

DELSA/HEA/WD/HWP(2007)6/ANN



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IMPROVED HEALTH SYSTEM PERFORMANCE  
THROUGH BETTER CARE COORDINATION

Annex

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Maria M. Hofmarcher, Howard Oxley, and Elena Rusticelli

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**Maria M. Hofmarcher, Howard Oxley, and Elena Rusticelli**

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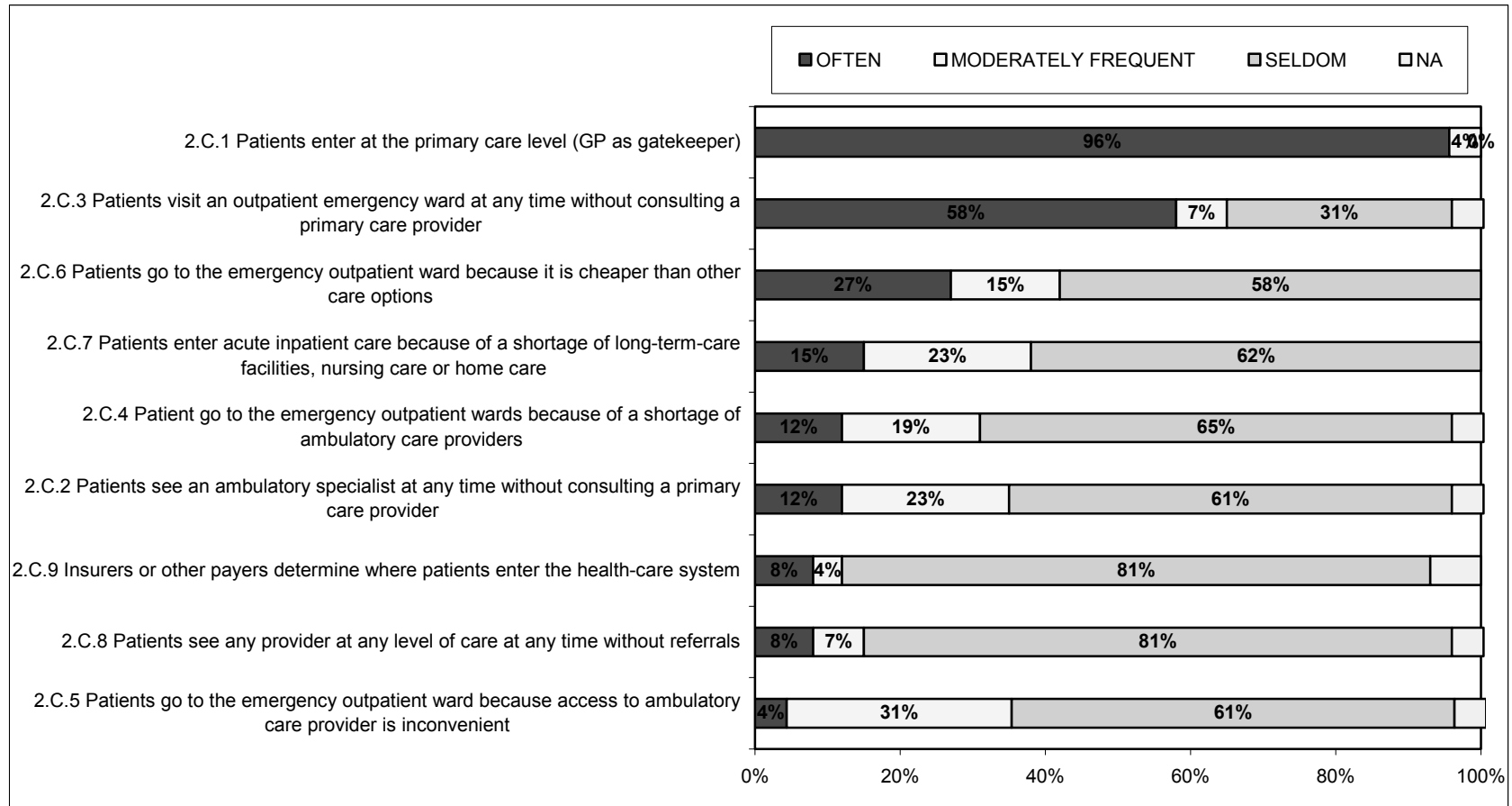
## INTRODUCTION AND OVERVIEW

1. This Paper brings together supplementary material for those interested in the approach used in this study to assess how care coordination is developing across selected OECD and EU non-OECD countries.

- Annex 1 presents first presents additional figures mainly in the form of bar charts. These provide supplementary information which mainly concerns the coordination of care practices at different points in the care chain. The remaining tables in the annex provide fuller information on the replies of individual countries to the detailed questionnaire presented in Annex 3. These answers are structured on the basis of the original questionnaire and are identified by the questionnaire subject headings. The corresponding table numbers of the questionnaire are indicated in the top left hand cell of each table and the questions and question numbers in the headings in the top row [in square brackets].
- Annex 2 describes the methodology used to analyse country responses to the questionnaire. It also presents some additional results that are not reported in the main text.
- As noted, the original questionnaire is found in Annex 3.

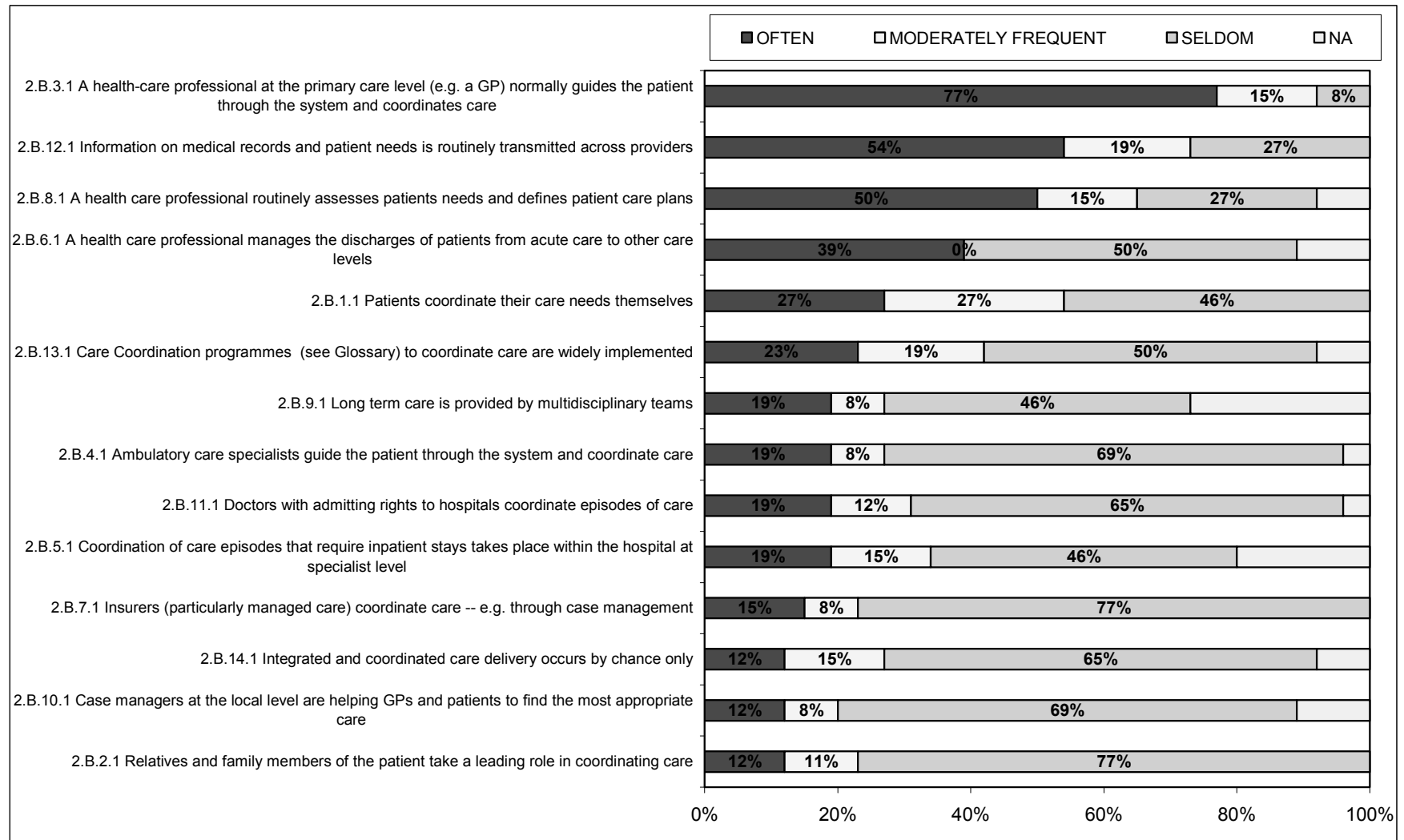
**ANNEX 1. ADDITIONAL FIGURES AND TABLES**

**Figure A 1.1 Where do patients enter the health-care system?**



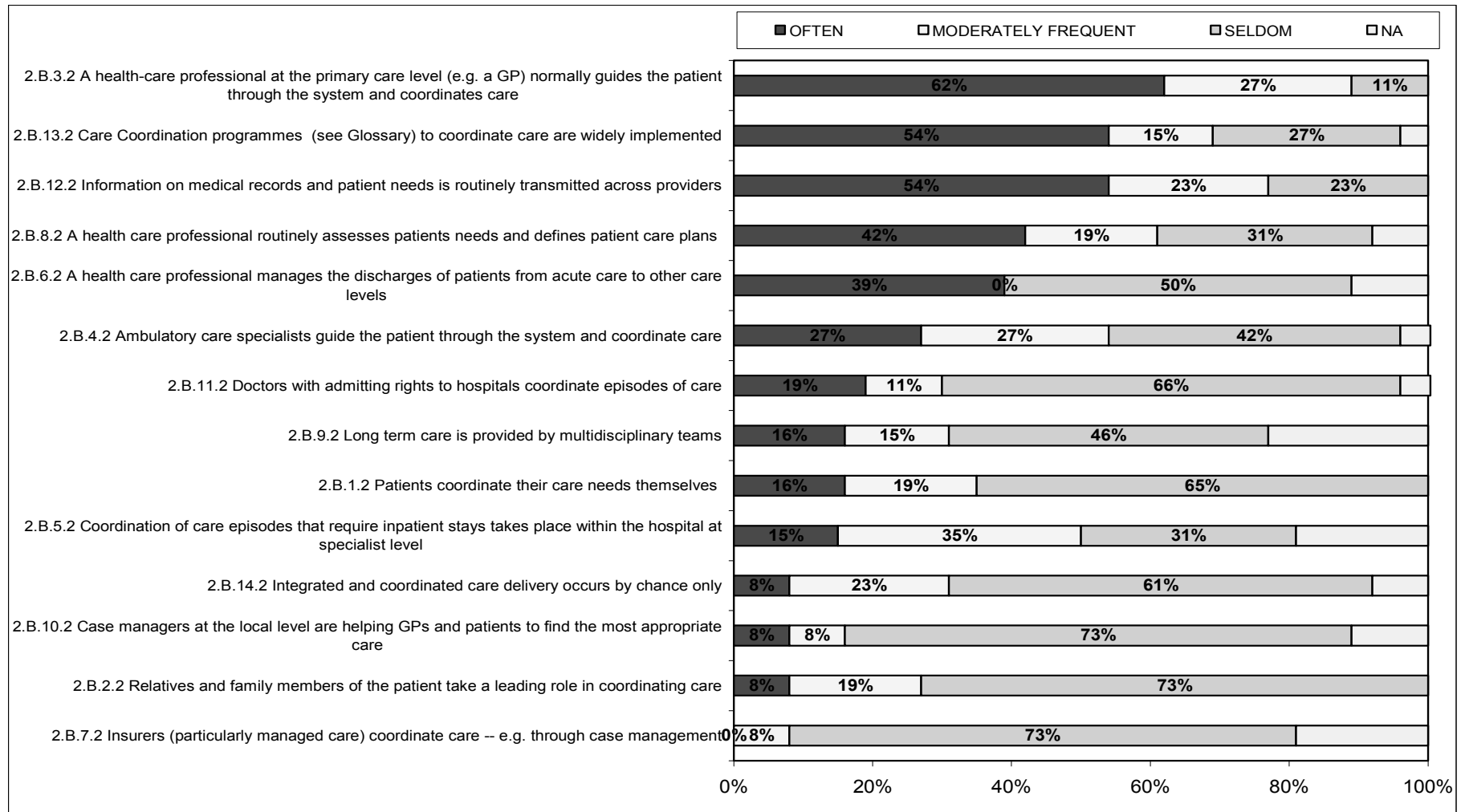
Source: OECD questionnaire on Coordination of Care 2006, Section 2C

**Figure A 1.2 Coordination of care practices at the interface between primary and ambulatory specialist doctors**



Source: OECD questionnaire on Coordination of Care 2006, Section 2B1

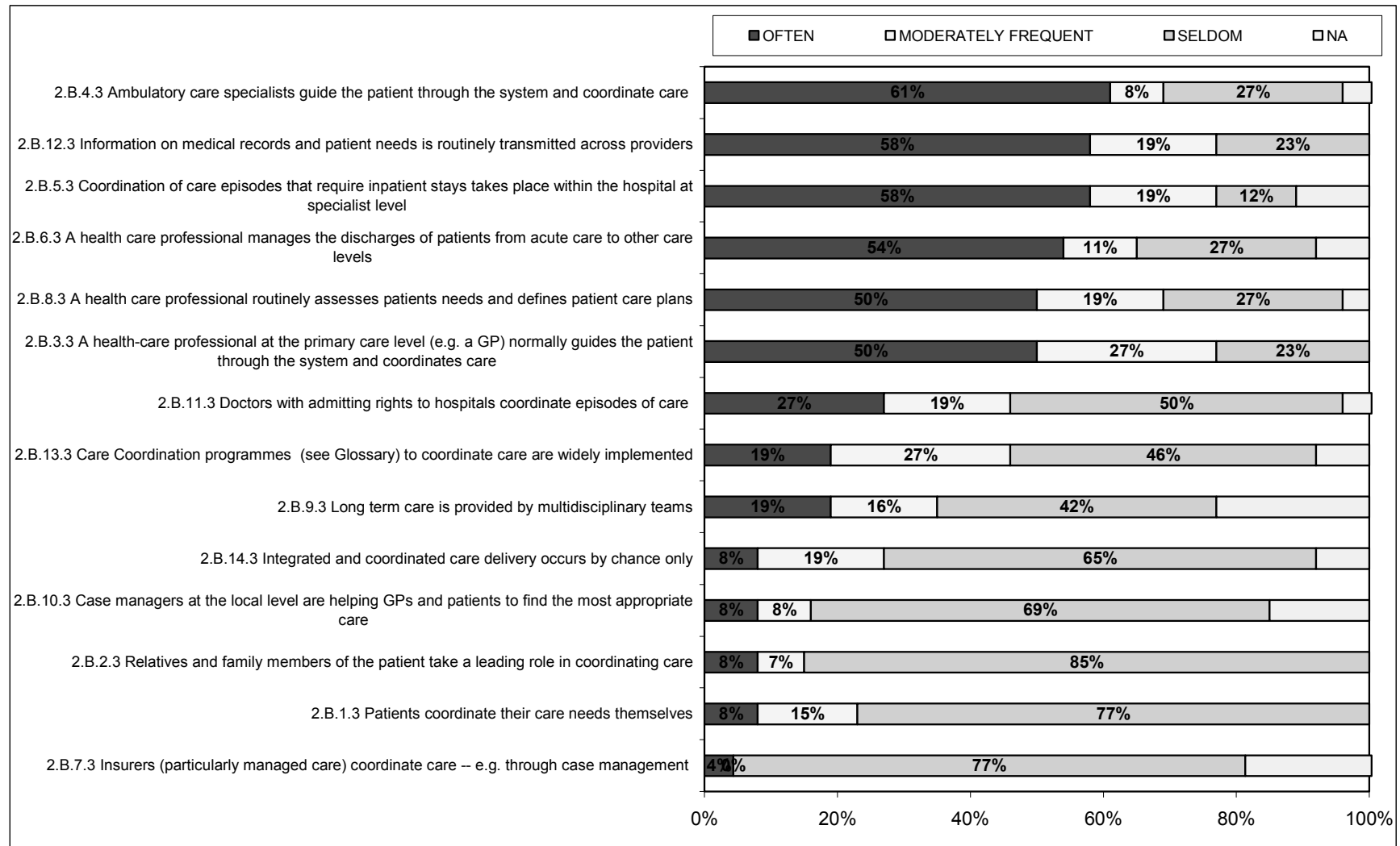
**Figure A 1.3 Coordination of care practices at the interface between primary/ambulatory specialist care and outpatient specialist care**



Source: OECD questionnaire on Coordination of Care 2006, Section 2B2

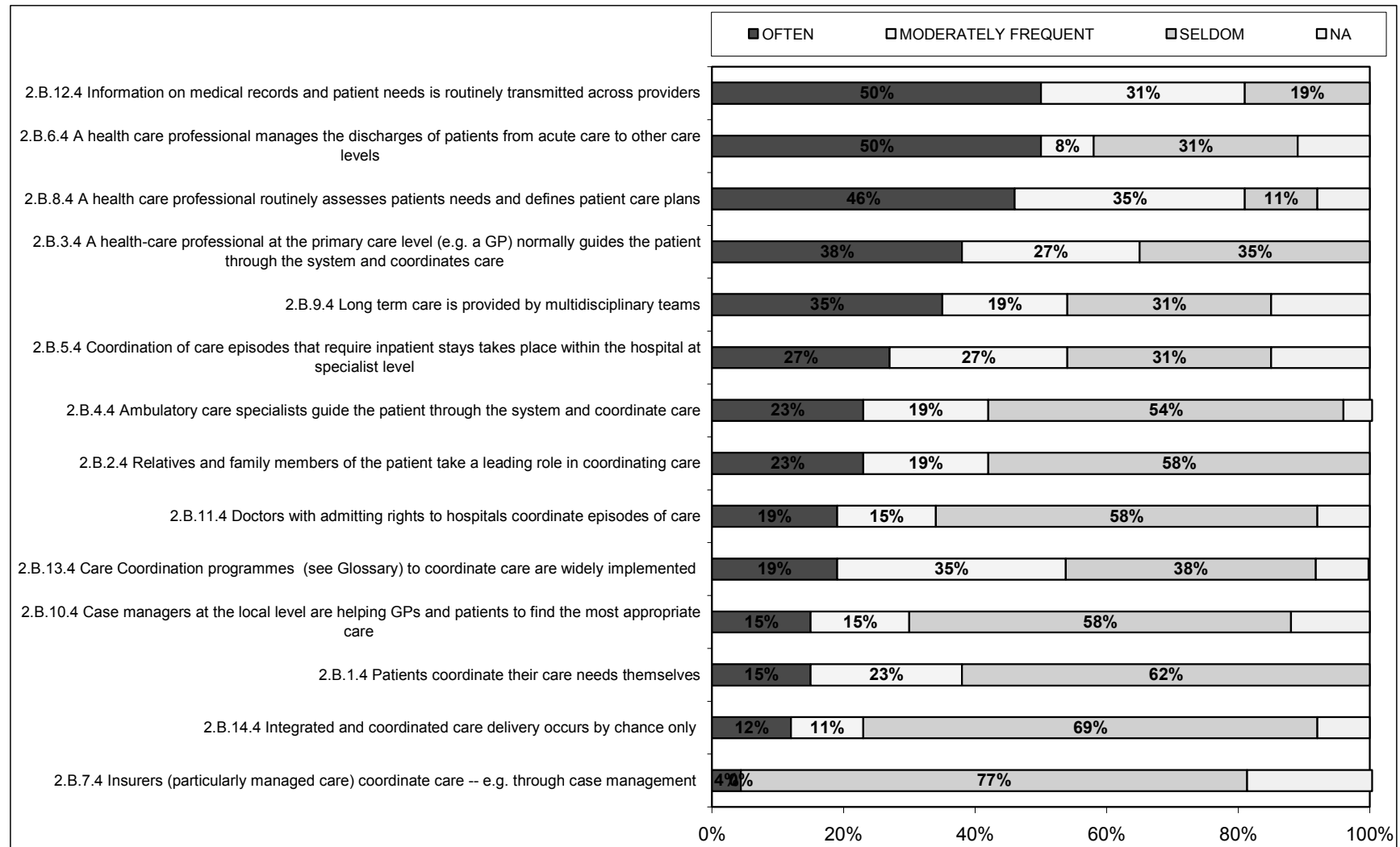


**Figure A 1.4 Coordination of care practices at the interface between ambulatory and acute inpatient care**



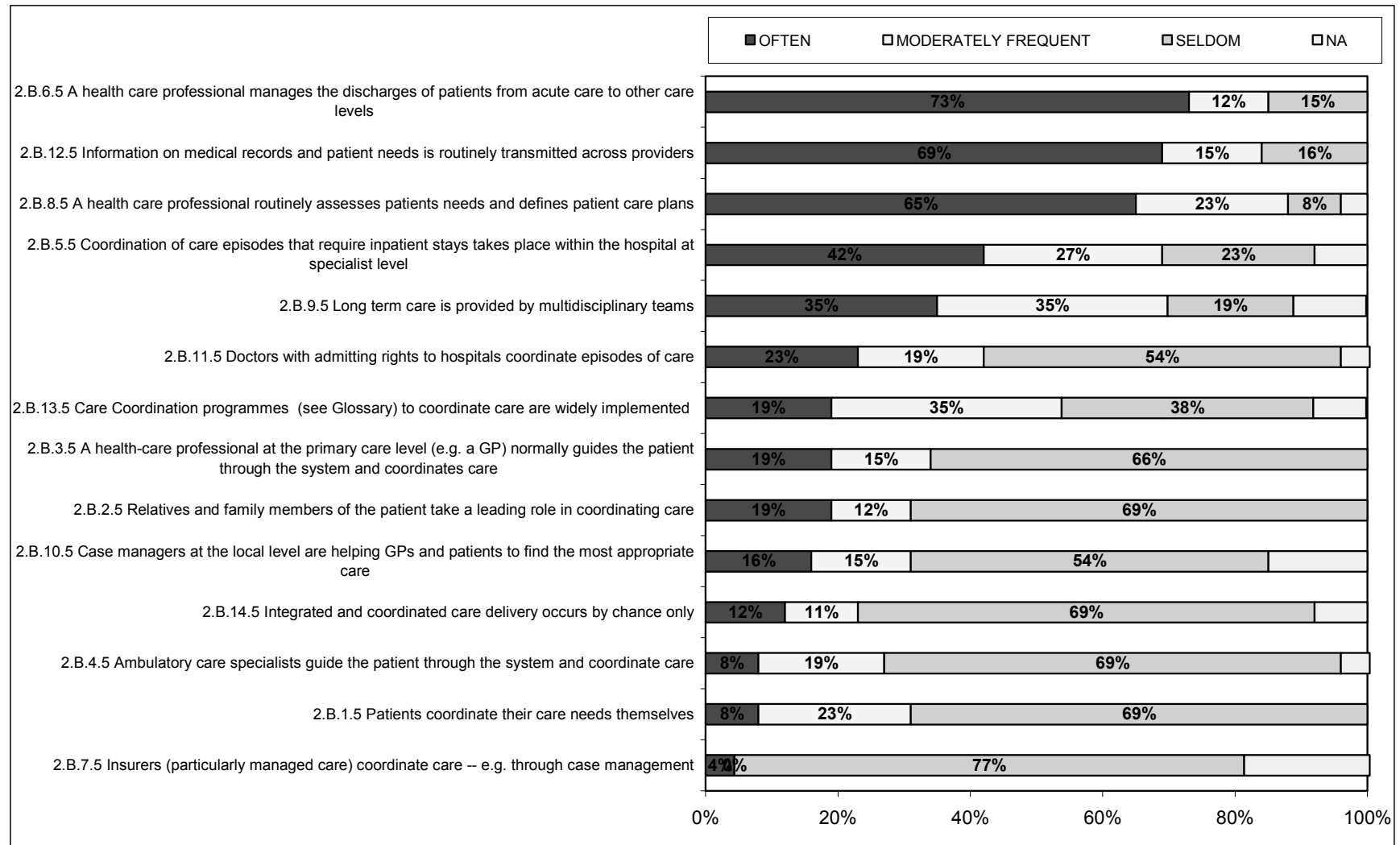
Source: OECD questionnaire on Coordination of Care; 2006 Section 2B3

