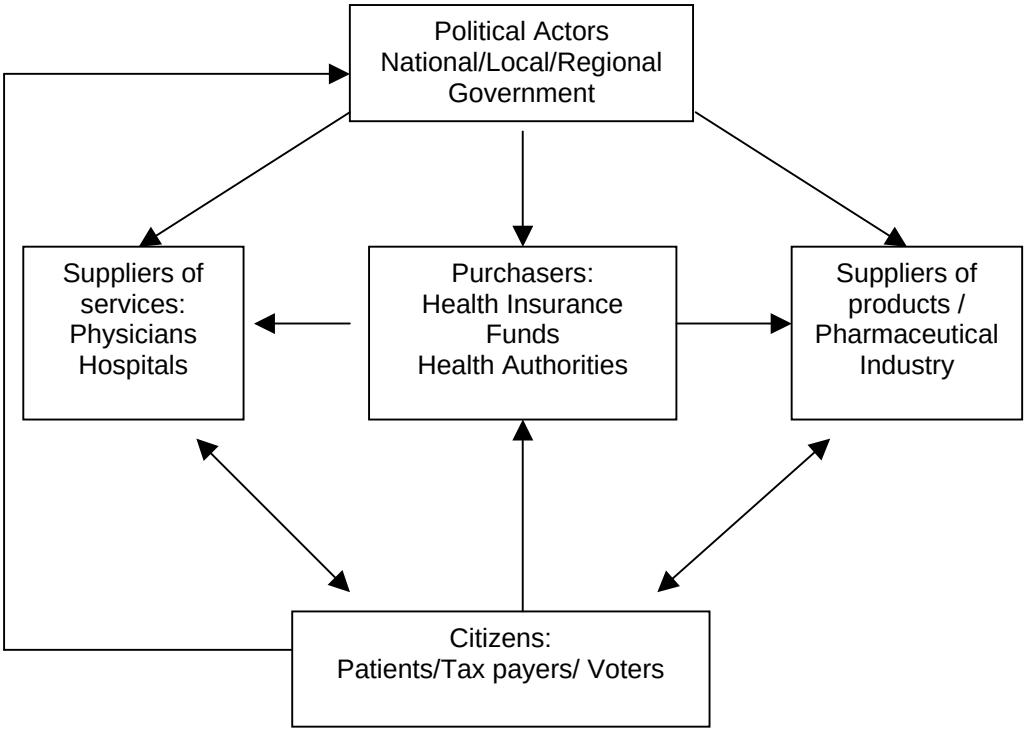
How does the organization of delegation and control affect the performance of a system? As a baseline prediction, uncontrolled delegation will reduce the system's performance. Given the lopsided distribution of information, agents have leeway for opportunistic behavior. This opportunistic behavior will increase those financial resources consumed by the system itself, without increasing the system's output. These losses will result either from agents extracting rents, i.e. use resources for other means, or by agents "shirking" from their task, without being observed to do so, while receiving full remuneration nevertheless.

With regard to health care it has to be remarked that delegation/agency-approach is not restricted to the financial aspects alone. Agency problems in health care equally concern the quality of the medical services provided; see Ma (1994), Chalkley/Malcomson (1998), Sari (2002) and Simonet (2003). Indeed, the double-edged nature of many regulations arises from the fact that they affect financial and quality aspects simultaneously, but in different, often opposite ways. While remunerating providers by salary or fee-for-services sets different incentives with regard to the problem of oversupplying medical services, neither guarantees high quality and effort. Shifting from fee-for-service to salary is likely to reduce costs, but it may also reduce output and in particular quality of services. If the provider receives the salary, s/he has a lower motivation to gain "customers" by investing effort in the medical care they obtain. Whether HCS performance, the bundle of input, output and quality, is actually improved by this change in remuneration is questionable and an empirical question. Introducing capitation, supplemented with free choice of providers may have an performance increasing effect. The provider's income is based on the number of patients enrolled with him, but independent of the quantity of services provided. While the fixed fee paid per patient enrolled with the provider sets an incentive to reduce the effort spent for each patient and to attract healthy patients as clients, giving patients a free choice among providers may counteract the problem of low effort because patients can leave a provider who is in their perception doing a poor job. But even giving patients free choice of the provider is of limited effect since patients usually lack the information necessary for making an informed choice of a provider; Hay/Leahy (1982). Lacking medical knowledge, they might misinterpret their observations, e.g. mistake the usage of high technology for quality of care.

Agency Relationships in Health Care

With application to health care, the concept of "agency" also refers to the delegation of a task to an independent actor in a setting of informational asymmetries. The agency relationships in health care are manifold. The characteristic ones are given in figure 1 below.

Figure 1: Delegation Relationships in Health Care Systems



Adapted from Jones/Zanola (2001) and Smith et al. (1997)

In particular in health care, advantages of delegation both for agents and principals are obvious. Among the immediately visible advantages are:

Specialization – medical knowledge is highly specific requiring large investments in education and training.

Economics of scale in the administration of health care provision and financing, the centralized provision of medical infrastructure, but also the pooling of resources and risks.

Unfortunately, the disadvantages of delegation are also strong in health care, since informational asymmetries are frequent and strong. Lacking information on the side of the patients with regard to quality of the medical providers and the performance of agents in

charge of administrative tasks precludes an informed choice of agents; see Culyer (1971), Reinhardt (1985), Arrow (1986) or Chalkley/Khalil (2005) for the problems.

Since the functions to be fulfilled by a HCS are basically identical, one can look at whether a function is delegated to an separate actor, or is integrated in a hierarchical setting. In the later case, the institution itself performs a task, in the former case, the institution delegated the task by way of a contract to another actor. Depending on the organizational form of the HCS, some delegation relationships are present, while others are absent. For instance the citizens can delegate the financial administration – collecting contributions, negotiating prices with providers, paying providers – to an agent. This agent can be the state, acting through Health Authorities (HA) or a Health Insurance Fund (HIF). How the financing side is handled does not say anything about how the supply side is handled; this can in both cases be public or private. Indeed, while the delegation of financial administration is near omnipresent[8], the delegation of the actual provision of services is organized differently. The provision of health care can be delegated to independent providers or be hierarchically integrated with the organization of health care financing. An example of the first case are independent GPs, contracted by the Health Authorities or Health Insurance Funds. An example of the later are health centers operated by local health authorities, with hired staff.
HCS of different ”types”, e.g. health insurance systems or NHS systems, are in these terms characterized by the existence of independent actors and delegation relationships between them. In this conception, there are no “types”, but constellations of structural features; see Przeworski/Teune (1982) and Ragin (1989: chap.3). For instance, the feature “existence of a purchaser provider split” is not strictly associated with a corporatist system, where Health Insurance Funds and provider associations jointly operate the HCS. Neither is the feature ”competition among purchasers” excluded in a HCS where regional health authorities are the purchasers acting on behalf of all inhabitants of an area. As can be seen in the sections of the data-handbook concerning purchasers, there are corporatist HCS, where competition among HIFs is only a pro forma affair. Similarly, there are public integrated systems, where local health authorities are under competitive pressure.

In the following, I will briefly discuss the relationships, the delegated tasks and possible control mechanisms. HCS are systems of layered delegation, where a task is delegated to one

agent, who in turn delegates part of the task to another agent further down the line. For instance, the provision of health care is delegated to the providers, while the administration of collecting and distributing funds is delegated to another agent, usually HIFs or some public administration. In particular control is delegated to several actors. Given this overlapping in tasks and issues, there is necessarily also some overlapping and redundancy between the sections on the individual relationships in the Health Care System Inventory, HCSI. This section serves also as the derivation of the HCSI: what features and what categories to describe the design of a certain feature were included in the data collection.

The Patient-Provider-Relationship I: Provision of Health Services

The most visible delegation relationship in the HCS is the delegation of the task "restoring health" from the patient, as the principal, to medical providers, as the agents. Lacking medical knowledge the patient has no choice but to consult a trained expert in the case of an illness. The patient makes a long term or ad hoc contract with a physician to maintain his health. Payment can be done either by a permanent fee or by an ad-hoc-payment to the provider. Usually, payment is indirect, with a third party acting as an intermediate agent, which is pooling the risks and is in charge of the administrative aspects of the relationship; see the respective section below.

While the patient is the consumer of medical services and products, the patient does not make the decision on what and how much medical services to consume. Instead, the agent decides on behalf of the principal. As an expert the medical provider has more information on what treatments might be necessary, what is sufficient and what is only of marginal or no effect at all on the health status. Because of this informational asymmetry the patient cannot evaluate the provider's decisions on the spot. Nor can the patient do so ex post, since the medical outcomes cannot be attributed to the medical interventions alone. Further, the patient is in a weak position to evaluate the quality and effort of the provider. First, it is not that easy to recognize a capable provider. Second, the patient has usually contact to only few providers mostly to those close to his place of living. This unobservable quality and effort raises problems of opportunistic behavior on the side of the providers of medical services. The principals have an interest in consuming only those services, which are appropriate and an

[8] The counterexample would be that the patient pays for the services directly, without an intermediary – apart from sectors like dental care or systems like the US, there is usually such an intermediary for most of the population.

interest that the services provided are of sufficient quality. The provider's interests diverge from these:

First, by deciding on what services to prescribe, the provider decides on the demand for his own services and thus on his income. The prototypical incentive problem in the patient-physician-relationship is the problem of supply-induced demand; see Hay/Leahy (1982), Rice (1984), Reinhardt (1985) or Phelps (1986). It is the physician who diagnoses the illness and decides on the appropriate therapy, which is often provided by the physician himself. The patient can neither evaluate whether the diagnosis is correct, whether the therapy is correct given the diagnosis, nor whether the service was actually necessary in the sense that it has a probable contribution to the health status.

If his income depends on the quantity of services delivered, the supplier of medical services may be tempted to oversupply medical services – doing everything, whether actually necessary or not, providing services, even if they are of no use in this case. The ethical evaluation of this behavior is not as simple as it may seem. There is the notion that health is achieved only if "perfect health" is achieved, even if the marginal improvements come at a very high price. Further, quality of care is sometimes defined in terms of "everything must be done, which can be done"; see the WHO's definition of health as perfect well being not the mere absence of illness, and Harteloh (2003). Doing everything that can possibly be done and has a potential positive impact on the patient's health status, however small, and explicitly not evaluating the cost-effectiveness may well be in line with the professional ethics; see Mooney (1992: chap7).

Second, there is the problem of quality. Quality requires substantial effort from the provider. During the actual treatment but also in the sense that the provider has to keep himself up to date with the state of the art in his profession. At the same time, the provider cannot signal his effort and skill to the patient in a reliable way. Because the patient might be unable to recognize effort and skill, but also, because, the outcome of medical treatment is not determined by the medical treatment alone. Neither improvements nor deterioration in health status can in every case be deterministically attributed to the treatment chosen. Nor is the relationship between the resulting health status and the physician's skill and effort a deterministic one. Even when focussing on the quality of the provision independent from the outcome, the patient cannot evaluate whether the quality was good or bad. The patient is lacking the medical knowledge required to evaluate whether the provider did a good or poor job (Is the effort spent by the physician to interpret an x-ray or the results of a laboratory analysis sufficient or not? Has the physician paid attention to everything there is to see on the

x-ray?). Moreover, the patient's relationship with the provider is an infrequent and bilateral one. The patient has no comparative information on the quality of other providers apart from informal sources of information like conversations with other patients. As I will elaborate later on, the collection and publishing of quality information, e.g. scores and rankings, is able to close this gap. However, quality measurement and quality assurance is among the most difficult issues in health policy.

Both incentive problems, supply-induced demand and the problem of unobservable quality, can interact, sometimes countervailing, sometimes aggravating each other. For instance, if the provider is paid on a fee for service basis, he may be induced to produce as much service as possible irrespective of their appropriateness in the case at hand, minimizing time and effort spent on each treatment episode. The result may be both oversupply and poor quality. The problem posed to the policy-makers is thus, how to design the HCS in a way which incentivizes the providers to produce good quality and to limit the quantity of services to what is necessary, but on the other hand no less than this. If these problems are not solved, the consumption of services will constantly increase, driving up health expenditure, while quality of treatment is likely to remain poor. The HCS as a whole will be inefficient.

The Patient-Provider-Relationship II: Provision of Medical Products

Since much of medical care involves using or consuming products and devices, the provision of medical products, be it in the form of medical devices or pharmaceuticals, is closely related to the provision of medical services. While the decision on what medical device or medicine to use is part of the task delegated to the physician, the production of these is another task, delegated to another agent. What I will look at here is the delegated task of developing, producing and using of safe and appropriate medical products. For reasons of simplicity, I will put primary focus on pharmaceuticals. The issues for medical devices, like dentures or cardiac pacemakers, are equivalent.

From the perspective of the delegation approach the pharmaceutical industry can be seen as an agent in charge of developing safe and effective medicines. In particular it shall improve existing therapies and develop new therapies, come up with products, which have a higher efficacy, fewer side effects or allow an effective treatment of conditions, which were untreatable hitherto. In exchange for the innovation per se, the pharmaceutical enterprise is granted a limited period of monopoly to recover its expenses for R&D and to make the profit necessary to make pharmaceuticals an interesting business; see Comanor (1986) and

Frank/Salkever (1992). The task of developing new medicines is an economically risky venture, with certain high expenses and uncertain chances of success; see DiMasi et al. (2003) and Grabowski/Vernon (2000a). In the end, it is this monopoly period and the associated profits, which is economically attractive for the producer and the main incentive to engage in developing new products. Once this period has expired, the market is open for competition from generic products sold basically at a price level a little above production costs. There is no economic legitimization to continue the monopoly position of the original inventor. Consequentially, prices for products which patent period expired are expected to drop, leading to lower pharmaceutical expenditure; see Bosanquet/Zammit-Lucia (1995) and Congressional Budget Office (1998). Two problems arise with regard to the pharmaceutical sector and pharmaceutical consumption:

First, the pharmaceutical industry might use an informational advantage – here the knowledge about the actual improvement the new product represents compared to existing ones – to secure a higher income. It might be economically more attractive to modify an existing product, obtain an new patent for the modification and thereby extend the period of patent protection and the higher income associated with this position, than to develop an entirely new product. The inventor is much better informed about the new product's real advantages relative to exiting products. And since market authorization procedures put most focus on safety issues, even marginal improvements may suffice to obtain a new patent. To counteract this information problem the step of market authorization or rather the decision to include the medicine into coverage by the HCS is the crucial point in time to address this informational asymmetry: Newer products may come at a substantially higher price, which can also be a continuation of the monopoly price level, without corresponding improvements in therapeutic value; see Kong/Seldon (2004). Lacking full information, the consumers and purchasers (HIFs, HA) of medicines cannot evaluate, whether the medicine represents a therapeutical improvement that is actually worth the higher costs associated with a new period of monopoly. In particular the patient, the actual consumer, has the least information to evaluate the new product. Usually patients also have the least incentive to act on such information, since the product is paid for by the HCS either completely or to a large share; see O'Brien (1989) and Hellerstein (1998). In this situation an agent – the prescriber, the agent in charge of financing pharmaceutical consumption or an institution in charge of evaluating pharmaceuticals – can be put in charge of the task to evaluate new pharmaceuticals on behalf of the patients. A possible mechanism to counteract these problems is to evaluate the therapeutic advantages of a new product relative to existing ones during phase of granting

coverage by the HCS, and to base coverage or the reimbursement level by the HCS on this evaluation. An evaluation can also be done later on, when more information on the therapeutical value of a new drug is available. Since most information arises decentrally at the level of the individual prescriber, the implementation of a systematical collection, analysis and distribution of information to the prescribers is advantageous. Regarding the actual usage of available information on the relative advantages of medicines, guidelines and pharmaceutical budgets for the prescribers might also serve as a mean to incentivize the usage of information on the improvement of a new medicine compared to existing ones: the prescriber, seeing how the medicine performed in all the cases he prescribed it, is usually better informed and in the better position to decide whether a therapeutical advantage is worth its price in a given case. The incentive to do so is absent, if the prescriber issuing the prescription is not involved in the payment; see Hellerstein (1998), Lundin (2000), and Hassell et al. (2003).

Second, the collective financing of pharmaceutical consumption creates a common pool problem. While containing pharmaceutical expenditure is in the interest of "everybody", there might not be an incentive for anybody to act accordingly. Patients might, out of pure habit, continue for favor the original brand they are used to, even if its price is higher than the generic alternative of equal effectiveness. This is in particular the case, if there are no co-payments for pharmaceuticals or co-payments which are independent of the price. To counteract this problem there should be the possibility and the incentive to switch to the generic alternative. That means, the prescriber or the pharmacists should inform the patient on the existence of generic alternatives, and the patient should actually switch to the generic. The assumed consequence is that this will either cause the price of the branded original drop to the level of the generic, or that the sales of the branded original drop, and its effectively replaced by the generic alternative. Empirically, this is not the case. Generic substitution is usually not working perfectly, either because patients as well as prescribers and pharmacists are unaware of the generic alternative or have no incentive to switch; Leibovitz et al. (1985), O'Brien (1989) and Grabowski/Vernon (1992).

The problem regarding medical devices is similar: First, there is the issue of the product's quality, e.g. for implants. Second, there is the issue of the cost effectiveness of its usage: is the usage of this device, the usage of this type of implant, the usage of this kind of diagnostic procedure appropriate in this particular case?

The purchasing and usage of medical devices, e.g. high technology diagnostics, be it in hospitals or by providers of specialized services is a major driver of health care expenditure; see Cutler/McClellan (2001), and Okunade/Murthy (2002). Again, patients do not decide on the usage, nor do they have sufficient information to evaluate the appropriateness of the usage in their case. They cannot evaluate if there's a real value added of a MRI to a simple x-ray in their case. Further, since patients at times (mis-)take high technology for high quality, they might be attracted by medical procedures using high-end devices, even if there is no substantial advantage.

To control this problem the investment in heavy equipment and the usage of technology could based on an evaluation of its cost effectiveness in order to increase efficiency, e.g. by way of guidelines. An example is the usage of diagnostics in the case of a suspected illness: When is the usage of this high-end diagnostic procedure appropriate, when is a less costly one sufficient, because the information obtained is sufficient to recognize the condition and to chose a therapy? Controlling costs in this issue may also be achieved by realizing economies of scale. For example by focussing all procedures requiring certain equipment in one place one can use the capacity of equipment to its full extent and thus lower the costs per usage episode.

The Patient-Purchaser-Relationship: Organizing and Administering Health Care

The HCS encompasses also various organizational tasks. Among them are the collection of funds, payments of providers or the negotiation of the prices for medical products and services. Contrary to the usual market setting of a consumer who is directly buying a service from a provider at a price they agreed upon, these tasks are not performed by the individual patients. Instead they are delegated to an institutional agent, the purchaser[9].

In National Health Services, NHS, the government fulfills most of these organizational tasks and acts as the purchaser. Contributions are collected by way of general or earmarked taxation, providers and medical infrastructure are either directly employed or contracted by the state. This can be organized on the national, regional or local level, with or without a Health Authority, HA, in which the tasks are bundled.

[9] In some HCS, the task of organizing health care is separated from the provision of services; i.e. there is a purchaser-provider-split. In other HCS, all functions are fully integrated, either at system level (state operated HCS) or at an intermediate level (Health Maintenance Organizations, which are providing the insurance function as well as the medical services to their clients). However, the incentive problems associated with the delegation of the administrative tasks are similar in all organizational forms.

In social health insurance systems the citizens delegate the organizational tasks to Health Insurance Funds; HIFs, which are the main purchaser. These HIFs collect contributions, negotiate prices and pay providers for services delivered to their clients. The incentive problems in the delegation relationship between the principal and the purchaser differ between HIFs and HA bureaucracies only by degree.

It is in the principal's interest that the purchaser, whatever it's institutional status, operates at low administrative costs, enforces quality of the providers and negotiate prices in a way, which is not to yielding vis-à-vis the providers' demands. However, the purchaser may not have an incentive to do so. Indeed, the purchaser has a preference to increase the health budget constantly. The motivation arises from a bureaucracy's institutional interest in administrating bigger budgets, but also from the motive to consume resources as "on the job consumption" or 'organizational slack'. Larger budgets can be used to hide larger absolute amounts consumed by the bureaucracy itself. Given that explicit profits are usually forbidden, larger budgets imply larger bureaucracies with more staff and hence more chances for the employees to raise in the growing hierarchy. The motivation to increase the overall health expenditure pertains equivalently to public administrations and semi-public Health Insurance Funds; see Niskanen (1971), Moe (1997) and Danzon (1992) for these "overhead costs". To achieve this constant increase, the purchaser can collude with the providers, e.g. by accepting their demand for higher prices. To the same effect, the purchaser can also set incentives or tolerate over-consumption of medical services by the citizens. In both cases, the responsibility, or rather the blame, can be shifted to other actors in the HCS.

Among the tasks delegated from the citizen to the purchaser is also the control of the provider's quality: the original principal puts one agent in charge of controlling another agent. The individual patient has little possibilities to evaluated a provider's quality. Nor can he enforce quality standards. The patient, who is in bilateral contact with only one or few providers, cannot identify providers which are overspending or delivering poor quality. What the patient can do, is to perform a very basic type control in the sense that if the provider gives a bill listing all services provided to the patient, the patient can check whether all services were actually delivered before passing the bill on to the purchaser.

A purchaser, acting on behalf of a larger group of patients, can exercise types of quality control, which are impossible for the individual patient. Purchasers can gather information on quality problems, like malpractice, arising in a large number of patient-provider-interactions. They can identify providers, where quality problems occur more often by collecting reports

and complaints by patients. The purchaser then may give the patients the information necessary to make an informed choice among providers, by publishing of quality information, e.g. rankings of providers. When negotiating contracts, the purchaser can make the abidance to guidelines of good medical practices part of the agreement. If selective contracting is possible, the purchaser can exclude individual providers if they provide insufficient quality.
Purchasers can also conduct routine auditing to preclude fraud. If the purchaser receives a detailed bill from the provider, giving the diagnosis and the medical measures taken, the purchaser can perform a check of plausibility and appropriateness. On this basis the purchaser can identify providers prone to oversupplying services. Again, in order to be effective this kind of control needs not be exercised in every case. The very existence of such control mechanism may limit certain problems which are reported for some HCS.

Given these options to act on behalf of the patient but also the divergence in the interests between client and the purchaser, how can the purchaser be incentivized to act in line with the client's preferences? The basic mechanism is competition, but for being effective, several problems must be handled. The main problem arises because there is also an informational asymmetry between the client and the purchaser. The patient might be unable to recognize a purchaser who is doing a good or a poor job.
Installing competition among the purchasers may incentivize them to perform well, and competition for clients is the control mechanism used most often. Basically, the mechanism makes use of the bureaucracy's motive to grow, but allows it to grow only by certain ways. By performing well, the purchaser attracts more clients, and more clients also imply a larger budget and the "spoils of office" associated with it: more resources available for on the job consumption and larger bureaucracies required to administrate the larger number of clients. If a purchaser is loosing clients, e.g. because it has to charge higher contributions to cover its administrative overhead costs, it might go out of business, which means that the employees of the purchaser loose their jobs. Competition incentives the purchasers by making a good performance the only way they can grow. However, to be effective, competition requires several preconditions.
First of all there must be several competing purchasers. If the HCS is operated by a monolithic purchaser, e.g. the bureaucracy of a NHS or a single HIF, control is not exercised by competition, since there are no competitors. The same is to some degree true for regional

monopolies[10]. Control can be exercised by the politically elected government by means of the hierarchical control.

Second, competition requires that purchasers can compete for clients. If a purchaser is doing a better job it is able either to extend the catalogue of services covered or to lower the contribution rate, thereby attracting more clients. If the purchaser is performing poorly it will loose clients – which might imply that the existence of the purchaser and the jobs of the employees are at risk. Thus, further requirements to establish a working competition among purchasers are: 1) There must be visible contributions. If the citizen sees the amount of money going into health, e.g. as an earmarked position on his wage bill or tax bill, he has a knowledge of what he pays for health that is absent if health care is paid for from the general taxation. 2) Next, citizens need to have a choice. In some HCS, citizens are assigned by occupational status or place of living to the purchaser, independent of its institutional status (public administration or an independent HIF). Since the clients cannot leave, there is no incentive for the purchaser to perform well. 3) Contributions must be informative about the purchaser's performance. Contributions differ for reasons apart from performance. One is the composition of the clientele and the degree to which the purchaser can engage in "cream skimming"; see Pauly (1974), Neudeck/Podczeck (1996) and Beck/Zweifel (1998). Instead of focussing on fulfilling the administrative tasks at least operating costs, acting in line with the preferences of the clients when negotiating contracts with providers, the purchasers may focus on attracting good risks – i.e. clients with a good health and / or high incomes – and getting rid of bad risks, clients with low health status and low incomes. While attracting good risks, i.e. healthy clients, always works, the motivation to attract clients with high income only occurs, if the contribution is a percentage of the income. The information contained in a contribution rate may also may removed or watered down by regulations. In some HCS, Germany is a particular good example, there is a financial equalization among the HIFs, which covers up differences in performance among them. If a HIF performs well, it is forced to pay contribution to the Risk Equalization Fund, sometimes up to the limit that it goes out of

[10] On the other hand a HCS in which public purchasers have regional monopoly positions does not exclude control by competition: in many Scandinavian countries the municipalities or counties organize health care, and sometimes they are under a competitive pressure, which is comparable (if not higher) to HCS with competing funds. The local (health) authorities raise local taxes, sometimes even taxes ear marked for health, and provide health services. Both, the level of the taxes and the services provided can be observed by the local population – which can for instance see, whether there are waiting times or other reasons to be dissatisfied with the way health is provided. The (political) responsibilities for financing and organizing health are also clear, while health is of course only one theme among many in local politics. Further, citizens living in the catchment area of a local health authority may not actually be free choose the membership, but they can nevertheless vote by feet, something citizens cannot do in some HCS, which pro forma have many funds.

business as a separate entity by being forced to merge with other funds. Thus, the equalization sets an incentive to concentrate on extracting transfer payments from the Risk Equalization Fund. 4) Purchasers must be allowed to compete by offering different catalogues or contributions levels. A HIF might offer a more encompassing catalogue than another HIF, covering some extras, even if the contribution levels have to be equal, as a signal that it is performing better than the competitors.

If these requirements for competition are given, the purchasers, HIF or public health authorities, are under an effective competition and it pays for them to perform well (keep administrative costs low, negotiate advantageous contracts with providers etc.). If not, they have no incentive to perform well and can shirk from the sometimes bothersome task of being a good agent. Again, HCS performance will decrease in the later case.

The Citizen-Government-Relationship: Controlling the Health Care System

In democracies the elected government is the citizen's agent in charge of setting the framework a society wants to live in. This also concerns health care as a crucial element of everyday life. HCS are very different in different countries, and it has to be kept in mind that all of them are results of choices and all can be changed, often enough fundamentally and often enough in the short run: a NHS can be introduced or abolished, see Blake/Adolino (2001) but also the many cases of abolishing NHS in countries in eastern Europe. A purchaser provider split can be established and revoked shortly after, see Ashton et al. (2004).

Independent of the state's current involvement in the provision of health care, citizens delegate a "meta-control" over the HCS to the government: The government is in charge of exerting an overall control over the HCS, controlling the societal actors or the public bureaucracy in charge of the HCS and keeping the HCS in line with the electorate's preferences by intervening or reforming the HCS. It is the government's job to set the "right" incentives for the actors in the HCS, be it a public bureaucracy or incorporated societal actors; see Saltman (2002). It is the government's job to represent and enforce the interests of the citizens. In particular since societal actors in charge of operating the HCS and factually making their living from health expenditure may have interests which diverge from those of the citizens.

Simplified, political control over the HCS is supposed to work as follows: if the HCS diverges from the preferences of the electorate, the HCS can become an issue in the electoral arena.

Health care is of course only one theme among others, but its a major one, which may at times decide an election. Political parties offer different models of how to run the HCS, often ideologically based, and compete for votes in the electoral arena. Parties can also gain electoral support by specific proposals. If citizens develop a preference for responsiveness and the HCS continues to be non-responsive, a party might offer changing the HCS, gain support in the elections and implement the program. So far the simple theory of parties and electoral competition working as a "transmission belt" for public preferences.

However in practice the government may shirk, renounce the exercise of control and let the HCS run its course.

A first reason to do this is because it doesn't want to risk opposition by the influential and well-organized interest groups pursing well defined interests in the HCS by acting on behalf of the only weakly organized patients, whose interests are rather diffuse and often self-contradicting; see Olson (1965) for the basic argument. Governments can be in collusion with special interests in the HCS, i.e. the providers and the purchasers (HIFs but also the administration of a NHS) all of whom share the interest in an ever increasing health budget.

A second reason is that while there may be strong dissatisfaction among a majority of voters with the HCS in its present form, the opinions about what to change may be very different and opposing. The situation may be one in which everybody agrees that changes are necessary, but everyone has different views about which changes. Engaging in health care reform when the public's preferences are unclear may be a loose-only situation for policy makers. It is probable that the current organizational form of a HCS persists, even when dissatisfaction with the HCS is high, for the very reason that there is no agreement on what to do.

A third reason is, that because the development of the HCS is often only one theme in the electoral arena, it may also be a neglected one. While everyone is dissatisfied, there are many other issues which dominate the political agenda and decide the elections.

To sum up, elections can be a control mechanism forcing the government to use its formal power to control or change the HCS, but this incentive can be quite weak in some circumstances.

A further aspect of the government's role as an external controller is the citizen's view that health care is a responsibility of the government.

The electoral pressure on the government is strong, if the government bears direct responsibility. For instance, the health budget, the catalogue of services covered, the decisions on capacities and waiting lists may be explicit political decisions made by a political

institution which is formally in charge. This political institution, often the ministry of health, is seen by the public as in charge of how the HCS works, and if its not working properly, the public has someone to hold accountable for this.

The electoral pressure is much lower, if the government is seen by the electorate as an outsider to the HCS and the parameters of the HCS are set somewhere by someone as a result of low profile negotiations, which are basically unobservable by the public. The public might be dissatisfied, but be at loss about whom to hold accountable.

A similar argument can also be applied to the impact of the level of government, which is the most important one for health care. Health is always just one theme among many in political competition, but the number of themes competing for the voter's attention differs among governmental levels, and so does the relative importance of a theme. A national election may be decided by an issue of foreign policy, but a local election will not. One could expect that the relative importance of health as an issue is ceteris paribus more important in elections for local government than in elections for national government. This would imply that political control exercised in countries, where lower levels of government are responsible for health care, is more effective than in countries were the national government is most important[11].

Controlling the Common Pool: Incentives for Limiting Health Care Consumption

Health care also creates an incentive problem at the level of the patients. Usually, health services are not paid for by the patients as it is the case with other consumption in the marketplace. Each patient consuming a medical service or product fully realizes the utility arising from this consumption. But s/he only pays part of the costs, which are split among all members of the 'pool', i.e. an insurance fund or the society as a whole[12]. The cost-benefit calculation at the individual level is hence biased, and the patient will over-consume services compared to consumption in a market setting; see Pauly (1974), Ma/McGuire (1997), Neudeck/Podczeck (1996), Manning et al. (1987) and Getzen (2000).

On the one hand the weak link between consumption and costs is a desired feature. In most HCS the implementation of the solidarity principle makes the contribution independent from

[11] This effect might be countervailed by the weaker position of smaller political entities in negotiations with providers of health care.

[12] In the simplest case, the "moral hazard" problem is as follows: If the patient has to pay for the whole costs of a service, s/he will consume services if their utility (measured in financial terms) is higher than or equal to the costs of the service. If a group of n patients contribute to a pool from which all treatment costs are paid, the patient has, in the short run, only to pay 1/n of the costs. The patient will consume services which utility is above or equal to 1/n of the costs. As a consequence, more services are consumed. While the contribution of each patient to the pool will have to increase in the next period, the situation remains unchanged.

consumption. E.g. the patient pays a certain contribution, a premium or a percentage of his income, or the HCS is financed from general taxation, but apart from some co-payments, health consumption is free. The pooling of risks, the avoidance of financial collapse if the individual falls ill, is in the interest each individual member of the group.

On the other hand, pooling resources and separating contributions from consumption creates a common pool problem, which constantly increases the health budget and the costs for everybody contributing to the pool. Since the marginal costs of consumption is often zero, there is the incentive to consume also services of only marginal utility. Services, the patients would never consume if they had to pay for them by themselves, may be consumed for the very reason that they are provided free of charge. Indeed, the time spent consuming services is an important factor in setting a limit to consumption; see Torgerson et al. (1994).

The problem is aggravated if patients are not involved in payment, and have no idea about the costs their consumption. Under "service in kind" forms of health care provision, patients are completely isolated from payments. Further, they cannot control the bill posed by the provider, e.g. check, whether the services billed were actually provided. Reimbursement systems in which the patients first pay the provider and are later on reimbursed by a third party make patients conscious of the costs of health care and allow them a basic control of the bill.

To sum up the incentive problem, the patient as an individual has an incentive to behave in a way which is opposed to the interests of the group. The interests are self-contradictory and inconsistent: It is in everyone's interest that HCE is limited, in order to contain the contributions each member has to pay into the pool. But no one has an incentive to limit his own consumption. Worse, even if one limits one's own consumption, there is no guarantee that the others do so as well. Also the impact of one's own consumption on the health budget is so marginal, that it is seen as negligible. The result at macro level is that to many health services are consumed. Even if they are of no impact on health status, i.e. of no actual benefits for the patient. Again, HCS performance will decrease because money is spent on services without measurable impact.

To counteract this problem, one can set incentives or put an agent in charge of controlling the individual patient's consumptive behavior on behalf of all other patients as a group. The idea is that the patients agree on constraining their consumption or hire an agent to exercise control over themselves in order to avoid that each individual exploits the common pool at the expense of the group.

The government or the purchaser as an agent can control consumption, at least to some degree. There are two options to do so.

First by directly controlling the provider's activities, an option difficult to implement in HCS where a purchaser-provider-split is established and the interaction among patient and provider is off limits.

Second, by setting incentives: A first variant of this mechanism addresses the providers of services. The purchaser, when negotiating the contracts with the providers, may also insist on a remuneration mode, which limits the incentive for the provider to supply services of marginal use. So even if the patient as a consumer would be ready to consume more health services of uncertain or marginal medical and financial value to him, the provider has no incentive to meet this demand. If the provider limits the quantity of services consumed by the patients by providing only what is strictly necessary for medical reasons, he acts also as an agent on behalf of the patients as a group; see Blomqvist (1991).

As a second variant of this mechanism, the HIF as purchaser may offer insurance contracts to the patients, which contain some incentives to limit the consumption of services. Examples are deductibles or the exclusion of some services from coverage (most often dental care). Co-payments may set an incentive at least to think about consuming a service. In particular, if the co-payment is flexible and is giving the patient a clue about the price of the services consumed.

Closely related to this issue is the problem of how to incentivize patients to behave in a healthy way, e.g. adopt healthy lifestyles. From the perspective of the purchaser, one option to achieve this is to set incentives to participate in preventive measures, e.g. regular medical checkups and screening. Examples of such incentives can most often be found in dental care. Instances are France and Germany, where the participation in regular dental check ups is rewarded by higher subsidies for dentures. A more recent trend can be seen in Germany, where some HIF reward efforts to reduce body weight or to quit smoking by boni, refunds or reduced contribution rates.

However, implementing this control is difficult; also because the purchasers as well as the providers have an incentive to shirk from this task:

From the provider's perspective, limiting the supply of services to what is necessary is a voluntarily renouncement of income which often arises proportional to the quantity of services provided. It is usually not in the interest of the provider to refuse services demanded

by the patient, even if these are, to his knowledge, of no use. In doing so, the provider renounces income and also risks to loose a client.

From the purchaser's perspective, limiting consumption goes against the motive to increase the health budget or rather to allow it to increase constantly. The purchaser shares with the providers an interest in a growing health budget, and thus may not have an interest in limiting the size and growth of the "cake" to be divided between them. Insisting on limiting consumption to what is necessary might create conflicts with the clients and might result in clients leaving the purchaser. Indeed, by limiting consumption the purchaser might loose more clients than it gains by lowering the contributions it has to charge. Clients might complain about the contribution rate, but when confronted with the consequences of cost containment, they might even more complain about these.

While being complicated in design and implementation, options to counteract the common pool problem exist. And in some HCS they are actually implemented, albeit their effectiveness is debated.

Control in Health Care

Control counteracting the incentive problems outlined in the above sections can be exercised by institutional mechanisms built into the HCS itself or by controlling it from the outside.

Built-in Control Mechanisms for Agency Problems

The description of the relationships in health care given above also gave a short overview on control mechanisms able to avoid problems. The incentive problems in health care, together with possible control mechanisms and their implications are widely discussed in the literature; see De Alessi (1989), Lopez (1991), and Scott/Farrar (2003). While theoretically straightforward, the factual effectiveness of the mechanisms is a debated empirical question; see Scheil-Adlung (1998), Faulkner et al. (2003) and Chaix-Couturier et al. (2000). Often, regulations have double-edged effects and their effectiveness is conditional on the wider setting. An incentive might work well in one HCS, but have no effect when copied into another; an incentive may have a positive impact on expenditure, but be a disaster for quality and responsiveness.

The point I want to emphasize here is that these mechanisms are built into the HCS. They define a situation in which actors behave in a certain way, i.e. not engage in opportunistic behavior, because it does not pay to behave otherwise. They are operative, without somebody

actually doing something. In particular, they do not require external intervention by the government, the kind of control I'll discuss next.

Exercising Control over the Health Care System: Levers and Capacity of the State

There exists also the possibility to control the HCS from the outside. Some states have the levers and the capacity to do so, other's don't.

In a corporatist HCS like Germany, associations of medical providers and HIFs are in charge of operating the HCS. The idea is that by incorporating all interests, there are enough checks and balances to keep the HCS performing well; see Döhler/Manow (1997). Using various arenas, organized interests negotiate all parameters of the German HCS. While the government has by law a substantial role, it's role would only be important, if the societal actors cannot reach an agreement. This is never the case – also because both sides share an institutional interest in retaining autonomy. The negotiations are very low profile, and it is not visible to the public, who is deciding on what. Responsibility is diffuse, and it is relatively easy for any party involved to blame other parties for whatever problems occur. The success of this self-government is questionable. One reasons is that both sides share an interest in increasing the overall expenditure for health care. The providers, because it directly determines their income. The HIFs, because they can extract an higher amount for organizational slack and on the job consumption. There is no actor involved representing the motive to contain costs. As for the degree of external control, the German government is currently not held directly accountable for the operation of the HCS. For instance, the HIFs decide on the contribution level. So it is them, not the government, announcing and charging higher contributions – usually justified by increased costs and "objective" reasons like demographic developments.

However, the government, also in Germany, is nevertheless potentially in charge of controlling the HCS and in particular the long term developments in the HCS. Whatever the government's current role for the HCS may be, neither health care expenditure nor the current institutional setting of the HCS does "just happen". They are either created or at least tolerated. The government is the society's instrument to control the HCS. As the superordinate steward it can intervene in the day-to-day operation of the HCS, or it may change the design of the HCS by reforms.

As for comparing HCS with regard to the political control over the system, one can distinguish internal levers and external levers of control:

The ultimate external lever is the reform of the HCS – e.g. abolishing self-government, acquiring the competence to set certain parameters politically etc.

Internal levers concern all aspects of the HCS which the government can currently influence under the given setting. Examples are overall budgets, contribution rates, growth rates for budgets, the number of hospitals or physicians in a region, catalogues of services covered etc. The number of levers for state control can encompass all aspects of the HCS, like it does in some NHS systems. In other countries, the government determines some aspects, e.g. the overall budget, but leaves the decision on other aspects to societal actors. In still others virtually all aspects are decided by societal actors. Government involvement can have the form of unilateral decisions, involvement in the decision making process or the ex post approval or disapproval of decisions made by societal actors.

HCS differ with regard to the levers currently available for government intervention. However, while the question of what levers a government has at hand is a first step to study political control, it is not a sufficient information. On the one hand, government control might be effective without visible usage. The very potential to exercise control may exert an disciplining effect on the actors running the HCS. On the other hand, the literature on health system reform shows that countries differ with regard to the chances that the government can bring about reforms or even use the levers it has currently at hand.

In my view, the effectiveness of both instruments of control depends on the government's capability to act. An additional question, which the data handbook does not cover, is, what factors influence whether such a potential exists, i.e. determine whether the government or the political system in general is capable to exercise its potential for control.

Summary: Delegation and HCS Performance

Incentives set for individual actors by the institutional design of a HCS are a genuinely institutional source of variation in all aspects of HCS performance, be it resource consumption, quality and overall productive efficiency of HCS.

There are typical functions necessary for running health care provision, many of which are delegated to actors. For each of these delegation relationships, there are potential incentive problems, i.e. a divergence of interests between principal – basically the citizen – and the agent – basically all actors in charge of providing or organizing health care.

The general hypothesis of the institutional economics approach is that the more delegation relationships exist in a HCS and the less – in particular the less effective – the control mechanisms implemented in the HCS, the higher – ceteris paribus – the risk for opportunistic

behavior, which decreases the performance of the HCS. Either by increasing the resource consumption for a given level of health output or by decreasing the health output or the quality of the services provided for a given level of resource input.

Theoretically, for each of these incentive problems, there exist control mechanisms, which can countervail the incentive problem. What the present data handbook does, is to make an inventory of the existent delegation relationships and the implemented control mechanisms in a selection of HCS.

On the Conditionality of Effects

This compilation of institutional information on delegation and control in HCS covers more issues than just delegation. The reasons is that the effectiveness of the control mechanisms is conditional on the wider environment in which the delegation relationship is embedded. Two examples may show why.

Cream skimming, the attempt of HIFs to attract "good risks" (clients with high income, low likelihood of cost arising from illness) and to deter "bad risks" occurs only under certain constellations of circumstances: only if there are several purchasers, if citizens have free choice, if contributions payable by the client to the purchaser or catalogues of medical services covered by the purchasers are allowed to differ. The degree to which it occurs is also conditional on the overall setting. First, it might be limited, but also increased by some kind of risk equalization among the purchasers, depending on how this equalization is designed. Second, if the contribution going to the HIF is a percentage of income the incentive for cream skimming is presumably higher than in situations where the contribution is a premium independent from the income level. In the first case, cream skimming is motivated by health status and income of the clients. In the later case it is only motivated by health status, since the attractiveness of a client is determined only by this person's health state and expected health care costs. If there is a risk equalization among the HIFs based on features of their clientele, it might even pay to attract bad risks.

Co-payments shall make people sensitive to the prices arising from consuming health care: their payment depends on their consumption. Thus, installing co-payments may serve as a measure to ameliorate common pool problems. On the downside, they might also discourage certain groups, in particular low income groups, from getting treatment required now, causing substantially higher costs later on. Their effect also depends on how co-payments are designed: Fixed co-payments, like a fixed fee payable for the prescription of a medicine, may have only a very limited effect on the decision to use a generic. If the prescription fee is the

same independent of whether the more expensive original or a cheaper generic is used, this will not affect the decision for or against a generic. Overall pharmaceutical expenditure is not reduced, only a share of the costs is shifted to the patients. The effect of co-payments also depends on other regulations: If patients can turn a flexible co-payment into a fixed co-payment by entering a supplementary insurance, the intended effect is also cancelled. While the amount paid by the individual for health care is higher, consisting of the basic contribution to the health system plus the contribution to the supplementary insurance, it is once more independent from the quantity of services consumed.

To summarize, the empirical effect of certain control mechanisms on the efficiency of the HCS is an open question, since they affect the input side (costs) as well as the output side (health status) simultaneously and often in opposite ways. To allow an evaluation, data must be provided for several related institutional features as well, which affect, whether and if so, what effect an individual feature will have.

3. The Health Care Systems Inventory

Based on the theoretical framework of delegation an inventory of delegation and control was developed to compare HCS. The aim of this "Health Care Systems Inventory", HCSI, is it to describe HCS in a standardized, directly comparable way. Whatever the HCS may look like, whatever it's "type", it will be described using the identical framework and the identical list of possible descriptive statements, so that the resulting descriptions can be directly compared.

Basically the HCSI captures the existence of actors, the delegation relationships among them, and in particular the allocation of tasks and control rights. The information collected concerns the design of the current settings, but also by whom and how these settings can be changed. For instance, what remuneration modes are currently in use, how are these set and by whom?

Further, because the lack of information and informational asymmetries among agents and principals, is a crucial factor in the provision of health care and organizational tasks related to this, I asked about whether and what information is available at all and if so, to whom and how it is used.

Apart from the mechanisms built into the design of the HCS, the HCSI also covers the levers currently available for the political actors by which these can influence the HCS from the outside.

The selection of features is based on and structured by the functions each HCS has to fulfill:

- Provision of health care – primary, specialized and in-patient care.

- Provision of medicines and medical products
- Administration of collecting funds from the individual citizens and the redistribution of the funds to the providers
- Decision-making on quantities and prices as the basic parameters of the health care provision
- Decision-making on the way decisions are made: competencies of each of the actors on issues concerning the HCS as a whole (e.g. catalogue of services) or the actors themselves (e.g. budget for primary care).

I have excluded the domains of mental health and social/long term care, since the classification – conceptually as well as organizationally – of these services as part of the HCS is not unanimous and identical in all HCS. In some HCS, social care belongs to the HCS and is financed from the health budget. In others, it's not part of the health system, but provided by separate institutions and controlled by different ministries.

The structure of a typical HCSI question is firstly, Does a delegation relationship exist?, secondly, Which of the possible control mechanisms are implemented in this relationship?
The "answer" categories for each "question" of the HCSI were derived by looking at how an aspect can be designed, but also how this aspect is actually designed in real HCS. Health economists have developed many fine tuned instruments, but the mechanisms actually implemented are of a much simpler nature.
The categories of an answer capture which of several possible control mechanisms is in place. According to theoretical considerations, control mechanisms are effective to different degrees. For instance, co-payments are a control mechanism to avoid the common pool problem. A co-payment of a fixed amount is less effective in making the patient sensitive to the price of a service or product than a flexible co-payment which depends on the price, e.g. a percentage of a price. But given that the impact of a certain control mechanism is an empirical question, I did not rank the control mechanisms a priori. The effectiveness of a control mechanism also depends on the institutional environment. For instance, whether there is a supplementary insurance, which covers any co-payment, eliminating the price sensitivity once again. I will also abstain from discussing the positive and negative implications of each mechanisms in detail, but will only give a short description when discussing the items of the HCSI.
The data handbook shall primarily serve as a source for information, which can be used for comparative analyses which in some way or other, use the institutional economics approach.

Part I: Providers and Consumers of Health Services

Occupational Status and Remuneration of Providers of Health Services

Section 1 of part I covers the existence of providers of health services by capturing the existence of the provider as an separate entity, an "agent". If the provider exists as a self-employed entity, it shall be treated as an "agent". This refers both to institutions (e.g. independent firms conducting laboratory services) and individuals (self employed GPs). Even if they are contracted, they are organizationally independent from the purchaser. The task is explicitly delegated to them in the delegation contract, usually leaving them leeway on how to perform the task. They are acting on their own behalf when negotiating the contract. Most important, they may enter the contract or not and can exit the contract; see Gray/Harrison (2004) and Barros/Martinez-Giralt (2005) for the role of professional bodies in negotiations in HCS.

On the other hand, if for instance primary care is provided by employed GPs working for a fixed salary in local health centers, they are not treated as an separate agent. The function is integrated into the institution operating the Health Center, which has a hierarchical control over the employed staff. Employed GPs for instance are not involved in deciding the catalogue of covered services the same way as GPs which are contracted on a cost-volume basis.

The existence as an agent defined in these terms is captured for GPs/primary care providers, providers of specialized care, dentist, laboratory services and pharmacists. In the later case, just to give one more elaboration, the "agent" pharmacy is non-existent, if pharmaceuticals are distributed by hospitals or dispensing GPs.

The set of inventory items on the remuneration modes implemented in the provision of medical services asks first about the predominant form, by which most of the services are remunerated. There is a wide range of possible remuneration modes, many of which have been discussed in terms of the incentives they set. However, while the mix of the modes is manifold, the variation in the predominant modes, i.e. the mode by which most money is paid to the provider, is much smaller. In many HCS, similar modes are implemented, usually either relying on fee for service or on a salary.

Second, the HCSI asks also for the "incentive at the margin", e.g. whether there is despite that the GPs get most of their income by a capitation the possibility – and hence the incentive – to increase their income by providing more services.

Interestingly, both the predominant mode and in particular the incentive at the margin does not correspond to the "type" of the HCS. In many NHS systems, usually supposed to set low incentives for supply-induced demand, there are contradicting incentives set at the margin. The provider is employed and receives a salary, but can nevertheless increase his income by providing more services. A typical example is that the provider refers the patient to his private practice where he works on his own account and delivers services on private terms. If these services are paid for by supplementary insurance, and are not counted as "official expenditure", the HCS appear less costly. However, it is not, because costs are just shifted.

Status and Autonomy of Hospitals

Because of its relevance for overall health expenditure the inpatient sector is treated in more detail. The status of the hospitals as an agent, i.e. the autonomy of a hospital, is captured by the following questions: who would cover potential deficits (this might be done by another institution, for instance the government in a formal or informal way), who has the control over the use of a potential surplus, who has the most influence on decisions on the building of new hospitals or closing of existing ones, who decides on the increase /decrease of capacities in existing hospitals and investments in high technology.

Because hospitals are a part of the medical infrastructure, they are often not under an existential competition. That is, even if they create substantial deficits, they will be kept operative somehow. But nevertheless, they may be incentivized by competition, e.g. by being allowed to re-invest a surplus in the hospital. The exposition of a hospital to competition, the main incentive to provide quality and to contain costs, is captured firstly by the question, whether several hospitals offering the same kind of services (e.g. cover the same indications, offering the same degree of specialization etc.), exist in the same region. The existence of several hospitals as a necessary condition is supplemented by the question, whether rates charged by the hospitals for treatments, i.e. the per diems or the price of a case, differ or are identical for all hospitals in a region, respectively the same degree of specialization. In some countries, all hospitals receive a per diem, which is identical for all hospitals in the country, so there is no price difference. In others, all hospitals in the country receive the same remuneration for a certain case, defined on a DRG, basis. Again, there is no price difference: a hospital might be unable to perform the intervention, but all hospitals who can receive the same price. Competition would be given, if the hospital can for instance offer a certain treatment for a certain price, which is determined by the hospital. If treatment costs vary, the purchaser, acting on behalf of the patients, can sent its clients to the most competitive

provider. To be effective as a control mechanism, the information on differences in treatment costs must be complemented by free choice on the side of the patients and by information on quality, on which this choice is based.

Regulations on Pharmaceuticals and Pharmaceutical Consumption

With regard to the pharmaceutical sector, the HCSI asks for the existence of some standard regulations, e.g. negative or positive lists, a pharmaceutical budget at the level of the HCS as a whole or at the level of the individual prescriber etc.

Positive and negative lists serve as instrument to exclude medicines, which are of little use or became obsolete from coverage by the HCS. It is also a decision about which indications to cover, e.g. some medicines against minor ailments are excluded in several countries.

As for the pricing of medicines the HCSI covers, whether the question of reimbursing a new medicine at all (coverage) and/or the price of a medicine is influenced by an evaluation of its (expected) medical efficacy and degree of innovation. Basically, the question is, whether the new medicine, which is usually introduced at a higher price than the existing ones, is actually worth the mark-up. As described above the main incentive problem with regard to the pharmaceutical industry is that it might introduce new products, which are only a marginally improved modification of an existing drug. This strategy allows to factually prolong the patent period and the monopoly profits associated with the original variant of the product without investing in a new innovation. A strict medical evaluation of the product might counteract this problem by identifying mere variants of the same product.

With regard to the competition among branded pharmaceuticals and generic substitutes, the HCSI asks, whether the generic substitution is possible at all, and whether an actor – the patient, the prescriber or the pharmacist – actually has an incentive to substitute. For instance the patient has an incentive to accept a generic substitute, if he can reduce a co-payment. If the patient is not involved in the payment, he might, for reason of mere habit, keep on using the branded product, even thought there are cheaper generic substitutes. Brand loyalty to pharmaceuticals is a factor in retaining high revenues even after the patent has expired.

A organizational precondition to the usage of generics and similar cost containment strategies is the grouping of pharmaceuticals. By putting different medicines which are used for the treatment of the same condition in a group, and reimbursing only the cheapest one of this group, the regulator sets an incentive for the patient to demand the cheapest option to avoid payment of the differences in price.

Pharmaceutical budgets at the overall level, but in particular at the level of the individual prescriber, set an incentive to realize possible savings, in particular by incentivizing also the prescriber to foster the usage of generics. If this incentive and restriction is absent, the actor making the decision on what medicine to use is not involved in the payment at all and indifferent to the differences in costs among various treatment options.

Patient Involvement in Provider Payment: Co-payments and Remuneration Modes

Compared to the consumption of other goods and services in the market place the problems associated with health care consumption often arise due to lacking information. This lack of information concerns quality, but also prices. Further, the lack of information removes the incentives to base the consumption of medical services on a cost-benefit calculation. This is an intended effect securing the individual from a financial disaster in the case of a severe illness. But as an unintended consequence it also generates a common pool problem by setting an incentive to over-consume medical services financed from the common pool. If services are free, the demand will encounter no limits, at least no financial ones. The patient as the consumer of health services can, if incentivized and provided with the necessary information, also adapt his behavior in order to contain costs and to exert competitive pressure on health care providers, while still obtaining appropriate treatment. To avoid an over-consumption of medical services, the patient needs to know about the prices of his consumption, and the price must be of some relevance for him. The patient must be incentivized to take costs and benefits into account when deciding on medical consumption.

With regard to the question, whether the patient gets some information on the prices of medical services consumed, the HCSI asks for the involvement of the patients in the payment of providers. In cost-reimbursement systems, the patient receives the bill from the provider, which is handed in for reimbursement to the purchaser, e.g. the Health Insurance Fund. In this situation the patient is aware of the costs incurred by his consumption. Under service-in-kind provision the patient is not at all involved in the payment of providers, in particular the patient does not receive a bill. In this situation, the patient has neither an awareness of the costs of the medical services consumed, nor can he perform a basic check, whether the services billed were actually provided. It is argued by informal studies and media reports, that fraud in the sense of billing services, which were not actually provided, is a serious problem in some systems.

But awareness of prices alone is not sufficient. There needs to be an incentive for the patient to take prices into account when deciding on what to consume. With regard to the relevance

of prices the inventory asks for the regulations on co-payments, which are the typical mechanism by which prices are made relevant in the patient's consumption decision. The incentive effect is however only relevant, if the co-payment depends on the price, as opposed to a fixed contribution independent of the actual price of a treatment. A fixed consultation fee payable at the first visit in each quarter might influence how often a patient visits the GP. But it is irrelevant for how sophisticated and expensive the services conducted during the visit are. Another illustrative example are generics. To decide to use a generic the patient must be aware of the price differences between the generic and the branded original, i.e. the patient needs information on what generic substitutes exist for a certain branded original. This information alone is not sufficient to influence the patient's decision for or against generic substitution. If there is no co-payment the information is irrelevant. If there is a co-payment, but a fixed one, like a fixed prescription fee, the information and price differential are also irrelevant. Only if the co-payment is dependent on the actual price, the price differential is relevant and the patient has an incentive first to ask for the possibility of substitution, second to actually accept a substitute. The HCSI asks for the type of co-payments as well. Another aspect are co-payments charged for non-standard treatments, e.g. less invasive treatments.

Further, co-payments – fixed as well as flexible ones – might become irrelevant as an control mechanism, because they are completely covered by a supplementary insurance. In this situation the costs of consumption no longer depend on the quantity consumed. The co-payment which depends on the consumption is transformed in the payment of a fixed premium to an insurance company. The HCSI covers the existence of such supplementary insurance.

Access and Choice in Health Care

Competition is a possible mean to incentivize providers, making them competing for clients by offering different prices or quality. Again, the consumers need information on prices and quality, but they also need formal and factual choice among providers.

The issue of gatekeeping and choice is an element of competition among providers as well as a restriction on the consumption of more specialized services, which are usually more expensive. Studies on gatekeeping have found that it is a possibility to contain costs, since often appropriate treatment can be given at a lower degree of specialization; Delnoij et al. (2000), and Garcia Marinoso/Jelovac (2003). The inventory asks about the existence of formal rules on gatekeeping for hospitals and specialized services but also, whether it can be skipped and circumvented one way or the other.

Apart from formal regulations on access and gatekeeping, factual choice is crucial: if there is no choice of GPs, they are not under a competitive pressure to perform well. The same is true if there is no choice among providers of secondary care like hospitals. Gatekeeping might have cost containing effects by making sure that care is not provided at a more expensive level when it could also be provided on a lower level. But for the performance of the secondary levels of health care provision, gatekeeping is not relevant. In some countries, factual choice is limited because the number of providers for a certain service or product is for some reason very limited. The HCSI asks for the factual choice among different specialists and hospitals, which could be consulted to obtain services.

Part II: Regulations and Institutions to ensure Quality in Medical Treatment

Part II is about measures to ensure quality of medical treatment. As argued above, apart from the problems arising from opportunistic behavior aiming at the extraction of financial rents, there is also a quality issue at stake: How can one ensure that high quality is delivered in a setting, where there is no deterministic relationship between action and result and the consumer has a strong informational disadvantage vis-à-vis the provider? The main point is to close this informational gap. First by ensuring that only providers enter the market, which fulfill certain criteria. But second by providing information on a provider's quality to patients, enabling them to make an informed choice on where to receive treatment.

As stated above, incentives set by some remuneration modes may have advantageous effects on costs, but negative effects on quality. Sometimes, a remuneration mode may affect both aspects negatively – for instance paying providers by the number of services provided may induce them to produce as many as possible. This, however may cause them to perform each service hasty, with little care and little quality.

While every HCS has in place formal requirements on the access to the medical market for providers, the way the quality assurance is handled later on, i.e. after market access was granted, differs substantially. The problem is how to assure that providers keep up to date with the scientific progress in their field. There emerge new "best answers" for standard problems, conditions which are quite frequent, e.g. diabetes, and which can be treated in a standardized way based on an earlier trial-and-error process. It might be reasonable to induce providers to abide by these "best answers" unless there is a qualified reason not to do so. Further, there are standards of good practice, for out-patient, in-patient treatments, and

pharmaceutical treatments, the enforcement of which may guarantee a certain quality of treatment but also cost efficiency.

For this to be operative, there needs to be some kind of organized information gathering, distribution and also some kind of enforcement. Information on various treatment options, their medical efficacy and cost effectiveness must be gathered and aggregated from the level of the individual providers where it arises from practical experience. Thus the HCSI asks for the existence of a national/ regional level institution setting clinical or medical guidelines. If there is such an institution, the HCSI ask if for which sectors the information is gathered (pharmaceuticals, specialized care provided in hospitals, ambulatory care, usage of technology etc).

The HCSI also asks for the provision of information on treatment options, i.e. whether there is there an institution gathering and distributing information on medical efficacy and cost effectiveness of different treatments for the same illness. The aggregated experiences made by the medical providers about which treatment is the best and most effective for a given indication is a valuable resource, relevant for both cost containment and quality assurance.

Regarding the patient's lack of information on quality – e.g. transparency about which provider fulfills certain quality standards – the inventory is asking, whether there is an institution gathering information on the quality of individual providers of medical services. An example of this is the star-ranking in the UK, but also reports on the occurrence of medical failures and maltreatment in different hospitals. Since the information is only relevant if known, the HCSI covers, whether this information is published one way or the other and to whom. In some HCS, there are institutions and associations collecting data on quality of treatment, but distribute it only internally – for the very reason to avoid public pressure.

A further issue of quality is the question how the transfer of new medical knowledge to the providers is handled. Given that most professional organizations of physicians provide some kind of voluntary continual education, the HCSI asked also whether a provider, the individual GP/Physician has to renew his approbation or license to provide medical services from time to time (recertification)?

Part III: Role of the Government for the Health Care System

Part III is about the role of the government, in particular the central government, for the HCS. As stated earlier, the government as an agent of the electorate has the task to exert a kind of "meta-control" over the HCS. This refers to controlling providers of health care, but also controlling purchasers of health care, and in particular to avoid collusion among both at

expense of the citizens. The national/central government is typically the politically most visible actor and hence the actor primarily in charge of the institutional design of the HCS.
A basic difference among HCS is the degree to which the HCS is political or a-political. "Political" refers in particular to whether the decision making on the basic parameters of health care provision is done by the political system in a political decision making process or not. The term "parameters" refers to budgets, contributions, the coverage of services and the coverage of population.
The degree of political decision making on these parameters is reflected in the levers available for government intervention. In some countries the government has fundamental and direct control over all parameters of the HCS. Either by setting them by a political decision, or by intervening substantially by other means, like setting restrictions on the decisions made by societal actors. In other countries the government has no levers at hand and/or restrains itself much more, leaving the day-to-day operation of the HCS to societal, non-state-actors, like HIFs and organizations of medical providers.
The extremes are NHS systems, like the UK, where the decision making is predominantly political, and corporatist HCS like Germany, where operative decision-making is basically a-political. In the first case, the political system is seen as clearly responsible for the operation of the HCS. In the second case, the responsibility is much more diffuse and spread among political and societal actors.

For exercising operative external control different levels of government – local, regional or national – are in charge in different countries. The HCSI asks first about the level of government, which is most important for control and interventions of the state in the HCS.
National level decision making gives the government more bargaining power – be it only the bargaining power derived from the aggregated demand of a whole nation. On the other hand, health care is but one theme in the national level political debate. The effectiveness of elections as a control mechanism forcing the political actors to do their job in the health care domain might be weaker, because other issues dominate the election campaigns.
Local level governments are to a higher degree evaluated with regard to their performance in this sector, because they are in charge of fewer tasks and health care is relatively more important. Further they are closer to the preferences of the population, which may differ among regions. Together, this might cause them to provide health care in a way which is closer to the preferences of the population they are accountable to. On the downside of decentralization, their standing and their bargaining power might be lower, in particular when

bargaining with national level organizations of providers. So, levels of government responsible or at least involved in health care have advantages and disadvantages. Which is predominant is an empirical question.

Levers for External Control over Providers

Apart from the political level most important for interventions, the HCSI covers the 'levers' available for intervention of a political actor on a sectorial basis. This section of the HCSI is based on the typical sectors of the HCS: primary care, specialized care, in-patient care, dental care, and pharmaceuticals. For each of the sectors the HCSI asks for the competencies of the government to set or to influence the parameters of the sector: catalogue of services covered by the health system, the overall budget, or a sectorial budget, questions of capacity (e.g. number of physicians or beds per capita or in a region), the way the providers of this type of health care are remunerated (e.g. fee for service or a per-capita budget etc.), the level of remuneration of medical services, e.g. the amount of fees or the level of budgets, the way the medical providers are organized, e.g. regional level or national-level organization and the determination of the top-level management of the provider organization. With regard to hospitals I have included also the question of investments in medical technology. For the pharmaceutical sector, there is also the question of pricing and reimbursement of pharmaceuticals, where the government can exert influence. To recover the R&D costs and to generate profits, a high price is important. To have a market for a new product, the product must be covered, i.e. paid for, by the health system. A pharmaceutical enterprise usually cannot hope to realize sufficient profits from products which are paid for by the patients themselves. In some countries, price and coverage are negotiated between the producer and the state, often officially, sometimes using "carrots and sticks procedures". Price and coverage are often interdependent in the sense, that coverage of a medicine by the HCS is only granted, if the price is reasonable or abides to certain criteria.

Levers for External Control over Purchasers

With regard to the question how the agents in charge of organizing the HCS can be controlled by the government as a political accountable entity, I ask, by what means does the government exert a control and supervision on the activities of the purchaser, i.e. Health Authorities or Health Insurance Funds. The selection of mechanisms is derived by looking at the functions of the purchaser, in which the purchaser might be tempted to extract rents, in

particular by consuming more resources “on the job”. Possible mechanisms of external, political control are:

The requirement of the purchaser to produce an annual report for the government or a government agency, in which all costs (in particular administrative costs, expenditure for health services purchased) are listed.

The requirement that budget plans of the purchaser must be endorsed by the government, which e.g. allows the government to set priorities, e.g. for prevention or for extending coverage.

The publication of the administrative costs of the purchaser as a mean to allow clients to identify purchasers, which consume more resources just for administrating.

The requirement that the purchaser must apply for a formal approval of an increase of contribution/premiums and must deliver reasons for this.

The criteria chosen are rather formal and by nature more auditing than steering. They are to be seen complementary to the control exercised by the market. Competition may incentivize purchasers to act in line with the client’s preferences, since the clients may shift to another purchaser, which is offering better conditions, i.e. a more encompassing coverage of services and/or lower contributions.

Part IV: Administration and Operation of the Health Care System

Part IV is about the administration and operation of the HCS, in particular about the relationship between the purchasers and the providers of health care. The purchaser of medical services can be either Health Insurance Funds or Health Authorities.

By Health Insurance Funds (HIF) I refer to for private or public, non-profit or for profit organizations which act as an insurance but which are not part of the state administration.

By Health Authorities (HA) I refer to institutions which are part of the public administration, comparable to the police force. Examples are local or regional Health Boards, local governments, county councils etc.

Agency Status of the Purchasers

The HCSI asks first about a characterization of the predominant status of the Health Insurance Funds (HIF) / Health Authority (HA). To characterize a purchaser one can for instance ask, whether it is for profit or non-profit, factually independent or only formally independent from the public administration or a part of the public administration, like an integral part of the

local government. Background of the question is, whether there is an independent agent or not. Empirically, there seems to be no clear distinction between NHS-systems and non-NHS-systems. In some HCS the control of the government over the HIFs is such that their agency status is only a formality. The state determines all financial parameters, like contributions, and often enough also determines the top-level administration. On the other hand, in some countries the independence of the Health Authorities from the government is substantial. The HA, while being formally part of the public administration, is factually not part of the hierarchical chain of "command and control" extending from the government downwards but has substantial leeway. The HCSI proxies agency status by asking, whether the purchaser can determine it's top-level management internally and can decide on the usage of a potential surplus. Both features proxy independence in decision making. If the government can determine the person leading the purchaser, the control exercised over the day to day business is also substantial; see the above section.

Fragmentation and Competition of the Demand Side

If there are negotiations between the purchasers and the providers the bargaining power of each side becomes relevant for the outcomes; see Ryll (1993). A basic measure of bargaining power is the fragmentation of each side. For the purchasers representing the demand side, fragmentation is captured by asking about how many purchasers there are. The position of the purchaser is stronger, if there is only one of them – acting as a monopsonist, at least in a region. It is substantially weaker, if the purchasers have to compete with other purchasers for contracts; see Anderson et al. (2003) and Barros/Martinez-Giralt (2005) for the role of bargaining power.

The relative strength of the purchaser vis-à-vis the providers is also stronger, when they can provide services themselves. In the case of a persisting or impending conflict with the supply side, they can provide some services and keep the health provision operative. It is weaker, if there is a strict purchaser-provider-split and they are forced to come to an agreement to be able to purchase any services at all.

As outlined above, competition is the main mechanisms to incentivize purchasers to perform all the task which are in the principal's interest. Competition takes the form of attracting clients, and competitive pressure in the end amounts to the threat that the purchaser goes out of business if not enough clients remain. This can take the form of being forced to merge with

another purchaser or that the purchaser is formally abolished and the clients become automatically members of a fall back purchaser, as it has happened in the Czech Republic.
The competition among the purchasers is captured by the free choice of the purchaser as opposed to the assignment of citizens to certain purchasers for instance by criteria like place of living or occupation. In the case both of municipalities as well as Health Insurance Funds, voting by feet exerts a basic pressure on the purchaser to perform well.
Competition is captured by asking whether it is possible that the citizen's contributions – be it premiums, percentage of income, or tax rates – to the Health Insurance Funds / Health Authorities may vary, or whether the contributions are the same for all purchasers in a country.
The same is asked for the catalogue of medical services covered. Even if the purchasers are forced to charge the same contributions, they may nevertheless compete for clients, and indicating their higher performance and administrative efficiency, by offering more services.
Setting identical contribution rates and identical catalogues of services covered by law prohibits any competition among the purchasers. They are unable to signal their efficiency to the clients. While clients are free to chose their purchaser, there is no competition among them.
Even if formally installed, competition might be offset by other regulations. The HCSI asks whether there is a financial equalization among purchasers, which limits the necessity to minimize administrative costs and allows a lax attitude in negotiations with providers. Depending on the design of the risk equalization and the transfers of funds, the threat of going out of business is more or less real.

Evaluating the impact of these features on HCS performance is again an empirical question. Most of these features are double-edged. More purchasers, which are competing, put each purchaser under pressure to perform well. But it also weakens the bargaining power of the demand side vis-à-vis the providers. A risk equalization among the purchasers may prevent cream skimming, but may also set perverse incentives, which make it reasonable to spend as much resources as possible.

Relationship among Purchaser and Patients

As outlined above, the patients are locked in a 'tragedy of the commons' situation, where collective and individual rationality diverge. It would be better for everybody in the group, if the individual would restrain its consumption to what is necessary and not exploit the

common pool. But for each individual, there is an incentive to over-consume services paid for from the common pool. In particular if the consumption is free at the point of use. Over-consumption in one period will lead to higher contribution levels in the next. Typically for such dilemma situations, this is true independent of what the other members do. The dilemma is aggravated by the high value of health for a person: it is not realistic to assume that individuals put their health even slightly at risk by renouncing services, for the reason that by doing so they avoid some expenditure, which – given the size of the common pool – will have not noticeable effect.

Given this problem, one of the purchaser's tasks as an agent acting in the clients' best interest consists of limiting the individual consumption to what is reasonable. Again, there are many possible options to do so. The HCSI covers those, which are actually implemented in at least some of the HCS:

First, with regard to the control exerted by the purchaser over the patients the HCSI asks, whether it is possible that the same purchaser offers different packages of contributions and covered services to the insured. Examples are that the patient agrees to go to the general practitioner first, before visiting a specialists or accepts that some services, e.g. dental care, are not covered. In return, the patient pays a lower contribution. This sets an incentive for the patient to restrain the consumption.

Second, the HCSI asks, whether the citizen can obtain a bonus by the Health Insurance Fund / Health Authority, if they participate in preventive health checks on a regular basis. Examples of these are a reduced contribution rate, a repayment or lower co-payments.

Purchasers and Providers of Medical Care

The problems in the relationship between the purchaser and the provider are similar to the problems in the patient-provider relationship: How can quality by assured?, How can the issue of supply-induced demand be tackled? The difference is, that while the individual patients is usually in no position to exercise control over the provider, the institution which is handling the affairs for a larger group of patients is able to do so. The purchaser may act as an agent in charge of controlling another agent on behalf of a principal.

The possibilities to do so are manifold, concerning financial and quality aspects. The purchaser has access to a large quantity of data, which is accumulated during the payment of providers. The patient gets ill, contacts a provider, who decides on a treatment, which is billed to the purchaser. From this bill alone, the purchaser sees, what the provider has done, and whether the treatment was a success, i.e. whether the patient requires a second episode of

treatment. The purchaser can install a department consisting of medically trained staff, to evaluate the incoming information. This way it can collect information on what is the typical treatment in of a certain medical condition, and what is the most cost effective treatment. It can also implement a sampling-based auditing process to see, whether bills handed in by providers make sense. It can also collect information on quality problems occurring during treatment, e.g. collect information on the occurrence of medical maltreatment and readmission rates.

With regard to the relationship among purchasers and providers of medical care, in particular the possibilities of control over the provider, I ask, whether the Health Insurance Fund / Health Authority can identify individual providers, e.g. individual GPs or Hospitals, who overspend. In particular, I ask, whether the Health Insurance Funds / Health Authorities usually receive a detailed bill from an individual provider, e.g. a hospital or a GP, which lists all medical services and medical goods provided in an individual case. In some countries, the provider bills directly to the purchaser, handing in bills listing all services provided. In others, the purchasers pay a lump sum to the organization of providers or the individual provider, and do not receive bills listing what services were provided in a case.

A further question is, whether the Health Insurance Funds / Health Authorities have the possibility to exclude individual providers of medical services (individual physicians, hospitals etc.) from the provision of services, if they significantly oversupply medical services, provide insufficient quality or work in an inefficient way.

Finally the HCSI asks, whether the Health Insurance Funds / Health Authorities can by one way or other force the providers (hospitals / physicians) to abide by clinical guidelines. In some countries, contracts specify obligations to quality, together with regulations on how the quality is controlled. An example would be that the provider's activities are controlled for medical appropriateness on a sample basis.

Two points have to be kept in mind: First, there are many possible options by which the purchaser can exert control over the providers on behalf of the patients. The list included in the HCSI covers only those, which can be found at least in some HCS. Second, the question whether and to what degree the purchaser actually uses the range of the possible options to control the providers, is a completely different question. The task of controlling providers is bothersome, requiring effort and is very likely to cause opposition from the providers. It might be easier to shirk from the task, just paying whatever costs arise.

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B. The Data Handbook: Delegation and Control in Health Care Systems 1995 and 2004

Part I: Providers and Consumers of Health Services

1. Primary Care and Outpatient Care

1.1. Occupational Status of the Providers of Primary Care / Outpatient Care

OS1 Primary Care Physicians / General Practitioners (GPs) are predominantly	
Austria 1995: Self-employed Remark: A substantial share of primary care is also provided by Primary Care Centers operated by the Health Insurance Funds (Kassenambulatorien)	2004: Self-employed Remark: A substantial share of primary care is also provided by Primary Care Centers operated by the Health Insurance Funds (Kassenambulatorien)
Belgium 1995: Self employed	2005: Self employed
Canada 1995: Self employed	2004: Self employed
Czech Republic 1995: Self-employed Remark: 80% of all GPs were self employed. The provision of services takes place in Health Centers, which belong to the municipalities. The GP work in these facilities, and pay rent for the usage.	2004: Self-employed Remark: The trend towards self employment continued and almost all GPs are self employed. Apart from private practices, the provision of services still takes place in Health Centers, which belong to the municipalities. The GP work in these facilities, and pay rent for the usage.
Denmark 1995: Self employed	2004: Self-employed
Finland 1995: Employed but with the possibility or provide additional services on own account Remark: Primary care is predominantly provided by the Health Centers operated by the Municipalities. GPs are employed by them, but about one third have some kind of private practice where they work part time.	2004: Employed but with the possibility or provide additional services on own account Remark: Primary care is predominantly provided by the Health Centers operated by the Municipalities. GPs are employed by them, but about one third have some kind of private practice where they work part time.
France 1995: Self employed	2004: Self employed
Germany 1995: Self employed	2004: Self employed
Greece 1995: Employed but with the possibility or provide	2004: Employed but with the possibility or provide

OS1 Primary Care Physicians / General Practitioners (GPs) are predominantly	
additional services on own account Remark: Primary care is predominantly provided by the out-patient departments of hospitals. Frequently, the GPs work part time in a private practice. Parallel to the public system, there is a small and purely private system where providers charge fees which are either paid for by the patients or their VHI	additional services on own account Remark: Primary care is predominantly provided by the out-patient departments of hospitals. Frequently, the GPs work part time in a private practice. Parallel to the public system, there is a small and purely private system where providers charge fees which are either paid for by the patients or their VHI
Hungary 1995 Self employed Remark: 85% are private entrepreneurs. Under the model of "functional privatization", the GP is contracted by the municipalities, which are in charge of providing primary care, and is sometimes even working in facilities provided by the municipality	2004: Self employed Remark: They are contracted by the Municipalities which are in charge of providing primary care
Ireland 1995: Self employed Remark: About 2/3 of all GPs have a contract with the Health Boards, to provide treatment of Medical Card holders.	2004: Self employed Remark: About 2/3 of all GPs have a contract with the Health Boards, to provide treatment of Medical Card holders.
Italy 1995: Employed by the ASL, Azienda Sanitaria Locale, the local health authority acting as the main provider and purchaser of health services at the local level. Remark: There are also self employed GPs, with a contract with the ASL. Both, the self employed and the employed have the possibility to provide additional services on own account	2004: Employed by the ASL. Remark: There are also self employed GPs, with a contract with the ASL. Both, the self employed and the employed have the possibility to provide additional services on own account
Luxembourg 1994: Self employed	2004: Self employed
Netherlands 1995: Self employed	2004: Self employed
New Zealand 1995: Self employed	2004: Self employed
Norway 1995: Self employed Remark: Some GPs are employed by municipalities. The share of the self employed, contracted by the municipalities, is increasing. In the beginning of the 90s, the split among employed and self-employed was about even.	2004: Self employed (95%)

OS1 Primary Care Physicians / General Practitioners (GPs) are predominantly	
Portugal 1995: Employed, but with the possibility to provide additional services on own account. Remark: GPs are employed in on of the about 350 Health Centers, which are the predominant provider of primary care. About 50% of them have a private practice as well, in which they offer services on private terms	2004: Employed, but with the possibility to provide additional services on own account Remark: GPs are employed in on of the about 350 Health Centers. About 50% of them have a private practice as well, in which they offer services on private terms
Poland 1995 Self employed Remark: There are also employed GPs working in one of the 3300 municipal Health Centers and GPs working part time on their own account. The tendency is towards self employment.	2004: Self employed
Spain 1995: Employed, but with the possibility to provide additional services on own account Remark: 90% of the GPs are employed in the Health Centers, many work part time in their own practice	2004: Employed, but with the possibility to provide additional services on own account Remark: 90% of the GPs are employed in the Health Centers, many work part time in their own practice
Sweden 1995: Employed Remark: GPs are employed by the county councils; Landstings, in charge of providing Primary care. Either they work in Primary Care Centers or in the outpatient departments of Hospitals	2004: Employed Remark: GPs are employed by the county councils; Landstings, in charge of providing Primary care. Either they work in Primary Care Centers or in the outpatient departments of Hospitals
Switzerland 1995: Self employed	2004: Self employed
United Kingdom 1995: Self employed Remark: The GPs are self employed, usually working in group-practices, but have a contract with the NHS. This contract is negotiated between the NHS and the representatives of the GPs, and leaves substantial autonomy for the GPs	2004: Self employed Remark: The GPs are self employed, usually working in group-practices, but have a contract with the NHS. This contract is negotiated between the NHS and the representatives of the GPs, and leaves substantial autonomy for the GPs

OS2 Specialists and Providers of specialized medical services - like orthopedics, eye doctors, radiologists etc. - are predominantly:	
Austria 1995: Self employed Remark: Specialized care is also provided in Primary Care Centers operated by the Health Insurance Funds (Kassenambulatorien)	2004: Self employed Remark: Specialized care is also provided in Primary Care Centers operated by the Health Insurance Funds (Kassenambulatorien)
Belgium 1995: Most Specialists are self employed Remark: Specialized care is predominantly provided in Hospitals, by specialists which also work in private practice. There is a strong tendency to provide specialized services on a ambulatory basis, i.e. in the practice of a self employed specialist	2005: Self employed Remark: Specialized care is predominantly provided in Hospitals, by specialists which also work in private practice. There is a strong tendency to provide specialized services on a ambulatory basis, i.e. in the practice of a self employed specialist.
Canada 1995: Self employed Remark: Specialized care is predominantly provided by self-employed specialists using hospital facilities, which are paid on a fee for service basis. Fees are negotiated among the provincial governments and the providers.	2004: Self employed Remark: Specialized care is predominantly provided by self-employed specialists using hospital facilities, which are paid on a fee for service basis. Fees are negotiated among the provincial governments and the providers.
Czech Republic 1995: Self employed Remark: Most Specialists are self employed. The provision of specialized services takes place in Health Centers and polyclinics, which belong to the municipalities. The specialists are self employed, but work in these facilities, and pay rent for the usage.	2004: Self employed Remark: Most Specialists are self employed. The provision of specialized services takes place in Health Centers and polyclinics, which belong to the municipalities. The specialists are self employed, but work in these facilities, and pay rent for the usage.
Denmark 1995: Employed, but with the possibility to provide additional services on own account Remark: Specialized medical care is predominantly provided by Hospitals. Specialists are employed by the hospitals, but have the possibility to provide additional services on their own account. Denmark has a number of private practicing specialists besides specialists employed by public hospitals	2004: Employed, but with the possibility to provide additional services on own account Remark: Specialized medical care is predominantly provided by Hospitals. Specialists are employed by the hospitals, but have the possibility to provide additional services on their own account. Denmark has a number of private practicing specialists besides specialists employed by public hospitals. In recent years, the counties reduce the number of extramural specialists in order to make better use of the capacities in hospitals operated by the counties. This is achieved by restrictive licensing.