**Figure A 1.5 Coordination of care practices at the interface between ambulatory and long-term care**



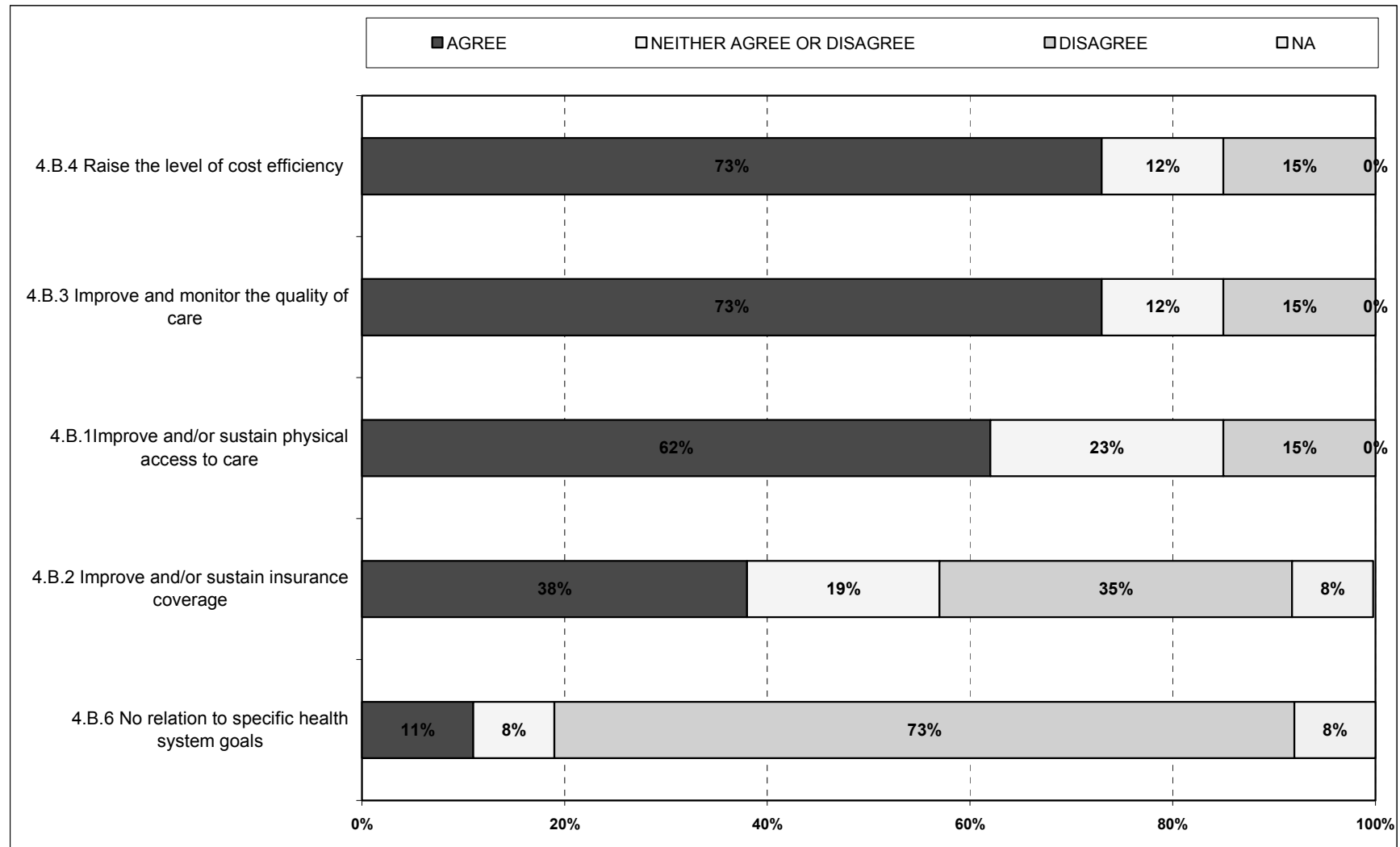
Source: OECD questionnaire on Coordination of Care 2006; Section 2B4

**Figure A 1.6 Coordination of care practices at the interface between acute inpatient and long-term care**



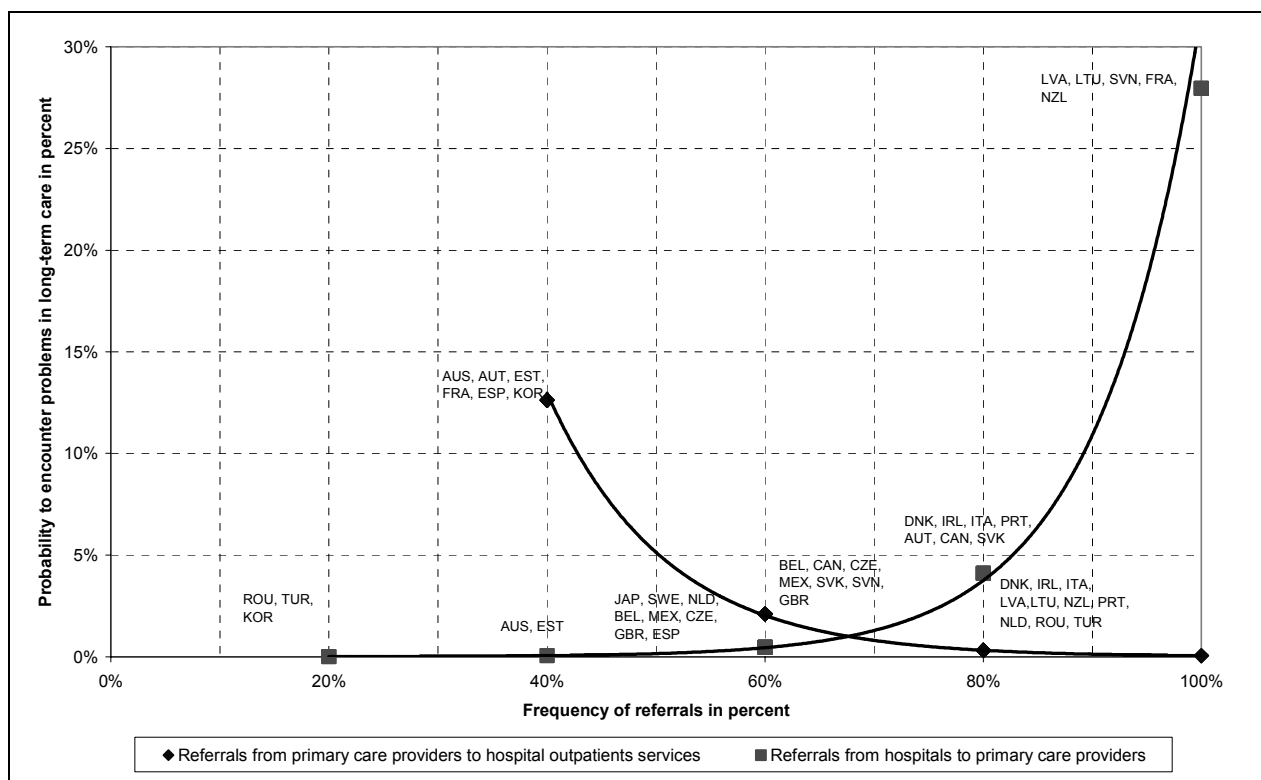
Source: OECD questionnaire on Coordination of Care; Section 2B5

Figure A 1.7 Health care system goals and target programmes



Source: OECD questionnaire on Coordination of Care; Section 4B

Figure A 1.8 The likelihood of problems in long-term care associated with of referral patterns



Note: The horizontal axis is a numerical transformation of questionnaire responses for referrals from hospitals to primary care and from hospitals to primary care where the lowest response "never or nearly never" is given a value of 20 per cent and always or nearly always a value of 100 per cent. See Annex 2 for further details. These curves show the estimated probability of encountering coordination problems in long-term care after controlling for health expenditure as a percent of GDP. The curves indicate that a high level of referrals from primary care to hospitals make problems of care coordination less likely (downward sloping curve); a high level of referrals from the hospital sector to primary care providers make problems more likely (upward sloping curve) (, see Model 10 in Table A 2.6). The two curves represented in the Figure are estimated using the logistic regression In Model 10 and holding constant the value of the two other explanatory variables included in the model.

Source: OECD questionnaire on Coordination of Care 2006; N=26

**Table A 1.1 Degree of disagreement or agreement with the following statements, concerning the link made, in policy debates, between coordination of care issues and the achievement of specific health care goals.**

<b>[1B]</b>	<b>Policy debates over coordination of care have been associated with the goal of improving and/or sustaining physical access to care [1B1]</b>	<b>Policy debates over coordination of care have been associated with the goal of improving and/or sustaining insurance coverage [1B2]</b>	<b>Policy debates over coordination of care have been associated with the goal of improving and monitoring the quality of care (impact on health outcomes) and responsiveness to patient needs [1B3]</b>	<b>Policy debates over coordination of care have been associated with the goal of raising the level of cost efficiency in health care delivery [1B4]</b>	<b>Policy debates over coordination of care have not been associated with any relation to specific health system goals [1B6]</b>
<b>DISAGREE</b>	FRA, SWE, NLD	AUT, DNK, HUN, IRL, JPN, NZL, SVN, SWE, NLD		JPN, TUR	AUS, AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LVA, LTU, NZL, ROU, SVN, SWE, NLD, TUR, GBR
<b>NEITHER AGREE OR DISAGREE</b>	DNK, HUN, SVN	CAN, MEX, ROU, SVK		NZL, SVN	PRT, SVK
<b>AGREE</b>	AUS, AUT, BEL, CAN, CZE, EST, IRL, ITA, JPN, KOR, LVA, LTU, MEX, NZL, PRT, ROU, SVK, ESP, TUR, GBR	BEL, CZE, EST, FRA, ITA, KOR, LVA, LTU, PRT, ESP, TUR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LVA, LTU, MEX, NZL, PRT, ROU, SVK, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, KOR, LVA, LTU, MEX, PRT, ROU, SVK, ESP, SWE, NLD, GBR	
<b>NA</b>		AUS, GBR			BEL, MEX, ESP

**Table A 1.2 Degree of debate at a national level concerning: a) problems that can arise from weak coordination of care; b) potential benefits from better coordination**

<b>[1C]</b>	<b>The health care system is unable to provide appropriate care at the appropriate time and place [1C1]</b>	<b>There is a lack of coordination and oversight in cases where care services are received from a variety of unrelated or weakly-related care settings [1C2]</b>	<b>There is a lack of a single health care professionals to oversee individual patients needs and to provide guidance on the most appropriate care pathway [1C3]</b>	<b>There is poor transfer of information between providers leading to, for example, duplication of tests etc. [1C4]</b>	<b>There is a lack of information for (and understanding of) patients about the most appropriate pathway for treatment of chronic or high-cost conditions [1C5]</b>	<b>There is inadequate encouragement of self-care by chronically-ill patients and an inadequate understanding of care options [1C6]</b>	<b>Greater care coordination can offset the impact of tighter supply by helping speed patients through the system [1C7]</b>
<b>HARDLY DEBATED</b>	AUT, BEL, CZE, FRA, SWE	BEL, CZE, EST, MEX, NZL, PRT, ROU, SVN, ESP, SWE	AUS, AUT, CZE, LTU, MEX, NZL, ROU, SVN, ESP	EST, LVA	AUS, AUT, EST, HUN, LVA, MEX, NZL, ROU, ESP, TUR	AUS, AUT, CZE, EST, FRA, HUN, IRL, LVA, LTU, ROU, SVN, SWE, TUR	AUS, AUT, DNK, EST, FRA, KOR, ROU, SVN, ESP
<b>REGULARLY DEBATED</b>	AUS, DNK, EST, IRL,ITA, LVA, LTU, MEX, NZL, PRT, SVK, SVN,GBR	AUS, CAN, DNK, HUN, IRL, ITA, KOR, LVA, SVK, NLD, TUR, GBR	CAN, DNK, HUN, IRL, KOR, PRT, SVK, SWE, NLD, TUR, GBR	AUS, CZE, DNK, IRL, KOR, PRT, ROU, SVK, SVN, SWE, NLD, TUR	CAN, CZE, DNK, IRL, KOR, LTU, SVK, SVN, SWE, NLD, GBR	CAN, DNK, ITA, KOR, MEX, NZL, SVK, ESP, NLD, GBR	BEL, CZE, IRL, ITA, MEX, NZL, PRT, SVK, NLD
<b>FREQUENTLY DEBATED</b>	CAN, HUN, JPN, KOR, ROU, ESP, NLD, TUR	AUT, FRA, JPN	BEL, EST, FRA, ITA, JPN, LVA	AUT, BEL, CAN, FRA, HUN, ITA, JPN, LTU, MEX, NZL, ESP, GBR	BEL, FRA, ITA, JPN, PRT	BEL, JPN, PRT	CAN, HUN, JPN, LVA, LTU, SWE, TUR, GBR
<b>NA</b>		<b>LTU</b>					

**Table A 1.3 Degree of awareness, at the level of local health authorities or care providers, concerning: a) problems that can arise from weak coordination of care; b) potential benefits from better coordination**

<b>[1D]</b>	<b>The health care system is unable to provide appropriate care at the appropriate time and place [1D1]</b>	<b>There is a lack of coordination and oversight in cases where care services are received from a variety of unrelated or weakly-related care settings [1D2]</b>	<b>There is a lack of a single health care professional to oversee individual patients needs and to provide guidance on the most appropriate care pathway [1D3]</b>	<b>There is poor transfer of information between providers leading to, for example, duplication of tests etc. [1D4]</b>	<b>There is a lack of information for (and understanding of) patients about the most appropriate pathway for treatment of chronic or high-cost conditions [1D5]</b>	<b>There is inadequate encouragement of self-care by chronically-ill patients and an inadequate understanding of care options [1D6]</b>	<b>Greater care coordination can offset the impact of tighter supply by helping speed patients through the system [1D7]</b>
<b>NOT AWARE</b>	AUT, CZE, EST, SWE, NLD	EST, PRT, ROU	CZE, MEX, ROU	ROU, NLD	EST, FRA, NZL, ROU, NLD, TUR	AUT, EST, FRA, HUN, ROU, SWE, NLD, TUR	KOR, ROU, SVN, NLD
<b>MODERATELY AWARE</b>	AUS, FRA, ITA, JPN, KOR, LVA, PRT, ROU, SVK, SVN	AUS, CZE, DNK, ITA, KOR, LTU, MEX, SVK, SVN, SWE, NLD	AUS, AUT, DNK, FRA, KOR, LTU, PRT, SVK, SWE, NLD, TUR	AUS, AUT, CZE, DNK, EST, FRA, LVA, LTU, PRT, SVK	AUS, AUT, CAN, CZE, DNK, KOR, SVK, SVN, SWE	AUS, CAN, CZE, DNK, ITA, KOR, LTU, SVK, SVN, ESP	AUS, AUT, CZE, DNK, EST, HUN, IRL, LTU, MEX, PRT, SVK, ESP, SWE
<b>MOSTLY AWARE</b>	CAN, DNK, HUN, IRL, LTU, MEX, NZL, ESP, TUR, GBR	AUT, CAN, FRA, HUN, IRL, JPN, LVA, NZL, ESP, TUR, GBR	CAN, EST, HUN, IRL, ITA, JPN, LVA, NZL, SVN, ESP, GBR	CAN, HUN, IRL, ITA, JPN, KOR, MEX, NZL, SVN, ESP, SWE, TUR, GBR	HUN, IRL, ITA, JPN, LVA, LTU, MEX, PRT, ESP, GBR	IRL, JPN, LVA, MEX, NZL, PRT, GBR	CAN, FRA, ITA, JPN, LVA, NZL, TUR, GBR
<b>NA</b>	<b>BEL</b>	<b>BEL</b>	<b>BEL</b>	<b>BEL</b>	<b>BEL</b>	<b>BEL</b>	<b>BEL</b>



**Table A1.4 In policy discussions, which of the following population groups are seen as likely to be the most affected by inadequate coordination of care**

[1E]	Children (<5 years old) [1E1]	Older workers (50 to 65) [1E2]	Retirement age (65 to 80) [1E3]	The very old (80+) [1E4]	Patients with chronic conditions/co-morbidities [1E5]
<b>NOT AFFECTED</b>	AUS, AUT, CZE, DNK, EST, FRA, HUN, MEX, NZL, PRT, ROU, SVN, ESP, SWE, NLD, GBR	AUT, BEL, CAN, CZE, EST, HUN, IRL, NZL, PRT, ROU, SVN, SWE	CZE, FRA, HUN, PRT, ROU, SWE	CZE, HUN, JPN, PRT	CZE, HUN, PRT
<b>MODERATELY AFFECTED</b>	IRL, ITA, JPN, KOR, SVK	AUS, DNK, FRA, ITA, JPN, KOR, LTU, ESP, NLD, GBR	BEL, EST, IRL, ITA, SVN	EST, ROU	EST, ROU
<b>MOSTLY AFFECTED</b>	BEL, CAN, LTU, TUR	MEX, SVK, TUR	AUS, AUT, CAN, DNK, JPN, KOR, LTU, MEX, NZL, SVK, ESP, NLD, TUR, GBR	AUS, AUT, BEL, CAN, DNK, FRA, IRL, ITA, KOR, LTU, MEX, NZL, SVK, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, BEL, CAN, DNK, FRA, IRL, ITA, JPN, KOR, LTU, MEX, NZL, SVK, SVN, ESP, SWE, NLD, TUR, GBR
NA	LVA	LVA	LVA	LVA	LVA

**Table A 1.5 Frequency that the following terms are used in policy discussions in your country that refer to efforts to coordinate care.**