OS2 Specialists and Providers of specialized medical services - like orthopedics, eye doctors, radiologists etc. - are predominantly:	
Finland 1995: Employed, but with the possibility to provide additional services on own account Remark: Specialized medical care is predominantly provided by Hospitals and in the Health Centers. Specialists are employed by them, but about one third have some kind of private practice where they work part time.	2004: Employed, but with the possibility to provide additional services on own account Remark: Specialized medical care is predominantly provided by Hospitals and in the Health Centers. Specialists are employed by them, but about one third have some kind of private practice where they work part time.
France 1995: About 50% of the Specialists are self employed; about 50 % employed by Hospitals, which are predominantly providing specialized care Remark: The status depends on the kind of specialty, Cardiology is mostly provided by specialists employed in Hospitals whereas gynecology and eye doctors are mostly self-employed	2004: About 50% are self employed, about 50 % employed by Hospitals, which are predominantly providing specialized care Remark: The status depends on the kind of specialty, Cardiology is mostly provided by specialists employed in Hospitals whereas gynecology and eye doctors are mostly self-employed
Germany 1995: Self employed	2004: Self employed
Greece 1995: Employed Remark: Specialized medical care is predominantly provided by Hospitals. There are also self-employed providers of specialized services which are contracted by the HIF. Some of the employed also work part time in private practice. Just like with primary care, there is a private system, parallel to the public health system, where fees are charged and paid directly by patients or VHI.	2004: Employed Remark: Specialized medical care is predominantly provided by Hospitals. There are also self-employed providers of specialized services with contracts. Some of the employed also work part time in private practice. Just like with primary care, there is a private system, parallel to the public health system, where fees are charged and paid directly by patients or VHI.
Hungary 1995: Employed Remark: Specialized medical care is predominantly provided by hospitals and polyclinics operated by municipalities and by hospitals operated by the counties	2004: Employed Remark: Specialized medical care is predominantly provided by hospitals and polyclinics operated by municipalities and by hospitals operated by the counties
Ireland 1995: Employed, but with the possibility to provide additional services on own account Remark: Specialized services are predominantly provided in hospitals by staff employed by the hospital.	2004: Employed, but with the possibility to provide additional services on own account Remark: Specialized services are predominantly provided in hospitals by staff employed by the hospital. In 2003, only 200 specialists worked in private practice only.

OS2 Specialists and Providers of specialized medical services - like orthopedics, eye doctors, radiologists etc. - are predominantly:	
Italy 1995: Employed by the ASL. Remark: There are also self employed specialists, with a contract with the ASL. Both, the self employed and the employed have the possibility to provide additional services on own account by working part time in their own private practice. Specialized medical care is predominantly provided in the outpatient department of Hospitals.	2004: Employed by the ASL. Remark: There are also self employed specialists, with a contract with the ASL. Both, the self employed and the employed have the possibility to provide additional services on own account by working part time in their own private practice. Specialized medical care is predominantly provided in the outpatient department of Hospitals.
Luxembourg 1994: Self employed Remark: Most specialists also use Hospital facilities. In fact, only in 2 of 34 hospitals, in-patient services are provided by employed staff. In the others, the Hospital is just the place where services are provided by specialist which are basically self employed and have hired the facilities.(Belegarztsystem)	2004: Self employed Remark: Most specialists also use Hospital facilities. In fact, only in 2 of 34 hospitals, in-patient services are provided by employed staff. In the others, the Hospital is just the place where services are provided by specialist which are basically self employed and have hired the facilities.(Belegarztsystem)
Netherlands 1995: Self employed Remark: Specialized Care is provided predominantly in but not by Hospitals. Usually, specialists are not employed by the Hospital but have a contract with the Hospital and work on their own account, remunerated on a fee for service basis	2004: Self employed Remark: Specialized Care is provided predominantly in but not by Hospitals. Usually, specialists are not employed by the Hospital but have a contract with the Hospital and work on their own account, remunerated on a fee for service basis
New Zealand 1995: Employed, but with the possibility to provide additional services on own account Remark: Specialized care is predominantly provided in outpatient departments of Hospitals. The specialists providing these services are employed by the DHB operating the Hospitals, but have the possibility to provide additional services on own account in a private practice, where they are remunerated on a fee for service basis. Further, there are also self-employed specialists providing specialized services in Hospitals.	2004: Employed, but with the possibility to provide additional services on own account Remark: Specialized care is predominantly provided in outpatient departments of Hospitals. The specialists providing these services are employed by the DHB operating the Hospital, but have the possibility to provide additional services on own account in a private practice, where they are remunerated on a fee for service basis. Further, there are also self-employed specialists providing specialized services in Hospitals.
Norway 1995: Employed, but with the possibility to provide additional services on own account Remark: Specialized medical care is predominantly	2004: Employed, but with the possibility to provide additional services on own account Remark: Specialized medical care is predominantly

OS2 Specialists and Providers of specialized medical services - like orthopedics, eye doctors, radiologists etc. - are predominantly:	
provided by Hospitals. The specialists are employed, but usually have the possibility to provide additional services on own account. There are also independent, contracted providers of specialized medical care.	provided by Hospitals. The specialists are employed, but usually have the possibility to provide additional services on own account. There are also independent, contracted providers of specialized medical care.
Portugal 1995: Employed but with the possibility to provide additional services on own account. Remark: Specialized Care is predominantly provided by hospitals; the specialists providing these services are employed and salaried by the Hospitals, but have the possibility to provide additional services on own account. Usually they also practice in a private practice.	2004: Employed but with the possibility to provide additional services on own account. Remark: Specialized Care is predominantly provided by hospitals; the specialists providing these services are employed and salaried by the Hospitals, but have the possibility to provide additional services on own account. Usually they also practice in a private practice.
Poland 1995: Employed but with the possibility to provide additional services on own account. Remark: Specialized services are predominantly provided in Hospitals and Polyclinics operated by Municipalities (Gminas) and Regions (Voivodships). Specialists are usually employed there, but work part time in a private practice.	2004: Employed but with the possibility to provide additional services on own account. Remark: Specialized services are predominantly provided in Hospitals and Polyclinics operated by Municipalities (Gminas) and Regions (Voivodships). Specialists are usually employed there, but work part time in a private practice.
Spain 1995: Employed but with the possibility to provide additional services on own account Remark: Specialized Care is predominantly provided by hospitals. Specialist are employed in the Hospitals but have the possibility to provide additional services on own account by working in their own practice.	2004: Employed but with the possibility to provide additional services on own account Remark: Specialized Care is predominantly provided by hospitals. Specialist are employed in the Hospitals but have the possibility to provide additional services on own account by working in their own practice.
Sweden 1995: Employed Remark: Specialists are employed by the county councils; Landstings. Specialized care is predominantly provided by Hospitals	2004: Employed by the county councils; Landstings Remark: Specialists are employed by the county councils; Landstings. Specialized care is predominantly provided by Hospitals
Switzerland 1995: Self employed	2004: Self employed
United Kingdom 1995: Employed but with the possibility to provide additional services on own account Remark: Specialized care is predominantly provided by hospitals; physicians providing specialized care are employed by the Hospitals but	2004: Employed but with the possibility to provide additional services on own account Remark: Specialized Care is predominantly provided by hospitals; physicians providing specialized care are employed by the Hospitals but

OS2 Specialists and Providers of specialized medical services - like orthopedics, eye doctors, radiologists etc. - are predominantly:	
usually have the possibility to provide additional services on their own account, often parallel in their own private practice	usually have the possibility to provide additional services on their own account, often parallel in their own private practice

OS3 Dentists and the providers of dental care are predominantly...	
Austria 1995: Self employed Remark: Dental care is also provided by dentists employed in Primary Care Centers operated by Health Insurance Funds, (Kassenambulatorien)	2004: Self employed Remark: Dental care is also provided by dentists employed in Primary Care Centers operated by Health Insurance Funds, (Kassenambulatorien)
Belgium 1995: Self employed	2005: Self employed
Canada 1995: self employed	2004: Self employed
Czech Republic 1995: Self employed Remark: The share of self-employed was 90% in 1995 and increasing. Dental care is part of the standard package of the HIF.	2004: Self employed Remark: Dental care is part of the standard package of the HIF.
Denmark 1995: Self-employed Remark: Dental care for the below 18 age group is community based with hired dentists and free for the patient. The cost of adult dental care is not covered by the Health System and is provided by self employed dentists	2004: Self-employed Remark: Dental care for the below 18 age group is community based with hired dentists and free for the patient. The cost of adult dental care is not covered by the Health System and is provided by self employed dentists
Finland 1995: About half of the dentists are self employed, the rest is employed in Health Centers operated by the municipalities Remark: Most of dental care is not covered by the Health Centers operated municipalities but is paid for by the NHI. The coverage of dental care differs largely among municipalities	2004: About half of the dentists are self employed, the rest is employed in Health Centers operated by the municipalities Remark: Most of dental care is not covered by the Health Centers operated municipalities but is paid for by the NHI. The coverage of dental care differs largely among municipalities
France 1995: Self employed	2004: Self employed
Germany 1995: Self employed	2004: Self employed
Greece 1995: Self employed Remark: Only the most basic dental care is covered, the majority of dental care is provided on a private basis outside of the public health system.	2004: Self employed Remark: Only the most basic dental care is covered, the majority of dental care is provided on a private basis outside of the public health system.
Hungary 1995: Self employed	2004: Self employed
Ireland 1995: Self employed	2004: Self employed

OS3 Dentists and the providers of dental care are predominantly...	
Italy 1995: Self employed Remark: The majority of dentists are self employed and the majority of dental services is purchased privately, outside of the SSN. Only dental care requiring hospital treatment is treated as hospital care.	2004: Self employed Remark: The majority of dentists are self employed and the majority of services - about 87% of all dental care - is purchased privately, outside of the SSN. Only dental care requiring hospital treatment is treated as hospital care.
Luxembourg 1994: Self employed	2004: Self employed
Netherlands 1995: Self employed	2004: Self employed
New Zealand 1995: Self employed	2004: self employed
Norway 1995: Self employed (70%) Remark: Only the dental care for the below 18 is covered by the public system. About 30% of the dentists are employed by the Health Centers, and in charge of providing dental care for those below 18 years of age.	2004: Self employed (70%) Remark: Only the dental care for the below 18 is covered by the public system. Some dentists are employed, mainly for providing the dental care which is covered by the public system.
Portugal 1995: Self employed Remark: The majority of dentists is in the private sector, since dental care for adults is factually not covered by the Health System and purchased privately	2004: Self employed Remark: The majority of dentists is in the private sector, since dental care for adults is factually not covered by the Health System and purchased privately
Poland 1995: Self employed	2004: Self employed
Spain 1995: Self employed Remark: The purchasing of dental care is mostly private, since only dental care for children and extractions are covered. The later are provided in Hospitals and classify as hospital treatment	2004: Self employed Remark: The purchasing of dental care is mostly private, since only dental care for children and extractions are covered. The later are provided in Hospitals and classify as hospital treatment
Sweden 1995: Employed (53%); Remark: The share of employed dentists varies from 43% to 80 % among the counties. A substantial share is also self-employed	2004: Employed (about 58% in 2003) Remark: The share of employed dentists varies from 43% to 80 % among the counties. A substantial share is also self-employed
Switzerland 1995: Self employed Remark: The purchasing of dental care is mostly private, since dental is not covered by the	2004: Self employed Remark: The purchasing of dental care is mostly private, since dental is not covered by the

OS3 Dentists and the providers of dental care are predominantly...	
Health Insurance Funds.	Health Insurance Funds.
United Kingdom 1995: Self employed Remark: Usually, dentists have a contract with the NHS to provide services covered by the NHS, which specifies which services are covered and at what price. 12% of the dentist work in community dental service, operated directly by the NHS	2004: Self employed Remark: Usually, dentists have a contract with the NHS to provide services covered by the NHS, which specifies which services are covered and at what price.

OS4 What is the prevailing distribution channel of medicines and pharmaceuticals for **out-patient use**?	
Austria 1995: Privately owned pharmacies Remark: A substantial share of pharmaceuticals for out-patient use is distributed by dispensing GPs	2004: Privately owned pharmacies Remark: A substantial share of pharmaceuticals for out-patient use is distributed by dispensing GPs
Belgium 1995: Privately owned pharmacies	2005: Privately owned pharmacies
Canada 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Czech Republic 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Denmark 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Finland 1995: Privately owned pharmacies	2004: Privately owned pharmacies
France 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Germany 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Greece 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Hungary 1995: Privately owned pharmacies Remark: Pharmacies used to be state-owned but were privatized after the reform process.	2004: Privately owned pharmacies Remark: By 1997, all previously state-owned pharmacies were privatized
Ireland 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Italy 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Luxembourg 1994: privately owned pharmacies	2004: privately owned pharmacies
Netherlands 1995: Privately owned pharmacies	2004: Privately owned pharmacies
New Zealand 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Norway 1995: Privately owned pharmacies Remark: Some pharmacies are owned by regional health authorities	2004: Privately owned pharmacies Remark: About 10% of the sales are made by pharmacies owned and operated by public regional health authorities.
Portugal 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Poland 1995: Privately owned pharmacies	2004: Privately owned pharmacies

OS4 What is the prevailing distribution channel of medicines and pharmaceuticals for **out-patient use**?	
Spain 1995: Privately owned pharmacies	2004: Privately owned pharmacies
Sweden 1995: Publicly owned pharmacies Remark: All Pharmacies belong to the “Apoteket”, a state-owned monopoly corporation	2004: Publicly owned pharmacies Remark: All Pharmacies belong to the “Apoteket”, a state-owned monopoly corporation
Switzerland 1995: Privately owned pharmacies (60%) Remark: A substantial share of pharmaceuticals for out-patient use is also distributed by dispensing GPs	2004: Privately owned pharmacies (60%) Remark: A substantial share of pharmaceuticals for out-patient use is also distributed by dispensing GPs
United Kingdom 1995: Privately owned pharmacies Remark: The pharmacies have a contract with the NHS, in which mark ups and discounts are settled	2004: Privately owned pharmacies Remark: The pharmacies have a contract with the NHS, in which mark ups and discounts are settled

OS5 What is the predominant occupational status of providers of laboratory services, like analyses of blood samples, tissue analyses?	
Austria 1995: Laboratory services are predominantly provided by self employed providers/ independent firms	2004: Laboratory services are predominantly provided by self employed providers/ independent firms
Belgium 1995: Laboratory services are provided predominantly in Hospitals, by hospital staff, as a part of the hospital treatment. But there are also by self employed providers/ independent firms	2005: Laboratory services are provided predominantly in Hospitals, by hospital staff, as a part of the hospital treatment. But there are also by self employed providers/ independent firms
Canada 1995: Laboratory services are provided by Hospitals; Remark: There are also independent firms providing laboratory services according to contracts. There is a trend of hospitals outsourcing laboratory services to independent providers in order to save costs.	2004: Laboratory services are provided by Hospitals; Remark: There are also independent firms providing laboratory services according to contracts. There is a trend of hospitals outsourcing laboratory services to independent providers in order to save costs.
Czech Republic 1995: Laboratory services are predominantly provided by independent firms	2004: Laboratory services are predominantly provided by independent firms
Denmark 1995: Laboratory services are predominantly provided by Hospitals as part of in-patient treatment. Remark: There are also independent firms; which are both private and publicly owned, e.g. KPLL (owned by an independent fund), or the Statens Serum Institute which is publicly owned	2004: Laboratory services are predominantly provided by Hospitals as part of in-patient treatment. Remark: There are also independent firms; which are both private and publicly owned, e.g. KPLL (owned by an independent fund), or the Statens Serum Institute which is publicly owned
Finland 1995: Laboratory services are predominantly provided by Hospitals Remark: Laboratory services are also provided by public local laboratories associated with municipal Health Centers, and smaller Hospitals. There are also independent firms offering laboratory services, which are contracted.	2004: Laboratory services are predominantly provided by Hospitals Remark: Laboratory services are also provided by public local laboratories associated with municipal Health Centers, and smaller Hospitals. There are also independent firms offering laboratory services, which are contracted.
France 1995: self employed /independent firms (commercial Laboratories)	2004: self employed /independent firms 4000 commercial Laboratories
Germany 1995: Laboratory services are predominantly provided by self employed and independent	2004: Laboratory services are predominantly provided by self employed and independent

OS5 What is the predominant occupational status of providers of laboratory services, like analyses of blood samples, tissue analyses?	
firms Hospitals also conduct laboratory services as a part of their treatment, the same holds true for Physicians, which also offer laboratory services	firms Hospitals also conduct laboratory services as a part of their treatment, the same holds true for Physicians, which also offer laboratory services
Greece 1995: Self employed /independent firms Remark: 80% of all diagnostic facilities are in the private sector. The sector providing laboratory and diagnostic services is largely unregulated. Some Health Insurance Funds run their own laboratory services, which have to be used by the insured of this HIF. Otherwise, the HIF will not cover the service.	2004: Self employed /independent firms Remark: 80% of all diagnostic facilities are in the private sector. The sector providing laboratory and diagnostic services is largely unregulated. Some HIF run their own laboratory services, which have to be used by the insured of this HIF. Otherwise, the HIF will not cover the service.
Hungary 1995: Self employed /independent firms but also in Hospitals as part of the in-patient treatment	2004: Self employed /independent firms but also in Hospitals as part of the in-patient treatment
Ireland1995: Laboratory services are predominantly provided by Hospitals	2004: Laboratory services are predominantly provided by Hospitals
Italy 1995: Laboratory services are provided by Hospitals contracted or operated by the SSN, but also by private laboratories, with a contract with the SSN	2004: Laboratory services are provided by Hospitals contracted or operated by the SSN, but also by private laboratories, with a contract with the SSN
Luxembourg 1994: Laboratory services are provided by the National Laboratory of Health, Hospital Laboratories as a part of the hospital treatment but also by self employed providers/ independent firms	2004: Laboratory services are provided by the National Laboratory of Health, Hospital Laboratories as a part of the hospital treatment but also by self employed providers/ independent firms
Netherlands 1995: Employed and salaried by Hospital Remark: Laboratory services are mainly provided in Hospitals as part of the hospital treatment There are also some self-employed, independent firms providing laboratory services	2004: Employed and salaried by Hospital Remark: Laboratory services are mainly provided in Hospitals as part of the hospital treatment There are also some self-employed, independent firms providing laboratory services
New Zealand 1995: Self-employed, independent firms	2004: Self-employed, independent firms
Norway 1995: Laboratory services are predominantly provided by staff employed by Hospitals and are provided during and as part of hospital treatment. Remark: There are some self employed /independent	2004: Laboratory services are predominantly provided by staff employed by Hospitals and are provided during and as part of hospital treatment. Remark: There are some self employed /independent

OS5 What is the predominant occupational status of providers of laboratory services, like analyses of blood samples, tissue analyses?	
firms which are contracted	firms which are contracted
Portugal 1995: Self employed / independent firms Sophisticated laboratory services are provided in Hospitals, as part of the Hospital treatment Remark: Most laboratory services provided on an out-patient basis are provided by independent firms, not in Health Centers, which are usually not equipped for these kind of services; e.g. x-rays are provided by contracted private providers. By the end of the 80s, about 50 % of the x-rays and 70% of all laboratory services were done by private and contracted providers. Most heavy medical equipment is in the private sector and public Hospitals are also contracting services from the private sector	2004: Self employed / independent firms Sophisticated laboratory services are provided in Hospitals, as part of the Hospital treatment Remark: Most laboratory services provided on an out-patient basis are provided by independent firms, not in Health Centers, which are usually not equipped for these kind of services; e.g. x-rays are provided by contracted private providers. Most heavy medical equipment is in the private sector and public Hospitals are also contracting services from the private sector
Poland 1995: Most laboratory services are provided in hospitals during in-patient treatment. Remark: There is a tendency to outsourcing to private, contracted providers	2004: A substantial share is now provided by self employed / independent firms, but laboratory services are still also provided in hospitals during in-patient treatment. Remark: There is a tendency to further outsourcing to private, contracted providers
Spain 1995: Laboratory services are predominantly provided by staff employed by Hospitals, where most of these services are provided as part of the hospital treatment Remark: Some are also provided by self employed providers and independent firms on a contract basis. There is a trend to outsource laboratory services to independent providers.	2004: Laboratory services are predominantly provided by staff employed by Hospitals, where most of these services are provided as part of the Hospital treatment Remark: Some are also provided by self employed providers and independent firms on a contract basis. There is a trend to outsource laboratory services to independent providers.
Sweden 1995: Employed and salaried by Hospital, where most of the laboratory services are provided	2004: Employed and salaried by Hospital, where most of the laboratory services are provided
Switzerland 1995: Self employed /independent firms Remark: There are about 500 laboratories operated by Hospitals, 100 private laboratories and 5000 laboratories operated by physicians, most of the turnover is generated by the later.	2004: Self employed /independent firms Remark: There are about 500 laboratories operated by Hospitals, 100 private laboratories and 5000 laboratories operated by physicians, most of the turnover is generated by the later.

OS5 What is the predominant occupational status of providers of laboratory services, like analyses of blood samples, tissue analyses?	
United Kingdom 1995: Employed and salaried by hospitals, where laboratory services are mainly provided	2004: Employed and salaried by hospitals, where laboratory services are mainly provided

1.2. Remuneration Modes in Primary Care / Outpatient Care

R1A What is the predominant remuneration mode for the majority of services provided by **General Practitioners / Providers of Primary Care?**	
Austria 1995: Fee for service Remark: The fee (monetary value) depends to some extend digressively on the quantity of services provided per period by the GPs. The value of the fee also differs among Health Insurance Funds, since the lump sum paid by HIF differs.	2004: Fee for service Remark: The fee (monetary value) depends to some extend digressively on the quantity of services provided per period by the GPs. The value of the fee also differs among Health Insurance Funds, since the lump sums paid by the HIF differs.
Belgium 1995: Fee for service Remark: Fees are negotiated between the Physician's Association and the Association of the Health Insurance Funds. However, GPs are free to accept the conventions or not, they can also charge their own fees, but patients then have to pay more.	2005: Fee for service Remark: Fees are negotiated between the Physician's Association and the Association of the Health Insurance Funds. However, GPs are free to accept the conventions or not, they can also charge their own fees, but patients then have to pay more.
Canada 1995: Fee for service Remark: Fees are negotiated among the provincial governments and the provider organizations; usually on the provincial level.	2004: Fee for service Remark: Fees are negotiated among the provincial governments and the provider organizations, usually on the provincial level.
Czech Republic 1995: Capitation per enrolled patient Remark: The capitation is age adjusted and negotiated between the providers and each of the HIF. It is part of a point-based remuneration system. Some services are remunerated on a fee for service basis: each service has a number of points assigned and the monetary value of a point results from the overall remuneration and the overall number of points billed by all providers.	2004: Capitation per enrolled patient Remark: The capitation is age adjusted and negotiated between the providers and each of the HIF. It is part of a point-based remuneration system. Some services are remunerated on a fee for service basis: each service has a number of points assigned and the monetary value of a point results from the overall remuneration and the overall number of points billed by all providers. The contracting of defined volumes limited the extension of the overall remuneration.
Denmark 1995: 2/3 Fee for service with fixed fees; 1/3 Capitation per enrolled patient	2004: 2/3 Fee for service with fixed fees 1/3 Capitation per enrolled patient
Finland 1995: Salary Remark: For the GPs in Health Centers, about 60% of the income is from salary, 20% is a capitation	2004: Salary Remark: For the GPs in Health Centers, about 60% of the income is from salary, 20% is a capitation

R1A What is the predominant remuneration mode for the majority of services provided by **General Practitioners / Providers of Primary Care?**	
per patient which is enrolled with the GP. There is also a fee for service component. When working in private practice, the remuneration is by fee for service.	per patient which is enrolled with the GP. There is also a fee for service component. When working in private practice, the remuneration is by fee for service.
France 1995: Fee for service for GPs working in sector 1 (about 90% of all GPs) Remark: For providers working in sector 2 the remuneration is also by fee for service, but the fees are higher and set by the provider unilaterally, while in sector 1, it is negotiated with the Health Insurance Funds	2004: Fee for service for GPs working in sector 1 (about 90% of all GPs) Remark: For providers working in sector 2 the remuneration is also by fee for service, but the fees are higher and set by the provider unilaterally, while in sector 1, it is negotiated with the Health Insurance Funds
Germany 1995: Fee for service Remark: The fee's monetary value depends to some extend on the overall quantity of services provided per period by all GPs. Each service has assigned a number of points. The fixed sum paid by the Health Insurance Funds to the GP association is divided by the sum of all points of all services provided. This yields the monetary value of a point.	2004: Fee for service Remark: The fee's monetary value depends to some extend on the overall quantity of services provided per period by all GPs. Each service has assigned a number of points. The fixed sum paid by the Health Insurance Funds to the GP association is divided by the sum of all points of all services provided. This yields the monetary value of a point.
Greece 1995: Salary Remark: Salaries are set by the Ministry of Health. Independent providers are remunerated with a fixed fee per visit.	2004: Salary Remark: Salaries are set by the Ministry of Health. Independent providers are remunerated with a fixed fee per visit
Hungary 1995: Capitation per enrolled patient Remark: The Municipalities pay for capital investments of the practices, and sometimes provide the facilities in which the GP is working. The Purchaser, the National Health Insurance Fund Administration, NHIFA pays the GP per inscribed patient. The capitation is age adjusted and sets an incentive to limit the number of patients enrolled. If the GP is employed by the municipality, the NHIFA pays the capitation to the municipality which then pays the salary of the GP	2004: Capitation per enrolled patient Remark: The Municipalities pay for capital investments of the practices, and sometimes provide the facilities in which the GP is working. The NHIFA pays the GP per inscribed patient. The capitation is age adjusted and sets an incentive to limit the number of patients enrolled. If the GP is employed by the municipality, the NHIFA pays the capitation to the municipality which then pays the salary of the GP
Ireland 1995 : Capitation per enrolled patient for the poorest third of the population (Medical Card holders) Fee for service for the remaining 2/3 of the	2004: Capitation per enrolled patient for the poorest third of the population (Medical Card holders) Fee for service for the remaining 2/3 of the population

R1A What is the predominant remuneration mode for the majority of services provided by **General Practitioners / Providers of Primary Care?**	
population Remark: Also for medical card holders, part of the GP's remuneration is activity based. The consumption of medical services by medical card holders is substantially higher than that of non-medical card holders	Remark: Also for medical card holders, part of the GP's remuneration is activity based. The consumption of medical services by medical card holders is substantially higher than that of non-medical card holders
Italy 1995: Capitation per inscribed patient Remark: This accounts for about 80% of the GPs income. There is also an activity based component, with fees for instance for minor surgeries. Further, the GP can treat patients on a private basis, charging individual fees	2004: Capitation per inscribed patient Remark: This accounts for about 80% of the GPs income. There is also a activity based component, with fees for instance for minor surgeries. Further, the GP can treat patients on a private basis, charging individual fees
Luxembourg 1994: Fee for service; Remark: The fee schedule is negotiated with the HIF Association; Union des Caisses de Maladie; UCM	2004: Fee for service Remark: The fee schedule is negotiated with the HIF Association; Union des Caisses de Maladie; UCM
Netherlands 1995: Capitation per enrolled patient Remark: There is also a fee for service component in the remuneration	2004: Capitation per enrolled patient Remark: There is also a fee for service component in the remuneration
New Zealand 1995: Fee for service Remark: Formally, the RHA as purchaser should negotiate contracts with the GPs, but the negotiations were not concluded by this time. So, most of the GPs continued to charge fees and the majority of GP services was still remunerated on a fee for service basis, with fees set by the GP, paid for by the patients with subsidies from the government.	2004: Fee for service Remark: The payment is fees from the patients and subsidies from the government. The fees are set by the GPs themselves, while the subsidy is set by the government. Nevertheless, the fees charged are oriented at the flat rate subsidy paid by the government and the level of the fee is subject to review by the DHBs. The gap between the fee and the subsidy has to be covered by the patient. A small share of GPs get a capitation 15%.
Norway 1995: Salaries for the GPs employed by the municipalities Fee for service with fixed fees Remark: The GPs who are contracted receive a general grant from the municipalities plus a fee for service component which is paid for by the National Insurance Scheme; NIS. Fees are set by the National Assembly.	2004: Fee for service plus a capitation component Remark: The GP receives a fixed grant per patient enrolled from the municipality. Services are financed from the NIS and from out-of-pocket payments of the patients.

R1A What is the predominant remuneration mode for the majority of services provided by **General Practitioners / Providers of Primary Care?**	
Portugal 1995: Salary Remark: GPs are employed by the Health Centers, their salary is negotiated with the Ministry of Health. When working in his private practice, the GP can set his own fees	2004: Salary Remark: GPs are employed by the Health Centers, their salary is negotiated with the Ministry of Health. When working in his private practice, the GP can set his own fees
Poland 1995: Capitation per patient enrolled with the GP for self employed. Remark: Those who are still employed in Health Centers are salaried, but the share is diminishing.	2004: Capitation per patient enrolled with the GP
Spain 1995: Salary Remark: GPs are employed by the Health Centers. There are some incentives based on a capitation formula	2004: Salary Remark: GPs are employed by the Health Centers. There are some incentives based on a capitation per patient enrolled by a certain GP
Sweden 1995: Salary Remark: GPs employed by the Primary Health Centers operated by the county councils (Landstings)	2004: Salary Remark: GPs employed by the Primary Health Centers operated by the county councils (Landstings)
Switzerland 1995: Fee for service Remark: The remuneration is based on a point system. A number of points is assigned to each service, and the financial value of a point is negotiated at the cantonal level between the HIFs and the provider, subject to approval by the cantonal government.	2004: fee for service Remark: The remuneration is based on a point system. A number of points is assigned to each service, and the financial value of a point is negotiated at the cantonal level between the HIFs and the provider, subject to approval by the cantonal government.
United Kingdom 1995: Capitation per enrolled patient Remark: Patients have to register with a GP, who is then their first contact for receiving medical care, acting as a gate keeper for specialized and in patient care. apart from the remuneration per patient enrolled, there are also elements of activity based remuneration	2004: Capitation per enrolled patient Remark: Patients have to register with a GP, who is then their first contact for receiving medical care, acting as a gate keeper for specialized and in patient care. apart from the remuneration per patient enrolled, there are also elements of activity based remuneration

R1B Can the provider of primary care / the GP increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
Austria 1995: Yes, by providing more services per case and period	2004: Yes, by providing more services per case and period
Belgium 1995. Yes, by increasing the quantity of services, follow up consultations, usage of laboratory services.	2004: Yes, by increasing the quantity of services, follow up consultations, usage of laboratory services
Canada 1995: Yes, by increasing the quantity of services	2004: Yes, by increasing the quantity of services provided
Czech Republic 1995: Yes, via the fee for service component of the remuneration Remark: The overall remuneration paid by a HIF is fixed. If more services are delivered, the value of a point and hence the remuneration for a service, declines.	2004: Yes, via the fee for service component of the remuneration, e.g. by providing additional services, preventive measures and screenings. Remark: The overall remuneration paid by a HIF is fixed. If more services are delivered, the value of a point and hence the remuneration for a service, declines. The explicit contracting of defined volumes limited the extension of the overall remuneration.
Denmark 1995: Yes, via the fee for service remuneration. The GP can ask the patient to come for a another consultation (e.g. a medical checkup or follow up consultation)	2004: Yes, via the fee for service remuneration. The GP can ask the patient to come for a another consultation (e.g. a medical checkup or follow up consultation)
Finland 1995: Not in the public sector, where most of the GP's income is a fixed salary Remark: In addition to their employment in Health Centers, some GPs work also in private practice, where they are remunerated on a fee for services directly by the patients, which in turn are partially reimbursed by the NHI	2004: Not in the public sector, where most of the GP's income is a fixed salary Remark: In addition to their employment in Health Centers, some GPs work also in private practice, where they are remunerated on a fee for services directly by the patients, which in turn are partially reimbursed by the NHI
France 1995: Yes, by increasing the number of services; also by providing services in sector 2, where the fees are higher	2004: Yes, by increasing the number of services; also by providing services in sector 2, where fees are higher
Germany 1995: Yes, by providing more services per patient	2004: Yes, by providing more services per patient
Greece 1995: Yes, by providing services on private terms Remark: While the GP's salary is fixed, there is a strong incentive to redirect patients from the public system to the private system, i.e. the GP refers the patient to receive services	2004: Yes, by providing services on private terms Remark: While the GP's salary is fixed, there is a strong incentive to redirect patients from the public system to the private system, i.e. the GP refers the patient to receive services

R1B Can the provider of primary care / the GP increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
provided in the GP's private practice at more lucrative terms. There is a strong "revolving door" effect in the public system. Further, the remuneration is usually by a fee per visit.	provided in the GP's private practice at more lucrative terms. There is a strong "revolving door" effect in the public system. Further, the remuneration is usually by a fee per visit.
Hungary 1995: No, the capitation provides a fixed income. Remark: This is the case for both, self employed and for employed GPs	2004: No, the capitation provides a fixed income. Remark: This is the case for both, self employed and for employed GPs
Ireland 1995: Yes, via the fee for service component of the provider's income for 2/3 of the patients, who are not medical card holders, and via the activity based remuneration for medical card holders	2004: Yes, via the fee for service component for the patients without medical card for 2/3 of the patients, who are not medical card holders, and via the activity based remuneration for medical card holders
Italy 1995: Yes, while the capitation per patient or the salary is fixed, income can be increased by providing additional services on own account, for instance by home visits, vaccinations, etc. which are remunerated activity based. Also by treating patients on a private basis.	2004: Yes, while the capitation per patient or while the salary is fixed, income can be increased by providing additional services on own account, for instance by home visits, vaccinations, etc. which are remunerated activity-based. Also by treating patients on a private basis.
Luxembourg 1994: Yes, by increasing the quantity of services	2004: Yes, by increasing the quantity of services
Netherlands 1995: Yes, via the fee for service component of remuneration which is paid in addition to the capitation. The GP can increase the repeated number of consultations. Services for privately insured and some activities are remunerated by fees for service	2004: Yes, via the fee for service component of remuneration which is paid in addition to the capitation. The GP can increase the repeated number of consultations. Services for privately insured and some activities are remunerated by fees for service
New Zealand 1995. Yes, by providing more services per case	2004: Yes, by proving more services per case
Norway 1995: Yes, by increasing the quantity of services provided per case Remark: In addition to the general grant from the municipality, the GPs get a fee for service component paid by the NIS.	2004: Yes, by increasing the quantity of services provided per case Remark: In addition to the general grant from the municipality, the GPs get a fee for service component paid by the NIS.
Portugal 1995: Yes. Remark: While the GP's income from his work in the NHS is fixed, he can increase the income he earns in his private practice by increasing activity there – the option to do so is limited since the patients, the subsistema (HIF) or	2004: Yes. Remark: While the GP's income from his work in the NHS is fixed, he can increase the income he earns in his private practice by increasing activity there – the option to do so is limited since the patients, the subsistema (HIF) or

R1B Can the provider of primary care / the GP increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
their VHI has to cover these services	their VHI has to cover these services
Poland 1995: No, the income per patient is fixed Remark: This is true both for the self-employed GP (a fixed capitation) as well as for the employed GPs (a fixed salary)	2004: No, the income per patient is fixed Remark: Income of the self-employed GPs is a fixed capitation per patient enrolled
Spain 1995: No, the GP's salary is fixed Remark: Since most GPs work only part time in Health Centers, the GP can increase the income by treating patients on private terms in his private practice.	2004: No, the GP's salary is fixed Remark: Since most GPs work only part time in Health Centers, the GP can increase the income by treating patients on private terms in his private practice.
Sweden 1995: No, the GP's income is fixed	2004: No, the GP's income is fixed
Switzerland 1995: Yes, by increasing the quantity of services	2004: Yes, by increasing the quantity of services
United Kingdom 1995: Yes, by providing certain additional services Remark: The contract with the NHS also contains fees for certain activities, others are also paid for by the patients themselves - e.g. inoculations before trips abroad. In some areas, vaccination of children, chronic disease programs, GPs are rewarded, if they meet a certain target	2004: Yes, by providing certain additional services Remark: The contract with the NHS also contains fees for certain activities, others are also paid for by the patients themselves - e.g. inoculations before trips abroad. In some areas, vaccination of children, chronic disease programs, GPs are rewarded, if they meet a certain target

R2A What is the predominant remuneration mode for the majority of services provided by **Specialists/providers of specialized medical services to outpatients** ? How are eye specialist, orthopedists, radiologists, gynecologists etc. remunerated?	
Austria 1995: Fee for service; Remark: The fee's money value depends to some extend on the number of services per case and on the overall number of services provided per period	2004: Fee for service Remark: The fee's money value depends to some extend on the number of services per case and on the overall number of services provided per period
Belgium 1995: Fee for service Remark: Fees are negotiated between the Physician's Association and the Association of the Health Insurance Funds. However, all physicians are free to accept the conventions or not, they can also charge their own fees, but patients then have to pay more.	2005: Fee for service Remark: Fees are negotiated between the Physician's Association and the Association of the Health Insurance Funds. However, all physicians are free to accept the conventions or not, they can also charge their own fees, but patients then have to pay more.
Canada 1995: Fee for service Remark: Fees are negotiated among the provincial governments and the provider organizations. Specialized out-patient care is organized similar to primary care	2004: Fee for service Remark: Fees are negotiated among the provincial governments and the provider organizations. Specialized out-patient care is organized similar to primary care
Czech Republic 1995: Fee for service for self employed providers of specialized medical care Remark: While delivering the services in Health Centers and Polyclinics, the specialists are self employed and only rent the facilities. The remuneration is point based.	2004: Fee for service for self employed providers of specialized medical care Remark: While delivering the services in Health Centers and Polyclinics, the specialists are self employed and only rent the facilities. The remuneration is point based, the contracting of defined volumes limited the extension of the overall remuneration.
Denmark 1995: Salary for hospital based specialists (the majority); Fee for service with fixed fees for private practicing specialists (minority). The counties pay the self-employed providers on a fee for service with "broken tariffs" where different levels of turnover lead to different payment reductions	2004: Salary for hospital based specialists (the majority); Fee for service with fixed fees for private practicing specialists (minority). The counties pay the self-employed providers on a fee for service with "broken tariffs" where different levels of turnover lead to different payment reductions
Finland 1995: Salary Remark: In addition to their employment in Hospitals or Health Centers, many specialists work also	2004: Salary Remark: In addition to their employment in Hospitals or Health Centers, many specialists work also

R2A What is the predominant remuneration mode for the majority of services provided by **Specialists/providers of specialized medical services to outpatients** ? How are eye specialist, orthopedists, radiologists, gynecologists etc. remunerated?	
part time in private practice, where they are remunerated on a fee for services directly by the patients, which in turn are partially reimbursed by the NHI	part time in private practice, where they are remunerated on a fee for services directly by the patients, which in turn are partially reimbursed by the NHI
France 1995: Fee for service for those who are self employed Salary for those who are employed by hospitals Remark: Payment mode depends on the status, the overall split is about 50-50, but it depends on the kind of specialty	2004: Fee for service for those who are self employed Salary for those who are employed by hospitals Remark: Payment mode depends on the status, the overall split is about 50-50, but it depends on the kind of specialty
Germany 1995: Fee for service; based on a point system Remark: The fee's money value depends to some extend on the overall number of services provided per period (see remuneration of GPs)	2004: Fee for service; based on a point system Remark: The fee's money value depends to some extend on the overall number of services provided per period (see remuneration of GPs)
Greece 1995: Salary; set by the Ministry of Health Remark Specialized care is provided predominantly by Hospitals, and specialists working in the Hospital are salaried. The minority of private providers are remunerated on a fee for service basis.	2004: Salary, set by the Ministry of Health Remark: Specialized care is provided predominantly by Hospitals, and specialists working in the Hospital are salaried. The minority of purely private providers is remunerated on a fee for service basis.
Hungary 1995: Fee for service Remark: Specialized medical services are predominantly provided by hospitals. The services are paid fee for service, but the specialists providing the services are predominantly employed and salaried. The remuneration is based on a point system, in which each service has a certain number of points. Before 2000, the sectorial budget allocated to specialized care was divided by the sum of points billed, which then yielded the financial value of a point. Services provided by private providers on private terms are not regulated	2004: Fee for service Remark: Specialized medical services are predominantly provided by hospitals. The services are paid fee for service, but the specialists providing the services are predominantly employed and salaried. The remuneration is based on a point system, in which each service has a certain number of points. Since 2000, the financial value of a point is fixed in advance. Services provided by private providers on private terms are not regulated
Ireland 1995: Fee for services Remark: While consultants and specialists are	2004: Fee for services Remark: While consultants and specialists are

R2A What is the predominant remuneration mode for the majority of services provided by **Specialists/providers of specialized medical services to outpatients** ? How are eye specialist, orthopedists, radiologists, gynecologists etc. remunerated?	
employed by Hospitals, where specialized medical services are predominantly provided, they are paid on a fee for service basis.	employed by Hospitals, where specialized medical services are predominantly provided, they are paid on a fee for service basis
Italy 1995: Fee for service with fixed fees Remark: Specialized services are predominantly provided in Hospitals. Most of the employed specialists also work in private practice, where they are paid on a fee for service basis like the self-employed specialists. Further, the specialist can treat patients on a private basis, charging individual fees	2004: Fee for service with fixed fees Remark: Specialized services are predominantly provided in Hospitals. Most of the employed specialists also work in private practice, where they are paid on a fee for service basis like the self-employed specialists. Further, the specialist can treat patients on a private basis, charging individual fees.
Luxembourg 1994: Fee for service Remark: This is also true for the services provided by the independent specialists using Hospital facilities	2004: Fee for service Remark: This is also true for the services provided by the independent specialists using Hospital facilities
Netherlands 1995: Fee for service dominates Remark: Specialized care is provided predominantly by Hospitals. In the Hospital, specialists are working on their own account and are paid on a fee for service basis. Private providers are also paid on a fee for service basis	2004: Fee for service dominates Remark: Specialized care is provided predominantly by Hospitals. In the Hospital, specialists are working on their own account and are paid on a fee for service basis. Private providers are also paid on a fee for service basis
New Zealand 1995: Fee for services for the majority of specialized services provided Remark: Self-employed providers of specialized services are paid on a fee for service basis. Most of those specialists employed in Hospitals also have private practice, where they are remunerated on a fee for service basis. For their work in hospitals, they are salaried.	2004: Fee for services for the majority of specialized services provided Remark: Self-employed providers of specialized services are paid on a fee for service basis. Most of those specialists employed in Hospitals also have private practice, where they are remunerated on a fee for service basis. For their work in hospitals, they are salaried.
Norway 1995: Salary - specialized care is provided predominantly by and in Hospitals by salaried staff. Remark: Hospitals receive a block grant, i.e. a global budget usually based on past costs. The salary levels are set at the national level, negotiated with the Medical Association of	2004: Salary - specialized care is provided predominantly by and in Hospitals by salaried staff. Remark: Hospitals receive a global budget plus a activity related component based on DRG The salary levels are set at the level of the individual Hospital.

R2A What is the predominant remuneration mode for the majority of services provided by **Specialists/providers of specialized medical services to outpatients** ? How are eye specialist, orthopedists, radiologists, gynecologists etc. remunerated?	
Norway. Contracted specialists receive a general grant, and a fee for service component from the NIS.	Contracted specialists receive a general grant from the Regional Health Authority (part of the state administration), and a fee for service component from the NIS
Portugal 1995: Salary when working in the Hospital Fee for service, when working in their private practice Remark: Most specialist do both. When working in his own practice, the specialist is paid on a fee for service basis where the setting of fees is free;	2004: Salary when working in the Hospital Fee for service, when working in their private practice Remark: Most specialist do both. When working in his own practice, the specialist is paid on a fee for service basis where the setting of fees is free;
Poland 1995: Fee for service Remark: Specialized services are predominantly provided in hospitals. The remuneration is based on a point system: each service is allocated a number of points, and the financial value of a point is fixed. Multiplying both yields the remuneration for a certain service. However, the overall remuneration is also specified in the contract, which is a cost-volume contract.	2004: Fee for service Remark: Specialized services are predominantly provided in hospitals. The remuneration is based on a point system: each service is allocated a number of points, and the financial value of a point is fixed. Multiplying both yields the remuneration for a certain service. However, the overall remuneration is also specified in the contract. which is a cost-volume contract.
Spain 1995: The specialists providing the services in the Hospitals are remunerated by fixed salaries There are also some financial incentives based on the number of patients treated Remark: Since most Specialists work part time in private practice as well, they can increase the income by treating patients on private terms in his private practice.	2004: The specialists providing the services in the Hospitals are remunerated by fixed salaries. There are also some financial incentives based on the number of patients treated Remark: Since most Specialists work part time in private practice as well, they can increase the income by treating patients on private terms in his private practice.
Sweden 1995: Salary Remark: Specialists are predominantly employed in the Health Centers and Hospitals	2004: Salary Remark: Specialists are predominantly employed in the Health Centers and Hospitals
Switzerland 1995: Fee for service Remark: The remuneration is based on a point system. A number of points is assigned to each service, and the financial value of a point is negotiated at the cantonal level between the HIFs and the provider, subject to approval by	2004: Fee for service Remark: The remuneration is based on a point system. A number of points is assigned to each service, and the financial value of a point is negotiated at the cantonal level between the HIFs and the provider, subject to approval by

R2A What is the predominant remuneration mode for the majority of services provided by **Specialists/providers of specialized medical services to outpatients** ? How are eye specialist, orthopedists, radiologists, gynecologists etc. remunerated?	
the cantonal government.	the cantonal government.
United Kingdom 1995: Salary Remark: While most physicians providing this kind of services are employed in Hospitals, the specialist can work part time in their own practice	2004: Salary Remark: While most physicians providing this kind of services are employed in Hospitals, the specialist can work part time in their own practice

R2B Can the **Specialist / Provider of Specialized Medical Services** increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
Austria 1995: Yes, by providing more services	2004: Yes, by providing more services
Belgium 1995: Yes, by providing more services - e.g. follow up consultations, usage of laboratory services	2005: Yes, by providing more services - e.g. follow up consultations, usage of laboratory services
Canada 1995: Yes, by providing more services	2004: Yes, by providing more services
Czech Republic 1995: Yes, for self employed providers who are remunerated on a fee for service basis. Remark: The fixed remuneration paid by a HIF to the providers limits this incentive, since more services provided decrease the financial value of a point and hence the remuneration for a service.	2004: Yes, for self employed providers who are remunerated on a fee for service basis. Remark: Again, the fixed remuneration paid by a HIF to the providers limits the incentive, since more services decrease the financial value of a point and hence the remuneration for a service.
Denmark 1995: No for the majority of employed specialists employed by the Hospitals where most specialized care is provided. Yes for the minority of self employed; for instance by asking the patient to return for a checkup, or giving extra services (minority)	2004: No for the majority of employed specialists employed by the Hospitals where most specialized care is provided. Yes for the minority of self employed; for instance by asking the patient to return for a checkup, or giving extra services (minority)
Finland 1995: Yes, by offering services in his private practice	2004: Yes, by offering services in his private practice
France 1995: Yes, for the self employed by increasing the number of visits and/or its structure of acts delivered within a visit (some care and services are better paid than other) and/or by increasing the amount of extra fees for those who are in sector 2; the percentage of specialists working in sector 2 is higher than that of GPs For those employed and salaried by Hospitals, there is no such incentive	2004: Yes, for the self employed by increasing the number of visits and/or its structure of acts delivered within a visit (some care and services are better paid than other) and/or by increasing the amount of extra fees for those who are in sector 2; the percentage of specialists working in sector 2 is higher than that of GPs For those employed and salaried by Hospitals, there is no such incentive
Germany 1995: Yes, by providing more services	2004: Yes, by providing more services
Greece 1995: Yes, in particular for those working in private practice; by providing more services and provide services on private terms Remark: While the specialist's salary is fixed, there is a strong incentive to redirect patients from the public system to the private system, i.e.	2004: Yes, in particular for those working in private practice; by providing more services and provide services on private terms Remark: While the specialist's salary is fixed, there is a strong incentive to redirect patients from the public system to the private system, i.e. the

R2B Can the **Specialist / Provider of Specialized Medical Services** increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
the specialists refers the patient to receive services provided in his private practice at more lucrative terms. There is a strong "revolving door" effect in the public system.	specialists refers the patient to receive services provided in his private practice at more lucrative terms. There is a strong "revolving door" effect in the public system.
Hungary 1995: Yes, by providing more services	2004: Yes, by providing more services
Ireland 1995: Yes, by providing more services which are remunerated on a fee for service basis	2004: Yes, by providing more services which are remunerated on a fee for service basis
Italy 1995: Yes, by providing additional services in particular when working on their own account. Also by treating patients on a private basis.	2004: Yes, by providing additional services in particular when working on their own account. Also by treating patients on a private basis.
Luxembourg 1994: Yes, by providing more services	2004: Yes, by providing more services
Netherlands 1995: Yes, by providing more services, e.g. a repeated number of visits	2004: Yes, by providing more services, e.g. a repeated number of visits
New Zealand 1995. Yes, by providing more services, since most specialized services are paid for on a fee for service basis. Remark: This holds true for self-employed as well as most employed providers, which can provide additional services on own account	2004: Yes, by providing more services, since most specialized services are paid for on a fee for service basis Remark: This holds true for self-employed as well as most employed providers, which can provide additional services on own account
Norway 1995: No, the provider's income is a fixed salary Yes for contracted providers Remark: Most specialized physicians are working in the Hospital, where the specialized services are predominantly provided. The Hospital itself has some incentives to increase activity, see H9/H10. Contracted providers can increase their income via the fee for service component.	2004: No, the provider's income is a fixed salary Yes for contracted providers Remark: Most specialized physicians are working in the Hospital, where the specialized services are predominantly provided. The Hospital itself has some incentives to increase activity, see H9/H10 Contracted providers can increase their income via the fee for service component.
Portugal 19995: No, when working in the Hospital Yes, by spending more time working in his own practice and providing more services there Remark: The incentive on the margin is that increasing income by providing more services is possible	2004: No, when working in the Hospital Yes, by spending more time working in his own practice and providing more services there Remark: The incentive on the margin is that increasing income by providing more services is possible

R2B Can the **Specialist / Provider of Specialized Medical Services** increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
Poland 1995: Yes, under some circumstances, the income can be increased by providing more services than were agreed on in the contract Remark: Since most specialized services are provided in hospitals, the relevant actor is the hospital. Usually, the contract is a cost volume contract, which limits the overall expenditure. This can be circumvented only in the case of emergencies.	2004: Yes, under some circumstances, the income can be increased by providing more services than were agreed in the contract Remark: Since most specialized services are provided in hospitals, the relevant actor is the hospital. Usually, the contract is a cost volume contract, which limits the overall expenditure. This can be circumvented only in the case of emergencies.
Spain 1995: Basically no Remark: The provider's income is a fixed salary. However, they can offer services to private patients in their extra time	2004: Basically no Remark: The provider's income is a fixed salary. However, they can offer services to private patients in their extra time.
Sweden 1995: No, the specialist's income is fixed, since he is employed by the County Council	2004: No, the specialist's income is fixed, since he is employed by the County Council
Switzerland 1995: Yes, by providing more services	2004: Yes, by providing more services
United Kingdom 1995: No, the salary is fixed Remark: They may earn up to 10% of their income from operating a private practice, where they provide services.	2004: No, the salary is fixed Remark: They may earn up to 10% of their income from operating a private practice, where they provide services

R3A What is the predominant remuneration mode for **Dentists and Dental Care**?	
Austria 1995: Fee for service Remark: The fee's monetary value depends to some extend on the number of services per case and on the overall number of services provided per period.	2004: Fee for service Remark: The fee's monetary value depends to some extend on the number of services per case and on the overall number of services provided per period.
Belgium 1995: Fee for service Remark: Fees for those services covered by the Health system are negotiated between the Dentist's Association and the Association of the HIFs, subject to approval by the Government.	2004: Fee for service Remark: Fees for those services covered by the Health system are negotiated between the Dentist's Association and the Association of the HIFs, subject to approval by the Government.
Canada 1995: Fee for service Remark: Dental care is predominantly privately purchased (either out of pocket or by the supplementary insurance) and dentists are fee to set their own fees	2004: Fee for service Remark: Dental care is predominantly privately purchased and dentists are fee to set their own fees
Czech Republic 1995: Fee for service Remark The remuneration is based on a catalogue of services and an assigned monetary price. The contracting of defined volumes for a defined remuneration limited the extension of the overall remuneration.	2004: Fee for service Remark The remuneration is based on a catalogue of services and an assigned monetary price. The contracting of defined volumes for a defined remuneration limited the extension of the overall remuneration.
Denmark 1995: Fee for service for the majority of services provided to adults. Salary for the dentists working under the municipal dental services which are free of charge for those under 18 years of age. Remark: The agreement with the Health Care Reimbursement Negotiation Committee contains fixed fee with fixed user-payment levels, however some services are not covered by the public funds, and there may be variable prices. Most dental care is privately purchased	2004: Fee for service for the majority of services provided to adults. Salary for the dentists working under the municipal dental services which are free of charge for those under 18 years of age. Remark: The agreement with the Health Care Reimbursement Negotiation Committee contains fixed fee with fixed user-payment levels, however some services are not covered by the public funds, and there may be variable prices. Most dental care is privately purchased
Finland 1995: Fee for service for the self-employed dentists Salary for the dentist employed Remark: The share is about 50:50, since many adults did not have access to the dental care	2004: Fee for service for the self-employed dentists Salary for the dentist employed Remark: Since 2002 all citizens have access to dental care provided in the Health Centers. The fees

R3A What is the predominant remuneration mode for **Dentists and Dental Care**?	
provided in Health Centers. The fees for privately provided dental services are paid for by the patient and partially reimbursed by the National Health Insurance according to a basic tariff schedule. Dentists are free to charge more than the basic tariff, but the reimbursement by the NHI is only based on the basic tariff. The patient has to cover the difference	for privately provided dental services are paid for by the patient and partially reimbursed by the National Health Insurance according to a basic tariff schedule. Dentists are free to charge more than the basic tariff, but the reimbursement by the NHI is only based on the basic tariff, and the patient has to cover the difference.
France 1995: Fee for service with fixed fees	2004: Fee for service with fixed fees
Germany 1995: Fee for service with variable fees; Remark: The fee's money value depends to some extend on the overall number of services provided per period.	2004: Fee for service with variable fees; Remark: The fee's money value depends to some extend on the overall number of services provided per period
Greece 1995: Fee for service Remark: Usually, a visit at a Dentists, including all treatment during this visit, is remunerated with a fixed fee. The Dentists can also offer services on private terms.	2004: Fee for service Remark: Usually, a visit at a Dentists, including all treatment during this visit, is remunerated with a fixed fee. The Dentists can also offer services on private terms.
Hungary 1995 Fee for service Remark: Dental care was excluded, then reintroduced in the catalogue again, but were subject to co-payments.	2004: Fee for service Remark: After the reintroduction of dental care in the catalogue of medical services covered, even the co-payments were abolished in 2001.
Ireland 1995: Fee for service for non medical card holders, which are the majority of the population Remark: Apart from those, there are dentists working full time in public dental care centers, and also dentists with a part time contract with the Health Boards	2004: Fee for service for non medical card holders, which are the majority of the population Remark: Apart from those, there are dentists working full time in public dental care centers, and also dentists with a part time contract with the Health Boards
Italy 1995: Fee for service within the SSN Fee for service outside of the SSN contracts; i.e. when the services are privately purchased. Remark: Fees are set in the contract between the dentists and the SSN. Most dental care is provided outside of the SSN, i.e. is purchased privately.	2004: Fee for service within the SSN Fee for service outside of the SSN contracts; i.e. when the services are privately purchased Remark: Fees are set in the contract between the dentists and the SSN. Most dental care is provided outside of the SSN, i.e. is purchased privately.

R3A What is the predominant remuneration mode for **Dentists and Dental Care**?	
Luxembourg 1994 Fee for service	2004: Fee for service Remark: The co-payments made directly by patients for dentures make up a substantial part of the dentist's income
Netherlands 1995: Fee for service with fixed fees	2004: Fee for service with fixed fees
New Zealand 1995: Fee for service Remark: The dentists sets his own fees according to market prices. There is a fee schedule only for patients under 18 years of age and event here with many exemptions.	2004: Fee for service Remark: The dentists sets his own fees according to market prices. There is a fee schedule only for patients under 18 years of age and event here with many exemptions.
Norway 1995: Fee for service Remark: The fees are set by the dentist himself. Only services for the under 18 are covered by the public health system, and provided by employed dentists.	2004: Fee for service Remark: The fees are set by the dentist himself. Only services for the under 18 are covered by the public health system, and provided by employed dentists.
Portugal 1995: Fee for service with variable fees for dentists in the private sector, where most dental care is provided Remark: While not formally excluded from coverage, dental care is factually not provided by the NHS. The dentists are free to set their own fees within a minimum and a maximum set by the National Dental Association. In the case of coverage by a subsistema, HIF, the fees are negotiated between the HIF and the Dentists. Fee is paid either by the patient, the VHI or the subsistema.	2004: Fee for service with variable fees for dentists in the private sector, where most dental care is provided Remark: While not formally excluded from coverage, dental care is factually not provided by the NHS. The dentists are free to set their own fees within a minimum and a maximum set by the National Dental Association. In the case of coverage by a subsistema, HIF, the fees are negotiated between the HIF and the Dentists. Fee is paid either by the patient, the VHI or the subsistema
Poland 1995 Fee for service Remark: The contract with the Dentists specifies both a volume of services and the overall remuneration. The fees are calculated using a point system, where each service has a number of points.	2004: Fee for service Remark: The contract with the Dentists specifies both a volume of services and the overall remuneration. The fees are calculated using a point system, where each service has a number of points.
Spain 1995: Fee for service with fixed and variable fees Remark: Dentists working in Health Centers are salaried. Most dental care is not covered by the public health system, but is	2004: Fee for service with fixed and variable fees Remark: Dentists working in Health Centers are salaried. Most dental care is not covered by the public health system, but is predominantly

R3A What is the predominant remuneration mode for **Dentists and Dental Care**?	
predominantly privately purchased. Each dentists sets his fees according to the market conditions.	privately purchased. Each dentists sets his fees according to the market conditions.
Sweden 1995: Salary for the employed dentists Fee for service for self employed providers; the share of both is about even Remark: The pricing of dental services is free, but there are fixed subsidies for some dental services. Dental care for persons over 20 years of age only partly subsidized. Thus most dental care is provided in a fee for service setting.	2004: Salary for the employed dentists Fee for service for self employed providers; the share of both is about even. Remark: The pricing of dental services is free, but there are fixed subsidies for some dental services. Dental care for persons over 20 years of age is only partly subsidized. Thus most dental care is provided in a fee for service setting.
Switzerland 1995: Fee for service Remark: The fees are loosely based on a fee schedule negotiated between the Dental Association and some HIFs. Most of dental care is privately paid for – either out of pocket or by a VHI.	2004: Fee for service Remark: The fees are loosely based on a fee schedule negotiated between the Dental association and some HIFs. Most of dental care is privately paid for – either out of pocket or by a VHI.
United Kingdom 1995: Fee for service with fixed fees for dentists working for the NHS. Fee for service also if the dental care is purchased on private terms Remark: Most dental care is privately purchased, fees there are fixed by the market. When visiting a dentists with a NHS contract, the patient has to indicate, whether he wants to be treated as a private patient or as a NHS patient on NHS terms. The access to treatment on NHS terms is limited due to supply.	2004: Fee for service with fixed fees for dentists working for the NHS. Fee for service also if the dental care is purchased on private terms Remark: Most dental care is privately purchased, fees there are fixed by the market. When visiting a dentists with a NHS contract, the patient has to indicate, whether he wants to be treated as a private patient or as a NHS patient on NHS terms. The access to treatment on NHS terms is limited due to supply

R3B Can the **Dentist /Provider of Dental Care** increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
Austria 1995: Yes, by providing more services	2004: Yes, by providing more services
Belgium 1995: Yes, by providing extra services Remark: E.g. more frequent consultations; the billing of implants and dentures is rather intransparent and offers another possibility of increasing the income	2004: Yes, by providing extra services Remark: E.g. more frequent consultations; the billing of implants and dentures is rather intransparent and offers another possibility of increasing the income
Canada 1995: Yes, by providing extra services	2004: Yes, by providing extra services
Czech Republic 1995: Yes, by providing extra services Remark: Like with other providers, the fixed remuneration paid by a HIF to the providers of dental care limits this incentive. If more services are provided, the financial value of a point and hence the remuneration for a service decrease.	2004: Yes, by providing extra services Remark: Like with other providers, the fixed remuneration paid by a HIF to the providers of dental care limits this incentive. If more services are provided, the financial value of a point and hence the remuneration for a service decrease.
Denmark 1995: Yes, by providing extra services	2004: Yes, by providing extra services
Finland 1995: Yes, the self employed dentists can do so by providing extra services	2004: Yes, the self employed dentists can do so by providing extra services Remark: Formally, the whole population has now access to dental care provided in Health Centers by salaried Dentists.
France 1995: Yes, by increasing the number of visits and/or structure of services delivered within a visit; but mostly by the amount of extra billing on dental prosthesis	2004: Yes, by increasing the number of visits and/or structure of services delivered within a visit; but mostly by the amount of extra billing on dental prosthesis
Germany 1995: Yes, by providing extra services	2004: Yes, by providing more services
Greece 1995: Yes, by providing extra services Remark: Since the payment is fee per visit, the incentive is to increase the number of visits. In particular, the Dentists can offer services on private terms.	2004: Yes, by providing extra services Remark: Since the payment is fee per visit, the incentive is to increase the number of visits. In particular, the Dentists can offer services on private terms.
Hungary 1995: Yes, by providing extra services	2004: Yes, by providing extra services
Ireland 1995: Yes by increasing the quantity of services – for non medical card holders	2004: Yes by increasing the quantity of services – for non medical card holders

R3B Can the **Dentist /Provider of Dental Care** increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
Italy 1995: Yes, by providing additional services	2004: Yes, by providing additional services
Luxembourg 1994: Yes, by providing more services; Remark: Also by providing services which are not covered by the Health Insurance	2004: Yes, by providing more services Remark: Also by providing services, which are not covered by the Health Insurance
Netherlands 1995: Yes, by providing additional services	2004: Yes, by increasing the quantity of services
New Zealand 1995: Yes, by providing more services	2004: Yes, by providing more services
Norway 1995: Yes, by increasing the number of visits; the dentist sets his own rates and fees Remark: Since dental services are not covered and there is only in some cases a subsidy by the NIS, the incentive is counteracted by the patient's willingness to pay.	2004: Yes, by increasing his activities; the dentist sets his own rates and fees Remark: Since dental services are not covered and there is only in some cases a subsidy by the NIS, the incentive is counteracted by the patient's willingness to pay.
Portugal 1995: Yes, by increasing the quantity of services; the dentist sets his own rates and fees within certain limits	2004: Yes, by increasing the quantity of services; the dentist sets his own rates and fees within certain limits
Poland 1995: Yes, by increasing the number of services. Remark: While the contract sets a volume of services and a total remuneration, the dentists may offer more services which are paid for by the patient.	2004: Yes, by increasing the number of services. Remark: While the contract sets a volume of services and a total remuneration, the dentists may offer more services which are paid for by the patient.
Spain 1995: Yes, the self employed dentists can do so by increasing activity and using more resources Remark: Since most dental care is purchased privately, this concerns the majority of dental care	2004: Yes, the self employed dentists can do so by increasing activity and using more resources Remark: Since most dental care is purchased privately, this concerns the majority of dental care
Sweden 1995: Yes, for the self-employed by increasing activity No only for the employed dentists, and only when providing dental care in the setting of their employment. Remark: While the share employed / self-employed is about even, most dental care is provided in the fee for service setting, which sets an incentive to increase the quantity of services. The employed dentists also treat adults on a private basis charging fee for service.	2004: Yes, for the self-employed by increasing activity No only for the employed dentists, and only when providing dental care in the setting of their employment. Remark: While the share employed / self-employed is about even, most dental care is provided in the fee for service setting, which sets an incentive to increase the quantity of services. The employed dentists also treat adults on a private basis charging fee for service.

R3B Can the **Dentist /Provider of Dental Care** increase his income one way or the other by extending the quantity of services provided in a given case, i.e. for a patient?	
Switzerland 1995: Yes, by providing extra services	2004: Yes, by providing extra services
United Kingdom 1995: Yes, by treating the patient on a private basis Remark: Treating patients on private terms is more attractive than those terms set by the NHS. Further, the dentists can increase the activity. Increasing activity leads to higher income, both within the contract with the NHS and the treatment on private terms.	2004: Yes, by treating the patient on a private basis Remark: Treating patients on private terms is more attractive than those terms set by the NHS. Further, the dentists can increase the activity. Increasing activity leads to higher income, both within the contract with the NHS and the treatment on private terms.

R4 How are the **Physicians/Surgeons working in a hospital** (e.g. surgeons, anesthetists) remunerated?	
Austria 1995: Fixed Salary plus a share of fees arising from patients treated outside of the Social Health Insurance System, i.e. on a private basis	2004: Fixed Salary plus a share of fees arising from patients treated outside of the Social Health Insurance System, i.e. on a private basis
Belgium 1995: Fee for service in private non-profit Hospitals (the predominant form) Fixed salary in University Hospitals and for consultants which are still in training Remark: Patients are on entry assigned to a consultant, who is billing the services provided on a fee for service basis directly to the patient. The fees are negotiated among the Physician's Association and the Association of the HIFs	2004: Fee for service in private non-profit Hospitals (the predominant form) Fixed salary in University Hospitals and for consultants which are still in training Remark: Patients are on entry assigned to a consultant, who is billing the services provided on a fee for service basis directly to the patient. The fees are negotiated among the Physician's Association and the Association of the HIFs
Canada 1995: Fee for service Remark: Physicians providing in-patient or specialized services in hospital's are actually self employed with a contract to use the hospital's facilities. Most surgeons are paid on a fee for service basis. Some are of the technical staff, are employed and salaried.	2004: Fee for service Remark: Physicians providing in-patient or specialized services in hospital's are actually self employed with a contract to use the hospital's facilities. Most surgeons are paid on a fee for service basis. Some are of the technical staff, are employed and salaried.
Czech Republic 1995: Fixed salary	2004: Fixed salary
Denmark 1995: Fixed salary	2004: Fixed salary
Finland 1995: Fixed salary	2004: Fixed Salary
France 1995: Fixed salary for physicians working in public hospitals, the majority, which are state employees. Their salary is set by the state – i.e. negotiated between their association and the state University hospital doctors can devote a part of their working time to private practice within the hospital (a minority). Fee for service for physicians working in private hospitals; the fee is paid by the patient to the provider, who transfers part of it to the private hospital, as a payment for the usage of the hospitals equipment	2004: Fixed salary for physicians working in public hospitals, the majority, which are state employees. Their salary is set by the state – i.e. negotiated between their association and the state University hospital doctors can devote a part of their working time to private practice within the hospital (a minority). Fee for service for physicians working in private hospitals; the fee is paid by the patient to the provider, who transfers part of it to the private hospital, as a payment for the usage of the hospitals equipment
Germany 1995: Salary Remark:	2004: Salary Remark:

R4 How are the **Physicians/Surgeons working in a hospital** (e.g. surgeons, anesthetists) remunerated?	
The salary is negotiated between the Association of Hospital Doctors, "Marburger Bund", and the association of the Regions respectively the association of the Municipalities operating the Hospitals The Chief consultants can obtain additional income from treating patients on a private basis	The salary is negotiated between the Association of Hospital Doctors, "Marburger Bund", and the association of the Regions respectively the association of the Municipalities operating the Hospitals The Chief consultants can obtain additional income from treating patients on a private basis
Greece 1995: Fixed Salary Remark: The salary is set by the Ministry of Health, or rather, negotiated among the Ministry and the professional representations	2004: Fixed Salary Remark: The salary is set by the Ministry of Health, or rather, negotiated among the Ministry and the professional representations
Hungary 1995: Salary	2004: Salary
Ireland 1995: Fee for service for most hospital consultants. Remark: While being formally employed, hospital consultants are paid on a fee for service basis, and also may work part time in a private practice. Fixed salary for some of the physicians working in the Hospital.	2004: Fee for service for most hospital consultants. Remark: While being formally employed, hospital consultants are paid on a fee for service basis, and also may work part time in a private practice. Fixed salary for some of the physicians working in the Hospital.
Italy 1995. Fixed salary in public Hospitals. Remark: The salaries are negotiated between the government and the association of hospital physicians. Up to 1999, consultants in Hospitals could earn additional income by treating patients privately, on a fee for service basis, paying part of the income to the hospitals in exchange for using the facilities	2004: Fixed salary in public Hospitals. Remark: The salaries are negotiated between the government and the association of hospital physicians
Luxembourg 1994: Fee for service Remark: Only in 2 of 34 hospitals, in-patient services are provided by staff which is employed by the Hospital. In the others, independent, self-employed specialists use Hospital facilities. The Hospital is just the place where services are provided. The specialist have detailed arrangements with the Hospitals, in which payments are defined. The fees themselves are negotiated by the specialists and the HIF Association	2004: Fee for service Remark: Only in 2 of 34 hospitals, in-patient services are provided by staff employed by the Hospital. In the others, independent, self-employed specialists use Hospital facilities. The Hospital is just the place where services are provided. The specialist have detailed arrangements with the Hospitals, in which payments are defined The fees themselves are negotiated by the specialists and the HIF Association

R4 How are the **Physicians/Surgeons working in a hospital** (e.g. surgeons, anesthetists) remunerated?	
Netherlands 1995: Fee for service for the majority of physicians which are basically self employed but have a contract with the hospital to use the hospitals equipment Remark: Only about one quarter of the physicians working in hospitals is employed and salaried.	2004: Fee for service for the majority of physicians which are basically self employed but have a contract with the hospital to use the hospitals equipment Remark: Only about one quarter of the physicians working in hospitals is employed and salaried.
New Zealand 1995: Fixed Salary Remark: Salaries were negotiated between the individual physician and the Hospital. Surgeons in private hospitals are paid on a fee for service basis.	2004: Fixed Salary Remark: Salaries were negotiated collectively between the physicians and the District Health Boards operating the Hospitals. Surgeons in private hospitals are paid on a fee for service basis.
Norway 1995: Fixed salary Remark: The salary levels are set at the national level; negotiated with the Medical Association of Norway.	2004: Fixed Salary Remark: The salary levels are set at the national level, negotiated with the Medical Association of Norway.
Portugal 1995 Fixed salary	2004: Fixed Salary
Poland 1995: Fixed salary	2004: Fixed salary
Spain 1995: Fixed Salary	2004: Fixed Salary
Sweden 1995: Fixed Salary	2004: Fixed Salary
Switzerland 1995: A fixed salary plus a fee for service component	2004: A fixed salary plus a fee for service component
United Kingdom 1995: Fixed Salary, with some elements of a merit awards Remark: Consultants have a fixed salaries, but can work part time in private practice. There are several types of employment contracts, allowing different shares of private activity outside the Hospital.	2004: Fixed Salary Remark: Consultants have a fixed salaries, but can work part time in private practice. There are several types of employment contracts, allowing different shares of private activity outside the Hospital

R5 How is the income of pharmacists / the pharmacy related to the quantity of medicines sold?	
Austria 1995: The pharmacy's profit is the difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Remark: Prices are regulated on manufacturer and retail level; the Health Insurance Funds fix a digressive relationship of the retail mark up to the amount of packages sold; mark ups were reduced during the period 1995–2004.	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Remark: Prices are regulated on both levels; Social Insurance fixes a relationship of the retail mark up to the amount of packages sold; mark ups were reduced during the period 1995 – 2004
Belgium 1995: A percentage of the total value of the medicines sold; (retail margin). Remark: In 1995, the percentage was 31% of the retail price of a drug, with a cap of 300 BFR. A substantial share of the pharmacies income arises from the sale of cosmetics etc	2004: A percentage of the total value of the medicines sold; (retail margin). Remark: A substantial share of income arises from the sale of cosmetics etc.
Canada 1995: A dispensing fee paid usually by the patient plus a retail margin for pharmacies Remark: The dispensing fee set by the pharmacy. In addition, the pharmacy can obtain profit from the difference between the price at which the Pharmacy buys the medicine from the wholesaler and the retail price.	2004: Dispensing fee paid usually by the patient plus a retail margin for pharmacies Remark: The dispensing fee set by the pharmacy. In addition, the pharmacy can obtain profit from the difference between the price at which the Pharmacy buys the medicine from the wholesaler and the retail price.
Czech Republic 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Remark: The retail margin is set by the government.	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin)
Denmark 1995: Income is the difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Plus a fixed amount per package sold (dispensing fee) Remark: The gross-income of a pharmacy is set by the Ministry of Health	2004: Income is the difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Plus a fixed amount per package sold (dispensing fee) Remark: The gross-income of a pharmacy is set by the Ministry of Health
Finland 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Remark:	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Remark:

R5 How is the income of pharmacists / the pharmacy related to the quantity of medicines sold?	
The retail margin is set by the government	The retail margin is set by the government
France 1995: For pharmacist who own pharmacies, income is the difference between the price at which the Pharmacy buys the medicine and the retail price. (retail margin) Remark: The retail price is fixed by the government for those pharmaceuticals which are reimbursed by the Health Insurance System	2004: For pharmacist who own pharmacies, income is the difference between the price at which the Pharmacy buys the medicine and the retail price. (retail margin) Remark: The retail price is fixed by the government for those pharmaceuticals which are reimbursed by the Health Insurance System
Germany 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price; plus a fixed percentage mark up of 3%	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price; An amount per package sold plus a mark-up of 3% Plus a fixed percentage mark up
Greece 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin) Remark: While the retail margin is formally set by the government; the retail margin is negotiated between the government and the pharmacy association	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin) Remark: While the retail margin is formally set by the government; the retail margin is negotiated between the government and the pharmacy association
Hungary 1995: Percentage of the total value of the medicines sold (pharmacy retail margin)	2004: Percentage of the total value of the medicines sold (pharmacy retail margin)
Ireland 1995: An amount per package sold (dispensing fee) Difference between the price at which the Pharmacy buys the medicine and the retail price	2004: An amount per package sold (dispensing fee) Difference between the price at which the Pharmacy buys the medicine and the retail price
Italy 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price – this is set nationally Remark: In 1996, this percentage was by the state to be 26,7 % of the price of the pharmaceutical before VAT.	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price– this is set nationally
Luxembourg 1994: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Remark: All issues concerning the remuneration are negotiated between the pharmacists'	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) Remark: All issues concerning the remuneration are negotiated between the pharmacists'

R5 How is the income of pharmacists / the pharmacy related to the quantity of medicines sold?	
association and the Union of Health Insurance Funds, UCM	association and the Union of Health Insurance Funds, UCM
Netherlands 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin) Plus a fixed amount per package sold	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin) Plus a fixed amount per package sold
New Zealand 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) An amount per package sold; "dispensing fee"	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price; (retail margin) An amount per package sold; "dispensing fee"
Norway 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin) Remark: The retail margin is set by the state	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin) Remark: The retail margin is set by the state
Portugal 1995: A percentage of the total value of the medicines sold (retail margin) Difference between the price at which the Pharmacy buys the medicine and the retail price Remark: The retail margin is negotiated among the Pharmacist's Association and the state. The patients pays his share of the price (0-100%), the rest of the bill is paid from the purchaser to which the prescriber is associated: if its a GP working for the NHS, the Regional Health Authority, Administração Regionais de Saúde, pays, if its a private provider contracted by the VHI or the subsistema. i.e. the HIF, the VHI or the subsistema pays for the drug. The payment goes in bulk to the Association of Pharmacies, which distributes the payments to the individual pharmacies. There is a strong incentive not to have cheaper medicines in stock to foster the sale of more expensive ones.	2004: A percentage of the total value of the medicines sold (retail margin) Difference between the price at which the Pharmacy buys the medicine and the retail price Remark: The retail margin is negotiated among the Pharmacist's Association and the state. The patients pays his share of the price (0-100%), the rest of the bill is paid from the purchaser to which the prescriber is associated: if its a GP working for the NHS, the Regional Health Authority pays, if its a private provider contracted by the VHI or the subsistema, the VHI or the subsistema pays for the drug. The payment goes in bulk to the Association of Pharmacies, which distributes the payments to the individual pharmacies. There is a strong incentive not to have cheaper medicines in stock to foster the sale of more expensive ones.
Poland 1995: Retail margin –the margin is set by the government and is degressive	2004: Retail margin –the margin is set by the government and is degressive
Spain 1995: A percentage of the total value of the medicines sold (retail margin)	2004: A percentage of the total value of the medicines sold (retail margin)

R5 How is the income of pharmacists / the pharmacy related to the quantity of medicines sold?	
Sweden 1995: Fixed Salary; the pharmacists are employed by the state-owned “Apoteket”	2004: Fixed Salary; the pharmacists are employed by the state-owned “Apoteket”
Switzerland 1995: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin) Remark: This is identical for Pharmacies and dispensing physicians. The retail margin is regressive, in order to limit the incentive to promote the usage of expensive drugs.	2004: Difference between the price at which the Pharmacy buys the medicine and the retail price (retail margin); plus a fixed amount per package sold (dispensing fee) Remark: This is identical for Pharmacies and dispensing physicians. The retail margin is regressive, in order to limit the incentive to promote the usage of expensive drugs.
United Kingdom 1995: An amount per package sold / prescription Difference between the price at which the Pharmacy buys the medicine and the retail price less a deduction for the discounts received by the pharmacies from the wholesaler	2004: An amount per package sold / prescription Difference between the price at which the Pharmacy buys the medicine and the retail price less a deduction for the discounts received by the pharmacies from the wholesaler

R6 How are **Laboratory Services** (diagnostics, analyses of blood and tissue samples etc.) predominantly remunerated?	
Austria 1995: Fee for services. Remark: These fees are limited; limits were stressed during the period 1995-2004	2004: Fee for services Remark: Fees are limited; limits were stressed during the period 1995-2004
Belgium 1995: Fee for services Remark: Both, laboratory services provided by the consultants in the Hospital as well as services provided by independent providers outside hospitals are remunerated on a fee for service basis; the fees are negotiated between the providers and the HIF Association	2004: Fee for services Remark: Both, laboratory services provided by the consultants in the Hospital as well as services provided by independent providers outside hospitals are remunerated on a fee for service basis; the fees are negotiated between the providers and the HIF Association
Canada 1995: Laboratory services provided in hospitals are part of the Hospital budget Fee for service for services provided by independent private firms	2004: Laboratory services provided in hospitals are part of the Hospital budget Fee for service for services provided by independent private firms
Czech Republic 1995: Fee for service for services provided by independent private firms providing most laboratory services Remark: Usually, the HIF negotiate an overall amount of remuneration. This limits the possibility to increase the remuneration by providing more services.	2004: Fee for service for services provided by independent private firms providing most laboratory services Remark: Usually, the HIF negotiate an overall amount of remuneration. This limits the possibility to increase the remuneration by providing more services.
Denmark 1995: Budgets. Remark: Laboratory services are predominantly provided by hospitals, here, the laboratory services are part of the hospital's budget Fee for services for services provided by self employed providers or independent firms	2004: Budgets. Remark: Laboratory services are predominantly provided by hospitals, here, the laboratory services are part of the hospital's budget Fee for services for services provided by self employed providers or independent firms
Finland 1995: Budgets – laboratory services are part of the budget of the Hospitals and Health Centers which are predominantly providing them. Self employed firms have contracts with the municipalities	2004: Budgets – laboratory services are part of the budget of the Hospitals and Health Centers which are predominantly providing them. Self employed firms have contracts with the municipalities.
France 1995: Fee for service for the commercial providers of laboratory services (majority of provision)	2004: Fee for service for the commercial providers of laboratory services (majority of provision)
Germany 1995: Those provided by independent firms are remunerated on a fee for service basis	2004: Those provided by independent firms are remunerated on a fee for service basis

R6 How are **Laboratory Services** (diagnostics, analyses of blood and tissue samples etc.) predominantly remunerated?	
(majority) Those provided by Hospitals are part of the hospitals budget	(majority) Those provided by Hospitals are part of the hospitals budget
Greece 1995: Fee for Service Remark: Laboratories have a contract with the HIF. The HIF also control the access to laboratory services, by requiring approval. Otherwise, the patients have to pay the services themselves.	2004: Fee for service Remark: Laboratories have a contract with the HIF. The HIF also control the access to laboratory services, by requiring approval. Otherwise, the patients have to pay the services themselves.
Hungary 1995: Fee for service for independent providers Part of the hospital's budget, if provided as part of the hospital treatment	2004: Fee for service for independent providers Part of the hospital's budget, if provided as part of the hospital treatment
Ireland 1995: Budgets Remark: Laboratory services are predominantly provided in Hospitals as part of the hospital treatment	2004: Budgets Remark: Laboratory services are predominantly provided in Hospitals as part of the hospital treatment
Italy 1995: Fee for service Remark: The fees are part of the contract the SSN concludes with the providers (independent laboratories or hospitals).	2004: Fee for service Remark: The fees are part of the contract the SSN concludes with the providers (independent laboratories or hospitals).
Luxembourg 1994: Fee for services Remark: Both, independent providers and Hospitals were remunerated this way for their laboratory services. In particular for the Hospitals, this set the incentive to provide many analyses and diagnostics	2004: Fee for service for the independent providers Budgets – costs for laboratory services are part of the Hospitals budget for those provided by the Hospitals themselves
Netherlands 1995: Budgets Remark: The majority of laboratory services is provided by Hospitals and is paid for by a part of the Hospital's budget Fee for services for services provided outside of the Hospital – i.e. by independent providers like GPs and self employed specialists	2004: Budgets Remark: The majority of laboratory services is provided by Hospitals and is paid for by a part of the Hospital's budget Fee for services for services provided outside of the Hospital – i.e. by independent providers like GPs and self employed specialists
New Zealand 1995: Fee for service for independent providers, the majority Budgets for services provided in Hospitals	2004: Fee for service for independent providers, the majority Budgets for services provided in Hospitals

R6 How are **Laboratory Services** (diagnostics, analyses of blood and tissue samples etc.) predominantly remunerated?	
Remark: Laboratories have contracts specifying either fees for defined services or a budget paid in advance. A Hospital's budget covers the provision of laboratory services.	Remark: Laboratories have contracts with the DHB specifying either fees for defined services or a budget paid in advance. A Hospital's budget covers the provision of laboratory services.
Norway 1995: Most of the laboratory services are provided in Hospitals and are covered from the Hospital's Budget; Remark: Services provided by the hospital on an out-patient basis and services from contracted independent providers are paid fee for services by the National Insurance Scheme.	2004: Most of the laboratory services are provided in Hospitals during in patient treatment. They are partly covered from the Hospital's Budget, partly financed on a DRG basis. Remark: Services provided by the hospital on an out-patient basis and services from contracted providers are paid fee for services by the National Insurance Scheme.
Portugal 1995: Laboratory services provided in private practices/by independent providers are remunerated by fee for service In public Hospitals, laboratory services are covered by the hospital's budget Remark: In the out-patient sector, most laboratory services are provided by independent providers. Most diagnostic equipment is in the private sector and even hospitals are contracting services from private providers	2004: Laboratory services provided in private practices/by independent providers are remunerated by fee for service In public Hospitals, laboratory services are covered by the hospital's budget Remark: In the out-patient sector, most laboratory services are provided by independent providers. Most diagnostic equipment is in the private sector and even hospitals are contracting services from private providers
Poland 1995: Fee for services Remark The contract with the between the providers of laboratory services includes a certain volume of services and a certain overall remuneration for this volume. The financial value of the fees are based on a point system.	2004: Fee for services Remark The contract with the providers includes a certain volume of services and a certain overall remuneration for this volume. The financial value of the fees are based on a point system.
Spain 1995: Laboratory services are part of the Hospital's budget – the majority of services Fee for service for contracted providers	2004: Laboratory services are part of the Hospital's budget – the majority of services Fee for service for contracted providers
Sweden 1995: Budgets Remark: Laboratory services are part of the Hospital's budget, where the majority of laboratory services is provided.	2004: Budgets Remark: Laboratory services are part of the Hospital's budget, where the majority of laboratory services is provided
Switzerland 1995: Fee for services	2004: Fee for services

R6 How are **Laboratory Services** (diagnostics, analyses of blood and tissue samples etc.) predominantly remunerated?	
United Kingdom 1995. Budgets Remark: Laboratory services are part of the budgets of Hospitals, where they are predominantly delivered , both for out patients and in patients	2004: Budgets Remark: Laboratory services are part of the budgets of Hospitals, where they are predominantly delivered , both for out patients and in patients

2. Hospitals and In-Patient Care

H0 Ownership and institutional status of Hospitals	
Austria 1995: Hospitals are predominantly public and non-profit, owned and operated by regional governments (Bundesländer; 54%), Municipalities (16%) or Welfare organizations, a small number also by the Health insurance Funds (8% of beds) Some are private but also have contracts with the Health Insurance Funds	2004: Hospitals are predominantly operated by regional governments (Bundesländer), Municipalities or Welfare organizations Most Hospitals are public and non-profit, some are private
Belgium 1995: Hospitals are owned and operated by Health Insurance Funds and religious associations on a private, but non-profit basis (63%). The rest is owned and operated by municipalities and districts. Remark: Since the required size of a hospital was increased by law in recent years, there was a wave of mergers.	2004: Hospitals are owned and operated by Health Insurance Funds and religious associations on a private, but non-profit basis The rest is owned and operated by municipalities and districts.
Canada 1995: Most of the hospitals are operated by the Provincial Governments (through their Regional Health Authorities, RHA) Remark: Most are semi-autonomous and self governed by a board of trustees, which have broad control over the management of the hospital.	2004: Most of the hospitals are operated by the Provincial Governments (through their Regional Health Authorities, RHA)
Czech Republic 1995: Most Hospitals are owned and operated by Municipalities Remark: Some, usually more specialized hospitals with a national level catchment area, are operated directly by the Ministry of Health. Ownership of the Hospitals was transferred from the Central Government to the Regions and the Municipalities.	2004: Most Hospitals are owned and operated by Municipalities Remark: Some, usually more specialized hospitals with a national level catchment area, are operated directly by the Ministry of Health.
Denmark 1995: Hospitals are operated by the county councils, “Amter”	2004: Hospitals are operated by the county councils, “Amter”.
Finland 1995: Hospitals are operated by the municipalities; Remark: There are 21 Hospital Districts, in which several Municipalities jointly own and operate Hospitals. The Council administrating the Hospital District is	2004: Hospitals are operated by the municipalities Remark: There are 21 Hospital districts, in which several Municipalities jointly own and operate Hospitals. The Council administrating the Hospital District is appointed by the

H0 Ownership and institutional status of Hospitals	
appointed by the municipalities, but is quite independent of them. Factually, the municipalities have little cost control over the Hospital District they are member of.	municipalities, but is quite independent of them. Factually, the municipalities have little cost control over the Hospital District they are member of.
France 1995: Public Hospitals, the majority of beds, are owned and operated by the municipalities and the "Departement". The mayor of the municipality respectively the president of the Departement is the head of the hospitals executive board. Some Hospitals are also owned by Welfare Foundations. There are many smaller, private "cliniques" operated on a for-profit basis.	2004: Public Hospitals, the majority of beds, are owned and operated by the municipalities and the "Departement". The mayor of the municipality respectively the president of the Departement is the head of the hospitals executive board. Some Hospitals are also owned by Welfare Foundations. There are many smaller, private "cliniques" operated on a for-profit basis
Germany 1995: Most hospitals are operated by regional governments (Bundesländer) or Municipalities (Gemeinden). Some are owned and operated by Welfare Associations and religious Orders While most Hospitals are public and non-profit, some are private for profit.	2004: Most hospitals are operated by regional governments (Bundesländer) or Municipalities (Gemeinden). Some are owned and operated by Welfare Associations and religious Orders While most Hospitals are public and non-profit, some are private for profit. Remark: Recently, the highly indebted municipalities have sold of hospitals to private firms
Greece 1995: About 70% of the Hospitals are owned and operated by the National Health Service ESY, i.e. by the state. The rest is privately owned and operated, offering either services on private terms or is contracted by the HIF.	2004: About 70% of the Hospitals are owned and operated by the ESY, i.e. by the state. The rest is privately owned and operated, offering either services on private terms or is contracted by the HIF.
Hungary 1995: Most Hospitals are owned and operated by Municipalities or at County Level, by the county governments	2004: Most Hospitals are owned and operated by Municipalities or at County Level, by the county governments
Ireland 1995: About half of the Hospitals are owned and operated by the Health Boards. Many of the remaining Hospitals are owned and operated by the Church. Remark: In 1993, there were 78 Health Board Hospitals, 27 Hospitals run by Charities and 22 private Hospitals, working for profit as well as non-profit	2004: About half of the Hospitals are owned and operated by the Health Boards. Many of the remaining Hospitals are owned and operated by the Church.
Italy 1995: Most Hospitals are operated by the SSN; directly by the ASL The biggest ones – University Hospitals and	2004: Most Hospitals are operated by the SSN. The biggest ones – University Hospitals and specialized hospitals -are organized as Trusts,

H0 Ownership and institutional status of Hospitals	
specialized hospitals - are organized as Trusts, with a high degree of financial autonomy – in 1995, there were about 82 Remark There are also private Hospitals which have a contract with the SSN – about 20% of the beds	with a high degree of financial autonomy. In 2000, in 1995, there were about 98 Remark: There are also private Hospitals which have a contract with the SSN
Luxembourg 1994: About half of the Hospitals are owned by the Municipalities, the rest is owned and operated by religious orders	2004: About half of the Hospitals are owned by the Municipalities, the rest is owned and operated by religious orders
Netherlands 1995: 9 University Hospitals are owned and operated by the Municipality or County where it is located. The rest is owned and operated by religious orders	2004: 9 University Hospitals are owned and operated by the Municipality or County where it is located. The rest is owned and operated by religious orders
New Zealand 1995: Most Hospitals are publicly owned and operated by way of 23 formally independent "Crown Health Enterprises". In particular they were independent from the 4 Regional Health Board, which had contracts with the Hospitals	2004: Most Hospitals are publicly owned and operated by the 21 District Health Boards Remark: The private hospitals are providing elective surgery or geriatric care.
Norway 1995: Hospitals are owned and operated by the counties, sometimes jointly by several of them. Remark: While the hospital usually has a board, the control rests with the councils. The Hospital system is layered: there are five hospital regions, with Regional Hospitals providing more specialized services. Below that is the level of the District Hospitals, owned and operated by the Counties. There are two very advanced national level Hospitals (for Transplantation and Oncology).	2004: Hospitals were transformed into Health Enterprises (2001), which are formally independent legal entities, but are factually owned and operated by the central government via five Regional Health Authorities. Remark: The factual control over the Hospitals has shifted to the National Government. The degree to which the hospitals are actually independent and self governed, is debated. The hospital system is still layered: there are five Hospital regions, with Regional Hospitals providing more specialized services. Below that is the level of the District Hospitals, owned and operated by the Counties. There are two very advanced national level Hospitals (for Transplantation and Oncology).
Portugal 1995: Most hospitals are owned and operated by the state, i.e. the Administrações Regionais de Saúde. About 80% of the capacity and of the bed-days are in NHS Hospitals Remark: Some are owned and operated by charitable	2004: Most hospitals are owned and operated by the state , i.e. the Administrações Regionais de Saúde Some are owned and operated by charitable Welfare Associations and religious Orders; some are private and for-profit.

H0 Ownership and institutional status of Hospitals	
Welfare Associations and religious Orders, some are private and for-profit.	Remark: Recently, a number of Hospitals have been transformed in public enterprises with more autonomy. These Hospitals are still contracted, the contracts are negotiated annually between the Ministry of Health and the Hospital
Poland 1995: Most hospitals are owned and operated by Municipalities (gmina) or the Region (voivodship) Remark: Many nationalized Hospitals were returned during the transition period to their previous owners, e.g. the church. The Hospitals are managed by a Hospital Director, accountable to a Hospital Executive Board, in which the owner (gmina; voivodship), the staff and the trade unions are present.	2004: Most hospitals are owned and operated by Municipalities (gmina) or the Region (voivodship) Remark: Formally, the Hospitals were transformed in Independent Health Care Institutions. The Hospitals are managed by a Hospital Director, accountable to a Hospital Executive Board, in which the owner (gmina; voivodship), the staff and the trade unions are present.
Spain 1995: About half of the Hospital beds are in Hospitals directly owned and operated by the INSALUD The rest is in private hospitals, but has a contract with the INSALUD Remark: There are strong regional differences, in Catalonia, 80% of the hospital beds are private	2004: About half of the Hospitals are directly owned and operated by the Regional Health Authorities of the Autonomous Communities; (Communidades Autónomas) the Servicio Regional de Salud, SRS. The rest is private, but is contracted by the SRS. Remark: There are strong regional differences in ownership. In Catalonia, about 80% of the Hospital capacity is private and independent.
Sweden 1995: Hospitals are owned and operated by the county councils; Landsting Remark: Specialized Hospitals are operated jointly by several Landstings and cover the area of all of these	2004: Hospitals are owned and operated by the county councils; Landsting Remark: Specialized Hospitals are operated jointly by several Landstings and cover the area of all of these
Switzerland 1995: Most of the Hospitals are owned and operated by the Regional Government, the Kanton. In some cases, several Kantons jointly own and operate a hospital. Remark: Some are owned and operated by municipalities. About 10% of the Hospitals are private and for profit, owned by Banks, Physicians etc.	2004: Most of the Hospitals are owned and operated by the Regional Government, Kanton. In some cases, several Kantons jointly own and operate a hospital. Remark: Some are owned by municipalities. About 10% of the Hospitals are private and for profit, owned by Banks, Physicians

H0 Ownership and institutional status of Hospitals	
United Kingdom 1995: The hospitals are organized as a “NHS Trust”, since 1991. Remark: While formally owned by the NHS, they are relatively autonomous and independent from the NHS, but with a contract with the regional Health Authority. The executive of the NHS trust is determined by the Ministry of Health. Contracting with the regional Health Authority is relatively free, it can be a defined budget, covering all cases expected in the catchment are, or a case-based remuneration and extra fees NHS	2004: The hospitals are organized as a “Trust”

H1 Would a **Deficit of a Hospital** be covered by the state or some other institution?	
Austria 1995: Deficits of public Hospitals (the majority) are covered almost completely ex post for public Hospitals by the Hospital Coordination Fund, KRAZAF	2004: Deficits of public Hospitals (the majority) are covered in some of the states (Bundesländer) completely, in some states partly. Usually the deficit is covered by whichever institution (regional or municipal government) is operating it. In the case of private non-profit Hospitals, deficits are only partly covered
Belgium 1995: No, for the majority of the private Hospitals, owned by religious orders or HIFs, deficits are not covered. If the hospital is public, e.g. owned by a municipality, deficits are automatically covered from local taxes	2004: No, for the majority of the private Hospitals, owned by religious orders or HIFs, deficits are not covered. If the hospital is public, e.g. owned by a municipality, deficits are automatically covered from local taxes
Canada 1995: Yes, deficits are covered partly by the provincial government Remark: While the budget is fixed in the short run, it will be covered in the long run by being allocated a higher budget. Hospitals may not take up loans.	2004: Yes, deficits are covered partly by the provincial government Remark: While the budget is fixed in the short run, it will be covered in the long run by being allocated a higher budget. Hospitals may not take up loans.
Czech Republic 1995: Yes, hospital deficits are covered completely Remark: While hospital deficits are not formally covered, they are covered in practice, usually by the owner (municipality or Ministry of Health).	2004: Yes, hospital deficits are covered completely Remark: Hospitals often run deficits over long periods of time. While these deficits are not formally covered, they are covered in practice, usually by the owner (Municipality or Ministry of Health).
Denmark 1995: Yes, hospital deficits are covered completely by the county councils, “Amter”, which are operating the hospitals. Remark: The deficit of an Amter is not covered but there are grants from the central government.	2004: Yes, hospital deficits are covered completely by the county councils, “Amter”, which are operating the hospitals. Remark: The deficit of an Amter is not covered but there are grants from the central government
Finland 1995: Yes, hospital deficits are covered completely by the municipalities operating the Hospital Remark: The hospitals are organized to Hospital Districts as the main administrative unit, in which several municipalities are member. The Hospital District can borrow money, i.e. can run debts. In the end, the deficits are covered by the municipalities.	2004: Yes, hospital deficits are covered completely by the municipalities operating the hospital Remark: The hospitals are organized to Hospital Districts as the main administrative unit, in which several municipalities are member. The Hospital District can borrow money, i.e. can run debts. In the end, the deficits are covered by the municipalities.

H1 Would a **Deficit of a Hospital** be covered by the state or some other institution?	
France 1995: Yes, deficits are covered partly by another institution Remark: This is the responsibility of the Regional Hospital Agency (Agence Régionale d'Hospitalisation, ARH), a regional body under the supervision of the central government, for public and not-profit private hospitals (who represent the majority of hospitals beds) to decide whether to cover or not the deficit. It the Hospital can also decide to contract a loan.	2004: Yes, deficits are covered partly by another institution Remark: This is the responsibility of the Regional Hospital Agency (Agence Régionale d'Hospitalisation, ARH), a regional body under the supervision of the central government, for public and not-profit private hospitals (who represent the majority of hospitals beds) to decide whether to cover or not the deficit. It the Hospital can also decide to contract a loan.
Germany 1995: Yes, deficits are covered by the Municipality or the Bundesland owning and operating the Hospital	2004: Yes, deficits are covered by the Municipality or the Bundesland owning and operating the Hospital
Greece 1995: Yes, hospital deficits are covered by the state via the ESY, which is owning and operating the Hospitals Remark: Most hospitals constantly run deficits, and substantial deficits may be accumulated. In the end, most of the deficits are covered by the Ministry of Health, by ad hoc funding. The rest is paid for by the HIFs which are paying for hospital care on a per diem basis. Deficits often take the form of unpaid bills.	2004: Yes, hospital deficits are covered by the state via the ESY, which is owning and operating the Hospitals Remark: Most hospitals constantly run deficits, and substantial deficits may be accumulated. In the end, most of the deficits are covered by the Ministry of Health, by ad hoc funding. The rest is paid for by the HIFs which are paying for hospital care on a per diem basis. Deficits often take the form of unpaid bills.
Hungary 1995: Yes, deficits are covered by the Municipality or County owning and operating the Hospital	2004: Yes, deficits are covered by the Municipality or County owning and operating the Hospital
Ireland 1995: Yes, the hospital's deficit is covered completely by another institution – either the state or the Health Boards	2004: Yes, the hospital's deficit is covered completely by another institution – either the state or the Health Boards
Italy 1995: Yes, a hospital's deficit is covered. In the case of public hospitals operated by the SSN, the deficit is covered completely by the SSN: the hospital is integrated in the ASL, and financed from the budget of the ASL Remark: For "Trust" hospitals independent of the ASL, the financing was a budget based on past expenditure, i.e. a deficit would be covered in the long run. In the case of private hospitals with contracts with the SSN, deficits are not covered.	2004: Yes, a hospital's deficit is covered. In the case of public hospitals operated by the SSN, the deficit is covered completely by the SSN: the hospital is integrated in the ASL, and financed from the budget of the ASL Remark: For "Trust" hospitals independent of the ASL, the financing was a budget based on past expenditure, i.e. a deficit would be covered in the long run. In the case of private hospitals with contracts with the SSN, deficits are not covered.

H1 Would a **Deficit of a Hospital** be covered by the state or some other institution?	
Luxembourg 1994: Yes, hospital deficits are covered completely by the state and the HIF Association, UCM	2004: Yes, while deficits are not covered by the State or the HIFs, they are covered by the owner Remark: In the end, hospital deficits are covered by the funding received from the state or the HIFs
Netherlands 1995: No, deficits are not covered but have to be covered from next year's budget	2004: No, deficits are not covered but have to be covered from next year's budget
New Zealand 1995: Yes, the Hospital's deficit is covered completely by the state Remark: Formally, hospitals were independent and supposed to operate like a commercial enterprise. Funding was done by historical budgets, based on a price volume contracts. While provision of services above the contracted volume was usually not remunerated, funding was usually increased, if it was insufficient.	2004: No. Remark: The Hospital may take a loan from the government, which has to be repaid later on from next years budget. The budget however will be adapted to need in the long run
Norway 1995: Yes, completely by the County (County Council) owning and operating the hospital Remark: While there is no formal obligation to cover the deficit, it is usually covered by the county council, e.g. by allocating a higher budget for the next period. There are also subsidies from the Central Government	2004: Yes, completely by the Central Government Remark: While there is still no formal obligation to cover the deficit, it is usually covered e.g. by allocating a higher budget for the next period. There are also subsidies for investments.
Portugal 1995: Yes, deficits are covered completely by the state Remark: This is done by special funds which are allocated in the case of need. The financing is negotiated and settled directly between the Hospital and the Ministry of Health, without involvement of the Regional Health Authority, Administração Regionais de Saúde.	2004: Yes, deficits are covered completely by the state Remark: This is done by special funds which are allocated in the case of need. The financing is negotiated and settled directly between the Hospital and the Ministry of Health, without involvement of the Administração Regionais de Saúde.
Poland 1995: No, formally, deficits of hospitals are not covered, but have to be covered from the income in the next year. Remark: Factually, debts can be covered by the Ministry of Health or the Local Governments. Many Hospitals have incurred	2004: No, formally deficits of hospitals are not covered, but have to be covered from the income in the next year. Remark: Factually, debts can be covered by the Ministry of Health or the founder and owner – the municipal or regional governments. Many

H1 Would a **Deficit of a Hospital** be covered by the state or some other institution?	
large debts, which were periodically covered by the state.	Hospitals have incurred large debts, which were later covered by the state.
Spain 1995: Yes, the deficit of public hospitals is covered completely by the Central Government via the INSALUD Deficits of independent hospitals are not covered.	2004: Yes, deficits of public hospitals are covered completely by the Autonomouy Communities, i.e. the Regions (Communidades Autónomas) via the SRS Deficits of independent hospitals are not covered.
Sweden 1995: Yes, the deficit is covered. Remark: Formally, the hospital receives a budget from the Landsting, and a deficit would have to be covered from next year's budget. In the end, the deficit is covered completely by the County council, Landsting, operating the hospital	2004: Yes, the deficit is covered. Remark: Formally, the hospital receives a budget from the Landsting, and a deficit would have to be covered from next year's budget. In the end, the deficit is covered completely by the County council, Landsting, operating the hospital
Switzerland 1995: Deficits are covered almost completely ex post by the regional government, Kanton, which owns and operates them.	2004: Deficits are covered almost completely ex post by the regional government, Kanton, which owns and operates them
United Kingdom 1995: No, deficits are not covered. Remark: The hospital ("Trust") has to cover deficits from reserves or by short term borrowing. Predominantly, there were block grants: a fixed sum of money in exchange for the provision of services to all residents in the Health Authority's catchment area. The block grant was partly based on past costs, so deficits were in the long run covered by higher grants. Deficits were also avoided by rationing. If there are more cases than expected, the trust receives a extra remuneration.	2004: No, formally deficits are not covered. Remark: Deficits of a hospital trust are in the end covered completely by the Health Authority

H2 In the case that a Hospital realizes a **Surplus** – who decides how this surplus is used?	
Austria 1995: In public hospitals (where the majority of inpatient services is provided) a surplus is not really possible; Remark: If existent, a surplus would belong to the regional government operating it but the Hospital may use it for investments In private hospitals the hospital owner decides about the use of the surplus	2004: In public hospitals (where the majority of inpatient services is provided) a surplus is not really possible; Remark: If existent, a surplus would belong to the regional government operating it but the Hospital may use it for investments In private hospitals the hospital owner decides about the use of the surplus
Belgium 1995: The hospital itself, it can use it for investments Remark: This holds true both for public and private hospitals. The Hospital can invest, but in doing so is subjects to constraints set by the Government. The government issues plans on what medical equipment is required in a region, and it determines, what investments can be made from the funds the hospital has available for investment.	2004: The hospital itself, it can use it for investments Remark: This holds true both for public and private hospitals. The Hospital can invest, but in doing so is subjects to constraints set by the Government. The government issues plans on what medical equipment is required in a region, and it determines, what investments can be made from the funds the hospital has available for investment.
Canada 1995: In public Hospitals, the Regional Health Authority in agreement with the Hospital board decides on the usage of a surplus. In Private Hospitals (run by charities) the owner decides	2004: In public Hospitals, the Regional Health Authority in agreement with the Hospital board decides on the usage of a surplus. In Private Hospitals (run by charities) the owner decides
Czech Republic 1995: The Hospital, together with the owner – Mostly the municipality, Regional Government or Central Government	2004: The Hospital, together with the owner – Mostly the municipality, Regional Government or Central Government
Denmark 1995: The Local/County Government, “Amter”, which is operating the Hospital but in consultation with the Hospital	2004: The Local/County Government, “Amter”, which is operating the Hospital but in consultation with the Hospital
Finland 1995: The Municipality / Municipalities operating the Hospital decides	2004: The Municipality / Municipalities operating the Hospital decides
France 1995: The Hospital itself, e.g. can use the surplus for investments	2004: The Hospital itself, e.g. can use it for investments
Germany 1995: The Hospital itself, e.g. can use it for investments	2004: The Hospital itself, e.g. can use it for investments
Greece 1995: The national government Remark: To some degree the Hospital itself can decide	2004: The national government Remark: To some degree the Hospital itself can decide

H2 In the case that a Hospital realizes a **Surplus** – who decides how this surplus is used?	
and can use it for investments; However, this is rarely the case, see H1.	and can use it for investments; However, this is rarely the case, see H1.
Hungary 1995: The Municipality or County owning and operating the Hospital	2004: The Municipality or County owning and operating the Hospital
Ireland 1995: For those hospitals in ownership of the Health Boards respectively the National Government, these decide. For those in ownership by religious orders, the Hospital or the owner decided on the usage Remark: The split among both forms of ownership is about equal; the national government's influence is substantial.	2004: For those hospitals in ownership of the Health Boards respectively the National Government, these decide. For those in ownership by religious orders, the Hospital or the owner decided on the usage Remark: The split among both forms of ownership is about equal; the national government's influence is substantial.
Italy 1995: In the case of the hospital integrated into and run by the ASL, the ASL decides (most Hospitals). The ASL is factually controlled of the local government In the case of independent Trust-Hospitals the Hospital itself and the regional Government decide. In the case of private Hospitals, the hospital itself decides	2004: In the case of the hospital integrated into and run by the ASL, the ASL decides (most Hospitals). The ASL is factually controlled of the local government. In the case of independent Trust-Hospitals the Hospital itself and the regional Government decide. In the case of private Hospitals, the hospital itself decides Remark: In the case of public Hospitals which are independent of the SSN, "Aziende Ospedaliere", the hospital itself and Region decide on the surplus, it can be used for investments
Luxembourg 1994: The Hospital itself, it can use it for investments	2004: The Hospital itself, it can use it for investments
Netherlands 1995: The Hospital itself, e.g. can use it for investments, cover previous deficits or keep it as a reserve.	2004: The Hospital itself, e.g. can use it for investments, cover previous deficits or keep it as a reserve.
New Zealand 1995: The Hospital and the Purchaser - Regional Health Authorities - decide on the usage of the surplus Remark: The idea was, that the Hospital should invest surpluses, e.g. in technology.	2004: The Hospital, albeit not single handed. Remark: There is a 50-50 sharing agreement between the Hospital and the District Health Board. The National Government in the Minister of Health have substantial influence
Norway 1995: The County Government (County Council) Remark: The county as the owner is most influential, but the Hospital itself also has some say. The	2004: The National Government Remark: The Hospital itself also has some say. The issue is not relevant, since there usually are no

H2 In the case that a Hospital realizes a **Surplus** – who decides how this surplus is used?	
issue is not relevant, since there are no surpluses.	surpluses.
Portugal 1995: National Government	2004: National Government
Poland 1995: The hospital itself Remark: The owner is consulted on the usage	2004: The hospital itself Remark: The owner is consulted on the usage
Spain 1995: The INSALUD which is operating the Hospital. Remark: Since the INSALUD is under direct control of the national government, its the government which decides. Public Hospitals cannot really realize a surplus; private Hospitals can, and then can decide on how to use it.	2004: The government of the Autonomous Community, via the Servicio Regional de Salud, SRS, which is directly controlled by it, since the devolution of 2002 Remark: Public Hospitals cannot really realize a surplus; private Hospitals can, and then can decide on how to use it.
Sweden 1995: The regional government; Landsting, which is operating the Hospital	2004: The regional government; Landsting, which is operating the Hospital
Switzerland 1995: Regional Government (Kanton), which is operating the Hospital Remark: Formally, a surplus is, like a deficit, transferred to the next year.	2004: Regional Government (Kanton), which is operating the Hospital Remark: Formally, a surplus is, like a deficit, transferred to the next year.
United Kingdom 1995: Surpluses can be retained by the Hospital, but cannot invest them without approval of the NHS authorities	2004: The Hospital, “NHS Trust” decides how to use surpluses, again, this is subject to approval by the NHS authorities

H3 Which actor is the most influential decision maker in questions of **Hospital Capacity** - i.e. whether the number of beds in a Hospital is to be increased or decreased?	
Austria 1995: Regional government (Bundesland)	2004: Regional government (Bundesland)
Belgium 1995: National Government Remark: The government increased the required minimum size of a hospital, leading to hospital mergers. While not determining the size of a hospital, the hospitals require accreditation by the Ministry of public Health, and this is granted only, if the hospital does meet certain requirements and not exceed the planned capacity in the region which is set by the government	2004: National Government Remark: The government increased the required minimum size of a hospital, leading to hospital mergers. While not determining the size of a hospital, the hospitals require accreditation by the Ministry of public Health, and this is granted only, if the hospital does meet certain requirements and not exceed the planned capacity in the region which is set by the government. Since 2002, hospitals can increase the number of beds, if they can justify this with an increased demand
Canada 1995: Provincial Government	2004: Provincial Government
Czech Republic 1995: The owner – mostly the municipality, or Central Government	2004: The owner – mostly the municipality, or Central Government
Denmark 1995: Local / Municipal Government; Amter Remark: For the three university hospitals (in Copenhagen, Aarhus and Odense) the national government decides	2004: Local / Municipal Government; Amter Remark: For the three university hospitals (Copenhagen, Aarhus and Odense) the national government decides
Finland 1995: The Hospital and the Municipality operating the Hospital decide together	2004: The Hospital and the Municipality operating the Hospital decide together
France 1995: The regional government through the regional hospital agencies ARH; acting under the national constraint defined by the ministry of health Remark: The Health Insurance Funds have some say	2004: The regional government through the regional hospital agencies ARH; acting under the national constraint defined by the ministry of health Remark: The Health Insurance Funds have some say
Germany 1995: The Regional Government or Municipality which is operating the Hospital; (Bundesländer or Gemeinden) Remark: The regional governments (Bundesländer) have a overall planning competence for Hospitals in a region and decide on investments	2004: The Regional Government or Municipality which is operating the Hospital; (Bundesländer or Gemeinden) Remark: The regional governments (Bundesländer) have a overall planning competence for Hospitals in a region and decide on investments

H3 Which actor is the most influential decision maker in questions of **Hospital Capacity** - i.e. whether the number of beds in a Hospital is to be increased or decreased?	
Greece 1995: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals	2004: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals
Hungary 1995: The Municipality or County owning and operating the Hospital	2004: The Municipality or County owning and operating the Hospital
Ireland 1995: National Government	2004: National Government
Italy 1995: Regional Government, by setting an overall health plan. Remark: In the case of independent public Hospitals ("Aziende Ospedaliere"), the Hospital and the Regional Government decide on the capacity. In the case of hospitals managed by the ASLs, the Local / Municipal Government which is in control of the ASL, decides.	2004: Regional Government, by setting an overall health plan. Remark: In the case of independent public Hospitals ("Aziende Ospedaliere"), the Hospital and the Regional Government decide on the capacity. In the case of hospitals managed by the ASLs, the Local / Municipal Government which is in control of the ASL, decides
Luxembourg 1994: National Government Remark: Most staff is not actually employed by the hospital but is "renting" hospital facilities	2004: National Government Remark: Most staff is not actually employed by the hospital but is "renting" hospital facilities
Netherlands 1995: National Government Remark: While the regional government of the province holds a formal planning competence, it is factually a joint decision of the Hospital, the Regional and the Central Government	2004: National Government Remark: While the regional government of the province holds a formal planning competence, it is factually a joint decision of the Hospital, the Regional and the Central Government
New Zealand 1995: The Hospital itself in consultation with the National Government Remark: While the Hospitals were, as Crown Health Enterprises, quite independent, the government had influence.	2004: The District Health Board which are now operating the hospitals decide in consultation with the National Government
Norway 1995: The County Government (County Councils) Remark: The central government has some influence. Investments like buildings etc. are often subsidized by government grants / loans.	2004: The National Government

H3 Which actor is the most influential decision maker in questions of **Hospital Capacity** - i.e. whether the number of beds in a Hospital is to be increased or decreased?	
Portugal 1995: National Government – by an overall planning competence	2004: National Government – by an overall planning competence
Poland 1995: The Hospital itself, together and in accordance with the founding entity, i.e. the municipality or the local government which owns and operates the Hospital	2004: The Hospital itself, together and in accordance with the founding entity, i.e. the municipality or the local government which owns and operates the Hospital
Spain 1995: National government, via the INSALUD	2004: The regional government of the Autonomous Communities via the Servicio Regional de Salud controlled by the regional government
Sweden 1995: The regional government; Landsting	2004: The regional government; Landsting
Switzerland 1995: Regional Government (Kanton)	2004: Regional Government (Kanton)
United Kingdom 1995: The hospital itself Remark: For major changes, approval of the, Health Authority is required	2004: The hospital itself Remark: For major changes, approval of the, Health Authority is required

H4 Which of the following actors is the most influential decision maker in questions of investments in the **Medical Technology** available in the Hospitals (e.g. procurement of new medical devices and equipment)?	
Austria 1995: Regional government (Bundesland) Remark: The Hospitals have some influence	2004: Regional government (Bundesland) Remark: The Hospitals have some influence
Belgium 1995: The national government Remark: The decision competence is split: the Hospital can purchase technology, which is not yet included in coverage by the Health system. The regional government is responsible for planing requirements but has to abide by the restrictions set in the national government's plan of what and how much of medical equipment is appropriate in a region. The national government is responsible for the funding of heavy equipment and the overall hospital planning. Control is exercised by the central government by subsidizing investments and determining, which investments can be paid for from the hospital's income	2004: The national government Remark: Decision competence is split: the Hospital can purchase technology, which is not yet included in coverage by the Health system. The regional government is responsible for planing requirements but has to abide by the restrictions set in the national government's plan of what and how much medical equipment is appropriate in a region. The national government is responsible for the funding of heavy equipment and the overall hospital planning. Control is exercised by the central government by subsidizing investments and determining, which investments can be paid for from the hospital's income
Canada 1995: Provincial Government Remark: Also the Hospital itself, by proposing investments in equipment, the Regional Health Authority which is the "instrument" of the Provincial Government and the federal (national-level) Government have influence	2004: Provincial Government Remark: Also the Hospital itself, by proposing investments in equipment, the Regional Health Authority which is the "instrument" of the Provincial Government and the federal (national-level) Government have influence
Czech Republic 1995: The Hospital, together with the municipality, or Central Government Remark: Capital investments are usually funded from the state budget. Funding for municipal hospitals mostly comes from the municipality.	2004: The Hospital, together with the Municipality, or Central Government Remark: Capital investments are usually funded from the state budget. Funding for municipal hospitals mostly comes from the municipality.
Denmark 1995: For major investments the county government; Amter For smaller investments the Hospital itself	2004: For major investments the county government; Amter For smaller investments the Hospital itself
Finland 1995: The hospital itself Remark: The Council of the Hospital District decides	2004: The Hospital itself Remark: The Council of the Hospital District decides

H4 Which of the following actors is the most influential decision maker in questions of investments in the **Medical Technology** available in the Hospitals (e.g. procurement of new medical devices and equipment)?	
France 1995: The regional government through the regional hospital agencies ARH; acting under the national constraint defined by the ministry of health	2004: The regional government through the regional hospital agencies ARH; acting under the national constraint defined by the ministry of health
Germany 1995: The Hospital itself	2004: The Hospital itself
Greece 1995: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals	2004: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals
Hungary 1995: The Municipality or County owning and operating the Hospital	2004: The Municipality or County owning and operating the Hospital
Ireland 1995: National Government via its control over the Health Boards	2004: National Government via its control over the Health Boards
Italy 1995: Regional Government, by setting an overall health plan. Remark: In the case of independent public Hospitals ("Aziende Ospedaliere"), the Hospital and the Regional Government decide on investment in medical technology In the case of Hospitals managed by the ASLs, the Local / Municipal Government which is in control of the ASL, decides	2004: Regional Government, by setting an overall health plan. Remark: In the case of independent public Hospitals ("Aziende Ospedaliere"), the Hospital and the Regional Government decide on investment in medical technology In the case of Hospitals managed by the ASLs, the Local / Municipal Government which is in control of the ASL, decides
Luxembourg 1994: The Hospital itself Remark: For major investments in equipment, the Ministry of health's approval is required	2004: The HIFs and the National Government
Netherlands 1995: The Hospital itself For larger investments the National and the Regional Government decide	2004: The Hospital itself For larger investments the National and the Regional Government decide
New Zealand 1995: The Hospital itself Remark: Hospitals were expected to use surpluses for investments in technology. Since surpluses almost never arose, there was very little investment in medical technology during the 1990s.	2004: The District Health Board, operating the Hospital, in consultation with the Ministry of Health, which plans and oversees all investments in the Health System. Major investments are financed by loans from the Government, which have to be paid back later on

H4 Which of the following actors is the most influential decision maker in questions of investments in the **Medical Technology** available in the Hospitals (e.g. procurement of new medical devices and equipment)?	
Norway 1995: The County Government (County Council) Remark: The National Government has influence, also because it is subsidizing investments in medical technology.	2004: The National Government
Portugal 1995: National Government – by an overall planning competence and a budget for capital investment Remark: If the procurement of the equipment requires an increase of the budget, the Hospital makes a proposal, which is negotiated with the Institute for Financial Management of Health (IGIF) and the Regional Health Authority (Administração Regionais de Saúde). When the budget increase is substantial the Secretary of State or, even, the Minister decide. Most of the heavy equipment is in the private sector	2004: National Government – by an overall planning competence and a budget for capital investment Remark: If the procurement of the equipment requires an increase of the budget, the Hospital makes a proposal, which is negotiated with the Institute for Financial Management of Health (IGIF) and the Regional Health Authority (Administração Regionais de Saúde). When the budget increase is substantial the Secretary of State or, even, the Minister decide. Most of the heavy equipment is in the private sector
Poland 1995: The Hospital itself, together and in accordance with the founding entity, i.e. the municipality or the local government which owns and operates the Hospital. Remark: Usually, there is also funding coming from the central government, which gives this level some control.	2004: The Hospital itself, together and in accordance with the founding entity, i.e. the municipality or the local government which owns and operates the Hospital Remark: Usually, there is also funding coming from the central government, which gives this level some control.
Spain 1995: The national government via the INSALUD; Remark: The Hospital proposes investments in medical technology, but cannot decide.	2004: The Governments of the Autonomous Communities / Servicio Regional de Salud Remark: The Hospital proposes investments in medical technology, but cannot decide.
Sweden 1995: The Hospital for minor investments, and the replacement of existing equipment The Regional Government, Landsting, for major investments and new procurements	2004: The Hospital for minor investments, and the replacement of existing equipment The Regional Government, Landsting, for major investments and new procurements
Switzerland 1995: Regional Government (Kanton), but also the Municipality	2004: Regional Government (Kanton) but also the Municipality
United Kingdom 1995: The hospital trust itself Remark: Both, the health authority and the regional	2004: The hospital trust itself Remark: Both, the health authority and the regional

H4 Which of the following actors is the most influential decision maker in questions of investments in the **Medical Technology** available in the Hospitals (e.g. procurement of new medical devices and equipment)?	
government have substantial influence	government have substantial influence

H5 Which actor is most important for deciding on the **Establishment of new Hospitals**?	
Austria 1995: Regional government (Bundesland)	2004: Regional government (Bundesland)
Belgium 1995: National Government. Remark: Hospitals need accreditation by the Ministry of Public Health. Among the accreditation criteria is the necessity of another hospital in a area and the capacity already existing. Due to over-capacities, the creation of new hospitals is not an issue; many hospitals are merging because the required minimum size of a hospital was increased by the national government. Regional government is funding the renovation of existing hospitals.	2004: National Government. Remark: Hospitals need accreditation by the Ministry of Public Health. Among the accreditation criteria is the necessity of another hospital in a area and the capacity already existing. Due to over-capacities, the creation of new hospitals is not an issue; many hospitals are merging because the required minimum size of a hospital was increased by the national government. Regional government is funding the renovation of existing hospitals.
Canada 1995: Provincial Government	2004: Provincial Government
Czech Republic 1995: The Central Government Remark: This question is purely hypothetical, because the overall trend is towards a reduction of over-capacities. A private hospital can factually only be established, if the HIFs are willing to contract it.	2004: The Central Government Remark: There is still an overall trend towards reducing over-capacities of hospital beds. A private hospital can factually only be established, if the HIFs are willing to contract it.
Denmark 1995: County Government; Amter for local hospitals Central government for university hospitals	2004: County government, Amter, for local hospitals Central government for university hospitals
Finland 1995: The Municipalities	2004: The Municipalities
France 1995: The regional government through the regional hospital agencies, ARH; acting under the national constraint defined by the Ministry of health	2004: The regional government through the regional hospital agencies, ARH ; acting under the national constraint defined by the Ministry of health
Germany 1995: The Regional Government or Municipality (Bundesländer or Gemeinden) Remark: The Regional Governments, Bundesländer, have a formal planning competence	2004: The Regional Government or Municipality (Bundesländer or Gemeinden) Remark: The Regional Governments, Bundesländer, have a formal planning competence
Greece 1995: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals	2004: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals
Hungary 1995: Central government	2004: Central government

H5 Which actor is most important for deciding on the **Establishment of new Hospitals**?	
Ireland 1995: National Government	2004: National Government
Italy 1995: Regional government, by setting an overall health plan	2004: Regional Government by setting an overall health plan
Luxembourg 1994: National Government	2004: National Government
Netherlands 1995: National Government Remark: There are no creations of new hospitals; only replacements of existing ones	2004: National Government Remark: There are no creations of new hospitals; only replacements of existing ones
New Zealand 1995: National Government – by overall planning of capacities	2004: National Government – by overall planning of capacities
Norway 1995: The county Government (County Council) Remark: The National Government has some influence	2004: National Government
Portugal 1995: National Government – by an overall planning competence	2004: National Government – by an overall planning competence
Poland 1995: The region and the central government. Remark: The region (Voivodship) or the municipality (Gmina) which usually own and operate the Hospitals, decide together with the Ministry of Health, whether another hospital is needed in a region. The Ministry of Health has the most influence in the decision, since it covers most of the costs. Factually, no new hospitals were established in the last years.	2004: The region and the central government. Remark: The region (Voivodship) or the municipality (Gmina) which usually own and operate the Hospitals, decide together with the Ministry of Health, whether another hospital is needed in a region. The Ministry of Health has the most influence in the decision, since it covers most of the costs. Factually, no new hospitals were established in the last years.
Spain 1995: Central Government; via the INSALUD	2004: Autonomous Communities via the Servicio Regional de Salud
Sweden 1995: Regional Government, Landsting	2004: Regional Government, Landsting
Switzerland 1995: Regional Government (Kanton)	2004: Regional Government (Kanton)
United Kingdom 1995: The Health Authorities are most important The national Government has influence Remark: New Hospitals are mostly re-buildings or replacement of existing ones. The major trend is towards closing down Hospitals	2004: The Health Authorities are most important The national Government has influence Remark: New Hospitals are mostly re-buildings or replacement of existing ones. The major trend is towards closing down Hospitals

H6 Which actor is most influential for deciding on **Closing of existing Hospitals**?	
Austria 1995: Regional government (Bundesland)	2004: Regional government (Bundesland)
Belgium 1995: National Government Remark: The national government does this by setting a minimum size for a hospital – which lead to hospital mergers.	2004: The national government Remark: The national government does this by setting a minimum size for a hospital – which lead to hospital mergers
Canada 1995: Provincial Government	2004: Provincial Government
Czech Republic 1995: The Municipality or Central Government Remark: To be operative, a Hospital needs contracts with the HIF. If the HIF do not contract the hospital any longer, it will go out of business. In the end, the political actors decide whether this happens or not, and usually, they are not really willing to close a hospital.	2004: The Municipality or Central Government Remark: To be operative, a Hospital needs contracts with the HIF. If the HIF do not contract the hospital any longer, it will go out of business. In the end, the political actors decide whether this happens or not, and usually, they are not really willing to close a hospital.
Denmark 1995: County Government, Amter, for local hospitals, National Government for the university hospitals.	2004: County Government, Amter, for local hospitals, National Government for the university hospitals.
Finland 1995: The municipalities	2004: The municipalities
France 1995: Regional government through the regional hospital agencies, ARH; acting under the national constraint defined by the ministry of health	2004: Regional government through the regional hospital agencies ARH; acting under the national constraint defined by the ministry of health
Germany 1995: The Regional Government or Municipality which is operating the Hospital (Bundesländer or Gemeinden)	2004: The Regional Government or Municipality which is operating the Hospital (Bundesländer or Gemeinden)
Greece 1995: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals	2004: National Government Remark: By exercising control over the ESY, which in turn is operating most hospitals
Hungary 1995: Central government Remark:	2004: Central government Remark:
Ireland 1995: National government	2004: National Government
Italy 1995: Regional government, by setting an overall health plan. The ASL operated by the local government has some say.	2004: Regional government, by setting an overall health plan. The ASL operated by the local government has some say.

H6 Which actor is most influential for deciding on **Closing of existing Hospitals**?	
Luxembourg 1994: National Government	2004: National Government
Netherlands 1995: National government Remark: The Health Insurance Fund, as Purchaser of in-patient services has some influence	2004: National Government Remark: The Health Insurance Fund, as Purchaser of in-patient services has some influence
New Zealand 1995: National Government – by an overall planing competence	2004: National Government - by an overall planing competence
Norway 1995: The County Government (County Council) Remark: The National Government has some influence	2004: National Government
Portugal 1995: National Government – by an overall planning competence	2004: National Government – by an overall planning competence
Poland 1995: The region (Voivodship) or the municipality (Gmina) which usually own and operate the Hospitals, decide on the closing of a hospital, but together with the Ministry of Health.	2004: The region (Voivodship) or the municipality (Gmina) which usually own and operate the Hospitals, decide on the closing of a hospital, but together with the Ministry of Health.
Spain 1995: Central Government / INSALUD	2004: The Regions (Autonomous Communities) /SRS
Sweden 1995: Regional Government, Landsting	2004: Regional Government, Landsting
Switzerland 1995: Regional Government (Kanton)	2004: Regional Government (Kanton)
United Kingdom 1995. The Health Authority Remark: The decision is a complex process involving all levels of government. In some cases of small Hospitals, the proposal to close the hospital came from the Hospital itself	2004: The Health Authorities Remark: The decision is a complex process involving all levels of government. In some cases of small Hospitals, the proposal to close the hospital came from the Hospital itself

H7 In some countries, several Hospitals offering the same kind of services (e.g. cover the same indications, the same degree of specialization etc.) exist in the same region. In others, a Hospital is typically the only provider of in-patient care in a region. What is the prevailing situation in [Country]?	
Austria 1995: There is usually only one Hospital for in-patient care in a certain region; in regions with high population density there exists competition between different hospitals	2004: There is usually only one Hospital for in-patient care in a certain region; in regions with high population density there exists competition between different hospitals Remark: There is a tendency, to remove over-capacities and redundancies in the Hospital sector
Belgium 1995: There is usually more than one Hospital in a region offering in-patient care	2004: There is usually more than one Hospital in a region offering in-patient care
Canada 1995: Usually, there are several Hospitals offering basic in-patient services in an area, but only one offering specialized services Remark: Availability of Hospitals differs among regions. In less populated areas, there is usually only one Hospital, in cities, there are typically more than one Hospital.	2004: Usually, there are several Hospitals offering basic in-patient services in an area, but only one offering specialized services Remark: Availability of Hospitals differs among regions. In less populated areas, there is usually only one Hospital, in cities, there are typically more than one Hospital.
Czech Republic 1995: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care, e.g. cardiac surgery. Remark: While Health Centers and Municipal Hospitals provide general care, the Hospitals operated by the Ministry of Health have a national level catchment area.	2004: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care, e.g. cardiac surgery
Denmark 1995: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care, e.g. cardiac surgery. Remark: The specialized hospitals cover larger regions, i.e. several counties	2004: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care, e.g. cardiac surgery Remark: The specialized hospitals cover larger regions, i.e. several counties
Finland 1995: There is usually only one Hospital for in-patient care in a certain region Remark: The provision of hospital services is based on Hospital districts, usually covering the area of several municipalities. The availability of	2004: There is usually only one Hospital for in-patient care in a certain region Remark: The provision of hospital services is based on Hospital districts, usually covering the area of several municipalities. The availability of

H7 In some countries, several Hospitals offering the same kind of services (e.g. cover the same indications, the same degree of specialization etc.) exist in the same region. In others, a Hospital is typically the only provider of in-patient care in a region. What is the prevailing situation in [Country]?	
Hospitals differs according to the population density – in some areas, there is just one Hospital.	Hospitals differs according to the population density – in some areas, there is just one Hospital.
France 1995: There is usually more than one Hospital in a region offering in-patient care. Remark: For certain, high specialized activities the provision of treatment is distributed between different hospitals (maternity, specialized cardiac surgery, cancer treatment etc.)	2004: There is usually more than one Hospital in a region offering in-patient care. Remark: For certain, high specialized activities the provision of treatment is distributed between different hospitals (maternity, specialized cardiac surgery, cancer treatment etc.) In 2004, there were 562 General Hospitals, 349 Local Hospitals and 29 regional Hospitals offering highly specialized treatment
Germany 1995: There is usually more than one Hospital in a region offering in-patient care. To some degree there are specialized Hospitals which have a focus on certain treatments, e.g. accidents.	2004: There is usually more than one Hospital in a region offering in-patient care. To some degree there are specialized Hospitals which have a focus on certain treatments, e.g. accidents.
Greece 1995: There is usually only one hospital in a region offering in-patient care. Remark: Availability of hospitals differs among areas. In some parts of the country, e.g. the islands, availability is low.	2004: There is usually only one hospital in a region offering in-patient care. Remark: Availability of hospitals differs among areas. In some parts of the country, e.g. the islands, availability is low.
Hungary 1995: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care Remark: This corresponds to the catchment area of the territorial unit operating the hospital. Hospitals operated by the municipalities offer basic in-patient and specialized out-patient care. Hospitals operated by the counties offer specialized in patient care, and the University Hospitals cover highly specialized treatment for the whole country	2004: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care Remark: This corresponds to the catchment area of the territorial unit operating the hospital. Hospitals operated by the municipalities offer basic in-patient and specialized out-patient care. Hospitals operated by the counties offer specialized in patient care, and the University Hospitals cover highly specialized treatment for the whole country
Ireland 1995: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care	2004: There are many Hospitals offering basic in-patient care in a certain region but only one offering specialized in patient care
Italy 1995. There are usually several Hospitals offering basic in-patient care in a certain region. For highly specialized treatments, there is usually	2004: There are usually several Hospitals offering basic in-patient care in a certain region. For highly specialized treatments, there is usually

H7 In some countries, several Hospitals offering the same kind of services (e.g. cover the same indications, the same degree of specialization etc.) exist in the same region. In others, a Hospital is typically the only provider of in-patient care in a region. What is the prevailing situation in [Country]?	
only one Hospital offering these services in a region Remark: The hospital system is layered: the more specialized the hospital, the larger the geographical are it covers. The Hospitals operated by the ASL cover the basic in-patient needs of a local population, the Trust-hospitals cover larger areas or regions	only one Hospital offering these services in a region Remark: The hospital system is layered: the more specialized the hospital, the larger the geographical are it covers. The Hospitals operated by the ASL cover the basic in-patient needs of a local population, the Trust-hospitals cover larger areas or regions
Luxembourg 1994: There is usually more than one Hospital in a region offering in-patient care	2004: Usually, there are several Hospitals offering basic in-patient services in an area, but only one offering specialized services Remark: The Ministry of Health publishes a “carte sanitaire”, in which services and the Hospitals to get them are listed.
Netherlands 1995: There is usually more than one Hospital in a region offering in-patient care	2004: There is usually more than one Hospital in a region offering in-patient care.
New Zealand 1995: There is usually only one Hospital for in-patient care in a certain region Remark: Only in more densely populated regions and big cities, there are more than one Hospital. These regions also have private Hospitals	2004: There is usually only one Hospital for in-patient care in a certain region; Remark: Only in more densely populated regions and big cities, there are more than one Hospital. these regions also have private Hospitals
Norway 1995: There are usually many hospitals offering basic in-patient care in a certain region but only one offering specialized in-patient care Remark: The hospital system is layered: There are district hospitals for basic services, five hospital regions with regional hospitals, for more specialized services and national level hospitals for very advanced treatments. The factual access depends on the area.	2004: There are usually many hospitals offering basic in-patient care in a certain region but only one offering specialized in-patient care. Remark: The hospital system is layered: There are district hospitals for basic services, five hospital regions with regional hospitals, for more specialized services and national level hospitals for very advanced treatments. The factual access depends on the area.
Portugal 1995: There is usually one Hospital offering basic in-patient care in a certain region and only one Hospital offering specialized in-patient care. Remark: There are highly specialized Hospitals covering more or less the whole country. Next, there are Central Hospitals for a region	2004: There is usually one Hospital offering basic in-patient care in a certain region and only one Hospital offering specialized in-patient care. Remark: There are highly specialized Hospitals covering more or less the whole country. Next, there are Central Hospitals for a region

H7 In some countries, several Hospitals offering the same kind of services (e.g. cover the same indications, the same degree of specialization etc.) exist in the same region. In others, a Hospital is typically the only provider of in-patient care in a region. What is the prevailing situation in [Country]?	
offering specialized services; below the regional level is the district level, usually two per region, with hospitals offering basic services. The density of Hospitals follows the population density. Availability is highest in Lisbon and the coastal area	offering specialized services; below the regional level is the district level, usually two per region, with hospitals offering basic services. The density of Hospitals follows the population density. Availability is highest in Lisbon and the coastal area
Poland 1995: There is usually one Hospital offering basic in-patient care in a certain geographic area and only one Hospital offering specialized in-patient care. Remark: The catchment area of hospitals corresponds to the area of the administrative entity operating the hospital (municipality/gmina or region/voivodship). More specialized hospitals have a larger catchment area.	2004: There is usually one Hospital offering basic in-patient care in a certain geographic area and only one Hospital offering specialized in-patient care. Remark: The catchment area of hospitals corresponds to the area of the administrative entity operating the hospital (municipality/gmina or region/voivodship). More specialized hospitals have a larger catchment area.
Spain 1995: There are many Hospitals offering basic in-patient care in a certain area but only one offering specialized in patient care Remark: The availability differs among and within Regions. Usually, the availability of basic services is distributed quite equally, while most often a Region has only one Hospital providing specialized services	2004: There are many Hospitals offering basic in-patient care in a certain area but only one offering specialized in patient care Remark: The availability differs among and within Regions. Usually, the availability of basic services is distributed quite equally, while most often a Region has only one Hospital providing specialized services
Sweden 1995: There is usually more than one Hospital in a region offering in-patient care Remark: The area belonging to a certain Landsting has usually a Hospital providing basic services. Hospitals offering specialized care are covering the areas of several Landstings	2004: There is usually more than one Hospital in a region offering in-patient care Remark: The area belonging to a certain Landsting has usually a Hospital providing basic services. Hospitals offering specialized care are covering the areas of several Landstings
Switzerland 1995: There are usually many Hospitals offering basic in-patient care in a certain region (Kanton) but only one offering specialized in patient care, e.g. cardiac surgery.	2004: There are usually many Hospitals offering basic in-patient care in a certain region (Kanton) but only one offering specialized in patient care, e.g. cardiac surgery.
United Kingdom 1995: There is usually only one Hospital for in-patient care in a certain region / district Remark: The Hospital structure is hierarchical: community hospitals, with typically 50 beds, District General Hospitals, providing basic	2004: There is usually only one Hospital for in-patient care in a certain region / district

H7 In some countries, several Hospitals offering the same kind of services (e.g. cover the same indications, the same degree of specialization etc.) exist in the same region. In others, a Hospital is typically the only provider of in-patient care in a region. What is the prevailing situation in [Country]?	
secondary care, then al level of highly specialized hospitals covering larger areas	

H8 If there is more than one Hospital to chose from, do the Treatment Costs charged by the Hospital (e.g. cost per case, per diem etc.) to the Purchaser (Health Authority/Health Insurance Fund) differ among these Hospitals? Or are the treatment costs charged by Hospitals the same for all Hospitals in a region / degree of specialization?	
Austria 1995: Treatment costs (per diem) are the same for all Hospitals of similar degree of specialization	2004: Treatment costs (DRGs) are the same for all Hospitals of similar degree of specialization Remark: For some Hospitals, there arise however additional costs for the Health Insurance Funds
Belgium 1995: Treatment costs differ among Hospitals Remark: The fees charged by the consultants are identical for all hospitals. But each Hospital receives also a prospective budget for covering non medical services and the infrastructure. This budget is based on a per diem / patient-day system. These per diems are different among different hospitals.	2004: Treatment costs differ among Hospitals Remark: The fees charged by the consultants are identical for all hospitals. But each Hospital receives also a prospective budget for covering non medical services and the infrastructure. This budget is based on a per diem / patient-day system. These per diems are different among different hospitals
Canada 1995: Treatment costs differ among Hospitals Remark: Hospitals are remunerated by budgets from the Regional Health Authorities, but the number of cases treated is taken into account. This budget predominantly covers the operating costs. Services are billed to the provincial governments. While no price per case is charged, hospital costs can be compared. However, there is no price competition.	2004: Treatment costs differ among Hospitals Remark: Hospitals are remunerated by budgets from the Regional Health Authorities, but the number of cases treated is taken into account. This budget predominantly covers the operating costs. Services are billed to the provincial governments. While no price per case is charged, hospital costs can be compared. However, there is no price competition.
Czech Republic 1995: Treatment costs are the same for all Hospitals, independent of the specialization Remark: The remuneration is by a point system/ fee for service. From the perspective of the HIF, the purchaser, the value of a point is identical for all Hospitals. The value of a point results from a budgetary limit negotiated between a HIF and the individual Hospital. The costs differ among HIFs since each HIF negotiates individually with all the Hospitals. The Hospital sends an invoice, listing the services and the points to the HIF and receives payments.	2004: Treatment costs are the same for all Hospitals, independent of the specialization Remark: The remuneration is by a point system/ fee for service. From the perspective of the HIF, the value of a point is identical for all Hospitals. The value of a point results from a budgetary limit negotiated between a HIF and the individual Hospital. The costs differ among HIFs since each HIF negotiates individually with all the Hospitals. The Hospital sends an invoice, listing the services and the points to the HIF and receives payments.

H8 If there is more than one Hospital to chose from, do the Treatment Costs charged by the Hospital (e.g. cost per case, per diem etc.) to the Purchaser (Health Authority/Health Insurance Fund) differ among these Hospitals? Or are the treatment costs charged by Hospitals the same for all Hospitals in a region / degree of specialization?	
Denmark1995: No rates are charged within a county, where hospitals are predominantly financed by prospective fixed budgets. Thus there is no price competition among hospitals. If a patient is treated outside the county, either a DRG charge is used, or a rate that is specifically calculated to cover total costs (specialized services). The payment of the treatment costs takes place between counties, Amter.	2004: No rates are charged within a county, where hospitals are predominantly financed by prospective fixed budgets. Thus there is no price competition among hospitals. If a patient is treated outside the county, either a DRG charge is used, or a rate that is specifically calculated to cover total costs (specialized services). The payment of the treatment costs takes place between counties, Amter.
Finland 1995: Treatment costs differ among hospitals Remark: Services and costs are negotiated in an informal agreement between the Hospital district and the Municipalities. The Hospital District can more or less unilaterally set the terms of the agreement but the Municipalities have to some degree a choice which Hospital district to join.	2004: Treatment costs differ among hospitals Remark: Services and costs are negotiated in an informal agreement between the Hospital district and the Municipalities. The Hospital District can more or less unilaterally set the terms of the agreement but the Municipalities have to some degree a choice which Hospital district to join.
France 1995: Treatment costs differ among hospitals Remark: Because of the predominance of budgeting, there is no price competition among hospitals	2004: Treatment costs differ among hospitals Remark: The DRGs charged by Hospitals differ, but because of the predominance of budgeting, there is no price competition among hospitals
Germany 1995: Treatment costs, the per diem, differ among Hospitals	2004: Treatment costs, price per DRG, differ among regions, but within a region (Bundesland) each Hospital charges the same amount for a defined DRG
Greece 1995: Treatment costs are the same independent of the degree of specialization Remark: Budgets for running costs differ among hospitals. HIF pay hospitals on a per diem basis. The per diem and other fees are set by the Government and are identical for all ESY run hospitals in the country. Main differences among hospitals are quality issues.	2004: Treatment costs are the same independent of the degree of specialization Remark: Budgets for running costs differ among hospitals. HIF pay hospitals on a per diem basis. The per diem and other fees are set by the Government and are identical for all ESY run hospitals in the country. Main differences among hospitals are quality issues.
Hungary 1995: Treatment costs are the same independent of the degree of specialization Remark:	2004: Treatment costs are the same independent of the degree of specialization Remark:

H8 If there is more than one Hospital to chose from, do the Treatment Costs charged by the Hospital (e.g. cost per case, per diem etc.) to the Purchaser (Health Authority/Health Insurance Fund) differ among these Hospitals? Or are the treatment costs charged by Hospitals the same for all Hospitals in a region / degree of specialization?	
The NHIFA pays the Hospitals on a DRG system based on points, and the financial value of a point is equal for the whole country	The NHIFA pays the Hospitals on a DRG system based on points, and the financial value of a point is equal for the whole country
Ireland 1995: Treatment costs differ among Hospitals according to the degree of specialization. Part of the Hospital's budget is calculated on costs per case indicators. Hospitals with high costs per case levels can be penalized financially. Hospitals with lower costs per case may be rewarded. Remark: Since the amount of the reward is very limited, there is no price competition among Hospitals. Hospitals were supposed to publish price lists, however, whether this was actually operative is unclear.	2004: Treatment costs differ among Hospitals according to the degree of specialization. Part of the Hospital's budget is calculated on costs per case indicators. Hospitals with high costs per case levels can be penalized financially. Hospitals with lower costs per case may be rewarded. Remark: Since the amount of the reward is very limited, there is no price competition among Hospitals. Hospitals were supposed to publish price lists, however, whether this was actually operative is unclear.
Italy 1995: Treatment cost differ among Hospitals of different degree of specialization Remark: The treatment costs charged by the Hospitals for a defined treatment are the same for all hospitals of similar degree of specialization in a region, but differ among the regions. There is a cost per admission, which is paid in addition to the DRG, and this may differ among Hospitals. The DRG rates are set nationally and are the maximum, the Regions can deviate, but only by setting lower rates.	2004: Treatment cost differ among Hospitals of different degree of specialization Remark: The treatment costs charged by the Hospitals for a defined treatment are the same for all hospitals of similar degree of specialization in a region, but differ among the regions. There is a cost per admission, which is paid in addition to the DRG, and this may differ among Hospitals. The DRG rates are set nationally and are the maximum, the Regions can deviate, but only by setting lower rates.
Luxembourg 1994: Treatment costs (a per diem) are the same for all Hospitals of similar degree of specialization; see H9 Remark: Up to the year 1995, a per diem, identical for all Hospitals, was the predominant remuneration form for Hospitals. The services provided by the specialists using the Hospital facilities were remunerated on a fee for services basis and remuneration took place between the Specialist and the HIF. There were extra fees for other activities. The per diem itself was negotiated between the HIFs and the Hospitals and was valid for all	2004: Treatment costs differ among Hospitals Remark: Since 1995, budgets are negotiated among the HIF association, UCM, and the individual Hospital. The budgets are of different size, making hospitals with bigger budgets relative to the capacities more expensive, e.g. highly specialized hospitals.

H8 If there is more than one Hospital to chose from, do the Treatment Costs charged by the Hospital (e.g. cost per case, per diem etc.) to the Purchaser (Health Authority/Health Insurance Fund) differ among these Hospitals? Or are the treatment costs charged by Hospitals the same for all Hospitals in a region / degree of specialization?	
hospitals	
Netherlands 1995: Treatment costs differ among Hospitals Remark: While Hospitals were predominantly remunerated by budgets, a part of the budget was actually paid in the form of a per diem. These per diems differed among the Hospitals	2004: Treatment costs differ among Hospitals, Remark: Only for services remunerated by the DRG system, the remuneration is the same for a defined service.
New Zealand 1995: Treatment costs differ among Hospitals Remark: Hospitals were independent entities, and the remuneration was case-based: there were fixed price-volume contracts, which resulted in a fixed annual budget. The price and volumes were negotiated. However, usually there was no competition among hospitals, e.g. only one hospital in a region, and the hospital could negotiate a higher remuneration. There was no price competition.	2004: Treatment costs differ among Hospitals Remark: Part of the Hospitals remuneration is a case based and this component differs among hospitals. However, usually the DHB do no longer purchase services in a market setting, but operate the hospitals directly, so differences in treatment costs are irrelevant and there is no price competition..
Norway 1995: Treatment costs differ among Hospitals; Remark: The budgets allocated to the hospitals differ and this yields a different price per treatment. There is further a price system if a patient is treated in another county. But there is no comparable data on how much prices and treatment costs differ and there is no price competition among hospitals.	2004: Treatment costs differ among Hospitals; Remark: The usage of DRGs in addition to block grants has increased transparency. The level of payment for a DRG does not differ. There is no comparable data on treatment costs and hence no price competition. This is true for in-patient care and for specialized out-patient care provided by hospitals.
Portugal 1995: Treatment costs do not differ. Remark: The payment of hospitals is based on a budget, which in turn partly rests on a DRG system. The budgets are negotiated directly between the Ministry of Health and the Hospital. The payment for a DRG is identical for all hospitals in the country.	2004: Treatment costs do not differ. Remark: The payment of hospitals is based on a budget, which in turn partly rests on a DRG system. The budgets are negotiated directly between the Ministry of Health and the Hospital. The payment for a DRG is identical for all hospitals in the country.
Poland 1995: Treatment costs differ with the degree of specialization, but there is no price competition Remark:	2004: Treatment costs differ with the degree of specialization, but there is no price competition Remark:

H8 If there is more than one Hospital to chose from, do the Treatment Costs charged by the Hospital (e.g. cost per case, per diem etc.) to the Purchaser (Health Authority/Health Insurance Fund) differ among these Hospitals? Or are the treatment costs charged by Hospitals the same for all Hospitals in a region / degree of specialization?	
The hospital remuneration is by budgets based on the budgets of previous years. Thus, treatment in some hospitals is cheaper. But nevertheless, gminas and voivodships refer patients to the local hospitals.	The hospital remuneration is case-based
Spain 1995: Treatment costs differ with the degree of specialization of the hospital. Remark: The degree of specialization is partly determined for each Hospital individually, depending on its resources. There is however no price competition.	2004: Treatment costs differ with the degree of specialization of the hospital. Remark: The degree of specialization is partly determined for each Hospital individually, depending on its resources. There is however no price competition.
Sweden 1995: Rates and treatment costs differ among Hospitals. Remark: The DRGs negotiated between the Landstings and the Hospitals differ among Hospitals. There is however, no price competition	2004: Rates and treatment costs differ among Hospitals Remark: The DRGs negotiated between the Landstings and the Hospitals differ among Hospitals. There is no price competition.
Switzerland 1995: Treatment costs differ among Hospitals Remark: The remuneration of Hospitals is by per diems, which differ primarily among cantons. Since usually patients are treated in their home-Canton, there is no real price competition.	2004: Treatment costs differ among Hospitals Remark: The remuneration of Hospitals is by per diems, which differ primarily among cantons. Since usually patients are treated in their home-Canton, there is no real price competition.
United Kingdom 1995: Treatment costs differ among Hospitals, but there is no price competition among hospitals, since they cannot actually charge different prices Remark: The degree of specialization influences the budget, which makes some Hospitals more expensive from the perspective of the health authority	2004: Treatment costs differ among Hospitals, but there is no price competition among hospitals, since they cannot actually charge different prices Remark: The degree of specialization influences the budget, which makes some Hospitals more expensive from the perspective of the Health Authority

H9 What is the predominant **Remuneration Mode for Hospitals?** How are Hospitals funded?	
Austria 1995: Per diem (up to 1996) Remark: The per diem was negotiated between the owner of the Hospitals and the Health Insurance Funds, which together funded the hospitals.	2004: DRGs Remark: While the running costs are financed by the Health Insurance Funds, the investment costs are covered by subsidies of the Regional Government
Belgium 1995: Fee for service for the services – the patient pays a per diem, the HIF the remainder A budget based on a per diem-indicator for the running costs of the hospital infrastructure	2004: Fee for service for the services – the patient pays a per diem, the HIF the remainder A budget based on a per diem-indicator for the running costs of the hospital infrastructure Remark: Both, the remuneration by the prospective fixed budget and the remuneration by fees for service make up about 50% each.
Canada 1995: Global capped budget Remark: The budget is negotiated between the RHA and the individual hospital. The budgeting takes to some degree the expected number of cases into account, to some degree it is based on the historical “need”. The budget is predominantly for covering the operating costs, usually not the services. Physicians providing the services are often self employed. They use the Hospital facilities, but are remunerated on a fee for service basis. The fees are negotiated among the providers and the provincial government.	2004: Global capped budget Remark: The budget is negotiated between the RHA and the individual hospital. The budgeting takes to some degree the expected number of cases into account, to some degree it is based on the historical “need”. The budget is predominantly for covering the operating costs, usually not the services. Physicians providing the services are often self employed. They use the Hospital facilities, but are remunerated on a fee for service basis. The fees are negotiated among the providers and the provincial government
Czech Republic 1995: Fee for service Remark: The remuneration is by a point system/ fee for service. Each HIF negotiates a value of a point with all Hospitals which is then identical for all the contracted Hospitals. The costs differ among HIFs since each HIF negotiates individually with the Hospitals. From the point of the Hospital, some patients are more attractive then others. The number of points a service is worth, is set by the Ministry of Health.	2004: Fee for service Remark: The remuneration is still by a point system/ fee for service like in 1995. But in practice, the remuneration has now strong elements of a capped budget, since the overall remuneration paid by a HIF for in-patient treatment for its insured is fixed. The budgetary limit is negotiated between the individual Hospital and the individual HIF. The point system now serves basically as an administrative tool, which shall show, what was delivered for the budget. Since 2001, there are degressive flat-fees for patients treated in addition to the budget. The number of points a medical service is worth, is set by

H9 What is the predominant **Remuneration Mode for Hospitals?** How are Hospitals funded?	
	the Ministry of Health.
Denmark 1995: Prospective global budget, negotiated between the Amter and the Hospital	2004: Global Capped Budget and DRGs (since 1999)
Finland 1995: Case based remuneration Remark: There is substantial variation in reimbursement modes among Hospital Districts. The services and costs are negotiated in an informal agreement between the Hospital District and the Municipalities; this yields a loose budget. The Council administrating the Hospital District can more or less unilaterally set the terms of the agreement but the Municipalities have to some degree a choice which Hospital District to join. The payment is done based on the services delivered for citizens of a municipality. Out-patient specialized services provided by Hospitals are usually remunerated with a prospective budget, which is negotiated between the Hospital District and each municipality.	2004: Case based remuneration (DRG) plus a fee for service component Remark: There is substantial variation in reimbursement modes among Hospital Districts. The services and costs are negotiated in an informal agreement between the Hospital District and the Municipalities; this yields a loose budget. The Council administrating the Hospital District can more or less unilaterally set the terms of the agreement but the Municipalities have to some degree a choice which Hospital District to join. The payment is done based on the services delivered for citizens of a municipality. Out-patient specialized services provided by Hospitals are usually remunerated with a prospective budget, which is negotiated between the Hospital District and each municipality.
France 1995: Prospective budget which is factually based on past costs Remark: The budget is set by the Ministry together with regional authorities; ARH	2004: Prospective budget The budget is still based on past costs, but also on DRGs, which differ among hospitals, and also on regional plans set by the ARH Remark: The prospective fixed budget is the authorized expenditure of the Hospital. Other types of income – e.g. arising from treatments of private patients and fees charged for accommodation - are subtracted from the payments made by the ARH to the Hospital. The ARH pays the difference between the income and the total expenditure allowance
Germany 1995: Per diem Remark: While the running costs are financed by the Health Insurance Funds, the investment costs are covered by subsidies of the Regional Government. The overall costs of the Hospitals are added and divided by the number of patient-days, this yields the per diem.	2004: Prospective fixed Budget and DRGs Remark: While the running costs are financed by the Health Insurance Funds, the investment costs are covered by subsidies of the Regional Government

H9 What is the predominant **Remuneration Mode for Hospitals?** How are Hospitals funded?	
Greece 1995: Per diem Remark: The hospital receives a budget for the running costs from the state. The HIF pay by per diems, the per diem is determined by the Government, it was raised substantially in the past to increase hospital financing. Some specialized services, like cardiac surgery, are remunerated separately by mark ups.	2004: Per diem Remark: The hospital receives a budget for the running costs from the state. The HIF pay by per diems, the per diem is determined by the Government. Some specialized services are remunerated separately by mark ups.
Hungary 1995: Case based remuneration based on DRGs Remark: The remuneration for the DRGs is based on a point system, each DRG has a certain number of points. Each point has a certain value, the national base fee, which are set at national level by the NHIFA. The Hospital reports the monthly sum of points and gets remuneration	2004: Case based remuneration, based on DRGs Remark: The remuneration for the DRGs is based on a point system, each DRG has a certain number of points. Each point has a certain value, the national base fee, which are set at national level by the NHIFA. The Hospital reports the monthly sum of points and gets remuneration
Ireland 1995: Prospective fixed budget Remark: The budget is negotiated annually between the individual Hospital and the Health Boards / Ministry of Health, and depended on the location of the Hospital. The budget was detailed and the allocation of funds to the functions was also settled.	2004: Prospective fixed budget Remark: The budget is negotiated annually between the individual Hospital and the Health Boards / Ministry of Health, and depended on the location of the Hospital. The budget was detailed and the allocation of funds to the functions was also settled.
Italy 1995: Case based remuneration: DRGs for Hospitals which are independent of the ASLs. Remark: Hospitals managed by the ASL are basically remunerated on a cost reimbursement ex-post budget basis: they are integrated part of the ASL. The DRG itself is set by the regional government for the region, it may differ among regions, but may not exceed a level set by the national government	2004: Case based remuneration: DRGs for Hospitals which are independent of the ASLs. Remark: Hospitals managed by the ASL are basically remunerated on a cost reimbursement ex-post budget basis: they are integrated part of the ASL. The DRG itself is set by the regional government for the region, it may differ among regions, but may not exceed a level set by the national government.
Luxembourg 1994: Per diem Remark: Up to the year 1995, a per diem, identical for all Hospitals, was the predominant remuneration form for Hospitals. The services provided by the specialists using the Hospital facilities were remunerated on a fee	2004: Prospective fixed Budget Remark: For each Hospital, a budget is negotiated between the Hospital and the HIF associations, UCM

H9 What is the predominant **Remuneration Mode for Hospitals?** How are Hospitals funded?	
for services basis and remuneration took place between the Specialist and the HIF. There were extra fees for other activities, like diagnostic services.	
Netherlands 1995: Global capped budget Remark: Part of the Hospital budget was paid as a per diem. This was calculated by dividing a part of the budget by the number of patient-days	2004: Prospective fixed budgets DRG system (10%)
New Zealand 1995: Hospital remuneration was largely case based. Contracts contained both volumes and prices, so factually, it was an annual budget. Remark: The remuneration was negotiated between the RHA and the Hospitals (then Crown Health Enterprises). Given the monopoly position of the Hospitals, this resulted in higher remuneration for them.	2004: Hospitals get a budget for the operating costs The services are remunerated using a DRG / case based system. This component is paid as a price-volume contract, using the number of patients and procedures as basis. Remark: Remuneration mode varies and there are still services which are remunerated on a fee for case basis.
Norway 1995: Global capped budget plus an additional "soft" budget Remark: The hospital receives a block grant from the county. The budget is soft, since deficits are covered and the budget is increased, if necessary.	2004: DRG plus an additional "Soft Budget" Remark: Part of the block grants are now paid based on activity. The share of payment by DRG and by the block grant is annually set by the state
Portugal 1995: Budgets based on past costs Remark: The budget used to be based on historical budgets increased by inflation and other factors. From 1995 on, part of the budget was based on a DRG system. The percentage of the budget, which is based on the DRG component was about 10% in 1997. Financing is negotiated annually between the individual Hospital and the Ministry of Health without involvement of the Regional Health Authorities.	2004: Budgets based on past costs, combined with a system of DRG based contracts Remark: The budget used to be based on historical budgets only, increased by inflation. From 1995 on, part of the budget was based on a DRG system. The percentage of the budget, which is based on the DRG component increased in 2002 to 50%. Financing is negotiated annually between the individual Hospital and the Ministry of Health without involvement of the Regional Health Authorities.
Poland 1995: Budgets Remark: Each hospitals gets a budget allocated by the owning entity (gmina, voivodship), which is based on the budgets the hospital had in the past.	2004: Case based remuneration Remark: Each procedure has a number of points assigned to it, and the remuneration for the procedure is calculated based on the financial value of a point, which is set in the contract.