[1F]	Care management [1F1]	Case management [1F2]	Continuing care [1F3]	Disease management [1F4]	Episodes of care [1F5]	Patient pathways [1F6]
<b>SELDOM</b>	AUS, AUT, BEL, DNK, IRL, JPN, NZL, SVK, SVN, SWE, NLD	BEL, DNK, FRA, LTU, PRT, SVK, SVN, SWE, TUR	AUS, HUN, SVK, SWE, NLD, TUR	AUT, SVK, SWE, TUR	AUT, CAN, DNK, JPN, SVK, SVN, NLD, TUR	AUS, CZE, EST, LTU, ROU, SVK
<b>MODERATELY FERQUENT</b>	ITA, KOR, LTU, ROU, ESP, GBR	AUS, AUT, KOR, ROU, ESP, NLD	AUT, DNK, EST, LTU, MEX, SVN	AUS, DNK, EST, IRL, KOR, LVA, LTU, ROU, SVN	AUS, BEL, FRA, IRL, KOR, LTU, PRT, ESP	AUT, IRL, JPN, PRT, NLD
<b>OFTEN</b>	CAN, CZE, EST, FRA, HUN, LVA, MEX, PRT, TUR	CAN, CZE, EST, HUN, IRL, ITA, JPN, LVA, MEX, NZL, GBR	BEL, CAN, CZE, FRA, IRL, ITA, JPN, KOR, LVA, NZL, PRT, ROU, ESP, GBR	BEL, CAN, CZE, FRA, HUN, ITA, JPN, MEX, NZL, PRT, ESP, NLD, GBR	CZE, EST, HUN, ITA, LVA, MEX, NZL, ROU, SWE, GBR	BEL, CAN, DNK, FRA, HUN, ITA, KOR, LVA, MEX, NZL, SVN, ESP, SWE, TUR, GBR
NA						

Table A 1.6 Degree of frequency to which the following coordination of care methods are used in your country (2A)

[2A]	Patients coordinate their care needs themselves [2A1]	Relatives and family members of the patient take a leading role in coordinating care [2A2]	A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care [2A3]	Ambulatory care specialists guide the patient through the system and coordinate care [2A4]	Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level [2A5]	A health care professional manages the discharges of patients from acute care to other care levels [2A6]	Insurers (particularly managed care) coordinate care -- e.g. through case management [2A7]
<b>SELDOM</b>	AUS, CAN, CZE, DNK, EST, HUN, ITA, JPN, SVK, GBR	AUS, CAN, CZE, DNK, FRA, HUN, ITA, JPN, KOR, SVK, SWE, NLD, GBR	KOR, SVN	AUS, AUT, BEL, CAN, DNK, FRA, HUN, ITA, NZL, SVN, ESP, SWE, NLD, GBR	GBR	SVN, ESP, SWE, GBR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LTU, PRT, ROU, SVK, SVN, SWE, NLD
<b>MODERATELY FREQUENT</b>	FRA, KOR, LTU, MEX, SVN, ESP, SWE, NLD	BEL, EST, LTU, MEX, NZL, SVN, ESP	AUS, CAN, CZE, DNK, FRA, HUN, LTU, NZL, GBR	CZE, EST, IRL, KOR, LTU	AUS, FRA, NZL	AUT, CAN, EST, FRA, ITA, KOR	MEX, NZL
<b>OFTEN</b>	AUT, BEL, IRL, LVA, NZL, PRT, ROU, TUR	AUT, IRL, LVA, PRT, ROU, TUR	AUT, BEL, EST, IRL, ITA, JPN, LVA, MEX, PRT, ROU, SVK, ESP, SWE, NLD, TUR	JPN, LVA, MEX, PRT, ROU, SVK, TUR	AUT, BEL, CAN, CZE, DNK, EST, HUN, IRL, ITA, PN, KOR, LVA, LTU, MEX, PRT, ROU, SVK, SVN, ESP, SWE, NLD, TUR	AUS, BEL, CZE, DNK, HUN, IRL, JPN, LVA, LTU, MEX, NZL, PRT, ROU, SVK, NLD, TUR	LVA, TUR
<b>NA</b>							ESP, GBR

[2A]	A health care professional routinely assesses patients needs and defines patient care plans [2A8]	Long term care is provided by multidisciplinary teams [2A9]	Case managers at local level are helping GPs and patients to find most appropriate care [2A10]	Doctors with admitting rights to hospitals coordinate episodes of care [2A11]	Information on medical records and patient needs is routinely transmitted between providers [2A12]	Care Coordination programmes to coordinate care are widely implemented (see Glossary) [2A13]	Integrated and coordinated care delivery occurs by chance only [2A14]
<b>SELDOM</b>	AUS, AUT, BEL, KOR, SVN, TUR, GBR	AUS, AUT, CAN, KOR, TUR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, ITA, KOR, LTU, NZL, ROU, SVK, SVN, ESP, NLD, TUR	AUS, AUT, BEL, CZE, DNK, EST, FRA, KOR, LTU, NZL, PRT, SVN, SWE, NLD, GBR	AUS, HUN, ITA, NZL, SVK, SVN, TUR, GBR	AUS, AUT, CAN, EST, FRA, IRL, ITA, JPN, KOR, LVA, LTU, NZL, SVN, ESP, NLD, GBR	AUS, CAN, CZE, DNK, EST, FRA, IRL, ITA, JPN, LVA, LTU, MEX, NZL, PRT, ESP, SWE, TUR, GBR
<b>MODERATELY FREQUENT</b>	CAN, FRA, MEX, NZL, ROU, ESP	BEL, EST, HUN, LTU, MEX, ROU, SVN, GBR	JPN, SWE, GBR	CAN, IRL, JPN	AUT, BEL, FRA, KOR, ROU, ESP	BEL, DNK, SVK	AUT, ROU, SVN, NLD
<b>OFTEN</b>	CZE, DNK, EST, HUN, ITA, JPN, LVA, LTU, PRT, SVK, SWE, NLD	CZE, DNK, FRA, ITA, JPN, LVA, NZL, PRT, SVK, ESP, SWE, NLD	LVA, MEX, PRT	HUN, ITA, LVA, MEX, ROU, SVK, TUR,	CAN, CZE, DNK, EST, IRL, JPN, LVA, LTU, MEX, PRT, SWE, NLD	CZE, MEX, PRT, ROU, SWE, TUR	BEL, KOR, SVK
<b>NA</b>	IRL	IRL	IRL, HUN	ESP		HUN	HUN

**Table A 1.7 Degree of frequency regarding the standard practice of coordination of care across care settings (2B1)**

[2B1]	Patients coordinate their care needs themselves (Interface between primary and ambulatory specialist care) [2B11]	Relatives and family members of the patient take a leading role in coordinating care (Interface between primary and ambulatory specialist care) [2B21]	A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care (Interface between primary and ambulatory specialist care) [2B31]	Ambulatory care specialists guide the patient through the system and coordinate care (Interface between primary and ambulatory specialist care) [2B41]	Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level (Interface between primary and ambulatory specialist care) [2B51]	A health care professional manages the discharges of patients from acute care to other care levels (Interface between primary and ambulatory specialist care) [2B61]	Insurers (particularly managed care) coordinate care – e.g. through case management (Interface between primary and ambulatory specialist care) [2B71]
<b>SELDOM</b>	AUS, CAN, CZE, EST, IRL, ITA, JPN, MEX, NZL, ESP, NLD, GBR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, MEX, NZL, SVK, SVN, ESP, SWE, NLD, GBR	BEL, SVN	AUS, AUT, BEL, CAN, CZE, DNK, FRA, HUN, IRL, ITA, KOR, ROU, SVK, SVN, ESP, SWE, NLD, GBR	AUT, CZE, DNK, EST, KOR, LTU, MEX, ROU, VN, ESP, TUR, GBR	AUT, CAN, CZE, FRA, LVA, LTU, MEX, ROU, VK, SVN, SWE, TUR, GBR	AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVK, SVN, SWE, NLD, TUR
<b>MODERATELY FREQUENT</b>	AUT, DNK, FRA, HUN, LTU, SVK, SWE	KOR, LVA, LTU	AUT, IRL, KOR, GBR	EST, NZL	BEL, CAN, PRT, SWE		BEL, MEX
<b>OFTEN</b>	BEL, KOR, LVA, PRT, ROU, SVN, TUR	PRT, ROU, TUR,	AUS, CAN, CZE, DNK, EST, FRA, TUN, ITA, JPN, LVA, LTU, MEX, NZL, PRT, ROU, SVK, ESP, SWE, NLD, TUR	JPN, LVA, MEX, PRT, TUR	AUS, IRL, JPN, LVA, SVK	AUS, DNK, EST, HUN, IRL, ITA, JPN, KOR, PRT, ESP	
<b>NA</b>				LTU	FRA, HUN, ITA, NZL, NLD	BEL, NZL, NLD	AUS, LVA, ESP, GBR

[2B1]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between primary and ambulatory specialist care) [2B81]	Long term care is provided by multidisciplinary teams (Interface between primary and ambulatory specialist care) [2B91]	Case managers at the local level are helping GPs and patients to find the most appropriate care (Interface between primary and ambulatory specialist care) [2B101]	Doctors with admitting rights to hospitals coordinate episodes of care (Interface between primary and ambulatory specialist care) [2B111]	Information on medical records and patient needs is routinely transmitted across providers (Interface between primary and ambulatory specialist care) [2B121]	Care Coordination programmes (see Glossary) to coordinate care are widely implemented (Interface between primary and ambulatory specialist care) [2B131]	Integrated and coordinated care delivery occurs by chance only (Interface between primary and ambulatory specialist care) [2B141]
<b>SELDOM</b>	AUS, AUT, CAN, FRA, KOR, SVN, GBR	AUS, AUT, CAN, CZE, EST, JPN, KOR, ROU, SVK, SVN, TUR, GBR	AUS, AUT, CAN, CZE, DNK, EST, ITA, JPN, KOR, LTU, NZL, ROU, SVK, SVN, ESP, NLD, TUR	AUS, AUT, BEL, CZE, DNK, HUN, JPN, KOR, LTU, MEX, ROU, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, ITA, NZL, SVN, TUR, GBR	AUS, AUT, CAN, CZE, IRL, JPN, KOR, VA,LTU, NZL, SVN, ESP, GBR	AUS, CZE, DNK, FRA, ITA, JPN, LVA, LTU, MEX, NZL, PRT, ROU, SVN, SWE, NLD, TUR, GBR
<b>MODERATELY FREQUENT</b>	HUN, NZL, ESP, NLD	DNK, LTU	BEL, GBR	CAN, EST, FRA	BEL, FRA, HUN, IRL, ROU	BEL, DNK, EST, ITA, SVK	BEL, CAN, EST, IRL
<b>OFTEN</b>	CZE, DNK, EST, ITA, JPN, LVA, LTU, MEX, PRT, ROU, SVK, SWE, TUR	HUN, ITA, MEX, PRT, SWE	LVA, MEX, PRT	IRL, LVA, NZL, PRT, SVK	CAN, CZE, DNK, EST, JPN, KOR, LVA, LTU, MEX, PRT, SVK, ESP, SWE, NLD	MEX, PRT, ROU, SWE, NLD, TUR	AUT, KOR, SVK
<b>NA</b>	BEL, IRL	BEL, FRA, IRL, LVA, NLD, ESP	FRA, HUN, IRL	ITA		FRA, HUN	HUN, ESP

Table A 1.8 Degree of frequency regarding the standard practice of coordination of care across care settings (2B2)

[2B2]	Patients coordinate their care needs themselves (Interface between primary and ambulatory and acute inpatient care) [2B12]	Relatives and family members of the patient take a leading role in coordinating care (Interface between primary and ambulatory and acute inpatient care) [2B22]	A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care (Interface between primary and ambulatory and acute inpatient care) [2B32]	Ambulatory care specialists guide the patient through the system and coordinate care (Interface between primary and ambulatory and acute inpatient care) [2B42]	Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level (Interface between primary and ambulatory and acute inpatient care) [2B52]	A health care professional manages the discharges of patients from acute care to other care levels (Interface between primary and ambulatory and acute inpatient care) [2B62]	Insurers (particularly managed care) coordinate care -- e.g. through case management (Interface between primary and ambulatory and acute inpatient care) [2B72]
<b>SELDOM</b>	AUS, AUT, CAN, CZE, DNK, EST, FRA, IRL, JPN, KOR, MEX, NZL, PRT, SVK, SVN, ESP, GBR	AUS, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, JPN, LVA, MEX, NZL, SVK, SVN, ESP, SWE, NZL, GBR	BEL, HUN, SVN	AUS, AUT, BEL, CAN, CZE, DNK, IRL, ITA, ESP, SWE, GBR	CZE, EST, LTU, MEX, ROU, ESP, TUR, GBR	AUT, CAN, CZE, FRA, LVA, LTU, MEX, ROU, SVK, SVN, SWE, TUR, GBR	AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVK, SVN, SWE, NZL, TUR
<b>MODERATELY FREQUENT</b>	BEL, HUN, ITA, LTU, SWE	AUT, ITA, KOR, LTU, PRT	AUS, AUT, IRL, KOR, PRT, NZL, GBR	EST, FRA, HUN, KOR, MEX, NZL, PRT	AUS, AUT, BEL, CAN, DNK, KOR, PRT, SVN, SWE		BEL, MEX
<b>OFTEN</b>	LVA, ROU, NZL, TUR	ROU, TUR	CAN, CZE, DNK, EST, FRA, ITA, JPN, LVA, LTU, MEX, NZL, ROU, SVK, ESP, SWE, TUR	JPN, LVA, ROU, SVK, SVN, NZL, TUR	IRL, JPN, LVA, SVK	AUS, DNK, EST, HUN, IRL, ITA, JPN, KOR, PRT, ESP	
<b>NA</b>				LTU	FRA, HUN, ITA, NZL	BEL, NZL	AUS, LVA, ESP, GBR

[2B2]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between primary and ambulatory specialist care and outpatient specialist care) [2B82]	Long term care is provided by multidisciplinary teams (Interface between primary and ambulatory specialist care and outpatient specialist care) [2B92]	Case managers at the local level are helping GPs and patients to find the most appropriate care (Interface between primary and ambulatory specialist care and outpatient specialist care) [2B102]	Doctors with admitting rights to hospitals coordinate episodes of care (Interface between primary and ambulatory specialist care and outpatient specialist care) [2B112]	Information on medical records and patient needs is routinely transmitted across providers (Interface between primary and ambulatory specialist care and outpatient specialist care) [2B122]	Care Coordination programmes (see Glossary) to coordinate care are widely implemented (Interface between primary and ambulatory specialist care and outpatient specialist care) [2B132]	Integrated and coordinated care delivery occurs by chance only (Interface between primary and ambulatory specialist care and outpatient specialist care) [2B142]
<b>SELDOM</b>	AUS, AUT, CAN, FRA, KOR, SVN, NLD, GBR	AUS, AUT, CZE, EST, JPN, KOR, LTU, ROU, SVK, SVN, TUR, GBR	AUS, AUT, CAN, CZE, DNK, EST, ITA, JPN, KOR, LTU, NZL, ROU, SVK, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, BEL, CZE, DNK, HUN, JPN, KOR, LTU, MEX, ROU, SVN, ESP, SWE, NLD, TUR, GBR	AUS, ITA, NZL, SVN, TUR, GBR	AUS, IRL, ITA, NZL, SVN, TUR, GBR	AUS, CZE, DNK, ITA, JPN, LVA, LTU, MEX, NZL, PRT, ROU, SVN, SWE, NLD, TUR, GBR
<b>MODERATELY FREQUENT</b>	CZE, HUN, MEX, NZL, ESP	CAN, DNK, MEX, NLD	BEL, MEX	CAN, EST, FRA	AUT, BEL, FRA, HUN, IRL, ROU	AUT, BEL, HUN, ROU	AUT, BEL, CAN, EST, FRA, IRL
<b>OFTEN</b>	DNK, EST, ITA, JPN, SVA, LTU, PRT, ROU, SVK, SWE, TUR	HUN, ITA, PRT, SWE	LVA, PRT	IRL, LVA, NZL, PRT, SVK	CAN, CZE, DNK, EST, JPN, KOR, LVA, LTU, MEX, PRT, SVK, ESP, SWE, NLD	CAN, CZE, DNK, EST, JPN, KOR, LVA, LTU, MEX, PRT, SVK, ESP, SWE, NLD	KOR, SVK
<b>NA</b>	BEL, IRL	BEL, FRA, IRL, LVA, NLD, ESP	FRA, HUN, IRL	ITA		FRA	HUN, ESP

Table A 1.9 Degree of frequency regarding the standard practice of coordination of care across care settings (2B3)

[2B3]	Patients coordinate their care needs themselves (Interface between primary and ambulatory and acute inpatient care) [2B13]	Relatives and family members of the patient take a leading role in coordinating care (Interface between primary and ambulatory and acute inpatient care) [2B23]	A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care (Interface between primary and ambulatory and acute inpatient care) [2B33]	Ambulatory care specialists guide the patient through the system and coordinate care (Interface between primary and ambulatory and acute inpatient care) [2B43]	Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level (Interface between primary and ambulatory and acute inpatient care) [2B53]	A health care professional manages the discharges of patients from acute care to other care levels (Interface between primary and ambulatory and acute inpatient care) [2B63]	Insurers (particularly managed care) coordinate care -- e.g. through case management (Interface between primary and ambulatory and acute inpatient care) [2B73]
<b>SELDOM</b>	AUS, AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, MEX, NZL, PRT, SVK, SVN, ESP, NZL, TUR, GBR	AUS, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, LVA, MEX, NZL, PRT, SVK, SVN, ESP, SWE, NZL, TUR, GBR	AUS, AUT, NZL, PRT, SVN, NZL	AUS, AUT, AN, IRL, PRT, SWE, GBR	AUT, PRT, GBR,	AUT, CZE, ITA, ROU, SVN, SWE, GBR	AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVK, SVN, SWE, NZL, TUR
<b>MODERATELY FREQUENT</b>	BEL, KOR, LTU, SWE	AUT, LTU	BEL, CAN, DNK, FRA, IRL, ESP, GBR	BEL, EST	AUS, EST, SVN, ESP, SWE	CAN, JPN, ESP	
<b>OFTEN</b>	LVA, ROU	KOR, ROU	CZE, EST, HUN, ITA, JPN, KOR, LVA, LTU, MEX, ROU, SVK, SWE, TUR	CZE, DNK, FRA, HUN, ITA, JPN, KOR, LVA, MEX, NZL, ROU, SVK, SVN, ESP, NZL, TUR	CAN, CZE, DNK, FRA, HUN, IRL, JPN, KOR, LVA, LTU, MEX, ROU, SVK, NZL, TUR	AUS, DNK, EST, FRA, HUN, IRL, KOR, LVA, LTU, MEX, PRT, SVK, NZL, TUR	MEX
<b>NA</b>				LTU	BEL, ITA, NZL	BEL, NZL	AUS, LVA, E SP, GBR

[2B3]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between primary and ambulatory and acute inpatient care) [2B83]	Long term care is provided by multidisciplinary teams (Interface between primary and ambulatory and acute inpatient care) [2B93]	Case managers at the local level are helping GPs and patients to find the most appropriate care (Interface between primary and ambulatory and acute inpatient care) [2B103]	Doctors with admitting rights to hospitals coordinate episodes of care (Interface between primary and ambulatory and acute inpatient care) [2B113]	Information on medical records and patient needs is routinely transmitted across providers (Interface between primary and ambulatory and acute inpatient care) [2B123]	Care Coordination programmes (see Glossary) to coordinate care are widely implemented (Interface between primary and ambulatory and acute inpatient care) [2B133]	Integrated and coordinated care delivery occurs by chance only (Interface between primary and ambulatory and acute inpatient care) [2B143]
<b>SELDOM</b>	AUS, AUT, FRA, KOR, SVN, NLD, GBR	AUS, AUT, CAN, CZE, EST, JPN, KOR, ROU, SVN, TUR, GBR	AUS, AUT, CAN, CZE, DNK, EST, ITA, JPN, KOR, LTU, NZL, ROU, SVK, SVN, ESP, SWE, NLD, TUR	AUT, BEL, DNK, JPN, LTU, PRT, ROU, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, ITA, SVN, NLD, GBR	AUS, AUT, CAN, CZE, IRL, JPN, KOR, LVA, LTU, SVN, ESP, GBR	AUS, CAN, CZE, DNK, ITA, JPN, LVA, LTU, MEX, NZL, PRT, ROU, SVN, SWE, NLD, TUR, GBR
<b>MODERATELY FREQUENT</b>	BEL, HUN, MEX, NZL, ESP	LTU, MEX, NZL, SVK	MEX, GBR	AUS, CZE, EST, FRA, KOR	BEL, CAN, FRA, HUN, ROU	BEL, DNK, EST, ITA, NZL, PRT, SVK	BEL, EST, FRA, IRL, SVK
<b>OFTEN</b>	CAN, CZE, DNK, EST, ITA, JPN, LVA, LTU, PRT, ROU, SVK, SWE, TUR	DNK, HUN, ITA, PRT, SWE	LVA, PRT	CAN, HUN, IRL, LVA, MEX, NZL, SVK	CZE, DNK, EST, IRL, KOR, LVA, LTU, MEX, NZL, PRT, SVK, ESP, SWE, TUR	MEX, ROU, SWE, NLD, TUR	AUT, KOR
<b>NA</b>	IRL	BEL, FRA, LVA, ESP, NLD	BEL, FRA, HUN, IRL	ITA		FRA, HUN	HUN, ESP

Table A1.10 Degree of frequency regarding the standard practice of coordination of care across care settings (2B4)