H9 What is the predominant **Remuneration Mode for Hospitals?** How are Hospitals funded?	
	The National Health Fund pays only the most expensive procedure listed in the patient's file.
Spain 1995: Budget for Hospitals operated by the INSALUD - factually all costs are covered ex post Remark: The setting of a Hospital's budget is increasingly based on activity, i.e. on cases and costs per case, resembling a DRG system. The setting of a hospital's budget takes place on the level of the individual hospital. Contracted hospitals are remunerated on a per diem basis, set in the contract.	2004: Budget for Hospitals operated by the SRS – factually, all costs are covered Remark: The setting of a Hospital's budget is increasingly based on activity, i.e. on cases and costs per case, resembling a DRG system. Usually, the funding of the operational costs is distinct from the funding of the service provision. The setting of a hospital's budget takes place on the level of the individual hospital. Contracted hospitals are remunerated on a per diem basis, set in the contract
Sweden 1995: Global capped budget fixed prospectively in negotiations between the Hospitals and the Landstings	2004: Predominantly by a global capped budget fixed prospectively by the Landsting, supplemented by a DRG remuneration with DRGs negotiated between Hospitals and Landstings. This is usually the case in counties which have installed a purchaser provider split.
Switzerland 1995: Per diem Remark: The per diems are negotiated at the cantonal level, between the cantonal HIFs and the cantonal association of Hospitals or individual Hospitals. The per diems differ primarily among cantons.	2004: Per diem is still predominant Remark: A prospective fixed budget plus DRGs are being introduced but not yet operative. The per diems are negotiated at the cantonal level, between the cantonal HIFs and the cantonal association of Hospitals or individual Hospitals. The per diems differ primarily among cantons.
United Kingdom 1995: Prospective fixed budget Remark: There is a contract between the District Health Authority, DHA, and the Hospital to provide certain services in exchange for a certain budget for all residents in the area covered by the DHA.	2004: Prospective fixed budget, Remark: While a DRG system with a national tariff is being introduced, but not yet operative

H10 Can the Hospital increase the remuneration received for an individual case ? E.g. by extending the quantity of services provided to a patient or by extending the length of a patient's stay in the Hospital?	
Austria 1995: Yes, until 1996 by increasing the length of stay (more per diems charged)	2004: Yes, the DRG-system introduced since 1997 is not exclusively related to the diagnosis, but also includes activity related elements. Increasing the activity, assigning more than one DRG to a case, can be used to increase remuneration
Belgium 1995: Yes, via the fee for service component, in particular for laboratory services, and by extending the length of stay Remark: This incentive exists both for the hospital providing the infrastructure and for the consultant providing the actual services.	2004: Yes, via the fee for service component and by extending the length of stay Remark: This incentive exists both for the hospital providing the infrastructure and for the consultant providing the actual services. Since 1996, there is a system of financial penalties and rewards counteracting the incentives to prolong the length of stay and extend the quantity of laboratory services provided by the hospitals.
Canada 1995: Yes, while the hospital cannot do so, the physician providing the services can do so by providing more services	2004: Yes, while the hospital cannot do so, the physician providing the services can do so by providing more services
Czech Republic 1995: Yes, by providing more services Remark: The remuneration is by a point system/ fee for service. Providing more and higher evaluated services and keeping patients longer, increases the remuneration in a case. However, the remuneration has strong elements of a capped budget, since the overall remuneration paid by a HIF for in-patient treatment for its insured is fixed, at least in short term.	2004: Yes, by providing more services Remark: The remuneration is by a point system/ fee for service. Providing more and higher evaluated services and keeping patients longer, increases the remuneration in a case. However, the remuneration has strong elements of a capped budget, since the overall remuneration paid by a HIF for in-patient treatment for its insured is fixed in negotiations with each hospital. Consequently, the value of a point decreases, if too many services are provided.
Denmark 1995: No, the hospital's budget is fixed Remark: Factually, hospitals have been encouraged to take in more patients and have been paid by a specific government fund for extra patients	2004: No for most treatments. Remark: An increase in remuneration is possible via the DRG component of remuneration, e.g. by increasing the number of complicating co-diagnosis; "DRG creep"
Finland 1995: Yes, the remuneration is activity based	2004: Yes, the remuneration is activity based

H10 Can the Hospital increase the remuneration received for an individual case ? E.g. by extending the quantity of services provided to a patient or by extending the length of a patient's stay in the Hospital?	
France 1995: No, for public hospitals, the majority. Yes, for private hospitals by increasing activity Remark: Since the budget is based on historical budgets, the hospital can increase its budget in the long run.	2004: Yes. Remark: Since 2004, both public and private hospitals can increase the remuneration by increasing activity and selecting the most well-paid cases
Germany 1995: Yes, by extending the length of stay (via the per diem component)	2004: Yes, by assigning the case to more than one DRG
Greece 1995: Yes, by extending the length of stay Remark: In ESY Hospitals, the incentive arises from the per diem component of remuneration. In private hospitals, the possibility arises from providing services and treatments without an indication.	2004: Yes, mainly by extending the length of stay Remark: In ESY Hospitals, the incentive arises from the per diem component of remuneration. In private hospitals, the possibility arises from providing services and treatments without an indication.
Hungary 1995 Yes, e.g. by DRG creep. Remark: While the sectorial budget for in-patient treatment is set in advance, there are problems of point inflation, DRG creep, and treating patients on an in-patient basis rather than on an out-patient basis.	2004: Yes, e.g. by DRG creep. Remark: While the sectorial budget for in-patient treatment is set in advance, there are problems of point inflation, DRG creep, and treating patients on an in-patient basis rather than on an out-patient basis.
Ireland 1995: No – at least not in the short run Remark: The specialists providing the services are paid for on a fee for service basis, and have an incentive to increase the quantity of services. In the long run, the budget will be increased too.	2004: No – at least not in the short run Remark: The specialists providing the services are paid for on a fee for service basis, and have an incentive to increase the quantity of services. In the long run, the budget will be increased too.
Italy 1995: Yes, to a limited degree by miscoding, "DRG creep"	2004: Yes, to a limited degree by miscoding, "DRG creep"
Luxembourg 1994 Yes. Remark: The remuneration obtained via the per diem did not suffice to cover the running costs of the Hospital. There were extra fees for other activities, like diagnostic services. By providing more of theses, the Hospital could in the end cover its costs.	2004: Yes Remark: While the Hospital cannot do so, the physicians working respectively using the Hospital facilities can do so

H10 Can the Hospital increase the remuneration received for an individual case ? E.g. by extending the quantity of services provided to a patient or by extending the length of a patient's stay in the Hospital?	
Netherlands 1995: Basically no, since most of the remuneration is a budget and deficits would not be covered. Even increasing the length of stay did not set an incentive, since the overall amount paid via the per diem was fixed in advance	2004: Basically no, since most of the remuneration is a budget and deficits would not be covered. Remark: To a limited degree the hospital can do so via the DRG component of remuneration
New Zealand 1995: No. Remark: While based on DRGs, the contracts specified both volumes and prices, resulting in a fixed annual budget. While provision of services above the contracted volume was usually not remunerated, funding was usually increased in the following period.	2004: Yes. The hospital has an incentive, to increase the throughput of patients and procedures, to maintain the flow of income which is dependent on the consumption
Norway 1995: No Remark: The hospital has not an incentive to increase efficiency. The incentive is to increase the budget in the long run.	2004: Partly, via the DRG component
Portugal 1995: No Remark: The budgeting did not set an explicit incentive to increase the costs, but neither set an incentive to reduce costs.	2004: Yes Remark: If there is more activity, the remuneration received increases via the DRG component; additional costs will also be covered.
Poland 1995: Yes. Remark: While the budget was a limit, the possibility of incurring debts which were covered later on by the state and possibility to get bigger budgets in the future set such an incentive.	2004: Yes. Remark: The National Health Insurance Fund pays only the most expensive procedure listed in the patient's file. While increasing the number of services provided does not increase the hospital's remuneration assigning the patient to a higher group, using higher paid procedures, may increase the payment.
Spain 1995: No for public hospitals Yes for private contracted hospitals, there is due to the per diem remuneration a certain incentive to prolong the length of stay.	2004: No for public hospitals Yes for private contracted hospitals, there is due to the per diem remuneration a certain incentive to prolong the length of stay.
Sweden 1995: No, the budget is fixed	2004: No; the budget is fixed. Remark: Also the DRG system does not set an incentive to increase the quantity of services

H10 Can the Hospital increase the remuneration received for an individual case ? E.g. by extending the quantity of services provided to a patient or by extending the length of a patient's stay in the Hospital?	
	provided.
Switzerland 1995: Yes, via the per diem remuneration, by increasing the length of stay	2004: Yes, via the per diem component in the overall remuneration, by increasing the length of stay
United Kingdom 1995: No, the budget is fixed Remark: Only in some contracts there were elements of activity based funding, which allowed an increase in remuneration	2004: No, the budget is fixed Remark: Only in some contracts there were elements of activity based funding, which allowed an increase in remuneration

3. Pharmaceuticals

PH1 Which of the following **Regulations on Pharmaceuticals** are in place in [Country]?	
Austria 1995: Price control – a maximum price level is negotiated between a committee and the producer Positive Listing (a list, from which the prescriber can choose)	2004: Price control – a maximum price level is negotiated between a committee and the producer Positive Listing Remark: While there is no budget for a physician, the Physician Association may claim back pharmaceutical expenditure which is above the average for this kind of physician
Belgium 1995: Price control – a maximum price is set by the Ministry of Economic Affairs Negative List (a list of pharmaceuticals, which are not covered by the health system albeit they are available) Positive List Overall pharmaceutical budget Grouping of Pharmaceuticals (Medicines are grouped to classes of equivalent products for treating similar medical conditions. The Health System covers only the cheapest product of this group; i.e. the reference price for this group of medicines. If the patient wants another, more expensive product, he has to pay the difference)	2004: Price control – a maximum price is set by the Ministry of Economic Affairs Negative List Positive List Overall pharmaceutical budget Grouping of Pharmaceuticals
Canada 1995: Price control - prices of patented drugs are regulated by the Patented Medicines Prices Review Board Negative List Positive List Pharmaceutical budget for Hospitals Grouping of Pharmaceuticals Remark: Most of pharmaceutical expenditure is paid for by the patients themselves, subject to subsidies by the provinces and to coverage by VHI	2004: Price control - prices of patented drugs are regulated by the Patented Medicines Prices Review Board Negative List Positive List Pharmaceutical budget for Hospitals Grouping of Pharmaceuticals Remark: Most of pharmaceutical expenditure is paid for by the patients themselves, subject to subsidies by the provinces and to coverage by VHI
Czech Republic 1995: Price regulation Positive List	2004: Price regulation Negative List Positive List Pharmaceutical budget for individual prescribers like GPs and Hospitals Grouping of Pharmaceuticals

PH1 Which of the following **Regulations on Pharmaceuticals** are in place in [Country]?	
	Remark: The budgets for pharmaceutical spending by individual prescribers were introduced in 1999 and concern only the GHIF. Further, the GHIF – as the largest purchaser of drugs - started to influence pharmaceutical prices.
Denmark 1995: Positive Listing Grouping of Pharmaceuticals for generics Remark: Since 1991, there is a scheme of groups of medicines, for each group, a generic is the cheapest alternative and only this is covered	2004: Positive Listing Grouping of Pharmaceuticals for generics Remark: Since 1991, there is a scheme of groups of medicines, for each group, a generic is the cheapest alternative and only this is covered
Finland 1995: Price regulation Positive Listing Remark: The National Agency for Medicines decides on the market authorization, the Pharmaceutical Pricing Board decides on the price of drugs which are reimbursed by the NHI. The price has to be reasonable, given the effectiveness of the drug.	2004: Price regulation Positive Listings Grouping of Pharmaceuticals Remark: The National Agency for Medicines decides on the market authorization, the Pharmaceutical Pricing Board decides on the price of drugs which are reimbursed by the NHI. The price has to be reasonable, given the effectiveness of the drug.
France 1995: Price regulation Positive List Negative list – only for Asthma, which is excluded from coverage	2004: Price regulation Positive List Negative list – only for Asthma, which is excluded from coverage Grouping of Pharmaceuticals – since 1998, therapeutic groups and generic substitution have been introduced
Germany 1995: Negative List Grouping of Pharmaceuticals A regional budget for pharmaceutical expenditure with a spending cap Remark: The regional budget was not effective in containing pharmaceutical expenditure	2004: Negative Lists Positive Lists Pharmaceutical budgets for individual prescribers (not really effective) Grouping of Pharmaceuticals
Greece 1995: Price regulation Positive List Budget for pharmaceutical expenditure for each HIF Remark: The positive list was introduced by one HIF, the IKA, but not effective. The budget for pharmaceutical expenditure for each HIF is set by the state, but is not effective.	2004: Price regulation Positive List Budget for pharmaceutical expenditure for each HIF Remark: A positive list for the whole country was introduced in 2004, but not effective and was abolished shortly afterwards. The budget for pharmaceutical expenditure for each HIF is

PH1 Which of the following **Regulations on Pharmaceuticals** are in place in [Country]?	
	set by the state, but is not effective.
Hungary 1995 Price control – prices are negotiated among the manufacturer and a government committee Positive List	2004: Price control – prices are negotiated among the manufacturer and a government committee Positive List
Ireland 1995: Price control - prices may not be higher than in the UK Positive Listing Pharmaceutical budgets for individual prescribers – since 1993, there is the Indicative Drug Targeting Saving Scheme, which is an indicative target for the GP's spending for pharmaceuticals prescribed to medical card holders Remark: Even if licensed, a pharmaceutical needs to be on the positive list, in order to have a substantial market.	2004: Price control - prices may not be higher than in the UK Positive Listing Pharmaceutical budgets for individual prescribers – since 1993, there is the Indicative Drug Targeting Saving Scheme Remark: Even if licensed, a pharmaceutical needs to be on the positive list, in order to have a substantial market
Italy 1995. Price control - price must not be higher than the European average price Positive Listings Negative Listings Overall budget for pharmaceuticals – introduced in 1994, this is however not really binding	2004: Price control - price must not be higher than the European average price Positive Listings Negative Listings Overall budget for pharmaceuticals since 1994 – this is however not really binding
Luxembourg 1994: Negative List	2004: Positive List Remark: Since 2002 but only for medicines in out-patient use
Netherlands 1995: Positive list – the Ministry of Health decides, whether the product is reimbursable by the HIFs Grouping of Pharmaceuticals	2004: Positive list Grouping of Pharmaceuticals with reference pricing Remark: There is also an overall ceiling for pharmaceutical expenditure targets
New Zealand 1995: Price Control Positive Listings Overall Pharmaceutical budget Grouping of Pharmaceuticals	2004: Price Control Positive Listing Overall pharmaceutical budget Grouping of Pharmaceuticals
Norway 1995: Price control – the price is controlled by the National Medicines Agency Positive Listing ("blue list") Grouping of Pharmaceuticals – the National	2004: Price control Positive Listing Grouping of Pharmaceuticals

PH1 Which of the following **Regulations on Pharmaceuticals** are in place in [Country]?	
Medicines Agency issues lists of substitutes for certain product classes	
Portugal 1995: Price control – based on the prices in other countries Positive Lists	2004: Price control – based on the prices in other countries Positive Lists Grouping of medicines with reimbursement based on reference pricing Remark: Since 2003, there is a grouping for medicines which are no longer protected by a patent. Reimbursement is based on a reference pricing system: the most expensive generic in the group is the reference for a therapeutic group, and this price may not exceed 65% of the original's price.
Poland 1995: Price control – the price is oriented at the level of the price in other countries Positive listing Overall pharmaceutical budget – a share of the health budget is earmarked for pharmaceuticals Grouping of pharmaceuticals	2004: Price control Positive listing Overall pharmaceutical budget Grouping of pharmaceuticals
Spain 1995: Price control Negative lists	2004: Price control Negative lists Grouping of Medicines
Sweden 1995: Negative Lists Positive Listing Grouping of Pharmaceuticals – since 1993 for generics	2004: Negative Lists Positive Listing Grouping of Pharmaceuticals; extended in 2002
Switzerland 1995: Positive Listing Remark: The Inter-Cantonal Office for the Control of Medicines and the Federal Office of Social Insurance decide on the coverage – i.e. the inclusion in the positive list.	2004: Positive listing Remark: The Inter-Cantonal Office for the Control of Medicines and the Federal Office of Social Insurance decide on the coverage – i.e. the inclusion in the positive list.
United Kingdom 1995: Negative Listing Budgets for pharmaceutical spending - indicative budgets for individual prescribers, albeit not binding since 1990	2004: Negative Listing -only products of doubtful value e.g. cough medicines, are excluded Positive Listing - while all licensed products can be prescribed, some Hospitals have their own lists to make control of usage and expenditure easier. Budgets for pharmaceutical spending - management budgets for pharmaceutical spending for individual prescribers, albeit for

PH1 Which of the following **Regulations on Pharmaceuticals** are in place in [Country]?	
Remark: While prices are not controlled, the overall profit a manufacturer may make from sales to the NHS is limited by an agreement.	purposes of management only and not binding Remark: While prices are not controlled, the overall profit a manufacturer may make from sales to the NHS is limited by an agreement.

PH2 Thinking about the introduction of new medicines: Is the **Price or the Coverage** by the Health Care System of a new medicine based on a evaluation of its medical efficacy and degree of innovation compared to existing medicines?	
Austria 1995: In principle price and coverage are based on an evaluation of medical efficacy. Remark: The form of evaluation does not fit the standards of NICE and is handled lax	2004: In principle price and coverage are based on an evaluation of medical efficacy Remark: The form of evaluation does not fit the standards of NICE and is handled lax
Belgium 1995: Price and coverage are based on an evaluation of medical efficacy Remark: The medicine requires registration. During the process, a maximum price is set, which is based on the innovative character of the drug. The manufacturer must then apply to the INAMI; Institute National d'Assurance Maladie Invalidité, to include the drug in the remuneration by the HIFs. While about 6000 drugs are available, only 2500 are covered by the HIF system, i.e. at least partially reimbursed.	2004: Price and coverage are based on an evaluation of medical efficacy
Canada 1995: Price and coverage are based on an evaluation of medical efficacy	2004: Price and coverage are based on an evaluation of medical efficacy
Czech Republic 1995: Yes, the coverage is based on an evaluation of medical efficacy Remark: This also concerns the level of reimbursement, i.e. whether the patients is full, partly or not at all reimbursed.	2004: Yes, the coverage is based on an evaluation of medical efficacy Remark: This also concerns the level of reimbursement, i.e. whether the patients is full, partly or not at all reimbursed.
Denmark 1995: Coverage, i.e. whether it is reimbursed by the HCS, is based on efficacy and the price demanded by the producer. Remark: The medicine is covered, if it is at least as effective as an existing one and has a "fair" price which is proportionate to its efficacy	2004: Coverage, i.e. whether it is reimbursed by the HCS, is based on efficacy and the price demanded by the producer. Remark: The medicine is covered, if it is at least as effective as an existing one and has a "fair" price which is proportionate to its efficacy
Finland 1995: No Remark: The Pharmaceuticals Pricing Board only includes a new drug into reimbursement by the NHI, if the price is "reasonable".	2004: Price and coverage are based on an evaluation of medical efficacy Remark: The Pharmaceuticals Pricing Board only includes a new drug into reimbursement by the NHI, if the price is reasonable. The decision is based on an explicit medical evaluation: Since 1997, therapeutic value and

PH2 Thinking about the introduction of new medicines: Is the **Price or the Coverage** by the Health Care System of a new medicine based on a evaluation of its medical efficacy and degree of innovation compared to existing medicines?	
	cost effectiveness must be demonstrated.
France 1995: Price and coverage are based on an evaluation of medical efficacy Remark: The efficacy is compared to existing medicines. Depending on the therapeutic value, and substitutability, the reimbursement rate is 100, 65 or 35%	2004: Price and coverage are based on an evaluation of medical efficacy Remark: The efficacy is compared to existing medicines. Depending on the therapeutic value, and substitutability, the reimbursement rate is 100, 65 or 35%
Germany 1995: No	2004: Factually not Remark: While price and coverage are only indirectly based on medical efficacy, by assigning them to classes of products, which determines whether the product is reimbursed by the HIFs and at what price.
Greece 1995: No, neither Remark: Prices are highly regulated, but the regulation follows financial aspects.	2004: Coverage is based on an evaluation of medical efficacy; since 1997 Remark: Prices are highly regulated, but the regulation follows financial aspects.
Hungary 1995: Coverage is based on an evaluation of medical efficacy Remark: “coverage” concerns the subsidy paid to the patient, which varies according to the class of the medicine	2004: Coverage is based on an evaluation of medical efficacy Remark: “coverage” concerns the subsidy paid to the patient, which varies according to the class of the medicine
Ireland 1995: Coverage is based on an evaluation of medical efficacy	2004: Coverage is based on an evaluation of medical efficacy
Italy 1995: Coverage is based on an evaluation of medical efficacy Remark: The Comissione Unica per if Farmaco, consisting of scientists, decides on public funding of a new drug. The price also influences the decision on coverage.	2004: Coverage is based on an evaluation of medical efficacy Remark: The Comissione Unica per if Farmaco, consisting of scientists, decides on public funding of a new drug. The price also influences the decision on coverage.
Luxembourg 1994: No	2004: Yes, coverage is based on medical efficacy
Netherlands 1995: Yes, the coverage is based on an evaluation of medical efficacy	2004: Coverage, i.e. whether it is reimbursed by the HCS, is based on medical efficacy

PH2 Thinking about the introduction of new medicines: Is the **Price or the Coverage** by the Health Care System of a new medicine based on a evaluation of its medical efficacy and degree of innovation compared to existing medicines?	
New Zealand 1995: Yes, the coverage and price of a new medicine is based on an evaluation of medical efficacy and cost effectiveness	2004: Yes, the coverage and the price (reimbursement price) of a new medicine is based on an evaluation of medical efficacy and cost effectiveness Remark: The PHARMAC is in charge of evaluating medicines and recommending price and coverage
Norway 1995: Yes, the price is based on an evaluation of medical efficacy Remark: The Norwegian Medicines Agency is in charge of controlling most aspects of the pharmaceutical sector, including coverage, pricing and reimbursement classification.	2004: Yes, the price is based on an evaluation of medical efficacy Remark: The Norwegian Medicines Agency is in charge of controlling most aspects of the pharmaceutical sector
Portugal 1995: Yes, price and coverage is based on an evaluation of medical efficacy Remark: The INFARMED can request cost-effectiveness studies to justify coverage by the NHS. This institute also determines, the percentage to which the medicine is reimbursed by the NHS	2004: Yes, price and coverage are based on an evaluation of medical efficacy; Remark: The INFARMED can request cost-effectiveness studies to justify coverage by the NHS. This institute also determines, the percentage to which the medicine is reimbursed by the NHS
Poland 1995 No, neither price and coverage is based on an evaluation of medical efficacy Remark: Before a drug is registered, the manufacturer has to prove its efficacy. The reimbursement price is compared to the prices of existing products. The whole process is however not formally based on a medical evaluation.	2004: No, neither price and coverage is based on an evaluation of medical efficacy Remark: Before a drug is registered, the manufacturer has to prove its efficacy. The reimbursement price is compared to the prices of existing products. The whole process is however not formally based on a medical evaluation.
Spain 1995: Yes, the coverage is based on an evaluation of medical efficacy	2004: Yes, the coverage is based on an evaluation of medical efficacy
Sweden 1995: Coverage, i.e. whether it is reimbursed by the HCS, is based on efficacy and price	2004: Coverage, i.e. whether it is reimbursed by the HCS, is based on efficacy and price Remark: The reimbursement price is negotiated between the Producer and the National Social Insurance Board
Switzerland 1995: Price and coverage of new medicines are based on an evaluation of medical efficacy	2004: Price and coverage of new medicines are based on an evaluation of medical efficacy

PH2 Thinking about the introduction of new medicines: Is the **Price or the Coverage** by the Health Care System of a new medicine based on a evaluation of its medical efficacy and degree of innovation compared to existing medicines?	
Remark: The Inter-Cantonal Office for the Control of Medicines and the Federal Office of Social Insurance decide on the coverage – i.e. the inclusion in the positive list.	Remark: The Inter-Cantonal Office for the Control of Medicines and the Federal Office of Social Insurance decide on the coverage – i.e. the inclusion in the positive list.
United Kingdom 1995: The coverage ("licensing") is based loosely on an evaluation of efficacy	2004: The coverage ("licensing") is based loosely on an evaluation of efficacy Remark: NICE makes recommendations, but prescribers are free to abide to them.

PH3 Generic products are medicines which are chemically identical to a branded medicine, but sold in a different dosage, form and under a different name. In some countries, branded medicines can be substituted by cheaper generic products, in others, this is forbidden. How is **Generic Substitution** regulated in [Country]?	
Austria 1995: Generic substitution is allowed but voluntary	2004: Generic substitution is encouraged by setting financial incentives
Belgium 1995: Generic substitution is allowed. Remark: Factually it was still forbidden, since the legal basis to do so was not completely defined in a way which would allow generic substitution to be implemented	2004: Generic substitution is encouraged but voluntary Remark: In 2000, the share of generics was only about 1% - partly, because the price difference to the branded products is small and there are only few generics substitutes available.
Canada 1995: Generic substitution is encouraged Remark: The situation differs among provinces. In some, it is compulsory. In all of them, there is a financial incentive to use generics.	2004: Generic substitution is encouraged Remark: The situation differs among provinces. In some, it is compulsory. In all of them, there is a financial incentive to use generics.
Czech Republic 1995: Generic substitution is encouraged Remark: There is a financial incentive to use generics, since they do not require out-of pocket payments.	2004: Generic substitution is encouraged Remark: There is a financial incentive to use generics, since they do not require out-of pocket payments.
Denmark 1995: Generic substitution is encouraged Remark: Doctors are encouraged by the Government to prescribe generics, 46% of the pharmaceutical consumption are generics	2004: Generic substitution is encouraged, if generic substitution is possible, it is compulsory unless the Prescriber indicates otherwise
Finland 1995: Generic substitution is forbidden Remark: The Prescriber had to give the brand name of the medicine. Factually, there were no possibilities for substitution.	2004: Generic substitution is encouraged Remark: While generic substitution is now possible, the volume of generic substitution is still small.
France 1995: Generic substitution is encouraged Remark: Factually, there was no generic market up to 1997	2004: Generic substitution is encouraged Remark: The necessary classification of groups of equivalent products has been made
Germany 1995: Generic substitution is allowed but voluntary Remark: There is some financial encouragement addressing the patients	2004: Generic substitution is encouraged Remark: There is some financial encouragement addressing the patients

PH3 Generic products are medicines which are chemically identical to a branded medicine, but sold in a different dosage, form and under a different name. In some countries, branded medicines can be substituted by cheaper generic products, in others, this is forbidden. How is **Generic Substitution** regulated in [Country]?	
Greece 1995: Generic substitution is allowed but voluntary Remark: There is factually no generic market. There is however the distinction among a branded original and a product from an alternative producer.	2004: Generic substitution is allowed but voluntary Remark: There is factually no generic market. There is however the distinction among a branded original and a product from an alternative producer.
Hungary 1995: Generic substitution is allowed but voluntary	2004: Generic substitution is allowed but voluntary
Ireland 1995: Generic substitution is voluntary, but encouraged	2004: Generic substitution is voluntary but encouraged
Italy 1995: Factually no generic substitution Remark: The term “generic” was introduced in the health legislation in 1995 for the first time	2004: Generic substitution is allowed but voluntary. Remark: It is however factually encouraged since the patient has to pay the difference in prices. Some regions are quite active in promoting the usage of generics by providing information on substitutes to GPs. Still, in 2001, generics accounted only for about 3% of the market.
Luxembourg 1994 Generic substitution is allowed but voluntary	2004: Generic substitution is allowed but voluntary
Netherlands 1995: Generic substitution is allowed but voluntary	2004: Generic substitution is encouraged Remark: There are financial incentives for the pharmacists as well as for the patients to use generics
New Zealand 1995: Generic substitution is allowed but voluntary	2004: Generic substitution is encouraged Remark: The Health system only pays the price of the generic of a therapeutic group – the patient has to pay the difference, if he wants a branded product. This sets a strong incentive.
Norway 1995: Generic substitution allowed but voluntary Remark: While there are financial incentives to use a cheaper product (the patient has to pay the difference between the cheapest product and the product used), there are no particular incentives addressing the usage of generics.	2004: Generic substitution is allowed but voluntary Remark: While there are financial incentives to use a cheaper product (the patient has to pay the difference between the cheapest product and the product used), there are no particular incentives addressing the usage of generics
Portugal 1995: Generic substitution is forbidden	2004: Generic substitution is allowed but voluntary

PH3 Generic products are medicines which are chemically identical to a branded medicine, but sold in a different dosage, form and under a different name. In some countries, branded medicines can be substituted by cheaper generic products, in others, this is forbidden. How is **Generic Substitution** regulated in [Country]?	
Remark: Generic substitution was forbidden till 2003	Remark: If both the prescribing physician and the patient don't oppose to it; the pharmacist can substitute, if the prescriber has indicated so. There are financial incentives addressing the patient to choose a generic. The pharmacists doesn't have an incentive to substitute. The role of generics is nevertheless substantial.
Poland 1995: Generic substitution is allowed but voluntary Remark: There were no incentives in place to encourage doctors to prescribe generics.	2004: Generic substitution is allowed but voluntary Remark: There are still no incentives in place to encourage doctors to prescribe generics. But there is some discussion to introduce such.
Spain 1995: Generic substitution is allowed but voluntary	2004: Generic substitution is compulsory, unless the patient pays the difference
Sweden 1995: Generic substitution is encouraged by financial incentives	2004: Generic substitution is encouraged by financial incentives
Switzerland 1995: Generic substitution is allowed but voluntary	2004: Generic substitution is now actively encouraged by introducing incentives
United Kingdom 1995: Generic substitution is encouraged	2004: Generic substitution is encouraged

PH4 If generic substitution is possible, who decides actually, whether a generic substitute of a branded medicine is used or not?	
Austria 1995: Prescriber, e.g. physician by indicating that the pharmacists may substitute or by prescribing a certain active chemical entity, no product name	2004: Prescriber
Belgium 1995: Prescriber; The pharmacists; The patient can tell whether he wants to substitute or not Remark: While the legal possibility to substitute was given, the substitution as such was not possible	2004: Prescriber; The pharmacists; The patient can tell whether he wants to substitute or not
Canada 1995: Prescriber; The pharmacists The patient can tell whether he wants to substitute or not	2004: Prescriber; The pharmacists The patient can tell whether he wants to substitute or not
Czech Republic 1995: Prescriber; The patient can tell whether he wants to substitute or not Remark: The patient has an incentive to demand a generic, which is available without co-payments.	2004: Prescriber; The patient can tell whether he wants to substitute or not Remark: The patient has an incentive to demand a generic, which is available without co-payments.
Denmark 1995: Prescriber; i.e. Physician can exclude generic substitution by indicating so The pharmacists can substitute, if the prescriber has not indicated otherwise The patient can tell, that he wants a more expensive product, but he has to pay the difference between the cheapest generic (the price of which is covered by the health system) and the price of the product he chose	2004: Prescriber; i.e. Physician can exclude generic substitution by indicating so The pharmacists must substitute, if the prescriber has not indicated otherwise (since 1997) The patient can tell, that he wants a more expensive product, but he has to pay the difference between the cheapest generic (the price of which is covered by the health system) and the price of the product he chose
Finland 1995: Generic substitution was forbidden	2004: The patient can tell whether he wants to substitute or not
France 1995: Pharmacists; unless the physician forbids it explicitly	2004: The physician can prescribe a generic name (since 2002) Pharmacists; unless the physician forbids it explicitly Remark: There is a “target rate” of substitution

PH4 If generic substitution is possible, who decides actually, whether a generic substitute of a branded medicine is used or not?	
	negotiated between the Pharmacists association and the state
Germany 1995: The Prescriber in accordance with the patient, who can tell, whether he wants a generic or not – in the later case, the patient has to pay the price difference	2004: The Prescriber in accordance with the patient, who can tell, whether he wants a generic or not. In the later case, the patient has to pay higher costs arising from the price difference.
Greece 1995: The prescriber can choose among branded originals and alternative products The pharmacist may not substitute without explicit authorization.	2004: The prescriber can choose among branded originals and alternative products The pharmacist may not substitute without explicit authorization.
Hungary 1995: Prescriber – by indicating substitution or by not prescribing a brand name.	2004: Prescriber – by indicating substitution or by not prescribing a brand name.
Ireland 1995: Prescriber – by indicating substitution or by not prescribing a name. In the later case, the dispensing pharmacist can substitute	2004: Prescriber– by indicating substitution or by not prescribing a name. In the later case, the dispensing pharmacist can substitute
Italy 1995: Factually no generic substitution	2004: The Prescriber, for positive list drugs only The patient can decide, whether he is ready to pay the mark up for a branded product
Luxembourg 1994: prescriber	2004: Prescriber
Netherlands 1995: Prescriber, e.g. physician Remark: The Pharmacists need the approval of the physician to substitute	2004: Prescriber Remark: The patient can insist on a certain product, but has to pay the difference among both prices.
New Zealand 1995: Prescriber The patient can indicate that he is willing to pay the higher price of a branded product	2004: Prescriber The patient can indicate that he is willing to pay the higher price of a branded product
Norway 1995: Prescriber, the physician can propose substitution Patient can oppose	2004: Pharmacist can unilaterally chose a generic, but Prescriber and Patient can oppose Remark: Factually, neither patient nor prescriber have an incentive to use generics, but the pharmacist has. Factually, generic substitution is growing.
Portugal 1995: Generic substitution was forbidden	2004: Prescriber can indicate substitution The Patient can accept or oppose substitution The pharmacists can substitute, if neither the prescriber nor the patient oppose.

PH4 If generic substitution is possible, who decides actually, whether a generic substitute of a branded medicine is used or not?	
Poland 1995: The Prescriber can prescribe a branded or a generic product and no product name The pharmacists can substitute, if it is not marked on the prescription, that the product may not be substituted The patient can ask for a cheaper alternative.	2004: The Prescriber can prescribe a branded or a generic product and no product name The pharmacists can substitute, if it is not marked on the prescription, that the product may not be substituted The patient can ask for a cheaper alternative.
Spain 1995: Prescriber can indicate Patient can opt for a branded product Remark: If the patient opts for a branded product, he has to pay the difference between the prices	2004: Prescriber The Pharmacist has to substitute, if a generic exists, unless the patient indicates otherwise The patient can indicate a preference for the original, but has to pay the difference
Sweden 1995: Prescriber, e.g. physician can indicate that the pharmacists may not substitute. The pharmacist is - as a baseline - is required to substitute The patient can reject the substitute, but has to pay the difference among the prices of the branded original and the generic.	2004: Prescriber, e.g. physician can indicate that the pharmacists may not substitute. The pharmacist is - as a baseline - is required to substitute The patient can reject the substitute, but has to pay the difference among the prices of the branded original and the generic.
Switzerland 1995: Patient can tell, whether he wants a generic or not	2004: Patient can tell, whether he wants a generic or not
United Kingdom 1995: Prescriber The Pharmacist may substitute, if the physician did not indicate otherwise; since 1995	2004: Prescriber

PH5 Can the patient reduce his costs, e.g. the co-payment for medicines, by choosing a generic medicine or the cheapest product of a therapeutic class?	
Austria 1995: Co-payments cannot be reduced by choosing a less expensive but equivalent product e.g. a generic Remark: There is a fixed co-payment; prescription fee, independent of the price of the product	2004: Co Payments can be reduced Remark: There is a fixed co-payment; prescription fee, independent of the price of the product; this co-payment can in some cases be reduced.
Belgium 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The price of the generic is lower, and the co payment is a percentage of the price	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The price of the generic is lower, and the co payment is a percentage of the price
Canada 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: Most of the pharmaceutical expenditure is made by the patients themselves, albeit often subsidized by the provincial government. This sets an incentive to use a cheaper alternative.	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: Most of the pharmaceutical expenditure is made by the patients themselves, albeit often subsidized by the provincial government. This sets an incentive to use a cheaper alternative.
Czech Republic 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The generic is not subject to co-payments.	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The generic is not subject to co-payments
Denmark 1995: Co-payments can be reduced by choosing a generic substitute or the cheapest product of a therapeutic class. Remark: The level of co-payment depends on the price of the medicine, consequentially, it is lower for a cheaper product	2004: Co-payments can be reduced by choosing a less expensive equivalent
Finland 1995: Generic substitution was forbidden	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The co-payment is a certain percentage of the price.
France 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The co-payment is the difference between the price and the reimbursement paid by the HIF. If the product is cheaper, the co-payment is	2004: Co-payments can be reduced by choosing a less expensive but equivalent product

PH5 Can the patient reduce his costs, e.g. the co-payment for medicines, by choosing a generic medicine or the cheapest product of a therapeutic class?	
lower	
Germany 1995 Co-payments can be reduced by choosing a less expensive but equivalent product Remark: For those groups, for which reference prices are introduced, the patient would have to pay the price difference if choosing a branded product	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: For those groups, for which reference prices are introduced, the patient would have to pay the price difference if choosing a branded product
Greece 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The co-payment is a certain percentage of the price, varying among HIFs. Since few generics are available, and the price regulation results in only small differences among substitutes and branded originals, the financial incentive to choose a alternative to the branded original is weak.	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The co-payment is a certain percentage of the price, varying among HIFs. Since few generics are available, and the price regulation results in only small differences among substitutes and branded originals, the financial incentive to choose a alternative to the branded original is weak.
Hungary 1995 Co-payments can be reduced by choosing a less expensive but equivalent product Remark: Co payments are a percentage of the price	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: Co payments are a percentage of the price
Ireland 1995: For Medical Card holders, one third of the population, there are no co-payments. Co-payments for the rest of the population cannot be reduced by choosing a less expensive but equivalent product	2004: For Medical Card holders, one third of the population, there are no co-payments. Co-payments for the rest of the population cannot be reduced by choosing a less expensive but equivalent product
Italy 1995. Co-payments cannot be reduced by choosing a less expensive but equivalent product; Factually, generic substitution was not possible	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: There is a financial incentive, since the patient has to pay the difference between the generic product and the branded one. the patient has to pay a percentage of the price, which is a larger amount if the product is a more expensive branded product.
Luxembourg 1994: Co-payments cannot be reduced by choosing a less expensive but equivalent product	2004: Co-payments cannot be reduced by choosing a less expensive but equivalent product
Netherlands 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The patient obtains the average price of the	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The patient obtains the average price of the

PH5 Can the patient reduce his costs, e.g. the co-payment for medicines, by choosing a generic medicine or the cheapest product of a therapeutic class?	
therapeutic class as a reimbursement. If the price of the medicine is above that, the patient has to pay the difference	therapeutic class as a reimbursement. If the price of the medicine is above that, the patient has to pay the difference
New Zealand 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The Prescriber prescribes the cheapest product of a therapeutic class. If the patient wants a more expensive product, he has to pay the difference.	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: The Prescriber prescribes the cheapest product of a therapeutic class. If the patient wants a more expensive product, he has to pay the difference.
Norway 1995: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: Since 1993, only the cheapest drug of a group is covered – if a more expensive product is used, the patient has to cover the difference. While there is no incentive to use generics, the price incentive is effective.	2004: Co-payments can be reduced by choosing a less expensive but equivalent product Remark: While the patient has to pay the difference between the reimbursement price (paid by the NIS) and the actual price, there is still no specific incentive to use a generic. But the price incentive of generics being cheaper still works.
Portugal 1995: Generic substitution was forbidden	2004: Yes, co-payments can be reduced by choosing a less expensive but equivalent product Remark: The co-payment is a percentage of the price and the price difference between the branded original and the generic substitute is substantial.
Poland 1995: Yes, co-payments can be reduced by choosing a less expensive but equivalent product Remark: The co-payment is in some cases a percentage of the actual price, in others, its a lump sum payment.	2004: Yes, co-payments can be reduced by choosing a less expensive but equivalent product Remark: The co-payment is the difference between the reimbursement price and the actual price.
Spain 1995: No, co-payments cannot be reduced Remark: Since there is a price difference between generics and branded products, there is an incentive since the co-payment is a percentage of the price. Since the price difference is not that large, the incentive is not strong.	2004: No, co-payments cannot be reduced Remark: Since there is a price difference between generics and branded products, there is an incentive since the co-payment is a percentage of the price. Since the price difference is not that large, the incentive is not strong.
Sweden 1995: Co-payments can be reduced by choosing a less expensive but equivalent product.	2004: Co-payments can be reduced by choosing a less expensive but equivalent product.

PH5 Can the patient reduce his costs, e.g. the co-payment for medicines, by choosing a generic medicine or the cheapest product of a therapeutic class?	
Remark: Agreeing to generic substitution saves money, since patients have to pay a certain percentage of the price, respectively the difference between the price of the generic and the branded product	Remark: Agreeing to generic substitution saves money, since patients have to pay a certain percentage of the price, respectively the difference between the price of the generic and the branded product
Switzerland 1995: Co-payments cannot be reduced by choosing a less expensive but equivalent product	2004: Co-payments can be reduced by choosing a less expensive but equivalent product since 1996
United Kingdom 1995: Co-payments cannot be reduced by choosing a less expensive but equivalent product – they concern the prescription itself	2004: Co-payments cannot be reduced by choosing a less expensive but equivalent product

4. The patients

4.1 "Cost-Reimbursement" and "Services in kind"

Health Systems differ with regard to how patients are involved in the payment of providers. In some countries, medical providers are first paid by the patients, who are later reimbursed by the Purchaser (Health Insurance Funds or Health Authority). In others, patients are not involved in the payment of the provider at all.

Under **service in kind**, the patient is not involved in the payment of providers, in particular the patient does not receive a bill listing the services provided.

Under **cost reimbursement** the patient receives the bill from the provider.
The bill is either paid directly by the patient, and handed in to the Purchaser (Health Insurance Funds / Health Authorities) for reimbursement ("bill paid and reimbursed later").
Or it is directly passed on to the Purchaser ("bill passed on").

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
Austria 1995 Services in kind: General Practitioners (GPs) / Primary Care Physicians Specialists Laboratory services (analysis of blood samples, tissue analysis) Dentists/ Dental Care Dentures Hospital / In-patient services Medicines Medical devices, like spectacles	2004: Services in kind: General Practitioners / Primary Care Physicians Specialists Laboratory services Dentists Dentures Hospital / In-patient services Medicines Medical devices, like spectacles
Belgium 1995: CR: Bill paid and reimbursed later GP / primary care Ambulatory Specialized services Ambulatory Laboratory services Hospitals / in-patient services – only a per diem is paid, the rest is paid by the HIF Dentists (limited reimbursement) Dentures (limited reimbursement only) Medicines – the patient pays only the deductible Medical devices (limited reimbursement, no reimbursement in some cases) Remark: Usually the patient pays and the gets reimbursed by the HIF, subject to a 25% deductible	2004: CR: Bill paid and reimbursed later GP / primary care Ambulatory Specialized services Ambulatory Laboratory services Hospitals / in-patient services – only a per diem is paid, the rest is paid by the HIF Dentists (limited reimbursement) Dentures (limited reimbursement only) Medicines – the patient pays only the deductible Medical devices (limited reimbursement, no reimbursement in some cases) Remark: Usually the patient pays and the gets reimbursed by the HIF, subject to a 25% deductible
Canada 1995: Service in kind for GP / Primary Care Specialists	2004: Service in kind for GP / Primary Care Specialists

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
Laboratory services in Hospitals Hospitals / In-patient services Not covered by the Health System Dental care Dentures Medicines Medical devices like spectacles Remark: Services not covered are either paid out of pocket or by the patient's supplementary insurance	Laboratory services in Hospitals Hospitals / In-patient services Not covered by the Health System: Dental care Dentures Medicines Medical devices like spectacles Remark: Services not covered are either paid out of pocket or by the patient's supplementary insurance
Czech Republic 1995: Service in kind for GPs/Primary Care Specialists Laboratory services Hospital / In-patient services Medicines Medical devices, like spectacles Dentists Dentures Remark: Some dental treatments which are not standard, are not covered. Usually, there is a co-payment for the usage of better materials in dental care	2004: Service in kind for GPs/Primary Care Specialists Laboratory services Hospital / In-patient services Medicines Medical devices, like spectacles Dentists Dentures Remark: Some dental treatments which are not standard, are not covered. Usually, there is a co-payment for the usage of better materials in dental care
Denmark 1995 Service in kind for: GPs, Primary Care Specialists Laboratory services, Hospitals and Inpatient services Medicines are provided in kind but are subject to co-payments Medical devices like prostheses are provided in kind Medical devices like spectacles are paid by the patients themselves Dental Care and Dentures are predominantly paid for by the patients themselves. For some groups, elderly with low income, the municipality subsidizes dental care Remark: The bill is directly passed on from the provider to the Amter	2004: Service in kind for: GPs, Primary Care Specialists Laboratory services, Hospitals and Inpatient services Medicines are provided in kind but are subject to co-payments Medical devices like prostheses are provided in kind Medical devices like spectacles are paid by the patients themselves Dental Care and Dentures are predominantly paid for by the patients themselves. For some groups, elderly with low income, the municipality subsidizes dental care Remark: The bill is directly passed on from the provider to the Amter
Finland 1995: Service in kind for GPs/Primary Care Physicians Specialists	2004: Service in kind for GPs/Primary Care Physicians Specialists

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
Laboratory services Dentists – in Health Centers Hospitals/In-patient services Medicines Some Medical devices CR bill is paid and reimbursed later Medicines Dental care provided by private providers Dentures Remark: Services provided by municipal Health Centers and Hospitals are provided in kind, but are subject to co-payments. Medicines and most of dental care (most of which is provided by private providers) is first paid for and then partly reimbursed by the NHI	Laboratory services Dentists – in Health Centers Hospitals/In-patient services Medicines Some Medical devices CR bill is paid and reimbursed later Medicines Dental care provided by private providers Dentures Remark: Services provided by municipal Health Centers and Hospitals are provided in kind, but are subject to co-payments. Medicines and most of dental care (most of which is provided by private providers) is first paid for and then partly reimbursed by the NHI
France 1995: CR bill is paid and reimbursed later: GPs/Primary Care Physicians Specialists Laboratory services, Dentists Dentures Hospitals/In-patient services Medicines Medical devices Remark: There was not really a bill, listing the services and their price, but a leaflet given to the patient which passed it on to the Health Insurance Fund. Factually, patients only paid for GPs, Specialists and Medicines. The rest was paid directly from the Health Insurance Funds to the Providers	2004: CR bill is paid and reimbursed later GPs/Primary Care Physicians Specialists Laboratory services, Dentists Dentures Hospitals/In-patient services Medicines Medical devices Remark: Since the diffusion of a special electronic system of reimbursement; “carte vitale”, linking Mandatory Health Insurance and providers directly, third party payment concerns about 75% of expenditures
Germany 1995: Services in kind: GPs and Primary Care Specialists Laboratory services Dentists Hospital / In-patient services Medicines Medical devices CR: Bill paid and reimbursed later for Dentures Remark: For some medical devices, e.g. spectacles,	2004: Services in kind: GPs and Primary Care Specialists Laboratory services Dentists Hospital / In-patient services Medicines Medical devices CR: Bill paid and reimbursed later for Dentures Remark: For some medical devices, e.g. spectacles, the

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
the patient pays the bill and gets a reimbursement of a certain amount from the Health Insurance Fund. In this case, the patient has to pay the difference.	patient pays the bill and gets a reimbursement of a certain amount from the Health Insurance Fund. In this case, the patient has to pay the difference.
Greece 1995: Services in kind: GPs and Primary Care Physicians Specialists Laboratory services Dentists Dentures Hospital / In-patient services Medicines CR: Bill paid and reimbursed later for: Medical devices, like spectacles Remark: The handling differs among services provided by the ESY as opposed to private providers and also among the HIF. There is a parallel-system of private provision and purchasing of services. The above information refers only to services obtained from public providers. If the service is paid for by the HIF, the handling differs among the HIF. Privately purchased services have to be paid privately, subject to coverage by a Supplementary Insurance. Dental care is predominantly provided on private terms.	2004: Services in kind: GPs and Primary Care Physicians Specialists Laboratory services Dentists Dentures Hospital / In-patient services Medicines CR: Bill paid and reimbursed later for: Medical devices, like spectacles Remark: The handling differs among services provided by the ESY as opposed to private providers and also among the HIF. There is a parallel-system of private provision and purchasing of services. The above information refers only to services obtained from public providers. If the service is paid for by the HIF, the handling differs among the HIF. Privately purchased services have to be paid privately, subject to coverage by a Supplementary Insurance. Dental care is predominantly provided on private terms.
Hungary 1995: Service in kind for GPs and Primary Care Physicians Specialists Laboratory services In patient services / Hospitals CR: Bill passed on for Dental care Dentures Medicines Medical devices Remark: Most dental care is not covered by the health system. The bills for the dental care, medicines and medical devices are passed on to the VHI	2004: Service in kind for GPs and Primary Care Physicians Specialists Laboratory services In patient services / Hospitals CR: Bill passed on for Dental care Dentures Medicines Medical devices Remark: Most dental care is not covered by the health system. The bills for the dental care, medicines and medical devices are passed on to the VHI
Ireland 1995: Fees paid for GPs / Primary Care Physicians – the fees are paid completely, payment by the VHI are subject to substantial deductibles	2004: Fees paid for GPs / Primary Care Physicians – the fees are paid completely, payment by the VHI are subject to substantial deductibles

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
Service in kind for Specialists (provided in hospitals) Hospital / In-patient services Some laboratory services Medicines (subject to co-payment) Medical devices (co-payments) CR bill paid and reimbursed later by the Voluntary Health Insurance for some Laboratory services Dentists Dentures Remark: For Medical Card Holders, 1/3 of the population, all services are provided in kind and usually without co-payments	Service in kind for Specialists (provided in hospitals) Hospital / In-patient services Some laboratory services Medicines (subject to co-payment) Medical devices (co-payments) CR bill paid and reimbursed later by the Voluntary Health Insurance for some Laboratory services Dentists Dentures Remark: For Medical Card Holders, 1/3 of the population, all services are provided in kind and usually without co-payments
Italy 1995: Service in kind for GPs / Primary Care Specialists Laboratory services Hospital services Medicines Medical devices Remark: Most dental care and dentures is provided and purchased privately; there are exemptions for some medical devices and medicines	2004: Service in kind for GPs / Primary Care Specialists Laboratory services Hospital services Medicines Medical devices Remark: Most dental care and dentures is provided and purchased privately; there are exemptions for some medical devices and medicines
Luxembourg 1994: Service in kind for Hospitals / in-patient services Medicines Laboratory services (since they are provided as a part of Hospital treatment either by the Hospital's laboratory itself or by a commission of the Hospital to an independent provider) CR: Bill paid and reimbursed later for GP / primary care Specialized services Dentists Dentures Medical devices	2004: Service in kind for Hospitals / in-patient services Medicines Laboratory services (since they are provided as a part of Hospital treatment either by the Hospital's laboratory itself or by a commission of the Hospital to an independent provider) CR: Bill paid and reimbursed later for GP / primary care Specialized services Dentists Dentures Medical devices
Netherlands 1995: Service in kind for GPs / Primary Care	2004: Service in kind for GPs / Primary Care

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
Specialists Laboratory services (in Hospitals) Hospital / In-patient services Medicines Medical devices (some) CR: Bill paid and reimbursed later: Dentists Dentures Medical devices (some)	Specialists Laboratory services (in hospitals) Hospital / In-patient services Medicines Some medical devices CR: Bill paid and reimbursed later: Dentists Dentures Medical devices (some)
New Zealand 1995: Service in kind for Primary Care / GPs – the state pays a subsidy, the patient the rest Public Specialists Laboratory Services Hospital services Medicines (subject to co-payments) Remark: Dental care, Dentures, and Medical devices are predominantly paid for by the patients themselves or their VHI. Visits to specialists on private terms have to be paid for privately.	2004: Service in kind for Primary Care / GPs – the state pays a subsidy, the patient the rest Public Specialists Laboratory Services Hospital services Medicines (subject to co-payments) Remark: Dental care, Dentures, and Medical devices are predominantly paid for by the patients themselves or their VHI. Visits to specialists on private terms have to be paid for privately.
Norway 1995: Service in kind for GPs / Primary Care Specialists Laboratory services In patient care/ Hospitals Medicines CR: bill passed on for Medical devices Bill paid, since the service is not covered Dental Care Dentures Remark: Medicines are paid for by the National Insurance Scheme. Medical devices like spectacles are not covered.	2004: Service in kind for GPs / Primary Care Specialists Laboratory services In patient care/ Hospitals Medicines CR: bill passed on for Medical devices Bill paid, since the service is not covered Dental Care Dentures Remark: Medicines are paid for by the National Insurance Scheme. Medical devices like spectacles are not covered.
Portugal 1995: Service in kind for GPs and primary care Specialists in public hospitals Laboratory services Majority of Hospital services Medicines (subject to co-payments) CR: Bill passed on to subsistema / VHI for	2004: Service in kind for GPs and primary care Specialists in public hospitals Laboratory services Majority of Hospital services Medicines (subject to co-payments) CR: Bill passed on to subsistema / VHI for

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
Dental care Dentures Some Hospital services CR: Bill paid and reimbursed later for Medical devices Remark: If the service is not consumed in a facility of the NHS, the bill is usually passed on to the HIF (subsistema) or the VHI. The same is true for dental care and dentures, which are not offered/covered by the NHS. Here the patient pays the full amount, unless covered by a VHI or a subsistema, a HIF. The HIFs, called subsistemas, cover about 25% of the population. They are supposed to cover all medical care for their insured but factually every citizen insured by a HIF can also receive services from the NHS. In 1995, the patients often did not tell that they were member in a subsistema, when receiving treatment in a facility operated by the NHS. Subsistema patients pay the bills first and are then reimbursed by their subsistema.	Dental care Dentures Some Hospital services CR: Bill paid and reimbursed later for Medical devices Remark: If the service is not consumed in a facility of the NHS, the bill is usually passed on to the HIF (subsistema) or the VHI. The same is true for dental care and dentures, which are not offered/covered by the NHS. Here the patient pays the full amount, unless covered by a VHI or a subsistema, a HIF. The HIFs, called subsistemas, cover about 25% of the population. They are supposed to cover all medical care for their insured but factually every citizen insured by a HIF can also receive services from the NHS. Recently, a Patient Identity Card was introduced in order to identify the members of the subsistemas, when receiving treatment in a facility operated by the NHS. Subsistema patients pay the bills first and are then reimbursed by their subsistema.
Poland 1995: Service in kind for Primary Care Specialists Laboratory services Dental Care Dentures Hospital / in-patient services Medicines Medical Devices	2004: Service in kind for Primary Care Specialists Laboratory services Dental Care Dentures Hospital / in-patient services Medicines Medical Devices
Spain 1995: Service in kind for Primary Care Specialists Laboratory services Hospital / in-patient services Medicines Medical Devices Remark: Apart from extractions and dental care for children, dental care is not covered by the health system but purchased on private terms. Some medical devices – e.g. spectacles and hearing aids - are not covered.	2004: Service in kind for Primary Care Specialists Laboratory services Hospital / in-patient services Medicines Medical Devices Remark: Apart from extractions and dental care for children, dental care is not covered by the health system but purchased on private terms. Some medical devices – e.g. spectacles and hearing aids - are not covered.
Sweden 1995:	2004:

CR Which is the prevailing mode of payments in the Health Care System in [Country]?	
Service in kind for GPs and Primary Care Specialists Laboratory services Hospital / In-patient services Medicines Medical devices CR: Bill passed on Dentists Dentures Remark: Dental care and Dentures for adults, and Medical Devices are subsidized with a certain amount, the patient has to pay the rest	Service in kind for GPs and Primary Care Specialists Laboratory services Hospital / In-patient services Medicines Medical devices CR: Bill passed on Dentists Dentures Remark: Dental care and dentures for adults, and Medical Devices are subsidized with a certain amount, the patient has to pay the rest
Switzerland 1995: Service in kind for Hospital / in-patient services Medicines Medical devices CR: Bill paid and reimbursed later for GPs/Primary Care Specialists / specialized care Laboratory services Note: For about 50% of all services; the rest is service provided in kind Remark: Dental care and dentures are not covered by the Health System but are predominantly privately purchased	2004: Service in kind for Hospital / in-patient services Medical devices CR: Bill paid and reimbursed later for GPs/ Primary Care Specialists / specialized care Laboratory services Medicines Remark: Dental care and dentures are not covered by the Health System but are predominantly privately purchased
United Kingdom 1995: Services in kind: GPs and Primary Care Physicians Specialists Laboratory services Dentists Dentures Hospital / In-patient services Medicines Medical devices, like spectacles Remark: Service in kind concerns only those dental services and dental devices, which are covered by the Health System	2004: Services in kind: GPs and Primary Care Physicians Specialists Laboratory services Dentists Dentures Hospital / In-patient services Medicines Medical devices, like spectacles Remark: Service in kind concerns only those dental services and dental devices, which are covered by the Health System

4.2. Co-payments to medical services and medical goods

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
Austria 1995: No co-payment for Services of GPs/Primary Care Specialists/Specialized Services Laboratory services (provided by Hospitals) Co-payment of a certain percentage for Medical devices e.g. spectacles Co-payment of a certain amount for In patient services/Hospitals (a daily fee) Dental care / Dentists Dentures / "false teeth" Medicines Remark: Members of the Health Insurance Funds for the state employees, and self employed, about 20% of the population, usually have to pay a certain percentage	2004: No co-payment for: Services of GPs/Primary Care Specialists/Specialized Services Laboratory tests(provided by Hospitals) Co-payment of a certain percentage Medical devices e.g. spectacles Co-payment of a certain amount In patient services/Hospitals (daily fee) Dental care / Dentists Dentures / "false teeth" Medicines Remark: Members of the Health Insurance Funds for the state employees, and self employed, about 20% of the population, usually have to pay a certain percentage
Belgium 1995: Co-payment of a certain percentage for: GPs / Primary Care Specialists / Specialized Care Laboratory services Dental Care Dentures Medicines Medical devices Co-payment of a certain amount for In-patient services/Hospitals (a daily fee) Remark: The co-payment is a certain percentage, but with an upper limit. Thus, the co-payment is often a fixed amount, the upper level.	2004: Co-payment of a certain percentage for: GPs / Primary Care Specialists / Specialized Care Laboratory services Dental Care Dentures Medicines Medical devices Co-payment of a certain amount for In-patient services/Hospitals (a daily fee) Remark: The co-payment is a certain percentage, but with an upper limit. Thus, the co-payment is often a fixed amount, the upper level.
Canada 1995: No co-payment for: GPs / Primary Care Specialists / Specialized Care Hospitals/ Inpatient Services Laboratory services in Hospitals Payment of the price, since the service is not	2004: No co-payment for: GPs / Primary Care Specialists / Specialized Care Hospitals /Inpatient Services Laboratory services in Hospitals Payment of the price, since the service is not

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
covered by the Health System Dental Care Dentures Medicines Medical devices Remark: For services not covered there is in some cases a system of subsidies at the provincial level	covered by the Health System Dental Care Dentures Medicines Medical devices Remark: For services not covered there is in some cases a system of subsidies at the provincial level
Czech Republic 1995: No co-payment for: GPs / Primary Care Specialists / Specialized Care Inpatient Services/Hospitals Laboratory services Medical devices Co-payment of a certain amount for Dental Care Dentures Medicines Remark: The standard treatment, i.e. the cheapest treatment available is covered completely. Only extras, like better materials, incur co-payments. For instance, the co-payment for dental care and dentures concerns mostly the usage of better materials. Co-payments for medicines concern branded products, while generics are free.	2004: No co-payment for: GPs / Primary Care Specialists / Specialized Care Inpatient Services/Hospitals Laboratory services Medical devices Co-payment of a certain amount for Dental Care Dentures Medicines Remark: The standard treatment, i.e. the cheapest treatment available is covered completely. Only extras, like better materials, incur co-payments. For instance, the co-payment for dental care and dentures concerns mostly the usage of better materials. Co-payments for medicines concern branded products, while generics are free.
Denmark 1995 No co-payment for Services of GPs / Primary Care Specialists/Specialists In patient services / Hospitals Laboratory tests Co-payment as a certain percentage of the price for Medicines (depending on the price of the medicine, the percentage is 100 to 15%) Co-payment of a certain amount: Medical devices; for spectacles the whole price	2004: No co-payment for Services of GPs / Primary Care Specialists/Specialists In patient services / Hospitals Laboratory tests Co-payment as a certain percentage of the price for Medicines (depending on the price of the medicine, the percentage is 100 to 15%) Co-payment of a certain amount: Medical devices; for spectacles the whole price

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
Remark: Dental care and Dentures are paid for by the patients themselves or by their supplementary insurance	Remark: Dental care and Dentures are paid for by the patients themselves or by their supplementary insurance
Finland 1995: No co-payment for Medical devices (most of them) Co-payment of a certain percentage for Medicines Dental Care on private terms – the rest is covered by the NHI Co-payment of a certain amount for Primary Care / GPs Specialized Care – in Hospitals In patient services / Hospitals (daily charge) Laboratory services Dental care in Health Centers Payment of the full price for Dentures Remark: Usually, the co-payment is a fee per visit. Municipalities set the co-payments but a maximum level is set by the government.	2004: No co-payment for Medical devices (most of them) Co-payment of a certain percentage for Medicines Dental Care on private terms – the rest is covered by the NHI Co-payment of a certain amount for Primary Care / GPs Specialized Care – in Hospitals In patient services / Hospitals (daily charge) Laboratory services Dental care in Health Centers Payment of the full price for Dentures Remark: Usually, the co-payment is a fee per visit. Municipalities set the co-payments but a maximum level is set by the government.
France 1995: Co-payment is a certain percentage (“ticket moderateur”) plus a certain amount of extra billing/fees (dépassement honoraire) for: GPs / Primary Care Specialists In patient services / Hospitals Dentures / "false teeth" Medical devices Certain percentage: Laboratory tests Dental care / Dentists Medicines Remark: There are three types of co-payment: For those providers, (sector 2) which charge higher fees than set in the convention between the HIFs and the providers, the patient has to pay the difference; dépassement honoraire.	2004: Co-payment is a certain percentage (“ticket moderateur”) plus a certain amount of extra billing/fees (dépassement honoraire) for: GPs / Primary Care Specialists In patient services / Hospitals Dentures / "false teeth" Medical devices Certain percentage: Laboratory tests Dental care / Dentists Medicines Remark: There are three types of co-payment: For those providers, (sector 2) which charge higher fees than set in the convention between the HIFs and the providers, the patient has to pay the difference; dépassement honoraire. For some services, the “ticket moderateur” is

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
For some services, the "ticket moderateur" is a percentage of the price or the difference between the payment made form the patient to the provider and the reimbursement obtained from the HIF. Further, there are charges of a fixed amount, for instance a daily fee in hospitals	a percentage of the price or the difference between the payment made from the patient to the provider and the reimbursement obtained from the HIF. Further, there are charges of a fixed amount, for instance a daily fee in hospitals
Germany 1995: No co-payment for: GPs Primary Care Specialists and Specialized Care Laboratory Services Dental Care Co-payment of a certain percentage for Dentures Co-payment of a certain amount for In Patient services (a daily fee) Medicines (a fixed amount plus the difference of the price to the reference price) Medical devices; e.g. for spectacles the difference between the price and the fixed amount reimbursed by the HIFs	2004: No co-payment for: GPs Primary Care Specialists and Specialized Care Laboratory Services Dental Care Co-payment of a certain percentage for Dentures (35-50%) Co-payment of a certain amount for In Patient services (a daily fee) Medicines (a fixed amount plus the difference of the price to the reference price) Medical devices; e.g. for spectacles the difference between the price and the fixed amount reimbursed by the HIFs
Greece 1995: No co-payment for: GPs and Primary Care Specialists and Specialized Care In Patient services Laboratory Services Co-payment of a certain percentage for Dental Care Dentures Medicines Co-payment of a certain amount for Medical devices Remark: Again, this refers to the public system only. Co-payments differ in existence and in magnitude among the HIF.	2004: No co-payment for: GPs and Primary Care Specialists and Specialized Care In Patient services Laboratory Services Co-payment of a certain percentage for Dental Care Dentures Medicines (25%; depending on the HIF) Co-payment of a certain amount for Medical devices Remark: Again, this refers to the public system only. Co-payments differ in existence and in magnitude among the HIF.
Hungary 1995: No co-payment for: GPs and Primary Care Specialists and Specialized Care In Patient services	2004: No co-payment for: GPs and Primary Care Specialists and Specialized Care In Patient services

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
Laboratory Services Co-payment of a certain percentage for Medicines Medical devices "Co-payment" of the full amount for Dental Care Dentures Remark: Dental care is not covered by the Health system. The price of medicines is subsidized by a certain percentage, ranging from zero to 100% of the price. For medical devices, there is also a system of subsidies.	Laboratory Services Co-payment of a certain percentage for Medicines Medical devices "Co-payment" of the full amount for Dental Care Dentures Remark: Dental care is not covered by the Health system. The price of medicines is subsidized by a certain percentage, ranging from zero to 100% of the price. For medical devices, there is also a system of subsidies.:
Ireland 1995 Fees are paid completely -payments for GPs/ Primary Care Co-payment of a certain amount for In patient services / Hospitals Dental care / Dentists Dentures / "false teeth" Medicines Medical devices e.g. spectacles Remark: Laboratory tests and services by specialists are predominantly provided in Hospitals, and require not extra co-payment. For Medical Card Holders, all services are provided in kind and usually without co-payments (1/3 of the population).	2004: Fees are paid completely -payments for GPs/ Primary Care Co-payment of a certain amount for In patient services / Hospitals Dental care / Dentists Dentures / "false teeth" Medicines Medical devices e.g. spectacles Remark: Laboratory tests and services by specialists are predominantly provided in Hospitals, and require not extra co-payment. For Medical Card Holders, all services are provided in kind and usually without co-payments (1/3 of the population).
Italy 1995: No co-payment for: GPs / Primary Care Hospitals / in-patient care Co-payment of a certain amount for Some specialized services Laboratory services (X-ray etc.) Medicines Remark: Most medical devices are paid completely out of pocket. Dental care and dentures are predominantly purchased privately	2004: No co-payment for: GPs / Primary Care Hospitals / in-patient care Co-payment of a certain amount for Some specialized services Laboratory services (X-ray etc) Medicines Remark: Most medical devices are paid completely out of pocket. Dental care and dentures are predominantly purchased privately

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
Luxembourg 1994: No co-payment for: Laboratory services (provided as a part of Hospital treatment) Co-payment of a certain percentage for: GPs / Primary Care Specialists / Specialized Care Dental Care Medicines Co-payment of a certain amount for Hospital/Inpatient Services Dentures Medical devices – the HIFs reimburse a certain price, the patient has to cover the difference	2004: No co-payment for: Laboratory services (provided as a part of Hospital treatment) Co-payment of a certain percentage for: GPs / Primary Care Specialists / Specialized Care Dental Care Medicines Co-payment of a certain amount for Hospital/Inpatient Services Dentures Medical devices – the HIFs reimburse a certain price, the patient has to cover the difference
Netherlands 1995: No co-payment for Services of GPs / Primary Care Specialists/Specialists In patient services / Hospitals Laboratory tests Dental care / Dentists Dentures Medicines Medical devices (spectacles are paid out of pocket) Remark: While existent, co-payments were very limited in their magnitude.	2004: No co-payment for: GPs and Primary Care Specialists Laboratory services In patient services and Hospitals Co-payment of a certain percentage for Dental Care Dentures Some medical devices, e.g. hearing aids Co-payment of a certain amount for Medicines (the difference between the reference price and the product chosen by the patient) Medical Devices
New Zealand 1995: No co-payment for: Public Hospitals Public specialists Laboratory services in public hospitals Co-payment of a certain amount for Primary Care / GPs (the remainder of the GPs fee after the subsidy) Medicines Patients have to pay the full price of Dental Care Dentures	2004: No co-payment for: Public Hospitals Public specialists Laboratory services in public hospitals Co-payment of a certain amount for Primary Care / GPs (the remainder of the GP's fee after the subsidy) Medicines Patients have to pay the full price of Dental Care Dentures

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
Specialized care provided on private terms Most medical devices	Specialized care provided on private terms Most medical devices
Norway 1995: No co-payments for In patient / Hospital - including all services provided Co-payment of a certain amount for GPs / Primary Care Services Specialists – also if provided in a hospital's out-patient department Laboratory services – e.g. x-rays Medicines Medical devices Payment of the total amount, since the service is not covered by the Health System Dental Care – not covered for adults Dentures – not covered for adults Medical devices - like spectacles	2004: No co-payments for In patient / Hospital - including all services provided Co-payment of a certain amount for GPs / Primary Care Services Specialists – also if provided in hospitals Laboratory services Medicines Medical devices Payment of the total amount: Dental Care– not covered for adults Dentures– not covered for adults Medical devices - like spectacles
Portugal 1995: Co-payment of a certain percentage for Medicines (0% to 100%) Medical devices Co-payment of a certain amount for GPs and primary care services Specialized services if provided in a Hospital In patient services / Hospitals (charged by the hospital) Some laboratory services Dentures and Dental care are not covered by the NHS and are paid out of pocket, unless covered by a Supplementary Insurance	2004: Co-payment of a certain percentage for Medicines (0% to 100%) Medical devices Co-payment of a certain amount for GPs and primary care services Specialized services if provided in a Hospital In patient services / Hospitals (charged by the hospital) Some laboratory services Dentures and Dental care are not covered by the NHS and are paid out of pocket unless covered by a Supplementary Insurance
Poland 1995: No co-payment for: GPs/ Primary Care Specialists Hospitals / in-patient services Laboratory services Dental Care – only covered standard services Dentures Co-payment of a certain percentage for Medicines Medical Devices For both, the co-payment is the difference	2004: No co-payment for: GPs/ Primary Care Specialists Hospitals / in-patient services Laboratory services Dental Care - only covered standard services Dentures Co-payment of a certain percentage for Medicines - difference between the reimbursement price and the actual price Medical Devices – 30-50% of the price

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
between the reimbursement price and the actual price Remark: Co-payment of a certain amount instead of a percentage are in place for some groups e.g. chronically ill. Non-standard dental care is not covered by the Health System and has to be paid out of pocket.	Co-payment of a certain amount for Diagnostics – for some diagnostic procedures, a flat fee is charged Remark: Co-payment of a certain amount instead of a percentage are in place for some groups e.g. chronically ill. Non-standard dental care is not covered by the Health System and has to be paid out of pocket.
Spain 1995: No co-payment for: GPs/ Primary Care Specialists Hospitals / in-patient services Laboratory services Dental Care (the services which are covered) Most medical devices Co-payment of a certain percentage for Medicines Remark: Most dental care and dentures are privately purchased. Some medical devices are paid for out of pocket	2004: No co-payment for: GPs/ Primary Care Specialists Hospitals / in-patient services Laboratory services Dental Care (covered services) Most medical devices Co-payment of a certain percentage for Medicines Remark: Most dental care and dentures are privately purchased. Some medical devices are paid for out of pocket
Sweden 1995: No co-payment for: Laboratory tests (part of hospital treatment) Co-payment of a certain percentage for Medicines Medical devices Dental Care Co-payment of a certain amount for GPs/Primary Care services (consultation fee) Specialists Hospitals (a daily fee) Remark: Dental care, Dentures, and Medical Devices are subsidized with a certain amount, the patient has to pay the rest	2004: No co-payment for: Laboratory tests (part of hospital treatment) Co-payment of a certain percentage for Medicines Medical devices Dental Care Co-payment of a certain amount for GPs/Primary Care services (consultation fee) Specialists Hospitals(a daily fee) Remark: Dental care, Dentures, and Medical Devices are subsidized with a certain amount, the patient has to pay the rest
Switzerland 1995: Co-payment of a certain percentage for all services	2004: Co-payment of a certain percentage for all services

CP1 Do patients have to pay a co-payment for the medical services and products listed below? If so, is this co-payment a certain amount, independent of the costs of the service or is it a percentage of the costs of the service?	
Remark: For all medical services, the patient has to pay the first 150 SFR arising as medical expenditure in a year. Then, he has to pay a percentage of the price of the medical service up to a certain limit. Patients (or their VHI) have to pay the full price of Dental Care and Dentures. There is only one commercial Insurance Company which offers coverage of these payments, and there is a discussion to forbid this kind of supplementary insurance.	Remark: For all medical services, the patient has to pay the first 300 SFR arising as medical expenditure in a year. Then, he has to pay a percentage (currently 10%) of the price of the medical service up to a certain limit, currently 700 SFR. Patients (or their VHI) have to pay the full price of Dental Care and Dentures. There is only one commercial Insurance Company which offers coverage of these payments, and there is a discussion to forbid this kind of supplementary insurance.
United Kingdom 1995: No co-payment for Services of GPs / Primary Care Specialists/Specialists In patient services / Hospitals Co-payment of a certain amount of for Laboratory services Medicines Medical devices – some are free Co-payment of a certain percentage Dental care / Dentists Dentures / "false teeth" – the co-payment is 80% of the price up to a limit of 250 GBP. For dental care not covered by the NHS, the patient has to pay the full price	2004: No co-payment for Services of GPs / Primary Care Specialists/Specialists In patient services / Hospitals Co-payment of a certain amount of for Laboratory services Medicines Medical devices – some are free Co-payment of a certain percentage Dental care / Dentists Dentures / "false teeth" – the co-payment is 80% of the price up to a limit of 250 GBP. For dental care not covered by the NHS, the patient has to pay the full price

CP2 Are there exemptions from co-payments?	
Austria 1995: People under a certain income are exempted People with a certain health status (chronically-ill-status) are exempted	2004: People under a certain income are exempted People with a certain health status (chronically-ill-status) are exempted Remark: People with a certain health status are exempted from co-payments, but only subject to certain income limits
Belgium 1995: Certain groups, the VIPO group is exempted. It consists of widows, orphans, retired and disabled. Remark: There is a wide range of co-payment regulations, which cover in an ad hoc fashion a wide range of groups. The exemption takes the form of an upper limit for the total sum of co-payments payable per period	2004: There is a upper limit for the total sum of co-payments payable per period – for some groups only People under a certain income are exempted – since 1997 People with a certain health status, disabled are exempted Certain groups, the "VIPO", are exempted
Canada 1995: There are basically no exemptions from co-payments Remark: Factually, there are exemptions in some provinces. For some groups, e.g. unemployed, the provincial government pays the co-payment. For services not covered there is in some cases a system of subsidies at the provincial level, which for instance cover up to 80% of a medicine's price or cover the expenditure for medicines in the case in some circumstances.	2004: There are basically no exemptions from co-payments Remark: Factually, there are exemptions in some provinces. For some groups, e.g. unemployed, the provincial government pays the co-payment. For services not covered there is in some cases a system of subsidies at the provincial level, which for instance cover up to 80% of a medicine's price or cover the expenditure for medicines in the case in some circumstances.
Czech Republic 1995: There are basically no exemptions from co-payment	2004: There are basically no exemptions from co-payment
Denmark 1995: There is a upper limit for the total sum of co-payments payable per period; for pharmaceuticals People under a certain income are exempted from co-payments (e.g. people on pensions) People with a certain health status (chronically-ill-status) are exempted from co-payments; for some indications e.g. physiotherapy for patient with muscular-skeletal diseases Certain groups, children, are exempted but for certain services only, e.g. dental care	2004: There is a upper limit for the total sum of co-payments payable per period; for pharmaceuticals People under a certain income are exempted from co-payments (e.g. people on pensions) People with a certain health status (chronically-ill-status) are exempted from co-payments; for some indications e.g. physiotherapy for patient with muscular-skeletal diseases Certain groups, children, are exempted but for certain services only, e.g. dental care
Finland 1995: There is a upper limit for co-payments	2004: There is a upper limit for co-payments

CP2 Are there exemptions from co-payments?	
People with a certain health status are exempted Certain groups are exempted	People with a certain health status are exempted Certain groups are exempted
France 1995: People under a certain income are exempted from co-payments; people under a certain income benefit of a “public” VHI in order to cover the co-payments. People with a certain health status (chronically-ill-status) are exempted from co-payments for those health care and services which are directly linked to the chronic illness Certain groups of patients, maternity and work accidents, are exempted	2004: People under a certain income are exempted from co-payments; people under a certain income benefit of a “public” VHI in order to cover the co-payments. People with a certain health status (chronically-ill-status) are exempted from co-payments for health care and services directly linked to the chronic illness Certain groups of patients, maternity and work accidents, are exempted Remark: Since 2000, the CMU act extended the share of the population, which whom co-payments are paid by the state substantially
Germany 1995: There is a upper limit for the total sum of co-payments payable per period – the limit is a certain percentage of the gross-income People under a certain income are exempted Certain groups – persons under 18 years of age and chronically ill - are exempted	2004: There is a upper limit for the total sum of co-payments payable per period– the limit is a certain percentage of the gross-income People under a certain income are exempted Certain groups – persons under 18 years of age and chronically ill - are exempted
Greece 1995: People with a certain health status (chronically-ill-status) and certain groups are exempted from some co-payments	2004: People with a certain health status (chronically-ill-status) and certain groups are exempted from some co-payments
Hungary 1995: People under a certain income are exempted People with a certain health status (chronically-ill-status) are exempted Dental care for those below 18 years of age is covered	2004: People under a certain income are exempted People with a certain health status (chronically-ill-status) are exempted Dental care for those below 18 years of age is covered
Ireland 1995 People under a certain income are exempted from co-payments (Medical Card Holders). This concerns about a third of the population	2004: People under a certain income are exempted from co-payments (Medical Card Holders). This concerns about a third of the population Since 2001, persons over 70 years of age are exempted from co-payments irrespective of their income For Pharmaceuticals and Hospital fees there is a upper limit of co-payments per period
Italy 1995: People under a certain income are exempted People with a certain health status are exempted Certain groups, children and elderly, are exempted	2004: People under a certain income are exempted People with a certain health status are exempted from co-payments Certain groups, children and elderly, are exempted

CP2 Are there exemptions from co-payments?	
Remark: Parallel to the introduction of co-payments, there has been a proliferation of exemptions for co-payments.	
Luxembourg 1994: People under a certain income are partially exempted People with a certain health status – medicines and treatments concerning chronic illnesses are exempted Certain groups, children, are exempted in some cases from co-payments e.g. in the case of hospitalization Treatments concerning but also preventive care are exempted	2004: People under a certain income are partially exempted People with a certain health status – medicines and treatments concerning chronic illnesses are exempted Certain groups, children, are exempted in some cases from co-payments e.g. in the case of hospitalization Treatments concerning but also preventive care are exempted
Netherlands 1995: While the possibility of a co-payment existed, co-payments hardly existed in practice	2004: There is a upper limit for the total sum of co-payments per period People under a certain income are exempted Certain groups, like children and elderly, are exempted
New Zealand 1995: There is a upper limit for the co-payments payable per period People under a certain income, People with a certain Health status, and People belonging to certain groups, receive higher subsidies. Remark: The co-payment is the same for all, but the subsidy received by the state differs. The co payment is the remainder of the price the patient has to pay and the subsidy received by the health system. The subsidy level - and hence the co-payment level - is determined and limited by the age and health status.	2004: There is a upper limit for the co-payments payable per period People under a certain income, People with a certain Health status, and People belonging to certain groups, receive higher subsidies. Remark: The co-payment is the same for all, but the subsidy received by the state differs. The co payment is the remainder of the price the patient has to pay and the subsidy received by the health system. The subsidy level - and hence the co-payment level - is determined and limited by the age and health status.
Norway 1995: There is a upper limit for the total sum of co-payments Certain groups are exempted (children under 7 years of age are exempted, dental care for persons under 18 is covered)	2004: There is a upper limit for the total sum of co-payments Certain groups are exempted: children under 7 years of age and people below a certain income are exempted. Dental care for persons under 18 is covered)
Portugal 1995: People under a certain income are exempted Certain groups are exempted People with a certain health status are exempted	2004: Reduced co-payments for people with a certain health status and pensioners People under a certain income are exempted People with a certain health status are exempted

CP2 Are there exemptions from co-payments?	
Poland 1995: While there are no complete exemptions, some groups (chronically ill) pay reduced co-payments, pay fixed amounts instead of percentages or get higher reimbursements for their expenses	2004: While there are no complete exemptions, some groups (chronically ill) pay reduced co-payments, pay fixed amount instead of percentages or get higher reimbursements for their expenses
Spain 1995: People with a certain health status and certain groups (retired people) are exempted from co-payments or pay only reduced co-payments	2004: People with a certain health status and certain groups (retired people) are exempted from co payments or pay only reduced co-payments
Sweden 1995: Upper limit for the total sum of co-payments Certain groups are exempted (under 20 years of age)	2004: Upper limit for the total sum of co-payments Certain groups are exempted
Switzerland 1995: There is a upper limit for the total sum of co-payments Treatments during pregnancy are exempted from co-payments	2004: There is a upper limit for the total sum of co-payments (700 SFR) Treatments during pregnancy are exempted from co-payments
United Kingdom 1995: Yes, there are exemptions for: People under a certain income, People with a certain health status Certain groups are exempted from co payments Remark: Exemptions also depend on the type of service, even for the groups mentioned, the exemptions hold for certain services only	2004: Yes, there are exemptions for: People under a certain income, People with a certain health status Certain groups are exempted from co payments Remark: Exemptions also depend on the type of service, even for the groups mentioned, the exemptions hold for certain services only

CP3 Can the patient cover the costs of the co-payments and out-of-pocket payments by an Supplementary Insurance?	
Austria 1995: Yes, a supplementary insurance may cover co-payments, and it may cover the complete co-payment	2004: Yes, a supplementary insurance may cover co-payments and it may cover the complete co-payment
Belgium 1995: Yes, a supplementary insurance may cover co-payments Remark: The HIFs are also the predominant providers of VHI, offering their members additional coverage on a voluntary basis for services not covered by the Health System. The Supplementary Insurance for hospital treatments usually covers the total co-payment arising during in-patient treatment. The Supplementary Insurance for primary care usually covers only part of the co-payment	2004: Yes, a supplementary insurance may cover co-payments Remark: The HIFs are also the predominant providers of VHI, offering their members additional coverage on a voluntary basis for services not covered by the Health System. The Supplementary Insurance for hospital treatments usually covers the total co-payment arising during in-patient treatment. The Supplementary Insurance for primary care usually covers only part of the co-payment
Canada 1995: Yes, a Supplementary Insurance may cover co-payments Remark: Usually organized and paid for by the employer, the Supplementary Insurance covers services which are not covered by the health system, e.g. dental care and expenditure for medicines. The actual coverage differs among insurers.	2004: Yes, a Supplementary Insurance may cover co-payments Remark: Usually organized and paid for by the employer, the Supplementary Insurance covers services which are not covered by the health system, e.g. dental care and expenditure for medicines. The actual coverage differs among insurers.
Czech Republic 1995: No, a Supplementary Insurance covering co-payments is not available Remark: There is no market for a supplementary insurance.	2004: No, an insurance covering co-payments is not available Remark: The role of the supplementary health insurance is still very limited and only supplementary. For persons, which are not eligible to participate in the Mandatory Health Insurance, the GHIF is also the supplementary insurance.
Denmark 1995: Yes, a Supplementary Insurance may cover co-payments. Usually it does not cover the complete co-payment	2004: Yes, a Supplementary Insurance may cover co-payments, and usually it covers the complete co-payment Remark: Supplementary Insurance covers medicines, dental care, medical devices and the access to private hospitals in order to skip waiting times

CP3 Can the patient cover the costs of the co-payments and out-of-pocket payments by an Supplementary Insurance?	
Finland 1995: Yes, a Supplementary Insurance may cover co-payments. Remark: Expenditure for dental care and medicines is mostly covered by the NHI which leaves only a small role for a VHI, even though the NHI does not cover the complete co-payment. Albeit a VHI to cover the complete co-payment is not forbidden, it factually does not exist.	2004: Yes, a Supplementary Insurance may cover co-payments. Remark: Expenditure for dental care and medicines is mostly covered by the NHI which leaves only a small role for a VHI, even though the NHI does not cover the complete co-payment. Albeit a VHI to cover the complete co-payment is not forbidden, it factually does not exist.
France 1995: Yes, a Supplementary Insurance may cover co-payments, usually it covers the complete co-payment. Remark: These insurance are offered either by for-profit insurance companies or mutualities. They aim in particular at covering the co-payments which arise.	2004: Yes, a Supplementary Insurance may cover co-payments, usually it covers the complete co-payment Remark: Even after taking into account the coverage of the Supplementary Insurance, the share of direct payments out-of-pocket is about 11% of the total health expenditure. Supplementary insurance is often associated with employment
Germany 1995: Supplementary Insurance may cover co-payments, and may cover the complete co-payment – but usually it doesn't. Remark: Most Supplementary Insurance is for extra services, e.g. single room, treatment by the chief consultant in a Hospital etc.	2004: Supplementary Insurance may cover co-payments, and may cover the complete co-payment – but usually it doesn't. Remark: Most Supplementary insurance is for extra services, e.g. single room, treatment by the chief consultant in a Hospital etc.
Greece 1995: Yes, a Supplementary Insurance covering co-payments is allowed and usually covers the complete co-payments Remark: Basically, there are three layers of coverage. The public system, ESY, the HIF and the VHI for services not covered by either of the two former.	2004: Yes, a Supplementary Insurance covering co-payments is allowed and usually covers the complete co-payments Remark: Basically, there are three layers of coverage. The public system, ESY, the HIF and the VHI for services not covered by either of the two former.
Hungary 1995: Yes, a Supplementary Insurance covering co-payments is allowed. Usually it does not cover the complete co-payments Remark: The VHI covers those services, which are not or not fully covered by the health system, e.g. co-payments and dental care. Its role is very limited, in 2000, it only accounted for 0.2% of the Health Expenditure.	2004: Yes, a Supplementary Insurance covering co-payments is allowed. Usually it does not cover the complete co-payments Remark: The VHI covers those services, which are not or not fully covered by the health system, e.g. co-payments and dental care. Its role is very limited, in 2000, it only accounted for 0.2% of the Health Expenditure.