[2B4]	Patients coordinate their care needs themselves (Interface between ambulatory and long-term care) [2B14]	Relatives and family members of the patient take a leading role in coordinating care (Interface between ambulatory and long-term care) [2B24]	A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care (Interface between ambulatory and long-term care) [2B34]	Ambulatory care specialists guide the patient through the system and coordinate care (Interface between ambulatory and long-term care) [2B44]	Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level (Interface between ambulatory and long-term care) [2B54]	A health care professional manages the discharges of patients from acute care to other care levels (Interface between ambulatory and long-term care) [2B64]	Insurers (particularly managed care) coordinate care – e.g. through case management (Interface between ambulatory and long-term care) [2B74]
<b>SELDOM</b>	AUS, AUT, CZE, DNK, EST, FRA, IRL, JPN, KOR, LTU, MEX, PRT, SVK, ESP, NZL, GBR	AUS, CZE, DNK, EST, IRL, JPN, KOR, LVA, LTU, MEX, PRT, SVK, ESP, SWE, GBR	AUS, DNK, FRA, KOR, PRT, SVK, NZL, TUR, GBR	AUS, AUT, BEL, CAN, CZE, FRA, IRL, ITA, LVA, PRT, SVN, SWE, TUR, GBR	AUS, CZE, LTU, PRT, ROU, ESP, TUR, GBR	AUT, CZE, ITA, LTU, ROU, ESP, SWE, GBR	AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVK, SVN, SWE, NZL, TUR
<b>MODERATELY FREQUENT</b>	BEL, CAN, ITA, NZL, SVN, SWE	CAN, ITA, NZL, SVN, NZL	AUT, BEL, CAN, EST, IRL, NZL, ESP	DNK, EST, KOR, SVK, ESP	AUT, CAN, EST, FRA, HUN, KOR, SWE	CAN, JPN	
<b>OFTEN</b>	HUN, LVA, ROU, TUR	AUT, BEL, FRA, HUN, ROU, TUR	CZE, HUN, ITA, JPN, LVA, LTU, MEX, ROU, SVN, SWE	HUN, JPN, MEX, NZL, ROU, NZL	DNK, IRL, JPN, LVA, MEX, SVK, SVN	AUS, DNK, EST, FRA, HUN, IRL, KOR, LVA, MEX, PRT, SVK, SVN, TUR	<b>MEX</b>
<b>NA</b>				LTU	FRA, HUN, ITA, NZL	BEL, NZL	AUS, BEL, LVA, ESP, GBR

[2B4]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between ambulatory and long-term care) [2B84]	Long term care is provided by multidisciplinary teams (Interface between ambulatory and long-term care) [2B94]	Case managers at the local level are helping GPs and patients to find the most appropriate care (Interface between ambulatory and long-term care) [2B104]	Doctors with admitting rights to hospitals coordinate episodes of care (Interface between ambulatory and long-term care) [2B114]	Information on medical records and patient needs is routinely transmitted across providers (Interface between ambulatory and long-term care) [2B124]	Care Coordination programmes (see Glossary) to coordinate care are widely implemented (Interface between ambulatory and long-term care) [2B134]	Integrated and coordinated care delivery occurs by chance only (Interface between ambulatory and long-term care) [2B144]
<b>SELDOM</b>	AUT, KOR, GBR	AUS, AUT, BEL, CAN, FRA, ITA, KOR, GBR	AUS, AUT, CZE, DNK, EST, ITA, KOR, LTU, NZL, ROU, SVK, ESP, SWE, TUR, GBR	AUS, AUT, BEL, DNK, FRA, JPN, KOR, LTU, ROU, SVN, ESP, SWE, NLD, TUR, GBR	AUT, ITA, NZL, NLD, GBR	AUS, AUT, CZE, KOR, LVA, LTU, NZL, SVN, ESP, TUR	AUS, CAN, CZE, DNK, FRA, IRL, ITA, JPN, LVA, LTU, MEX, NZL, PRT, SVK, SWE, NLD, TUR, GBR
<b>MODERATELY FREQUENT</b>	CAN, CZE, DNK, HUN, MEX, NZL, SVN, ESP, NLD	EST, JPN, MEX, SVN, NLD	CAN, FRA, MEX, SVN	CAN, EST, IRL, PRT	AUS, BEL, CAN, FRA, HUN, KOR, ROU, ESP	BEL, CAN, DNK, EST, ITA, PRT, SVK, NLD, GBR	AUT, BEL, EST
<b>OFTEN</b>	AUS, EST, FRA, ITA, JPN, LVA, LTU, PRT, ROU, SVK, SWE, TUR	CZE, DNK, HUN, LTU, PRT, ROU, SVK, SWE, TUR	JPN, LVA, PRT, NLD	CZE, HUN, VA, MEX, SVK	CZE, DNK, EST, IRL, JPN, LVA, LTU, MEX, PRT, SVK, SVN, SWE, TUR	IRL, JPN, MEX, ROU, SWE	<b>KOR, ROU, SVK</b>
<b>NA</b>	BEL, IRL	IRL, LVA, NZL, ESP	BEL, HUN, IRL	ITA, NZL		FRA, HUN	HUN, ESP

Table A 1.11 Degree of frequency regarding the standard practice of coordination of care across care settings (2B5)

[2B5]	Patients coordinate their care needs themselves (Interface between acute inpatient care and long-term care) [2B15]	Relatives and family members of the patient take a leading role in coordinating care (Interface between acute inpatient care and long-term care) [2B25]	A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care (Interface between acute inpatient care and long-term care) [2B35]	Ambulatory care specialists guide the patient through the system and coordinate care (Interface between acute inpatient care and long-term care) [2B45]	Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level (Interface between acute inpatient care and long-term care) [2B55]	A health care professional manages the discharges of patients from acute care to other care levels (Interface between acute inpatient care and long-term care) [2B65]	Insurers (particularly managed care) coordinate care -- e.g. through case management (Interface between acute inpatient care and long-term care) [2B75]
<b>SELDOM</b>	AUS, CAN, CZE, DNK, EST, FRA, IRL, JPN, KOR, LTU, MEX, NZL, PRT, SVK, SVN, ESP, TUR, GBR	AUS, CZE, DNK, EST, IRL, JPN, KOR, LVA, LTU, MEX, NZL, PRT, SVK, ESP, SWE, NZL, TUR, GBR	AUS, BEL, CAN, CZE, DNK, FRA, HUN, JPN, KOR, LTU, NZL, PRT, ROU, SVK, NZL, TUR, GBR	AUS, AUT, BEL, CAN, CZE, NK, FRA, HUN, IRL, ITA, LVA, PRT, ROU, SVK, SVN, SWE, TUR, GBR	AUS, CZE, LTU, NZL, PRT, GBR	AUT, LTU, SWE, GBR	AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVK, SVN, SWE, NZL, TUR
<b>MODERATELY FREQUENT</b>	AUT, BEL, HUN, ITA, SWE, NZL	AUT, CAN, ITA,	AUT, EST, IRL, ESP	KOR, MEX, NZL, ESP, NZL	AUT, EST, FRA, HUN, KOR, ESP, SWE	BEL, NZL, ESP	
<b>OFTEN</b>	LVA, ROU	BEL, FRA, HUN, ROU, SVN	ITA, LVA, MEX, SVN, SWE	EST, JPN	CAN, DNK, IRL, JPN, LVA, MEX, ROU, SVK, SVN, NZL, TUR,	AUS, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LVA, MEX, PRT, ROU, SVK, VN, NZL, TUR	<b>MEX</b>
<b>NA</b>				LTU	BEL, ITA		AUS, BEL, LVA, ESP, GBR

[2B5]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between acute inpatient care and long-term care) [2B85]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between acute inpatient care and long-term care) [2B95]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between acute inpatient care and long-term care) [2B105]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between acute inpatient care and long-term care) [2B115]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between acute inpatient care and long-term care) [2B125]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between acute inpatient care and long-term care) [2B135]	A health care professional routinely assesses patients needs and defines patient care plans (Interface between acute inpatient care and long-term care) [2B145]
<b>SELDOM</b>	KOR, GBR	AUT, ITA, KOR, LTU, GBR	AUS, AUT, CZE, DNK, EST, ITA, KOR, LTU, NZL, ROU, SVK, ESP, SWE, TUR	AUS, AUT, BEL, DNK, FRA, IRL, JPN, KOR, LTU, SVN, ESP, SWE, NLD, GBR	AUT, NZL, NLD, GBR	AUS, AUT, CZE, IRL, KOR, LVA, LTU, NZL, SVN, ESP	AUS, CAN, CZE, DNK, FRA, IRL, ITA, JPN, LVA, LTU, MEX, NZL, PRT, SVN, SWE, NLD, TUR, GBR
<b>MODERATELY FREQUENT</b>	AUT, BEL, CZE, HUN, NZL, ESP	AUS, BEL, CAN, EST, FRA, JPN, NZL, SVN, NLD	CAN, PRT, SVN, GBR	CAN, EST, HUN, NZL, PRT	AUS, BEL, FRA, KOR	BEL, CAN, DNK, EST, ITA, PRT, SVK, NLD, GBR	<b>BEL, EST, ROU</b>
<b>OFTEN</b>	AUS, CAN, DNK, EST, FRA, ITA, JPN, LVA, LTU, MEX, PRT, ROU, SVK, SVN, SWE, NLD, TUR	CZE, DNK, HUN, MEX, PRT, ROU, SVK, SWE, TUR	JPN, LVA, MEX, NLD	CZE, LVA, MEX, ROU, SVK, TUR	CAN, CZE, DNK, EST, HUN, IRL, ITA, JPN, LVA, LTU, MEX, PRT, ROU, SVK, SVN, ESP, SWE, TUR	JPN, MEX, ROU, SWE, TUR	<b>AUT, KOR, SVK</b>
<b>NA</b>	IRL	IRL, LVA, ESP	BEL, HUN, IRL	ITA		FRA, HUN	HUN, ESP

Table A 1.12 Frequency with which patients tend to enter the health care system at different points

<b>[2C]</b>	<b>Patients enter at primary care level (GP as gatekeeper) [2C1]</b>	<b>Patients see an ambulatory specialist at any time without consulting a primary care provider [2C2]</b>	<b>Patients visit an outpatient emergency ward at any time without consulting a primary care provider [2C3]</b>	<b>Patients go to emergency outpatient wards because of a shortage of ambulatory care providers [2C4]</b>	<b>Patients go to emergency outpatient ward because access to ambulatory care provider is inconvenient [2C5]</b>	<b>Patients go to emergency outpatient ward because it is cheaper than other care options [2C6]</b>	<b>Patients enter acute inpatient care because of a shortage of long-term-care facilities, nursing care or home care [2C7]</b>	<b>Patients see any provider at any level of care at any time without referrals [2C8]</b>	<b>Insurers or other payers determine where patients enter health-care system [2C9]</b>
<b>SELDOM</b>		AUS, CAN, DNK, EST, FRA, IRL, ITA, LVA, MEX, NZL, PRT, SVN, ESP, SWE, NLD, GBR	BEL, DNK, HUN, IRL, SVN, SWE, NLD, GBR	AUS, BEL, CZE, DNK, EST, FRA, HUN, IRL, JPN, LVA, NZL, SVK, SVN, SWE, NLD, TUR, GBR	AUS, AUS, BEL, CZE, DNK, EST, FRA, IRL, LVA, PRT, SVK, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, BEL, CAN, DNK, FRA, HUN, IRL, ITA, NZL, SVN, ESP, SWE, NLD, GBR	AUS, BEL, CAN, CZE, DNK, FRA, IRL, LVA, LTU, MEX, NZL, PRT, ESP, SWE, NLD, GBR	AUS, CAN, CZE, DNK, EST, FRA, IRL, ITA, LVA, LTU, MEX, NZL, PRT, ROU, SVK, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LVA, LTU, MEX, PRT, ROU, SVK, SWE, NLD
<b>MODERATELY FREQUENT</b>	TUR	AUT, BEL, CZE, HUN, ROU, TUR	EST, PRT	CAN, ITA, PRT, ROU, ESP	AUT, CAN, HUN, ITA, JPN, MEX, NZL, ROU	CZE, EST, KOR, LTU	AUT, EST, ITA, JPN, SVK, SVN	AUT, HUN	NZL
<b>OFTEN</b>	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LVA, LTU, MEX, NZL, PRT, ROU, SVK, SVN, ESP, SWE, NLD, GBR	JPN, KOR, SVK	AUS, AUT, CAN, CZE, FRA, ITA, JPN, KOR, LVA, MEX, NZL, ROU, SVK, ESP, TUR	AUT, KOR, MEX	KOR	JPN, LVA, MEX, PRT, ROU, SVK, TUR	HUN, KOR, ROU, TUR	BEL, JPN	SVN, TUR
<b>NA</b>		LTU	LTU	LTU	LTU			KOR	ESP, GBR



**Table A 1.13 Frequency of referrals to the various levels of care**

[2D]	Primary care providers (GPs) refer patients to ambulatory care specialists [2D1]	Primary care providers (GPs) refer patients to hospital outpatients services [2D2]	Ambulatory care providers refer patients to hospitals [2D3]	Hospitals refer patients back to primary care providers [2D4]	Hospitals refer patients back to ambulatory care specialists [2D5]	Insurers or other payers determine referral practice [2D6]	Hospitals refer patients to long-term-care facilities [2D7]	Patients refer themselves [2D8]
<b>SELDOM</b>	IRL, KOR, NLD, GBR	AUS, AUT, EST, FRA, KOR, ESP, GBR	AUS, BEL, EST, FRA, IRL, KOR, NLD, GBR	AUS, EST, KOR, ROU, TUR, GBR	AUT, BEL, EST, FRA, IRL, ITA, KOR, NZL, ROU, SWE, TUR, GBR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, IRL, ITA, JPN, KOR, LVA, LTU, MEX, NZL, PRT, ROU, SWE, NLD	AUS, DNK, EST, ITA, KOR, LTU, MEX, ROU, SVN, ESP, GBR	AUS, CAN, CZE, DNK, EST, FRA, IRL, ITA, JPN, LVA, LTU, MEX, PRT, SVK, SVN, ESP, SWE, NLD, TUR, GBR
<b>MODERATELY FREQUENT</b>	AUT, BEL, CZE, DNK, MEX, NZL	BEL, CAN, CZE, HUN, MEX, SVK, SVN	CAN, CZE, DNK, MEX, NZL, ROU, SWE	BEL, CZE, JPN, MEX, ESP, SWE, NLD	AUS, CZE, DNK, HUN, JPN, MEX, PRT, SVK, NLD	SVK	AUT, CAN, HUN, NZL, SVK	AUT, KOR, ROU
<b>OFTEN</b>	AUS, CAN, EST, FRA, HUN, ITA, JPN, SVA, PRT, ROU, SVK, SVN, ESP, SWE, TUR	DNK, IRL, ITA, JPN, LVA, LTU, NZL, PRT, ROU, SWE, NLD, TUR	AUT, HUN, ITA, JPN, LVA, PRT, SVK, SVN, ESP, TUR	AUT, CAN, DNK, FRA, HUN, IRL, ITA, LVA, LTU, NZL, PRT, SVK, SVN	CAN, LVA, SVN, ESP	HUN, SVN, ESP, TUR	CZE, FRA, IRL, JPN, PRT, SWE, NLD, TUR	BEL
<b>NA</b>	LTU		LTU		LTU	GBR	LVA	HUN, NZL

**Table A 1.14 Agreement/disagreement as to where problems of coordination of care occur in the health care system**

[3A]	Problems occur within the ambulatory care sector (primary care and ambulatory specialists) [3A1]	Problems occur within acute inpatient care [3A2]	Problems occur within long-term care (nursing care and home care) [3A3]	Problems occur at the interface between ambulatory and outpatient (emergency) care [3A4]	Problems occur at the interface between ambulatory and acute inpatient care [3A5]	Problems occur at the interface between outpatient (or emergency) care and long-term care [3A6]	Problems occur at the interface between ambulatory and long-term care [3A7]	Problems occur at the interface between acute inpatient care and long-term care [3A8]	Problems occur because of waiting lists that prevent timely access to care at the specialist, acute hospital or nursing care level [3A9]
<b>DISAGREE</b>	BEL, CZE, DNK, ITA, JPN, PRT, SVN, NLD, TUR	BEL, CZE, EST, ITA, JPN, MEX, PRT, SVN, SWE, TUR	CZE, DNK, ITA, JPN, NZL, SVN, SWE, NLD	BEL, CZE, HUN, JPN, PRT, ROU, SWE, NLD, TUR	BEL, CZE, ITA, ROU, SWE, TUR	BEL, ROU, TUR	NZL, PRT, ROU, SWE, TUR	TUR	BEL, CZE, FRA, JPN, KOR, ESP, TUR
<b>NEITHER AGREE OR DISAGREE</b>	AUS, EST, IRL, ROU, SWE	AUS, AUT, DNK, LTU, ROU, NLD	AUS, AUT, BEL, FRA, PRT, TUR, GBR	AUS, AUT, DNK, FRA, IRL, ITA, NZL, SVN, GBR	AUS, LVA, NZL, NLD	AUS, AUT, DNK, SWE	AUS, BEL, DNK	AUS, PRT, NLD	AUS, DNK, SWE, NLD, GBR
<b>AGREE</b>	AUT, CAN, FRA, KOR, LVA, LTU, MEX, NZL, SVK, ESP, GBR	CAN, FRA, IRL, KOR, LVA, NZL, SVK, ESP, GBR	CAN, EST, IRL, KOR, LVA, LTU, MEX, SVK, ESP	CAN, EST, KOR, LVA, LTU, MEX, SVK, ESP	AUT, CAN, DNK, EST, FRA, IRL, JPN, KOR, LTU, MEX, PRT, SVK, SVN, ESP, GBR	CAN, CZE, EST, FRA, IRL, ITA, JPN, KOR, LVA, LTU, MEX, NZL, PRT, SVK, SVN, ESP, NLD, GBR	AUT, CAN, CZE, EST, FRA, IRL, ITA, JPN, KOR, LVA, LTU, MEX, SVK, SVN, ESP, NLD, GBR	AUT, BEL, CAN, CZE, DNK, EST, FRA, IRL, ITA, JPN, KOR, LVA, LTU, MEX, ZL, ROU, SVK, SVN, SWE, GBR	AUT, CAN, EST, ITA, LVA, LTU, NZL, PRT, SVK, SVN
<b>NA</b>	HUN	HUN	HUN, ROU		HUN	HUN	HUN	HUN	HUN, IRL

**Table A 1.15 Degree of agreement regarding whether current divisions of administrative responsibilities for health care affect efforts to coordinate care in your country**

<b>[3B]</b>	<b>Policy setting in the area of care coordination is hindered by the lack of a single institution overseeing all aspects of public health-care policy [3B1]</b>	<b>Coordination of care is impeded by vertical dispersion of responsibility for providing care between different levels of government (e.g. primary and/or long-term care at the local level and hospital care at the regional or national level) [3B2]</b>	<b>Coordination of care is hindered by the organisation of care within narrow geographical areas (e.g. cantons, lander, states/provinces) with weak links between them [3B3]</b>	<b>Bodies or institutions with the potential to introduce coordinated care policies lack information about performance of providers in terms of quality and cost efficiency [3B4]</b>	<b>The presence of competing multiple payers and providers reduces the incentives for payers to contract with providers to enhance care coordination [3B6]</b>
<b>DISAGREE</b>	CZE, DNK, IRL, JPN, PRT, ROU, ESP, NLD, TUR, GBR	CZE, EST, ITA, JPN, ROU, SVK, ESP, TUR, GBR	BEL, CZE, DNK, EST, JPN, KOR, LTU, ROU, SVK, SVN, NLD, TUR	CZE, PRT, SVK, GBR	CAN, DNK, HUN, IRL, ITA, JPN, KOR, MEX, ROU, ESP, SWE, TUR, GBR
<b>NEITHER AGREE OR DISAGREE</b>	AUS, CAN, EST, HUN, KOR, SVK, SWE	AUS, CAN, DNK, KOR	AUS, FRA, HUN, IRL, ITA, MEX, ESP, SWE, GBR	AUS, DNK, HUN, ITA, LVA, LTU, SVN, NLD	AUS, EST, LVA, LTU, NZL, SVK, SVN, NLD
<b>AGREE</b>	AUT, BEL, FRA, ITA, LVA, LTU, MEX, NZL, SVN	AUT, BEL, FRA, HUN, IRL, LVA, LTU, MEX, NZL, PRT, SVN, SWE, NLD	AUT, CAN, LVA, NZL, PRT	AUT, BEL, CAN, EST, FRA, IRL, JPN, KOR, MEX, NZL, ROU, ESP, SWE, TUR	AUT, BEL, CZE, PRT
<b>NA</b>					FRA

**Table A 1.16 Frequency of occurrence of current arrangement that may generate incentives for care coordination**

<b>[3C]</b>	<b>Arrangements to provide care designate one provider as care coordinator (e.g. gatekeeper) [3C1]</b>	<b>Arrangements to provide care include explicit payments for care coordination for primary care physicians (e.g. incentive payments) [3C2]</b>	<b>Arrangements to provide care include explicit payments for care coordination by other (non-GP) providers (e.g. at the level of ambulatory-care specialists or hospitals) [3C3]</b>	<b>Arrangements to provide care include a budget for the care coordinator to purchase necessary care for patients [3C4]</b>	<b>Arrangements to provide care allow or encourage the formation of group practices or multidisciplinary care models [3C5]</b>
<b>SELDOM</b>	AUS, AUT, CAN, CZE, DNK, JPN, KOR, SVK, SVN, ESP	AUS, AUT, CAN, DNK, IRL, KOR, LTU, MEX, PRT, ROU, SVN, ESP, SWE, NLD, GBR	AUS, AUT, CAN, CZE, DNK, EST, IRL, ITA, JPN, KOR, LTU, MEX, NZL, PRT, ROU, SVN, ESP, SWE, GBR	AUS, AUT, CAN, CZE, DNK, EST, FRA, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, BEL, CAN, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, MEX, PRT, SVN, NLD, TUR
<b>MODERATELY FREQUENT</b>	IRL, NZL, PRT, SWE, GBR	NZL	NLD		LTU, NZL, ROU, SVK, ESP, SWE, GBR
<b>OFTEN</b>	EST, ITA, LVA, LTU, MEX, ROU, NLD, TUR	CZE, EST, FRA, ITA, JPN, LVA, SVK, TUR	FRA, LVA, SVK, TUR	LVA, SVK	CZE, LVA
<b>NA</b>	<b>BEL, FRA, HUN</b>	<b>BEL, HUN</b>	<b>BEL, HUN</b>	<b>BEL, HUN</b>	

**Table A 1.17 Frequency of the following arrangements that may facilitate care coordination in your country**

<b>[3D]</b>	<b>Arrangements to provide and pay for care include stipulations regarding quality goals [3D1]</b>	<b>Information on the quality of service delivery is regularly disseminated among providers [3D2]</b>	<b>Providers and payers are equipped with IT so as to encourage communication of patient information amongst themselves [3D3]</b>	<b>A patients file in electronic format exists and contains medical information about the patient [3D4]</b>	<b>Payers selectively contract with providers on the basis of the capacity to coordinate care or to provide coordinated care [3D5]</b>	<b>Contractual arrangements to provide care target the promotion of cooperation among providers as an explicit objective [3D6]</b>
<b>SELDOM</b>	AUS, AUT, CAN, DNK, EST, FRA, HUN, IRL, KOR, LTU, MEX, NZL, PRT, ROU, SVK, SWE, NLD, TUR	AUS, AUT, BEL, CAN, EST, FRA, HUN, IRL, ITA, KOR, MEX, NZL, ROU, SVK, SWE, TUR, GBR	AUS, CAN, CZE, FRA, IRL, ITA, KOR, LTU, ROU, SVN, ESP, SWE, NLD, TUR	AUS, CAN, IRL, ITA, LTU, MEX, NZL, PRT, ROU, SVK, SVN, TUR, GBR	AUS, AUT, BEL, CAN, CZE, NK,FRA, IRL, ITA, JPN, KOR, LTU, MEX, NZL, PRT, ROU, SVK, SVN, ESP, SWE, NLD, TUR, GBR	AUS, AUT, CAN, DNK, IRL, KOR, LTU, MEX, PRT, ROU, SVK, SVN, SWE, NLD, TUR, GBR
<b>MODERATELY FREQUENT</b>	BEL, CZE, ITA, SVN	DNK, JPN, PRT, SVN, NLD	AUT, DNK, EST, NZL, PRT, SVK, GBR	AUT, DNK, EST, FRA, KOR		BEL, ITA, JPN, NZL
<b>OFTEN</b>	JPN, LVA, GBR	CZE, LVA, LTU	BEL, HUN, JPN, LVA	BEL, CZE, HUN, JPN, LVA, SWE, NLD	EST, LVA	CZE, EST, FRA, LVA
<b>NA</b>	ESP	ESP		ESP	HUN	HUN, ESP

**Table A 1.18 Degree of agreement as to which regulations on the scope of permitted activities of health-care professionals currently affect efforts to coordinate care**

<b>[3E]</b>	<b>There are professional or regulatory barriers between doctors practicing in the ambulatory and the hospital sector (e.g. the sharp division of responsibility between the two sectors in Germany) [3E1]</b>	<b>Other health-care professionals than doctors (e.g. nurses) are actively involved in organising/ensuring care coordination [3E2]</b>	<b>The scope of care coordination is limited by inadequate numbers of doctors and other health care professionals at the primary care level [3E3]</b>	<b>Your country explicitly defines the role of primary care doctors as gatekeepers and ascribes coordination of care to them [3E4]</b>	<b>Your country permits primary-care doctors or ambulatory-care specialists to practice inside the hospital/nursing home [3E5]</b>	<b>There are wide enough professional profiles (scope of practice rules) of non-medical primary-care providers (e.g. nurses) to permit them to undertake coordination of care [3E6]</b>	<b>Primary care providers and providers of long-term care services enjoy an equally high professional esteem as health professionals working in acute hospital care environments [3E7]</b>
<b>DISAGREE</b>	BEL, CAN, CZE, DNK, EST, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVN, SWE, GBR	FRA, KOR, ROU	BEL, CZE, EST, FRA, HUN, ITA, JPN, NZL, PRT, ROU, SVK, SWE, NLD, TUR, GBR	AUT, CZE, JPN, KOR	AUT, CZE, DNK, EST, HUN, ITA, KOR, MEX, NZL, PRT, ROU	AUT, EST, HUN, IRL, KOR, LTU, ROU, SVK, SVN, TUR	FRA, HUN, IRL, ITA, KOR, NZL, ROU, SVK, SVN, ESP, SWE, NLD, TUR
<b>NEITHER AGREE OR DISAGREE</b>	AUS, LVA, TUR	AUS, BEL, EST, LVA, LTU, MEX	AUS, AUT, CAN, DNK, KOR, LVA, LTU, ESP	AUS, DNK, IRL, SWE	AUS	AUS, CAN, CZE, DNK, FRA, JPN, MEX, NLD	AUS, AUT, BEL, CAN, DNK, EST, LVA, LTU, GBR
<b>AGREE</b>	AUT, FRA, MEX, SVK, ESP, NLD	AUT, CAN, CZE, DNK, IRL, ITA, JPN, NZL, PRT, SVK, SVN, ESP, SWE, NLD, TUR, GBR	IRL, MEX, SVN,	BEL, CAN, EST, FRA, HUN, ITA, LVA, LTU, MEX, NZL, PRT, ROU, SVK, SVN, ESP, NLD, TUR, GBR	BEL, CAN, FRA, IRL, JPN, LTU, SVK, SVN, SWE, NLD, TUR, GBR	ITA, LVA, NZL, PRT, ESP, SWE, GBR	CZE, JPN, MEX, PRT
<b>NA</b>	HUN,	HUN			LVA, ESP	BEL	

**Table A 1.19 Degree of agreement/disagreement as to why existing care coordination policies were introduced**

<b>[4B]</b>	<b>Care Coordination policies were implemented to improve and/or sustain physical access to care [4B1]</b>	<b>Care Coordination policies were implemented to improve and/or sustain insurance coverage [4B2]</b>	<b>Coordination policies were implemented to improve and monitor the quality of care (impact on health outcomes) and responsiveness to patient needs [4B3]</b>	<b>Coordination policies were implemented to raise the level of cost efficiency in health care delivery [4B4]</b>	<b>Care Coordination policies were implemented without any relation to specific health system goals [4B6]</b>
<b>DISAGREE</b>	KOR, SVN, SWE, NLD	AUS, AUT, CAN, DNK, EST, HUN, IRL, ITA, SWE	CZE, KOR, ROU, SVN	AUT, CZE, KOR, TUR	AUS, AUT, CAN, DNK, EST, FRA, HUN, IRL, ITA, JPN, LTU, MEX, NZL, PRT, ROU, ESP, NLD, TUR, GBR
<b>NEITHER AGREE OR DISAGREE</b>	AUS, AUT, DNK, EST, HUN, SVK	JPN, KOR, PRT, SVK, SVN	AUT, MEX, SVK	AUS, ROU, SVK	SVK, SVN
<b>AGREE</b>	BEL, CAN, CZE, FRA, IRL, ITA, JPN, LVA, LTU, MEX, NZL, PRT, ROU, ESP, TUR, GBR	BEL, CZE, FRA, LVA, LTU, MEX, NZL, ROU, NLD, TUR	AUS, BEL, CAN, DNK, EST, FRA, HUN, IRL, TA, JPN, LVA, LTU, NZL, PRT, ESP, SWE, NLD, TUR, GBR	BEL, CAN, DNK, EST, FRA, HUN, IRL, ITA, JPN, LVA, LTU, MEX, NZL, PRT, SVN, ESP, SWE, NLD, GBR	<b>CZE, KOR, SWE</b>
<b>NA</b>		<b>ESP, GBR</b>			<b>BEL, HUN</b>

**Table A 1.20 Extent to which payment/contracting systems have been modified to aid the introduction of care coordination policies in your country**

<b>[4C]</b>	<b>Organised payments for care on the basis of the care episode [4C1]</b>	<b>Established a single payer responsible for paying for the entire episode of care (e.g. Primary Care Trusts in the UK) [4C2]</b>	<b>Provides specific payments to insurers or providers to take responsibility for coordinating care [4C3]</b>	<b>Pays providers on the basis of performance to encourage quality improvements [4C4]</b>	<b>Defines legal provisions to allow more rapid access to care (e.g. patients cared for in another country or sector because of long waiting lists) [4C5]</b>
<b>SELDOM</b>	AUT, CAN, DNK, FRA, IRL, ITA, KOR, LTU, MEX, NZL, PRT, SVK, SVN, SWE	AUS, AUT, CAN, CZE, DNK, EST, FRA, HUN, IRL, ITA, JPN, KOR, LTU, MEX, NZL, PRT, ESP, SWE	AUS, AUT, CAN, CZE, DNK, EST, IRL, ITA, JPN, KOR, LTU, NZL, PRT, ROU, SVK, SVN, ESP, SWE, TUR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, HUN, IRL, JPN, KOR, LTU, MEX, NZL, PRT, ROU, SVK, SWE, NLD, GBR	AUS, AUT, CAN, CZE, EST, FRA, IRL, JPN, KOR, LTU, MEX, NZL, PRT, ROU, SVK, SVN, SWE, NLD, GBR
<b>MODERATELY OFTEN</b>	AUS, BEL, JPN, NLD, GBR			ITA	HUN
<b>OFTEN</b>	CZE, EST, HUN, ROU, TUR	ROU, SVK, SVN, NLD, TUR, GBR	FRA, MEX, NLD	SVN, TUR	<b>DNK, ITA, TUR</b>
<b>NA</b>	<b>LVA, ESP</b>	<b>BEL, LVA</b>	<b>BEL, HUN, LVA, GBR</b>	<b>LVA, ESP</b>	<b>BEL, LVA, ESP</b>

**Table A 1.21 Degree to which current formal programmes include efforts to evaluate their impact in terms of broader health system goals**

<b>[4D]</b>	<b>Quality indicators (e.g. changes in survival rates, premature mortality) are defined and regularly monitored [4D1]</b>	<b>Resource utilization in care coordination is regularly monitored [4D2]</b>	<b>Total direct costs and direct benefits in terms of lower health-care spending are regularly estimated for coordinated care programmes [4D3]</b>	<b>Total economic net costs (e.g. including avoided costs due to reduced sick leave and decreased utilization of health services) are regularly estimated for care coordination programmes [4D4]</b>	<b>The continuation of the programmes is subject to meeting specified health and cost efficiency goals [4D5]</b>	<b>Additional administrative costs are regularly monitored [4D6]</b>
<b>SELDOM</b>	AUT, CAN, EST, FRA, JPN, KOR, SVN	AUS, AUT, CAN, DNK, IRL, ITA, KOR, MEX, NZL, ROU, SWE	AUS, AUT, CAN, CZE, DNK, FRA, IRL, KOR, MEX, NZL, ROU, SVK, SVN, ESP, SWE, TUR	AUS, AUT, BEL, CAN, CZE, DNK, EST, FRA, IRL, ITA, JPN, KOR, LTU, MEX, NZL, PRT, ROU, SVK, SVN, ESP, SWE, TUR, GBR	AUS, AUT, CAN, CZE, DNK, FRA, IRL, JPN, KOR, MEX, NZL, ROU, SVK, ESP, NLD	AUS, AUT, CAN, CZE, DNK, FRA, IRL, ITA, JPN, KOR, LTU, MEX, NZL, PRT, ROU, SVK, SVN, ESP, SWE, GBR
<b>MODERATELY OFTEN</b>	AUS, BEL, HUN, IRL, MEX, SVK, TUR	SVN, NLD, HUR	ITA, LTU, PRT, NLD, GBR	NLD	EST, PRT, SVN, TUR	EST, TUR
<b>OFTEN</b>	CZE, DNK, ITA, SVA, LTU, NZL, PRT, ROU, ESP, WE, NLD, GBR	BEL, CZE, EST, FRA, JPN, LVA, LTU, PRT, SVK, GBR	BEL, EST, JPN		ITA, LVA, LTU, SWE, GBR	LVA, NLD
<b>NA</b>		HUN, ESP	HUN, LVA	HUN, LVA	BEL, HUN	BEL, HUN

**Table A 1.22 Existing care coordination policies have (or have not) increased efficiency**

[4E]	System costs are lower because improved flows of information reduce the need for repeating tests [4E1]	Reduced acute hospital stays because patients are moved to more appropriate and lower cost settings [4E2]	Overall costs are lowered by the shifting of follow-up care from hospital to less expensive ambulatory settings [4E3]	Overall care costs per episode are reduced because best practice protocols are used [4E4]	Rehospitalisation is reduced because better follow-up as regards medication and self-care [4E5]	Care delivery is faster because a single health care professional follows the care episode [4E6]	Economic costs are reduced because of a reduction of sick leaves [4E7]	Resource savings have been offset by higher administration costs [4E8]	Gatekeeper systems have been more costly than expected because of a rise in the number of visits to gatekeepers (for referral) but no (or little) fall in specialist visits. [4E9]
<b>DISAGREE</b>	EST, FRA, HUN, KOR, MEX, PRT, ROU, SVN	HUN, PRT, SVN	HUN, PRT, TUR	EST, ROU	EST, ROU	FRA, IRL, KOR, EX, ROU, SVN, SWE	EST, ITA, KOR, MEX, ROU	BEL, DNK, EST, IRL, ITA, ROU, SWE	CZE, DNK, EST, JPN, KOR, LTU, PRT, ROU, SVN, SWE, NLD
<b>NEITHER AGREE OR DISAGREE</b>	AUS, AUT, BEL, CAN, ITA, LVA, SVK, TUR, GBR	AUS, AUT, EST, KOR, LVA, MEX, SVK, TUR	AUS, AUT, EST, JPN, KOR, LVA, MEX, SVK, NLD, GBR	AUS, AUT, FRA, IRL, JPN, KOR, LVA, MEX, PRT, SVK, NLD, GBR	AUS, AUT, CAN, DNK, FRA, JPN, KOR, LVA, MEX, PRT, SVK, SVN	AUS, AUT, CAN, CZE, DNK, EST, ITA, JPN, LVA, PRT, SVK, NLD	AUS, AUT, CAN, DNK, HUN, IRL, JPN, LVA, NZL, PRT, SVK, SVN, SWE, GBR	AUS, AUT, CAN, CZE, FRA, JPN, KOR, LVA, MEX, NZL, PRT, SVN, NLD, TUR, GBR	AUS, AUT, BEL, CAN, FRA, ITA, LVA, NZL, SVK, TUR, GBR
<b>AGREE</b>	CZE, DNK, IRL, JPN, LTU, NZL, SWE, NLD	BEL, CAN, CZE, DNK, FRA, IRL, ITA, JPN, LTU, NZL, ROU, SWE, NLD, GBR	BEL, CAN, CZE, DNK, FRA, IRL, ITA, LTU, NZL, ROM, SVN, SWE	BEL, CAN, CZE, DNK, HUN, ITA, LTU, NZL, SVN, SWE, TUR	BEL, CZE, HUN, IRL, ITA, LTU, NZL, SWE, NLD, TUR, GBR	BEL, HUN, LTU, NZL, TUR, GBR	BEL, CZE, FRA, LTU, NLD, TUR	HUN, LTU	HUN
<b>NA</b>	ESP	ESP	ESP	ESP	ESP	ESP	ESP	ESP	IRL, MEX, ESP

**Table A1.23 Existing care coordination policies have improved quality and patient responsiveness. On a scale from 1 to 5 please rate the degree of agreement or disagreement**

[4F]	Because one professional oversees care, care is more coherent [4F1]	Care delivery is speeded up by better organisation of contacts with providers [4F2]	Prevalence of medical errors is reduced by better adherence to best practice protocols [4F3]	More complete and more rapid transfer of information between providers (e.g. through an unique electronic patient's medical record) [4F4]	Better understanding of treatment alternatives and better self-care through education [4F5]	Patient satisfaction has increased because of more appropriate and timely care delivery [4F6]
<b>DISAGREE</b>	BEL, CZE, KOR, MEX, SVN, SWE	KOR, TUR	EST, KOR, ROU	EST, KOR, MEX, ROU, NLD, TUR	KOR, ROU, TUR	KOR, ROU, SVN
<b>NEITHER AGREE OR DISAGREE</b>	AUS, AUT, CAN, DNK, JPN, LVA, NZL, TUR	AUS, AUT, CZE, DNK, EST, JPN, LVA, NZL, SVN, NLD	AUS, AUT, CAN, JPN, LVA, NZL, SVN, TUR, GBR	AUS, AUT, BEL, CAN, ITA, JPN, LVA, NZL, SVN, SWE	AUS, AUT, CAN, CZE, DNK, EST, ITA, JPN, LVA, NZL	AUS, AUT, CZE, DNK, IRL, ITA, JPN, LVA, NZL, SVK
<b>AGREE</b>	EST, FRA, HUN, IRL, ITA, LTU, PRT, ROU, SVK, NLD, GBR	BEL, CAN, FRA, HUN, IRL, ITA, LTU, MEX, PRT, ROU, SVK, SWE, GBR	BEL, CZE, DNK, FRA, HUN, IRL, ITA, LTU, MEX, PRT, SVK, SWE, NLD	CZE, DNK, FRA, HUN, IRL, LTU, SVK, GBR	BEL, FRA, HUN, IRL, LTU, MEX, PRT, SVK, SVN, SWE, NLD, GBR	BEL, CAN, EST, FRA, HUN, LTU, MEX, PRT, SWE, NLD, TUR, GBR
<b>NA</b>	ESP	ESP	ESP	PRT, ESP	ESP	ESP

## ANNEX 2. METHODS OF ANALYSING THE OECD QUESTIONNAIRE ON COORDINATION OF CARE

2. This annex provides information on the coordination of care questionnaire and the information contained therein. It first describes the questionnaire. It then looks at the sample of countries covered, their participation and a number of data-related issues. This is followed by a discussion of the approach used to analyse and present the data. The Annex concludes by a discussion of a number of additional results not addressed in the main text.

### Approach used in the OECD Coordination-of-Care Questionnaire

3. The OECD care-coordination questionnaire contained three parts: Part I requested countries to respond to a series of specific statements or questions related to care coordination (see Annex 3); Part II requested a succinct written description of the nature of care coordination in individual countries; and, Part III asked countries to provide an annotated bibliography of studies on care coordination in their country and reports or studies dealing with care-coordination policies.

4. Responses to specific statements or questions in the questionnaire in Part I of the questionnaire use a Likert scale<sup>1</sup> which is used to capture the *intensity* of concerns or the frequency of occurrence of certain problems, policies or events. In this case, a scale of 1 to 5 was used. The words or "label" used to express the intensity vary with the type of statements made or questions asked. Five different word forms ("labels") were employed (Table A2.1). For example, in the case of the frequency of an event, the following five "labels" were used: "never or nearly never", "sometimes", "moderately frequent", "most of the time", and "always or nearly always".

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<sup>1</sup> A *Likert scale* is a rating scale designed to measure attitudes or reactions by quantifying subjective information. Participants indicate where along a continuum their attitude or reaction resides. Likert scales are widely used in social research, including health services research. Usually, three to seven responses (i.e. degrees of frequency or intensity of agreement) are used. The precision increases with the number of elements in the scale.

**Table A 2.1 Categories and dimensions of subjective answers**

<i>CATEGORIES</i>				
1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
disagree		neither agree nor disagree	agree	
not debated	very little debated	regularly debated	frequently debated	hotly debated
little debated		regularly debated	frequently debated	
not aware	weakly aware	moderately aware	mostly aware	highly aware
not very aware		moderately aware	mostly aware	
not or little affected	partly affected	moderately affected	significantly affected	always or nearly affected
little affected		moderately affected	mostly affected	
never or nearly never	sometimes used	moderately used	often used	used all or nearly all the time
little used		moderately used	often used	
never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
<b>seldom</b>		moderately frequent	often	

5. These “labels” indicate the likelihood of an event occurring relative to a subjective and hypothetical maximum (as judged by the respondents). While heuristic, the Secretariat suggested that respondents associate the 1 to 5 scale with quintile ranges – i.e. the category "never or nearly never" should be interpreted as having a likelihood of occurrence of 0 to 20 per cent relative to this hypothetical maximum. Similarly "always or nearly always" would have a likelihood of occurrence of 80-100%. The different sets of “labels” are presented in Table A2.1 for the different types of statements/question.

6. These 1 to 5 scales were subsequently "collapsed" into a 1 to 3 scale for ease of presentation in this report (see Table A2.1).<sup>2</sup> Continuing with the preceding example of "frequency of occurrence", this "collapsed" scale becomes:

- "seldom" = "never or nearly never" + "sometimes" -- i.e. up to 40 per cent of the time;
- "moderately frequent" = "moderately frequent" -- i.e. up to 60 per cent of the time; and,
- "often" = "most of the time" + "always or nearly always" -- i.e. up to 100 percent of the time.

<sup>2</sup> It should be noted that even though the 1 to 3 scale has been used in much of this report, the 1 to 5 scale was, nonetheless, necessary to carry out the statistical analysis described below. As noted in footnote 1, the accuracy of statistical tests on the results is a function of the number of Likert scale items.