CP3 Can the patient cover the costs of the co-payments and out-of-pocket payments by an Supplementary Insurance?	
Ireland 1995: Yes, a Supplementary Insurance may cover co-payments. Usually it covers only a share of the co-payment. There is a substantial deductible, in particular for GP fees Remark: The Voluntary Health Insurance Board, VHI, is the main Supplementary Insurance, covering about a third of the population in 1995	2004: Yes, a Supplementary Insurance may cover co-payments. Usually it covers only a share of the co-payment. There is a substantial deductible, in particular for GP fees Remark: The Voluntary Health Insurance, VHI, is the main Supplementary Insurance, covering about 45% of the population in 2004
Italy 1995: Yes, a Supplementary Insurance may cover co-payments, but factually does not	2004: Yes, a supplementary insurance may cover co-payments, but factually does not. Remark: Of the private payments for health care, 91 % are direct out of pocket payments.
Luxembourg 1994: Yes, a Supplementary Insurance may cover co-payments. Usually, it covers only a share of the co-payments, in some case, e.g. dentistry, it may not cover the complete co-payment. Remark: The supplementary insurance covering dentistry is the most important one	2004: Yes, a Supplementary Insurance may cover co-payments. Usually, it covers only a share of the co-payments, in some case, e.g. dentistry, it may not cover the complete co-payment Remark: The supplementary insurance covering dentistry is the most important one
Netherlands 1995: No, since co-payments hardly existed, there was no necessity for a supplementary insurance to cover them	2004: A Supplementary Insurance covering the co-payments is not forbidden but not offered. Remark: Those insurance contracts offered cover only part of the co-payments and extras, like dental care.
New Zealand 1995: Yes, a Supplementary Insurance /VHI may cover co-payments. Remark: It may cover the complete co-payment, but whether it does so, depends on the contract. Usually the VHI is used to cover gaps between the price and the subsidy or to cover services which are not covered by the health system, e.g. dental care.	2004: Yes, a Supplementary Insurance / VHI may cover co-payments, Remark: It may cover the complete co-payment, but whether it does so, depends on the contract. Usually the VHI is used to cover gaps between the price and the subsidy or to cover services which are not covered by the health system, e.g. dental care.
Norway 1995: Yes, a Supplementary Insurance may cover co-payments, usually it covers only a share of the co-payment Remark: Usually, the National Insurance Scheme, NIS, covers most of the out of pocket	2004: Yes, a Supplementary Insurance may cover co-payments, usually it covers only a share of the co-payment Remark: Usually, the National Insurance Scheme acts as a Supplementary Health Insurance and

CP3 Can the patient cover the costs of the co-payments and out-of-pocket payments by an Supplementary Insurance?	
payments, in particular for medicines. But also for services from providers independent of the public system. The NIS is a mandatory national level insurance controlled by the government, for all persons, covering co-payments but also income loss during illness. There is factually no market for a additional VHI apart from insurance which offer extra monetary benefits.	covers most of the out of pocket payments. There is no market for a additional VHI apart from insurance which offer extra monetary benefits.
Portugal 1995: Yes, a supplementary insurance may cover the co-payments, but usually doesn't cover them completely Remark: About 10% of the population have supplementary insurance, mostly organized and paid for by the employer, who pays the largest part of the contribution. There is not really a market since co-payments are relatively low apart from those for medicines. Usually, the VHI does not cover the complete co-payment.	2004: Yes, a supplementary insurance may cover the co-payments, but usually doesn't cover them completely Remark: About 10% of the population have supplementary insurance, mostly organized and paid for by the employer, who pays the largest part of the contribution. There is not really a market since co-payments are relatively low apart from those for medicines. Usually, the VHI does not cover the complete co-payment.
Poland 1995: There is no Supplementary Insurance covering co-payments. Remark: Existing VHI cover the income loss during the time of illness.	2004: There is no VHI covering co-payments. Remark: Existing VHI cover the income loss during the time of illness.
Spain 1995: Supplementary Insurance does not cover co-payments, but is primarily for covering services which are nor covered by the health system; e.g. dental care.	2004: Supplementary Insurance does not cover co-payments, but is primarily for covering services which are nor covered by the health system; e.g. dental care.
Sweden 1995: Yes, a Supplementary Insurance may cover the co-payments Remark: The role of Supplementary Insurance is very limited, contributing only about 1% to the health expenditure. Usually it is paid partly by the employer as a bonus	2004: Yes, a Supplementary Insurance may cover the co-payments Remark: The role of Supplementary Insurance is very limited, contributing only about 1% to the health expenditure. Usually it is paid partly by the employer as a bonus.
Switzerland 1995: A supplementary insurance to cover co-payments is forbidden Remark: There is only one commercial Insurance Company implicitly offering coverage of the co-payments, but it is rarely used. There is a debate on whether to forbid this type of	2004: A Supplementary Insurance to cover co-payments is forbidden Remark: There is only one commercial Insurance Company implicitly offering coverage of the co-payments, but it is rarely used. There is a debate on whether to forbid this type of

CP3 Can the patient cover the costs of the co-payments and out-of-pocket payments by an Supplementary Insurance?	
supplementary insurance formally. The VHI is usually for coverage of dental care or superior accommodation in Hospitals.	supplementary insurance formally. The VHI is usually for coverage of dental care or superior accommodation in Hospitals.
United Kingdom 1995: No supplementary Insurance for co-payments is available. Remark: A Supplementary Insurance is not forbidden, but does not exist with the exemption of an insurance covering dental care.	2004: No supplementary Insurance for co-payments is available. Remark: A Supplementary Insurance is not forbidden, but does not exist with the exemption of an insurance covering dental care.

4.3. Gatekeeping, Choice and Access to In-Patient-Care, Hospitals and Specialists

In some countries, the patient can directly visit a Specialist or a Hospital (no gatekeeping). In other countries, the patient has to visit his General Practitioner / Primary Care Provider before going to a specialist or a Hospital (gatekeeping); see GK1.
The way the gatekeeping is handled, differs. In some countries, it can be skipped easily, in others, it's binding and either cannot be skipped at all or can only be skipped at substantial costs; see GK2.
In some countries, there are also regulations in place concerning not only whether the patient can visit a specialists or a hospital, but also where a patient has to receive treatment; see GK3.
Apart from the regulations and implementation of gatekeeping regulations, the factual choice among providers offering a certain medical service differs. In some countries, while choice is formally free, the supply of a provider in a region may be very limited, see GK4.
Remark: while listed, gatekeeping for dental care does usually not exist, cancel it in the table

GK1 Is there Gatekeeping of General Practitioners for Hospitals, Specialists, or Dentists?	
Austria 1995: No gatekeeping Remark: According to law there is some gatekeeping, in practice not really executed.	2004: No gatekeeping Remark: According to law there is some gatekeeping, in practice not really executed. In recent years there is a tendency to enforce existing regulations on gatekeeping
Belgium 1995: No gatekeeping	2004: No gatekeeping
Canada 1995: Gatekeeping for Hospitals (unless in case of emergencies) and Specialists	2004: Gatekeeping for Hospitals (unless in case of emergencies) and Specialists
Czech Republic 1995: No gatekeeping Remark: There are no formal regulations on gatekeeping. While most patients visit hospitals and specialists upon referral of a GP, this is not required. Some specialties are usually contacted directly, e.g. eye-doctors, gynecologists.	2004: No gatekeeping Remark: There are no formal regulations on gatekeeping. While most patients visit hospitals and specialists upon referral of a GP, this is not required. Some specialties are usually contacted directly, e.g. eye-doctors, gynecologists.
Denmark 1995: Gatekeeping for Hospitals and Specialists With exemption of ear-,nose-, throat and eye specialists and dentists Remark: For 98% of the population, there is gatekeeping. The rest, "type 2" insured, has more choice in access to providers but has to pay higher costs	2004: Gatekeeping for Hospitals and Specialists With exemption of ear-,nose-, throat and eye specialists and dentists Remark: For 98% of the population, there is gatekeeping. The rest, "type 2" insured, has more choice in access to providers but has to pay higher costs
Finland 1995: No gatekeeping for specialized services provided in the Health Centers Gatekeeping for hospitals and specialized services provided in Hospitals on an out-	2004: No gatekeeping for specialized services provided in the Health Centers Gatekeeping for hospitals and specialized services provided in Hospitals on an out-

GK1 Is there Gatekeeping of General Practitioners for Hospitals, Specialists, or Dentists?	
patient basis. Remark: Health Centers usually are well equipped, more sophisticated specialized services are predominantly provided in Hospitals	patient basis. Remark: Health Centers usually are well equipped, more sophisticated specialized services are predominantly provided in Hospitals
France 1995: No gatekeeping	2004: Since August 2004 there is gatekeeping for specialists and hospitals; for hospitals with the exception of the case of emergencies, for specialists with the exemption of eye specialists, psychiatrist, gynecologist, pediatrician where there is a direct access with no sanction
Germany 1995: Gatekeeping for Hospitals; unless in case of emergencies Remark: For a long time, there was a gatekeeping of first contact GPs for Specialists; this was abolished mid 90s	2004: Gatekeeping for Hospitals; unless in the case of emergencies No gatekeeping for Specialists
Greece 1995: No gatekeeping Remark: The patient can access facilities of the ESY. The patient has free choice among those providers with a contract with his HIF	2004: No gatekeeping Remark: The patient can access facilities of the ESY. The patient has free choice among those providers with a contract with his HIF
Hungary 1995 Gatekeeping for Hospitals and for Specialist Remark: Specialized services are predominantly provided in Hospitals and polyclinics. The gatekeeping for Specialists is subject to many exemptions	2004: Gatekeeping for Hospitals and for Specialist Remark: Specialized services are predominantly provided in Hospitals and polyclinics. The gatekeeping for Specialists is subject to many exemptions
Ireland 1995 Gatekeeping for Hospitals and for Specialist. Remark: Specialized care is predominantly provided in Hospitals	2004: Gatekeeping for Hospitals and for Specialist. Remark: Specialized care is predominantly provided in Hospitals
Italy 1995: Gatekeeping for Hospitals and Specialists Remark: Specialized medical care is predominantly provided in Hospitals. There are exemptions for certain specialties, e.g. gynecologists, eye doctors and pediatrics. Dentistry / and Dentures is predominantly privately purchased	2004: Gatekeeping for Hospitals and Specialists Remark: Specialized medical care is predominantly provided in Hospitals. There are exemptions for certain specialties, e.g. gynecologists. Dentistry / and Dentures is predominantly privately purchased
Luxembourg 1994: No gatekeeping	2004: No gatekeeping

GK1 Is there Gatekeeping of General Practitioners for Hospitals, Specialists, or Dentists?	
Netherlands 1995: Gatekeeping for Hospitals and Specialist Remark: Patients have to register with a GP as well	2004: Gatekeeping for Hospitals and Specialist Remark: Patients have to register with a GP as well
New Zealand 1995: Gatekeeping for Hospitals and public specialist Remark: Specialized care is predominantly provided in Hospitals	2004: Gatekeeping for Hospitals and public specialists Remark: Specialized care is predominantly provided in Hospitals
Norway 1995: Gatekeeping for Hospitals and Specialists Remark: Dentistry for adults is not covered by the Health System but is privately purchased. The patient can in principle opt out of the public system, but this incurs substantial costs.	2004: Gatekeeping for Hospitals and Specialists Remark: Dentistry for adults is not covered by the Health System but is privately purchased. The patient can in principle opt out of the public system, but this incurs substantial costs.
Portugal 1995: Gatekeeping for Hospitals and Specialists Remark Dentistry / and Dentures are not covered by the Health System but is privately purchased	2004: Gatekeeping for Hospitals and Specialists Remark Dentistry / and Dentures are not covered by the Health System but is privately purchased
Poland 1995: Gatekeeping for Hospitals and Specialists Remark: For some specialties, the access is direct, e.g. to eye doctors, dentists and gynecologists.	2004: Gatekeeping for Hospitals and Specialists Remark: For some specialties, the access is direct, e.g. to eye doctors, dentists and gynecologists.
Spain 1995: Gatekeeping for Hospitals and Specialists Dental care is predominantly privately purchased Remark: The choice of the GP is usually also limited to those within the health area, as the lowest unit of the Health System.	2004: Gatekeeping for Hospitals and Specialists Dental Care is predominantly privately purchased Remark: The choice of the GP is usually also limited to those within the health area, as the lowest unit of the Health System.
Sweden 1995: Gatekeeping for Hospitals and Specialist Remark Dentistry / and Dentures for adults are not covered by the Health System but is privately purchased	2004: Gatekeeping for Hospitals and Specialist Remark Dentistry / and Dentures for adults are not covered by the Health System but is privately purchased
Switzerland 1995: No gatekeeping	2004: No gatekeeping
United Kingdom 1995: Gatekeeping for Hospitals and Specialist No gatekeeping for Dentists, even for those services covered by the NHS	2004: Gatekeeping for Hospitals and Specialist No gatekeeping for Dentists, even for those services covered by the NHS

GK2 If there is gatekeeping, how strict is the gatekeeping factually handled?	
Austria 1995: Factually no gatekeeping	2004: Factually no gatekeeping
Belgium 1995: No gatekeeping	2004: No gatekeeping
Canada 1995: Gatekeeping for hospitals cannot be skipped unless in case of an emergency Gatekeeping for specialists cannot be skipped	2004: Gatekeeping for hospitals cannot be skipped unless in case of an emergency Gatekeeping for specialists cannot be skipped
Czech Republic 1995: No gatekeeping	2004: No gatekeeping
Denmark 1995 Gatekeeping for hospitals cannot be skipped, unless in the case of an emergency Gatekeeping for specialists cannot be skipped	2004: Gatekeeping for hospitals cannot be skipped unless in case of an emergency Gatekeeping for specialists cannot be skipped
Finland 1995: Gatekeeping to hospitals can be skipped, but the service is not covered	2004: Gatekeeping can be skipped, but the service is not covered
France 1995: No gatekeeping	2004: Gatekeeping to Hospitals and Specialists is being introduced but not yet operative
Germany 1995: Gatekeeping for hospitals cannot be skipped unless in case of an emergency As long as the gatekeeping for specialists existed, up to the mid 90s, it could not be skipped	2004: Gatekeeping for hospitals cannot be skipped unless in case of an emergency No gatekeeping for specialists
Greece 1995: No gatekeeping Remark: The patient can directly access facilities of the ESY. For non-ESY providers, the patient has free choice among those providers with a contract with his HIF.	2004: No gatekeeping Remark: The patient can directly access facilities of the ESY. For non-ESY providers, the patient has free choice among those providers with a contract with his HIF.
Hungary 1995: Gatekeeping for hospitals can be skipped, but it incurs higher costs. There are also many cases where it can be skipped without higher costs Gatekeeping for specialists can be skipped, but it incurs higher costs.	2004: Gatekeeping for hospitals can be skipped, but it incurs higher costs. There are also many cases where it can be skipped without higher costs Gatekeeping for specialists can be skipped, but it incurs higher costs.
Ireland 1995: Gatekeeping to Hospitals and specialized care provided in Hospitals can be skipped, but it incurs higher costs Remark: There is a extra fee if the patient wants to receive specialized outpatient services without having a referral of a GP	2004: Gatekeeping to Hospitals and specialized care provided in Hospitals can be skipped, but it incurs higher costs Remark: There is a extra fee if the patient wants to receive specialized outpatient services without having a referral of a GP

GK2 If there is gatekeeping, how strict is the gatekeeping factually handled?	
Italy 1995: Gatekeeping for hospitals and specialists can be skipped, but the service is not covered and has to be purchased privately or by the supplementary insurance Remark: As a rule, gatekeeping for hospitals cannot be skipped unless in case of an emergency. This also concerns the access to specialized medical services provided in hospitals. Gatekeeping for Specialists cannot be skipped unless for certain specialists, e.g. gynecologists, eye doctors or pediatrics.	2004: Gatekeeping for hospitals and specialists can be skipped, but the service is not covered and has to be purchased privately or by the supplementary insurance Remark: As a rule, gatekeeping for hospitals cannot be skipped unless in case of an emergency. This also concerns the access to specialized medical services provided in hospitals. Gatekeeping for Specialists cannot be skipped unless for certain specialists, e.g. gynecologists, eye doctors or pediatrics
Luxembourg 1994: No gatekeeping	2004: No gatekeeping
Netherlands 1995: Gatekeeping for hospitals and specialists cannot be skipped (unless in the case of an emergency)	2004: Gatekeeping for hospitals and specialists cannot be skipped (unless in the case of an emergency)
New Zealand 1995: Gatekeeping for hospitals cannot be skipped unless in case of an emergency Gatekeeping for specialists can be skipped, but the service is not covered, people can go to private specialists and get treatment on private terms Remark: People can self-refer to hospitals in the case of an emergency. Factually, they are not turned away in non-urgent situations	2004: Gatekeeping for hospitals cannot be skipped unless in case of an emergency Gatekeeping for specialists can be skipped, but the service is not covered, people can go to private specialists and get treatment on private terms Remark: People can self-refer to hospitals in the case of an emergency. Factually, they are not turned away in non-urgent situations
Norway 1995: Both instances of gatekeeping can be skipped, but doing so incurs higher costs. Remark In the case of Hospitals, gatekeeping can be skipped even without higher costs. In the case of specialists, gatekeeping can be skipped, but this incurs higher costs, or the service is not covered: The National Insurance Scheme reimburses part of the expenses, but only if there is a referral.	2004: Both instances of gatekeeping can be skipped, but doing so incurs higher costs. Remark: In the case of Hospitals, gatekeeping can sometimes be skipped even without higher costs. In the case of specialists, gatekeeping can be skipped, but this incurs higher costs, or the service is not covered
Portugal 1995: Both instances of gatekeeping cannot be skipped unless in case of emergencies Remark: Gatekeeping for specialists can be skipped, but this incurs higher costs. The service might be purchased from a private provider on private terms, the costs of which are covered either by the patient, the subsistema	2004: Both instances of gatekeeping cannot be skipped unless in case of emergencies Remark: Gatekeeping for specialists can be skipped, but this incurs higher costs. The service might be purchased from a private provider on private terms, the costs of which are covered either by the patient, the subsistema or the

GK2 If there is gatekeeping, how strict is the gatekeeping factually handled?	
or the VHI.	VHI.
Poland 1995: Both instances of gatekeeping cannot be skipped unless in case of emergencies Remark: Some specialties, like eye doctors, are not subject to gatekeeping.	2004: Both instances of gatekeeping cannot be skipped unless in case of emergencies Remark: Some specialties, like eye doctors, are not subject to gatekeeping.
Spain 1995: Both instances of gatekeeping cannot be skipped; Remark: In the case of hospitals, it can be skipped by using the emergency department	2004: Both instances of gatekeeping cannot be skipped Remark: In the case of hospitals, it can be skipped by using the emergency department
Sweden 1995: Both instances of gatekeeping can be skipped sometimes, but getting a referral from the GP grants faster access and is cheaper	2004: Both instances of gatekeeping can be skipped, but doing so incurs slightly higher costs. Some counties charge higher fees if there is no referral from a GP
Switzerland 1995: No gatekeeping	2004: No gatekeeping
United Kingdom 1995: Both instances of gatekeeping cannot be skipped	2004: Both instances of gatekeeping cannot be skipped

GK3 Apart from formal gatekeeping: Has the patient (after the gatekeeper has agreed to the referral per se) free choice of the Specialist (eye doctor etc.), the Hospital or the Dentist? That is: once the GP has agreed that the patient may visit a Specialist, is the patient free to visit a specialist of his own choosing? Or, has the patient to go to a certain Specialist to obtain treatment? The patient has free choice of the:	
Austria 1995: Specialist Hospital Dentist	2004: Specialist Hospital Dentist
Belgium 1995. Specialist Hospital Dentist	2004: Specialist Hospital Dentist
Canada 1995: Specialist Hospital Dentist (privately paid, hence free choice) Remark: The patients can get treatment in other provinces. Availability differs largely among the provinces and sometimes patients have to travel to get treatment.	2004: Specialist Hospital Dentist (privately paid, hence free choice) Remark: The patients can get treatment in other provinces. Availability differs largely among the provinces and sometimes patients have to travel to get treatment.
Czech Republic 1995: Specialist Hospital Dentist Remark: The patient can only contact providers, which have a contract with the HIF the patient is insured with. This usually is no problem.	2004: Specialist Hospital Dentist Remark: The patient can only contact providers, which have a contract with the HIF the patient is insured with. This usually is no problem.
Denmark Specialist Hospital (in the region, i.e. county) Dentist (privately paid, hence free choice) Remark: If the waiting time would be to long, or the service is unavailable in a county, the patient can go to another county	2004: Specialist Hospital (in the region) Dentist (privately paid, hence free choice) Remark: If the waiting time would be to long, or the service is unavailable in a county, the patient can go to another county
Finland 1995: Factually no free choice of specialists and hospitals Free choice of dentists (if privately paid) Remark: The citizens have only access to those facilities operated by the municipalities or the providers contracted by the municipalities. Choice of Hospitals (for in-patient services and most specialized services) is limited to the Hospitals in the	2004: Factually no free choice of specialists and hospitals Free choice of dentists (if privately paid) Remark: The citizens have only access to those facilities operated by the municipalities or the providers contracted by the municipalities. Choice of Hospitals (for in-patient services and most specialized services) is limited to the Hospitals in the Hospital District the

GK3 Apart from formal gatekeeping: Has the patient (after the gatekeeper has agreed to the referral per se) free choice of the Specialist (eye doctor etc.), the Hospital or the Dentist? That is: once the GP has agreed that the patient may visit a Specialist, is the patient free to visit a specialist of his own choosing? Or, has the patient to go to a certain Specialist to obtain treatment? The patient has free choice of the:	
Hospital District the municipality belongs to.	municipality belongs to.
France 1995 Specialist Hospital Dental care is predominantly purchased privately, hence the choice is free	2004: Specialist Hospital Dental care is predominantly purchased privately, hence the choice is free
Germany 1995: Specialist Hospital Dentist	2004: Specialist Hospital Dentist
Greece 1995: Specialist Hospital Dentist Remark: The actual choice is subject to local availability, which is sometimes limited. Usually patients contact first an ESY provider, e.g. health center. Then, if necessary, e.g. for a second opinion, a provider contracted by their HIF. If they do not go to a provider a contracted by their HIF, the services might not be covered by the HIF. The patient's choice is limited to those providers with a contract with his HIF.	2004: Specialist Hospital Dentist Remark: The actual choice is subject to local availability, which is sometimes limited. Usually patients contact first an NHS provider, then, if necessary, e.g. for a second opinion, a provider contracted by their HIF. If they do not go to a provider a contracted by their HIF, the services might not be covered by the HIF. The patient's choice is limited to those providers with a contract with his HIF.
Hungary 1995: Specialist (limited) Hospital Dentist	2004: Specialist (limited) Hospital Dentist
Ireland 1995: Specialist Hospital Dentist Remark: The actual availability differs regionally, and is highest in the Dublin area	2004: Specialist Hospital Dentist Remark: The actual availability differs regionally, and is highest in the Dublin area
Italy 1995: Specialist Hospital Dentist (privately purchased) Remark: After the gatekeeper has agreed to the referral, the patient can chose a provider, also outside of the area of his ASL or in another region. There is substantial "medical	2004: Specialist Hospital Dentist (privately paid, hence free choice) Remark: After the gatekeeper has agreed to the referral, the patient can chose a provider, also outside of the area of his ASL. There is substantial "medical tourism".

GK3 Apart from formal gatekeeping: Has the patient (after the gatekeeper has agreed to the referral per se) free choice of the Specialist (eye doctor etc.), the Hospital or the Dentist? That is: once the GP has agreed that the patient may visit a Specialist, is the patient free to visit a specialist of his own choosing? Or, has the patient to go to a certain Specialist to obtain treatment? The patient has free choice of the:	
tourism".	
Luxembourg 1994: Specialist Hospital Dentist	2004: Specialist Hospital Dentist
Netherlands 1995: Specialist Hospital Dentist	2004: Specialist Hospital Dentist
New Zealand 1995: No free / limited choice of Specialists and Hospitals Free choice of dentists, since dental care is privately purchased. The same is true for specialized care purchased on private terms. Remark: The limited choice is due to the availability of providers in the area. While in most areas, a Hospital is available, usually only one hospital is available in most regions outside of the densely populated areas.	2004: No free / limited choice of Specialists and Hospitals Free choice of dentists, since dental care is privately purchased. The same is true for specialized care purchased on private terms. Remark: The limited choice is due to the availability of providers in the area. While in most areas, a Hospital is available, usually only one hospital is available in most regions outside of the densely populated areas.
Norway 1995: Specialist Hospital Dentist (because purchased privately) Remark: Due to differences in population density, the factual access and choice among providers differs among areas.	2004: Specialist Hospital Dentist (because purchased privately) Remark: Due to differences in population density, the factual access and choice among providers differs among areas
Portugal 1995: No free choice of Hospital or Specialist Free choice of the Dentist, since this is paid out of pocket Remark: The availability of providers differs among regions and this sets restrictions to the choice, in particular outside the coastal area and Lisbon.	2004: No free choice of Hospital or Specialist Free choice of the Dentist, since this is paid out of pocket Remark: The availability of providers differs among regions and this sets restrictions to the choice, in particular outside the coastal area and Lisbon.
Poland 1995 Factually no free choice Remark: The choice is locally limited to the Hospitals and facilities in the municipality or region.	2004: Factually only limited choice, albeit patients are since 1999 free to chose any hospital in the country. Remark: The choice of Hospitals is factually still locally limited. If patients were referred to a

GK3 Apart from formal gatekeeping: Has the patient (after the gatekeeper has agreed to the referral per se) free choice of the Specialist (eye doctor etc.), the Hospital or the Dentist? That is: once the GP has agreed that the patient may visit a Specialist, is the patient free to visit a specialist of his own choosing? Or, has the patient to go to a certain Specialist to obtain treatment? The patient has free choice of the:	
	general hospital but choose a specialized hospital, they have to have to cover the difference in treatment costs. The choice among GPs and Dentists is limited to those who are contracted by the National Health Insurance Fund.
Spain 1995: Factually no free choice of the Hospital nor Specialist even after the gatekeeper agreed to the referral Free choice of the Dentist, since this is privately purchased Remark: For those dental services which are covered, the choice is also limited. The choice of the GP is limited to those GPs available in the health area as the smallest unit of the Health System	2004: Factually no free choice of the Hospital nor Specialist even after the gatekeeper agreed to the referral Free choice of the Dentist, since this is privately purchased Remark: For those dental services which are covered, the choice is also limited. The choice of the GP is limited to those GPs available in the health area as the smallest unit of the Health System
Sweden 1995: Specialist Hospital Dentist Remark: Choice among Specialists and Hospitals is limited to those in a Landsting's area. All three are subject to availability in the respective Landsting's area	2004: Specialist Hospital Dentist Remark: Choice among Specialists and Hospitals is limited to those in a Landsting's area. All three are subject to availability in the respective Landsting's area
Switzerland 1995: Specialist Hospital Dentist Remark: Choice of hospital services are usually limited to the Kanton the patient is living in.	2004: Specialist Hospital Dentist Remark: Choice of hospital services are usually limited to the Kanton the patient is living in.
United Kingdom 1995: Even after the gatekeeper has agreed, the patient cannot chose freely the specialist or hospital. Usually there is only a limited choice since both inpatient and specialized care is provided by Hospitals.	2004: Even after the gatekeeper has agreed, the patient cannot chose freely the specialist or hospital. Usually there is only a limited choice since both inpatient and specialized care is provided by Hospitals.

GK4 Independent of gatekeeping regulations. Do patients actually have a choice in the sense that there are several providers offering services to choose from? Do patients factually have the choice among different Specialists, Hospitals or Dentists?:	
Austria 1995: Specialists Hospitals Dentists	2004: Specialists Hospitals Dentists
Belgium 1995: Specialist Hospital Dentist	2004: Specialists Hospitals Dentists
Canada 1995: Specialist Hospital Dentist Remark: The patient can get treatment in other provinces. Availability differs largely among the provinces and sometimes patients have to travel to get treatment	2004: Specialists Hospitals Dentists Remark: The patient can get treatment in other provinces. Availability differs largely among the provinces and sometimes patients have to travel to get treatment
Czech Republic 1995: Specialist Hospital Dentist Remark: The patient can only contact providers, which have a contract with the HIF the patient is insured with. This usually is no problem.	2004: Specialist Hospital Dentist Remark: The patient can only contact providers, which have a contract with the HIF the patient is insured with. This usually is no problem.
Denmark 1995 Specialists Hospitals Dentists	2004: Specialists Hospitals Dentists
Finland 1995: Factually no free choice of Specialists and Hospitals Free choice of Dentists (if privately paid) Remark: The citizens have only access to those facilities operated by the municipalities or the providers contracted by the municipalities.	2004: Factually no free choice of Specialists and Hospitals Free choice of Dentists (if privately paid) Remark: The citizens have only access to those facilities operated by the municipalities or the providers contracted by the municipalities.
France 1995: Factually free choice, of Specialist, Hospital and Dentist subject to regional availability of providers Remark: In theory there is no problem of capacity and access to care because the number of physicians has grown up very rapidly in the last decades but there is some problem of	2004: Factually free choice, of Specialist, Hospital and Dentist subject to regional availability of providers Remark: There are substantial differences in regional availability

GK4 Independent of gatekeeping regulations. Do patients actually have a choice in the sense that there are several providers offering services to choose from? Do patients factually have the choice among different Specialists, Hospitals or Dentists?:	
geographical imbalance which can generate tension in some specific areas (rural or deprived areas) for some specialty (e.g. eye specialists)	
Germany 1995: Specialist Hospital Dentist	2004: Specialist Hospital Dentist
Greece 1995: Specialist Hospital Dentist Remark: The actual choice is subject to local availability, which differs substantially among regions and specialties. There is a co-existence of over- and under-capacities in the same region for different specialties. Patients often travel to bigger cities, e.g. Athens or Thessaloniki to get treatment. For some services, patients can only choose among providers contracted by their HIF. Otherwise, the services might not be covered by the HIF. The patient's choice is limited to those providers with a contract with his HIF	2004: Specialist Hospital Dentist Remark: The actual choice is subject to local availability, which differs substantially among regions and specialties. There is a co-existence of over- and under-capacities in the same region for different specialties. Patients often travel to bigger cities, e.g. Athens or Thessaloniki to get treatment. For some services, patients can only choose among providers contracted by their HIF. Otherwise, the services might not be covered by the HIF. The patient's choice is limited to those providers with a contract with his HIF
Hungary 1995: Specialist (limited choice) Hospital Dentist	2004: Specialist (limited choice) Hospital Dentist
Ireland 1995: Specialist Hospital Dentist Remark: The actual availability differs regionally, and is highest in the Dublin area	2004: Specialist Hospital Dentist Remark: The actual availability differs regionally, and is highest in the Dublin area
Italy 1995. Specialist Hospital Dentist (privately paid, hence free choice) Remark: The actual availability and also the quality of care differs regionally. There is substantial "medical tourism" among regions.	2004: Specialist Hospital Dentist (privately paid, hence free choice) Remark: The actual availability and also the quality of care differs regionally. There is substantial "medical tourism" among regions.
Luxembourg 1994: Specialist Hospital Dentist	2004: Specialist Hospital Dentist

GK4 Independent of gatekeeping regulations. Do patients actually have a choice in the sense that there are several providers offering services to choose from? Do patients factually have the choice among different Specialists, Hospitals or Dentists?:	
Netherlands 1995: Factually free choice of Specialist, Hospital, and Dentist	2004: Factually free choice of Specialist, Hospital, and Dentist
New Zealand 1995: Factually no free choice of Specialists and Hospitals Free choice of Dentists (since privately paid) Remark: Factual choice depends on local availability in an area. Obtaining a certain service may require to travel.	2004: Factually no free choice of Specialists and Hospitals Free choice of Dentists (since privately paid) Remark: Factual choice depends on local availability in an area. Obtaining a certain service may require to travel.
Norway 1995: Specialist Hospital Dentist (purchased privately) Remark: Factual choice is subject to regional availability. There are waiting lists, and patients which are treated in Hospitals operated by other counties.	2004: Specialist Hospital Dentist (purchased privately) Remark: Factual choice is subject to regional availability.
Portugal 1995: Usually yes for all three Remark: Whether the patients actually have a choice depends on the availability of providers, which is higher in more densely populated areas; availability varies substantially among regions. Usually they have a choice among different specialists and dentists, but choice among hospitals is more limited. Here, the selection of a Hospital is determined by the degree of specialization: for basic services, the patient is usually referred to the District Hospital. There are not many hospitals offering highly specialized services in the country.	2004: Usually yes for all three; Remark: Whether the patients actually have a choice depends on the availability of providers, which is higher in more densely populated areas; availability varies substantially among regions. Usually they have a choice among different specialists and dentists, but choice among hospitals is more limited. Here, the selection of a Hospital is determined by the degree of specialization: for basic services, the patient is usually referred to the District Hospital. There are not many hospitals offering highly specialized services in the country.
Poland 1995: Usually, the choice is limited	2004: Usually, the choice is limited Remark: Since 1999, patients have formally free choice among all hospitals in the country. If they were referred to a general hospital but choose a specialized hospital, they have to have to cover the difference in treatment costs.
Spain 1995: Factual no choice among Hospitals, and specialists Factually choice among dentists, for services	2004: Factual no choice among Hospitals, and specialists Factually choice among dentists, for services

GK4 Independent of gatekeeping regulations. Do patients actually have a choice in the sense that there are several providers offering services to choose from? Do patients factually have the choice among different Specialists, Hospitals or Dentists?:	
which are privately purchased Remark: Specialized services are predominantly provided in Hospitals. The availability differs among areas. The choice of dentists is also limited if the service is covered by the health system, i.e. is consumed in a hospital.	which are privately purchased Remark: Specialized services are predominantly provided in Hospitals. The availability differs among areas. The choice of dentists is also limited if the service is covered by the health system, i.e. is consumed in a hospital.
Sweden 1995: Factually no choice among different Hospitals and Specialists, Factual choice among Dentists Remark: All three are subject to availability in the respective Landsting's area	2004: Factually no choice among different Hospitals and Specialists, Factual choice among Dentists Remark: All three are subject to availability in the respective Landsting's area
Switzerland 1995: Specialist Hospital Dentist Remark: Choice of hospital services are usually limited to the Kanton the patient is living in.	2004: Specialist Hospital Dentist Remark: Choice of hospital services are usually limited to the Kanton the patient is living in.
United Kingdom 1995: Due to limits in capacity and availability of facilities, there is - apart from the area of Greater London - usually no factual choice of Hospital or Specialist.	2004: Due to limits in capacity and availability of facilities, there is - apart from the area of Greater London - usually no factual choice of Hospital or Specialist.

Part II: Regulations and Institutions to ensure Quality in Medical Treatment

In some countries, there are institutions which define clinical / medical guidelines for standard treatments in certain indications. Given a certain diagnosis, what is the most medical effective treatment to tackle this condition. These "standard routines" may be defined for several areas of medical treatment:

Usage of Pharmaceuticals – When is the usage of a certain medicine appropriate, e.g. prescription of anti-hypertension drugs, aspirin for post-infarct treatment. But also which of several existing medicines is the most appropriate for treating a certain medical condition?
Hospital treatments – When is a patient an appropriate candidate for a certain intervention in the sense, that the expected outcomes and the medical risks imposed by the intervention are acceptable? Which is the most appropriate treatment procedure for a certain medical condition, which is usually treated in Hospitals
Usage of High Technology – when is the usage of a certain technology, in particular for high-tech-diagnostics, appropriate?
Out patient treatment – what is the most appropriate treatment procedure for treatments in the Primary care sector.

In some countries, these guidelines also take into account which of several possible treatments procedures is the most cost effective

Q1 Is there an institution which sets clinical / medical guidelines?	
Austria 1995: Yes, a national level institution. Remark: Medical societies perform this task to some degree, but not comparable to Institutions such as NICE. The guidelines are recommendations only.	2004: Yes, a national level institution. Remark: Medical societies perform this task to some degree, but not comparable to Institutions such as NICE. The guidelines are recommendations only.
Belgium 1995: Yes, a national as well as regional level institutions. Remark: For instance the technical councils at the INAMI, the Comité Remboursement Medicaments, Medical Associations. However, studies show that there are substantial differences in the usage of procedures among providers.	2004: Yes, a national as well as regional level institutions.
Canada 1995: Yes, national as well as provincial level institutions. Several institutions affiliated with several professions / specialties. Remark: Guidelines and their impact differs substantially among provinces	2004: Yes, national as well as provincial level institutions. Several institutions affiliated with several professions / specialties. Remark: Guidelines and their impact differs substantially among provinces
Czech Republic 1995: Yes, a national level institution Remark:	2004: Yes, a national level institution Remark:

Q1 Is there an institution which sets clinical / medical guidelines?	
There is a Center for Quality at the national level, in addition, the professional associations (notably the Czech Medical Chamber) issue guidelines.	There is a Center for Quality at the national level, in addition, the professional associations (notably the Czech Medical Chamber) issue guidelines.
Denmark 1995 Yes, national level institutions. Remark: Medical societies issued guidelines for specialties. For instance, the Danish College of General Practice. There are also county based institutions.	2004: Yes, national level institutions. Remark: The National Board of Health, a national level institution, issues reference programs and clinical guidelines –but they are not mandatory in the judicial sense Clinical guidelines may also be issued at local, e.g. hospital department level. Since 1999, the Institute of Rational Pharmacotherapy issues guidelines on the usage of Pharmaceuticals
Finland 1995 Yes, a national level institution Remark: The Finnish Medical Society sets guidelines, but these are rather informal.	2004: Yes, a national level institution, Remark: The Finnish Medical Society (Duodecim) and specialist organizations. The usage of guidelines has been extended.
France 1995: Yes, a national level institution; HAS (Haute Autorité de Santé) and AFSSAPS (for medicines)	2004: Yes, a national level institution; HAS (Haute Autorité de Santé) and AFSSAPS (for medicines)
Germany 1995: No	2004: Yes, several national level institutions Remark: Among them are Gemeinsamer Bundesausschuß (GemBA), Institut für Qualität und Wirtschafltichkeit im Gesundheitswesen (IQWIG). Some are created by the Ministry of Health for the development of Disease Management Programs.
Greece 1995: No	2004: No Remark: There have been some attempts of some HIF to introduce guidelines, but these had no effect.
Hungary 1995: Yes, a national level institution	2004: Yes, a national level institution Remark: In 2002, the Ministry of Health issued guidelines on how to conduct evaluations of treatments, products etc.
Ireland 1995: Yes, regional and local level institutions	2004: Yes, regional and local level institution

Q1 Is there an institution which sets clinical / medical guidelines?	
Italy 1995. Yes, national and regional level institutions Remark: There is a strong role of the national as well as the regional Ministries of Health	2004: Yes, national and regional level institutions Remark: There is a strong role of the national as well as the regional Ministries of Health
Luxembourg 1994: No	2004: No
Netherlands 1995: Yes, a national level institution Remark: There are several; e.g. NIVEL, the Netherlands Institute for Health Services Research, also professional associations of GPs and specialists.	2004: Yes, a national level institution Remark: There are several; e.g. NIVEL, the Netherlands Institute for Health Services Research, also professional associations of GPs and specialists.
New Zealand 1995: No Remark: While some institutions were already active in 1995, e.g. the National Health Committee, there was no systematic approach to issue guidelines.	2004: Yes, national and regional level institutions
Norway 1995: Yes, a regional and national level institutions Remark: The Norwegian Board of Health is active in this domain. Mostly other institutions active in this domain are professional organizations. The guidelines issued are factually not effective.	2004: Yes, a regional and national level institutions Remark: The Norwegian Board of Health is active in this domain. Mostly other institutions active in this domain are professional organizations. The guidelines issued are factually not effective. Further, there is the “Knowledge Center for Health Services”, created in 2004.
Portugal 1995: Yes, a national level institution Remark: The INFARMED issues guidelines for the economic usage of pharmaceuticals and their evaluation. They are addressing the GPs as the main prescribers but are not mandatory. Since 1994, the scope of the INFRAMED was widened, to cover also the evaluation of medical technology. While the Portuguese Medical Association is entitled to set clinical guidelines, it does not do so or only rarely; e.g. there is a guideline for the treatment of stroke. Some hospitals have internal guidelines. While there are some guidelines, these are not effective.	2004: Yes, a national level institution Remark: The INFARMED for the economic usage of pharmaceuticals and for the evaluation of medical equipment. While the Portuguese Medical Association is entitled to set clinical guidelines, it does not do so or only rarely; e.g. there is a guideline for the treatment of stroke. Some hospitals have internal guidelines. While there are some guidelines, these are not effective.
Poland 1995: Yes, a national level institution Remark:	2004: Yes, a national level institution Remark:

Q1 Is there an institution which sets clinical / medical guidelines?	
Several scientific associations issue guidelines, which are however not obligatory.	Several scientific associations issue guidelines, which are however not obligatory.
Spain 1995. Yes, a national level institution Remark: The guidelines are only recommendations	2004: Yes, national level institution as well as regional level institutions Remark: The guidelines are only recommendations
Sweden 1995: Yes, national and regional level institutions Remark: For instance the National Board of Health and Welfare; there is further an extensive system of disease-based quality registries, which collected data on treatments and issue advisory information on treatment options.	2004: Yes, national and regional level institutions Remark: For instance the National Board of Health and Welfare; there is further an extensive system of disease-based quality registries, which collected data on treatments and issue advisory information on treatment options
Switzerland 1995: No	2004: No
United Kingdom 1995: Yes, national level institutions Remark: While NICE is the predominant one, there is for instance also the National Prescribing Centre	2004: Yes, several national level institutions Remark: While NICE is the most important one, there is for instance also the National Prescribing Centre for pharmaceuticals.

Q2 For which of the following sectors do clinical guidelines exist in [Country]?	
Austria 1995: Usage of Pharmaceuticals Hospital treatments; Usage of High Technology (CAT Scans, MRI etc.); Out patient treatment. Remark: The guidelines for pharmaceuticals concern in particular for the economic usage. All guidelines are subject to the remark mentioned in Q1.	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment. Remark: The guidelines for pharmaceuticals concern in particular for the economic usage All guidelines are subject to the remark mentioned in Q1.
Belgium 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatment Remark: Guidelines exist, but are not compulsory	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatment Remark: Guidelines exist, but are not compulsory
Canada 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatment	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatment
Czech Republic 1995: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment	2004: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment
Denmark 1995: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment	2004: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment
Finland 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatment	2004: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment
France 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment
Germany 1995 None, see Q1	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment
Greece 1995:	2004:

Q2 For which of the following sectors do clinical guidelines exist in [Country]?	
None, see Q1 Remark: There has been substantial activity in influencing the usage of pharmaceuticals, which had the effect of guidelines. This however was not based on guidelines.	None, see Q1 Remark: There has been substantial activity in influencing the usage of pharmaceuticals, which had the effect of guidelines. This however was not based on guidelines.
Hungary 1995: Usage of pharmaceuticals Remark: Since pharmaceuticals are a substantial part of health expenditure, governmental activity aims at rationalizing the usage of pharmaceuticals by addressing the prescribers via guidelines and the consumers by financial incentives	2004: Usage of pharmaceuticals
Ireland 1995: Usage of Pharmaceuticals; Hospital treatments;	2004: Usage of Pharmaceuticals; Hospital treatments;
Italy 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatment	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatment
Luxembourg 1994: None, see Q1	2004: None, see Q1
Netherlands 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment
New Zealand 1995: Usage of Pharmaceuticals Remark: The usage of pharmaceuticals was one domain for which guidelines existed already in 1995. Since 1993, the PHARMAC is in charge of decisions on listing, subsidy levels and grouping. This also resulted in guidelines for the usage of pharmaceuticals.	2004: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment
Norway 1995: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment Remark: Mostly these are professional organizations, the guidelines issued are factually not effective. For Pharmaceuticals and Technology, guidelines are issued by national level institutions, like the Norwegian	2004: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment Remark: Mostly these are professional organizations, the guidelines issued are factually not effective. For Pharmaceuticals and Technology, guidelines are issued by national level institutions, like the Norwegian Board of

Q2 For which of the following sectors do clinical guidelines exist in [Country]?	
Board of Health.	Health, or the Norwegian Centre of Health Technology Assessment at the SINTEF Unimed.
Portugal 1995: Usage of Pharmaceuticals Remark: Subject to the limitations in Q1. The guidelines in question are issued from the INFRAMED to the GPs and concern the economic usage of medicines. They are not mandatory	2004: Usage of Pharmaceuticals Remark: The guidelines are issued from the INFRAMED to the GPs and concern the economic usage of medicines. They are not mandatory
Poland 1995: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment Remark: The guidelines are recommendations only	2004: Usage of Pharmaceuticals Hospital treatments Usage of High Technology Out patient treatment Remark: The guidelines are recommendations only
Spain 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Remark: The guidelines are only recommendations	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Remark: The guidelines are only recommendations
Sweden 1995: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment.	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology Out patient treatment
Switzerland 1995: None of these, see Q1	2004: None of these, see Q1
United Kingdom 1995 Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatments	2004: Usage of Pharmaceuticals; Hospital treatments; Usage of High Technology; Out patient treatments

Q3 Is there an institution gathering and distributing information on **Medical Efficacy** of different treatments for the same illness?	
Austria 1995: National level institutions in some fields, but not as a single institution Remark: E.g. the Institut für Technikfolgenabschätzung, several Departments on Evidence based Medicine, also Health Insurance Funds	2004: National level institutions in some fields, but not as a single institution Remark: E.g. the Institut für Technikfolgenabschätzung, several Departments on Evidence based Medicine, also Health Insurance Funds
Belgium 1995: No	2004: Yes, a national level institution Remark: The HIFs, the INAMI and several technical advisory councils affiliated with the INAMI are engaged in technology assessment. This takes into account the medical efficacy and effectiveness of treatments and technologies
Canada 1995: Yes, national level as well as provincial level institutions Remark: e.g. Canadian Coordinating Office for Health Technology Assessment, since 1989	2004: Yes, national level as well as provincial level institutions
Czech Republic 1995: No	2004: Yes, a national institution Remark: The Drug and Technology Control Institute, attached to the Ministry of Health, evaluates different treatments with regard to efficacy
Denmark 1995: Several national level institutions Remark: The National Board of Health and the Institute for Evaluation and Health Technology Assessment, but there no formalized approach, neither are the evaluations binding	2004: Yes, several institutions at various levels Remark: The Nordic Cochrane Center; a supra-national organization. At national level the Danish Medicines Agency; the National Board of Health, the Danish Institute of Evaluation and Health Technology Assessment
Finland 1995: Yes, a national level institution Remark: The Finnish Office of Health Technology Assessment at the STAKES Institute, beginning in 1995.	2004: Yes, a national level institution, Remark: The Finnish Office of Health Technology Assessment at the STAKES Institute. The STAKES supports HTA and distributes the results of national as well as international studies in HTA.
France 1995: Yes, national level institutions Remark:	2004: Yes, national level institutions Remark:

Q3 Is there an institution gathering and distributing information on **Medical Efficacy** of different treatments for the same illness?	
The CEPS, HAS and AFSSAPS	HAS and AFSSAPS. Since 1997 also the ANAES. They are mostly concerned with issues of safety, not efficacy or costs
Germany 1995: No	2004: Yes, a national level institution, the IQWiG
Greece 1995: No	2004: No
Hungary 1995: Yes, a national level institution Remark: There are National Institutes of Health for several specialties	2004: Yes, a national level institution Remark: There are National Institutes of Health for several specialties
Ireland 1995: No	2004: Yes, the National Medicines Information Center
Italy 1995: Yes, a national level institutions, in some regions also regional level institutions. Remark: There is a strong role of the national as well as the regional Ministries of Health	2004: Yes, a national level institutions, in some regions also regional level institutions Remark: There is a strong role of the national as well as the regional Ministries of Health
Luxembourg 1994: No	2004: No
Netherlands 1995: Yes, a national level institution	2004: Yes, a national level institution
New Zealand 1995: Yes, a national level institution Remark: The National Health Committee was created to identify the most cost-effective treatment for certain illnesses, in order to exclude sub-optimal treatments. However, the resulting recommendations were was not actually implemented.	2004: Yes, a national level institution
Norway 1995: Yes, a national level institution Remark: There are studies by the National Agency of Health and Social Affairs, the Norwegian Board of Health, and the Sosial- og helsedirektoratet, at the Ministry of Health.	2004: Yes, a national level institution Remark: There are studies by the National Agency of Health and Social Affairs, the Norwegian Board of Health, and the Directorate for Health and Social Affairs, Sosial- og helsedirektoratet, at the Ministry of Health.
Portugal 1995: No Remark: To some degree, the coverage of a new medicine is based on the evaluation of the medical efficacy of a new drug.	2004: Yes, a national level institution Remark: Since 1998, the INFARMED is also in charge to evaluate the medical efficacy and the cost effectiveness of new technologies. There are guidelines issued by the Ministry of Health on

Q3 Is there an institution gathering and distributing information on **Medical Efficacy** of different treatments for the same illness?	
	how to conduct evaluations of medical technology and treatments.
Poland 1995 Yes, a national level institution Remark: The scientific associations, usually of specialties, which issue guidelines also evaluate medical efficacy of different treatments.	2004: Yes, a national level institution; Remark: The scientific associations, usually of specialties, which issue guidelines also evaluate medical efficacy of different treatments.
Spain 1995: No	2004: No
Sweden 1995: Yes, a national level institution; e.g. the Swedish council on Technology Assessment, SBU.	2004: Yes, a national level institution; e.g. the Swedish council on Technology Assessment, SBU
Switzerland 1995: No	2004: No
United Kingdom 1995: Yes, national level as well as local level institutions, NICE the most important one at national level	2004: Yes, national level as well as local level institutions, NICE the most important one at national level

Q4 Is there an institution gathering and distributing information on the **Cost Effectiveness** of different treatments for the same illness?	
Austria 1995: No	2004: No. Remark: There is no institution with formal or binding competence, but several Departments on evidence-based Medicine, and also Health Insurance Funds are active in this area
Belgium 1995: No	2004: Yes, a national level institution Remark: The INAMI and several Technical Advisory Boards associated with it.
Canada 1995: Yes, a national level institution; Canadian Institute for Health Information, CIHI, since 1994 Remark: A non-governmental institution, the Canadian Council on Health Services Accreditation, is engaged in reviewing and assessing hospitals, giving them advice on how to improve performance. This is however done on bilateral basis.	2004: Yes, a national level institution; CIHI Remark: A non-governmental institution, the Canadian Council on Health Services Accreditation, is engaged in reviewing and assessing hospitals, giving them advice on how to improve performance. This is however done on bilateral basis.
Czech Republic 1995: No	2004: Yes, a national institution Remark: The Drug and Technology Control Institute, attached to the Ministry of Health, evaluates different treatments with regard to cost and effectiveness.
Denmark 1995: Yes, the institutions listed in Q3. Remark: The evaluation based on cost-effectiveness is not the main issue, is not done systematically and binding way	2004: Yes, the institutions listed in Q3. Remark: The evaluation based on cost-effectiveness is not the main issue, is not done systematically and binding way
Finland 1995: No	2004: Yes, national level institution Remark: The Finnish office of Health Technology Assessment at the STAKES Institute
France 1995: Yes, the national level institutions listed in Q3. Remark: The focus is safety, not cost effectiveness and the outcomes are but of marginal relevance	2004: Yes, the national level institutions listed in Q3. Remark: The focus is safety, not cost effectiveness and the outcomes are but of marginal relevance

Q4 Is there an institution gathering and distributing information on the **Cost Effectiveness** of different treatments for the same illness?	
Germany 1995: No	2004: Yes, a national level institution, the IQWiG Remark: The impact is marginal
Greece 1995: No	2004: No
Hungary 1995: Yes, a national level institution Remark: There are National Institutes of Health for several specialties	2004: Yes, a national level institution
Ireland 1995: Yes, for pharmaceuticals Remark: The General Medical Services Board issues a bulletin on different medicines for treating the same illnesses. The impact is estimated to be limited	2004: Yes, for pharmaceuticals Remark: The National Center for Pharmacoeconomics and the General Medical Services Board – which issues a bulletin on different medicines for treating the same illnesses. The impact is estimated to be limited
Italy 1995. Yes, a national level institution Remark: There is a strong role of the national as well as the regional Ministries of Health	2004: Yes, a national level institution Remark: There is a strong role of the national as well as the regional Ministries of Health
Luxembourg 1994: No	2004: No
Netherlands 1995: Yes, national and regional level institutions	2004: Yes, national and regional level institutions
New Zealand 1995: Yes, national level institutions Remark: Apart from a national level institution, involved in grouping of pharmaceuticals to classes of therapeutical equivalents, PHARMAC,. The National Health Committee was created to identify the most cost-effective treatment for certain illnesses, in order to exclude sub-optimal treatments. To some degree, this involved an evaluation of health technology or procedures and the comparison of cost effectiveness. However, the results were not implemented.	2004: Yes, national level institutions for several domains
Norway 1995: Yes, national as well as regional/local level institutions Remark: There are studies on cost effectiveness for products and treatments conducted by the National Agency of Health and Social	2004: Yes, national as well as regional/local level institutions Remark: Cost effectiveness studies are conducted e.g. by the National Agency of Health and Social Affairs, the Sosial- og helsedirektoratet,

Q4 Is there an institution gathering and distributing information on the **Cost Effectiveness** of different treatments for the same illness?	
Affairs, the Directorate for Health and Social Affairs, Sosial- og helsedirektoratet, of the Ministry of Health, and several publicly funded research institutions.	within the Ministry of health, and several publicly funded research institutions. The evaluation of pharmaceuticals is done by the Norwegian Medicines Agency.
Portugal 1995: No	2004: Yes, a national level institution Remark: Since 1998, the INFARMED is also in charge to evaluate the medical efficacy and the cost effectiveness of new technologies. There exist official guidelines, issued by the Ministry of Health, for economic evaluation of medicines. Results of evaluation studies should be handed over to the regulatory agency, INFARMED. Results are however not published and have no influence on the practice.
Poland 1995: No Remark: While there are scientific associations associated with medical specialties, cost effectiveness is not an issue in their evaluations.	2004: No Remark: While there are scientific associations associated with medical specialties, cost effectiveness is not an issue in their evaluations. The newly created Health Technology Assessment Agency, a national level institution, is expected to cover this aspect.
Spain 1995: Yes, a national level institution, Spanish Office of Technology Assessment; in several regions there are similar institutions as well	2004: Yes, a national level institution, Spanish Office of Technology Assessment; in several regions there are similar institutions as well
Sweden 1995: Yes, a national level institution, the SBU and the National Board of Health and Welfare	2004: Yes, a national level institution, the SBU and the National Board of Health and Welfare
Switzerland 1995: No	2004: No
United Kingdom 1995; Yes, national level as well as local level institutions; NICE and NIHCE	2004: Yes, national level institutions; NICE / NIHCE

Q5 Is there an institution gathering information on the **Quality of Providers** of medical services? For instance is there institution performing an evaluation of hospitals, comparable to the star-rating in the UK? Or, is there an institution issuing reports of the occurrence of medical failures etc. in different Hospitals or for GPs?	
Austria 1995: No	2004: No, there is no institution with formal competence to do so Remark: The Österreichische Gesellschaft für Qualitätssicherung und Qualitätsmanagement is involved in this task and does evaluations of the GPs.
Belgium 1995. No	2004: No Remark: In 1997, evaluation committees for Hospitals were established, their task was to help the hospitals to increase their quality of care but also the financial performance. The data is collected in a database, which allows hospitals to compare their performance with others. The Health Insurance Funds provide some information on extra-payments charged by different hospitals. Occasionally, they also collect information on the quality of treatments
Canada 1995: No Remark: A non-governmental institution, the Canadian Council on Health Services Accreditation, is engaged in reviewing and assessing hospitals, giving them advice on how to improve performance. This is however done on bilateral basis.	2004: Yes, several national as well as provincial level institutions, e.g. the Quality Health Care network Remark: In some provinces there is an extensive system of provider evaluations, covering quality, outcomes and financial matters. Further, there is still Canadian Council on Health Services Accreditation.
Czech Republic 1995: No	2004: Yes, a national level institution Remark: There is a National Reference Center founded by the HIF which gathers and evaluates the cost effectiveness of health facilities. The Ministry of Health is also active in evaluating treatment quality.
Denmark 1995: No	2004: Yes, at the national level the Ministry of the Interior and Health and institutes handling patient errors and medical maltreatment

Q5 Is there an institution gathering information on the **Quality of Providers** of medical services? For instance is there institution performing an evaluation of hospitals, comparable to the star-rating in the UK? Or, is there an institution issuing reports of the occurrence of medical failures etc. in different Hospitals or for GPs?	
Finland 1995: Yes, a national level institution	2004: Yes, a national level institution affiliated with the STAKES /CHESS, conducts a Benchmarking on a voluntary basis
France 1995: No Remark: There are rankings done by newspapers	2004: No Remark: There are rankings done by newspapers
Germany 1995: No	2004: No Remark: There are some voluntary initiatives and also comparisons done by the press
Greece 1995: No	2004: No
Hungary 1995: Yes, a national level institution Remark: The NPHMOS and the Information Center for Health Care at the Ministry of Health are formally in charge of quality control	2004: Yes, a national level institution Remark: The NPHMOS and the Information Center for Health Care at the Ministry of Health are formally in charge of quality control
Ireland 1995: No	2004: No
Italy 1995: Yes, a national level institution; but it does not perform rankings and has no formalized approach. Further, the media performs some rankings Remark: Many contracts between the SSN and independent providers specify quality requirements and also measures to ensure that these are met in practice	2004: Yes, a national level institution; but it does not perform rankings and has no formalized approach. Further, the media performs some rankings Remark: Many contracts between the SSN and independent providers specify quality requirements and also measures to ensure that these are met in practice
Luxembourg 1994: No	2004: No
Netherlands 1995. No	2004: Yes, a national level institution
New Zealand 1995: No	2004: Yes, a national level institution Remark: The purchasers are required to evaluate the contracting partners, but this is more in the sense of an auditing. Further there is the "Quality Health New Zealand", an agency in charge of assessing medical providers, also to improve their performance

Q5 Is there an institution gathering information on the **Quality of Providers** of medical services? For instance is there institution performing an evaluation of hospitals, comparable to the star-rating in the UK? Or, is there an institution issuing reports of the occurrence of medical failures etc. in different Hospitals or for GPs?	
Norway 1995: No	2004: Yes, a national level institution Remark: The Directorate for Health and Social Affairs, Sosial- og helsedirektoratet. The Norwegian Board of Health is also active in supervising health professionals and the delivery of health services.
Portugal 1995: No	2004: Yes. Remark: Since 2000, an Institute for Quality in Health was founded, which is responsible for quality assessment of Hospitals
Poland 1995: No Remark: There are rankings of providers published in professional journals and the press.	2004: No Remark: There are rankings of providers published in professional journals and the press.
Spain 1995: No	2004: No
Sweden 1995: Yes, for some specialties and by the counties which are conducting a quality control of their Hospitals	2004: Yes, for some specialties and by the counties which are conducting a quality control of their Hospitals Remark: In addition, a more systematic collection of data on quality is now introduced by the National Board of Health and Welfare and the Association of Local Authorities, SKL
Switzerland 1995: No	2004: No
United Kingdom 1995: Yes, several national level institutions. Remark: The star-ranking done by the NHS is the most important public evaluation of hospital trusts. There is also internal quality control exercised by the NHS over the providers holding contracts with DHA	2004: Yes, several national level institutions. Remark: The star-ranking done by the NHS is the most important public evaluation of Hospital trusts. There is also internal quality control exercised by the NHS over the providers holding contracts with DHA

Q6 If collected: is the information on the **Quality of Providers** published or made available? E.g. are evaluations, rankings or performance indicators of Hospitals published to the public or only to the providers themselves?	
Austria 1995: Not applicable; see Q5	2004: Not applicable; see Q5
Belgium 1995: No; see Q5	2004: Yes, but only to the providers themselves Remark: This concerns the data base on quality and (financial) performance for hospitals. Hospitals can access the data to compare their own performance in issues of quality and financial issues
Canada 1995: No – information on quality was not collected in a systematic way	2004: Yes, information on provider quality is published to everybody
Czech Republic 1995: No such information is collected, see Q5	2004: Yes, information on provider quality is published to everybody Remark: Ministry of Health is also active in evaluating treatment quality, and has published the results, which are however debated for methodological reasons. There are various research projects, which evaluate health facilities.
Denmark 1995: No; see Q5	2004: Yes, from 2004 on, quality reports are made public via www.sundhet.dk
Finland 1995: Yes, some information is published to everybody, but the information on quality assessment is published only to the providers themselves. Remark: Information on costs, outputs, treatment practice and to some extent on the outcomes is collected and distributed	2004: Yes, some information is published to everybody, but the information on quality assessment is published only to the providers themselves. Remark: Information on costs, outputs, treatment practice and to some extent on the outcomes is collected and distributed
France 1995: No	2004: No
Germany 1995: No; see Q5	2004: No, see Q5. Remark: There are some comparisons in the press, in particular for Hospitals
Greece 1995: No, see Q5	2004: No; see Q5
Hungary 1995: Yes, but the information on quality	2004: Yes, but the information on quality

Q6 If collected: is the information on the **Quality of Providers** published or made available? E.g. are evaluations, rankings or performance indicators of Hospitals published to the public or only to the providers themselves?	
assessment is published only to the providers themselves.	assessment is published only to the providers themselves.
Ireland 1995: No	2004: No
Italy 1995: Yes; information on provider quality is published to everybody. Rankings and evaluations made by the mass media are published.	2004: Yes, information on provider quality is published to everybody. Rankings and evaluations made by the mass media are published.
Luxembourg 1994: No; see Q5	2004: No; see Q5
Netherlands 1995: No	2004: Yes, the information is published. Remark: The information is usually published to the providers themselves only, in some cases it is published to everybody
New Zealand 1995: No	2004: Yes, the information on provider quality is published to everybody
Norway 1995: No Remark: No such information is gathered	2004: Yes, the information is published to everybody
Portugal 1995: Not applicable; see Q5	2004: Yes, but the information is published to the providers themselves only.
Poland 1995: No Remark: While there is no formal ranking or evaluation done, the rankings done by professional journals and the press are publicly available.	2004: No Remark: While there is no formal ranking or evaluation done, the rankings done by professional journals and the press are publicly available.
Spain 1995: No; see Q5	2004: No; see Q5
Sweden 1995: Yes, but the information is published to the providers themselves only; it is collected and published within the different specialties and used within the Local/ Hospital administration only	2004: Yes, but the information is published to the providers themselves only; it is collected and published within the different specialties and used within the Local/ Hospital administration only Since 2004, mortality of infarct treatment in Hospitals is published
Switzerland 1995: No	2004: No

Q6 If collected: is the information on the **Quality of Providers** published or made available? E.g. are evaluations, rankings or performance indicators of Hospitals published to the public or only to the providers themselves?	
United Kingdom 1995: Yes; evaluations are published to everybody, Remark: The most prominent example is the star rating. Only in some cases, the evaluation is only given to the providers	2004: Yes; evaluations are published to everybody Remark: The most prominent example is the star rating, available in the internet. Only in some cases, the evaluation is only given to the providers.

Q7 Do General Practitioners / Physicians have to renew their approbation or licence to provide medical services from time to time (**Recertification**) ?	
Austria 1995: No, once GPs / Physicians have obtained their licence, the don't have to renew it (No recertification)	2004: No, once GPs / Physicians have obtained their licence, the don't have to renew it (No recertification)
Belgium 1995. No recertification Remark In 1994, a system of accreditation was introduced as a mean of quality assurance. In order to get accreditation the physician must meet certain requirements, e.g. engage in continuous training. However, while accreditation leads to higher reimbursement, it is not compulsory	2004: No recertification Remark: The accreditation system is still operative
Canada 1995: No recertification	2004: No recertification
Czech Republic 1995: No recertification Remark: There is however an obligatory system of life-long education, which requires each physician to participate in a certain number of educational activities.	2004: No recertification Remark: There is however an obligatory system of life-long education, which requires each physician to participate in a certain number of educational activities.
Denmark: 1995: No recertification	2004: No recertification
Finland 1995: No recertification	2004: No recertification
France 1995: No recertification	2004: No recertification
Germany 1995: No recertification	2004: no recertification
Greece 1995: No recertification	2004: No recertification
Hungary 1995: Yes, medical providers have to renew their licence periodically	2004: Yes, medical providers have to renew their licence periodically
Ireland 1995: No recertification	2004: No recertification
Italy 1995: No recertification	2004: no recertification
Luxembourg 1994: No recertification	2004: No recertification
Netherlands 1995: Yes, medical providers have to renew their licence periodically	2004: Yes, medical providers have to renew their licence periodically
New Zealand 1995: No recertification	2004: Yes, medical providers have to renew their licence periodically

Q7 Do General Practitioners / Physicians have to renew their approbation or licence to provide medical services from time to time (**Recertification**) ?	
Norway 1995: No Remark: Renewal of a specialty license leads to higher income, the right to practice is not subject to recertification.	2004: No Remark: Renewal of a specialty license leads to higher income, the right to practice is not subject to recertification.
Portugal 1995: No recertification	2004: No recertification
Poland 1995: No recertification	2004: No recertification Remark: There is no formal recertification obligation, but a system of continual education is being introduced. Only some providers have to renew their license in intervals of five years.
Spain 1995. No recertification	2004: No recertification
Sweden 1995: No recertification	2004: No recertification
Switzerland 1995: No recertification	2004: No recertification Remark: Physicians have to attend to further education for a certain number of hours.
United Kingdom 1995: No recertification	2004: No recertification Remark: Recertification is currently introduced but not yet fully operational in 2004

Part III: Role of Government for the Health Care System

This section is about the role of the Government for the operation of the Health System, its timing and the degree to which it is actually involved in decisions made in the Health System. The term “Government” refers to a politically responsible, i.e. elected actor, be it the national, the regional or local government.

Governmental control ....
In some countries, the Government has encompassing and direct control over the Health Care System or can intervene substantially by other means – e.g. by setting annual budgets for health care.
In other countries, the Government restrains itself more, leaving the day-to-day operation of the Health Care System to societal, non-state-actors, like Health Insurance Funds, and Organizations of Medical Providers.

... or negotiations as central decision making mode.
In the case that decisions are made by societal actors, for instance by negotiations among purchasers and providers of medical care, the government can retain some influence in these negotiations. It can, for instance retain the right to approve or disapprove decisions reached in a binding way or by acting as an arbitrator in the case of persisting disagreement.

CG0 Which level of government is most important for control and interventions of the state in the Health Care System?	
Austria 1995: Central government; but on the hospital sector it only designed basic legislation The regional governments (Bundesländer) are most important for the Hospital sector Remark: Factually, the Central Government sets a frame, in which HIFs and Providers negotiate. The Regional Governments have direct influence on the hospital sector, usually by direct ownership	2004: Central government; but in the hospital sector only it designed basic legislation. The regional governments (Bundesländer) are most important for the Hospital sector) Remark: Factually, the Central Government sets a frame, in which HIFs and Providers negotiate. The Regional Governments have direct influence on the hospital sector, usually by direct ownership
Belgium 1995: Central government Remark: The regional governments are involved, but mainly execute the plans set up by the central government	2004: Central Government
Canada 1995: Provincial Governments Remark: The federal government sets some limits, but most of the financing and organizing is done by the Provincial governments. While the provincial governments have the option to determine unilaterally many of the aspects	2004: Provincial Governments Remark: The federal government sets some limits, but most of the financing and organizing is done by the Provincial governments. While the provincial governments have the option to determine unilaterally many of the aspects

CG0 Which level of government is most important for control and interventions of the state in the Health Care System?	
listed in the following, they only rarely do so. Most often, the decisions are made in negotiations with the providers of medical services. Further, they have abide to certain restraints set by the central Government, in particular on coverage.	listed in the following, they only rarely do so. Most often, the decisions are made in negotiations with the providers of medical services. Further, they have abide to certain restraints set by the central Government
Czech Republic 1995: Central government	2004: Central Government Remark: Regional governments have gained some importance during the decentralization process of the last decade: Ownership of Hospitals and Health Centers but also the execution of policy and decision by the central government were transferred to them and they have substantial leeway in doing this. Depending on the political orientation of the regional government, the usage of market mechanisms is very strong in some regions.
Denmark 1995: Local government: Municipalities “Kommuner” and Counties “Amter”; the later are in charge of the Hospitals	2004: Local government: Municipalities, “Kommuner”, and Counties “Amter””; the later are in charge of the Hospitals
Finland 1995: Local Government (Municipalities and counties)	2004: Local Government (Municipalities and Counties)
France 1995: Central government	2004: Central Government
Germany 1995: Central government, which sets frames for other actors The Regional Governments are most important for Hospitals with a formal planning competence	2004: Central government, which sets frames for other actors The Regional Governments are most important for Hospitals with a formal planning competence
Greece 1995: Central Government	2004: Central Government
Hungary 1995: Central Government	2004: Central Government
Ireland 1995: Central Government Remark: The central government exercises influence either directly via the Department of Health or via the Health Boards. The control is stronger for the domain of services provided to medical card holder, and less strict for the remaining 2/3 of the population.	2004: Central Government Remark: The central government exercises influence either directly via the Department of Health or via the Health Boards. The control is stronger for the domain of services provided to medical card holder, and less strict for the remaining 2/3 of the population.
Italy 1995: Central Government	2004: Central Government;

CG0 Which level of government is most important for control and interventions of the state in the Health Care System?	
	The regional government Remark: There is an increased role for the Regional Government as a consequence of decentralization in the 90s. Powers are shared between the regional and the national government, organizational and administrative powers are located at the regional level. Regions obtain funds from the central government and execute the health policy set by the national government.
Luxembourg 1994: Central Government	2004: Central Government
Netherlands 1995: Central Government	2004: Central Government Remark: The competencies for Hospitals are held at the Provincial Level
New Zealand 1995: Central Government Remark: Regional Health Authorities have an important role and leeway, but they are appointed by the Central Government.	2004: Central Government Remark: The District Health Boards have an important role and some leeway, but they are under strong control of the Central Government and part of their executive is appointed by the Central Government.
Norway 1995. County councils and Central Government Remark: County Councils are in charge of hospital care, they own and operate most hospitals; Municipalities are in charge of primary care, by running health centers.	2004: Central Government Remark: Control was transferred from the counties to the central government. The division of responsibilities for primary and inpatient care remained unchanged. Most of the primary care is now provided by self employed GPs working in private practice.
Portugal 1995: Central Government Remark: The control is exercised directly on the hospitals and indirect, via the Regional Health Authorities, Administração Regionais de Saúde, on the health Centers providing primary care.	2004: Central Government Remark: The control is exercised directly on the hospitals and indirect, via the Regional Health Authorities, Administração Regionais de Saúde, on the health Centers providing primary care. The sub regional level as the tier between the RHA and the Health Centers has lost importance and is disappearing.
Poland 1995: Central Government Remark: The municipalities/gminas and regional	2004: Central Government Remark: The municipalities/gminas and regional

CG0 Which level of government is most important for control and interventions of the state in the Health Care System?	
governments/ voivodships have substantial influence on the hospitals, since they are owning and operating most of them.	governments/ voivodships have substantial influence on the hospitals, since they are owning and operating most of them. With the introduction of the NHF, political actors are involved in controlling the NHF at their level.
Spain 1995: Central Government Remark: Some regions were quite autonomous by then. Most control was exercised by the INSALUD, which was directly under control of the central government	2004: The regional Governments of the Autonomous Communities Remark: The decentralization process of devolving competencies to the Regions was completed in 2002. The control is exercised by the Regional Health Authorities, Servicio Regional de Salud, SRS, which is under direct control of the regional government.
Sweden 1995: Regional Government: Landsting, county councils	2004: Regional Government (Landsting, county councils)
Switzerland 1995: Central (Federal) Government and Regional Government (Kanton) Remark: The Central (Federal) Government is in charge of coordinating and setting a common frame for the Cantons, e.g. the basic service package. It is also in charge of deciding on the market authorization and the coverage of pharmaceuticals. The Cantons, Regional Governments, control most of the Hospital sector and can approve / disapprove the results of negotiations among providers and HIFs in the Canton.	2004: Central (Federal) Government and Regional Government (Kanton) Remark: The Central (Federal) Government is in charge of coordinating and setting a common frame for the Cantons, e.g. the basic service package. It is also in charge of deciding on the market authorization and the coverage of pharmaceuticals. The Cantons, Regional Governments, control most of the Hospital sector and can approve / disapprove the results of negotiations among providers and HIFs in the Canton.
United Kingdom 1995: Central Government	2004: Central Government

1. Role of the Central Government

Thinking about the role of the Central Government vis-à-vis of societal actors.

CG1 Are there are negotiations among Providers of medical services on the one side and Health Insurance Funds/ Health Authorities on the other side, in which e.g. issues of level of remuneration, fees or coverage are negotiated? Or, does the Central government determine these issues unilaterally? If there are negotiations, what is the timing and the role of the Central Government's participation in these negotiations?	
Austria 1995: There are Negotiations, but the Central Government has no role in the negotiations; Remark: Only in the case of no agreement, there is some role of the Government	2004: There are Negotiations, but the Central Government has no role in the negotiations; Remark: Only in the case of no agreement, there is some role of the Government
Belgium 1995: There are negotiations among medical providers and the HIF on catalogues of services and fees. The Central Government participates after the negotiations. The Governments approval is required for any negotiation outcome reached by the HIF and the Providers. It can unilaterally change the results and set results unilaterally, if negotiations fail to reach an outcome, and has done so in the past.	2004: There are negotiations among medical providers and the HIF on catalogues of services and fees. The Central Government participates after the negotiations. The Governments approval is required for any negotiation outcome reached by the HIF and the Providers. It can unilaterally change the results and set results unilaterally, if negotiations fail to reach an outcome, and has done so in the past.
Canada 1995: There are negotiations, the provincial governments participate in the negotiations, either directly or via the Regional Health Authorities, RHA. Fees are negotiated with providers, budgets are negotiated with the hospitals.	2004: There are negotiations, the provincial governments participate in the negotiations, either directly or via the Regional Health Authorities, RHA. Fees are negotiated with providers, budgets are negotiated with the hospitals.
Czech Republic 1995: There are negotiations, and the Central Government supervises the negotiations. It has to approve the outcomes, which have to be in accordance with the public interest. Further, it can unilaterally change the results and set results unilaterally, if negotiations fail to reach an outcome Remark: Most negotiations are among individual HIF and providers / provider associations. Via the direct control over the largest HIF, the GHIF, which sets a benchmark for the negotiations of other HIF, the central government also is participating.	2004: There are negotiations, and the Central Government supervises the negotiations. It has to approve the outcomes, which have to be in accordance with the public interest. Further, it can unilaterally change the results and set results unilaterally, if negotiations fail to reach an outcome Remark: Most negotiations are among individual HIF and providers / provider associations. Via the direct control over the largest HIF, the GHIF, which sets a benchmark for the negotiations of other HIF, the central government also is participating.
Denmark 1995: There are negotiations, and the central	2004: There are negotiations, and the central

CG1 Are there are negotiations among Providers of medical services on the one side and Health Insurance Funds/ Health Authorities on the other side, in which e.g. issues of level of remuneration, fees or coverage are negotiated? Or, does the Central government determine these issues unilaterally? If there are negotiations, what is the timing and the role of the Central Government's participation in these negotiations?	
government participates mostly after the negotiations Grants from the Central government to the Amter are negotiated among both Negotiation outcomes reached between the Amter and the Providers of medical care need the approval of the central Government	government participates mostly after the negotiations Grants from the Central government to the Amter are negotiated among both Negotiation outcomes reached between the Amter and the Providers of medical care need the approval of the central Government
Finland 1995: There are negotiations among the municipalities and the providers, but the Central Government has no role in these	2004: There are negotiations among the municipalities and the providers, but the Central Government has no role in these
France 1995: There are negotiations among HIF and the providers and the Central Government can approve or disapprove of the results Remark: Health Insurance Funds and the providers negotiate the catalogue of medical services covered (nomenclature) and the price of the services. The state can approve or disapprove	2004: There are negotiations among HIF and the providers and the Central Government can approve or disapprove of the results. Remark: Health Insurance Funds and the providers negotiate the catalogue of medical services covered (nomenclature) and the price of the services. The state can approve or disapprove
Germany 1995: There are negotiations among providers and Health Insurance Funds Remark: While the Central Government sets a broad frame for these negotiations, it has no role in the negotiations unless they fail to reach an outcome. It can however disapprove of the results, in which case the Health Insurance Funds and the Providers have to renegotiate. However, this never happens	2004: There are negotiations among providers and Health Insurance Funds Remark: While the Central Government sets a broad frame for these negotiations, it has no role in the negotiations unless they fail to reach an outcome. It can however disapprove of the results, in which case the Health Insurance Funds and the Providers have to renegotiate. However, this never happens
Greece 1995: There are negotiations, the Central Government participates during the negotiations Remark: Negotiations take place between the government and other actors, e.g. the hospitals, the HIF etc. Many issues concerning contracts made by the HIF are also influenced by the government, since it controls closely the largest HIF – the IKA and OGA, covering 80% of the population.	2004: There are negotiations, the Central Government participates during the negotiations Remark: Negotiations take place between the government and other actors, e.g. the hospitals, the HIF etc. Many issues concerning contracts made by the HIF are also influenced by the government, since it controls closely the largest HIF – the IKA and OGA, covering 80% of the population.
Hungary 1995: There are no negotiations, the Central	2004: There are no negotiations, the Central

CG1 Are there are negotiations among Providers of medical services on the one side and Health Insurance Funds/ Health Authorities on the other side, in which e.g. issues of level of remuneration, fees or coverage are negotiated? Or, does the Central government determine these issues unilaterally? If there are negotiations, what is the timing and the role of the Central Government's participation in these negotiations?	
Government controls all aspects of the Health System Remark: It does so by directly setting sectorial budgets and by controlling the NHIFA, which negotiates contracts with the providers	Government controls all aspects of the Health System
Ireland 1995: There are negotiations on many aspects of the Health System, the Government participates during these negotiations and has a strong position.	2004: There are negotiations on many aspects of the Health System, the Government participates during these negotiations and has a strong position.
Italy 1995: There are negotiations, e.g. between the ASL and the providers, the Central Government participates during the negotiations but also has possibilities to intervene after the negotiations	2004: There are negotiations at several levels The Central Government participates during the negotiations with the Regions, but also has possibilities to intervene after the negotiations that have taken place at lower levels.
Luxembourg 1994: There are Negotiations among HIFs and the providers; while the Central Government has no direct role in the negotiations, it participates nevertheless, since one member of the HIF association, the UCM, is determined by the government and the decisions of the UCM require the approval of the government	2004: There are Negotiations among HIFs and the providers; while the Central Government has no direct role in the negotiations, it participates nevertheless, since one member of the HIF association UCM, is determined by the government and the decisions of the UCM require the approval of the government
Netherlands 1995: There are negotiations, and in some domains the Central Government participates during the negotiations. It can also set results unilaterally, if the negotiations failed to reach an outcome. Usually, outcomes reached are subject to approval of the Government	2004: There are negotiations, and in some domains the Central Government participates during the negotiations. It can also set results unilaterally, if the negotiations failed to reach an outcome. Usually, outcomes reached are subject to approval of the Government
New Zealand 1995: There are negotiations among the Regional Health Authorities and providers of medical services on fees, services and costs. Remark: The four Regional Health Authorities (RHA), which are purchasing health services, are negotiating contracts with providers, here the central government does not participate. The RHA administration is appointed by the central government, which also sets the	2004: There are negotiations among the District Health Boards and the providers of medical services on costs and services. The central government can afterwards approve or disapprove of the results. Remark: This does however, not have consequences for the outcomes. The central government sets the budgets of the DHBs. During the period of 1996 and 2000, the then four Regional Health

CG1 Are there are negotiations among Providers of medical services on the one side and Health Insurance Funds/ Health Authorities on the other side, in which e.g. issues of level of remuneration, fees or coverage are negotiated? Or, does the Central government determine these issues unilaterally? If there are negotiations, what is the timing and the role of the Central Government's participation in these negotiations?	
budgets of the RHA.	Authorities were replaced by the Health Funding Authority, which centrally managed all purchasing.
Norway 1995: The central government as well as the county governments are in charge of the Health system. Remark: There is little negotiating and contracting between the state and independent providers, since only primary care is contracted. Hospital care and specialized care provided by hospitals are under close control of the state, counties and the national government.	2004: The competencies are still split among the counties and the central government. Remark: The role of the central government has increased. Most elements of the health system are still under control of the state.
Portugal 1995: There are no negotiations. The Government controls most aspects of the Health System Remark: The Central government sets the prices of the NHS, remuneration of professionals and decides on the coverage of medical services by providing the funds for them. If there are negotiations, it is the Central Government, i.e. the Ministry of Health, which is leading the negotiations. Instances of negotiations are the setting of hospital budgets, the retail margins for pharmacies or prices of medicines. The allocation of funds to the Regional Health Authorities, Administração Regionais de Saúde, which is going into the Health Centers providing primary care is set by the government. The central government has also some, but less control over the private sector. The subsistemas have relative autonomy, and so have the providers of privately purchased care, e.g. private specialists or dentists. Societal groups, e.g. providers and patients, are heard, but have an advisory role only.	2004: There are no negotiations, the government controls all aspects of the public NHS system. Remark: The Central government sets the prices of the NHS, remuneration of professionals and decides on the coverage of medical services by providing the funds for them. If there are negotiations, it is the Central Government, i.e. the Ministry of Health, which is leading the negotiations. Instances of negotiations are the setting of hospital budgets, the retail margins for pharmacies or prices of medicines. The allocation of funds to the Regional Health Authorities, Administração Regionais de Saúde, which is going into the Health Centers providing primary care is set by the government. The central government has also some, but less control over the private sector. The subsistemas have relative autonomy, and so have the providers of privately purchased care, e.g. private specialists or dentists. Societal groups, e.g. providers and patients, are heard, but have an advisory role only.
Poland 1995: There are no negotiations, the government controls all elements of the health care system. Remark: Both, provision and financing, were public.	2004: There are negotiations among the National Health Fund and providers of medical services. The Central government participates directly in the negotiations and can also set results

CG1 Are there are negotiations among Providers of medical services on the one side and Health Insurance Funds/ Health Authorities on the other side, in which e.g. issues of level of remuneration, fees or coverage are negotiated? Or, does the Central government determine these issues unilaterally? If there are negotiations, what is the timing and the role of the Central Government's participation in these negotiations?	
The municipalities/gminas and the regions/voivodships were in charge of providing primary and secondary care. They were financed by allocations from the central government's budget.	unilaterally, if the negotiations fail. Remark: In 2004, questions of services, remuneration level and remuneration mode are negotiated among providers and the NHF. The contracting is done by a competitive tendering: the NHF puts out a defined bundle of services and costs to tender. Providers can apply for this tender. Specifics of the contract are then negotiated among the NHF and the applicant. Providers have hence some influence, but the influence of the NHF is much stronger. Since the government closely controls the NHF, this gives the government a strong role
Spain 1995: There are negotiations among the INSALUD and the provider organizations, the Central Government participates in these by controlling the INSALUD There are also negotiations among the Central Government and the Regional Governments on the Funding	2004: There are Negotiations among the Regional health Authorities, SRS, and the provider organizations. The regional Government of the autonomous community participates by controlling the SRS There are also negotiations among the Central Government and the Regional Governments on the Funding
Sweden 1995: There are no Negotiations, the Landsting (regional Government) controls all aspects of the Health System. Remark: Only the salaries of the physicians employed are negotiated between the Landstings and the Physicians	2004: There are no Negotiations, the Landsting (regional government) controls all aspects of the Health System Remark: Only the salaries of the physicians employed are negotiated between the Landstings and the Physicians
Switzerland 1995: There are negotiations among medical providers and the Health Insurance Funds. The Regional (cantonal) government participates after the negotiations – it can set results unilaterally, if the negotiations failed to reach an outcome.	2004: There are negotiations among medical providers and the Health Insurance Funds. The Regional (cantonal) government participates after the negotiations – it can set results unilaterally, if the negotiations failed to reach an outcome.
United Kingdom 1995: There are no negotiations as an instrument of setting the basic elements of the Health system; the Government can set the elements of the health system almost unilaterally. Remark:	2004: There are no negotiations as an instrument of setting the basic elements of the Health system; the Government can set the elements of the health system almost unilaterally. Remark:

CG1 Are there are negotiations among Providers of medical services on the one side and Health Insurance Funds/ Health Authorities on the other side, in which e.g. issues of level of remuneration, fees or coverage are negotiated? Or, does the Central government determine these issues unilaterally? If there are negotiations, what is the timing and the role of the Central Government's participation in these negotiations?	
The national Governments sets the overall budget and negotiates the budgets assigned to the District Health Authorities. These then negotiate contracts with the Hospitals. The contract with the GPs is negotiated directly between the Department of Health and the GPs' association, the General Medical Services Committee. Overall the system is a strong command and control system, in which the national level institutions, the NHS and the Department of Health, can exert substantial control and supervision.	The national Governments sets the overall budget and negotiates the budgets assigned to the District Health Authorities. These then negotiate contracts with the Hospitals. The contract with the GPs is negotiated directly between the Department of Health and the GPs' association, the General Medical Services Committee. Overall the system is a strong command and control system, in which the national level institutions, the NHS and the Department of Health, can exert substantial control and supervision.