### **Participation and sample size**

7. The questionnaire was sent to a total of 38 countries. Twenty six countries replied, corresponding to a response rate of 68 per cent (see Table A2.2). Given the range of government departments, agencies and professional bodies involved in monitoring and promoting care coordination, countries were encouraged to enlist the help of a range of stakeholders at different governmental and professional levels in answering the questionnaire. For example, there may be considerable diversity across sub-national administrations in countries with a federal or decentralised system. This is particularly the case where lower levels of government have responsibility for care provision and have the remit to set policies for provision independently of the central or federal authorities. In this context, the Secretariat recommended that the federal or central authorities prepare the questionnaire, drawing on expertise at the sub-national level where available.

8. By and large, countries put considerable effort into completing the questionnaire. For example, Denmark sent the questionnaire to fourteen counties, of which nine replied. Federal authorities consolidated answers from counties and involved senior officials in this process. A similar approach was chosen in Spain. Some countries outsourced the completion of the questionnaire to experts or research institutions, e.g. Austria, Japan. Under the guidance of Haute Autorité de Santé, France, for example, involved all relevant stakeholders in the process of completion. In the course of validation of responses, the Secretariat contacted countries to ensure consistency and precision of the information provided.

Table A 2. 2 Country responses to the questionnaire

	Part I	Part II	Part II	Part I included in the data analysis	Date received
	x= rec'd	x= rec'd	x= rec'd	x=yes	
Australia	x	x	x	x	August 4, 2006
Austria	x	x	x	x	May 5, 2006
Belgium	x		x	x	April 26, 2006
Bulgaria					
Canada	x	x	x	x	May 2, 2006
Cyprus <sup>3 4</sup>	section 5	x			May 2, 2006
Czech Republic	x	x	x	x	June 23, 2006
Denmark	x	x		x	May 27, 2006
Estonia	x	x	x	x	June 13, 2006
France	x	x	x	x	September 8, 2006
Germany	section 5	x			May 12, 2006
Greece					
Hungary	x	x	x	x	June 14, 2006
Iceland					
Ireland				x	December 4, 2006
Italy	x	x	x	x	July 7, 2006
Japan	x	x		x	May 30, 2006
Korea	x	x	x	x	June 15, 2006
Latvia	x			x	May 3, 2006
Lithuania	x	x		x	July 19, 2006
Malta					
Mexico	x			x	May 29, 2006
Netherlands	x			x	August 24, 2006
New Zealand	x	x		x	June 22, 2006
Norway					
Poland					
Portugal	x	x	x	x	June 7, 2006
Romania	x	x	x	x	April 18, 2006
Slovak Republic	x			x	June 20, 2006
Slovenia	x			x	July 11, 2006

<sup>3</sup> Footnote by Turkey:

The information in this document with reference to « Cyprus » relates to the southern part of the Island. There is no single authority representing both Turkish and Greek Cypriot people on the Island. Turkey recognizes the Turkish Republic of Northern Cyprus (TRNC). Until a lasting and equitable solution is found within the context of United Nations, Turkey shall preserve its position concerning the "Cyprus issue".

<sup>4</sup> Footnote by all the European Union Member States of the OECD and the European Commission:

The Republic of Cyprus is recognized by all members of the United Nations with the exception of Turkey. The information in this document relates to the area under the effective control of the Government of the Republic of Cyprus.

	Part I	Part II	Part II	Part I included in the data analysis	Date received
Spain	x	x	x	x	May 26, 2006
Sweden	x	x	x	x	April 27, 2006
Turkey	x	x	x	x	June 22, 2006
United Kingdom				x	November 7, 2006
United States		x			July 13, 2006

### Some important data issues for the analysis

9. The internal consistency of a questionnaire, as well as the reliability of its responses may depend on the type of variables used to measure the issue under consideration. Likert scales are often used because they are applicable to a range of situations, widely understood and easy to administer. However, wording of questions/statements can affect how respondents answer. Different studies comparing the Likert scale technique and other scaling methods for ordered categorical data (e.g. graphic rating scale, visual analogue scale, verbal descriptor scale, etc.) point out that these variables are more sensitive to the wording of questions than in other methods<sup>5</sup>.

10. The Secretariat has attempted to ensure data *reliability* and *validity*.<sup>6</sup> Some measure of the reliability of the results has been captured by evaluating the internal consistency across similar items. For example, some similar questions in e.g. Table 1C and Table 1D, or Table 2A and Table 2B have been included in the questionnaire in order to cross-check that answers correspond. Checks of reliability show that answers are broadly consistent across response categories.

11. It is much more difficult to evaluate the validity of the questionnaire -- i.e. whether the questions/statements chosen in the OECD questionnaire unambiguously capture relevant issues in the area of care coordination. In this context, the use of Likert-type items probably introduces some degree of subjectivity and variability in filling in the questionnaire. To limit the subjectivity of responses, the Secretariat has:

- Recommended that respondents, when completing the questionnaire, make sure that other individuals or experts of different backgrounds are included. For example, it was suggested that these could include members of health ministries, other government departments (e.g. Ministries of Social Affairs), health insurance, health agencies, academics or clinicians;
- Made an effort to give clear instructions and to explain the context of the questions/statements made. In the explanatory note to the questionnaire, the types of questions that are being asked have been described accordingly.

<sup>5</sup> Vickers, A.J. Comparison of an ordinal and a continuous outcome measure of muscle soreness. *Int. J. Technol. Assess Health Care*. Fall 1999; 15(4): 709-716. McCormack H.M., Horne D.J. and Sheather S. Clinical applications of visual analogue scales: a critical review. *Psychol. Med*. Nov 1988; 18(4): 1007-1019.

<sup>6</sup> *Reliability* is related to the extent to which repeated measurement of the same statement or question yields similar results under similar conditions. *Validity* refers to the extent to which an instrument (in this case a statement or question) measures what it is intended to measure.

### Some specific issues

12. In assessing the results of the questionnaire, the Secretariat has had difficulties in interpreting some of the results:

- In the answers analysed in Chapter 3 ("targeted" care coordination programmes), some countries responded positively to the presence of all of the specific programmes without exception, while a number of others also replied "yes" to several similar types of programmes for the same medical condition. Other countries replied that there were programmes of care management, case management, continuing care and disease management for virtually the same pathologies and it is difficult to know whether this reflects the fact that there is one programme with characteristics that cover all of the definitions provided or there are a number of separate programmes for the same type of disease. In the case of the former, this may lead to an overestimate of the number of existing programmes. Contacts with the countries were unable to resolve these difficulties.
- In Chapter 3 there is also some concern over how the countries may have interpreted the questions regarding incentives and the impact of specific care coordination programmes on health-care system objectives. Even though this part of the questionnaire concerned "Targeted" care-coordination programmes such as disease or case management, a number of countries which replied that they had no specific programmes (or no information on programmes) of the types just mentioned, nonetheless provided answers to these questions. For these countries, the answers may have concerned broader care coordination programmes – for example those already built into primary care practitioner arrangements as described in Chapter 2. Alternatively, the answers to these questions could relate to the views as to the expected impact of care coordination policies on system-wide goals.

### Strategy for analysing the Coordination-of-Care Survey data

13. The survey results are assessed at three levels. First, frequency analysis - using collapsed Likert scales (1 to 3) - was performed to compile bar charts as presented in Chapters 1 to 3 of the report and in Annex 1. The frequencies represent the share of countries falling into each of the three categories as a share of the total number of countries. The degree of non-response – where it occurs -- is also indicated. The specific statements/items that were responded to are identified on the left-hand vertical scale of the bar charts; each statement has a number as an identifier which corresponds to item identifiers in the original questionnaire (see Annex 3). Individual statements are ranked in descending order, beginning with the highest frequency or degree of agreement. Tables A1.1 to A1.19 in Annex 1 provide the answers of individual countries to the questionnaire using the three-category scale as defined in Table A2.1) (ISO country abbreviations)

14. Second, the sample has been partitioned on the grounds that the nature and strength of any relationship as stylized in Figure A2.1 may differ depending on institutional features. Differences in funding health care can have implications for the way health-care services are delivered. Thus, countries have been divided into those that are largely financed by tax or through social insurance<sup>7</sup> (see Table A2.3). Although there is not a perfect correspondence, many social health insurance (SHI) countries have self-employed ambulatory care providers (including specialists) paid for on a fee-for service basis and often

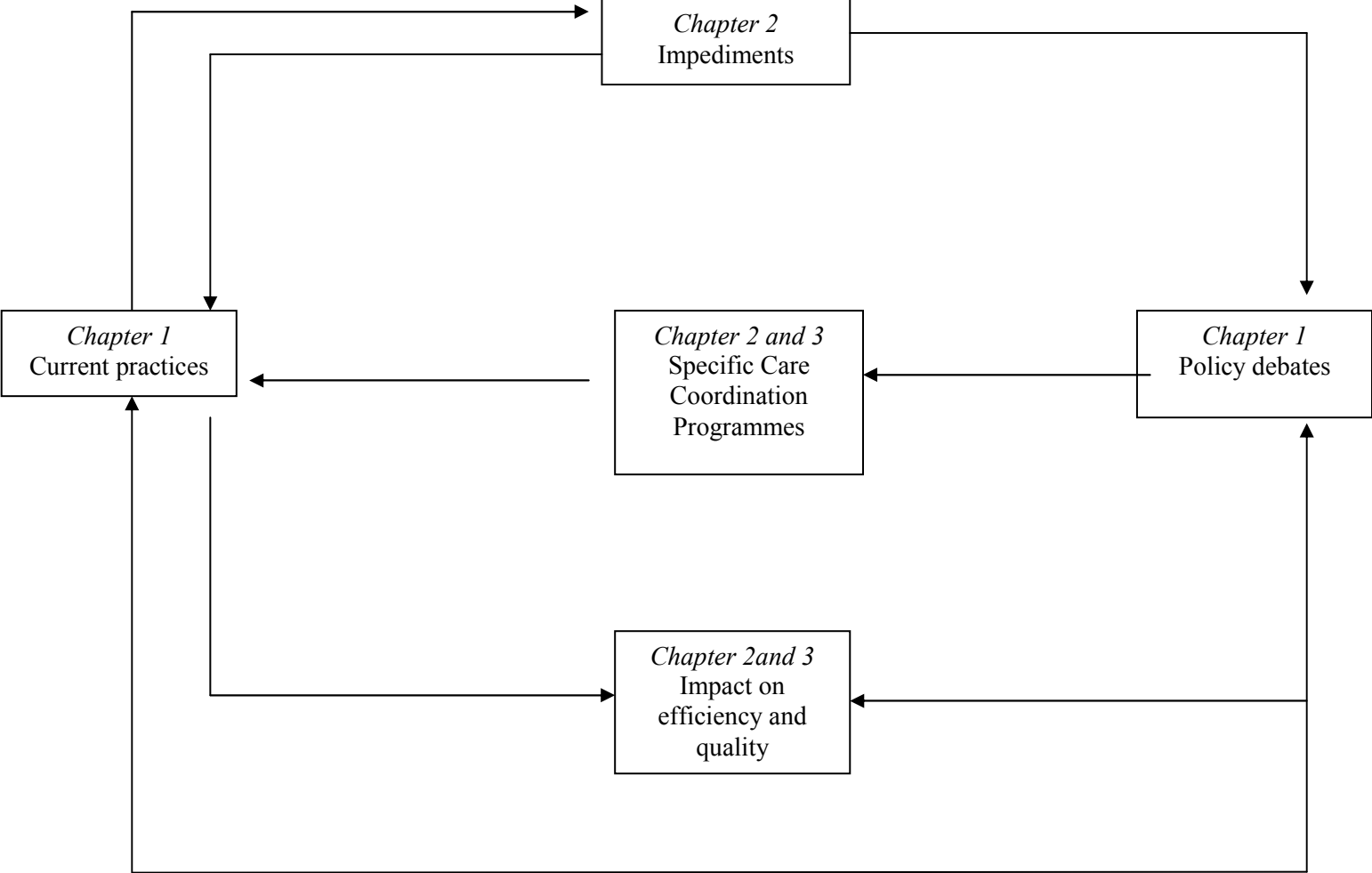
<sup>7</sup> A country is classified as a public contract model (SHI) if 50 per cent or more of public expenditure on health is financed by payroll contributions to mandatory health insurance. It is tax financed (TAX-F) if less than half of health spending is financed by social insurance contributions. These groups were formed on the basis of OECD (2000) and largely on information about financing source in OECD Health Data June 2006.

working as private contractors. In contrast, ambulatory care providers in tax-funded countries are more often paid for on a capitation basis or as employees within larger units, such as Health Centres (e.g. in Finland or Spain).

**Table A 2.3 Institutional features and country groupings of responding countries**

	<i>Country</i>	<i>Financing scheme</i>	
		SHI	TAX-F
1	Australia		x
2	Austria	x	
3	Belgium		x
4	Canada		x
5	Czech Republic	x	
6	Denmark		x
7	France	x	
8	Estonia	x	
9	Hungary	x	
10	Ireland		x
11	Italy		x
12	Japan	x	
13	Korea	x	
14	Latvia		x
15	Lithuania	x	
16	Mexico	x	
17	Netherlands	x	
18	New Zealand		x
19	Portugal		x
20	Romania	x	
21	Slovak Republic	x	
22	Slovenia	x	
23	Spain		x
24	Sweden		x
25	Turkey	x	
26	United Kingdom		x

Figure A 2.1 Possible links between different segments of the OECD questionnaire  
(Chapters refer to the main document)



15. Third, the Secretariat has looked for associations between individual survey items as a means of identifying linkages between problems/impediments, current practices, policies and outcomes. Figure A2.1 presents possible links between different segments of the questionnaire that might be identified using statistical methods. For example, problems of care coordination can be assumed to fuel policy discussions associated with health system goals. As debates over goals – such as improving efficiency or quality of care – intensify, the more likely it is that countries introduce policies to improve coordination of care. This would, in turn, feed through to current contractual and regulatory arrangements, into incentives and, subsequently, into the way health care is delivered. For example, in searching for quality-enhancing practices that reduce cost growth, countries often build-in evaluations when introducing specific care coordination policies. The next section deals with these in greater detail.

### *Descriptive and inferential analysis*

16. Nonparametric methods have been applied to identify possible associations and linkages between different statements or items in the questionnaire. These correlations were calculated on the basis of the 1 to 5 Likert scale. A number of correlation tests were performed including: *Goodman and Kruskal's Gamma*, *Kendall's Tau-b* and *Taub-c* and the *Spearman's Rho* tests). These tests take the total number of "concordances" (i.e. two variables change in the same direction) and "discordances" (variables move in the opposite direction) for all countries in the sample. In addition, correlations were calculated in the same way looking at sub-samples of the countries, e.g. those belonging to the group of social health insurance countries as defined in Table A2.3. A statistically significant correlation at 5% has been assumed as evidence of a possible association between two or more items<sup>8</sup>.

17. Direction of causality has also been explored. For example, the way patients enter the health-care system turns out to be strongly associated with the way primary-care providers are paid and has the expected sign. However, at this level of evaluation it is a priori unknown if the payment scheme makes patients enter the health-care system the way they do or if the way patients enter has influenced the payment scheme. In order to approximate possible directions of causality between pairs of items, the *Somer's Asymmetric D* coefficient has been applied.<sup>9</sup>

### *Multivariate modelling*

18. While the descriptive analysis provides some indication about links between care coordination issues, it gives only limited information whether concerns over care coordination are related to the way the health-care system operates. Thus, logistic regression modelling (GLM) was used to tease out underlying linkages between questionnaire items. Multivariate modelling aims at identifying potential causality and its importance in "explaining" problems of care coordination across countries. To this end, factors or items (i.e. explanatory variables, X) thought to be linked to response variables (Y) have been selected for modelling purposes. To identify these effects and their magnitude, both non-parametric correlations and Generalized Linear Models (*GLM*) were used to analyse survey responses. This work progressed through three stages.

19. **Stage 1.** To compress the number of questionnaire items, additional correlation analysis was performed across all items within each table of the questionnaire. Where there were significant

<sup>8</sup> Siegel, S., Castellan, N. (1988) *Non-Parametric Statistics for the Behavioural Sciences*, Second Edition, McGraw Hill, New York.

<sup>9</sup> Somer's Asymmetric D minimises the prediction error when the categories ("labels") of one variable (the independent variable) are used to predict the categories ("labels") of the another variable (the dependent variable).

correlations between any two items in a table only one of the two was kept, the choice being made on the basis of policy relevance. Moreover, the selected questionnaire items referring to the frequency of occurrence of problems, policies or entries were assigned with the likelihood of occurrence between 0 and 100 per cent of a hypothetical maximum occurrence. This procedure involved tables 2A, 2B, 2C, 2D, 3C and 3D of the questionnaire.

20. **Stage 2.** In this stage, the response variables (Y) used in the regression analysis were constructed on the basis of items in Table 3A of the questionnaire (see Annex 3).

21. This set of items concerned answers to questions relating to where problems of care coordination lie. To facilitate the analysis, these items were grouped into one of the three main care sectors (ambulatory care, acute-inpatient care and long-term care) as is shown in Table A 2.4. The overall degree (intensity) of concern in each of these three sectors was then established by taking the median value for the replies to the questions grouped within each sector for each country. Problems of care coordination arising from waiting lists (item 3A.9 in questionnaire Table 3A) were allocated equally to all care sectors. In a further step, these response variables were linked to the set of explanatory variables identified in Stage 1. This was done using stepwise logistic regression to further limit the number of variables by eliminating items which were not significantly associated with the likelihood of problems of care coordination<sup>10</sup>.

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<sup>10</sup> Due to the lack of normality and homoscedasticity of response data, other commonly-used data reduction methods, e.g. ANOVA and factorial analysis, were not appropriate. The results of this step are available from the Authors.



**Table A 2.4 The construction of response variables**

Item	Description	Median value of problems in
		<b>Ambulatory care (AMB)</b>
3A1	<i>Problems occur within the ambulatory care sector (primary care and ambulatory specialists)</i>	Ambulatory care encompasses all health services that are provided to patients/clients who are not residing in health-care institutions at the time that care is given. Ambulatory care includes emergency services, day/night care; specialist clinics; non-specialist clinics; community clinics; day surgery; private practice; and home care (Canadian Institute for Health Information) <sup>11</sup>
3A4	<i>Problems occur at the interface between ambulatory and outpatient (emergency) care</i>	
3A5	<i>Problems occur at the interface between ambulatory and acute inpatient care</i>	
3A7	<i>Problems occur at the interface between ambulatory and long-term care</i>	
3A9	<i>Problems occur because of waiting lists that prevent timely access to care at the specialist, acute hospital or nursing care level</i>	
		<b>Acute inpatient care (AIC)</b>
3A2	<i>Problems occur within acute inpatient care</i>	Acute care accommodates patients where the principal clinical intent is to manage labour, cure illness or provide treatment of injury, protect complications of illness or injury and perform diagnostic or therapeutic procedures (adapted from OECD Health Data 2006)
3A5	<i>Problems occur at the interface between ambulatory and acute inpatient care</i>	
3A8	<i>Problems occur at the interface between acute inpatient care and long-term care</i>	
3A9	<i>Problems occur because of waiting lists that prevent timely access to care at the specialist, acute hospital or nursing care level</i>	
		<b>Long-term care (LTC)</b>
3A3	<i>Problems occur within long-term care (nursing care and home care)</i>	Long-term care comprises services ranging from medical care, home care, personal care, institutional care and informal care (adapted from Long-Term Care for Older People OECD 2005).
3A6	<i>Problems occur at the interface between outpatient (or emergency) care and long-term care</i>	
3A7	<i>Problems occur at the interface between ambulatory and long-term care</i>	
3A8	<i>Problems occur at the interface between acute inpatient care and long-term care</i>	
3A9	<i>Problems occur because of waiting lists that prevent timely access to care at the specialist, acute hospital or nursing care level</i>	
	3A1 to 3A9	<b>At the system level (ALL)</b>

22. **Stage 3.** Subsequently, logistic regressions were used to re-estimate models with a set of explanatory variables known from Stage 2 as having a significant effect on the probability of perceived problems of care coordination. Tables A2.5 and A2.6 report results of a series of eleven models which proved particularly robust (as measured by the pseudo  $R^2$ ) or appeared, *a priori*, most relevant for identifying likely barriers to improved care coordination. Questionnaire items including identifiers explaining care coordination concerns appear in the left column of these tables. Results are presented on the basis of the construction of the dependent variable as shown in Table A2.4 for the entire health sector (A 2.5) and for health-care sub-sectors (A2.6).

<sup>11</sup> In general, it would include primary care health professionals (nurses or doctors (GPs)), specialists operating outside the acute-care hospital system and hospital-specialists or GPs working in hospital outpatient or emergency departments or in private practice where this is allowed (e.g. UK, Mexico).

**Table A 2.5 The impact of health system characteristics on the likelihood of care coordination problems**

(dependent variable) in the health system, selected logistic regression results, N=26

			ALL CARE SECTORS					
			MODEL 1	MODEL 2	MODEL 3	MODEL 4	MODEL 5	MODEL 6
			(pseudo R <sup>2</sup> : 0.49)	(pseudo R <sup>2</sup> : 0.60)	(pseudo R <sup>2</sup> : 0.68)	(pseudo R <sup>2</sup> : 0.56)	(pseudo R <sup>2</sup> : 0.38)	(pseudo R <sup>2</sup> : 0.11)
			Odds Ratio (p-value)					
<b>National level debates</b>								
1C1	The health care system is unable to provide appropriate care at the appropriate time and place	- hardly debated - regularly debated - frequently debated	- - -	- - -	- - -	- - -	0.43 [0.525] 10.08 [0.060] 1.00	- - -
1C4	There is a poor transfer of information between providers leading to, for example, duplication of tests etc.	- hardly debated - regularly debated - frequently debated	- - -	- - -	- - -	- - -	0.00 [0.999] 0.17 [0.012] 1.00	- - -
1C5	There is a lack of information for (and understanding of) patients about the most appropriate pathway for treatment of chronic or high-cost conditions	- hardly debated - regularly debated - frequently debated	- - -	- - -	- - -	- - -	13.71 [0.093] 74.11 [0.018] 1.00	- - -
1C6	There is inadequate encouragement of self-care by chronically-ill patients and an inadequate understanding of care options	- hardly debated - regularly debated - frequently debated	- - -	- - -	- - -	- - -	- - -	8.00 [0.120] 20.21 [0.031] 1.00
<b>Patient entry</b>								
2C4	Patients go to the emergency outpatient wards because of a shortage of ambulatory care providers		-	1.11 [0.067]	1.18 [0.090]	-	-	-
<b>Referrals</b>								
2D1	Primary care providers (GPs) refer patients to ambulatory care specialist		-	0.92 [0.087]	0.85 [0.065]	-	-	-
2D2	Primary care providers (GPs) refer patients to hospital outpatient services		0.85 [0.009]	0.8 [0.021]	0.76 [0.033]	0.87 [0.006]	-	-
2D4	Hospitals refer patients back to primary care providers		1.10 [0.038]	1.23 [0.019]	1.27 [0.026]	1.14 [0.005]	-	-
2D7	Hospital refer patients to long-term care facilities		-	-	-	-	-	-
<b>Payment arrangements</b>								
2E1	Fee for service	- yes - no	- -	- -	- -	- -	- -	- -
2E4	Mixed (combination of fee for service, capitation and/or salary)	- yes - no	- -	- -	- -	- -	- -	- -
2E5	Case rates, e.g. DRG	- yes - no	0.05 [0.095] <sup>1</sup> 1.00	0.04 [0.097] <sup>2</sup> 1.00	- -	- -	- -	- -
2E8	Out-of-pocket payments	- yes - no	- -	- -	117.36 [0.059] <sup>1</sup> 1.00	- -	- -	- -
<b>Administrative responsibilities</b>								
3B2	Coord. of care is impeded by vertical dispersion of responsibility for providing care between different levels of government (e.g. primary and /or long-term care at the local level, hospital care at the reg. or national level)	- disagree - neither agree or disagree - agree	- - -	- - -	- - -	- - -	- - -	- - -
<b>Regulatory barriers</b>								
3E1	There are professional or regulatory barriers between doctors practicing in the ambulatory and the hospital sector (e.g. the sharp division of responsibility between the two sectors in Germany)	- disagree - neither agree or disagree - agree	- - -	- - -	- - -	- - -	- - -	- - -
3E7	Primary care providers and providers of long-term care services enjoy an equally high professional esteem as health professionals working in acute hospital care environments	- disagree - neither agree or disagree - agree	- - -	- - -	- - -	- - -	- - -	- - -
<b>Economic determinants</b>								
	Total expenditures on health (% of gross domestic product)		-	-	-	0.29 [0.029]	-	-
	Public social expenditure (% of gross domestic product)		-	-	-	-	-	-

<sup>1</sup>Long-term care

<sup>2</sup>Specialist care (ambulatory)

**Table A 2.6 The impact of health system characteristics on the likelihood of care coordination problems**  
(dependent variable) in individual care sectors, selected logistic regression results,  
N=26

	AMBULATORY CARE SECTOR			ACUTE INPATIENT CARE SECTOR		LONG-TERM CARE SECTOR				
	MODEL 5 (pseudo R <sup>2</sup> : 0.34)	MODEL 6 (pseudo R <sup>2</sup> : 0.41)	MODEL 7 (pseudo R <sup>2</sup> : 0.30)	MODEL 8 (pseudo R <sup>2</sup> : 0.48)	MODEL 9 (pseudo R <sup>2</sup> : 0.61)	MODEL 10 (pseudo R <sup>2</sup> : 0.41)	MODEL 11 (pseudo R <sup>2</sup> : 0.57)			
	Odds Ratio (p-value)									
<b>Patient entry</b>										
2C4	Patients go to the emergency outpatient wards because of a shortage of ambulatory care providers			-	-	-	1.12 [0.019]	1.12 [0.076]	-	-
<b>Referrals</b>										
2D1	Primary care providers (GPs) refer patients to ambulatory care specialist			-	-	-	-	-	-	-
2D2	Primary care providers (GPs) refer patients to hospital outpatients services			-	-	-	-	-	0.91 [0.002]	0.85 [0.039]
2D4	Hospitals refer patients back to primary care providers			-	1.10 [0.006]	1.07 [0.019]	1.12 [0.015]	1.13 [0.039]	1.12 [0.009]	1.16 [0.027]
2D7	Hospital refer patients to long-term care facilities			-	-	0.95 [0.071]	-	-	-	-
<b>Payment arrangements</b>										
2E1	Fee for service			- yes - no	- 1.00	15.29 [0.038] <sup>2</sup> 1.00	11.04 [0.046] <sup>2</sup> 1.00	- -	- -	- -
2E4	Mixed (combination of fee for service, capitation and/or salary)			- yes - no	- -	- -	- -	0.01 [0.091] <sup>4</sup> 1.00	- -	- -
2E5	Case rates, e.g. DRG			- yes - no	0.08 [0.061] <sup>1</sup> 1.00	- -	- -	0.01 [0.026] <sup>3</sup> 1.00	- -	- -
2E8	Out-of-pocket payments			- yes - no	- -	- -	- -	170.17 [0.029] <sup>4</sup> 1.00	- -	- -
<b>Administrative responsibilities</b>										
3B2	Coord. of care is impeded by vertical dispersion of responsibility for providing care between different levels of government (e.g. primary and /or long-term care at the local level, hospital care at the reg. or national level)			- disagree - neither agree or disagree - agree	- - -	- - -	- - -	- - -	- -	36.40 [0.049] 0.04 [0.271] 1.00
<b>Regulatory barriers</b>										
3E1	There are professional or regulatory barriers between doctors practicing in the ambulatory and the hospital sector (e.g. the sharp division of responsibility between the two sectors in Germany)			- disagree - neither agree or disagree - agree	1.00 0.23 [0.332] 15.25 [0.050]	- - -	- - -	- - -	- - -	- - -
3E7	Primary care providers and providers of long-term care services enjoy an equally high professional esteem as health professionals working in acute hospital care environments			- disagree - neither agree or disagree - agree	13.16 [0.146] 69.37 [0.035] 1.00	1.00 4.02 [0.253] 0.02 [0.040]	- - -	- - -	- - -	- - -
<b>Economic determinants</b>										
	Total expenditures on health (% of gross domestic product)			-	0.18 [0.010]	0.45 [0.093]	-	-	0.41 [0.027]	-
	Public social expenditure (% of gross domestic product)			-	-	-	-	-	-	0.57 [0.020]

<sup>1</sup>Acute inpatient care

<sup>2</sup>Primary care

<sup>3</sup>Specialist care (ambulatory)

<sup>4</sup>Long-term care

23. The size of the effect of questionnaire items on the health care sector is presented in the form of adjusted "Odds Ratios" together with their p-values to indicate their statistical significance. "Odds Ratios" measure the likelihood that an explanatory variable will impact on perceived problems of care coordination. For example, model 8 in Table A2.6 – with an Odds Ratio of 1.12 -- shows that the perceived probability of problems in the acute inpatient care sector increases i.e. is twelve times higher, in countries where patients frequently enter emergency care because of a shortage of ambulatory care providers<sup>12</sup>. This suggests that a more adequate supply of ambulatory care providers may mitigate some of the coordination problems in the hospital sector.

24. Results in Tables A2.5 and A2.6 present issues or incentives most closely linked – across countries -- with the intensity of care-coordination problems and, consequently, where policy attention should be focused.

25. Care coordination issues are perceived to be more important in countries where:

- The ability of health systems to provide appropriate care are regularly debated (Model 5, Table A2.5);
- Respondents see patients as having inadequate understanding about the most appropriate pathways for treatment of chronic or high cost conditions (Model 5, Table A2.5); and,
- Questionnaire replies indicate that there was inadequate encouragement of self care by the chronically ill and lack of understanding of patients about chronic conditions (Model 6, Table A2.5).
- In contrast, concerns seem less widespread in countries that regularly debate issues of poor information transfer between providers. This could suggest that a high level of awareness about information issues in care delivery may have led to remedial policies (Models 5 Table A2.5).

26. Results suggest further that the interplay of the way patient enter the health care system and referral practice, often linked with payment incentives influences care coordination:

- Countries consistently report care coordination problems as being less intense where primary care providers frequently refer patient to higher levels of care, e.g. to ambulatory care specialists or outpatient wards in hospitals (Table A 2.5 Models 1 to 4).
- Conversely, concerns about care coordination seem stronger in countries where hospitals frequently refer patients to primary care (Table A 2.5 Models 1 to 4 and Models 6 to 11 in Table A2.6). In this context, these effects impact on long-term care -- as well as on ambulatory and acute inpatient care – suggesting that there are indirect effects on other sectors (Model 10, Table A 2.6).
- Finally, concern over care coordination appears to be more intense in countries where patients go to emergency and accident wards because of a shortage of ambulatory care providers (Models 2 and 3 Table A 2.5 and models 8 and 9 Table A 2.6).

<sup>12</sup>

Conversely, an Odds Ratio of 0.85 (as for example for item 2D2 in Model 1) indicates that more referrals from primary care to hospital outpatient services is associated with a lower level of concern over coordination practices. For a fuller description of procedures for estimating logistic models see Agresti, A., Finlay, B. (1997) *Statistical Methods for the Social Sciences*, Third Edition, Prentice Hall International, Inc.

27. These patterns are consistent across models and may suggest that care coordination problems are seen as more important where ambulatory care or long-term care providers lack the capacity and the incentives to adequately coordinate health care needs.<sup>13</sup>

28. In parallel with the impact of referral pattern, care-coordination problems appear to be less important in countries where health systems are well resourced. For example, the probability of problems of care coordination falls with rising health expenditure levels, measured in percent of total expenditure on health (see Model 4 in A2.5 and Model 10 in A2.6), although results also suggest that the marginal effects of increased spending may decline as the level of spending increases<sup>14</sup>. As noted in the main text, this may reflect that the greater availability of financial resources may ease some of the more general supply-side issues, such as lengthy waiting lists and the resulting low level of patient satisfaction. In addition, high-spending countries are more concerned about improving efficiency, for example through a reduction in the duplication of tests (OR 1.76, p-value 0.042, not shown in Table A2.5 and A2.6) reflecting awareness about the need for better performance gained by enhancing coordination through better tailoring service delivery across sectors.

29. In this context, payment incentives also affect the perception of care coordination problems but their impact is often captured through the effect of practice patterns, such as referrals. Some relevant results nevertheless remain.

- The presence of prospective payment arrangements (e.g. DRGs) in ambulatory specialist care appears to reduce the probability of perceived coordination problems (see Model 2 in Table A2.5 and Model 8 in Table A2.6). This result may suggest that such payment mechanisms are probably better suited for encouraging coordinated care delivery in ambulatory care settings than fee-for-service payment models (see also Box 3 in the main document).
- Fee-for-service payment in primary care makes concerns about poor coordination of care more likely. This effect is less important where spending levels are higher (Models 6 and 7 in Table A 2.6) but remains consistent with what would be expected on the basis of the literature (see Box 3 in the main text).
- A high level of health care finance through out of pocket payments tend to be seen as making care coordination problems more important (see Box 3 in the main document).

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<sup>13</sup> This is also illustrated in Figure A 2.1 which shows the relation between the reported frequencies of referrals from primary care to hospitals and from hospitals to primary care on the probability of care coordination concerns in long-term care, given spending levels as measured in health expenditure in percent of GDP. These show that where the intensity of referrals to hospitals increases the probability of care coordination problems being perceived decreases. The opposite is the case for referrals from hospitals back to ambulatory care.

<sup>14</sup> For example, the French reply to the questionnaire indicated very high level of concern over poor care coordination practices. This suggests that the way health care delivery is organized, e.g. referral practice, payment schemes or regulatory issues, is much more important than the level of health expenditure at least in high spending countries.

30. Finally regulatory barriers between health-care sectors are associated with greater intensity of perceived care-coordination problems.

- Coordination problems in ambulatory care (Model 5 in Table A2.6) are seen as being more intense in countries where there are marked regulatory barriers between the ambulatory and hospital-care sectors.
- Sharp division of professional responsibility across sectors (e.g. between ambulatory and hospital) is positively associated with the degree of concern over care coordination. Similarly, the perceived intensity of such problems falls as mutual esteem between professional groups rises. One possible explanation of this result is that weak esteem between providers--and the predominance of "cure giving" as opposed to "care giving"--may impede the emergence of better cooperation and care coordination among professional groups. But the statistical significance of this result remains weak.
- Despite the concerns expressed in many countries, divisions in administrative responsibility for care across different levels government do not appear to be linked with greater concern over care coordination issues. Indeed the opposite appears to be the case: countries indicating that divisions of responsibility are not a problem (i.e. "disagree" in question 3B2) tend to have greater concern over care coordination in the area of long-term care than countries that indicate that they do have such problems (Model 11, A 2.6). This result suggests that a high level of awareness may have already helped mitigate some governance-related coordination problems.

ANNEX 3

OECD Survey on Coordination of Care

Questionnaire Part I: Introduction

**Please provide the following information:**

**Country or region/land/state or province:**

**Name of contact person and contact information:**

**Describe how the Questionnaire was filled in and the names and positions of those who contributed (See the Explanatory Note for the method suggested by the Secretariat):**

**The completed questionnaire should be sent in electronic form to Maria M. Hofmarcher-Holzacker ([maria.hofmarcher@oecd.org](mailto:maria.hofmarcher@oecd.org))**

## Questionnaire Part I: Section 1

Country  
(Region)**1. Discussions about coordination of care in your country**

This section intends to gather information on policy-level discussions/debate on coordination of care. We first ask whether or not policy makers see problems of coordination of care as an impediment to achieving health care goals in your country (A). This is followed by questions aimed at identifying specific areas of concern in this area. In B, the relation between weak coordination of care and specific health system goals is addressed. C. and D. concern debates in your country as to where coordination problems arise in the health care system while E. examines the groups most likely to be affected by poor care coordination; F. and G. attempt to clarify the concepts of coordination of care underlying the debate. Countries are invited to make any country-specific comments to clarify the answers to the preceding questions in section H. Please answer the following questions by using 1 for YES or 2 for NO in question 1.A. and by utilizing the numbers 1 to 5 for the remaining questions.

1 A		Please indicate whether a lack of coordination of care is seen as an impediment to achieving health system goals in your country.	YES	NO
			1	2
1 A 1	1	<i>Is "uncoordinated care" or "inadequate coordination of care" seen as a impediment to achieving health system goals in your country?</i>		
<b>If the answer is "2 (No)", this is because:</b>				
1 A 1,1		<i>Care coordination is not considered to be a problem</i>		
<b>or</b>				
1 A 1,2		<i>Policies are thought to have already rectified care-coordination problems</i>		
<b>or</b>				
1 A 1,3		<i>Question is not relevant for my country</i>		



1 B		Please indicate the degree of disagreement or agreement with the following statements. These statements concern the <u>link made, in policy debates, between coordination of care issues and the achievement of specific health care goals.</u>	strongly disagree	disagree	neither agree or disagree	agree	strongly agree
			1	2	3	4	5
1 B	1	<i>Policy debates over coordination of care have been associated with the goal of improving and/or sustaining physical access to care</i>					
1 B	2	<i>Policy debates over coordination of care have been associated with the goal of improving and/or sustaining insurance coverage</i>					
1 B	3	<i>Policy debates over coordination of care have been associated with the goal of improving and monitoring the quality of care (impact on health outcomes) and responsiveness to patient needs</i>					
1 B	4	<i>Policy debates over coordination of care have been associated with the goal of raising the level of cost efficiency in health care delivery</i>					
1 B	5	<i>Policy debates over coordination of care have been associated with ..... (please specify)</i>					
1 B	6	<i>Policy debates over coordination of care have not been associated with any relation to specific health system goals</i>					

1 C Please indicate the degree of debate at a national level <sup>(1)</sup> concerning : a) problems that can arise from weak coordination of care; b) potential benefits from better coordination.		not debated	little debated	regularly debated	very frequently debated	hotly debated	
		1	2	3	4	5	
1 C	1	<i>The health care system is unable to provide appropriate care at the appropriate time and place</i>					
1 C	2	<i>There is a lack of coordination and oversight in cases where care services are received from a variety of unrelated or weakly-related care settings</i>					
1 C	3	<i>There is a lack of a single health care professionals to oversee individual patients needs and to provide guidance on the most appropriate care pathway</i>					
1 C	4	<i>There is poor transfer of information between providers leading to, for example, duplication of tests etc.</i>					
1 C	5	<i>There is a lack of information for (and understanding of) patients about the most appropriate pathway for treatment of chronic or high-cost conditions</i>					
1 C	6	<i>There is inadequate encouragement of self-care by chronically-ill patients and an inadequate understanding of care options</i>					
1 C	7	<i>Greater care coordination can offset the impact of tighter supply by helping speed patients through the system</i>					

1) This could be at the state/provincial level where they have responsibility for such policies and for system oversight.

1 D		Please indicate the degree of awareness, <u>at the level of local health authorities or care providers</u> , concerning: a) problems that can arise from weak coordination of care; b) potential benefits from better coordination.	not aware	weakly aware	moderately aware	mostly aware	highly aware
			1	2	3	4	5
1 D	1	<i>The health care system is unable to provide appropriate care at the appropriate time and place</i>					
1 D	2	<i>There is a lack of coordination and oversight in cases where care services are received from a variety of unrelated or weakly-related care settings</i>					
1 D	3	<i>There is a lack of a single health care professional to oversee individual patients needs and to provide guidance on the most appropriate care pathway</i>					
1 D	4	<i>There is poor transfer of information between providers leading to, for example, duplication of tests etc.</i>					
1 D	5	<i>There is a lack of information for (and understanding of) patients about the most appropriate pathway for treatment of chronic or high-cost conditions</i>					
1 D	6	<i>There is inadequate encouragement of self-care by chronically-ill patients and an inadequate understanding of care options</i>					
1 D	7	<i>Greater care coordination can offset the impact of tighter supply by helping speed patients through the system</i>					
1 D	8	<i>Other aspects of note (please specify .....)</i>					

1 E	In policy discussions, which of the following population groups are seen as likely to be the most affected by inadequate coordination of care.	not or little affected	partly affected	moderately affected	significantly affected	always or almost always affected
		1	2	3	4	5
1 E 1	<i>Children (&lt;5 years old)</i>					
1 E 2	<i>Older workers (50 to 65)</i>					
1 E 3	<i>Retirement age (65 to 80)</i>					
1 E 4	<i>The very old (80+)</i>					
1 E 5	<i>Patients with chronic conditions/co-morbidities</i>					

1 F	Please rate the <u>frequency that the following terms are used</u> <sup>(2)</sup> in policy discussions in your country that refer to efforts to coordinate care.	never or nearly never used	sometimes used	used moderately	often used	used all or nearly all the time
		1	2	3	4	5
1 F 1	<i>Care management</i>					
1 F 2	<i>Case management</i>					
1 F 3	<i>Continuing care</i>					
1 F 4	<i>Disease management</i>					
1 F 5	<i>Episodes of care</i>					
1 F 6	<i>Patient pathways</i>					
1 F 7	<i>Other..... please specify</i>					

2) See attached glossary for the definition of terms.

<b>1 G</b>	<b>If applicable please provide a short definition of the terms most frequently used in discussions on care coordination in your country using lines 1.G.1, 1.G.2 and 1.G.3.</b>
1 G 1	<i>Definition 1</i>
1 G 2	<i>Definition 2</i>
1 G 3	<i>Definition 3</i>

<b>1 H</b>	<b>Any clarifying comments to the questions presented in Section 1</b>
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## Questionnaire Part I: Section 2

Country  
(Region)

### **2. The current process of care coordination in your country**

Some form of coordination of care probably exists in most countries, even in those without formal care-coordination policies. The aim of the first part of this section is to elicit information on existing practices in this area for your country. We first ask how patients seeking care normally find their way through the health care system in A. and B. (Note that question 2.A concerns methods of care coordination while 2.B links those methods to the interfaces between the various institutional levels of care). Part C. concerns where patients normally enter the health care system. In part D. referral patterns among providers are addressed. Part E. captures current payment arrangements on specified levels of care in your country. Countries are invited to make any country-specific comments to clarify the answers to the preceding questions in section F. Please answer the following questions by utilizing the numbers 1 to 5 and 1 for Yes or 2 for No where indicated.