2. Unilateral competencies of the Government

The following questions concern the competencies of the central government: Which elements of the Health Systems can be set by the central government unilaterally?
Unilaterally refers to whether the Central Government has currently the legal possibility to determine the aspect, e.g. by making directive or issuing a decree etc.
Not, whether the Central Government actually does exert the competence, but has the formal right to do so under the current laws.

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
Austria 1995: None; Remark: Everything its negotiated among Health Insurance Funds and the Provider Organizations. The central government can influence the way providers of primary care are organized, i.e. on regional or national level	2004: None Remark: Everything its negotiated among Health Insurance Funds and the Provider Organizations. The central government can influence the way providers of primary care are organized, i.e. on regional or national level
Belgium 1995: Catalogue of Primary Care services covered by the health system Questions of capacity (e.g. number of Primary Care Physicians per capita or in a region)– by controlling access to the medical education; for GPs this access control is quite weak The overall budget for expenditure for Primary Care – sectorial target budget The way Primary Care is remunerated The level of remuneration of Primary Care services, e.g. the amount of fees – disapproval of the fees negotiated between the HIF and the Provider The way, the providers of Primary Care are organized, e.g. regional level or national-level organization Remark: While the government can in theory set all these elements, it does so only rarely in a unilateral way. Most often, the issues are negotiated among the HIF and the Providers with influence by the government	2004: Catalogue of Primary Care services covered by the health system Questions of capacity, since 1996 there is extensive human resources planning, using a numerus clausus to contain the number of physicians The overall budget for expenditure for Primary Care – sectorial target budget The way Primary Care is remunerated The level of remuneration of Primary Care services, e.g. the amount of fees - disapproval of the fees negotiated between the HIF and the Provider The way, the providers of Primary Care are organized, e.g. regional level or national-level organization Remark: While the government can in theory set all these elements, it does so only rarely in a unilateral way. Most often, the issues are negotiated among the HIF and the Providers with influence by the government
Canada 1995: Provincial Government controls: Catalogue of Primary Care services covered by the health system Questions of capacity (e.g. number of Primary Care Physicians per capita or in a region)	2004: Provincial Government controls: Catalogue of Primary Care services covered by the health system Questions of capacity (e.g. number of Primary Care Physicians per capita or in a region) The overall budget for expenditure for

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
The overall budget for expenditure for Primary Care The way Primary Care is remunerated (e.g. fee for service or a per-capita budget etc.) The level of remuneration of Primary Care services, e.g. the amount of fees The way, the providers of Primary Care are organized, e.g. regional level or national-level organization. Remark: The catalogue – according to the constraint set by the federal government - must cover everything that is medically necessary. The provincial governments could act unilaterally, but usually, these issues are negotiated with the physician associations	Primary Care The way Primary Care is remunerated (e.g. fee for service or a per-capita budget etc.) The level of remuneration of Primary Care services, e.g. the amount of fees The way, the providers of Primary Care are organized, e.g. regional level or national-level organization. Remark: The catalogue – according to the constraint set by the federal government - must cover everything that is medically necessary. The provincial governments could act unilaterally, but usually, these issues are negotiated with the physician associations
Czech Republic 1995: Central Government: Catalogue of Primary Care services covered by the health system Questions of capacity (e.g. number of physicians per capita or in a region) The way Primary Care is remunerated Remark: The government defines a basic package of services by law. Most negotiations of these issues are among individual HIF and providers, the Central government has influence on the results. The remuneration is based on a point system, and the number of points a service is worth, is set by the Ministry of Health.	2004: Central Government Catalogue of Primary Care services covered by the health system Questions of capacity The way Primary Care is remunerated Remark: The government defines a basic package of services by law. Most negotiations of these issues are among individual HIF and providers, the Central government has influence on the results. The remuneration is based on a point system, and the number of points a service is worth, is set by the Ministry of Health.
Denmark 1995: Competencies at County “Amter” Level The overall budget for Primary Care services Questions of capacity - by controlling the access to the medical education, it can also indicate, where providers have to be located but does not do so The level of remuneration of Primary Care is negotiated with the providers Competencies of the Central Government The Central Government is involved in the way Primary Care is remunerated (e.g. fee for service or a per-capita budget etc.) The central Government can recommend levels of overall health spending at the Amter level	2004: Competencies at County “Amter” Level The overall budget for Primary Care services Questions of capacity - by controlling the access to the medical education, it can also indicate, where providers have to be located but does not do so The level of remuneration of Primary Care is negotiated with the providers Competencies of the Central Government The Central Government is involved in the way Primary Care is remunerated (e.g. fee for service or a per-capita budget etc.) The central Government can recommend levels of overall health spending at the Amter level

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
Remarks: There is no positive catalogue of primary care services covered by the Health System but some treatments are excluded.	Remarks: There is no positive catalogue of primary care services covered by the Health System but some treatments are excluded.
Finland 1995: Municipalities control: Catalogue of primary care services covered Questions of capacity – employment in the health centers operated by the Municipalities Overall budget for primary care Determine the top-level management of the organizations of providers of primary care Remark: The central Government has some say on the Catalogue of Primary Care services covered by the National Health Insurance, but this concerns only private services.	2004: Municipalities control: Catalogue of primary care services covered Questions of capacity – employment in the health centers operated by the Municipalities Overall budget for primary care Determine the top-level management of the organizations of providers of primary care Remark: The central Government has some say on the Catalogue of Primary Care services covered by the National Health Insurance, but this concerns only private services.
France 1995: Catalogue of Primary Care services covered by the health system, is subject to approval Questions of capacity - the number of Primary Care Physicians entering the job: by a national numerus clausus (access in 2 years of medical study) and repartition by specialty by decree. The government sets a "concours", i.e. determines how many students may pass the exams and proceed in their education Remark: The catalogue of services, (nomenclature) and the tariffs for each service listed in the nomenclature (convention) is negotiated between the HIFs and the Providers, but subject to approval of the government	2004: Catalogue of Primary Care services covered by the health system, is subject to approval Questions of capacity - the number of Primary Care Physicians entering the profession by a "concours" procedure) and repartition by specialty by decree The overall budget for Primary Care services is set by parliamentary vote, since 1996 Remark The catalogue of services, (nomenclature) and the tariffs for each service listed in the nomenclature (convention) is negotiated between the HIFs and the Providers, but subject to approval of the government
Germany 1995: None Remark: While the Government could by law influence many aspects, its actual role is very limited, and it never exerts its rights	2004: None Remark: While the Government could by law influence many aspects, its actual role is very limited, and it never exerts its rights
Greece 1995 The central government controls: Catalogue of Primary Care services covered by the health system Questions of capacity – by deciding on employment in the ESY The overall budget for expenditure for Primary Care provided by the ESY	2004: The central government controls: Catalogue of Primary Care services covered by the health system Questions of capacity – by deciding on employment in the ESY The overall budget for expenditure for Primary Care provided by the ESY

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
The way Primary Care is remunerated The level of remuneration of primary care – the salaries of GPs employed in the ESY The way, providers of Primary Care are organized Remark: This concerns only the public part of the system, there is a private system operating parallel to the public system, with little or no control by the government. Many issues concerning contracts made by the HIF are also influenced by the government, since it controls closely the largest HIF IKA, OGA.	The way Primary Care is remunerated The level of remuneration of primary care – the salaries of GPs employed in the ESY The way, providers of Primary Care are organized Remark: This concerns only the public part of the system, there is a private system operating parallel to the public system, with little or no control by the government. Many issues concerning contracts made by the HIF are also influenced by the government, since it controls closely the largest HIF IKA, OGA.
Hungary 1995: Catalogue of Primary Care services covered by the health system Questions of capacity – there is a system o practice rights. In order to be allowed to practice, a GP needs a "practice right", the number of which is set by the government The overall budget for expenditure for Primary Care – sectorial budget The way Primary Care is remunerated The level of remuneration of Primary Care services – the capitation	2004: Catalogue of Primary Care services covered by the health system Questions of capacity – by the practice right system (i.e. a licensing) The overall budget for expenditure for Primary Care – sectorial budget The way Primary Care is remunerated The level of remuneration of Primary Care services - the level of the capitation
Ireland 1995: Catalogue of Primary Care services covered by the health system Questions of capacity - the number of Primary Care Physicians who are providing services for medical card holders The overall budget for expenditure for primary care – the budget for medical care for the medical card holders The level of remuneration of Primary Care services Remark: The capitation for the GPs who treat medical card holders as well as the catalogue and the fees for GPs treating non-medical card holders are negotiated	2004: Catalogue of Primary Care services covered by the health system Questions of capacity - the number of Primary Care Physicians who are providing services for medical card holders The overall budget for expenditure for primary care – the budget for medical care for the medical card holders The level of remuneration of Primary Care services Remark: The capitation for the GPs who treat medical card holders as well as the catalogue and the fees for GPs treating non-medical card holders are negotiated
Italy 1995: Central Government controls Catalogue of Primary Care services covered by the health system – no defined catalogue, but minimum requirements of what the regions have to provide Questions of capacity The overall budget for expenditure for	2004: Central Government controls Catalogue of Primary Care services covered by the health system – no defined catalogue, but minimum requirements of what the regions have to provide Questions of capacity The overall budget for expenditure for

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services, e.g. the fees and salaries	Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services, e.g. the fees and salaries
Luxembourg 1994: Central Government controls Catalogue of Primary Care services covered by the health system – subject to advice of the providers and the HIFs The way Primary Care is remunerated	2004: Central Government controls Catalogue of Primary Care services covered by the health system – subject to advice of the providers and the HIFs The way Primary Care is remunerated
Netherlands 1995: Catalogue of Primary Care services covered by the health system The overall budget for expenditure for Primary Care – the tariffs for services are set in a way that expenditure targets are met The way Primary Care is remunerated; by the WTG law and a commission controlled by the Ministry of health The level of remuneration of Primary Care services, e.g. the amount of fees; ; by the WTG law and a commission controlled by the Ministry of health Remark: There is no defined positive catalogue of services covered, instead, some services are classified as less necessary and excluded from the basic package, they are covered by VHI	2004: Catalogue of Primary Care services covered by the health system The overall budget for expenditure for Primary Care – the tariffs for services are set in a way that the government's expenditure targets are met The way Primary Care is remunerated; by the WTG law and a commission controlled by the Ministry of health The level of remuneration of Primary Care services, e.g. the amount of fees; by the WTG law and a commission controlled by the Ministry of health Remark: There is no defined positive catalogue of services covered, instead, some services are classified as less necessary and excluded from the basic package, they are covered by VHI
New Zealand 1995: Catalogue of Primary Care services covered by the health system The overall budget for expenditure for Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services – the government sets the level of subsidies for Primary Care The way the providers of primary care are organized – in the early 90s, GPs negotiated contracts individually. The creation of larger organizations for conducting negotiations with the RHA was encouraged by law Remark: The government sets the level of the subsidy, GPs can set their own fees, i.e. can charge higher fees and also extra bills, which have to be paid for by the patients themselves	2004: Catalogue of Primary Care services covered by the health system The overall budget for expenditure for Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services – the government can set the amount of the subsidy component The way the providers of primary care are organized Remark: The government sets the level of the subsidy, GPs can set their own fees, i.e. can charge higher fees and also extra bills, which have to be paid for by the patients themselves.

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
Norway 1995: Catalogue of primary care services covered by the Health system Questions of capacity Overall budget for primary care The level of remuneration of primary care The way Primary Care is remunerated The way providers of primary care are organized (regional or national level) Remark: The central government sets a frame and the municipalities set the details. They are free to employ GPs or to contract independent providers. Some elements are also negotiated with the GP association. Capacity is controlled by limiting access to the medical education.	2004: Catalogue of primary care services covered by the Health system Questions of capacity Overall budget for primary care The level of remuneration of primary care The way Primary Care is remunerated The way providers of primary care are organized (regional or national level) Remark: The central government sets a frame and the municipalities set the details. They are free to employ GPs or to contract independent providers. Increasingly, contracts are in use and elements thus negotiated with the GP association. Capacity is controlled by limiting access to the medical education.
Portugal 1995: Catalogue of Primary Care services covered by the health system Questions of capacity The overall budget for expenditure for Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services - the salaries of the GPs Remark: Private providers are largely free to set their own fees. This however concerns only a minor share of the health care provided and consumed	2004: Catalogue of Primary Care services covered by the health system Questions of capacity The overall budget for expenditure for Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services - the salaries of the GPs Remark: Private providers are largely free to set their own fees. This however concerns only a minor share of the health care provided and consumed
Poland 1995: Catalogue of Primary Care services covered by the health system Questions of capacity The overall budget for expenditure for Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services Remark: While the government always had a strong role, factually many issues were negotiated with the providers.	2004: Catalogue of Primary Care services covered by the health system Questions of capacity The overall budget for expenditure for Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services Remark: Most of these items are negotiated by the National Health Fund and the providers. The former is effectively controlled by the government.
Spain 1995: The Central Government controls The catalogue of Primary Care services covered by the health system	2004: The Central Government controls The catalogue of Primary Care services covered by the health system

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
Questions of capacity – employment in the INSALUD The overall budget for expenditure for Primary Care The way Primary Care is remunerated The level of remuneration of Primary Care services, salaries in the INSALUD The way, the providers of Primary Care are organized, e.g. regional level or national-level organization.	The Autonomous Communities control Questions of capacity – employment in the regional SRS The overall budget for expenditure for Primary Care The way Primary Care is remunerated (e.g. fee for service or a per-capita budget etc.) The level of remuneration of Primary Care services, salaries The way, the providers of Primary Care are organized, e.g. regional level or national-level organization.
Sweden 1995: Competencies are held at the level of the Landstings Catalogue of Primary Care services covered by the health system Questions of capacity (e.g. number of physicians per capita or in a region) The overall budget for expenditure for Primary Care The way Primary Care is remunerated (e.g. fee for service or a per-capita budget etc.) The level of remuneration of Primary Care services, the salaries	2004: Competencies are held at the level of the Landstings Catalogue of Primary Care services covered by the health system Questions of capacity (e.g. number of physicians per capita or in a region) The overall budget for expenditure for Primary Care The way Primary Care is remunerated (e.g. fee for service or a per-capita budget etc.) The level of remuneration of Primary Care services, the salaries
Switzerland 1995: The Central Government controls: Catalogue of Primary Care services covered by the health system; in the sense of a negative list, enumerating services which are not covered Fees are negotiated between providers and HIFs at cantonal level subject to approval of the Regional Government (Kanton) The mode primary care is remunerated	2004: The Central Government controls: Catalogue of Primary Care services covered by the health system; in the sense of a negative list, enumerating services which are not covered Fees are negotiated between providers and HIFs at cantonal level subject to approval of the Regional Government (Kanton) The mode primary care is remunerated
United Kingdom 1995: Catalogue of primary care services covered by the health system - while there is no "official" catalogue of primary care services covered by the NHS, but the government determines some things e.g. immunization programs, which have to be included Questions of capacity – this is subject to influence by planning but not unilateral control. The overall budget for expenditure for Primary Care - in 1995 there was a separate budget for Primary Care provision The way Primary Care is remunerated –	2004: Catalogue of primary care services covered by the health system - while there is no "official" catalogue of primary care services covered by the NHS, but the government determines some things e.g. immunization programs, which have to be included Questions of capacity – this is subject to influence by planning but not unilateral control The overall budget for expenditure for health care including Primary Care - there is no longer a separate budget for Primary Care The way Primary Care is remunerated – while

CG2 Which elements of the **Primary Care Sector** can be controlled by the Central Government unilaterally?	
while the main remuneration is by capitation, there are also elements of activity based funding, this is negotiated, as noted above	the main remuneration is by capitation, there are also elements of activity based funding, this is negotiated, as noted above
The level of remuneration of Primary Care services, level of the capitation a GP receives – this is subject to negotiations, as noted as above	The level of remuneration of Primary Care services, level of the capitation a GP receives – this is subject to negotiations, as noted as above
The way, the providers of Primary Care are organized, e.g. regional level or national-level organization	The way, the providers of Primary Care are organized, e.g. regional level or national-level organization
Remark: While there is substantial leeway for the lower levels in the NHS administration, the government sets the overall budget which is the effective limit to health service provision	Remark: While there is substantial leeway for the lower levels in the NHS administration, the government sets the overall budget which is the effective limit to health service provision

CG3 Which elements of the sector providing **Specialized Medical Services** (orthopedics, eye doctors, radiologists etc.) can be controlled by the Central Government unilaterally?	
Austria 1995: None Remark: The Central Government has some influence on how the providers of specialized medical care are organized (regional or national level)	2004: None Remark: The Central Government has some influence on how the providers of specialized medical care are organized (regional or national level)
Belgium 1995. Catalogue of specialized services covered by the health system Questions of capacity (e.g. number of specialists per capita or in a region) – the access to medical education is controlled and compared to GPs the control exercised on the number of specialists is stricter The overall budget for expenditure for specialized care – sectorial target budget, also a target budget for Laboratory services The way specialized services are remunerated The level of remuneration of specialized services - disapproval of the fees negotiated between the HIF and the Provider The way, the providers of specialized care are organized, e.g. regional level or national-level organization Remark: While the government can in theory set all those elements, it does so only rarely in a unilateral way. Most often, the issues are negotiated among the HIF and the Providers with influence by the government	2004: Catalogue of specialized services covered by the health system Questions of capacity (e.g. number of specialists per capita or in a region) - since 1996 there is extensive human resources planning, using a numerus clausus to contain the number of physicians The overall budget for expenditure for specialized care – sectorial target budget, also a target budget for Laboratory services The way specialized services are remunerated The level of remuneration of specialized services - disapproval of the fees negotiated between the HIF and the Provider The way, the providers of specialized care are organized, e.g. regional level or national-level organization Remark: While the government can in theory set all those elements, it does so only rarely in a unilateral way. Most often, the issues are negotiated among the HIF and the Providers with influence by the government
Canada 1995: Provincial Governments control Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: The federal government exerts influence by setting standards the provincial governments have to meet to obtain federal subsidies. For instance, the catalogue – according to the	2004: Provincial Governments control Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: The federal government exerts influence by setting standards the provincial governments have to meet to obtain federal subsidies. For instance, the catalogue – according to the

CG3 Which elements of the sector providing **Specialized Medical Services** (orthopedics, eye doctors, radiologists etc.) can be controlled by the Central Government unilaterally?	
constraint set by the federal government – must cover everything that is medically necessary. Within the limits set by the federal government, the provincial governments could act unilaterally, but usually, these issues are negotiated with the physician associations. A substantial share of outpatient specialized services, in particular those requiring heavy equipment, is provided in hospitals, but by self-employed specialists which use the hospitals facilities.	constraint set by the federal government – must cover everything that is medically necessary. Within the limits set by the federal government, the provincial governments could act unilaterally, but usually, these issues are negotiated with the physician associations. A substantial share of outpatient specialized services, in particular those requiring heavy equipment, is provided in hospitals, but by self-employed specialists which use the hospitals facilities.
Czech Republic 1995: Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: The government defines a basic package of services by law. Most negotiations of these issues are among individual HIF and providers, the Central government has influence on the results. The remuneration is based on a point system, and the number of points a service is worth, is set by the Ministry of Health.	2004: Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: The government defines a basic package of services by law. Most negotiations of these issues are among individual HIF and providers, the Central government has influence on the results. The remuneration is based on a point system, and the number of points a service is worth, is set by the Ministry of Health.
Denmark 1995: Competencies at County level, Amter The overall budget for specialized services provided outside of hospitals Questions of capacity – by licensing self-employed specialized providers The way specialized services are remunerated – negotiated with providers The level of remuneration of specialized services – negotiated with providers Remark: Specialized medical services are provided predominantly by Hospitals, and most control of the Amter is exercised by operating the Hospitals The catalogue of specialized services covered	2004: Competencies at County level, Amter The overall budget for specialized services provided outside of hospitals Questions of capacity – by licensing self-employed specialized providers The way specialized services are remunerated – negotiated with providers The level of remuneration of specialized services– negotiated with providers Remark: Specialized medical services are provided predominantly by Hospitals, and most control of the Amter is exercised by operating the Hospitals The catalogue of specialized services covered

CG3 Which elements of the sector providing **Specialized Medical Services** (orthopedics, eye doctors, radiologists etc.) can be controlled by the Central Government unilaterally?	
is negotiated between the Amter association and the specialists' association	is negotiated between the Amter association and the specialists' association
Finland 1995: Municipalities control: Catalogue of specialized services covered Overall budget for specialized medical services Determine the top-level management of the organization of providers of specialized care Remark: Specialized care is predominantly provided by Hospitals and the Hospital District has substantial influence on these issues.	2004: Municipalities control: Catalogue of specialized services covered Overall budget for specialized medical services Determine the top-level management of the organization of providers of specialized care Remark: Specialized care is predominantly provided by Hospitals and the Hospital District has substantial influence on these issues. The central Government has some say on: the Catalogue of specialized services covered. The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees All three elements apply to the private services covered by the National Sickness Insurance only. Specialized Health Care is predominantly provided by Hospitals
France 1995: Catalogue of specialized services covered by the health system – the nomenclature is negotiated between the HIFs and the Provider but subject to approval The level of remuneration of specialized services– the convention negotiated between the HIFs and providers, but subject to approval Questions of capacity - the number of specialists entering the job and repartition by specialty by decree (concours procedure). Remark: In a concours-procedure, the Ministry of health sets the number of students which may pass an examination and proceed to the next step of the medical education	2004: Catalogue of specialized services covered by the health system – the nomenclature is negotiated between the HIFs (i.e. the UNCAM) and the Provider but subject to approval The level of remuneration of specialized services– the convention negotiated between the HIFs and providers, but subject to approval Questions of capacity - the number of specialists entering the job and repartition by specialty by decree (concours procedure). The overall budget for expenditure for specialized care is set by vote of parliament since 1996
Germany 1995: None, see the remarks to CG2	2004: None, see the remarks to CG2
Greece 1995: Catalogue of specialized services covered by the health system The overall budget for expenditure for specialized care provided by the ESY The way specialized services are remunerated	2004: Catalogue of specialized services covered by the health system The overall budget for expenditure for specialized care provided by the ESY The way specialized services are remunerated The level of remuneration for specialized

CG3 Which elements of the sector providing **Specialized Medical Services** (orthopedics, eye doctors, radiologists etc.) can be controlled by the Central Government unilaterally?	
The level of remuneration for specialized services The way, providers of specialized care are organized Remark: Specialized services are provided predominantly by hospitals; there the government has much control. Specialized care provided by the private sector is under little or no control of the government	services The way, providers of specialized care are organized Remark: Specialized services are provided predominantly by hospitals; there the government has much control. Specialized care provided by the private sector is under little or no control of the government
Hungary 1995: Catalogue of specialized services covered by the health system Questions of capacity – there is a system of specialist consultation hours for out-patient treatment, the number of which is specified in the contract of the hospital providing these services and the NHIFA The overall budget for expenditure for specialized care – sectorial budget The way specialized services are remunerated The level of remuneration of specialized services - the amount of fees Remark: Specialized services are provided predominantly by Hospitals	2004: Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care – sectorial budget The way specialized services are remunerated The level of remuneration of specialized services - the amount of fees Remark: Specialized services are provided predominantly by Hospitals
Ireland 1995: Catalogue of specialized services covered by the health system The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: Specialized services are provided predominantly by hospitals; there the government has much control. The providers of specialized services are paid on a fee for service basis; catalogue and fees are negotiated.	2004: Catalogue of specialized services covered by the health system The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: Specialized services are provided predominantly by hospitals; there the government has much control. The providers of specialized services are paid on a fee for service basis; catalogue and fees are negotiated.
Italy 1995: Central Government controls Catalogue of specialized services covered by the health system – no defined catalogue, but minimum requirements of what the regions	2004: Central Government controls Catalogue of specialized services covered by the health system – no defined catalogue, but minimum requirements of what the regions

CG3 Which elements of the sector providing **Specialized Medical Services** (orthopedics, eye doctors, radiologists etc.) can be controlled by the Central Government unilaterally?	
have to provide Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: Specialized health services are predominantly provided in hospitals	have to provide Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees Remark: Specialized services are predominantly provided by hospitals
Luxembourg 1994: Catalogue of specialized services covered by the health system The way specialized services are remunerated	2004: Catalogue of specialized services covered by the health system The way specialized services are remunerated
Netherlands 1995: The catalogue of specialized services covered by the Health System The overall budget for specialized services covered by the Health System Questions of capacity The way specialized services are remunerated The level of remuneration of specialized services Remark: Specialized Care is provided predominantly by Hospitals. The government exerts influence by a commission, which ensures that tariffs for services are set in a way that the government's intended expenditure targets are met. There is no defined positive catalogue of services covered, instead, some services are classified as less necessary and excluded from the basic package, they are covered by VHI	2004: The catalogue of specialized services covered by the Health System The overall budget for specialized services Questions of capacity The way specialized services are remunerated The level of remuneration of specialized services Remark: Specialized Care is provided predominantly by Hospitals The government exerts influence by a commission, which ensures that tariffs for services are set in a way that the government's intended expenditure targets are met. There is no defined positive catalogue of services covered, instead, some services are classified as less necessary and excluded from the basic package, they are covered by VHI
New Zealand 1995: Catalogue of specialized services covered by the health system The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services – by setting the subsidy level Remark:	2004: Catalogue of specialized services covered by the health system The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services – by setting the subsidy level Remark:

CG3 Which elements of the sector providing **Specialized Medical Services** (orthopedics, eye doctors, radiologists etc.) can be controlled by the Central Government unilaterally?	
Specialized medical services are provided predominantly by Hospitals.	Specialized medical services are provided predominantly by Hospitals
Norway 1995: Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration for specialized services The way, the providers of specialized care are organized, e.g. regional level or national-level organization. Remark: Specialized services are predominantly provided by Hospitals. Hospitals are owned and operated by the Counties, which control most of these elements. Capacity is controlled by limiting access to the medical education.	2004: Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration for specialized services The way, the providers of specialized care are organized, e.g. regional level or national-level organization. Remark: Specialized services are predominantly provided by Hospitals. Hospitals are now Health Enterprises, but factually controlled by Regional Health Authorities, which are part of the central government. These control most of the elements. Capacity is controlled by limiting access to the medical education..
Portugal 1995: Catalogue of specialized services covered by the health system Remark: Specialized services are predominantly provided by Hospitals. Control is exercised by controlling the Hospitals. There is no explicit distinction among in-patient / Hospital care and out-patient specialized care as far as the provision of care is concerned Private providers – private specialists, specialists providing services on private terms and private hospitals are relatively free in setting their own terms.	2004: Catalogue of specialized services covered by the health system Remark: Specialized services are predominantly provided by Hospitals. Control is exercised by controlling the Hospitals. There is no explicit distinction among in-patient / Hospital care and out-patient specialized care as far as the provision of care is concerned. Private providers – private specialists, specialists providing services on private terms and private hospitals are relatively free in setting their own terms.
Poland 1995: The Central government controls Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated Remark: Specialized care is provided predominantly in hospitals, and control is exercised by	2004: The Central government controls Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care – the share of the NHF budget going into specialized care contracts The way specialized services are remunerated Remark: Specialized care is still provided predominantly in hospitals.

CG3 Which elements of the sector providing **Specialized Medical Services** (orthopedics, eye doctors, radiologists etc.) can be controlled by the Central Government unilaterally?	
controlling the hospitals.	
Spain 1995: The central government controls The Catalogue of specialized services covered by the health system Remark: Specialized medical services are provided by Hospitals, and control is exercised by controlling the hospitals.	2004: The central Government controls The Catalogue of specialized services covered by the health system The Autonomous Communities control many aspects of specialized control, since specialized medical services are provided by Hospitals, and control is exercised by controlling the hospitals.
Sweden 1995: The control rests with the Landstings; specialized services are predominantly provided in Hospitals operated by the Landstings Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees	2004: The control rests with the Landstings; specialized services are predominantly provided in Hospitals operated by the Landstings Catalogue of specialized services covered by the health system Questions of capacity The overall budget for expenditure for specialized care The way specialized services are remunerated The level of remuneration of specialized services, e.g. the amount of fees
Switzerland 1995: The Central government controls: Catalogue of specialized services covered by the health system; in the sense of a negative list, enumerating services which are not covered Fees are negotiated between providers and HIFs at cantonal level subject to approval of the Regional Government The mode specialized care is remunerated	2004: The Central government controls: Catalogue of specialized services covered by the health system; in the sense of a negative list, enumerating services which are not covered Fees are negotiated between providers and HIFs at cantonal level subject to approval of the Regional Government The mode specialized care is remunerated
United Kingdom 1995: Specialized services are provided predominantly by Hospitals. Control is hence exercised by controlling the Hospitals	2004: Specialized services are provided predominantly by Hospitals. Control is hence exercised by controlling the Hospitals

CG4 Which elements of the sector providing **Dental Care** can be controlled by the Central Government unilaterally?	
Austria 1995: None Remark: Dental Care, in particular dentures, is predominantly privately purchased. The Central Government has some influence on how the providers of dental medical care are organized (regional or national level).	2004: None Remark: Dental Care, in particular dentures, is predominantly privately purchased. The Central Government has some influence on how the providers of dental medical care are organized (regional or national level).
Belgium 1995: Catalogue of dental services covered by the health system The overall budget for expenditure for dental care – sectorial target budget Questions of capacity (e.g. number of dentists per capita or in a region)- by controlling access to medical education The way dental care is remunerated (e.g. fee for service or a per-capita budget etc.) The level of remuneration of dental care, e.g. the amount of fees - disapproval of the fees negotiated between the HIF and the Provider Remark: While the government can in theory set all those elements, it does so only rarely in a unilateral way. Most often, the issues are negotiated among the HIF and the Providers with influence by the government	2004: Catalogue of dental services covered by the health system The overall budget for expenditure for dental care – sectorial target budget Questions of capacity (e.g. number of dentists per capita or in a region) The way dental care is remunerated (e.g. fee for service or a per-capita budget etc.) The level of remuneration of dental care, e.g. the amount of fees - disapproval of the fees negotiated between the HIF and the Provider Remark: While the government can in theory set all those elements, it does so only rarely in a unilateral way. Most often, the issues are negotiated among the HIF and the Providers with influence by the government
Canada 1995: For those dental services covered by the Health Systems, Provincial Governments control Catalogue of dental services covered by the health system The overall budget for expenditure for dental services and dental care Questions of capacity (e.g. number of dentists per capita or in a region) The way dental care is remunerated (e.g. fee for service or a per-capita budget etc.) Remark: Only dental care which requires in-patient treatment is covered by the health system. Dental care is predominantly paid for by the patients themselves, the sector providing dental care is hence not under control of the provincial government. The fees are set by the dentists themselves and are paid for by the patients or the VHI.	2004: For those dental services covered by the Health Systems, Provincial Governments control Catalogue of dental services covered by the health system The overall budget for expenditure for dental services and dental care Questions of capacity (e.g. number of dentists per capita or in a region) The way dental care is remunerated (e.g. fee for service or a per-capita budget etc.) Remark: Only dental care which requires in-patient treatment is covered by the health system. Dental care is predominantly paid for by the patients themselves, the sector providing dental care is hence not under control of the provincial government. The fees are set by the dentists themselves and are paid for by the patients or the VHI.

CG4 Which elements of the sector providing **Dental Care** can be controlled by the Central Government unilaterally?	
Czech Republic 1995: Catalogue of dental services covered by the health system The overall budget for expenditure for dental services and dental care Questions of capacity The way dental care is remunerated The level of remuneration of dental care, e.g. the amount of fees Remark: The government defines a basic package of services by law. Most negotiations of these issues are among individual HIF and providers, the Central government has influence on the results.	2004: Catalogue of dental services covered by the health system The overall budget for expenditure for dental services and dental care Questions of capacity The way dental care is remunerated The level of remuneration of dental care, e.g. the amount of fees Remark: The government defines a basic package of services by law. Most negotiations of these issues are among individual HIF and providers, the Central government has influence on the results.
Denmark 1995: Competencies at county Level, Amter Catalogue of dental services covered by the health system – or rather not covered The way dental care is remunerated Remark: Dental care for adults is not covered by the Health System. The tariffs are however negotiated between the Amter and the Dentists' organization	2004: Competencies at county Level, Amter Catalogue of dental services covered by the health system – or rather not covered The way dental care is remunerated Remark: Dental care for adults is not covered by the Health System. The tariffs are however negotiated between the Amter and the Dentists' organization
Finland 1995: The Municipalities control: Catalogue of dental care covered by the Health System The way dental care is remunerated Remark: The Municipalities control what is offered for whom in the Health Centers operated by the Municipalities. Dental care is predominantly paid either by the patients themselves or by the NHI. For the NHI, the central government has some say on what is covered, how it is paid and how much is paid.	2004: The Municipalities control: Catalogue of dental care covered by the Health System The way dental care is remunerated Remark: The Municipalities control what is offered for whom in the Health Centers operated by the Municipalities. Dental care is predominantly paid either by the patients themselves or by the NHI. For the NHI, the central government has some say on what is covered, how it is paid and how much is paid.
France 1995: Catalogue of dental services covered by the health system – negotiated between the HIFs and the dentists' organization, it is subject to approval Remark: About 2/3 of the dental care is purchased privately and covered by the VHI	2004: Catalogue of dental services covered by the health system; - while negotiated between the HIFs Organization (UNCAM) and the dentists' organization, it is subject to approval The overall budget for those dental services covered by the Health system is set by parliamentary vote since 1996 Remark: About 2/3 of the dental care is purchased

CG4 Which elements of the sector providing **Dental Care** can be controlled by the Central Government unilaterally?	
	privately and covered by the VHI
Germany 1995: None Remark: A limit to the growth rate of dental care was set, but was not effective	2004: None
Greece 1995: Catalogue of dental services covered by the health system The overall budget for expenditure for dental services and dental care for those services provided by the Health System The level of remuneration for dental care – for those employed by the ESY The way dental care is remunerated Remark: This concerns only dental care provided by the ESY or based on contracts between the ESY and providers. Dental care is predominantly paid for by the patients themselves, the sector providing dental care is hence not under control of the government	2004: Catalogue of dental services covered by the health system The overall budget for expenditure for dental services and dental care for those services provided by the Health System The level of remuneration for dental care – for those employed by the ESY The way dental care is remunerated Remark: This concerns only dental care provided by the ESY or based on contracts between the ESY and providers. Dental care is predominantly paid for by the patients themselves, the sector providing dental care is hence not under control of the government
Hungary 1995: Catalogue of dental services covered by the health system They way dental care is remunerated The level of remuneration for dental care Remark: Dental services are predominantly paid by the patients themselves. Only the dental care for some groups is covered. Only for this small domain, the items mentioned above are under governmental control	2004: Catalogue of dental services covered by the health system They way dental care is remunerated The level of remuneration for dental care Remark: Dental services are predominantly paid by the patients themselves. Only the dental care for some groups is covered. Only for this small domain, the items mentioned above are under governmental control
Ireland 1995: Catalogue of dental services covered by the health system – for medical card holders The overall budget for expenditure for dental services and dental care for those services provided by the Health System – for medical card holders Remark: Dental services are predominantly paid by the patients themselves and hence not under political control. Catalogues and fees are negotiated	2004: Catalogue of dental services covered by the health system – for medical card holders The overall budget for expenditure for dental services and dental care for those services provided by the Health System – for medical card holders Remark: Dental services are predominantly paid by the patients themselves and hence not under political control. Catalogues and fees are negotiated
Italy 19995: Central Government controls The catalogue of dental services covered by the health system	2004: Central Government controls The catalogue of dental services covered by the health system

CG4 Which elements of the sector providing **Dental Care** can be controlled by the Central Government unilaterally?	
The way dental care is remunerated The level of remuneration of dental care Remark: This concerns only dental services provided in the SSN. Dental services are predominantly paid by the patients themselves, where the state has neither control over the fees nor the coverage of services.	The way dental care is remunerated The level of remuneration of dental care Remark: This concerns only dental services provided in the SSN. Dental services are predominantly paid by the patients themselves, where the state has neither control over the fees nor the coverage of services.
Luxembourg 1994: Catalogue of dental services covered by the health system The way dental care is remunerated	2004: Catalogue of dental services covered by the health system The way dental care is remunerated
Netherlands 1995: Catalogue of dental services covered by the health system – that is included in the basic package The level of remuneration of dental care, the amount of fees – for those included in the basic package Remark: Dental services are predominantly paid by the patients themselves; the influence of the Government in this area is factually very limited	2004: Catalogue of dental services covered by the health system – that is included in the basic package Overall budget of dental services provided by the Health Insurance system The way dental care is remunerated The level of remuneration of dental care, e.g. the amount of fees – for those included in the basic package Remark: The elements listed concern the services provided by the Health Insurance System. Dental services are predominantly paid by the patients themselves; the influence of the Government in this area is factually very limited
New Zealand 1995: The way dental care is remunerated The level of remuneration of dental care Remark: This concerns only the small share of dental care provided by the public health system. The Central government can set the budget for publicly funded dental care. Most of the dental care is paid for by the patients themselves or their VHI.	2004: The way dental care is remunerated The level of remuneration of dental care Remark: This concerns only the small share of dental care provided by the public health system. The Central government can set the budget for publicly funded dental care. Most of the dental care is paid for by the patients themselves or their VHI.
Norway 1995: Questions of capacity Remark: Dental care is not covered by the Health System and predominantly paid for by the patients themselves. It is thus not under the control of the state. The issue of capacity concerns those dentists employed to provide	2004: Questions of capacity Remark: Dental care is not covered by the Health System and predominantly paid for by the patients themselves. It is thus not under the control of the state. The issue of capacity concerns those dentists employed to provide

CG4 Which elements of the sector providing **Dental Care** can be controlled by the Central Government unilaterally?	
dental care for patients under 18 years of age.	dental care for patients under 18 years of age.
Portugal 1995: Dental services are not covered by the Health System but are predominantly paid by the patients themselves or by their VHI Remark: The dentists is, within limits set by the national dental association, free to set his own fees. Dental care is not explicitly excluded, but not provided by the NHS.	2004: Dental services are not covered by the Health System but are predominantly paid by the patients themselves or by their VHI Remark: The dentists is, within limits set by the national dental association, free to set his own fees. Dental care is not explicitly excluded, but not provided by the NHS.
Poland 1995: Catalogue of dental services covered by the health system Overall budget of dental services covered by the National Health Fund Questions of capacity The way dental care is remunerated Remark: These issues refer only to the dental care covered by the health system. Dental care is predominantly paid for by the patients themselves.	2004: Catalogue of dental services covered by the health system Overall budget of dental services covered by the National Health Fund Questions of capacity The way dental care is remunerated Remark: These issues refer only to the dental care covered by the health system, i.e. by the NHF. Dental care is predominantly paid for by the patients themselves.
Spain 1995: The Central Government controls The Catalogue of dental services covered by the health system Questions of capacity – employment of dentists in the INSALSUD Remark: Dental services are predominantly paid by the patients themselves, and hence outside of the central government's control	2004: The Central Government controls The Catalogue of dental services covered by the health system The Autonomous Communities control Questions of capacity – employment of dentists in the SRS Remark: Dental services are predominantly paid by the patients themselves, and hence outside of the regional government's control
Sweden 1995: The competencies rests with the Landstings All aspects are controlled for the services provided for patients under 20 years of age. Remark: Dental care is predominantly paid for by the patients themselves, and is hence not under control of the Landstings	2004: The competencies rests with the Landstings All aspects are controlled for the services provided for patients under 20 years of age. Remark: Dental care is predominantly paid for by the patients themselves, and is hence not under control of the Landstings
Switzerland 1995: Dental care is not covered by the health system and hence not subject to government regulation	2004: Dental care is not covered by the health system and hence not subject to government regulation
United Kingdom 1995: Catalogue of dental services covered by the health system – i.e. paid for by the NHS Questions of capacity e.g. number of dentists	2004: Catalogue of dental services covered by the health system – i.e. paid for by the NHS Questions of capacity e.g. number of dentists

CG4 Which elements of the sector providing **Dental Care** can be controlled by the Central Government unilaterally?	
in a region - the government can only influence this e.g. by financial incentives. The way dental care is remunerated – for those services covered by the NHS The level of remuneration of dental care, e.g. the amount of fees – for those services covered by the NHS Remark: There are contracts between the NHS and the Dentist association, in which the services and the remuneration of dental care within the NHS is settled. Apart from this, patients may get treatment on private terms. Most of dental care is privately purchased	in a region - the government can only influence this e.g. by financial incentives. The way dental care is remunerated – for those services covered by the NHS The level of remuneration of dental care, e.g. the amount of fees – for those services covered by the NHS Remark: There are contracts between the NHS and the Dentist association, in which the services and the remuneration of dental care within the NHS is settled. Apart from this, patients may get treatment on private terms. Most of dental care is privately purchased

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
Austria 1995: For Public Hospitals, the majority, regional governments (Bundesländer) can set: The overall budget for in-patient services – for the Region The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology in Hospitals Employment decisions in Hospitals The actual remuneration - hospital's overall budget The mode how in-patient services provided by Hospitals are remunerated (e.g. remuneration by per-diem instead of DRG) Organizational questions (e.g. how the Hospitals are organized and administered) The usage of technology in Hospitals The Central Government controls Catalogue of in-patient services covered by the health system	2004: For Public Hospitals, the majority, regional governments (Bundesländer) can set: The overall budget for in-patient services – for the Region The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology in Hospitals Employment decisions in Hospitals The actual remuneration - hospital's overall budget The mode how in-patient services provided by Hospitals are remunerated (e.g. remuneration by per-diem instead of DRG) Organizational questions (e.g. how the Hospitals are organized and administered) The usage of technology in Hospitals The Central Government controls Catalogue of in-patient services covered by the health system
Belgium 1995: The Central Government controls Catalogue of in-patient services covered by the health system The national overall budget for in-patient services- since 1986, the national government sets a budget for running costs of the infrastructure; since services provided are paid on a fee for service basis, this does not limit the overall expenditure for in-patient care, there is also a sectorial target budget The number of Hospitals in a region – by accreditation and planning The size of Hospitals in a region – by accreditation and planning The investments in medical technology in Hospitals – by subsidizing investments and determining, which investments can be paid for from the hospital's income The mode how in-patient services provided by Hospitals are remunerated Organizational questions (e.g. how the Hospitals are organized and administered) – the Government sets the size of the Hospital and the number of different department it must have.	2004: The Central Government controls Catalogue of in-patient services covered by the health system The national overall budget for in-patient services – running costs for the infrastructure and a sectorial target budget The number of Hospitals in a region– by accreditation and planning The size of Hospitals in a region– by accreditation and planning The investments in medical technology in Hospitals – by subsidizing investments and determining, which investments can be paid for from the hospital's income The mode how in-patient services provided by Hospitals are remunerated Organizational questions (e.g. how the Hospitals are organized and administered) – the Government sets the size of the Hospital and the number of different department it must have.

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
Remark: While not determining the size of a hospital, the hospitals require accreditation by the Ministry of Public Health, and this is granted only if the hospital does meet certain requirement, among them a certain size, and not exceed the planned capacity in the region which is set by the government	Remark: While not determining the size of a hospital, the hospitals require accreditation by the Ministry of Public Health, and this is granted only if the hospital does meet certain requirements, among them a certain size, and not exceed the planned capacity in the region which is set by the government
Canada 1995: The Provincial Governments, which are operating most Hospitals, control Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in Hospitals – the provincial government allocated grants for investments Employment decisions in Hospitals - Hospitals have leeway, but the provincial government sets limits Actual remuneration level for Hospitals (the budgets are negotiated) The mode how in-patient services provided by Hospitals are remunerated (e.g. remuneration by DRGs instead of budgets) Organizational / administrative questions (e.g. how the Hospitals are organized and administered- e.g. one province abolished the individual Hospital boards and replaced them by regionally defined governing bodies) The usage of medical technology in Hospitals Remark: Despite formal competence, there are extensive negotiations among the provincial governments and the Hospitals	2004: The Provincial Governments, which are operating most Hospitals, control Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in Hospitals Employment decisions in Hospitals; Hospitals have leeway, but the provincial government sets limits Actual remuneration level for Hospitals (the budgets are negotiated) The mode how in-patient services provided by Hospitals are remunerated (e.g. remuneration by DRGs instead of budgets) Organizational / administrative questions (e.g. how the Hospitals are organized and administered) The usage of medical technology in Hospitals Remark: Despite formal competence, there are extensive negotiations among the provincial governments and the Hospitals
Czech Republic 1995: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology in Hospitals Remark: The government defined a basic package of	2004: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology in Hospitals Remark: The government defined a basic package of

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
health services by law. Most negotiations of these issues are among individual HIF and Hospitals, the Central government has influence on the results. In Hospitals owned by the Central Government / Ministry of Health, the Government can set salaries, make investment decisions and decide organizational questions. In regional hospitals, the Central government can influence salaries, management and investments in technology. The remuneration is based on a point system, and the number of points a service is worth, is set by the Ministry of Health.	health services by law. Most negotiations of these issues are among individual HIF and Hospitals, the Central government has influence on the results. In Hospitals owned by the Central Government / Ministry of Health, the Government can set salaries, make investment decisions and decide organizational questions. In regional hospitals, the Central government can influence salaries, management and investments in technology. The remuneration is based on a point system, and the number of points a service is worth, is set by the Ministry of Health.
Denmark 1995: Competencies at the county level, Amter: Catalogue of in-patient services covered by the health system – mainly by excluding services The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in Hospitals Employment decisions in Hospitals Actual remuneration level – the hospital's overall budget The mode how in-patient services provided by Hospitals are remunerated Organizational / administrative questions The usage of medical technology in Hospitals Remark: Hospitals are directly operated by the Amter	2004: Competencies at the county level, Amter: Catalogue of in-patient services covered by the health system – mainly by excluding services The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in Hospitals Employment decisions in Hospitals Actual remuneration level – the hospital's overall budget The mode how in-patient services provided by Hospitals are remunerated Organizational / administrative questions The usage of medical technology in Hospitals Remark: Hospitals are directly operated by the Amter
Finland 1995: Municipalities control: Catalogue of in-patient services covered by the health system The overall budget for in-patient services Influence on the way, hospitals are administered Remark: These issues are negotiated between the Hospital District and the Municipalities. Here, the Hospital Districts have substantial say on all issues.	2004: Municipalities control: Catalogue of in-patient services covered by the health system The overall budget for in-patient services Influence on the way, hospitals are administered Remark: These issues are negotiated between the Hospital District and the Municipalities. Here, the Hospital Districts have substantial say on all issues.
France 1995: Catalogue of in-patient services covered by the health system	2004: Catalogue of in-patient services covered by the health system; influence also by the

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
The number of Hospitals in a region; at Central level and ARH The size of Hospitals in a region; at central level and ARH The investments in medical technology in Hospitals; at Central level and ARH Employment decisions in Hospitals (number and type of staff employed); there are national references and guidelines in order to obtain an accreditation (by HAS) Questions of actual remuneration (Hospital's overall budget) at Central level and ARH. This concerns also the salary of the physicians employed in Hospitals The mode how in patient services provided by Hospitals are remunerated (e.g. remuneration by per-diem instead of DRG) : Central level The usage of technology in Hospitals; at Central level and ARH The investment in technology in Hospitals : Central level and ARH Remark: The central government sets a central, national level frame of planning, which is elaborated by the ARH, which are negotiating with the individual hospitals within this frame.	UNCAM The overall budget for in-patient services; vote by parliament since 1996 The number of Hospitals in a region; at Central level and ARH The size of Hospitals in a region; at: Central level and ARH The investments in medical technology in Hospitals; at Central level and ARH Employment decisions in Hospitals (number and type of staff employed); there are national references and guidelines in order to obtain an accreditation (by HAS) Questions of actual remuneration (e.g. level of remuneration; Hospital's overall budget); at central level and ARH The mode how in patient services provided by Hospitals are remunerated; at Central level The usage of technology in Hospitals; at central level and ARH The investment in technology in Hospitals : Central level and ARH Remark: The central government sets a central, national level frame of planning, which is elaborated by the ARH, which are negotiating with the individual hospitals within this frame.
Germany 1995: Regional Government (Bundesland) controls, by ownership of the Hospital as well as by a formal planning competence: Number of Hospitals in a region Size of Hospitals in a region Investments in medical technology Organizational questions None at the level of the Central Government Remark: The planning competence of the regional government also holds for hospitals owned and operated by municipalities	2004: Regional Government (Bundesland) controls, by ownership of the Hospital as well as by a formal planning competence:: Number of Hospitals in a region Size of Hospitals in a region Investments in medical technology Organizational questions None at the level of the Central Government Remark: The planning competence of the regional government also holds for hospitals owned and operated by municipalities
Greece 1995: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in	2004: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
Hospitals Employment decisions in Hospitals Actual remuneration level – budgets of the hospitals and the per diem paid by HIF The mode how in-patient services provided by Hospitals are remunerated Organizational / administrative questions Usage of technology in hospitals Remark: Most Hospitals are owned and operated by the ESY, which is part of the public administration and under governmental control.	Hospitals Employment decisions in Hospitals Actual remuneration level – budgets of the hospitals and the per diem paid by HIF The mode how in-patient services provided by Hospitals are remunerated Organizational / administrative questions Usage of technology in hospitals Remark: Most Hospitals are owned and operated by the ESY, which is part of the public administration and under governmental control.
Hungary 1995: The Central government controls Catalogue of in-patient services covered by the health system The national overall budget for in-patient services – sectorial budget The number of Hospitals in a region Actual remuneration level – the point values on which the DRG system is based The mode how in-patient services provided by Hospitals are remunerated The Municipalities and Counties control: Organizational / administrative questions The usage of medical technology The size of Hospitals in a region (number of beds) The investments in medical technology in Hospitals Employment decisions in Hospitals (number and type of staff employed) Remark: Hospitals are predominantly operated by Municipalities and Counties. They have more control over the practical questions of how the hospital is administered	2004: The Central government controls: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services sectorial budget The number of Hospitals in a region Actual remuneration level – the point values on which the DRG system is based The mode how in-patient services provided by Hospitals are remunerated The Municipalities and Counties control: Organizational / administrative questions The usage of medical technology in Hospitals The size of Hospitals in a region (number of beds) The investments in medical technology in Hospitals Employment decisions in Hospitals (number and type of staff employed) Remark: Hospitals are predominantly operated by Municipalities and Counties. They have more control over the practical questions of how the hospital is administered
Ireland 1995: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) Investments in medical technology in Hospitals Employment decisions in Hospitals	2004: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) Investments in medical technology in Hospitals Employment decisions in Hospitals

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
Actual remuneration level – the budgets The mode how in-patient services provided by Hospitals are remunerated Remark: About half of the hospitals are owned and operated by the Health Boards / national government. Here the state's control is substantial. The control over the non-state hospitals (run by charities) is weaker.	Actual remuneration level – the budgets The mode how in-patient services provided by Hospitals are remunerated Remark: About half of the hospitals are owned and operated by the Health Boards / national government. Here the state's control is substantial. The control over the non-state hospitals (run by charities) is weaker.
Italy 1995: Central Government controls: Catalogue of in-patient services covered by the health system – no defined catalogue, only minimum requirements, which have to be provided by the Regions The national overall budget for in-patient services – no earmarked budget, but the overall budget The number of Hospitals in a region – set by the regional government by accreditation The size of Hospitals in a region (beds) The mode how in-patient services provided by Hospitals are remunerated – the mode is set by law Remark: For those hospitals owned and operated by the ASL. The ASL decides on medical technology, employment, but does so within limits set by the regional Government. Regional Governments operate the Hospitals within the limits set by the central government	2004: Central Government controls: Catalogue of in-patient services covered by the health system – no defined catalogue, only minimum requirements, which have to be provided by the Regions The national overall budget for in-patient services – no earmarked budget, but the overall budget The number of Hospitals in a region – set by the regional government by accreditation The size of Hospitals in a region (beds) The mode how in-patient services provided by Hospitals are remunerated – the mode is set by law Remark: For those hospitals owned and operated by the ASL. The ASL decides on medical technology, employment, but does so within limits set by the regional Government. Regional Governments operate the Hospitals within the limits set by the central government
Luxembourg 1994: Catalogue of in-patient services covered by the health system The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology The mode how in-patient services provided by Hospitals are remunerated (per-diem instead of DRG) Organizational questions, how Hospitals are organized ad administered	2004: Catalogue of in-patient services covered by the health system The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology The mode how in-patient services provided by Hospitals are remunerated (per-diem instead of DRG) Organizational questions, how Hospitals are organized ad administered
Netherlands 1995: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds)	2004: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds)

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
The investments in medical technology The actual remuneration level The mode how in patient services provided by Hospitals are remunerated Remark: Usually, the provincial governments plan and propose, the central government approves.	The investments in medical technology The actual remuneration level The mode how in-patient services provided by Hospitals are remunerated Remark: Usually, the provincial governments plan and propose, the central government approves.
New Zealand 1995: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology in hospitals - procurement of technology has to be reported to and approved by the Ministry of Health The mode how in-patient services provided by Hospitals are remunerated – usually by budgets Organizational questions; how the Hospitals are organized and administered Remark: While the hospitals were quite independent, the central government did merge them and split the mergers back again.	2004: Catalogue of in-patient services covered by the health system The national overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology in hospitals - procurement of technology has to be reported to and approved by the Ministry of Health The mode how in-patient services provided by Hospitals are remunerated – usually by budgets Organizational questions; how the Hospitals are organized and administered
Norway 1995: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology The mode how in-patient services provided by Hospitals are remunerated Organizational questions; how the Hospitals are organized and administered Remark: The county councils as owner of the hospitals could determine these issues. The Hospitals usually received a block grant and had substantial autonomy.	2004: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology The mode how in-patient services provided by Hospitals are remunerated Organizational questions; how the Hospitals are organized and administered Remark: Hospitals are now legally independent Health Enterprises and supposed to be self governed. Factually, they are seen as to be factually controlled by Regional Health Authorities, which in turn are part of the national government. Remuneration – the share of block grant and DRG based funding - is annually decided by the parliament.

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
Portugal 1995: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in Hospitals – the ratio of heavy equipment per population is set by law Employment decisions in Hospitals The actual remuneration – the hospital's budget The mode how in-patient services provided by Hospitals are remunerated – share of the budget which is calculated using a DRG system Organizational questions; how the Hospitals are organized and administered The usage of technology in Hospitals Remark: While private hospitals have much more leeway, the government has also some control over them, in particular on capacities and available technology. Control is directly exercised by negotiations between the hospital and the Ministry of health.	2004: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology in Hospitals – the ratio of heavy equipment per population is set by law Employment decisions in Hospitals The actual remuneration – the hospital's budget The mode how in-patient services provided by Hospitals are remunerated – share of the budget which is calculated using a DRG system Organizational questions; how the Hospitals are organized and administered – some hospitals have been transformed into public enterprises The usage of technology in Hospitals Remark: While private hospitals have much more leeway, the government has also some control over them, in particular on capacities and available technology. Control is directly exercised by negotiations between the hospital and the Ministry of health.
Poland 1995: The Central Government controls: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The investments in medical technology in Hospitals – the government can give a grant The mode how in-patient services provided by Hospitals are remunerated Competencies for hospitals also rest with the municipalities and regions, which can exert some influence on: Employment decisions in Hospitals The number of Hospitals in a region The size of Hospitals in a region	2004: The Central Government controls: Catalogue of in-patient services covered by the health system The overall budget for in-patient services The investments in medical technology in Hospitals – the government can give a grant The mode how in-patient services provided by Hospitals are remunerated Competencies for hospitals also rest with the municipalities and regions, which can exert some influence on: Employment decisions in Hospitals The number of Hospitals in a region The size of Hospitals in a region Remark: Factually, many issues are negotiated with the hospitals

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
Spain 1995: The Central Government controls Catalogue of in-patient services covered by the health system The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology Employment decisions in Hospitals (number and type of staff employed) Actual remuneration level (i.e. the hospital's budget) The mode how in-patient services provided by Hospitals are remunerated - i.e. the way the hospitals budget is determined, e.g. based on historical budgets or on a DRG system Organizational / administrative questions (e.g. how the Hospitals are organized and administered Remark: About half of the hospital beds are operated by the INSALUD, which is directly under control of the Central Government. Here, the Central Government can control these elements. For the remaining half, the control only concerns the remuneration levels for the hospitals, which are contracted by the INSALUD.	2004: The Central Government controls Catalogue of in-patient services covered by the health system The Autonomous Communities control: The overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region (beds) The investments in medical technology Employment decisions in Hospitals (number and type of staff employed) Actual remuneration level (i.e. the hospital's overall budget) The mode how in-patient services provided by Hospitals are remunerated - i.e. the way the hospitals budget is determined, e.g. based on historical budgets or on a DRG system Organizational / administrative questions (e.g. how the Hospitals are organized and administered) Remark: About half of the hospital beds are operated by the SRS, which are directly under control of the respective Regional Government. Here, the Regional Government can control these elements. For the remaining half, the control only concerns the remuneration levels for the hospitals, which are contracted.
Sweden 1995: The competencies rests with the Landstings, which are owning and operating them Catalogue of in-patient services covered by the health system The regional overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology Employment decisions in Hospitals Actual remuneration level of Hospitals The mode how in-patient services provided by Hospitals are remunerated Organizational / administrative questions Usage of medical technology in Hospitals	2004: The competencies rests with the Landstings, which are owning and operating them Catalogue of in-patient services covered by the health system The regional overall budget for in-patient services The number of Hospitals in a region The size of Hospitals in a region The investments in medical technology Employment decisions in Hospitals Actual remuneration level of Hospitals The mode how in-patient services provided by Hospitals are remunerated Organizational / administrative questions Usage of medical technology in Hospitals
Switzerland 1995: The Central Government controls The catalogue of in-patient services covered by the Health System in the sense of an	2004: The Central Government controls The catalogue of in-patient services covered by the Health System in the sense of an

CG5 Which of the following elements of the **in-patient / hospital sector** can be controlled by the Central Government unilaterally?	
enumeration of services which are excluded from coverage The Regional Government (Kanton) controls The number of Hospitals in a region; Kanton The size of Hospitals in a region (Kanton) The investments in medical technology in Hospitals Employment decisions of Hospitals	enumeration of services which are excluded from coverage The Regional Government (Kanton) controls The number of Hospitals in a region; Kanton The size of Hospitals in a region (Kanton) The investments in medical technology in Hospitals Employment decisions of Hospitals
United Kingdom 1995: Catalogue of in-patient services covered Remuneration level of in-patient services The regional overall budget for in-patient services – by setting the budget of a DHA The number of hospitals in a region Employment decisions - this answer applies to pay structure for staff Organizational questions, how hospitals are organized and administered Remark: Most questions are negotiated locally by NHS trusts and the District Health Authorities: the remuneration level, the services covered and the way the hospital is remunerated (e.g. a budget, or case-based remuneration). The central government exercises overall budget control, sets the DHA's budget and exerts supervision over the DHAs. The government will have influence – but no deterministic control	2004: Catalogue of in-patient services covered Remuneration level of in-patient services The regional overall budget for in-patient services – by setting the budget of a DHA The number of hospitals in a region Employment decisions - this answer applies to pay structure for staff Organizational questions, how hospitals are organized and administered – by creating new organizational forms like foundation trusts Remark: Most questions are negotiated locally by NHS trusts and the District Health Authorities: the remuneration level, the services covered and the way the hospital is remunerated (e.g. a budget, or case-based remuneration). The central government exercises overall budget control, sets the DHA's budget and exerts supervision over the DHAs. The government will have influence – but no deterministic control

CG6 Which of the following elements of the **Pharmaceutical Sector** can be controlled by the Central Government unilaterally?	
Austria 1995: Central Government can control: the price of a medicine – price levels are set by a commission, factually they are negotiated.	2004: Central Government can control: the price of a medicine The number of pharmacies in a region Remark: Inclusion and reimbursement price of a medicine is negotiated between the manufacturer and the HIFs. Mark ups, for distributors, are also negotiated.
Belgium 1995. Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for pharmaceuticals – sectorial target budget Pharmaceutical budget for individual prescribers (Hospitals, Physicians) Number of Pharmacies in a region – since 1986	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for pharmaceuticals – sectorial target budget Pharmaceutical budget for individual prescribers (Hospitals, Physicians) Number of Pharmacies in a region
Canada 1995: Provincial Governments control Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for pharmaceuticals – the total amount of subsidies paid Pharmaceutical budget for Hospitals, albeit not for Physicians Federal Government controls Prices of medicines Remark: Apart form subsidies, most of the pharmaceutical expenditure is paid for directly by the patients or their VHI	2004: Provincial Governments control Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for pharmaceuticals– the total amount of subsidies paid Pharmaceutical budget for Hospitals, albeit not for Physicians Federal Government controls Prices of medicines Remark: Apart form subsidies, most of the pharmaceutical expenditure is paid for directly by the patients or their VHI
Czech Republic 1995: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Pharmaceutical Budget for individual prescribes Remark: Since 1999, the HIFs set limits for prescriptions issued by physicians. The government exerts influence via control over the HIFs.

CG6 Which of the following elements of the **Pharmaceutical Sector** can be controlled by the Central Government unilaterally?	
Denmark 1995: Competencies of the Central Government: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – by price caps Number of Pharmacies in a region Competencies at county level; Amter: Overall Budget for expenditure for pharmaceuticals in the region Pharmaceutical budget for individual prescribers (Hospitals, Physicians)	2004: Competencies of the Central Government: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – by price caps Number of Pharmacies in a region Competencies at county level; Amter: Overall Budget for expenditure for pharmaceuticals in the region Pharmaceutical budget for individual prescribers (Hospitals, Physicians)
Finland 1995: The Central Government controls: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for pharmaceuticals Pharmaceutical Budgets for individual prescribers Number of Pharmacies in a region	2004: The Central Government controls: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for pharmaceuticals Pharmaceutical Budgets for individual prescribers Number of Pharmacies in a region
France 1995: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – reimbursement price in negotiations with the Manufacturer Number of Pharmacies in a region	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – reimbursement price in negotiations with the Manufacturer Number of Pharmacies in a region Overall Budget for expenditure for pharmaceuticals; by vote of parliament since 1996
Germany 1995: Number of pharmacies in a region Remark: There have been various attempts of spending caps and regional budgets, however, not effective	2004: Number of Pharmacies in a region
Greece 1995: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Number of pharmacies in a region Remark There are attempts to budget pharmaceutical expenditure, but they are not effective.	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Number of pharmacies in a region Remark There are attempts to budget pharmaceutical expenditure, but they are not effective.
Hungary 1995: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine Overall Budget for expenditure for

CG6 Which of the following elements of the **Pharmaceutical Sector** can be controlled by the Central Government unilaterally?	
pharmaceuticals – sectorial budget, which is however, not really binding Number of Pharmacies in a region	pharmaceuticals – sectorial budget, which is however, not really binding Number of Pharmacies in a region
Ireland 1995: Price of a medicine – negotiated with the industry, the price shall not be above the price in the UK	2004: Inclusion of new drugs into reimbursement by the Health System - introduction of a Drug Payment System in 1999 Price of a medicine – negotiated with the Industry
Italy 1995: Inclusion of new drugs into reimbursement by the Health System Price of a medicine Overall Budget for expenditure for pharmaceuticals- there is a budget, but it's impact is weak	2004: Inclusion of new drugs into reimbursement by the Health System Price of a medicine Overall Budget for expenditure for pharmaceuticals- there is a budget, but it's impact is weak
Luxembourg 1994: Price of a medicine Number of Pharmacies in a region – new pharmacies need the approval of the Ministry of health	2004: Price of a medicine Number of Pharmacies in a region – new pharmacies need the approval of the Ministry of health
Netherlands 1995: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Overall Budget for expenditure for pharmaceuticals	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – by setting maximum prices for reimbursement Overall Budget for expenditure for pharmaceuticals – by setting expenditure targets
New Zealand 1995: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – by grouping and reference pricing Overall Budget for expenditure for pharmaceuticals Number of Pharmacies in a region	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – by grouping and reference pricing Overall Budget for expenditure for pharmaceuticals Number of Pharmacies in a region
Norway 1995: Inclusion of new drugs into reimbursement by the Health System Price of a medicine Number of Pharmacies in a region – licensing system by the Norwegian Board of Health	2004: Inclusion of new drugs into reimbursement by the Health System Price of a medicine Number of Pharmacies in a region
Portugal 1995: Inclusion of new drugs into reimbursement by the Health System (positive lists) Price of a medicine – the price is negotiated with the manufacturer and depends on the	2004: Inclusion of new drugs into reimbursement by the Health System (positive lists) Price of a medicine– the price is negotiated with the manufacturer and depends on the

CG6 Which of the following elements of the **Pharmaceutical Sector** can be controlled by the Central Government unilaterally?	
price of the drug in other countries Overall budget for pharmaceuticals – for those paid for by the NHS Number of Pharmacies in a region – the Ministry of Health decides, whether there is a need for a pharmacy in a region	price of the drug in other countries Overall budget for pharmaceuticals – for those paid for by the NHS Number of Pharmacies in a region Remark: There was a spending cap for pharmaceuticals in 1997, but it was not really effective
Poland 1995: Inclusion of new drugs into reimbursement by the Health System Price of a medicine Overall budget for pharmaceuticals	2004: Inclusion of new drugs into reimbursement by the Health System Price of a medicine Overall budget for pharmaceuticals – the budget of the NHF for pharmaceuticals
Spain 1995: The Central Government controls Inclusion of drugs; via Positive/Negative Lists The price of a medicine Overall Budget for expenditure for pharmaceuticals Number of Pharmacies in a region	2004: The Central Government controls Inclusion of drugs; via Positive/Negative Lists The price of a medicine The Autonomous Communities control Overall Budget for expenditure for pharmaceuticals Number of Pharmacies in a region
Sweden 1995: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – by negotiation Overall Budget for expenditure for pharmaceuticals Pharmaceutical budget for Hospitals Number of Pharmacies in a region	2004: Inclusion of new drugs into reimbursement by the Health System (positive/negative lists) Price of a medicine – by negotiation Overall Budget for expenditure for pharmaceuticals Pharmaceutical budget for Hospitals Number of Pharmacies in a region
Switzerland 1995: The Central Government controls: Inclusion of new drugs into reimbursement by the Health System (Positive lists) Price of a medicine; is negotiated with the Pharmaceutical Industry Remark: The Inter-Cantonal Office for the Control of Medicines and the Federal Office of Social Insurance decide on the coverage – i.e. the inclusion in the positive list.	2004: The Central Government controls: Inclusion of new drugs into reimbursement by the Health System (Positive lists) Price of a medicine; negotiated with the Pharmaceutical Industry Remark: The Inter-Cantonal Office for the Control of Medicines and the Federal Office of Social Insurance decide on the coverage – i.e. the inclusion in the positive list.
United Kingdom 1995: Inclusion of drugs; via a Negative List, which excludes some pharmaceuticals from reimbursement by the NHS Overall budget for pharmaceuticals – in the Pharmaceutical Price Regulation Scheme, PPRS, the overall profit the Pharmaceutical industry is allowed to make from selling drugs to the NHS is negotiated	2004: Inclusion of drugs; via a Negative List, which excludes some pharmaceuticals from reimbursement by the NHS Overall budget for pharmaceuticals – in the Pharmaceutical Price Regulation Scheme, PPRS, the overall profit the Pharmaceutical industry is allowed to make from selling drugs to the NHS is negotiated

CG6 Which of the following elements of the **Pharmaceutical Sector** can be controlled by the Central Government unilaterally?	
Remark: All drugs have to be licensed, but not all licensed products are also reimbursed by the NHS	Budget for pharmaceutical expenditure for individual GPs – since 1999 Remark: All drugs have to be licensed, but not all licensed products are also reimbursed by the NHS

CG7 Which of the following elements of the **Health System** as a whole can be controlled by the Central Government unilaterally?	
Austria 1995: The central Government controls Catalogue of medical services covered by the health system The level of citizen's contributions to the HIFs are set by law, but factually negotiated between the government and the HIF The way negotiations among the Societal Actors in the Health System are conducted (e.g. negotiation at national or regional level etc.)	2004: Central Government can set Catalogue of medical services covered by the health system The level of citizen's contributions to the HIFs are set by law, but factually negotiated between the government and the HIF The way negotiations among the Societal Actors in the Health System are conducted (e.g. negotiation at national or regional level etc.)
Belgium 1995: Catalogue of medical services covered by the health system – negotiated between the HIF and the providers, but subject to government approval The overall budget for health expenditure – by setting the contribution level and the level of subsidies going into health care. The subsidies to the INAMI, Institute National d'Assurance Maladie Invalidité, cover the difference between the set overall budget of health expenditure by the HIF-system and the funds obtained from contributions The level of citizen's contributions to the health system – while this is formally negotiated among the trade unions and the employers, the government's approval is required The way negotiations among the Societal Actors in the Health System, (Medical Providers and Health Insurance Funds) are conducted (e.g. whether negotiations take place at national or regional level etc.) Remark: The decision making on all the issues is very consensual. However, since 1993, the Ministry of Social Affairs can take unilateral action and has done so in the past, for instance, in 1995, it reduced the fees negotiated by the HIF and the Providers by 3%	2004: Catalogue of medical services covered by the health system – negotiated between the HIF and the providers, but subject to government approval The overall budget for health expenditure - by setting the contribution level and the level of subsidies going into health care. The subsidies to the INAMI cover the difference between the set overall budget of health expenditure by the HIF-system and the funds obtained from contributions The level of citizen's contributions to the health system- – while this is formally negotiated among the trade unions and the employers, the government's approval is required The way negotiations among the Societal Actors in the Health System, (Medical Providers and Health Insurance Funds) are conducted (e.g. whether negotiations take place at national or regional level etc.) Remark: The decision making on all the issues is very consensual. However, since 1993, the Ministry of Social Affairs can take unilateral action and has done so in the past.
Canada 1995: Provincial Governments control Catalogue of medical services covered by the health system The overall budget for health expenditure – at the provincial level	2004: Provincial Governments control Catalogue of medical services covered by the health system The overall budget for health expenditure – provincial budget

CG7 Which of the following elements of the **Health System** as a whole can be controlled by the Central Government unilaterally?	
The level of citizen's contributions to the health system (e.g. amount of premiums or the percentage of income going into the Health financing) The way negotiations among the Societal Actors in the Health System, like Medical Providers and the Regional Health Authorities, are conducted Federal Government controls The federal government defined the catalogue of services covered as all services which are medically necessary. The level of citizen's contributions to the health system – federal taxes The way negotiations among the Societal Actors in the Health System, like Medical Providers and the Provincial Health Authorities, are conducted.	The level of citizen's contributions to the health system (e.g. amount of premiums or the percentage of income going into the Health financing) The way negotiations among the Societal Actors in the Health System, like Medical Providers and the Regional Health Authorities, are conducted Federal Government controls The federal government defined the catalogue of services covered as all services which are medically necessary. The level of citizen's contributions to the health system – federal taxes The way negotiations among the Societal Actors in the Health System, like Medical Providers and the Provincial Health Authorities, are conducted.
Czech Republic 1995: Catalogue of medical services covered by the health system The overall budget for health expenditure The level of citizen's contributions to the health system The way negotiations among the Societal Actors in the Health System (Medical Providers and HIF) are conducted. Remark: The government defines a basic package of services by law. Based on this, most negotiations of these issues are among individual HIF and providers, hospitals etc. The central government has influence on the results and can disapprove or replace the outcomes, if they are not in the public interest. The central government decided, that the HIF negotiate individually with the provider associations, leading to different remuneration levels for different HIF. However, most HIF orient their contracts on what the GHIF as the largest HIF, negotiated.	2004: Catalogue of medical services covered by the health system The overall budget for health expenditure The level of citizen's contributions to the health system The way negotiations among the Societal Actors in the Health System (Medical Providers and HIF) are conducted. Remark: The government defines a basic package of services by law. Based on this, most negotiations of these issues are among individual HIF and providers, hospitals etc. The central government has influence on the results, can disapprove and replace the results. The central government decided, that the HIF negotiate individually with the provider associations, leading to different remuneration levels for different HIF. However, most HIF orient their contracts on what the GHIF as the largest HIF, negotiated.
Denmark 1995: Catalogue of medical services covered by the health system – by excluding services The level of citizen's contributions to the health system – local taxes are set by the Amter The way negotiations among Societal Actors	2004: Catalogue of medical services covered by the health system – by excluding services The level of citizen's contributions to the health system – local taxes are set by the Amter The way negotiations among Societal Actors

CG7 Which of the following elements of the **Health System** as a whole can be controlled by the Central Government unilaterally?	
in the Health System are conducted; whether at national or Amter level) Remark: While the Amter are autonomous, the central government recommends levels of local taxes going into health care, as well as the overall expenditure for health	in the Health System are conducted; whether at national or Amter level) Remark: While the Amter are autonomous, the central government recommends levels of local taxes going into health care, as well as the overall expenditure for health
Finland 1995: Municipalities control: Catalogue of medical services covered by the health system The overall budget for health expenditure – at local level The level of citizen's contributions to the health system – local taxes The Central government controls The level of citizen's contributions to the National Health Insurance – setting the payroll tax level The maximum level of co-payments	2004: Municipalities control: Catalogue of medical services covered by the health system The overall budget for health expenditure – at local level The level of citizen's contributions to the health system – local taxes The Central government controls The level of citizen's contributions to the National Health Insurance – setting the payroll tax level The maximum level of co-payments
France 1995: Catalogue of medical services covered by the health system; negotiated between the HIFs and the Providers, but subject to approval The level of citizen's contributions to the health system – the percentage of income going to the HIFs is set by the parliament The way negotiations among the Societal Actors in the Health System are conducted (e.g. negotiation at national or regional level etc.): government and parliament	2004: Catalogue of medical services covered by the health system; negotiated between the HIFs (UNCAM) and the Providers, but subject to approval The overall budget for medical services and health expenditure; set by parliament since 1996 The level of citizen's contributions to the health system – the percentage of income going to the HIFs is set by the parliament The way negotiations among the Societal Actors in the Health System are conducted (e.g. negotiation at national or regional level etc.) is set by the government and parliament
Germany 1995: The central government sets a loose frame, in which HIFs and Provider negotiated – factually autonomously. It can influence the way negotiations among the Societal Actors in the Health System are conducted	2004: The central government sets a loose frame, in which HIFs and Provider negotiated – factually autonomously. It can influence the way negotiations among the Societal Actors in the Health System are conducted
Greece 1995: Catalogue of medical services covered by the health system – offered by the ESY The overall budget for health expenditure – only the public expenditure, however, the budgeting is not binding The level of citizen's contributions to the	2004: Catalogue of medical services covered by the health system – offered by the ESY The overall budget for health expenditure – only the public expenditure, however, the budgeting is not binding The level of citizen's contributions to the

CG7 Which of the following elements of the **Health System** as a whole can be controlled by the Central Government unilaterally?	
health system - taxation and the contributions to the HIF	health system - taxation and the contributions to the HIF
Hungary 1995: Catalogue of medical services covered by the health system The overall budget for health expenditure The level of citizen's contributions to the health system Remark: Payment methods and the levels of the remuneration are set either by the government by decree or by the NHIFA. There are national level budgets for 20 sectors of the health system. A sectorial budget is usually capped, and the payment modes are chosen in a way which ensures, that the budget is met, e.g. by discounted payments if the quantity of services has reached a certain level.	2004: Catalogue of medical services covered by the health system The overall budget for health expenditure The level of citizen's contributions to the health system Remark: Payment methods and the levels of the remuneration are set either by the government by decree or by the NHIFA. There are national level budgets for 20 sectors of the health system. A sectorial budget is usually capped, and the payment modes are chosen in a way which ensures, that the budget is met, e.g. by discounted payments if the quantity of services has reached a certain level.
Ireland 1995: Catalogue of medical services covered by the health system The overall budget for health expenditure The level of citizen's contributions to the health system (taxation) Remark: Catalogues and remuneration are negotiated for all citizens. The overall budget mainly concerns the provision of health to medical card holders and subsidies to non-medical card holders	2004: Catalogue of medical services covered by the health system The overall budget for health expenditure The level of citizen's contributions to the health system (taxation) Remark: Catalogues and remuneration are negotiated for all citizens. The overall budget mainly concerns the provision of health to medical card holders and subsidies to non-medical card holders
Italy 1995: Catalogue of medical services covered by the health system – there is no defined catalogue, but only minimum requirements, which have to be met by the Regions. The overall budget for medical services and health expenditure (i.e. the SSN budget) The level of citizen's contributions to the health system – by taxation Remark: While there is a budget, the regions spend more than the allocated budget, financing additional expenditure by incurring debts. These are later covered by additional funds extracted from the national government	2004: Catalogue of medical services covered by the health system – there is no defined catalogue, but only minimum requirements, which have to be met by the Regions. The overall budget for medical services and health expenditure (i.e. the SSN budget) The level of citizen's contributions to the health system – by taxation Remark: While there is a budget, the regions spend more than the allocated budget, financing additional expenditure by incurring debts. These are later covered by additional funds extracted from the national government
Luxembourg 1994: Catalogue of medical services covered by the health system – subject to advice from HIFs	2004: Catalogue of medical services covered by the health system – subject to advice from HIFs

CG7 Which of the following elements of the **Health System** as a whole can be controlled by the Central Government unilaterally?	
and providers The way negotiations among the HIFs and the Providers are conducted (e.g. negotiation at national or regional level etc.)	and providers The way negotiations among the HIFs and the Providers are conducted (e.g. negotiation at national or regional level etc.)
Netherlands 1995: Catalogue of medical services covered by the health system – by excluding services The overall budget for medical services and health expenditure - by setting tariffs The level of citizen's contributions to the health system – the percentage of income going to the HIFs The way negotiations among the Societal Actors in the Health System are conducted	2004: Catalogue of medical services covered by the health system – by excluding services The overall budget for medical services and health expenditure - by setting tariffs The level of citizen's contributions to the health system – the percentage of income going to the HIFs The way negotiations among the Societal Actors in the Health System are conducted
New Zealand 1995: Catalogue of medical services covered by the health system The overall public budget for medical services and health expenditure – by setting the budget for publicly funded health care The level of citizen's contribution to the health system – while there is no earmarked tax, the government sets the tax levels The way negotiations among providers and Purchasers are conducted Remark: The Health system works by subsidizing, the level of subsidies determines how much the government pays for health. apart from that, there is a large area of payments going directly from patients /VHI to providers	2004: Catalogue of medical services covered by the health system The overall public budget for medical services and health expenditure – by setting the budget for publicly funded health care The level of citizen's contribution to the health system – while there is no earmarked tax, the government sets the levels of taxation The way negotiations among providers and Purchasers are conducted Remark: The Health system works by subsidizing, the level of subsidies determines how much the government pays for health. apart from that, there is a large area of payments going directly from patients /VHI to providers
Norway 1995: Catalogue of medical services covered by the health system The overall budget for medical services and health expenditure The level of citizen's contribution to the health system Remark: The central government controls these questions. The Health system is financed from general taxation, but there are no earmarked taxes for health. The budget is usually binding, at least in the short run. There have been efforts by the government, to increase acitity.	2004: Catalogue of medical services covered by the health system The overall budget for medical services and health expenditure The level of citizen's contribution to the health system Remark: The central government controls these questions. The Health system is financed from general taxation, but there are no earmarked taxes. All public services must be provided within this budget. The leeway of the county councils in implementing the organization of health care was reduced.
Portugal 1995: Catalogue of medical services covered by the health system; there is no official catalogue,	2004: Catalogue of medical services covered by the health system; there is no official catalogue,

CG7 Which of the following elements of the **Health System** as a whole can be controlled by the Central Government unilaterally?	
but the government has influence on what is actually offered The overall budget for medical services and health expenditure – the budget is explicitly set by the Ministry of Finance The level of contributions – the funding is from the general taxation The way negotiations among the Societal Actors in the Health System are conducted – the NHS – the RHA - but also Hospitals negotiate contracts with private providers which are offering services for which they don't have the facilities.	but the government has influence on what is actually offered The overall budget for medical services and health expenditure – the budget is explicitly set by the Ministry of Finance The level of contributions – the funding is from the general taxation The way negotiations among the Societal Actors in the Health System are conducted – the NHS – the RHA - but also Hospitals negotiate contracts with private providers which are offering services for which they don't have the facilities.
Poland 1995: The Central government controls Catalogue of medical services covered by the health system; there is no official catalogue, but the government has influence on what is actually offered The overall budget for medical services and health expenditure – the health budget is determined by the Government The level of contributions – the tax levels, however there was no earmarked tax going into health care The way negotiations among the Purchasers (municipalities/regions) and the providers are conducted – while there was some contracting, most services were provided directly by the municipalities and regions in own facilities and by employed staff	2004: The Central government controls Catalogue of medical services covered by the health system; there is no official positive catalogue, but the government has excluded some services and has influence on what is actually offered by the NHF The overall budget for medical services and health expenditure – the NHF budget is implicitly determined by setting the contribution rate and subsidies going into health funding The level of contributions – the contributions to the National Health Fund are set by the parliament The way negotiations among medical providers of and the National Health Fund are conducted – the government gave the NHF a very strong position vis-a-vis the providers
Spain 1995: The Central Government controls The Catalogue of medical services covered by the health system The overall budget for health expenditure - the funding going into the INSALUD The level of citizen's contributions to the health system (i.e. amount of taxes going into the Health financing) The way negotiations among the INSALUD and contracted providers of medical services are conducted	2004: The Central Government controls The Catalogue of medical services covered by the health system – the Regional Governments have some leeway The level of citizen's contributions to the health system (i.e. amount of taxes going into the Health financing) The Autonomous Communities control The overall budget for health expenditure in their Region – they can increase the budgets allocated from the Central Government by raising additional funds The way negotiations among the SRS and contracted providers of medical services are conducted

CG7 Which of the following elements of the **Health System** as a whole can be controlled by the Central Government unilaterally?	
Sweden 1995. The Central government controls: Catalogue of medical services covered by the health system – by excluding services The overall budget for health expenditure The level of citizen's contributions to the health system (e.g. amount of premiums or the percentage of income going into the Health financing) The way negotiations among the Societal Actors in the Health System, Landstings and Medical Providers, are conducted Remark: The central government influences the Health expenditure by setting national levels of taxation and by influencing regional levels of taxation	2004: The Central government controls: Catalogue of medical services covered by the health system – by excluding services The overall budget for health expenditure The level of citizen's contributions to the health system (e.g. amount of premiums or the percentage of income going into the Health financing) The way negotiations among the Societal Actors in the Health System, Landstings and Medical Providers, are conducted Remark: The central government influences the Health expenditure by setting national levels of taxation and by influencing regional levels of taxation
Switzerland 1995: The Central Government controls: Catalogue of medical services covered by the health system; by excluding services The way negotiations among the Societal Actors in the Health System are conducted (e.g. negotiation at national or regional, i.e. Kanton, level etc.) The amount of co-payments	2004: The Central Government controls: Catalogue of medical services covered by the health system; by excluding services The way negotiations among the Societal Actors in the Health System are conducted (e.g. negotiation at national or regional, i.e. Kanton, level etc.) The amount of co-payments
United Kingdom 1995: Catalogue of medical services which have to be covered by the health system – while there is no "positive" catalogue, the central government has a strong (albeit not absolute) influence over what is provided The overall budget for health expenditure – by an explicit budget set annually by the Department of health The level of citizen's contributions to the health system – by setting the taxation, albeit there is no earmarked tax for health care The way negotiations among the Societal Actors in the Health System, like Medical Providers and District Health Authorities, are conducted (e.g. whether negotiations take place at national or regional level etc.)	2004: Catalogue of medical services which have to be covered by the health system – while there is no "positive" catalogue, the central government has a strong (albeit not absolute) influence over what is provided The overall budget for health expenditure – by an explicit budget set annually by the Department of health The level of citizen's contributions to the health system – by setting the taxation, albeit there is no earmarked tax for health care The way negotiations among the Societal Actors in the Health System, like Medical Providers and District Health Authorities, are conducted (e.g. whether negotiations take place at national or regional level etc.)

CG8 In some countries, the Organizations of Medical Providers, Health Insurance Funds and Health Authorities internally decide on the composition of the top level administration (the executive board etc.) of the organization. In other countries, the head of these organizations is determined externally by the Central Government. How are these positions determined in [Country]?	
Austria 1995: Provider organizations and Health Insurance Funds determine their top-level Management	2004: Provider organizations and Health Insurance Funds determine their top-level Management
Belgium 1995: Provider organizations and Health Insurance Funds determine their top-level Management	2004: Provider organizations and Health Insurance Funds determine their top-level Management
Canada 1995: Provider Organizations determine their top level management The main purchasers are the Provincial Governments, which are elected by the citizens at a provincial level	2004: Provider Organizations determine their top level management The main purchasers are the Provincial Governments, which are elected by the citizens at a provincial level
Czech Republic 1995: Provider organizations and Health Insurance Funds determine their top-level management Remark: The Executive Board of a HIF consists of representatives of the employers, the trade unions, and the state. In the most important HIF, the General Health Insurance Fund, the Executive Board is determined by the state.	2004: Provider organizations and Health Insurance Funds determine their top-level management Remark: The Executive Board of a HIF consists of representatives of the employers, the trade unions, and the state. In the most important HIF, the General Health Insurance Fund, the Executive Board is determined by the state
Denmark 1995: Provider Organizations determine their top level management The Amter government, which is the main purchaser, is elected by the citizens living in the county	2004: Provider Organizations determine their top level management The Amter government, which is the main purchaser, is elected
Finland 1995: Medical provider organizations determine their own top-level executive. The municipal governments determine the top-level executives of the municipal health authorities The municipal government itself is elected.	2004: Medical provider organizations determine their own top-level executive. The municipal governments determine the top-level executives of the municipal health authorities The municipal government itself is elected.
France 1995: Provider Organizations determine their top level management The HIFs are determining their top-level management which is negotiating with the provider organizations	2004: Provider Organizations determine their top level management The central government appoints the director of the UNCAM, which is the association of the Mandatory Health Insurance Funds. The UNCAM is negotiating with the provider organizations

CG8 In some countries, the Organizations of Medical Providers, Health Insurance Funds and Health Authorities internally decide on the composition of the top level administration (the executive board etc.) of the organization. In other countries, the head of these organizations is determined externally by the Central Government. How are these positions determined in [Country]?	
Germany 1995: Provider organizations and Health Insurance Funds determine their top-level Management	2004: Provider organizations and Health Insurance Funds determine their top-level Management
Greece 1995: Provider organizations determine their top-level management The top-level management of the health authorities i.e. the ESY and Health Insurance Funds are determined by the Central Government	2004: Provider organizations determine their top-level management The top-level management of the health authorities i.e. the ESY and Health Insurance Funds are determined by the Central Government
Hungary 1995: Provider organizations determine their top-level Management The top-level Management of the health authorities at county level is determined by the County Government. The top-level management of the National Health Insurance Fund Administration is determined by the Central Government	2004: Provider organizations determine their top-level Management The top-level Management of the health authorities at county level is determined by the County Government. The top-level management of the National Health Insurance Fund Administration is determined by the Central Government
Ireland 1995: Provider Organizations determine their top level management The central government determines the top level administration of the Health Boards	2004: Provider Organizations determine their top level management The Central Government determines the top level administration of the Health Service Executive
Italy 1995: Provider Organizations determine their top level management The head of the local ASL is determined by the regional government	2004: Provider Organizations determine their top level management The head of the local ASL is determined by the regional government
Luxembourg 1994: Provider organizations and Health Insurance Funds determine their top-level Management Remark: The Members of the HIF's executive board are elected by the insured employees and the employers. One Representative is determined by the Government	2004: Provider organizations and Health Insurance Funds determine their top-level Management Remark: The Members of the HIF's executive board are elected by the insured employees and the employers. One Representative is determined by the Government
Netherlands 1995: Provider organizations and Health Insurance Funds determine their top-level management	2004: Provider organizations and Health Insurance Funds determine their top-level management
New Zealand 1995: Provider Organizations determine their top level management The Central Government appoints the top	2004: Provider Organizations determine their top level management The Central Government appoints part of the

CG8 In some countries, the Organizations of Medical Providers, Health Insurance Funds and Health Authorities internally decide on the composition of the top level administration (the executive board etc.) of the organization. In other countries, the head of these organizations is determined externally by the Central Government. How are these positions determined in [Country]?	
level management of the Regional Health Authority.	top level management of the District Health Board. Remark: The Central Government appoints the Chairperson of the District Health Board. The Chairperson then appoints the Chief Executive Officer of the District Health Board, who is in charge of the day-to-day operation of the District Health Board. Part of the executive of the DHB is elected locally.
Norway 1995 The top level management for health care provision both at the county level and the municipality is determined by the County Council respectively the Municipality. Apart from professional associations, provider organizations do not exist. The administration of the National Insurance Scheme is determined by the government	2004: The top level management for health care provision both at the County level and the municipality is determined by the County Council respectively the Municipality. Apart from professional associations, provider organizations do not exist. The administration of the National Insurance Scheme is determined by the government
Portugal 1995: Provider Organizations determine their top level management Top Level Management of the Regional Health Administration, Administração Regionais de Saúde, is determined by the Central Government The Central Government determines the top-level management of the “subsistemas” (Health Insurance Funds) for civil servants and military; The other “subsistemas” determine their top-level management	2004: Provider Organizations determine their top level management Top Level Management of the Regional Health Administration, Administração Regionais de Saúde, is determined by the Central Government The Central Government determines the top-level management of the “subsistemas” (Health Insurance Funds) for civil servants and military; The other “subsistemas” determine their top-level management
Poland 1995: The medical providers determine the top-level management of their organization. The local Health Administration was determined by the local government (gmina, voivodship)	2004: The medical providers determine the top-level management of their organization. The Central Government determines the top-level management of the National Health Fund
Spain 1995: Medical provider organizations determine their top-level management; The senior management of the Health authority INSALUD acting as a purchaser, is determined by the Central Government	2004: Medical provider organizations determine their top-level management; The senior management of the Health authorities SRS acting as a purchaser, is determined by the Regional Government

CG8 In some countries, the Organizations of Medical Providers, Health Insurance Funds and Health Authorities internally decide on the composition of the top level administration (the executive board etc.) of the organization. In other countries, the head of these organizations is determined externally by the Central Government. How are these positions determined in [Country]?	
Sweden 1995: Medical Provider organizations determine their top-level management The Landsting government is elected locally	2004: Medical Provider organizations determine their top-level management The Landsting government is elected locally
Switzerland 1995: Provider organizations and Health Insurance Funds determine their top-level management	2004: Provider organizations and Health Insurance Funds determine their top-level management
United Kingdom 1995: Medical provider organizations determine their top-level management; The District Health Authorities are directed by a chairperson determined by the Central Government (Department of Health). There is also a board of executive and non-executives directors .	2004: Medical provider organizations determine their top-level management The District Health Authorities are directed by a chairperson determined by the Central Government (Department of Health). There is also a board of executive and non-executives directors.

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
Austria 1995: Health Insurance Funds must apply for a formal approval of an increase of contribution/premiums and must deliver reasons for this. The contribution rate (percentage of income) is then set by law Budget plans must be endorsed by the Government	2004: Health Insurance Funds must apply for a formal approval of an increase of contribution/premiums and must deliver reasons for this. The contribution rate (percentage of income) is then set by law Budget plans must be endorsed by the Government
Belgium 1995. Health Insurance Funds must apply for a formal approval of an increase of contribution/Premiums and must deliver reasons for this – in order to get more funds from the INAMI Publication of the administrative costs of the Health Insurance Fund Remark: Supervision is exercised by the INAMI. Health Insurance Funds are organized according to a law, by changing this law, the government can change the type and degree of control exercised	2004: Health Insurance Funds must apply for a formal approval of an increase of contribution/Premiums and must deliver reasons for this – in order to get more funds from the INAMI Publication of the administrative costs of the Health Insurance Fund Remark: Supervision is exercised by the INAMI. Health Insurance Funds are organized according to a law, by changing this law, the government can change the type and degree of control exercised
Canada 1995: Main Purchasers of Health are the Provincial Governments, which fulfill the insurance function Provincial Governments are obliged to produce an annual report for the Central government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed Administrative costs of the Provincial Government must be published Provincial Governments must apply with the Central Government for a formal approval of an increase of contribution/Premiums and must deliver reasons for this Funding of Provincial Government by the Central Government is conditional on the province's abidance to the frame set by the federal government	2004: Main Purchasers of Health are the Provincial Governments, which fulfill the insurance function Provincial Governments are obliged to produce an annual report for the Central government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed Administrative costs of the Provincial Government must be published Provincial Governments must apply with the Central Government for a formal approval of an increase of contribution/Premiums and must deliver reasons for this Funding of Provincial Government by the Central Government is conditional on the province's abidance to the frame set by the federal government
Czech Republic 1995: Health Insurance Funds must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed.	2004: Health Insurance Funds must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed.

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
Budget plans of the HIF must be endorsed by the Government Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds must apply for a formal approval of an increase of contribution/Premiums and must deliver reasons for this The government can replace part of the top level administration of a HIF. Remark: For the GHIF, the largest HIF, the government appoints the director-general, and basically all decisions are subject to parliamentary approval.	Budget plans of the HIF must be endorsed by the Government Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds must apply for a formal approval of an increase of contribution/Premiums and must deliver reasons for this The government can replace part of the top level administration of a the HIF Remark: For the GHIF, the largest HIF, the government appoints the director-general, and basically all decisions are subject to parliamentary approval.
Denmark 1995: Health Authorities, Amter, are obliged to produce an annual report in which all costs (administrative costs, expenditure for health services purchased) are listed - each county, Amter, issues a health plan annually to be commented on by the National Board of Health Remark: Central Government and the Amter negotiate annual budgets for health care. The central Government sets an overall budget ceiling for Amter activities, including health care. it recommends levels of local taxes and overall expenditure. The central Government influences the activities of the Amter by giving grants for certain projects.	2004: Health Authorities, Amter, are obliged to produce an annual report in which all costs (administrative costs, expenditure for health services purchased) are listed - each county, Amter, issues a health plan annually to be commented on by the National Board of Health Remark: Central Government and the Amter negotiate annual budgets for health care. The central Government sets an overall budget ceiling for Amter activities, including health care. it recommends levels of local taxes and overall expenditure. The central Government influences the activities of the Amter by giving grants for certain projects
Finland 1995: Municipal governments are autonomous Remark: Apart from the Municipalities, the National Health Insurance is a second purchaser of health – in charge of covering pharmaceuticals, private procurement of health and payments for the time of illness – is under the control and supervision of the Finnish Parliament.	2004: Municipal governments are autonomous Remark: Apart from the Municipalities, the National Health Insurance is a second purchaser of health – in charge of covering pharmaceuticals, private procurement of health and payments for the time of illness – is under the control and supervision of the Finnish Parliament.
France 1995: The Health insurance Funds are formally independent, but since the government would cover the deficit, it also retains control The government sets the contribution rates, it has to approve the contracts negotiated between the HIFs and the providers	2004: The Health insurance Funds are formally independent, but since the government would cover the deficit, it also retains control The government sets the contribution rates, it has to approve the contracts negotiated between the HIFs and the providers

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
The central government has substantial and extensive financial and administrative control over the HIFs	The central government has substantial and extensive financial and administrative control over the HIFs The government appoints the director and can replace the top level administration of a the Health Insurance fund - with the agreement of 2/3 of Director Council of Sickness Fund, representing the insurers)
Germany 1995: Health Insurance Funds must submit an annual report to the government or a government agency, in which all costs are listed. Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds have to apply for a formal approval of an increase in the contributions and must deliver reasons for this	2004: Health Insurance Funds must submit an annual report to the government or a government agency, in which all costs are listed. Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds have to apply for a formal approval of an increase in the contributions and must deliver reasons for this
Greece 1995: With regard to the ESY: ESY is obliged to produce an annual report for the government, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs of the ESY ESY must apply for a formal approval of an increase of the allocated budget and must deliver reasons for this. The government can replace the administration of the ESY With regard to the HIF, i.e. the IKA, OGA HIF must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs Health Insurance Funds must apply for a formal approval of an increase of contribution levels and must deliver reasons for this - contribution rates are set by the state but in negotiations with the HIF The government can replace the top level	2004: With regard to the ESY: ESY is obliged to produce an annual report for the government, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs of the ESY ESY must apply for a formal approval of an increase of the allocated budget and must deliver reasons for this. The government can replace the administration of the ESY With regard to the HIF, i.e. the IKA, OGA HIF must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs Health Insurance Funds must apply for a formal approval of an increase of contribution levels – the contribution level is set by the state but in negotiations with the HIF The government can replace the top level administration of the HIF

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
administration of the HIF Remark: The ESY is not really an entity of its own, but is controlled directly by the Central Government. The Central Government also controls the largest HIF, which cover most of the population. Some smaller HIF have more autonomy.	 Remark: The ESY is not really an entity of its own, but is controlled directly by the Central Government. The Central Government also controls the largest HIF, which cover most of the population. Some smaller HIF have more autonomy.
Hungary 1995: Regarding the county governments: The county governments must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Regarding the National Health Insurance Fund Administration The NHIFA must submit an annual report to the government, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans of the NHIFA must be endorsed by Government and the parliament The government can replace the top level administration of the NHIFA	2004: Regarding the county governments: The county governments must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Regarding the National Health Insurance Fund Administration The NHIFA must submit an annual report to the government, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans of the NHIFA must be endorsed by the Government and the parliament The government can replace the top level administration of the NHIFA
Ireland 1995: A Health Board is obliged to produce an annual report for the government, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans of the Health Boards must be endorsed by the Government The government can replace the top level administration of the Health Board Remark: The budget of a Health Board is negotiated between the Department of Health and the Health Board. The Department of Health can earmark funds for certain activities	2004: A Health Board is obliged to produce an annual report for the government, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans of the Health Boards must be endorsed by the Government The government can replace the top level administration of the Health Board Remark: The budget of a Health Board is negotiated between the Department of Health and the Health Board. The Department of Health can earmark funds for certain activities
Italy 1995: Health authorities, the Azienda Sanitaria Locale, ASLs, must submit an quarterly report to the regional government, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans of the ASL must be endorsed by the Government The regional government can replace the administration of the USL	2004: Health authorities, the ASLs, must submit an quarterly report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans of the ASL must be endorsed by the Government The regional government can replace the administration of the ASL

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
Luxembourg 1994: Health Insurance Funds must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds must apply for a formal approval of an increase of contributions (percentage of income) and must deliver reasons for this While the government cannot replace the top level administration of a Health Insurance Fund, it determines one member thereof. Remark: Every decision of the HIF and the HIF Association is subject to governments approval. The contribution rate to the HIFs is set by the government and is unitary for all.	2004: Health Insurance Funds must submit an annual report to the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds must apply for a formal approval of an increase of contributions (percentage of income) and must deliver reasons for this While the government cannot replace the top level administration of a Health Insurance Fund, it determines one member thereof. Remark: Every decision of the HIF and the HIF Association is subject to governments approval. The contribution rate to the HIFs is set by the government and is unitary for all.
Netherlands 1995: Health Insurance Funds must submit an annual report to the Health Care Insurance Board, a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs of the Health Insurance Funds	2004: Health Insurance Funds must submit an annual report to the Health Care Insurance Board, a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed Budget plans must be endorsed by the Government Publication of the administrative costs of the Health Insurance Funds The Government can replace the top level administration of the Health Insurance Fund
New Zealand 1995: The Regional Health Authorities are obliged to produce an annual report for the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs of the Regional Health Authorities The government can replace the administration (governing board) of the Regional Health Authority	2004: Health Authorities (District Health Boards) are obliged to produce an annual report for the government or a government agency, in which all costs (administrative costs, expenditure for health services purchased) are listed. Budget plans must be endorsed by the Government Publication of the administrative costs of the District Health Board – the annual plans as well as the funding agreements have to be published The government can replace the administration (governing board) of the District Health Board) – it can replace the

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
	chief executive Remark: The DHB have to ensure, that the public, i.e. the population in the area covered, is consulted when decisions on coverage, budgeting etc. are made. The DHB has to apply for funding of investments.
Norway 1995: The Ministry of Local Government and Local Authorities at the national level exercises a supervision over the activities of the County Councils and the Municipalities: All costs and budget plans are published. Budget plans of the counties and municipalities are subject to control by the central government The National Insurance Scheme is under the direct control of the central government Remark: Counties and municipalities are funded by block grants from the central government. The grants oriented at the needs, but are not earmarked.	2004: The Ministry of Local Government and Local Authorities exercises a supervision over the activities of the Municipalities: All costs and budget plans are published. Budget plans of the municipalities are subject to control by the central government The National Insurance Scheme is under the direct control of the central government Remark: Municipalities are funded by block grants from the central government. The grants oriented at the needs, but are not earmarked. The functions of organizing hospital care were transferred from the counties to the Regional Health Authorities, which are part of the national government.
Portugal 1995: Regarding the Regional Health Administrations; Administração Regionais de Saúde: Regional Health Administrations are obliged to produce an annual report for the government in which all costs and all activities are listed Budget plans must be endorsed by the Government – the funding is allocated from the Ministry of Health to the RHA The Government can replace the administration of the RHA Regarding the subsistemas (HIFs): The subsistemas for civil servants and military staff are treated like Regional Health Administrations The other subsistemas have complete autonomy but must publish the administrative costs and budget plans.	2004: Regarding the Regional Health Administrations; Administração Regionais de Saúde: Regional Health Administrations are obliged to produce an annual report for the government in which all costs and all activities are listed Budget plans must be endorsed by the Government– the funding is allocated from the Ministry of Health to the RHA Publication of the administrative cost The Government can replace the administration of the RHA Regarding the subsistemas (HIFs): The subsistemas for civil servants and military staff are treated like Regional Health Administrations The other subsistemas have complete autonomy but must publish the administrative costs and budget plans.

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
Poland 1995: Regarding the Local Health Authorities at the municipal and regional level The Health Authorities are obliged to produce an annual report for the government in which all costs and all activities are listed Budget plans must be endorsed by the Government Publication of the administrative cost The central government can replace the administration of the local health authority	2004: Regarding the National Health Fund (NHF) The NHF is obliged to produce an annual report for the government in which all costs and all activities are listed NHF budget plans must be endorsed by the Government Publication of the administrative cost of the NHF The level of the contributions to the NHF is set by the parliament The government can replace the top level administration of the NHF Remark: The NHF is closely monitored and controlled by the Government. The Fund Council, which is supervising the NHF is appointed by the Government. The Ministry of Health sets plans which the NHF has to abide to. These contain overall policy targets as well as the volume and the costs of health services.
Spain 1995: The Central Government can replace the top-level Management of the Health authorities (INSALUD) and its regional branches The INSALUD is under close control of the Central Government, comparable to an integral part of the central public administration	2004: The Regional Government can replace the top-level Management of the regional Health Authorities SRS. The SRS is basically integral part of the regional governments public administration.
Sweden 1995: The Central Government can set ceilings for local taxes. Part of a Landsting's Budget is a grant from the Central Government, this gives the Central government some control The Landsting has to publish annual reports listing income and expenditure, albeit not explicitly for the Central government but to everybody	2004: The Central Government can set ceilings for local taxes. Part of a Landsting's Budget is a grant from the Central Government, this gives the Central government some control The Landsting has to publish annual reports listing income and expenditure, albeit not explicitly for the Central government but to everybody
Switzerland 1995: Health Insurance Funds are obliged to produce an annual report for the Government in which all costs are listed Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds must apply for a formal approval of an increase of contributions/ premiums and must deliver reasons for this	2004: Health Insurance Funds are obliged to produce an annual report for the Government in which all costs are listed Publication of the administrative costs of the Health Insurance Funds Health Insurance Funds must apply for a formal approval of an increase of contributions/ premiums and must deliver reasons for this.

CG9/CG10 By what means does the Central Government exert a control and supervision on the activities of the **Health Insurance Funds / Health Authorities**?	
Remark: HIFs are not allowed to make profit. If they have a surplus, this surplus has to be used either to increase the reserves until the level set by the Central Government is reached or to lower the contribution levels	Remark: HIFs are not allowed to make profit. If they have a surplus, this surplus has to be used either to increase the reserves until the level set by the Central Government is reached or to lower the contribution levels
United Kingdom 1995: District Health Authorities are obliged to produce an annual report for the Government in which all costs are listed Budget plans must be endorsed by the Government The Government can replace the chairperson of the District Health Authority Remark: The funding of a DHA is based on the budget plan the DHA developed and negotiated between the DHA and the Department of Health, apart from this, the Department of Health and the NHS executive exert substantial control, e.g. by setting priorities for activities and by monitoring the performance of the various DHAs	2004: District Health Authorities are obliged to produce an annual report for the Government in which all costs are listed Budget plans must be endorsed by the Government The Government can replace the chairperson of the District Health Authority Remark: The funding of a DHA is based on the budget plan the DHA developed and negotiated between the DHA and the Department of Health, apart from this, the Department of Health and the NHS executive exert substantial control, e.g. by setting priorities for activities and by monitoring the performance of the various DHAs. Since 1998, the DHAs are the only tier of the NHS administration below the national level

Part IV: Administration and Operation of the Health Care System

1. Purchasers of Health: Health Insurance Funds / Health Authorities

HIF1/HA1 What is the predominant status of the Health Insurance Funds / Health Authorities?	
Austria 1995: Non-profit Insurance Funds under public law In addition, there are several private for profit insurance companies offering supplementary insurance	2004: Non-profit Insurance Funds under public law In addition, there are several private for profit insurance companies offering supplementary insurance
Belgium 1995: Public non-profit Health Insurance Funds under public law Remark: The HIF are affiliated with political parties	2004: Public non-profit Health Insurance Funds under public law Remark: The HIF are affiliated with political parties
Canada 1995: Provincial Governments are the main purchaser of health. They fulfill the insurance function, and act either directly (e.g. negotiate fees with providers) or via the Regional Health Authorities.	2004: Provincial Governments are the main purchaser of health. They fulfill the insurance function, and act either directly (e.g. negotiate fees with providers) or via the Regional Health Authorities.
Czech Republic 1995: Public non-profit Health Insurance Funds	2004: Public non-profit Health Insurance Funds
Denmark 1995: Health Authorities are part of the county government (Amter) respectively Municipality (Kommuner)	2004: Health Authorities are part of the county government (Amter); respectively part of the local government (Kommuner)
Finland 1995. The Health Authorities are part of the municipal government. The Municipal government determines a committee which is in charge of organizing health care in the municipality, the political responsibility rests with the municipal government. Remark: Municipalities organize most of the health care and finance about two thirds of the overall expenditure. They raise their own taxes and provide or contract most of the health services. The National Health Insurance, NHI, is a second, complementary purchaser of health in charge of covering pharmaceutical expenditure, privately provided health care and payments during times of illness. It is a national level institution, is financed from pay roll taxes and under direct control of the national government, which decides on the level of the contributions and the coverage of	2004: The Health Authorities are part of the municipal government. The Municipal government determines a committee which is in charge of organizing health care in the municipality, the political responsibility rests with the municipal government. Remark: Municipalities organize most of the health care and finance about two thirds of the overall expenditure. They raise their own taxes and provide or contract most of the health services. The National Health Insurance, NHI, is a second, complementary purchaser of health in charge of covering pharmaceutical expenditure, privately provided health care and payments during times of illness. It is a national level institution, is financed from pay roll taxes and under direct control of the national government, which decides on the level of the contributions and the coverage of

HIF1/HA1 What is the predominant status of the Health Insurance Funds / Health Authorities?	
services.	services.
France 1995: Mandatory Health Insurance Funds are under extensive supervision of the state Voluntary Health Insurance (non profit or for profit) is independent from the state	2004: Mandatory Health Insurance Funds are under extensive supervision of the state Voluntary Health Insurance (non profit or for profit) is independent from the state
Germany 1995: Non-profit Health Insurance Funds under public law ("Krankenkassen")	2004: Non-profit Health Insurance Funds under public law ("Krankenkassen")
Greece 1995: The Health Insurance Funds are public non profit Insurance Funds, The ESY, i.e. the Health Authorities of the NHS, are under direct control of the Central Government	2004: The Health Insurance Funds are public non profit Insurance Funds, The ESY, i.e. the Health Authorities of the NHS, are under direct control of the Central Government
Hungary 1995: The National Health Insurance Fund Administration, NHIFA, is only formally independent of the Central Government and the public administration	2004: The National Health Insurance Fund Administration, NHIFA, is only formally independent of the Central Government and the public administration
Ireland 1995: Health Boards are under direct control of the Central Government; i.e. the Department of Health	2004: The Health Boards were combined into the Health Service Executive, which is under control of the Central Government
Italy 1995: The Health Authorities, ASL, are part of the regional government Remark: Up to the 1992 Reforms, the then Unita Sanitaria Locale, were part of the local government, operated by the municipal administration.	2004: The Health Authorities, ASL, are part of the regional government, albeit they have gained more autonomy
Luxembourg 1994: Non-profit Insurance Funds under public law and supervision Remark: Basically every decision of the HIFs is subject to government approval	2004: Non-profit Insurance Funds under public law and supervision Remark: Basically every decision of the HIFs is subject to government approval
Netherlands 1995: Non-profit Insurance Funds like public Insurance Funds, mutualities etc. Some for profit Insurance Funds for VHI Remark: There is the AWBZ for social care, mental care and long term care, but not actually involved in the financing of health services. the following concerns those HIFs which are in charge of financing the health services	2004: Non-profit Insurance Funds like public Insurance Funds, mutualities etc. Some for profit Insurance Funds for VHI Remark: There is the AWBZ for social care, mental care and long term care, but not actually involved in the financing of health services. the following concerns those HIFs which are in charge of financing the health services

HIF1/HA1 What is the predominant status of the Health Insurance Funds / Health Authorities?	
New Zealand 1995: The Regional Health Boards are under direct control of the Central Government, they are basically part of the national administration Remark: Factually, the Regional Health Boards had a high degree of autonomy	2004: The District Health Boards are under direct control of the Central Government, they are basically part of the national administration
Norway 1995: County Councils and Municipalities in charge of providing Hospital and Primary Care are political entities; elected by the citizens The National Insurance Scheme is the second purchaser in the health system. It is funded from payroll contributions and controlled by the government. It finances medicines, and services in addition to the payments made by the Municipalities. Most of all, it covers financial losses arising during illness.	2004: Municipalities in charge of providing Primary Care. They are political entities; elected by the citizens. The role of the Central government has increased, by acquiring control over Hospitals The National Insurance Scheme is the second purchaser in the health system. It is funded from payroll contributions and controlled by the government. It finances medicines, and services in addition to the payments made by the Municipalities. Most of all, it covers financial losses arising during illness.
Portugal 1995: Regional Health Administrations, Administrações Regionais de Saúde, are under direct control of the Central Government, and basically part of the national administration. Remark: The role of the subsistemas, the HIFs, and the VHI is very limited.	2004: Regional Health Administrations, Administrações Regionais de Saúde, are still under direct Control of the Central Government, and basically part of the national administration. They have however gained some autonomy in the last years. The importance of the sub-regions is disappearing. Remark: The role of the subsistemas, the HIFs, and the VHI is very limited.
Poland 1995: The municipalities/gmina and regions/voivoda were most important for the provision of care. They are locally elected governments. The administration in charge of organizing health care is determined by the municipal and regional government (gmina and voivodship). It receives funding from the central government	2004: The National Health Fund (NHF) is the main purchaser of health services. It is under close control of the national government Remark: There was a short period in which 16 HIFs were created, but they were merged in 2003 to only one Fund, the National Health Fund. The NHF is supervised by a Fund Council, which in turn is appointed by the Government.
Spain 1995: The Health Authority, the INSALUD, and its regional branches are under direct control of the Central Government Remark: Even in the mid 90s, the devolution had begun and in some of the Regions, the regional government was already in charge	2004: The regional Health Authorities, Servicios Regional de Salud, in the Autonomous Communities are under direct control of the Government of the respective Autonomous Community Remark: With the completion of the decentralization

HIF1/HA1 What is the predominant status of the Health Insurance Funds / Health Authorities?	
of operating the regional branch of the NHS.	process, the regional governments are in charge of the NHS in all regions. The competencies have basically shifted to the regional governments, but have not changed otherwise.
Sweden 1995: Health Authorities are the regional government; the Landsting is in charge of organizing and providing Health Care	2004: Health Authorities are the regional government; the Landsting is in charge of organizing and providing Health Care
Switzerland 1995: Non-profit Health Insurance Funds Remark: The non-profit funds are in charge of the basic coverage – the VHI is offered by commercial insurance companies.	2004: Non-profit Health Insurance Funds Remark: The non-profit funds are in charge of the basic coverage – the VHI is offered by commercial insurance companies.
United Kingdom 1995: District Health Authorities are under the direct control of the Central Government; albeit not on a day-by-day basis and not in every detail	2004: Health Authorities are under the direct control of the Central Government; albeit not on a day-by-day basis and not in every detail

HIF2 How many Health Insurance Funds / Health Authorities, that can offer the full coverage of a health insurance, exist in [Country]?	
Austria 1995: 27 Health Insurance Funds	2004: 20 Health Insurance Funds
Belgium 1995: 6 Health Insurance Funds cover most of the population Remark: The 6 national level organizations comprise about 100 local Health Insurance Funds. The HIF act as a unitary actor vis-a-vis the providers of medical services.	2004: 6 Health Insurance Funds cover most of the population Remark: The 6 national level organizations comprise about 100 local Health Insurance Funds. The HIF act as a unitary actor vis-a-vis the providers of medical services.
Canada 1995: 13 Provinces with their own health insurance programs (10 provinces, 3 territories) are acting as purchasers and providers of health services for their population.	2004: 13 Provinces with their own health insurance programs (10 provinces, 3 territories) are acting as purchasers and providers of health services for their population.
Czech Republic 1995: 23 in 1995 Remark: Some HIF went bankrupt, since they offered more services in addition to the basic packaged without having the financial means to cover them. Their clients were transferred to the General Health Insurance Fund.	2004: 9 Remark: The biggest HIF is the General Health Insurance Fund GHIF, covering 68% of the population. It has a regional structure. It acts as a fall-back insurance, if a HIF – as has happened- goes bankrupt.
Denmark: 16; 14 counties; plus the Copenhagen and Frederiksberg municipalities which have county status. 273 municipalities	2004: Currently 16; 14 counties; plus the Copenhagen and Frederiksberg municipalities which have county status 273 municipalities
Finland 1995: 455 Local communities and municipalities in charge of organizing health care provision Remark: The National Health Insurance, NHI, is a second, complementary purchaser of health in charge of covering pharmaceutical expenditure, privately provided health care and payments during times of illness. It is a national level institution, is financed from pay roll taxes and under direct control of the national government, which decides on the level of the contributions and the coverage of services.	2004: 432 Local communities and municipalities in charge of organizing health care provision Remark: The National Health Insurance, NHI, is a second, complementary purchaser of health in charge of covering pharmaceutical expenditure, privately provided health care and payments during times of illness. It is a national level institution, is financed from pay roll taxes and under direct control of the national government, which decides on the level of the contributions and the coverage of services.
France 1995: About 2/3 of all citizens are member in the régime général, CNAMTS, covering employed citizens. The régime général itself consists of 16 regional and 129 local branches, which are however only regional	2004: About 84% of the population are member of the régime général; CNAMTS. The régime général itself consists of regional and local branches, which are however only regional representations of the same HIF.

HIF2 How many Health Insurance Funds / Health Authorities, that can offer the full coverage of a health insurance, exist in [Country]?	
representations of the HIF. Further, there are health insurance funds for special occupational groups like farmers, miners, or those employed by the railway.	There still exist funds for special occupations like farmers, covering about 7% of the population
Germany 1995: About 500 Health Insurance Funds Remark: In earlier years, there were even about 1200 HIFs, many of them associated with individual enterprises, covering the employed of this enterprise.	2004: 292 Health Insurance Funds (January 2004)
Greece 1995: About 6-7 major Health Insurance Funds, many smaller mutualities for special occupations. In 1996 in total 239 HIF. The two main funds, IKA and OGA, cover ¾ of the population Many local health authorities as local representation of the ESY, which is one administrative entity.	2004: About 6-7 major Health Insurance Funds, many smaller mutualities for special occupations. The two main funds, IKA and OGA, cover ¾ of the population Many local health authorities as local representation of the ESY, which is one administrative entity.
Hungary 1995: There is only one fund, the NHIFA, acting as purchaser of health services for the whole population	2004: There is only one fund, the NHIFA, acting as purchaser of health services for the whole population
Ireland 1995: 8 Health Boards	2004: The Health Boards were combined to the Health Service Executive
Italy 1995: 228 ASL	2004: 183 ASL Remark: In some regions, the number of ASL was reduced.
Luxembourg 1994: One Remark: While there are formally 9 branches of the HIF for certain occupational classes, all act together as a unitary actor, the Union des Caisses de Maladie, UCM	2004: One Remark: While there are formally 9 branches of the HIF for certain occupational classes, all act together as a unitary actor, the Union des Caisses de Maladie, UCM
Netherlands 1995: About 28 Health Insurance Funds	2004: 22 Health Insurance Funds; Remark: 5 of them cover 70% of the population
New Zealand 1995: 4 Regional Health Authorities acting as purchasers of health services; Remark: In addition there were 23 public Hospital Organizations. In 96/97 the purchaser	2004: 21 District Health Boards acting as regional purchasers but also providing health services

HIF2 How many Health Insurance Funds / Health Authorities, that can offer the full coverage of a health insurance, exist in [Country]?	
function was merged to one institution, the Health Funding Authority	
Norway 1995: 19 Counties in charge of hospitals, which are combined to five Hospital Regions. 435 Municipalities in charge of primary care provision The National Insurance Scheme is a second, national level purchaser.	2004: 5 five Hospital Regions, which are effectively controlled by the government. 435 Municipalities in charge of primary care provision The National Insurance Scheme is a second, national level purchaser. Remark: The role of the central government in the provision of health care has increased substantially.
Portugal 1995: 5 Regions - Administração Regionais de Saúde - in mainland Portugal; Remark: The Administrações Regionais de Saúde are the most important tier. Below that level are 20 subregions including Madeira and the Azores as 2 of the subregions There are several HIFs and VHI acting as purchasers, but their role is very limited	2004: 5 Regions - Administração Regionais de Saúde - in mainland Portugal Remark: The 20 subregions, including Madeira and Azores as subregions, are still existent, but not relevant as a level. There are several HIFs and VHI acting as purchasers, but their role is very limited
Poland 1995: 49 regional units. Remark: The number depends on the kind of care. Basic care is provided by the municipalities, more specialized care is provided by larger administrative units.	2004: One Remark: There was a short period in which 16 HIFs were created, but they were merged in 2003 to only one Fund, the National Health Fund, NHF.
Spain 1995: In 7 Regions, the regional Health Authorities, SRS, were acting as purchaser of health For the remaining 10 Regions, the INSALUD was in charge of purchasing and providing health care Remark: The Purchasers, the INSALUD as well as the SRS, are both, providers of health services in facilities operated directly by them, and purchasing health services from independent providers.	2004: 17 autonomous communities with own Health Authorities SRS in charge of organizing health care by either providing it in own facilities ore by contracting it from independent providers
Sweden 1995: 21 in total: 18 Landstings, 2 Regions and one Municipality with the same status as a Landsting	2004: 21 in total: 18 Landstings, 2 Regions and one Municipality with the same status as a Landsting
Switzerland 1995: About 200 Health Insurance Funds	2004: 87 Health Insurance Funds

HIF2 How many Health Insurance Funds / Health Authorities, that can offer the full coverage of a health insurance, exist in [Country]?	
United Kingdom 1995: About 200 District Health Authorities in charge of organizing health care Remark: Previously, there were 14 Regional Health Authorities as an intermediate level in the NHS administration. They were combined in the NHS Executive	2004: In England alone more than 50 Health Authorities in charge of organizing health care.

HIF3 Which of the following medical services can be provided by the Health Insurance Fund / Health Authority itself?	
Austria 1995: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments in a few selected fields In-patient services by Hospitals operated by the Health Insurance Funds, albeit only in selected fields (injuries)	2004: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments in a few selected fields In-patient services by Hospitals operated by the Health Insurance Funds, albeit only in selected fields (injuries)
Belgium 1995. None, all services are contracted from providers independent of the Health Insurance Funds	2004: None, all services are contracted from providers independent of the Health Insurance Funds
Canada 1995: Hospitals are operated by the provincial governments; these provide in-patient as well as out patient services	2004: Hospitals are operated by the provincial governments; these provide in-patient as well as out patient services
Czech Republic 1995: None, all services are contracted from providers independent of the HIF	2004: None, all services are contracted from providers independent of the HIF
Denmark 1995: All services can be and often are provided by the Amter or the municipality; Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by the Health Authority; Amter Remark: If not available in the county, the patient will bet treated in another county (e.g. receive highly specialized service from a university hospital). The home county will pay the other county according to pre-determined rates; based on a DRG system	2004: All services can be and often are provided by the Amter or the municipality; Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by the Health Authority; Amter Remark: If not available in the county, the patient will bet treated in another county (e.g. receive highly specialized service from a university hospital). The home county will pay the other county according to pre-determined rates based on a DRG system
Finland 1995: The Municipalities can provide: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by the Health Authorities (i.e. Municipalities) Remark: The Municipalities can provide the services, but can also contract them from independent providers	2004: The Municipalities can provide: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by the Health Authorities (i.e. Municipalities) Remark: The Municipalities can provide the services, but can also contract them from independent providers
France 1995: None, all services are contracted from providers independent of the Health	2004: None, all services are contracted from providers independent of the Health Insurance

HIF3 Which of the following medical services can be provided by the Health Insurance Fund / Health Authority itself?	
Insurance Funds. The later are forbidden to provide services	Funds. The later are forbidden to provide services
Germany 1995. None, all services are contracted from providers independent of the Health Insurance Funds	2004: None, all services are contracted from providers independent of the Health Insurance Funds
Greece 1995: Some of the Health Insurance Funds, the IKA and the OPAD, provide primary care and operate own Hospitals and Laboratories. The smaller HIF have contracts with the IKA and OPAD, to use their hospitals. The ESY provides primary care in Health Centers and operates Hospitals	2004: Some of the Health Insurance Funds, the IKA and the OPAD, provide primary care and operate own Hospitals and Laboratories. The smaller HIF have contracts with the IKA and OPAD, to use their hospitals. The ESY provides primary care in Health Centers and operates Hospitals
Hungary 1995: None, all services are contracted from providers independent of the NHIFA Remark: Providers of services may be independent and private, but also publicly owned, e.g. hospitals and polyclinics owned and operated by municipalities and counties	2004: None, all services are contracted from providers independent of the NHIFA Remark: Providers of services may be independent and private, but also publicly owned, e.g. hospitals and polyclinics owned and operated by municipalities and counties
Ireland 1995: In-patient services by Hospitals operated by the Health Boards Remark: Since Hospitals also offer primary care and specialized outpatient care on an ambulatory basis, the Health Boards also offer these services	2004: In-patient services by Hospitals operated by the Health Service Executive Remark: Since Hospitals also offer primary care and specialized outpatient care on an ambulatory basis, the Health Executive also offer these services
Italy 1995: The ASL can provide Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by ASL Remark: The ASL also provides services hired staff and owned facilities, but also by making contracts with independent providers	2004: The ASL can provide Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by ASL Remark: The ASL also provides services hired staff and owned facilities, but also by making contracts with independent providers
Luxembourg 1994: None, all services are contracted from providers independent of the Health Insurance Funds.	2004: None, all services are contracted from providers independent of the Health Insurance Funds.
Netherlands 1995: All services are contracted from providers independent of the Health Insurance Funds Remark:	2004: All services are contracted from providers independent of the Health Insurance Funds Remark:

HIF3 Which of the following medical services can be provided by the Health Insurance Fund / Health Authority itself?	
By law, the Health Insurance Funds can offer services, but they do not	By law, the Health Insurance Funds can offer services, but they do not.
New Zealand 1995: None, the Regional Health Authorities were part of a strict purchaser provider split.	2004: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by the Health Authority (District Health Boards) Remark: The 1996 and 2000 reforms cancelled the Purchaser-Provider split, and the public Hospitals were integrated into the District Health Boards, which also contract services from independent providers.
Norway 1995: County Councils are in charge of hospitals and in patient care Municipalities are in charge of primary care provision The NIS contracts all services Remark: Both can either provide the services in own facilities (mostly done for specialized care and in patient services) or by contracting independent providers (mostly done for primary care)	2004: Hospital regions are in charge of hospitals and in patient care since the centralization. Municipalities are in charge of primary care provision The NIS contracts all services Remark: Hospitals are more or less directly controlled by the government. Municipalities can either employ or contract GPs, the tendency is to contract.
Portugal 1995: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments in-patient services by Hospitals operated by the Regional Health Administrations; Administrações Regionais de Saúde Remark: The Hospitals are not directly operated by the Regional Health Administration but are under the control of the Ministry of Health. The HIFs and VHI are contracting most services.	2004: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments provided by the Primary Health Centers operated by the RHA; Administrações Regionais de Saúde Remark: The Hospitals are not directly operated by the Regional Health Administration but are under the control of the Ministry of Health. The HIFs and VHI are contracting most services.
Poland 1995: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments In-patient services by Hospitals operated by the Health Authority Remark: The municipalities and regional governments were in charge of organizing health care, either by providing it in own facilities, like	2004: None, the National Health Fund has to contract all services from independent providers.

HIF3 Which of the following medical services can be provided by the Health Insurance Fund / Health Authority itself?	
health centers or hospitals or by contracting it from providers.	
Spain 1995: The purchaser – either the INSALUD or the SRS, can provide services: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments in-patient services by Hospitals operated by the INSALUD or the SRS Remark: Parallel to the provision in own facilities, like Health Centers and Hospitals, health services are also contracted from independent providers	2004: The purchasers, the SRS, can provide Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments in-patient services by Hospitals operated by the regional Health Authorities (Servicios Regional de Salud) Remark: Parallel to the provision in own facilities, like Health Centers and Hospitals, health services are also contracted from independent providers
Sweden 1995: The Landsting provides: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments in Primary Care Centers In-patient services by Hospitals operated by the Landsting	2004: The Landsting provides: Primary Care for minor treatments like immunization against influenza Primary Care also for substantial treatments in Primary Care Centers In-patient services by Hospitals operated by the Landsting
Switzerland 1995: None, everything is contracted from independent providers	2004: None, everything is contracted from independent providers
United Kingdom 1995: None, everything is contracted from independent providers Remark: Since the creation of the internal market, there is a purchaser / provider spilt, with regional bodies of the public administration acting as purchasers. The DHA negotiate contracts with the hospitals, the Department of Health negotiates the national contract with the GPs	2004: None, everything is contracted from independent providers

HIF4 In some Health Care Systems, citizens are free to choose the Health Insurance Fund/ Health Authority. In others, they are assigned by law, e.g. all self employed / public employees are members of a certain Health Insurance Fund/ Health Authority. Or, all people living in a certain area are members of a certain local Health Insurance Fund / Health Authority. How is the situation in [Country]?	
Austria 1995: Citizens are assigned by occupation and by place of living to a certain Health Insurance Fund – to the regional branch of a certain HIF, which is covering persons of this occupation	2004: Citizens are assigned by occupation and by place of living to a certain Health Insurance Fund – to the regional branch of a certain HIF, which is covering persons of this occupation
Belgium 1995: Citizens have free choice	2004: Citizens have free choice
Canada 1995: Citizens are assigned by place of living - the province they are living in Remark: The province they are living in acts as the purchaser of health care. Citizens are free to chose a VHI	2004: Citizens are assigned by place of living- the province they are living in Remark: The province they are living in acts as the purchaser of health care. Citizens are free to chose a VHI
Czech Republic 1995: Citizens have free choice of the HIF Remark: Since the level of remuneration a provider receives differ among funds, providers encourage patients to change to HIF which pay higher prices for treatment.	2004: Citizens have free choice of the HIF Remark: Since the level of remuneration a provider receives differ among funds, providers encourage patients to change to HIF which pay higher prices for treatment.
Denmark: Citizens are assigned by place of living – to the county, Amter, or municipality, where they are living	2004: Citizens are assigned by place of living – to the county, Amter, or municipality, where they are living
Finland 1995: Citizens are assigned by place of living; i.e. to the municipality, where they are living	2004: Citizens are assigned by place of living; i.e. to the municipality, where they are living
France 1995: Citizens are assigned by occupation; three Mandatory Health Insurance Funds for employees, farmers and self-employed; Free choice of the VHI	2004: Citizens are assigned by occupation; three Mandatory Health Insurance Funds for employees, farmers and self-employed; Free choice of the VHI
Germany 1995: Up to 1996 free choice for white collar employees only.	2004: Free choice among all health insurance funds for all citizens
Greece 1995: Citizens are assigned by occupation to a certain Health Insurance Fund Citizens are “assigned” by place of living to the regional branch of the ESY	2004: Citizens are assigned by occupation to a certain Health Insurance Fund Citizens are “assigned” by place of living to the regional branch of the ESY
Hungary 1995: There is only one HIF, the National Health Insurance Fund Administration	2004: There is only one HIF, the National Health Insurance Fund Administration

HIF4 In some Health Care Systems, citizens are free to choose the Health Insurance Fund/ Health Authority. In others, they are assigned by law, e.g. all self employed / public employees are members of a certain Health Insurance Fund/ Health Authority. Or, all people living in a certain area are members of a certain local Health Insurance Fund / Health Authority. How is the situation in [Country]?	
Ireland 1995: Citizens are assigned by place of living to the Health Board covering the area they are living in.	2004: Citizens are assigned by place of living.
Italy Citizens are assigned by place of living to the ASL respectively the region The assignment to supplementary health insurance funds, is by occupation, since it is usually organized as a group insurance policy by the employer.	2004: Citizens are assigned by place of living to the ASL respectively the region The assignment to supplementary health insurance funds, is by occupation, since it is usually organized as a group insurance policy by the employer.
Luxembourg 1994: Citizens are assigned by occupation to a certain branch of the Health Insurance Fund Remark: Since all HIFs are united in one association, the UCM, the assignment does not matter from the perspective of the citizen	2004: Citizens are assigned by occupation to a certain branch of the Health Insurance Fund Remark: Since all HIFs are united in one association, the UCM, the assignment does not matter from the perspective of the citizen
Netherlands1995: Citizens have free choice among the HIFs since 1991	2004: Citizens have free choice among the HIFs
New Zealand 1995: Citizens are assigned by place of living; i.e. to the Regional Health Board covering the Region where they are living	2004: Citizens are assigned by place of living; i.e. to the District Health Board, covering the District where they are living
Norway 1995: Citizens are assigned to the County Council / Municipality they are living in The NIS is mandatory for all employed	2004: Citizens are assigned to the Hospital Region/ Municipality they are living in. The NIS is mandatory for all employed
Portugal 1995: Citizens are assigned by place of living to the Regional Health Administration. Citizens are assigned by occupational sector to the subsistemas (Health Insurance Funds). Remark: The subsistemas basically cover only public employees, with the various subsistemas covering certain groups of public employees: post, military, health staff etc. Membership is usually compulsory.	2004: Citizens are assigned by place of living to the Regional Health Administration. Citizens are assigned by occupational sector to the subsistemas (Health Insurance Funds). Remark: The subsistemas basically cover only public employees, with the various subsistemas covering certain groups of public employees: post, military, health staff etc. Membership is usually compulsory.
Poland 1995: Citizens are assigned by place of living to the municipality and regional government they are living in.	2004: There is only one Health Insurance Fund, the National Health Fund.

HIF4 In some Health Care Systems, citizens are free to choose the Health Insurance Fund/ Health Authority. In others, they are assigned by law, e.g. all self employed / public employees are members of a certain Health Insurance Fund/ Health Authority. Or, all people living in a certain area are members of a certain local Health Insurance Fund / Health Authority. How is the situation in [Country]?	
Spain 1995: Citizens are assigned by place of living Remark: This concerns the assignment to a regional branch of the INSALUD or the SRS of the Region where the person is living in the case that the region already is in charge of organizing health care	2004: Citizens are assigned by place of living to the Region /SRS
Sweden 1995. Citizens are assigned by place of living – to the Landsting	2004: Citizens are assigned by place of living to the Landsting
Switzerland 1995: Citizens are assigned, also by the criterion of place of living i.e. to the HIF in the Kanton. Remark: Some Health Insurance Funds operate only in certain regions; Kanton. Many elements of the health system as well as the contributions to the HIF, differ among cantons.	2004: Citizens have free choice. Remark: Some Health Insurance Funds operate only in certain regions; Kanton. Many elements of the health system as well as the contributions to the HIF, differ among cantons.
United Kingdom 1995: Citizens are assigned by place of living to the DHA covering the area	2004: Citizens are assigned by place of living

HIF5 Is it possible that the citizen's contributions (premiums, percentage of income, tax rates) to the Health Insurance Fund / Health Authority vary, or are the contributions the same for all Health Insurance Funds / Health Authorities in [Country]? Do different Health Insurance Funds charge different contributions? Do different Health Authorities, e.g. in different regions, charge different contributions?	
Austria 1995: Contributions to the Health Insurance Funds actually differ. Remark: The rates are fixed by the central government for the different branches of the Health Insurance	2004: Contributions to the Health Insurance Funds actually differ. Remark: The rates are fixed by the central government for the different branches of the Health Insurance
Belgium 1995. Contributions to the Health Insurance Funds are not allowed to differ Remark: The contribution levels are set by law, contributions are collected by the INAMI, which also receives subsidies from the central government, and then distributed to the individual HIF based on a demographically adjusted capitation system. This precludes different contribution levels.	2004: Contributions to the Health Insurance Funds are not allowed to differ Remark: The contribution levels are set by law, contributions are collected by the INAMI which also receives subsidies from the central government, and then distributed to the individual HIF based on a demographically adjusted capitation system. This precludes different contribution levels. However, in some cases, the members of a HIF have to pay a small extra contribution directly to the HIF, in the magnitude of about 10 Euros.
Canada 1995: Contributions, i.e. taxes, actually differ among provinces Remark: Contributions differ substantially among provinces: Premiums can differ, and so can the mode in which contributions are raised: premiums, percentage of income, additional earmarked taxes	2004: Contributions, i.e. taxes, actually differ among provinces Remark: Contributions differ substantially among provinces: Premiums can differ, and so can the mode in which contributions are raised: premiums, percentage of income, additional earmarked taxes
Czech Republic 1995: Contributions to the Health Insurance Funds may differ, but factually all charge the same rates Remark: Factually, contribution levels are set by the state by law, the employee pays 4,5% the employer 9% of the contribution	2004: Contributions to the Health Insurance Funds may differ, but factually all charge the same rates Remark: Factually, contribution levels are set by the state by law, the employee pays 4,5% the employer 9% of the contribution.
Denmark: The local taxes from which Health Care is paid, differ among the Amter. The taxes are however not earmarked for health spending. Remark: The central government and the local governments negotiate recommended	2004: The local taxes from which Health Care is paid, differ among the Amter. The taxes are however not earmarked for health spending. Remark: The central government and the local governments negotiate recommended

HIF5 Is it possible that the citizen's contributions (premiums, percentage of income, tax rates) to the Health Insurance Fund / Health Authority vary, or are the contributions the same for all Health Insurance Funds / Health Authorities in [Country]? Do different Health Insurance Funds charge different contributions? Do different Health Authorities, e.g. in different regions, charge different contributions?	
maximum levels for local taxes.	maximum levels for local taxes.
Finland 1995: Contributions actually differ among Municipalities – the level of local taxes differs among municipalities, but the local taxes are not earmarked	2004: Contributions actually differ among Municipalities – the level of local taxes differs among municipalities, but the local taxes are not earmarked
France 1995 Contributions to the mandatory HIFs actually differ. Remark: The contributions are set by the government	2004: Contributions to the mandatory HIF may differ, but factually all charge the same rates Remark: The contributions are set by act of parliament. Currently it is for the employed 13,5 %, of which 12,8% is paid by the employer. The rate is 6,5% for self-employed and 8,13 % for farmers
Germany 1995: Yes, contributions factually differ among health insurance funds Remark: Since the insured pay only half of the contribution and the difference among the contribution rates is small, there is little incentive to switch to the cheapest HIF	2004: Yes, contributions factually differ among health insurance funds Remark: Since the insured pay only half of the contribution and the difference among the contribution rates is small, there is little incentive to switch to the cheapest HIF
Greece 1995: Yes, contributions factually differ among health insurance funds The ESY is financed from general taxation, hence, there are no contributions to the regional branches	2004: Yes, contributions factually differ among health insurance funds The ESY is financed from general taxation, hence, there are no contributions to the regional branches
Hungary 1995: No, contributions cannot differ. Remark: The contributions are a percentage of the income, and are collected by the Health Insurance. The level of the contribution is set by the parliament	2004: No, contributions cannot differ. Remark: The contributions – percentage of income -are now collected by the state, i.e. by the tax authority. The level of the contribution is set by the parliament
Ireland 1995: No, financing is by general taxation	2004: No, financing is by general taxation
Italy 1995: Contributions are not allowed to differ, since the main financing is by general taxation Remark: In theory, regions can charge higher regional taxes and introduce additional co-payments at regional level to cover the deficits due to the provision of health in the region. But they	2004: Contributions are not allowed to differ, since the main financing is by general taxation Remark: In theory, regions can charge higher regional taxes and introduce additional co-payments at regional level to cover the deficits due to the provision of health in the region. But they do

HIF5 Is it possible that the citizen's contributions (premiums, percentage of income, tax rates) to the Health Insurance Fund / Health Authority vary, or are the contributions the same for all Health Insurance Funds / Health Authorities in [Country]? Do different Health Insurance Funds charge different contributions? Do different Health Authorities, e.g. in different regions, charge different contributions?	
do not	not
Luxembourg 1994: Contributions to the Health Insurance Funds are not allowed to differ Remark: Despite the 9 different branches, these are not really different HIFs and they are not competing over contribution rates. The rates are set by the government.	2004: Contributions to the Health Insurance Funds are not allowed to differ Remark: Despite the 9 different branches, these are not really different HIFs and they are not competing over contribution rates, the rates are set by the government
Netherlands 1995: Contributions to Health Insurance Funds are allowed to differ, but do only little in practice Remark: The contribution consists of a flat rate, set by the HIFs and a percentage of income, set by the state. The contribution differs only for the flat rate charged by the HIFs	2004: Contributions to Health Insurance Funds differ, but do so only very little Remark: The contribution consists of a flat rate, set by the HIFs and a percentage of income, set by the state. The contribution differs only for the flat rate charged by the HIFs
New Zealand 1995: The health system is financed from general taxation; funds are allocated from the central government to the Regional Health Boards. there are no contributions from citizens to the Regional Health Boards and hence differences	2004: The health system is financed from general taxation; funds are allocated from the central government to the District Health Boards. There are no contributions from citizens to the District Health Boards and hence differences
Norway 1995: The health system is predominantly financed from general taxation; there are no earmarked contributions and no differences. Co payments are set at the national level, and so is the contribution level to the NIS.	2004: The health system is predominantly financed from general taxation; there are no earmarked contributions and no differences. Co payments are set at the national level, and so is the contribution level to the NIS.
Portugal 1995: The health system is tax-funded. The Regional Health Administrations are financed by an allocated budget from the Central Government, which is taken from the general taxation. There are no identifiable contributions going from citizens to the Regional Health Administrations. Remark: The contributions to the subsistema differ, and are mostly paid for by the employer.	2004: The health system is tax-funded. The Regional Health Administrations are financed by an allocated budget from the Central Government, which is taken from the general taxation. There are no identifiable contributions going from citizens to the Regional Health Administrations. Remark: The contributions to the subsistema differ, and are mostly paid for by the employer.
Poland 1995: Contributions to health care were not allowed to differ Remark: The municipalities and regions received	2004: Contributions to health care cannot differ, since there is only one Health Insurance Fund.

HIF5 Is it possible that the citizen's contributions (premiums, percentage of income, tax rates) to the Health Insurance Fund / Health Authority vary, or are the contributions the same for all Health Insurance Funds / Health Authorities in [Country]? Do different Health Insurance Funds charge different contributions? Do different Health Authorities, e.g. in different regions, charge different contributions?	
government grants, there were no contributions.	
Spain 1995: Contributions are not allowed to differ. Remark: The Health System in financed from general taxation at the level of the Central Government so there are no contributions comparable to a insurance premium. Funds are collected by the Central government and allocated to the Regions (Autonomous Communities). The regions can however raise additional funds by taxation.	2004: Contributions are not allowed to differ. Remark: The Health System in financed from general taxation at the level of the Central Government so there are no contributions comparable to a insurance premium. Funds are collected by the Central government and allocated to the Regions (Autonomous Communities). The regions can however raise additional funds by taxation.
Sweden 1995: Contributions – local tax levels and patient fees - actually differ among Landstings Remark: Patients pay fees for medical services, in particular for outpatient services. Each Landsting is free to set its own fee schedule within upper limits set by the central government.	2004: Contributions - local tax levels and patient fees - actually differ among Landstings Remark: Patients pay fees for medical services, in particular for outpatient services. Each Landsting is free to set its own fee schedule within upper limits set by the central government.
Switzerland 1995: Contributions actually differ among HIFs Remark: Contributions differ among different HIFs and among the Kanton, i.e. among the regional branches of a HIF.	2004: Contributions actually differ among HIFs Remark: Contributions differ among different HIFs and among the Kanton, i.e. among the regional branches of a HIF.
United Kingdom 1995: The funding is by general taxation, Remark: The funding is by general taxation with no earmarked taxes. There are no contributions going to the District Health Authorities	2004: The funding is by general taxation, thus contributions cannot differ among Health Authorities

HIF6 Is it possible that the catalogues of benefits and medical services covered or offered vary among different Health Insurance Funds / Health Authorities? Does for instance a certain Health Insurance Fund cover medical services which are not covered by another Health Insurance Fund? Does the Health Authority in one region offer medical services, which are not offered in another region?	
Austria 1995: Catalogues of services covered may differ, but factually all cover the same basic medical services. The differences concern extras like spa-treatments	2004: Catalogues of services covers may differ, but factually all cover the same basic medical services. Some cover additional services like spa-treatments
Belgium 1995. The catalogue of medical services covered is not allowed to differ among Health Insurance Funds. Remark: The convention, consisting of the catalogue and the fees, is negotiated among the HIF association and the provider and is valid at the national level.	2004: The catalogue of medical services covered is not allowed to differ among Health Insurance Funds Remark: The convention, consisting of the catalogue and the fees, is negotiated among the HIF association and the provider and is valid at the national level.
Canada 1995: The range of services offered factually differ among the provinces, also due to availability Remark: While the federal government determined, that all medically services have to be covered, the provinces have leeway in what services to cover, what services to subsidizes and to what degree. The access to services also differs due to availability.	2004: The range of services offered factually differ among the provinces Remark: While the federal government determined, that all medically services have to be covered, the provinces have leeway in what services to cover, what services to subsidizes and to what degree. The access to services also differs due to availability.
Czech Republic 1995: The catalogue of services covered actually differ among HIF Remark: While a minimum package is set by the state, the HIF can offer additional services and conveniences. Some did so, without having the financial capacities to do so, and went bankrupt.	2004: The catalogue of services covered actually differ among HIF Remark: While a minimum package is set by the state, the HIF can offer additional services and conveniences. The possibility to do so was limited given the experiences of HIF going bankrupt due to covering too many services.
Denmark 1995: There is no formal catalogues of services, instead some services are excluded. The capacity to provide a certain type of medical treatment may not be established in a county or the waiting time may be longer	2004: There is no formal catalogues of services, instead some services are excluded. The capacity to provide a certain type of medical treatment may not be established in a county or the waiting time may be longer
Finland 1995: The medical services offered actually differ among municipalities – mainly due to availability of facilities and providers. The coverage of dental care differs largely among	2004: The medical services offered actually differ among municipalities – mainly due to availability of facilities and providers. The coverage of dental care differs largely among

HIF6 Is it possible that the catalogues of benefits and medical services covered or offered vary among different Health Insurance Funds / Health Authorities? Does for instance a certain Health Insurance Fund cover medical services which are not covered by another Health Insurance Fund? Does the Health Authority in one region offer medical services, which are not offered in another region?	
municipalities. Some provide only very basic services to the whole population.	municipalities. There is a trend to extend the number of people for which dental care is covered.
France 1995: For the Mandatory Health Insurance Funds, the catalogue of services covered is not allowed to differ. The nomenclature, the list of services covered, is identical for all France Packages offered by the VHI differ	2004: For the Mandatory HIFs, the catalogue of services covered is not allowed to differ. The nomenclature, the list of services covered, is identical for all France Packages offered by the VHI differ
Germany 1995: There is no positive catalogue of services, and basically all HIFs cover the same basic services. They differ in that some Health Insurance Funds also cover some extras like homeopathic treatments and spa-treatments	2004: There is no positive catalogue of services, and basically all HIFs cover the same basic services. They differ in that some Health Insurance Funds also cover some extras like homeopathic treatments and spa-treatments
Greece 1995: The catalogue of medical services covered differs among Health Insurance Funds The catalogue of services offered and covered by the regional branches of the ESY is not allowed to differ Remark: The differences in coverage among HIF concern e.g. dental care, gatekeeping regulations and co-payments. Basically, the HIF determine their own catalogue	2004: The catalogue of medical services covered differs among Health Insurance Funds The catalogue of services offered and covered by the regional branches of the ESY is not allowed to differ Remark: The differences in coverage among HIF concern e.g. dental care, gatekeeping regulations and co-payments. Basically, the HIF determine their own catalogue
Hungary 1995: No, there is only one HIF, the NHIFA, which covers the same catalogue of medical services for the whole population	2004: No, there is only one HIF, the NHIFA, which covers the same catalogue of medical services for the whole population
Ireland 1995: The catalogues of services covered may differ among regions/districts, since Health Boards negotiate with the Hospitals and providers. But factually all Health Boards cover the same medical services Remark: Availability may differ substantially among areas	2004: The catalogues of services covered may differ among regions, since some elements are negotiated at a regional level. While the coverage does differ in a legal sense, availability may differ substantially among areas
Italy 1995: The catalogues of services covered may differ among regions and ASLs; but factually all cover and offer the same services since the national government set minimum requirements	2004: The catalogues of services covered may differ among regions and ASLs; but factually all cover and offer the same services since the national government set minimum requirements

HIF6 Is it possible that the catalogues of benefits and medical services covered or offered vary among different Health Insurance Funds / Health Authorities? Does for instance a certain Health Insurance Fund cover medical services which are not covered by another Health Insurance Fund? Does the Health Authority in one region offer medical services, which are not offered in another region?	
Remark: Availability and quality differs substantially among regions.	Remark: Availability and quality differs substantially among regions.
Luxembourg 1994: The catalogue of services covered by the Health Insurance Funds is not allowed to differ, it is set by the Ministry of Health	2004: The catalogue of services covered by the Health Insurance Funds is not allowed to differ, it is set by the Ministry of Health
Netherlands 1995: The basic catalogue of medical services covered is not allowed to differ among Health Insurance Funds An exemption are Supplementary Insurance	2004: The basic catalogue of medical services covered is not allowed to differ among Health Insurance Funds An exemption are Supplementary Insurance
New Zealand 1995: The catalogue of medical services covered is not allowed to differ Remark: The medical services covered differ among Regional Health Authorities due to availability	2004: While the overall catalogue of services is similar, the medical services covered and offered actually differ among District Health Boards due to availability.
Norway 1995: The medical services covered actually differ among counties and municipalities due to availability of infrastructure. If the service cannot be provided in one county/ municipality, the patient is sent in a neighboring district	2004: The medical services covered actually differ among counties and municipalities due to availability of infrastructure. If the service cannot be provided in one county/ municipality, the patient is sent in a neighboring district
Portugal 1995: There is no official catalogues of medical services covered. What services are actually available may differ among regions, but factually all RHA cover the same medical services Remark: The coverage of the subsistemas varies, but there citizens have only a choice as to participate or not. If they become member, they are assigned to a subsistema by occupation.	2004: There is no official catalogues of medical services covered. What services are actually available may differ among regions, but factually all RHA cover the same medical services Remark: The coverage of the subsistemas varies, but there citizens have only a choice as to participate or not. If they become member, they are assigned to a subsistema by occupation.
Poland 1995: The catalogue of services covered is not allowed to differ among municipalities and regions. Remark: There was no official catalogue, availability could differ.	2004: The catalogue of services covered cannot differ, since there is only one Health Insurance Fund

HIF6 Is it possible that the catalogues of benefits and medical services covered or offered vary among different Health Insurance Funds / Health Authorities? Does for instance a certain Health Insurance Fund cover medical services which are not covered by another Health Insurance Fund? Does the Health Authority in one region offer medical services, which are not offered in another region?	
Spain 1995: Catalogues of covered services are not allowed to differ among regions. Factually, the availability differs among regions	2004: While not allowed to differ, catalogues of covered services still differ to some degree among regions due to differences in availability
Sweden 1995: The medical services covered and covered actually differ among the Landstings; but only to a small degree and due to availability and waiting times	2004: The medical services covered and covered actually differ among the Landstings; but only to a small degree and due to availability and waiting times
Switzerland 1995: The catalogue of medical services covered is allowed to differ among HIFs Remark: The government set a minimum catalogue, the HIF had some leeway to cover more services.	2004: The catalogue of medical services covered is not allowed to differ Remark: Since 1996, the catalogues of services covered are no longer allowed to differ among HIFs
United Kingdom 1995: The medical services offered by the Health Authorities differ but for minor services only. Usually, the contracts between the DAH and the individual Hospital specify no positive list of services Remark: There occur differences in availability and waiting times among different DHA	2004: The medical services offered by the Health Authorities differ but for minor services only. Usually, the contracts between the DAH and the individual Hospital specify no positive list of services Remark: There occur differences in availability and waiting times among different DHA

HIF7 Is it possible that the same Health Insurance Fund / Health Authority offers different packages of contributions and covered services to the insured? An example would be that the patient agrees to go to the general practitioner first, before visiting a specialists and pays a lower contribution in return. Another example would be, that the patient agrees to pay out of pocket for certain services and has to pay a lower contribution in return.	
Austria 1995: No; citizens do not have the choice among different packages of services and contributions	2004: No; citizens do not have the choice among different packages of services and contributions
Belgium 1995: No	2004: No
Canada 1995: No	2004: No
Czech Republic 1995 No	2004: No
Denmark 1995: Yes, people can chose having more choice and no gatekeeping at a higher price (type 2 insured, about 2 % of the population)	2004: Yes, people can chose having more choice and no gatekeeping at a higher price (type 2 insured, about 2 % of the population)
Finland 1995: No Remark: There are no packages of contributions and services covered.	2004: No Remark: There are no packages of contributions and services covered.
France 1995: Not for the Mandatory Health Insurance	2004: Since 2004, accepting gatekeeping leads to lower contributions for the insured
Germany 1995: No	2004: Yes, some Health Insurance Funds offer models with a deductible and gatekeeping in exchange for lower contributions
Greece 1995: No; neither the Health Insurance Funds nor the ESY offer different packages of contributions and services to choose from Remark: Only the VHI does offer different packages, but this does not concern the main health system	2004: No; neither the Health Insurance Funds nor the ESY offer different packages of contributions and services to choose from
Hungary 1995: No; the NHIFA does not offer different packages of contributions and services to choose from	2004: No; the NHIFA does not offer different packages of contributions and services to choose from
Ireland 1995: No Remark: The system is tax financed, there is no package of coverage and contribution, apart from the supplementary insurance (VHI)	2004: No Remark: The system is tax financed, there is no package of coverage and contribution, apart from the supplementary insurance by the VHI

HIF7 Is it possible that the same Health Insurance Fund / Health Authority offers different packages of contributions and covered services to the insured? An example would be that the patient agrees to go to the general practitioner first, before visiting a specialists and pays a lower contribution in return. Another example would be, that the patient agrees to pay out of pocket for certain services and has to pay a lower contribution in return.	
Italy 1995: No	2004: No
Luxembourg 1994: No	2004: No
Netherlands 1995: No	2004: Yes, the patient can chose varying amounts of co-payments.
New Zealand 1995: No Remark: The system is tax-financed, there is no individual level bundle of contribution and coverage	2004: No Remark: The system is tax-financed, there is no individual level bundle of contribution and coverage
Norway 1995: No Remark: There are no identifiable contributions going into health care. There are no “packages” of services and contributions.	2004: No Remark: There are no identifiable contributions going into health care. There are no “packages” of services and contributions.
Portugal 1995. No Remark: The health system is funded from general taxation and publicly provided to all residents. There are no identifiable contributions going to the RHA or in the health system.	2004: No Remark: The health system is funded from general taxation and publicly provided to all residents. There are no identifiable contributions going to the RHA or in the health system.
Poland 1995: No	2004: No
Spain 1995: No for the INSALUD Remark: The health system is tax financed, there are no individual contributions comparable to a health insurance premium or an earmarked tax.	2004: No for the NHS Remark: The health system is tax financed, there are no individual contributions comparable to a health insurance premium or an earmarked tax.
Sweden 1995. No Remark: While there is a range of patient fees payable, for which exemptions are granted, there is no system of e.g. accepting gatekeeping and paying lower contributions and co-payments.	2004: No Remark: While there is a range of patient fees payable, for which exemptions are granted, there is no system of e.g. accepting gatekeeping and paying lower contributions and co-payments

HIF7 Is it possible that the same Health Insurance Fund / Health Authority offers different packages of contributions and covered services to the insured? An example would be that the patient agrees to go to the general practitioner first, before visiting a specialists and pays a lower contribution in return. Another example would be, that the patient agrees to pay out of pocket for certain services and has to pay a lower contribution in return.	
Switzerland 1995: Yes, a Health Insurance Fund may offer different packages to the Insured Remark: This concerns in particular the deductible. Patients may agree to pay out of pocket for health up to a higher limit, and pay lower contribution in exchange. Some HIF also offer additional packages on private terms.	2004: Yes, a Health Insurance Fund may offer different packages Remark: Since the catalogue of services may no longer differ, this concerns only the deductible. Patients may agree to pay out of pocket for health up to a higher limit, and pay lower contribution in exchange. Some HIF also offer additional packages on private terms.
United Kingdom 1995: No	2004: No

HIF8 In some countries, the citizen can obtain a bonus if they participate in preventive health checks on a regular basis. Examples of such bonus programs are a reduced contribution rate, a repayment or lower co-payments. Are there bonus / malus programs?	
Austria 1995: No, neither bonus nor malus regulations related to the participation in preventive health checks etc.	2004: No, neither bonus nor malus regulations related to the participation in preventive health checks etc.
Belgium 1995. No, neither bonus nor malus regulations related to the participation in preventive health checks etc.	2004: Yes, there is a bonus if the patient participates in preventive check-ups, for instance in dental care
Canada 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Czech Republic 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Denmark 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Finland 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
France 1995: Yes, a bonus system for dental care for children and adolescents up to 18 years	2004: Yes, a bonus system for dental care for children and adolescents up to 18 years
Germany 1995 Yes, there is a bonus system but only for dental care	2004: Yes, for dental care. More recently there are some programs addressing weight reduction and smoking behavior
Greece 1995: No, neither Health Insurance Funds nor the ESY have bonus nor malus regulations related to the participation in preventive health checks etc.	2004: No, neither Health Insurance Funds nor the ESY have bonus nor malus regulations related to the participation in preventive health checks etc.
Hungary 1995: Yes, there is a malus, if the patient does not participate in preventive health checks	2004: Yes, there is a malus, if the patient does not participate in preventive health checks
Ireland 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Italy 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Luxembourg 1994: Yes, a bonus system for dental care leading to a lower co-payment	2004: Yes, a bonus system for dental care leading to a lower co-payment
Netherlands 1995: Yes, since 1995 for dental care	2004: Yes, for dental care
New Zealand 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Norway 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Portugal 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations

HIF8 In some countries, the citizen can obtain a bonus if they participate in preventive health checks on a regular basis. Examples of such bonus programs are a reduced contribution rate, a repayment or lower co-payments. Are there bonus / malus programs?	
Poland 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Spain 1995: No, neither bonus nor malus in related to the participation to preventive health checks etc	2004: No, neither bonus nor malus in related to the participation to preventive health checks etc
Sweden 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
Switzerland 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations
United Kingdom 1995: No, neither bonus nor malus regulations	2004: No, neither bonus nor malus regulations

HIF9 Is there a **Financial Equalization** among different Health Insurance Funds / Health Authorities? E.g. are Funds are taken from one Health Insurance Fund/ Health Authority and given to another one? Or are state subsidies and budgets distributed according to need?	
Austria 1995: Yes, but not substantial	2004: Yes, there is substantial equalization among the Health Insurance Funds
Belgium 1995: Yes, there is substantial equalization among the Health Insurance Funds; Remark: The Equalization is done via the INAMI, which collects the contributions and distributes them to the HIF according to a capitation system. This system takes into account the structure of persons insured by the HIF, but is still strongly based on the historical budget and needs. Before 1994, the equalization was even stronger, based on the need, i.e. the expenses of the funds. The socialist HIFs (mainly workers) usually received more funds, the Christian HIFs (mainly while collar employees) less	2004: Yes, there is substantial equalization among the Health Insurance Funds; Remark: The Equalization is done via the INAMI, which collects the contributions and distributes them to the HIF according to a capitation system. This system takes into account the structure of persons insured by the HIF. While still based on funds required in the past, the equalization is increasingly based on the demographic structure of the HIFs.
Canada 1995: Yes, there is substantial equalization Remark: There is an equalization among the provinces by way of central government grants. There is also an equalization among RHA within a province by allocating funds from the provincial government to the RHA according to need	2004: Yes, there is substantial equalization Remark: There is an equalization among the provinces by way of central government grants. There is also an equalization among RHA within a province by allocating funds from the provincial government to the RHA according to need
Czech Republic 1995: Yes, there is substantial equalization among health insurance funds Remark: 60% of the allocation of funds is based on age-based capitation. The General Health Insurance Fund receives 3 times the standard capitation for an insured aged over 60.	2004: Yes, there is substantial equalization among health insurance funds Remark: The allocation of funds is based on age-based capitation. The General Health Insurance Fund receives 3 times the standard capitation for an insured aged over 60.
Denmark 1995: Yes Remark: Government subsidies to counties, Amter, depend on objective criteria like the taxable income of the citizens and the “need” of an Amter	2004: Yes Remark: Government subsidies to counties, Amter, depend on objective criteria like the taxable income of the citizens and the “need” of an Amter
Finland 1995: Yes, there is some equalization among the	2004: Yes, there is some equalization among the

HIF9 Is there a **Financial Equalization** among different Health Insurance Funds / Health Authorities? E.g. are Funds are taken from one Health Insurance Fund/ Health Authority and given to another one? Or are state subsidies and budgets distributed according to need?	
municipalities. Remark: The equalization operates by a system of state subsidies from the central government to the municipalities. In addition to this, the joint financing of Hospitals by several municipalities has an equalizing effect.	municipalities. Remark: The equalization operates by a system of state subsidies from the central government to the municipalities. In addition to this, the joint financing of Hospitals by several municipalities has an equalizing effect.
France 1995: Yes, there is substantial equalization among health insurance funds	2004: Yes, there is substantial equalization among health insurance funds
Germany 1995: Yes, there is substantial equalization among health insurance funds Remark: Funds are take from one HIF, and transferred via the Risk Equalization Fund to other HIFs	2004: Yes, there is substantial equalization among health insurance funds; Remark: Funds are take from one HIF, and transferred via the Risk Equalization Fund to other HIFs
Greece 1995: No, there is no financial equalization among HIF, but since the contributions may differ, a HIF can apply at the Government for higher contribution rates to cover higher expenditure. Regarding the ESY, there is no equalization among the regional branches of the ESY. The funds are funds allocated from the central government to the ESY	2004: No, there is no financial equalization among HIF, but since the contributions may differ, a HIF can apply at the Government for higher contribution rates to cover higher expenditure. Regarding the ESY, there is no equalization among the regional branches of the ESY. The funds are funds allocated from the central government to the ESY
Hungary 1995: No, there no equalization, since there is only one HIF	2004: No, there no equalization, since there is only one HIF
Ireland 1995: No, there is no formal financial equalization among the Health Boards Remark: The budgets are negotiated between the Department of Health and the Health Board. Here, need and the previous budget is important	2004: No, there is no formal financial equalization within the Health Service Executive Remark: The budgets are negotiated between the Department of Health and the Health Board. Here, need and the previous budget is important
Italy 1995: Yes, there is a substantial financial equalization. Remark: There is a equalization among regions, by allocating funds from the national level to the regional level and by a National Solidarity Fund, which is distributing additional subsidizes to the regions. At the lower level,	2004: Yes, there is a substantial financial equalization. Remark: There is a equalization among regions, by allocating funds from the national level to the regional level and by a National Solidarity Fund, which is distributing additional subsidizes to the regions. At the lower level,

HIF9 Is there a **Financial Equalization** among different Health Insurance Funds / Health Authorities? E.g. are Funds are taken from one Health Insurance Fund/ Health Authority and given to another one? Or are state subsidies and budgets distributed according to need?	
there is an equalization between the ASL: a risk adjustment takes into account the age composition covered by the different ASLs	there is an equalization between the ASL: a risk adjustment takes into account the age composition covered by the different ASLs
Luxembourg 1994: No Remark: Despite the different branches, there is basically just one HIF. The insurance contributions are paid to the Association of the HIFs, the UCM, which is paying the patients back their expenses.	2004: No Remark: Despite the different branches, there is basically just one HIF. The insurance contributions are paid to the Association of the HIFs, the UCM, which is paying the patients back their expenses.
Netherlands 1995: Yes, there is substantial equalization among health insurance funds Remark: The equalization operates via a central fund which is administering about 2/3rds of the contributions and distributes these funds to the individual HIF according to their risk-structure.	2004: Yes, there is substantial equalization among health insurance funds Remark: The equalization operates via a central fund which is administering about 2/3rds of the contributions and distributes these funds to the individual HIF according to their risk-structure.
New Zealand 1995: Yes, there is financial equalization among the Regional Health Authorities Remark: The allocation of funds to the Regional Health Authorities was based on historical budgets and need	2004: Yes, there is a financial equalization among the District Health Boards. Remark: While the allocation of funds to the District Health Boards is getting more population-based, it is still adapted to the need.
Norway 1995: Yes, there is a substantial equalization among the counties and municipalities Remark: Counties and municipalities are financed by the central government. The grants are not earmarked and are allocated according to need.	2004: Yes, there is a substantial equalization among the counties and municipalities Remark: Counties and municipalities are financed by the central government. The grants are not earmarked and are allocated according to need. The equalization takes into account characteristics of the population.
Portugal 1995: No, there is no financial equalization among the Regional Health Administrations. Remark: Funds are not allocated to the RHA according to risks. The budget allocated to a RHA is based on the historical budget, with some elements of capitation	2004: Yes, there is some financial equalization among the Regional Health Administrations, but not substantial Remark: Since 1995, the capitation component in the allocation of funds to the RHA was extended and was also based on factors like age, sex and disease burden. The magnitude of this equalization is small. In the late 90s, there was a small episode of risk based allocation of

HIF9 Is there a **Financial Equalization** among different Health Insurance Funds / Health Authorities? E.g. are Funds are taken from one Health Insurance Fund/ Health Authority and given to another one? Or are state subsidies and budgets distributed according to need?	
	funds to Regional Health Administrations, but it was short lived
Poland 1995 No, there is no financial equalization among the Local / Regional Health Administrations. Remark: The allocation of funds to the local / regional administrations in charge of organizing health care was based on needs.	2004: There is only one Health Insurance Fund, and equalization takes place within this Fund, among regional branches
Spain 1995: Yes, there is substantial equalization among the regional branches of the INSALUD Remark: The Allocation of funds is oriented at the need and the past budgets. The funding of the Regions (Autonomous Communities) which were already in charge of health provision, was basically negotiated between the Central Government and the Autonomous Communities.	2004: Yes, there is substantial equalization among the Autonomous communities. Remark: The allocation of funds for the Regions (Autonomous Communities) is based on population, insularity etc. Budgets are assigned accordingly. It is still much of a bargaining. A Cohesion Fund, funded by the Central Government, is installed to subsidize the flow of patients among regions.
Sweden 1995: Yes, there is substantial equalization among the Landstings Remark: The grants by the central government are allocated according to need	2004: Yes, there is substantial equalization among the Landstings Remark: The grants by the central government are allocated according to need
Switzerland 1995: Yes, there is substantial equalization among health insurance funds	2004: Yes, there is substantial equalization among health insurance funds Remark: Funds are transferred from HIF with a favorable risk structure to funds with a unfavorable risk structure.
United Kingdom 1995: Yes, there is substantial equalization by budget allocation from the Department of Health to the District Health Authorities, which is based on past budgets and need	2004: Yes, there is substantial equalization by budget allocation from the Department of Health to the Health Authorities which is based on past budgets and need

HIF10 If a Health Insurance Fund / Health Authority realizes a surplus, who decides on what is done with the surplus?	
Austria 1995: The Health Insurance Fund itself	2004: The Health Insurance Fund itself
Belgium 1995: The Health Insurance Fund itself; a surplus is bound to cover previous deficits. Remark: The state sets requirements for minimum reserves. If these requirements are not met, surplus goes into the reserves.	2004: The Health Insurance Fund itself; a surplus is bound to cover previous deficits. Remark: The state sets requirements for minimum reserves. If these requirements are not met, surplus goes into the reserves.
Canada 1995: The Provincial Government itself decides on the usage of a surplus. The RHA itself decides on the usage of a surplus	2004: The Provincial Government itself decides on the usage of a surplus. The RHA itself decides on the usage of a surplus
Czech Republic 1995: The Health Insurance Fund itself Remark: This is a formality only. By law, each HIF must put a surplus in a “Reserve Fund”.	2004: The Health Insurance Fund itself Remark: This is a formality only. By law, each HIF must put a surplus in a “Reserve Fund”.
Denmark 1995: The Health Authority, Amter, itself Remark: This is never the case	2004: The Health Authority, i.e. the Amter
Finland 1995: The Municipality, of which the Health Authority is part	2004: The Municipality, of which the Health Authority is part
France 1995: The state	2004: The state
Germany 1995: The Health Insurance Fund Remark: By law, a surplus has to be used to lower the contributions or to repay debts incurred in earlier periods. Further, persisting surpluses are transferred to Health Insurance Funds which are indebted via the Risk-Equalization-Fund	2004: The Health Insurance Fund Remark: By law, a surplus has to be used to lower the contributions or to repay debts incurred in earlier periods. Further, persisting surpluses are transferred to Health Insurance Funds which are indebted via the Risk-Equalization Fund
Greece 1995: If the HIF realizes a surplus, the HIF may decide on its usage, but the state, i.e. the Central Government, has also influence. The state decides on the usage of a surplus of the regional branches of the ESY Remark: This is hypothetical, there never is any surplus	2004: If the HIF realizes a surplus, the HIF may decide on its usage, but the state, i.e. the Central Government, has also influence. The state decides on the usage of a surplus of the regional branches of the ESY Remark: This is hypothetical, there never is any surplus

HIF10 If a Health Insurance Fund / Health Authority realizes a surplus, who decides on what is done with the surplus?	
Hungary 1995: If the NHIFA realizes a surplus, it is formally entitled to decide on its usage, but the state, i.e. the Central Government, has also influence.	2004: If the NHIFA realizes a surplus, it is formally entitled to decide on its usage, but the state, i.e. the Central Government, has also influence.
Ireland 1995: The Health Board, but the Central Government has some say	2004: The Health Board, but the Central Government has some say
Italy 1995: The Heath Authority, i.e. the ASL, itself	2004: The Heath Authority, i.e. the ASL, itself
Luxembourg 1994: The HIF has to use the surplus to lower the contribution level Remark: The HIFs annual budget has to be balanced. There is a financial reserve required, which may fluctuate from 10 to 20% of the annual expenditure. If current expenditure levels make the reserve drop out of this range, the HIFs have either to increase the contributions ore to restrict the provision of services	2004: the HIF has to use the surplus to lower the contribution level Remark: The HIFs annual budget has to be balanced. There is a financial reserve required, which may fluctuate from 10 to 20% of the annual expenditure. If current expenditure levels make the reserve drop out of this range, the HIFs have either to increase the contributions ore to restrict the provision of services
Netherlands 1995: The Health Insurance Fund itself	2004: The Health Insurance Fund itself
New Zealand 1995: The Regional Health Board but in consultation with the Ministry of Health	2004: The District Health Board but in consultation with the Ministry of Health
Norway 1995: The county council / municipality would decide, but this is never the case.	2004: The central government would decide, but this is never the case.
Portugal 1995: The Central Government which is controlling the RHA	2004: The Central Government which is controlling the RHA
Poland 1995: The local Health Authority itself. Remark: Within a fiscal year, the Health Authority was free to decide on how to use funds not yet used. By the end of the year, a surplus had to be transferred back to the central government	2004: The National Health Fund can decide but only subject to approval of the Minister of Finance
Spain 1995 The central government controlling the INSALUD would decide on the usage, however, this situation does not occur	2004: The regional government controlling the SRS would decide on the usage, however, this situation does not occur
Sweden 1995: The Landstings themselves	2004: The Landstings themselves
Switzerland 1995: The Health Insurance Fund itself, Remark:	2004: The Health Insurance Fund Remark:

HIF10 If a Health Insurance Fund / Health Authority realizes a surplus, who decides on what is done with the surplus?	
A surplus has to be used to lower the contributions, to repay debts incurred in earlier periods or to increase the reserves up to the limit set by the Central Government.	A surplus has to be used to lower the contributions, to repay debts incurred in earlier periods or to increase the reserves up to the limit set by the Central Government.
United Kingdom 1995: The District Health Authority itself Remark: Factually, this is never the case	2004: The Health Authority itself

HIF11 If a deficit arises for a Health Insurance Fund / Health Authority (because the available funds are not sufficient to cover the expenditure in a period.) Is this deficit covered? For instance by the state or some other institution?	
Austria 1995: Formally no Remark: The deficit is covered to some extent by a steering institution of the Health Insurance Funds	2004: Formally no Remark: To some extent, a deficit is covered by a steering institution of the Health Insurance Funds
Belgium Yes, the deficit is factually covered by the INAMI Remark: Despite more financial responsibility of the funds introduced in 1995, deficits are covered by the INAMI; if the overall deficit is larger than 2% of the HIF's budget, it is covered completely by the social security	2004: Yes, the deficit is factually covered by the INAMI Remark While financial responsibility was further increased, the HIF has not to cover the deficit, if it is "not responsible" for the deficit. At maximum, it has to cover 2% of the deficit.
Canada1995: Deficits of the Provinces are not covered, they have to be equalized by other forms of income, higher taxation or become a debt The deficit of a RHA is covered by the provincial government. Some RHA are explicitly allowed to run debts	2004: Deficits of the Provinces are not covered, they have to be equalized by other forms of income, higher taxation or become a debt The deficit of a RHA is covered by the provincial government. Some RHA are explicitly allowed to run debts
Czech Republic 1995: The state covers the deficit of the General Health Insurance Fund. Deficits of the other HIF are not covered. Remark: Smaller HIF which go bankrupt are dissolved and their insured are transferred to the General Health Insurance Fund (covering 68% of the population). The state covers the deficits of this HIF.	2004: The state covers the deficit of the General Health Insurance Fund. Deficits of the other HIF are not covered. Remark: Smaller HIF which go bankrupt are dissolved and their insured are transferred to the General Health Insurance Fund. The state covers the deficits of this HIF.
Denmark 1995: While the deficit of an Amter isn't covered, the grant from the central government will be adapted in the next period to cover the expenses	2004: While the deficit of an Amter isn't covered, the grant from the central government will be adapted in the next period to cover the expenses
Finland 1995: The Municipality, of which the Health Authority is part, covers the deficit. The Municipalities' deficit in turn is not covered	2004: The Municipality, of which the Health Authority is part, covers the deficit. The Municipalities' deficit in turn is not covered
France 1995: The state covers the deficit of HIF	2004: The state covers the deficit of HIF
Germany 1995: No, deficits are not covered, the Health Insurance Fund either have to make debts or have to increase the level of contributions.	2004: No, deficits are not covered, the Health Insurance Fund either have to make debts or have to increase the level of contributions.

HIF11 If a deficit arises for a Health Insurance Fund / Health Authority (because the available funds are not sufficient to cover the expenditure in a period.) Is this deficit covered? For instance by the state or some other institution?	
Remark: In the long run, the deficit will either be covered by transfers from the Risk-Equalization Fund or the Health Insurance Fund will merge with another one	Remark: In the long run, the deficit will either be covered by transfers from the Risk-Equalization Fund or the Health Insurance Fund will merge with another one
Greece 1995: If the ESY or a regional branch of the ESY or a Health Insurance Fund realizes a deficit, the state, i.e. the Central Government, will cover the deficit Remark: This will take the form of a subsidy, a higher budget or the approval to increase the contribution levels in the case of the HIF. Deficits may persist for a long time.	2004: If the ESY or a regional branch of the ESY or a Health Insurance Fund realizes a deficit, the state, i.e. the Central Government, will cover the deficit Remark: This will take the form of a subsidy, a higher budget or the approval to increase the contribution levels in the case of the HIF. Deficits may persist for a long time.
Hungary 1995: Yes, a deficit of the NHIFA is covered by the state	2004: Yes, a deficit of the NHIFA is covered by the state
Ireland 1995: Yes, it is covered by the state	2004: Yes, it is covered by the state
Italy 1995: A deficit of a ASL is covered by the regional government, but there are conditions attached to this, which aim at avoiding another deficit in the future Remark: The ASL, as well as Hospital-trusts, may to some degree contract loans. The coverage of the deficit is by allocating larger budgets in the next period. The region itself does not use its own resources, but extracts money from the national government	2004: A deficit of a ASL is covered by the regional government, but there are conditions attached to this, which aim at avoiding another deficit in the future Remark: The ASL, as well as Hospital-trusts, may to some degree contract loans. The coverage of the deficit is by allocating larger budgets in the next period. The region itself does not use its own resources, but extracts money from the national government
Luxembourg 1994: No, deficits are not covered Remark: The HIFs annual budget has to be balanced. There is a financial reserve required, which may fluctuate from 10 to 20% of the annual expenditure. If current expenditure levels make the reserve drop out of this range, the HIFs have either to increase the contributions ore to restrict the provision of services	2004: No, deficits are not covered Remark: The HIFs annual budget has to be balanced. There is a financial reserve required, which may fluctuate from 10 to 20% of the annual expenditure. If current expenditure levels make the reserve drop out of this range, the HIFs have either to increase the contributions ore to restrict the provision of services
Netherlands 1995: Yes, the difference between a HIFs income and its expenditure it is covered by the Central Fund	2004: Yes, the difference between a HIFs income and its expenditure it is covered by the Central Fund

HIF11 If a deficit arises for a Health Insurance Fund / Health Authority (because the available funds are not sufficient to cover the expenditure in a period.) Is this deficit covered? For instance by the state or some other institution?	
New Zealand 1995: The deficit of a RHA is covered by the state Remark: Usually, this is done by allocating a larger budget in the long run	2004: No the deficit is not covered; the DHB may obtain a loan from the Government, which has to be repaid later on
Norway 1995: Deficits of counties and municipalities are covered by the central government. Remark: Deficits of hospitals operated by the counties are factually covered by the Central Government. The grants from the central government are not earmarked. If they are not sufficient, the grant usually will be increased to cover the expenditure.	2004: Deficits of counties and municipalities are covered by the central government. Remark: Deficits of hospitals are factually covered by the Central Government, which is now in charge of them. The same is true for deficits of a municipality. The grants from the central government to lower levels of government are not earmarked. If they are not sufficient, the grant usually will be increased to cover the expenditure.
Portugal 1995: Deficits of Regional Health Administrations are covered by the Central Government	2004: Deficits of Regional Health Administrations are covered by the Central Government
Poland 1995: A deficit of a Local Health Authority would be covered by the state Remark: Deficits in the form of a loan were forbidden.	2004: A deficit of the National Health Fund would be covered by the state
Spain 1995 Deficits of Regional INSALUD branches are covered by the Central Government	2004: Deficits of Servicios Regional de Salud the regional health authorities are covered by the government of the Autonomous Communities; in part by regional extra taxes
Sweden 1995. A Landsting's deficit is not covered Remark: It has to increase local taxes.	2004: A Landsting's deficit is not covered Remark: It has to increase local taxes.
Switzerland 1995: No, deficits are not covered, the Health Insurance Funds either have to make debts or have to increase the level of contributions. Remark: Each HIF has to have a reserve fund up to a level set by the Central Government, which are for covering deficits.	2004: No, deficits are not covered, the Health Insurance Funds either have to make debts or have to increase the level of contributions. Remark: Each HIF has to have a reserve fund up to a level set by the Central Government, which are for covering deficits.
United Kingdom 1995: Yes, the deficit of a Health Authority is covered. Remark: It is covered by the state by allocating a larger budget in the next period.	2004: Yes, the deficit of a Health Authority is covered. Remark: It is covered by the state by allocating a larger budget in the next period.

HIF12 How is the top level administration of the Health Insurance Fund /Health Authority determined? The term "top-level management" in particular refers to who represents the Health Insurance Fund / Health Authority to the outside and conducts negotiations.	
Austria 1995: The top-level management is determined by the Health Insurance Fund itself	2004: By the Health Insurance Fund itself
Belgium 1995: By the Health Insurance Fund itself	2004: By the Health Insurance Fund itself
Canada 1995: The administration of the Regional Health Authority is determined by the Provincial Government. The Provincial Government itself is elected on provincial level.	2004: The administration of the Regional Health Authority is determined by the Provincial Government The Provincial Government itself is elected on provincial level.
Czech Republic 1995: By the Health Insurance Fund itself Remark: Factually, by the state. In all HIF, the state is represented directly or by appointed representatives in the boards which make plans or execute them. The supervisory board of a HIF is composed of representatives of the state, the employers and the trade unions. The Board then appoints the top-level management, i.e. the director. For the GHIF, the biggest HIF the Government appoints the Director General.	2004: By the Health Insurance Fund itself Remark: Factually, by the state. In all HIF, the state is represented directly or by appointed representatives in the boards which make plans or execute them. The supervisory board of a HIF is composed of representatives of the state, the employers and the trade unions. The Board then appoints the top-level management, i.e. the director. For the GHIF, the biggest HIF the Government appoints the Director General directly.
Denmark 1995: The Health Authority is the county council, Amter, which consists of elected politicians	2004: The Health Authority is the county government, Amter, consisting of elected politicians
Finland 1995: The Municipality, of which the Health Authority is part, determines the top level executive of the Health Authority. The Municipalities' government itself is elected	2004: The Municipality, of which the Health Authority is part, determines the top level executive of the Health Authority. The Municipalities' government itself is elected
France 1995: By the state Remark: Some members of an individual HIF's executive board are determined by the state, others are determined by the employers and the employees.	2004: By the state. In particular the director of the UNCAM, in charge of negotiating with providers, is determined by the state Remark: Some members are determined by the state, others are determined by the employers and the employees.
Germany 1995: By the Health Insurance Fund itself, formally by elections of the insured Remark: The insured determine some members by	2004: By the Health Insurance Fund itself, formally by elections of the insured Remark: The insured determine some members by

HIF12 How is the top level administration of the Health Insurance Fund /Health Authority determined? The term “top-level management” in particular refers to who represents the Health Insurance Fund / Health Authority to the outside and conducts negotiations.	
elections, others are determined by the employer organizations and trade unions.	elections, others are determined by the employer organizations and trade unions.
Greece 1995: The top level executive of the ESY as well of the Health Insurance Funds is determined by the Central Government	2004: The top level executive of the ESY as well of the Health Insurance Funds is determined by the Central Government
Hungary 1995: The top level executive of the NHIFA is determined by the Government	2004: The top level executive of the NHIFA is determined by the Government
Ireland 1995: By the state	2004: By the State (Central Government)
Italy 1995: By the regional government Remark: The general manager of an ASL is appointed by the regional government for a five year term. The general manager in turn appoints the two senior managers, one of them is in charge of administrative questions, the other in charge of health matters	2004: By the regional government Remark: The general manager of an ASL is appointed by the regional government for a five year term. The general manager in turn appoints the two senior managers, one of them is in charge of administrative questions, the other in charge of health matters
Luxembourg 1994: The top level administration of the HIFs is determined partly internally, partly by the state Remark: The insured determine some members of the top-level administration by elections, others are determined by the employer organizations. One delegate is determined by the state.	2004: The top level administration of the HIFs is determined partly internally, partly by the state Remark: The insured determine some members of the top-level administration by elections, others are determined by the employer organizations. One delegate is determined by the state.
Netherlands 1995: By the Health Insurance Fund itself	2004: By the Health Insurance Fund itself
New Zealand 1995: The top-level executive of the Regional Health Authorities was appointed by the Central Government	2004: The Central Government appoints the Chairperson of the District Health Board. The Chairperson then appoints the Chief Executive Officer of the District Health Board, who is in charge of the day-to-day operation. Remark: The board of a DHB consists of 7 members elected by the population of the district, and 4 members appointed by the Central Government
Norway 1995: Municipal Governments consist of locally elected politicians; and the Regional Health Authorities are part of the local government.	2004: Municipal Governments consist of locally elected politicians; and the Regional Health Authorities are part of the local government.

HIF12 How is the top level administration of the Health Insurance Fund /Health Authority determined? The term “top-level management” in particular refers to who represents the Health Insurance Fund / Health Authority to the outside and conducts negotiations.	
The NIS is controlled by the national government	The NIS is controlled by the national government
Portugal 1995: By the Central Government Remark: The national government determines the top-administration of the Regional Health Administrations in the different regions.	2004: By the Central Government Remark: The national government determines the top-administration of the Regional Health Administrations in the different regions.
Poland 1995: The administration of the Local Health Authority is determined by the municipal or regional government (gmina or voivodship)	2004: The top level administration of the National Health Fund is determined by the state.
Spain 1995: The top level administration of the INSALUD is appointed by the Central Government	2004: The top level administration of the Servicio Regional de Salud is determined by the governments of the Autonomous Communities
Sweden 1995: By the Landsting itself Remark: The Landsting itself is a politically elected body. It determines the board in charge of health provision in the Landsting	2004: By the Landsting itself; the Landsting itself is a politically elected body
Switzerland 1995: By the Health Insurance Fund itself	2004: By the Health Insurance Fund itself
United Kingdom 1995: By the central government Remark: The Department of Health determines the chairperson of the DHA, which is in charge of the general direction of the DHA.	2004: By the central government Remark: The Department of Health determines the chairperson of the DHA, which is in charge of the general direction of the DHA.

2. Purchasers and Providers of Medical Care

CO1 Can the Health Insurance Funds / Health Authorities identify individual providers, e.g. individual GPs or Hospitals, who overspend?	
Austria 1995: Yes, for Hospitals but with no consequences; Yes, for GPs Remark: Further, the Physician's association can identify providers and exert pressure. It does so, since overspending of one provider impacts negatively on the other providers' income	2004: Yes, for Hospitals but with no consequences; Yes, for GPs Remark: Further, the Physician's association can identify providers and exert pressure. It does so, since overspending of one provider impacts negatively on the other providers' income
Belgium 1995. Yes, for Hospitals Yes, for GPs Remark: There is an extensive system of cost-reimbursement, where bills are handed in by the patients. In these bills, services are listed. This also holds true for Hospitals, since the services provided there are also remunerated on a fee for service basis.	2004: Yes, for Hospitals Yes, for GPs Remark: There is an extensive system of cost-reimbursement, where bills are handed in by the patients. In these bills, services are listed. This also holds true for Hospitals, since the services provided there are also remunerated on a fee for service basis.
Canada 1995: Yes, for Hospitals Yes, for GPs Remark: While operating costs of hospitals are financed by global budgets, the services provided in the Hospitals by independent providers are paid for on a fee for service basis. The Provincial Government receives bills from providers for services.	2004: Yes, for Hospitals Yes, for GPs Remark: While operating costs of hospitals are financed by global budgets, the services provided in the Hospitals by independent providers are paid for on a fee for service basis. The Provincial Government receives bills from providers for services.
Czech Republic 1995: Yes, for Hospitals Yes, for GPs Remark: The remuneration is done by an invoice system: each provider sends an invoice, listing all services and the sum of points to the HIF. The HIF then pays the financial value of a point to the provider. The system is identical for out-patient and in-patient care.	2004: Yes, for Hospitals Yes, for GPs Remark: The remuneration is done by an invoice system: each provider sends an invoice, listing all services and the sum of points to the HIF. The HIF then pays the financial value of a point to the provider. The system is identical for out-patient and in-patient care
Denmark 1995 Yes, for Hospitals Yes, for GPs Remark: Hospitals are owned and operated by the Amter, which have cost control. GPs are contracted on a fee for service and capitation	2004: Yes, for Hospitals Yes, for GPs Remark: Hospitals are owned and operated by the Amter, which have cost control. GPs are contracted on a fee for service and capitation

CO1 Can the Health Insurance Funds / Health Authorities identify individual providers, e.g. individual GPs or Hospitals, who overspend?	
basis.	basis.
Finland 1995: Yes, for Hospitals Yes, for GPs Remark: The Municipalities can identify GPs employed in the municipal health centers which overspend. In theory they can identify more expensive Hospitals, but in practice it is difficult to compare the prices and services offered by different hospitals.	2004: Yes, for Hospitals; Yes, for GPs Remark: The Municipalities can identify GPs employed in the municipal health centers which overspend. In theory they can identify more expensive Hospitals, but in practice it is difficult to compare the prices and services offered by different hospitals.
France 1995: Yes, for Hospitals Yes, for GPs Remark: There is a system of billing for most services	2004: Yes, for Hospitals Yes, for GPs Remark: There is a system of billing for most services
Germany 1995: No for GPs; the Health Insurance Funds have only overall contracts with the regional Provider Organizations; it can identify regions which overspend. Yes for hospitals; the Health Insurance Funds see the per diem charged by a Hospital and can identify expensive hospitals Remark: The Physician's association in charge of distributing the funds obtained by the HIFs can identify providers and exert pressure. It does so, since overspending of one provider impacts negatively on the other providers' income	2004: No for GPs; the Health Insurance Funds have only overall contracts with the regional Provider Organizations; it can identify regions which overspend. Yes for hospitals; the Health Insurance Funds see the per diem charged by a Hospital and can identify expensive hospitals Remark: The Physician's association in charge of distributing the funds obtained by the HIFs can identify providers and exert pressure. It does so, since overspending of one provider impacts negatively on the other providers' income
Greece 1995 No for GPs - neither the Health Insurance Funds nor the ESY can identify GPs which overspend. Yes for hospitals; the ESY, which is operating the hospitals, can identify hospitals which require more resources.	2004: No for GPs - neither the Health Insurance Funds nor the ESY can identify GPs which overspend. Yes for hospitals, the ESY, which is operating the hospitals, can identify hospitals which require more resources.
Hungary 1995: No, neither for GPs nor for Hospitals Remark: The NHIFA has the right to monitor performance reports. But the remuneration mode– capitation for GPs respectively the providers usually report the sum of the points for the services provided - give, little information to do so	2004: No, neither for GPs nor for Hospitals Remark: The NHIFA has the right to monitor performance reports. But the remuneration mode– capitation for GPs respectively the providers usually report the sum of the points for the services provided - give, little information to do so
Ireland 1995: Yes for hospitals	2004: Yes, for Hospitals

CO1 Can the Health Insurance Funds / Health Authorities identify individual providers, e.g. individual GPs or Hospitals, who overspend?	
No for GPs Remark: This holds true for independent Hospitals as well as for Hospitals operated by the Health boards. Services by GPs are only subsidized, there is no billing.	No for GPs Remark: This holds true for independent Hospitals as well as for Hospitals operated by the Health boards. Services by GPs are only subsidized, there is no billing.
Italy 1995: Yes, for Hospitals Remark: In particular for those Hospitals operated by the ASL	2004: Yes, for Hospitals Remark: In particular for those Hospitals operated by the ASL
Luxembourg 1994: No	2004: Yes, for GPs
Netherlands 1995: Yes, for Hospitals Yes, for GPs	2004: Yes, for Hospitals Yes, for GPs
New Zealand 1995: No Remark: There is an institution, the Health Benefits Limited, which collects and monitors data on payments made as subsidies to providers. It allows a control against frauds.	2004: No Remark: There is an institution, the Health Benefits Limited, which collects and monitors data on payments made as subsidies to providers. It allows a control against frauds.
Norway 1995: Yes for Hospitals Yes for GPs Remark: Hospitals are operated by the counties but receive a block grant. The counties can see if a hospital runs a deficit. GPs are contracted and receive a fee for service payment from the NIS.	2004: Yes for Hospitals Yes for GPs Remark: Hospital's remuneration is partly based on a DRG system, and the Hospital is giving information on the activity to the state, respectively the Regional Health Authorities. GPs are contracted and receive a fee for service payment by the NIS
Portugal 1995: Yes, for Hospitals – if a deficit accrues Yes for GPs and Health Centers Remark: Since there is no real purchaser provider split between the ARS and the providers, the control is internal, not operating by services billed by the provider. However, the information is treated just as a piece of information and usually has no consequences for the provider.	2004: Yes, for Hospitals – e.g. if a deficit accrues Yes for GPs and Health Centers Remark: Since there is no real purchaser provider split, the control is internal, not operating by services billed by the provider. However, the information is treated just as a piece of information and usually has no consequences for the provider.
Poland 1995: Most GPs were employed Gminas (municipalities) and Voivodships (regional governments) could identify hospitals which overspent.	2004: The National Health Fund can identify both Hospitals and GPs who overspend

CO1 Can the Health Insurance Funds / Health Authorities identify individual providers, e.g. individual GPs or Hospitals, who overspend?	
Spain 1995: The INSALUD can identify both, Hospitals and GPs Remark: Only for those Hospitals, which are directly operated by the INSALUD and those GPs which are working for the INSALUD (the majority)	2004: The Servicio Regional de Salud, SRS, can identify both, Hospitals and GPs Remark: Only for those Hospitals, which are directly operated by the SRS and those GPs which are working for the SRS (the majority)
Sweden 1995: Yes, for Hospitals (operated by the Landstings) Yes, for GPs (employed by the Landstings)	2004: Yes, for Hospitals (operated by the Landstings) Yes, for GPs (employed by the Landstings)
Switzerland 1995: Yes, for GPs	2004: Yes, for GPs
United Kingdom 1995: Yes, for Hospitals Yes, for GPs	2004: Yes, for Hospitals Yes, for GPs

CO2 Do the Health Insurance Funds / Health Authorities have the possibility to exclude individual providers of medical services (individual physicians, Hospitals etc.) from the provision of medical services, if they significantly oversupply medical services, provide insufficient quality or work in an inefficient way?	
Austria 1995: No, neither hospitals nor GPs can be excluded Remark: Hospitals cannot be excluded; doctors can loose their treatment contracts only by offering insufficient quality.	2004: Basically no; neither hospitals nor GPs can be excluded Remark: Hospitals cannot be excluded; doctors can loose their treatment contracts only by offering insufficient quality.
Belgium 1995. No; neither Hospitals nor GPs can be excluded	2004: No; neither Hospitals nor GPs can be excluded
Canada 1995: Yes, Hospitals and GPs can be excluded. Remark: Hospitals however never are excluded, instead they get instructions on how to change their management.	2004: Yes, Hospitals and GPs can be excluded. Remark: Hospitals however never are excluded, instead they get instructions on how to change their management.
Czech Republic 1995: Yes, Hospitals and GPs can be excluded Remark: The HIF contract with providers, and factually not with all providers. Usually however, the contract is negotiated with the association of the provider for all members.	2004: Yes, Hospitals and GPs can be excluded Remark: The HIF contract with providers, and factually not with all providers. Usually however, the contract is negotiated with the association of the provider and binding for all members. Selective contracting is being introduced, but not yet operative.
Denmark 1995: No, neither Hospitals nor GPs can be excluded Remark: Physicians working in private practice can be excluded, but only under very extreme circumstances. Their turnover is monitored. Hospitals are owned and operated by the Amter, and cannot be excluded.	2004: No, neither Hospitals nor GPs can be excluded Remark: Physicians working in private practice can be excluded, but only under very extreme circumstances. Their turnover is monitored. Hospitals are owned and operated by the Amter, and cannot be excluded.
Finland 1995: Yes for hospitals Yes for GPs – if contracted Remark: The majority of GPs are employed by the municipal Health Centers, they can be given notice that they cause to high expenditure. Only contracted GPs can be excluded. The Municipality has some choice in which hospital district to join.	2004: Yes, for Hospitals; Yes for GPs – if contracted Remark: The majority of GPs are employed by the municipal Health Centers, they can be given notice that they cause to high expenditure. Only contracted GPs can be excluded. Since 1999, the Municipality has some choice in which hospital district to join. However, there are limitations to do so due to geographical constraints.

CO2 Do the Health Insurance Funds / Health Authorities have the possibility to exclude individual providers of medical services (individual physicians, Hospitals etc.) from the provision of medical services, if they significantly oversupply medical services, provide insufficient quality or work in an inefficient way?	
France 1995: No	2004: No
Germany 1995: No Remark: GPs are not contracted individually, but the contract is between the GP association and the HIF. Since 1988, the HIFs can de-contract Hospitals, but never did so.	2004: No Remark: GPs are not contracted individually, but the contract is between the GP association and the HIF. Since 1988, the HIFs can de-contract Hospitals, but never did so.
Greece 1995: No, neither the Health Insurance Funds nor the ESY can exclude GPs or public Hospitals from the provision of services Remark: Private Hospitals / providers or provider offering services on private terms can be excluded	2004: No, neither the Health Insurance Funds nor the ESY can exclude GPs or public Hospitals from the provision of services Remark: Private Hospitals / providers or provider offering services on private terms can be excluded
Hungary 1995: No for hospitals Yes, GPs can be excluded by decontracting Remark: Most Hospitals are owned and operated by Municipalities or at County Level, by the county governments	2004: No for hospitals Yes, GPs can be excluded by decontracting Remark: Most Hospitals are owned and operated by Municipalities or at County Level, by the county governments
Ireland 1995: Yes, contracted Hospitals can be excluded Yes for GPs which are contracted Remark: Only contracted hospitals can be de-contracted; about half of the hospitals are run by the health boards and cannot be excluded. About 2/3 of all GPs have a contract with the Health Boards to provide treatment of Medical Card holders (1/3 of the population) For the remaining majority of the population, the patients pay for services.	2004: Yes, contracted Hospitals can be excluded Yes for GPs which are contracted Remark: Only contracted hospitals can be de-contracted; about half of the hospitals are run by the health boards and cannot be excluded. About 2/3 of all GPs have a contract with the Health Boards to provide treatment of Medical Card holders (1/3 of the population) For the remaining majority of the population, the patients pay for services.
Italy 1995: No for most services, since hospitals are predominantly operated by the ASL and staff is predominantly employed. Remark: Independent providers can be excluded, by not renewing their contracts.	2004: No for most services, since hospitals are predominantly operated by the ASL and staff is predominantly employed. Remark: Independent providers can be excluded, by not renewing their contracts
Luxembourg 1994: No	2004: No
Netherlands 1995: Yes, for Hospitals	2004: Yes, for Hospitals

CO2 Do the Health Insurance Funds / Health Authorities have the possibility to exclude individual providers of medical services (individual physicians, Hospitals etc.) from the provision of medical services, if they significantly oversupply medical services, provide insufficient quality or work in an inefficient way?	
Yes, for GPs	Yes, for GPs
New Zealand 1995: No Remark: The strict purchaser-provider split with contracting allowed a de-contracting by the RHA, but usually, there was no alternative provider for hospital services.	2004: No
Norway 1995: No, for Hospitals Yes, for GPs Remark: The county cannot exclude a hospital it owns and operates. Contracted GPs and other providers can be excluded.	2004: No, for Hospitals Yes, for GPs Remark: The Regional Health Authority cannot exclude a hospital it basically owns and operates. Contracted GPs and other providers can be excluded.
Portugal 1995: No Remark: While information on supply and oversupply of services is collected and available, it is not used to evaluate the providers and has no consequences for them.	2004: No Remark: While information on supply and oversupply of services is collected and available, it is not used to evaluate the providers and has no consequences for them.
Poland 1995: Yes for GPs, if they were contracted No for Hospitals and employed providers. Remark: Hospitals were owned and operated by the gminas and voivodships. They could intervene. Only if the purchaser had contracted services, providers could be excluded.	2004: Yes, for Hospitals Yes, for GPs Remark: Hospitals and GPs are now predominantly contracted by the National Health Fund. De-contracting is hence possible, but seldom used in practice. It has never happened to hospitals.
Spain 1995: No Remark: Most GPs are employed, can be controlled, but not really excluded. The INSALUD can exclude Hospitals which are contracted, but not those Hospitals operated by the INSALUD	2004: No Remark: Most GPs are employed, can be controlled, but not really excluded. The Servicio Regional de Salud can exclude Hospitals which are contracted – but not Hospitals which are operated by the SRS
Sweden 1995: Hospitals are operated by the Landstings and Physicians are usually employed, so neither can be excluded. Only independent providers can be excluded – a minority of providers	2004: Hospitals are operated by the Landstings and Physicians are usually employed, so neither can be excluded. Only independent providers can be excluded – a minority of providers

CO2 Do the Health Insurance Funds / Health Authorities have the possibility to exclude individual providers of medical services (individual physicians, Hospitals etc.) from the provision of medical services, if they significantly oversupply medical services, provide insufficient quality or work in an inefficient way?	
Switzerland 1995: No	2004: No
United Kingdom 1995: Yes, for Hospitals Yes, for GPs Remark: While the option of de-contracting is existent for both cases, this option is only theoretical. GPs can only be excluded from providing services by the professional organization, and only in the case of serious misbehavior relating to treatment quality, not to cost-effectiveness of treatment.	2004: Yes, for Hospitals Yes, for GPs Remark: While the option of de-contracting is existent for both cases, this option is only theoretical. GPs can only be excluded from providing services by the professional organization, and only in the case of serious misbehavior relating to treatment quality, not to cost-effectiveness of treatment.

CO3 Do the Health Insurance Funds / the Health Authority usually receive a detailed bill from an individual provider, e.g. a Hospital or a GP, which lists all medical services and medical goods which were provided in an individual case?	
Austria 1995: There is a per diem charged by Hospitals Yes for GPs, where the billing takes place between the GP and the HIF	2004: There is a per diem charged by Hospitals Yes for GPs, where the billing takes place between the GP and the HIF
Belgium 1995. Yes, from Hospitals and from GPs Remark: There is an extensive system of cost-reimbursement, where bills are handed in by the patients	2004: Yes, from Hospitals and from GPs Remark: There is an extensive system of cost-reimbursement, where bills are handed in by the patients
Canada 1995: Yes, from Hospitals and from GPs Remark: There are various billing systems between the provinces and the GPs. The provinces run the hospitals, and have cost control.	2004: Yes, from Hospitals and from GPs Remark: There are various billing systems between the provinces and the GPs. The provinces run the hospitals, and have cost control.
Czech Republic 1995: Yes, from Hospitals and from GPs Remark: The remuneration of all services is done by an invoice system, in which bills listing all services are sent from the provider to the HIF	2004: Yes, from Hospitals and from GPs Remark: The remuneration of all services is done by an invoice system, in which bills listing all services are sent from the provider to the HIF
Denmark 1995: Yes, for Hospitals. Hospitals receive a global budget, but in the case that a patient is treated outside of his county, the home county receives a bill. Yes for GPs who are billing their services to the Amter	2004: Yes, for Hospitals. Hospitals receive a global budget, but in the case that a patient is treated outside of his county, the home county receives a bill. Yes for GPs who are billing their services to the Amter
Finland 1995: Yes, from Hospitals No for GPs Remark: Payment of Hospitals is activity based. Hospitals bill the services provided to citizens of a municipality to the municipality according the terms set in the (informal) agreement between the Hospital District and the Municipality. GPs are predominantly salaried by the Municipalities' health centers.	2004: Yes, from Hospitals No for GPs Remark: Payment of Hospitals is activity based. Hospitals bill the services provided to citizens of a municipality to the municipality according the terms set in the (informal) agreement between the Hospital District and the Municipality. GPs are predominantly salaried by the Municipalities' health centers.
France 1995: Yes, from Hospitals Yes, from GPs	2004: Yes, from Hospitals Yes, from GPs
Germany 1995: Yes for Hospitals, via the per diem No for GPs Remark:	2004: Yes, from Hospitals via the DRG system No for GPs Remark:

CO3 Do the Health Insurance Funds / the Health Authority usually receive a detailed bill from an individual provider, e.g. a Hospital or a GP, which lists all medical services and medical goods which were provided in an individual case?	
The HIF pays a lump sum to the Physicians organization, which is distributing the money internally according to a fee schedule.	The HIF pays a lump sum to the Physicians organization, which is distributing the money internally according to a fee schedule.
Greece 1995: No Remark: The Health Insurance Fund's payments to a Hospital are based on a per diem. The ESY operating the Hospital does not receive a detailed bill listing the medical services provided in a case from Hospitals. Only in few cases of specific services provided by laboratories or x-ray facilities, the services are explicitly billed.	2004: No Remark: The Health Insurance Fund's payments to a Hospital are based on a per diem. The ESY operating the Hospital does not receive a detailed bill listing the medical services provided in a case from Hospitals. Only in few cases of specific services provided by laboratories or x-ray facilities, the services are explicitly billed.
Hungary 1995: No Remark: GP payment is by capitation. Payment of Hospitals and specialists is based on the sum of the points resulting for the services delivered.	2004: No Remark: GP payment is by capitation. Payment of Hospitals and specialists is based on the sum of the points resulting for the services delivered.
Ireland 1995: No Remark: Hospitals receive a budget, and GPs providing services to medical card holders receive a capitation	2004: No Remark: Hospitals receive a budget, and GPs providing services to medical card holders receive a capitation
Italy 1995: Yes, from Hospitals, which have to deliver the DRG of a case No for GPs – because of capitation as the predominant remuneration, there is little data for monitoring them. Bills concern only the additional services which are remunerated on a fee for service basis	2004: Yes, from Hospitals, which have to deliver the DRG of a case No for GPs – because of capitation as the predominant remuneration, there is little data for monitoring them. Bills concern only the additional services which are remunerated on a fee for service basis
Luxembourg 1994: Yes, from hospitals Remark: To get reimbursement by the state or the HIFs, the hospital needed to hand in a bill.	2004: No
Netherlands1995: Yes, from hospitals and from GPs	2004: Yes, from hospitals and from GPs
New Zealand 1995: No Remark: The contracting arrangements stated, that the Hospitals should deliver information on what services were provided. This was not done on	2004: No Remark: The GP receive a subsidy per consultation, there is no billing. The Hospitals receive price-volume based

CO3 Do the Health Insurance Funds / the Health Authority usually receive a detailed bill from an individual provider, e.g. a Hospital or a GP, which lists all medical services and medical goods which were provided in an individual case?	
the basis of individual cases. A monitoring was however usually not performed. The GP receive a subsidy per consultation, there is no billing.	budgets, there is also no billing done.
Norway 1995: No for Hospitals Partly from GPs and independent providers Remark: The Municipality pays the provider (GPs etc.) a block grant; the services of the provider are then partly paid for by the NIS on a fee for service basis. Hospitals receive a block grant.	2004: Yes, from Hospitals Partly for GPs and independent providers Remark The Municipality pays the provider (GPs etc.) a block grant; the services of the provider are then partly paid for by the NIS on a fee for service basis. Part of the Hospitals remuneration is activity based and the Hospital provides the necessary information.
Portugal 1995: No Remark: In the NHS usually, the GP is salaried and the Hospital is operating on a budget, and there is no billing for a case. Billing occurs only, if services are provided by contracted providers. But most of these services are not paid for by the NHS but from the patients or their VHI	2004: No Remark: In the NHS usually, the GP is salaried and the Hospital is operating on a budget, and there is no billing for a case. Billing occurs only, if services are provided by contracted providers. But most of these services are not paid for by the NHS but from the patients or their VHI
Poland 1995: No, neither hospitals nor GPs Remark: Hospitals received a budget; GPs receive a capitation per enrolled patient	2004: Yes, from Hospitals No for GPs Remark: Hospitals are now remunerated on a DRG basis. GPs receive a capitation per enrolled patient.
Spain 1995: No Remark: The INSALUD provides services by staff which is employed. Only in the case of contracted services, there is some billing. However, in the case of contracted services from Hospitals, remuneration is predominantly done on a per diem basis.	2004: No Remark: The SRS provides services by staff which is employed. Only in the case of contracted services, there is some billing. However, in the case of contracted services from Hospitals, remuneration is predominantly done on a per diem basis.
Sweden 1995: No. The Landstings operate the Hospitals and employ the GPs. Remark: Billing occurs only, if a citizen is treated outside of his Landsting	2004: No. The Landstings operate the Hospitals and employ the GPs. Remark: Billing – based on DRGs - occurs only, if a citizen is treated outside of his Landsting

CO3 Do the Health Insurance Funds / the Health Authority usually receive a detailed bill from an individual provider, e.g. a Hospital or a GP, which lists all medical services and medical goods which were provided in an individual case?	
Switzerland 1995: Yes, for GPs Remark: Hospitals were paid for on a per diem basis, which did not list the services provided.	2004: Yes, for GPs Remark: Since for some in-patient treatments DRGs have been introduced, the HIF gets a bill for these from the Hospitals.
United Kingdom 1995: No Remark: Hospitals have a bloc contract with a DHA, so there is no billing for the majority of services. GPs are predominantly remunerated on a capitation basis per enrolled patient, so there is no billing either.	2004: No Remark: Hospitals have a bloc contract with a DHA, so there is no billing for the majority of services. GPs are predominantly remunerated on a capitation basis per enrolled patient, so there is no billing either.

CO4 Can the Health Insurance Funds / Health Authority force the providers (Hospitals / Physicians) to abide by clinical guidelines?	
Austria 1995: Factually, neither Hospitals nor Physicians can be forced to abide by clinical guidelines	2004: Yes, Hospitals and Physicians can be forced to abide by clinical guidelines
Belgium 1995: No, neither Hospitals nor Physicians can be forced to abide by clinical guidelines	2004: No, neither Hospitals nor Physicians can be forced to abide by clinical guidelines Remark: There is a system of accreditation. Hospitals need accreditation to receive funds from the HIFs. In order to get accreditation, they have to meet certain standards, concerning the financial administration but also practice. This does however not determine how medical services are provided. Since 1995, GPs may gain accreditation, which is voluntary and means that they receive a higher income. The accreditation requirements encompass abidance to certain rules of good therapeutical practices. Again, this does not determine the way medical services are provided and the whole system is voluntary.
Canada 1995: No, neither Hospitals nor Physicians can be forced to abide by clinical guidelines Remark: Following guidelines can be encouraged, but not enforced. The medical professions exert pressure to abide by good practice.	2004: No, neither Hospitals nor Physicians can be forced to abide by clinical guidelines Remark: Following guidelines can be encouraged, but not enforced. The medical professions exert pressure to abide by good practice.
Czech Republic 1995: No, neither Hospitals nor Physicians can be forced to abide by clinical guidelines Remark: While some pressure can be exercised, the factual enforcement is limited to quality standards	2004: No, neither Hospitals nor Physicians can be forced to abide by clinical guidelines Remark: While some pressure can be exercised, the factual enforcement is limited to quality standards. Selective contracting is being introduced, but not yet operative.
Denmark 1995: Yes, Hospitals can be forced. No for GPs; Remark: In the case of GPs, there may be sanctions if guidelines are violated, but these sanctions are exerted by the medical societies, which issued the guidelines.	2004: Yes, Hospitals can be forced. No for GPs Remark: There may be sanctions if guidelines are violated, but these sanctions are exerted by the medical societies, which issued the guidelines
Finland 1995: No	2004: Yes, Hospitals and GPs can in principle be forced to abide by clinical guidelines;

CO4 Can the Health Insurance Funds / Health Authority force the providers (Hospitals / Physicians) to abide by clinical guidelines?	
	however, this is not current practice
France 1995: No, neither Hospitals nor GPs Remark: The usage of guidelines usually can be encouraged, some are mandatory, but with no sanction in case of non-abidance	2004: No, neither Hospitals nor GPs Remark: The usage of guidelines usually can be encouraged, some are mandatory, but with no sanction in case of non-abidance. The ANAES started creating and distributing guidelines in 1997 for cost consciousness, good medical practice and rational use of pharmaceuticals. The conventions contains also agreements on the abidance to guidelines, but the impact is weak
Germany 1995: Basically no, albeit Hospitals can be forced to some degree	2004: Basically no, albeit Hospitals can be forced to some degree
Greece 1995: No, neither Health Insurance Funds nor the ESY can force Hospitals or Physicians to abide by clinical guidelines Remark: There are no medical guidelines. There are some restrictions, on how often certain services can be provided to a patient in a period. These can be enforced by economic sanctions.	2004: No, neither Health Insurance Funds nor the ESY can force Hospitals or Physicians to abide by clinical guidelines Remark: There are no medical guidelines. There are some restrictions, on how often certain services can be provided to a patient in a period. These can be enforced by economic sanctions.
Hungary 1995: No Remark: The Hungarian Medical Chamber and the NPHMOS are in charge of quality control, but not the NHIFA	2004: No Remark: The Hungarian Medical Chamber and the NPHMOS are in charge of quality control, but not the NHIFA
Ireland 1995: No	2004: No
Italy 1995: Yes, Hospitals can be forced Remark: Hospitals operated by the ASL are under direct control. Independent hospitals - like the Hospital Trusts – need an accreditation by the regional government as a precondition to get public funding. This accreditation is conditional on accepting certain measures of quality control and financial accountability.	2004: Yes, Hospitals can be forced Remark: Hospitals operated by the ASL are under direct control. Independent hospitals - like the Hospital Trusts – need an accreditation by the regional government as a precondition to get public funding. This accreditation is conditional on accepting certain measures of quality control and financial accountability
Luxembourg 1994: No	2004: No
Netherlands 1995: Yes, Hospitals and GPs can be forced to abide by clinical guidelines	2004: Yes, Hospitals and GPs can be forced to abide by clinical guidelines

CO4 Can the Health Insurance Funds / Health Authority force the providers (Hospitals / Physicians) to abide by clinical guidelines?	
New Zealand 1995: No Remark: While contracts between the RHA and the Hospitals usually contained clauses on quality and also the abidance to guidelines, no such information on abidance was collected and control was performed.	2004: No. Remark: Guidelines may be recommended, but the providers retain leeway for clinical judgements.
Norway 1995: No Remark: The Norwegian Board of Health exercises some control also on quality, but does not implement guidelines.	2004: No Remark: The Norwegian Board of Health exercises some control, also on quality. Still, guidelines are recommendations only and not part of the contracts.
Portugal 1995: No	2004: No
Poland 1995: No, insofar guidelines exist, they are only recommendations. Remark: Yes, Hospitals and GPs can be forced to abide by quality standards. Hospitals are operated by the municipalities and the regional governments, which have direct control, GPs are employed	2004: No, insofar guidelines exist, they are only recommendations. Remark: The National Health Fund can de-contract the providers. The NHF only contracts with providers – both hospitals and GPs – which meet the requirements on quality.
Spain 1995: No	2004: No
Sweden 1995: In principle yes, factually, it is not possible	2004: In principle yes, factually, it is not possible
Switzerland 1995: No	2004: No
United Kingdom 1995: No Remark: While there is no formal system, the Health Authority can exercise some influence on hospitals and the professional organizations can exercise pressure on individual providers	2004: No Remark: While there is no formal system, the Health Authority can exercise some influence on hospitals and the professional organizations can exercise pressure on individual providers

3. Parameters of the Health Care System

N1 How and by whom is the **Catalogue of Medical Services** covered by the Health System determined? The term "catalogue" refers to which medical services are covered in the Health Care System, and which have to be purchased by the patients themselves.	
Austria 1995: Negotiations among Purchasers (Health Insurance Funds) and Providers of medical services	2004: Negotiations among HIFs and Providers of medical services
Belgium 1995: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: The HIF Association and the Provider negotiate fees and the catalogue of services, the nomenclature, the central government can approve or disapprove, but also replace the outcome. The nomenclature is a defined list of services, encompassing about 6000 medical services and is quite stable over time	2004: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: The HIF Association and the Provider negotiate fees and the catalogue of services, the nomenclature, the central government can approve or disapprove, but also replace the outcome.
Canada 1995: Negotiations among the Central Government, the Provincial governments and the Providers of Medical Services Remark: The Federal Government determined in the Canada Health Act that all medically necessary services provided by hospitals, physicians and surgical dental care, which requires in-patient treatment in hospitals is covered. This sets a kind of minimum catalogue, to which all provinces have to abide. Within this limit, the Provincial Governments negotiate contracts with providers, in which fees and services are set.	2004: Negotiations among the Central Government, the Provincial governments and the Providers of Medical Services Remark: The Federal Government determined in the Canada Health Act that all medically necessary services provided by hospitals, physicians and surgical dental care, which requires in-patient treatment in hospitals is covered. This sets a kind of minimum catalogue, to which all provinces have to abide. Within this limit, the Provincial governments negotiate contracts with providers, in which fees and services are set.
Czech Republic 1995: Negotiations among the Central Government, the HIF and the Providers Remark: While the minimum catalogue is set by the government, the providers and the HIF negotiate contracts based on this. The Central Government supervises the negotiations. Outcomes need governmental approval and have to be in accordance with the public interest. The central government has further influence by controlling the largest HIF and by being represented in the Executive Boards of the other HIF. The government controlled	2004: Negotiations among the Central Government, the HIF and the Providers Remark: While the minimum catalogue is set by the government, the providers and the HIF negotiate contracts based on this. The Central Government supervises the negotiations. Outcomes need governmental approval and have to be in accordance with the public interest. The central government has further influence by controlling the largest HIF and by being represented in the Executive Boards of the other HIF. The government controlled

N1 How and by whom is the **Catalogue of Medical Services** covered by the Health System determined? The term “catalogue” refers to which medical services are covered in the Health Care System, and which have to be purchased by the patients themselves.	
GHIF sets a benchmark for the negotiations of other HIF. If results are not in the public interest, the government can unilaterally change the results. It can set results unilaterally, if negotiations fail to reach an outcome. Most negotiations are among individual HIF and providers / provider associations.	GHIF sets a benchmark for the negotiations of other HIF. If results are not in the public interest, the government can unilaterally change the results. It can set results unilaterally, if negotiations fail to reach an outcome. Most negotiations are among individual HIF and providers / provider associations.
Denmark 1995: Negotiations among the Amter and Providers Remark: There is no defined catalogue, but some services are excluded	2004: Negotiations among the Amter and Providers Remark: There is no defined catalogue, but some services are excluded
Finland 1995: The Municipal Government decides unilaterally on most issues; some issues of what can be provided are negotiated with the providers Remark: Some restraints are set by the Central Government which also has control over what services are covered by the National Health Insurance. The central Government only sets the basic framework, the details are decided on by the municipalities	2004: Unilateral decision by the Municipal Government; some elements of what services are provided are negotiated among the Municipal Government and the providers of medical care Remark: Some restraints are set by the Central Government which also has control over what services are covered by the National Health Insurance. The central Government only sets the basic framework, the details are decided on by the municipalities
France 1995: Unilateral decision of the Health Insurance Funds, but with advice form the government, a High Health Authority and professional representatives The Purchasers and the Providers negotiate a nomenclature, as a list of services covered by the Health system. This nomenclature has to be approved by the state.	2004: Unilateral decision of the Health Insurance Funds, but with advice form the government, a High Health Authority and professional representatives The Purchasers and the Providers negotiate a nomenclature, as a list of services covered by the Health system. This nomenclature has to be approved by the state.
Germany 1995: Negotiations among Purchasers (Krankenkassen) and Associations of Medical Providers; albeit within loose limits set by the State by law	2004: Negotiations among Purchasers (Krankenkassen) and Associations of Medical Providers; albeit within loose limits set by the State by law
Greece 1995: Unilateral decision by the State, Central Government, by law or decree Remark: The decision is made by the ESY, but this is factually part of the state. This concerns the catalogue of services covered by the ESY. Apart from a basic catalogue, the HIF have	2004: Unilateral decision by the State, Central Government, by law or decree Remark: The decision is made by the ESY, but this is factually part of the state. This concerns the catalogue of services covered by the ESY. Apart from a basic catalogue, the HIF have

N1 How and by whom is the **Catalogue of Medical Services** covered by the Health System determined? The term “catalogue” refers to which medical services are covered in the Health Care System, and which have to be purchased by the patients themselves.	
some leeway on what services to cover	some leeway on what services to cover
Hungary 1995: Unilateral decision by the State, Central Government, by law or decree	2004: Unilateral decision by the State, Central Government, by law or decree
Ireland 1995: Unilateral decision by the State, Central Government, by law or decree Remark: Some elements are negotiated, but the role of the government is strongest	2004: Unilateral decision by the State, Central Government, by law or decree Remark: Some elements are negotiated, but the role of the government is strongest
Italy 1995: The state Remark: There are negotiations among the central and the regional Government; the central government sets a catalogue of minimum requirements, the regions have to provide. There was no strictly defined catalogue, rather, everything that was feasible and medically necessary was covered.	2004: The state Remark: There are negotiations among the central and the regional Government; the central government sets a catalogue of minimum requirements, the regions have to provide
Luxembourg 1994: Formally a unilateral decision of the state, which sets the nomenclature by law. Factually, negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services. Remark: The catalogue of covered services, the nomenclature, is a defined list set by the Ministry of Health. It is however developed and updated with advice from the providers and the HIF Association, UCM. The nomenclature lists all services and the level of the fee for each service with reference to a standard fee, which is negotiated among the providers and the UCM	2004: Formally a unilateral decision of the state, which sets the nomenclature by law. Factually, negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services. Remark: The catalogue of covered services, the nomenclature, is a defined list set by the Ministry of Health. It is however developed and updated with advice from the providers and the HIF Association, UCM. The nomenclature lists all services and the level of the fee for each service with reference to a standard fee, which is negotiated among the providers and the UCM
Netherlands 1995: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services. The results are then set by law. There is no formal catalogue, but some services are excluded form the basic package and transferred to the VHI	2004: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services. The results are then set by law. There is no formal catalogue, but some services are excluded form the basic package and transferred to the VHI
New Zealand 1995: The state by law Remark: The National Health Committee was	2004: The state by law Remark: Factually, it is still a multilevel decision: the

N1 How and by whom is the **Catalogue of Medical Services** covered by the Health System determined? The term "catalogue" refers to which medical services are covered in the Health Care System, and which have to be purchased by the patients themselves.	
commissioned in the early 90s to develop a catalogue. This resulted in the exclusion of some services only. Actually it was a multilevel decision. The Regional Health Authorities which had substantial leeway, decided what services to buy from Providers, this was set in a negotiated contract between the RHA and the Providers which set broad categories of medical services which were to be supplied. The central government could intervene, if the RHA did not purchase some services and the Providers had some leeway on what services were provided in a category. Factually, the RHA had most say on what services were covered.	District Health Boards decided what services to buy from Providers or to provide in hospitals operated by themselves. Again, the Central Government can intervene, e.g. if certain services are not purchased.
Norway 1995: Negotiations among the Central Government and the County Councils / Municipalities	2004: Negotiations among the Central Government and the County Councils / Municipalities.
Portugal 1995: Unilateral decision the Central Government Remark: There are no services explicitly excluded, but some, like dental care, are not provided by the NHS.	2004: Unilateral decision the Central Government Remark: There are no services explicitly excluded, but some, like dental care, are not provided by the NHS.
Poland 1995: Unilateral decision the Central Government Remark: The list of what has to be covered is determined in consensus with the providers.	2004: Unilateral decision the Central Government Remark: There is no defined positive catalogue, but a list of services excluded from coverage. The catalogue of services, i.e. what is factually provided is also influenced by the National Health Fund and the providers, which negotiate the contracts.
Spain 1995: Unilateral decision by the Central Government sets a frame of a minimum package for the INSALUD, which determines the details. The Regional governments, to which the control over the Health service provision was already devolved, had some leeway.	2004: Unilateral decision by the Central Government and the Regional Government of the Autonomous Community sets the frame of a minimum package. The Regional Governments have some leeway.
Sweden 1995: Formally, there is no such Catalogue Some services are excluded form the basic package	2004: Formally, there is no such Catalogue Some services are excluded form the basic package
Switzerland 1995: Unilateral decision by the Health Insurance Funds	2004: Unilateral decision by the State (e.g. by law or decree)

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Remark: The Central government did set a minimum catalogue of services, but the HIFs had some leeway on what to cover in the basic package. The minimum catalogue is set on a national level.	Remark: The HIF do no longer have leeway to cover additional services as part of the basic package – if they do, this is done in an additional private contract.
United Kingdom 1995: The state Remark: There is no “official” catalogue, but the Government can determine which services must be covered in the contracts of the DHA with Hospitals and in the contract negotiated between the Department of Health and the GP association	2004: The state Remark: There is no “official” catalogue, but the Government can determine which services must be covered in the contracts of the DHA with Hospitals and in the contract negotiated between the Department of Health and the GP association

N2 What describes best the way the **Levels of Remuneration** for medical services, e.g. the fees, budgets etc., are set in [Country]?	
Austria 1995: Negotiations among HIFs (Krankenkassen) and Providers of medical services; with some influence of the state Negotiations among HIFs and Providers of medical services for out patient medical care Negotiations among the Regional Governments, HIFs and Providers of medical services for in-patient medical care	2004: Negotiations among HIFs (Krankenkassen) and Providers of medical services; with some influence of the state Negotiations among HIFs and Providers of medical services for out patient medical care Negotiations among the Regional Governments, HIFs and Providers of medical services for in-patient medical care
Belgium 1995: Negotiations among the Health Insurance Funds and the Providers of Medical Services Remark: The HIF Association and the Provider negotiate the fees, the central government can approve or disapprove, but also replace the outcome. The Central government controls the overall budget, this sets a limit to what the HIF and Providers can negotiate. It has, in the past, reduced the fees negotiated among the HIFs and the Providers unilaterally.	2004: Negotiations among the Health Insurance Funds and the Providers of Medical Services Remark: The HIF Association and the Provider negotiate fees and services, the central government can approve or disapprove, but also replace the outcome. The Central government controls the overall budget, this sets a limit to what the HIF and Providers can negotiate. It has, in the past, reduced the fees negotiated among the HIFs and the Providers unilaterally.
Canada 1995: Negotiations among the Central Government, the Provincial governments and the Providers of Medical Services Remark: Subsidies from the federal government to the provincial government are negotiated between the Federal and Provincial Governments. The provincial fee schedules are negotiated between the provider associations and the provincial Ministries of health, and differ among provinces. Hospital budgets are negotiated among hospitals and the RHA/ Provincial Governments.	2004: Negotiations among the Central Government, the Provincial governments and the Providers of Medical Services Remark: Subsidies from the federal government to the provincial government are negotiated between the Federal and Provincial Governments. The provincial fee schedules are negotiated between the provider associations and the provincial Ministries of health, and differ among provinces. Hospital budgets are negotiated among hospitals and the RHA/ Provincial Governments.
Czech Republic 1995: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: Remuneration is negotiated among providers and each HIF. The Central Government supervises the negotiations. Outcomes need governmental approval and have to be in accordance with the public interest. The central government has further influence by controlling the largest HIF and by being	2004: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: Remuneration is negotiated among providers and each HIF. The Central Government supervises the negotiations. Outcomes need governmental approval and have to be in accordance with the public interest. The central government has further influence by controlling the largest HIF and by being

N2 What describes best the way the **Levels of Remuneration** for medical services, e.g. the fees, budgets etc., are set in [Country]?	
represented in the Executive Boards of the other HIF. The government controlled GHIF sets a benchmark for the negotiations of other HIF. If results are not in the public interest, the government can unilaterally change the results. It can set results unilaterally, if negotiations fail to reach an outcome. Most negotiations are among individual HIF and providers / provider associations.	represented in the Executive Boards of the other HIF. The government controlled GHIF sets a benchmark for the negotiations of other HIF. If results are not in the public interest, the government can unilaterally change the results. It can set results unilaterally, if negotiations fail to reach an outcome. Most negotiations are among individual HIF and providers / provider associations.
Denmark 1995: Negotiations among Amter, county government and the Providers of medical services. The Central government has to approve.	2004: Negotiations among Amter, county government and the Providers of medical services. The Central government has to approve.
Finland 1995: Unilateral decision by the Municipal Government Remark: Some elements are negotiated among the Municipal Government and the providers of medical care; in particular with the Hospital Districts.	2004: Unilateral decision by the Municipal Government; Remark: Some elements are negotiated among the Municipal Government and the providers of medical care
France 1995: Negotiations among State, Purchaser (Mandatory Health Insurance Funds) and the Providers of medical services. The Purchasers and the Providers negotiate a convention, which sets a tariff for each medical service listed in the nomenclature, as a list of service. The tariff is identical for the whole country and all Insurance Funds	2004: Negotiations among State, Purchaser (Mandatory Health Insurance Funds) and the Providers of medical services
Germany 1995: Negotiations among Purchasers (Krankenkassen) and Associations of Medical Providers	2004: Negotiations among Purchasers (Krankenkassen) and Associations of Medical Providers
Greece 1995: Unilateral decision by the State, Central Government, by law or decree Remark: The Government can set the per diems, the salaries and the budget of the ESY. The largest HIF are under close control of the government. However, there is a private system operating parallel to the public system of ESY and HIF.	2004: Unilateral decision by the State, Central Government, by law or decree Remark: The Government can set the per diems, the salaries and the budget of the ESY. The largest HIF are under close control of the government. However, there is a private system operating parallel to the public system of ESY and HIF.
Hungary 1995: Unilateral decision by the State, Central Government, by law or decree Remark:	2004: Unilateral decision by the State, Central Government, by law or decree Remark:

N2 What describes best the way the **Levels of Remuneration** for medical services, e.g. the fees, budgets etc., are set in [Country]?	
The Central government sets the overall and sectorial budgets. The NHIFA then sets remuneration levels in order to met the budget restrictions set.	The Central government sets the overall and sectorial budgets. The NHIFA then sets remuneration levels in order to met the budget restrictions set.
Ireland 1995: Unilateral decision by the State, Central Government, by law or decree Remark: Some elements – the level of the capitation, the budgets and the fees - are negotiated, but the role of the government is strongest	2004: Unilateral decision by the State, Central Government, by law or decree Remark: Some elements – the level of the capitation, the budgets and the fees - are negotiated, but the role of the government is strongest
Italy 1995. The state Remark: The central government sets the overall budget of the SSN, which is however usually exceeded. The distribution of the overall budget to the regions is then negotiated among the central and the regional governments. Salaries of the medical staff employed in the SSN is negotiated between the trade unions and the Ministry of Health at a national level. Budgets of the hospital trusts are negotiated between the Hospital and the regional government. The budget of an ASL is negotiated between the ASL and the Regional government. The ASL as the lowest level negotiates contracts with independent providers of medical services	2004: The state Remark: The central government sets the overall budget of the SSN, which is however usually exceeded. The distribution of the overall budget to the regions is then negotiated among the central and the regional governments. Salaries of the medical staff employed in the SSN is negotiated between the trade unions and the Ministry of Health at a national level. Budgets of the hospital trusts are negotiated between the Hospital and the regional government. The budget of an ASL is negotiated between the ASL and the Regional government. The ASL as the lowest level negotiates contracts with independent providers of medical services
Luxembourg 1994: Negotiations among the Health Insurance Funds Association, UCM, and the Providers of Medical Services but subject to approval of the Central Government Remark: The nomenclature lists all services and sets the level of the fee for each service with reference to a standard fee, which is negotiated among the providers and the UCM. While the standard fee is formally negotiated between the medical providers and the UCM, the decision of the UCM needs the approval of the Ministry of Health	2004: Negotiations among the Health Insurance Funds Association, UCM, and the Providers of Medical Services but subject to approval of the Central Government Remark: The nomenclature lists all services and sets the level of the fee for each service with reference to a standard fee, which is negotiated among the providers and the UCM. While the standard fee is formally negotiated between the medical providers and the UCM, the decision of the UCM needs the approval of the Ministry of Health
Netherlands 1995: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: The central government ensures via a	2004: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: The central government ensures via a

N2 What describes best the way the **Levels of Remuneration** for medical services, e.g. the fees, budgets etc., are set in [Country]?	
commission, that the tariffs are set in a way that expenditure targets are met	commission, that the tariffs are set in a way that expenditure targets are met
New Zealand 1995: The state Remark: The Central government sets the overall budget for Health Care – the amount of money going into health services. This is the overall limit for all other actors involved, but not the overall limit to health expenditure. This budget is then distributed to the Regional Health Authorities in negotiations among the Central Government and the RHA. The RHA had to negotiated contracts, usually price-volume contracts based on DRGs, with the providers. The GPs can charge higher prices to the patients	2004: The state Remark: The Central government sets the overall budget for Health Care – the amount of money going into subsidizing health services. This budget is then distributed to the District Health Boards in negotiations among the Central Government and the District Health Boards. The Providers, in particular the GPs, can charge higher prices to the patients
Norway 1995: Negotiations among the Central Government and the County Councils / Municipalities Remark: This refers to the overall budget available for health care. In a second step, remuneration is negotiated with the providers: For GPs, the levels of the fixed grants from the Municipalities are mostly set by the Municipalities. The fees, which are paid for by the NIS, are negotiated between the Norwegian Medical Association and the NIS. The budgets for hospitals were negotiated between the Hospital and the county. Salaries are negotiated among the provider association and the State, represented by the "State Negotiation Body".	2004: Negotiations among the Central Government and the County Councils / Municipalities Remark: This still refers to the overall budget available for health care. Formally, the government sets an overall budget. The exact levels are then negotiated with the providers. Salaries are negotiated among the provider association and the State, represented by the "State Negotiation Body".
Portugal 1995: The overall budget for health care is set unilaterally by the Central Government /Ministry of Finance, based on historical expenditure Remark: Remuneration and wages of NHS staff is negotiated between the Central Government and the Civil Service Unions. Budgets of the RHA and the Health Center budgets are negotiated between them, the Regional Health Administration and the Ministry of Health, the budgeting is done with little leeway for negotiations. Hospital budgets are usually negotiated between the	2004: The overall budget for health care is set unilaterally by the Central Government / Ministry of Finance, based on historical expenditure Remark: Remuneration and wages of NHS staff is negotiated between the Central Government and the Civil Service Unions. Budgets of the RHA and the Health Center budgets are negotiated between them, the Regional Health Administration and the Ministry of Health, the budgeting is done with little leeway for negotiations. Hospital

N2 What describes best the way the **Levels of Remuneration** for medical services, e.g. the fees, budgets etc., are set in [Country]?	
Ministry of Health and the Hospital itself, according to set rules. Providers operating outside of the NHS have substantial leeway in setting their own fees	budgets are usually negotiated between the Ministry of Health and the Hospital itself, according to set rules. Providers operating outside of the NHS have substantial leeway in setting their own fees
Poland 1995: The central government set an overall budget for health, which was then allocated to the lower tiers of government, municipalities/gminas and regions/voivodas, which then purchased and provided medical services to their population.	2004: Negotiations among the National Health Fund and the Providers. Remark: The negotiations are basically a tendering of a contract: the NHF publicly offers a specified task (a cost volume contract, containing a certain volume of serivices for which the NHF is willing to pay a certain amount), and providers can apply for it. Negotiations take place within the framework. The NHF has a strong position as the only purchaser of services.
Spain 1995: Unilateral decision by the Central Government Remark: The Central Government sets the overall budget for the INSALUD and the budgets for those Regions, to which the organization of health care was already devolved. The regions can raise additional funding. Up to 2002, the funds were allocated from the central government to the Autonomous Communities by an unadjusted capitation formula.	2004: Unilateral decision by the Central Government Remark: The Central Government sets the overall budget for the health system, from which the regional budgets are funded. The regions can raise additional funding. Since 2002, the funds are allocated from the central government to the Autonomous Communities by an adjusted capitation formula, which takes into account population and demographics, but no health indicators.
Sweden 1995: Unilateral Decision by the Landstings, which stet budgets for Hospitals and negotiates salaries	2004: Unilateral Decision by the Landstings, which stet budgets for Hospitals and negotiates salaries
Switzerland 1995: Negotiations among Purchasers (Health Insurance Funds) and Providers of medical services, usually at cantonal level Remark: The Regional Governments can approve or disapprove of the outcomes.	2004: Negotiations among Purchasers (Health Insurance Funds) and Providers of medical services, usually at cantonal level Remark: The Regional Governments can approve or disapprove of the outcomes.
United Kingdom 1995: The state. Remark: The department of health sets the overall budget for the services provided by the NHS in a period. This sets a limit. The actual remuneration levels (hospital budgets, level	2004: The state. Remark: The department of health sets the overall budget for the services provided by the NHS in a period. This sets a limit. The actual remuneration levels (hospital budgets, level of

N2 What describes best the way the **Levels of Remuneration** for medical services, e.g. the fees, budgets etc., are set in [Country]?	
of capitation and fees for GPs) is negotiated within in this limit, either by the Department of Health or the District Health Authority	capitation and fees for GPs) is negotiated within in this limit, either by the Department of Health or the District Health Authority

N3 The **Remuneration Mode** in which a provider of is remuneratedcan differ. Medical services can be remunerated for instance by fee for service, by capitation, budgets etc. What describes best the **Way in which the Remuneration Mode** is determined?	
Austria 1995: Negotiations among Purchasers, HIF, and Providers of medical services, with some influence of the central government, which sets limits	2004: Negotiations among Purchasers, HIF, and Providers of medical services, with some influence of the central government, which sets limits
Belgium 1995: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: The basic modes of remuneration (fee for service for GPs and Specialists, the funding of Hospitals) are set by law. The HIF Association and the Provider negotiate fees and services, the central government can approve or disapprove, but also replace the outcome.	2004: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: The basic modes of remuneration (fee for service for GPs and Specialists, the funding of Hospitals) are set by law. The HIF Association and the Provider negotiate fees and services, the central government can approve or disapprove, but also replace the outcome.
Canada 1995: Negotiations among the Provincial Governments and the Providers of Medical Services Remark: The provincial governments negotiate the fee schedules with providers. The RHA have leeway on in which mode contracted providers are remunerated. Usually the mode is not subject to change: its fee for service for physicians and budgets for hospitals.	2004: Negotiations among the Provincial Governments and the Providers of Medical Services Remark: The provincial governments negotiate the fee schedules with providers. The RHA have leeway on in which mode contracted providers are remunerated. Usually the mode is not subject to change: its fee for service for physicians and budgets for hospitals.
Czech Republic 1995: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: Remuneration mode is set by the government but the exact terms and the shares remunerated using each mode (fee for service vs. Capitation) are negotiated among providers and the HIF. The government has further influence by controlling the largest HIF and by being represented in the Executive Boards of the HIF.	2004: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services Remark: Remuneration mode is set by the government but the exact terms and the shares remunerated using each mode (fee for service vs. Capitation) are negotiated among providers and the HIF. The government has further influence by controlling the largest HIF and by being represented in the Executive Boards of the HIF.
Denmark 1995: Negotiations among the Purchaser (Amter) and the Providers of medical services, the results are subject to approval by the central Government	2004: Negotiations among the Purchaser (Amter) and the Providers of medical services, the results are subject to approval by the central Government
Finland 1995:	2004:

N3 The **Remuneration Mode** in which a provider of is remunerated can differ. Medical services can be remunerated for instance by fee for service, by capitation, budgets etc. What describes best the **Way in which the Remuneration Mode** is determined?	
Negotiations among the Municipal Government and the providers of medical care	Unilateral decision by the Municipal Government; Some elements are negotiated among the Municipal Government and the providers of medical care
France 1995: Negotiations among the Central Government, Purchaser (Mandatory Health Insurance Funds) and the Providers of medical services	2004: Negotiations among the Central Government, Purchaser (Mandatory Health Insurance Funds) and the Providers of medical services
Germany 1995: Negotiations among Purchasers (Krankenkassen) and Associations of Medical Providers; albeit within loose limits set by the State by law	2004: Negotiations among Purchasers (Krankenkassen) and Associations of Medical Providers; albeit within loose limits set by the State by law
Greece 1995: Unilateral decision by the State, Central Government, by law or decree Remark: Some of the more independent HIF have leeway to negotiate with providers, the largest HIF are under close control of the government.	2004: Unilateral decision by the State, Central Government, by law or decree Remark: Some of the more independent HIF have leeway to negotiate with providers, the largest HIF are under close control of the government.
Hungary 1995: Unilateral decision by the State, Central Government, by law or decree	2004: Unilateral decision by the State, Central Government, by law or decree
Ireland 1995: Unilateral decision by the State (e.g. by law or decree). The mode of remuneration is not part of negotiations but set unilaterally.	2004: Unilateral decision by the State (e.g. by law or decree). The mode of remuneration is not part of negotiations but set unilaterally
Italy 1995: The state by law Remark: The remuneration by capitation for GPs as well as the DRG system for hospitals was set by the national government. The ASL and the independent providers of medical services negotiate contracts	2004: The state by law Remark: The remuneration by capitation for GPs as well as the DRG system for hospitals was set by the national government. The ASL and the independent providers of medical services negotiate contracts
Luxembourg 1994: Unilateral decision by the State, Central Government, by law or decree.	2004: Unilateral decision by the State, Central Government, by law or decree
Netherlands 1995: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services	2004: Negotiations among the Central Government, the Health Insurance Funds and the Providers of Medical Services
New Zealand 1995: Negotiations among the Health Authorities and the Providers of Medical Services Remark:	2004: Negotiations among the Central Government, the District Health Boards and the Providers of medical services

N3 The **Remuneration Mode** in which a provider of is remunerated can differ. Medical services can be remunerated for instance by fee for service, by capitation, budgets etc. What describes best the **Way in which the Remuneration Mode** is determined?	
The state decides by law for primary care, which was fee for service by default. There were negotiations among the Regional Health Authorities and the Hospitals for medical services provided in Hospitals. The RHA had leeway to decide on the remuneration mode set in the contract with the provider. The GPs continued to be remunerated on a fee for service basis, since the development of contracts took very long	
Norway 1995: Negotiations among the Central Government and the County Councils / Municipalities	2004: Negotiations among the Central Government and the County Councils / Municipalities
Portugal 1995: Unilateral decision by the State; Central Government	2004: Unilateral decision by the state; Central Government
Poland 1995: Unilateral decision by the Central Government Remark: The central government sets a frame, but the municipalities and regional governments which do the actual contracting, have some leeway on how to remunerate.	2004: Unilateral decision by the National Health Fund, which has most influence on the contracts with the providers. Remark: The NHF tenders packages of services and costs, the modes of remuneration are specified in the contract which is negotiated among the NHF and the providers which apply for the contract.
Spain 1995: Unilateral decision by the Central Government The regions to which the organization of health care was already devolved, have some leeway	2004: Unilateral decision by the Central Government The Regional Governments have substantial leeway, e.g. by determining how budgets of hospitals are calculated
Sweden 1995: The Landsting	2004: The Landsting
Switzerland 1995: Unilateral decision by the Central Government Remark: The remuneration mode itself is a given fact in the negotiations among the HIF and the providers of services.	2004: Unilateral decision by the Central Government Remark: The remuneration mode itself is a given fact in the negotiations among the HIF and the providers of services.
United Kingdom 1995: Negotiations among the state and Providers of medical services Remark: The District Health Authorities negotiate the way hospitals are remunerated, e.g. a budget or case-based remuneration. The department	2004: Negotiations among the state and Providers of medical services Remark: The District Health Authorities negotiate the way hospitals are remunerated, e.g. a budget or case-based remuneration. The department

N3 The **Remuneration Mode** in which a provider of is remunerated can differ. Medical services can be remunerated for instance by fee for service, by capitation, budgets etc. What describes best the **Way in which the Remuneration Mode** is determined?	
of Health negotiates the remuneration of fees and other forms of remuneration in addition to the capitation which is the basic remuneration mode	of Health negotiates the remuneration of fees and other forms of remuneration in addition to the capitation which is the basic remuneration mode

C. Contributors and Sources

1 Gathering the Data and Disclaimer

The institutional information was gathered in two ways.

First, by sending out standardized, while slightly tailored versions of the HCSI to respondents – either academics e.g. who have conducted case studies on a certain HCS or persons working in the health system respectively its administration. The adaptation of the HCSI concerned the names of actors, governmental levels, not the content of the questions. The main problems of completing the inventories for is, that available data is imprecise, the issues the HCSI covers are not covered and the time, for which a description given in a case study is not exact.

Second, I supplemented and completed the inventories for the cases by using the available HiT reports and the case study literature on the HCS.

Some of the information obtained from the different sources was contradictory or did not fit the categories. In this case, I had to make a decision and give an answer. To do this, I checked up the issue in the available descriptions of the HCS, literature but also in the internet. I also supplemented the information provided by respondents by information based on the case literature available for a country.

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