2	A	Please rate the degree of frequency to which of the following <u>coordination of care</u> <sup>(1)</sup> methods are used in your country	never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
			1	2	3	4	5
2	A	1 <i>Patients coordinate their care needs themselves</i>					
2	A	2 <i>Relatives and family members of the patient take a leading role in coordinating care</i>					
2	A	3 <i>A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care</i>					
2	A	4 <i>Ambulatory care specialists guide the patient through the system and coordinate care</i>					
2	A	5 <i>Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level</i>					
2	A	6 <i>A health care professional manages the discharges of patients from acute care to other care levels</i>					
2	A	7 <i>Insurers (particularly managed care) coordinate care -- e.g. through case management</i>					
2	A	8 <i>A health care professional routinely assesses patients needs and defines patient care plans</i>					
2	A	9 <i>Long term care is provided by multidisciplinary teams</i>					
2	A	10 <i>Case managers at the local level are helping GPs and patients to find the most appropriate care</i>					
2	A	11 <i>Doctors with admitting rights to hospitals coordinate episodes of care</i>					
2	A	12 <i>Information on medical records and patient needs is routinely transmitted between providers</i>					
2	A	13 <i>Care Coordination programmes to coordinate care are widely implemented (see Glossary)</i>					
2	A	14 <i>Integrated and coordinated care delivery occurs by chance only</i>					
2	A	15 <i>Other forms of care coordination (please specify .....)</i>					

1) Coordination of care is defined in the glossary.

2	B	Please indicate the degree of frequency regarding the standard practice of coordination of care across care settings. Indicate the degree of frequency, in the case of each of the following statements, by entering in each cell the values <u>1= never or nearly never; 2= sometimes; 3= moderately frequent; 4= most of the time; 5= always or nearly always.</u> <sup>(2)</sup>	Interface between primary and ambulatory specialist care	Interface between primary/ambulatory specialist care and outpatient specialist care	Interface between ambulatory and acute inpatient care	Interface between ambulatory and long-term care	Interface between acute inpatient care and long-term care
2	B	1 <i>Patients coordinate their care needs themselves</i>					
2	B	2 <i>Relatives and family members of the patient take a leading role in coordinating care</i>					
2	B	3 <i>A health-care professional at the primary care level (e.g. a GP) normally guides the patient through the system and coordinates care</i>					
2	B	4 <i>Ambulatory care specialists guide the patient through the system and coordinate care</i>					
2	B	5 <i>Coordination of care episodes that require inpatient stays takes place within the hospital at specialist level</i>					
2	B	6 <i>A health care professional manages the discharges of patients from acute care to other care levels</i>					
2	B	7 <i>Insurers (particularly managed care) coordinate care -- e.g. through case management</i>					
2	B	8 <i>A health care professional routinely assesses patients needs and defines patient care plans</i>					
2	B	9 <i>Long term care is provided by multidisciplinary teams</i>					
2	B	10 <i>Case managers at the local level are helping GPs and patients to find the most appropriate care</i>					
2	B	11 <i>Doctors with admitting rights to hospitals coordinate episodes of care</i>					
2	B	12 <i>Information on medical records and patient needs is routinely transmitted across providers</i>					
2	B	13 <i>Care Coordination programmes (see Glossary) to coordinate care are widely implemented</i>					
2	B	14 <i>Integrated and coordinated care delivery occurs by chance only</i>					
2	B	15 <i>Other forms of care coordination (please specify .....)</i>					

2) See the annex to the explanatory note for further information in answering this sub-section.



2	C	Where do patients most frequently enter the health care system? Please rate the frequency with which patients tend to enter the health care system at different points.	never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
			1	2	3	4	5
2	C	1 Patients enter at the primary care level (GP as gatekeeper)					
2	C	2 Patients see an ambulatory specialist at any time without consulting a primary care provider					
2	C	3 Patients visit an outpatient emergency ward at any time without consulting a primary care provider					
2	C	4 Patient go to the emergency outpatient wards because of a shortage of ambulatory care providers					
2	C	5 Patients go to the emergency outpatient ward because access to ambulatory care provider is inconvenient					
2	C	6 Patients go to the emergency outpatient ward because it is cheaper than other care options					
2	C	7 Patients enter acute inpatient care because of a shortage of long-term-care facilities, nursing care or home care					
2	C	8 Patients see any provider at any level of care at any time without referrals					
2	C	9 Insurers or other payers determine where patients enter the health-care system					
2	C	10 Other entry points (please specify .....)					

2	D	Where are patients most frequently referred to? Please rate the frequency of referrals to the various levels of care.	never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
			1	2	3	4	5
2	D	1 <i>Primary care providers (GPs) refer patients to ambulatory care specialists</i>					
2	D	2 <i>Primary care providers (GPs) refer patients to hospital outpatients services</i>					
2	D	3 <i>Ambulatory care providers refer patients to hospitals</i>					
2	D	4 <i>Hospitals refer patients back to primary care providers</i>					
2	D	5 <i>Hospitals refer patients back to ambulatory care specialists</i>					
2	D	6 <i>Insurers or other payers determine referral practice</i>					
2	D	7 <i>Hospitals refer patients to long-term-care facilities</i>					
2	D	8 <i>Patients refer themselves</i>					
2	D	9 <i>Other forms of referral (please specify .....)</i>					

2	E	What are, currently, the predominant payment arrangements to individual or to institutional providers <sup>(3)</sup> ? <u>Please answer 1 for Yes or 2 for No<sup>(4)</sup></u>	Primary care	Specialist care (ambulatory)	Specialist care (hospital outpatient)	Acute inpatient care	Long-term care
2	E	1 <i>Fee for service</i>					
2	E	2 <i>Capitation</i>					
2	E	3 <i>Salary</i>					
2	E	4 <i>Mixed (combination of fee for service, capitation and/or salary)</i>					
2	E	5 <i>Case rates, e.g. DRG</i>					
2	E	6 <i>Per diem rates, e.g. bed days</i>					
2	E	7 <i>Budget envelopes per period</i>					
2	E	8 <i>Out-of-pocket payments</i>					
2	E	9 <i>Other payment arrangements</i>					

3) See glossary. 4) More than one answer per column is possible.

2	F	<b>Any clarifying comments to the questions presented in Section 2</b>					
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## Questionnaire Part I: Section 3

Country  
(Region)

### **3. Impediments to improving coordination of care in your country**

The institutional structures of health-care systems can influence incentives for care coordination in a variety of ways. Part A asks where in the health care system problems of coordination of care occur most frequently. Part B looks at problems associated in coordination where responsibility for types of care is divided among different levels of government (e.g. selected Nordic countries). Care coordination can also be affected by the incentives arising from payment arrangements for providers and for quality control although the direction of the impact it is not always clear *a priori* (see questions under C and D). Finally, regulations governing the permitted activities and responsibilities of health professionals can also inhibit or encourage coordination. (See questions under E). Countries are invited to make any country-specific comments to clarify the answers to the preceding questions in section F. Please answer the following questions by utilizing the scale of 1 to 5.

3 A		Please indicate the degree of agreement/disagreement as to where <u>problems of coordination of care occur in the health care system</u>	strongly disagree	disagree	neither agree or disagree	agree	strongly agree
			1	2	3	4	5
3	A 1	<i>Problems occur within the ambulatory care sector (primary care and ambulatory specialists)</i>					
3	A 2	<i>Problems occur within acute inpatient care</i>					
3	A 3	<i>Problems occur within long-term care (nursing care and home care)</i>					
3	A 4	<i>Problems occur at the interface between ambulatory and outpatient (emergency) care</i>					
3	A 5	<i>Problems occur at the interface between ambulatory and acute inpatient care</i>					
3	A 6	<i>Problems occur at the interface between outpatient (or emergency) care and long-term care</i>					
3	A 7	<i>Problems occur at the interface between ambulatory and long-term care</i>					
3	A 8	<i>Problems occur at the interface between acute inpatient care and long-term care</i>					
3	A 9	<i>Problems occur because of waiting lists that prevent timely access to care at the specialist, acute hospital or nursing care level</i>					
3	A 10	<i>Other problems of coordination (please specify.....)</i>					

3 B		Please rate the degree of agreement regarding the following statements. These concern whether <u>current divisions of administrative responsibilities</u> for health care affect efforts to coordinate care in your country	strongly disagree	disagree	neither agree or disagree	agree	strongly agree
			1	2	3	4	5
3	B 1	<i>Policy setting in the area of care coordination is hindered by the lack of a single institution overseeing all aspects of public health-care policy</i>					
3	B 2	<i>Coordination of care is impeded by vertical dispersion of responsibility for providing care between different levels of government (e.g. primary and /or long-term care at the local level and hospital care at the regional or national level)</i>					
3	B 3	<i>Coordination of care is hindered by the organisation of care within narrow geographical areas (e.g. cantons, lander, states/provinces) with weak links between them</i>					
3	B 4	<i>Bodies or institutions with the potential to introduce coordinated care policies lack information about performance of providers in terms of quality and cost efficiency</i>					
3	B 5	<i>The presence of competing multiple payers and providers reduces the incentives for payers to contract with providers to enhance care coordination</i>					
3	B 6	<i>Other factors (please specify)</i>					

3 C		Please indicate the frequency of occurrence of current arrangement that may <u>generate incentives for care coordination</u> .	never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
			1	2	3	4	5
3	C 1	Arrangements to provide care designate one provider as care coordinator (e.g. gatekeeper)					
3	C 2	Arrangements to provide care include explicit payments for care coordination for primary care physicians (e.g. incentive payments)					
3	C 3	Arrangements to provide care include explicit payments for care coordination by other (non-GP) providers (e.g. at the level of ambulatory-care specialists or hospitals)					
3	C 4	Arrangements to provide care include a budget for the care coordinator to purchase necessary care for patients					
3	C 5	Arrangements to provide care allow or encourage the formation of group practices or multidisciplinary care models					
3	C 6	Other incentives generated (please specify .....)					

3 D		Please indicate the frequency of the following arrangements that may <u>facilitate care coordination</u> in your country	never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
			1	2	3	4	5
3	D 1	Arrangements to provide and pay for care include stipulations regarding quality goals					
3	D 2	Information on the quality of service delivery is regularly disseminated among providers					
3	D 3	Providers and payers are equipped with IT so as to encourage communication of patient information amongst themselves					
3	D 4	A patients file in electronic format exists and contains medical information about the patient					
3	D 5	Payers selectively contract with providers on the basis of the capacity to coordinate care or to provide coordinated care					
3	D 6	Contractual arrangements to provide care target the promotion of cooperation among providers as an explicit objective					
3	D 7	Other arrangements (please specify .....)					

3 E		Please rate the degree of agreement as to which <u>regulations on the scope of permitted activities of health-care professionals</u> currently affect efforts to coordinate care.	strongly disagree	disagree	neither agree or disagree	agree	strongly agree
			1	2	3	4	5
3	E 1	<i>There are professional or regulatory barriers between doctors practicing in the ambulatory and the hospital sector (e.g. the sharp division of responsibility between the two sectors in Germany)</i>					
3	E 2	<i>Other health-care professionals than doctors (e.g. nurses) are actively involved in organising/ensuring care coordination</i>					
3	E 3	<i>The scope of care coordination is limited by inadequate numbers of doctors and other health care professionals at the primary care level</i>					
3	E 4	<i>Your country explicitly defines the role of primary care doctors as gatekeepers and ascribes coordination of care to them</i>					
3	E 5	<i>Your country permits primary-care doctors or ambulatory-care specialists to practice inside the hospital/nursing home</i>					
3	E 6	<i>There are wide enough professional profiles (scope of practice rules) of non-medical primary-care providers (e.g. nurses) to permit them to undertake coordination of care</i>					
3	E 7	<i>Primary care providers and providers of long-term care services enjoy an equally high professional esteem as health professionals working in acute hospital care environments</i>					
3	E 8	<i>Other aspects (please specify .....)</i>					



**3 F Any clarifying comments to the questions presented in Section 3**

Empty response box for clarifying comments.

## Questionnaire Part I: Section 4

Country  
(Region)**4. Specific policies of care coordination in health care delivery and their impact**

This section attempts to gather information on formal care coordination policies and any information on their expected impact. In A. we ask about the existence of specific programmes to coordinate care that have been implemented and, in B., the policy goals that these programmes have been targeted towards. Parts C. and D. concern evaluations of existing programmes and whether information is available concerning whether health-care system goals have been better achieved through these policies. Sections E. and F. request assessment of any positive impact of coordination of care for system efficiency and for improved quality of care. Countries are invited to make any country-specific comments to clarify the answers to the preceding questions in section G. Please use the scale 1 to 5 where requested.

4 A	Please indicate if there are <u>formal policies/programmes</u> <sup>(1)</sup> to coordinate care that are targeted on specific conditions. <u>Please answer Y (yes) or N (no).</u>	Cancer (C00-D48, Neoplasms)	Diseases of the circulatory system (I00-I99)	Diabetes (E10-E14)	Chronic lower respiratory diseases (J43-J47)	Dementia and other degenerative diseases of the nervous system (F00-F03, G30-G32)
		1	2	3	4	5
4 A 1	<i>Care management</i>					
4 A 2	<i>Case management</i>					
4 A 3	<i>Continuing care</i>					
4 A 4	<i>Disease management</i>					
4 A 5	<i>Episodes of care</i>					
4 A 6	<i>Patient pathways</i>					
4 A 7	<i>Other..... please specify</i>					

1) See attached glossary for the definition of terms.

<b>4 B</b> <b>Please indicate the degree of agreement/disagreement with the following statements. These concern why existing care coordination policies were introduced.</b>	<b>strongly disagree</b>	<b>disagree</b>	<b>neither agree or disagree</b>	<b>agree</b>	<b>strongly agree</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
4 B 1 <i>Care Coordination policies were implemented to improve and/or sustain physical access to care</i>					
4 B 2 <i>Care Coordination policies were implemented to improve and/or sustain insurance coverage</i>					
4 B 3 <i>Care Coordination policies were implemented to improve and monitor the quality of care (impact on health outcomes) and responsiveness to patient needs</i>					
4 B 4 <i>Care Coordination policies were implemented to raise the level of cost efficiency in health care delivery</i>					
4 B 5 <i>Care Coordination policies were implemented to..... (please specify)</i>					
4 B 6 <i>Care Coordination policies were implemented without any relation to specific health system goals</i>					

4 C Please indicate the extent to which <u>payment/contracting</u> systems have been modified to aid the introduction of care coordination policies in your country	never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
	1	2	3	4	5
4 C 1 <i>Organised payments for care on the basis of the care episode</i>					
4 C 2 <i>Established a single payer responsible for paying for the entire episode of care (e.g. Primary Care Trusts in the UK)</i>					
4 C 3 <i>Provides specific payments to insurers or providers to take responsibility for coordinating care</i>					
4 C 4 <i>Pays providers on the basis of performance to encourage quality improvements</i>					
4 C 5 <i>Defines legal provisions to allow more rapid access to care (e.g. patients cared for in another country or sector because of long waiting lists)</i>					
4 C 6 <i>Other modification (please specify .....)</i>					

<b>4 D</b> Please indicate the degree to which current formal programmes include <u>efforts to evaluate</u> their impact in term of broader health system goals	never or nearly never	sometimes	moderately frequent	most of the time	always or nearly always
	1	2	3	4	5
4 D 1 <i>Quality indicators (e.g. changes in survival rates, premature mortality) are defined and regularly monitored</i>					
4 D 2 <i>Resource utilization in care coordination is regularly monitored</i>					
4 D 3 <i>Total direct costs and direct benefits in terms of lower health-care spending are regularly estimated for coordinated care programmes</i>					
4 D 4 <i>Total economic net costs (e.g. including avoided costs due to reduced sick leave and decreased utilization of health services) are regularly estimated for care coordination programmes</i>					
4 D 5 <i>The continuation of the programmes is subject to meeting specified health and cost efficiency goals</i>					
4 D 6 <i>Additional administrative costs are regularly monitored</i>					
4 D 7 <i>Other forms of evaluation (please specify...)</i>					

4 E	Please indicate whether existing care coordination policies have (or have not) increased efficiency. On a scale from 1 to 5, please rate the degree of agreement or disagreement.	strongly disagree	disagree	neither agree or disagree	agree	strongly agree
		1	2	3	4	5
4 E 1	<i>System costs are lower because improved flows of information reduce the need for repeating tests</i>					
4 E 2	<i>Reduced acute hospital stays because patients are moved to more appropriate and lower cost settings</i>					
4 E 3	<i>Overall costs are lowered by the shifting of follow-up care from hospital to less expensive ambulatory settings</i>					
4 E 4	<i>Overall care costs per episode are reduced because best practice protocols are used</i>					
4 E 5	<i>Rehospitalisation is reduced because better follow-up as regards medication and self-care</i>					
4 E 6	<i>Care delivery is faster because a single health care professional follows the care episode</i>					
4 E 7	<i>Economic costs are reduced because of a reduction of sick leaves</i>					
4 E 8	<i>Resource savings have been offset by higher administration costs</i>					
4 E 9	<i>Gatekeeper systems have been more costly than expected because of a rise in the number of visits to gatekeepers (for referral) but no (or little) fall in specialist visits.</i>					
4 E 10	<i>Other effects/channels (please specify)</i>					

<b>4 F Please indicate whether existing care coordination policies have <u>improved quality and patient responsiveness</u>. On a scale from 1 to 5 please rate the degree of agreement or disagreement.</b>						
		strongly disagree	disagree	neither agree or disagree	agree	strongly agree
		1	2	3	4	5
4	F 1	<i>Because one professional oversees care, care is more coherent</i>				
4	F 2	<i>Care delivery is speeded up by better organisation of contacts with providers</i>				
4	F 3	<i>Prevalence of medical errors is reduced by better adherence to best practice protocols</i>				
4	F 4	<i>More complete and more rapid transfer of information between providers (e.g. through an unique electronic patient's medical record)</i>				
4	F 5	<i>Better understanding of treatment alternatives and better self-care though education</i>				
4	F 6	<i>Patient satisfaction has increased because of more appropriate and timely care delivery</i>				
4	F 7	<i>Other effects/channels (please specify)</i>				

**4 G Any clarifying comments to the questions presented in Section 4**

## Questionnaire Part I: Section 5

Country  
(Region)

### 5. Statistical information on care coordination in health care delivery.

This section requests statistical information on the need for -- and scope of -- care coordination policies, focusing on conditions that could benefit potentially from care coordination. Section A requests information on prevalence; Section B asks for data on enrollment in existing programmes and C. looks at cost per enrollee of the programme while D. concerns the information on the cost of illness of specific pathology groups. Finally, E. asks for information on the cost of budgetary allocations on specific programmes associated with improving the coordination of care. Countries are invited to make any country specific-comments to clarify the answers to the preceding questions in section F. It is recognized that complete data may not be easily available or in a form that does not fit with the definitions requested. Countries are requested to provide as much information as possible -- either on an aggregate level or disaggregated on the basis of age and disease category. Countries may have collected data using other age or programme breakdowns. In this case, we encourage countries to send this data and to indicate the age groupings that they have used.

5	A	Please indicate the prevalence <sup>(1)</sup> of the following pathologies in a recent year per age group	= 15	15-35	35-50	50-65	= 65	Total
(Column identifier for secretariat use)			1	2	3	4	5	6
5	A	1 <i>Cancer (C00-D48, Neoplasms)</i>						
5	A	2 <i>Diseases of the circulatory system (I00-I99) (including ischaemic heart disease)</i>						
5	A	3 <i>Diabetes (E10-E14, Diabetes mellitus)</i>						
5	A	4 <i>Chronic lower respiratory diseases (J43-J47) (including asthma)</i>						
5	A	5 <i>Dementia and other degenerative diseases of the nervous system (F00-F03, G30-G32) (including Alzheimer's Disease)</i>						
5	A	6 <i>Multiple pathologies</i>						
5	A	7 <i>Other important conditions (please specify): .....</i>						

1) Prevalence is defined in the glossary.



5 B Please indicate the <u>enrollment rate</u> of the following pathology groups per age group. (Approximate ICD10 codes are in brackets).							= 15	15-35	35-50	50-65	= 65	Total
(Column identifier for secretariat use)							1	2	3	4	5	6
5	B	1	Cancer (C00-D48, Neoplasms)									
5	B	2	Diseases of the circulatory system (I00-I99) (including ischaemic heart disease)									
5	B	3	Diabetes (E10-E14, Diabetes mellitus)									
5	B	4	Chronic lower respiratory diseases (J43-J47) (including asthma)									
5	B	5	Dementia and other degenerative diseases of the nervous system (F00-F03, G30-G32) (including Alzheimer's Disease)									
5	B	6	Multiple pathologies									
5	B	7	Other important conditions (please specify): .....									

5 C Please indicate the <u>cost per enrollee</u> for the following pathologies broken down by age group if available (see header for instructions) in a recent year							= 15	15-35	35-50	50-65	= 65	Total
(Column identifier for secretariat use)							1	2	3	4	5	6
5	C	1	Cancer (C00-D48, Neoplasms)									
5	C	2	Diseases of the circulatory system (I00-I99) (including ischaemic heart disease)									
5	C	3	Diabetes (E10-E14, Diabetes mellitus)									
5	C	4	Chronic lower respiratory diseases (J43-J47) (including asthma)									
5	C	5	Dementia and other degenerative diseases of the nervous system (F00-F03, G30-G32) (including Alzheimer's Disease)									
5	C	6	Multiple pathologies									
5	C	7	Other important conditions (please specify): .....									

5 D		Please indicate the <u>cost of illness</u> <sup>(2)</sup> of the following pathologies per age group	= 15	15-35	35-50	50-65	= 65	Total
		(Column identifier for secretariat use)	1	2	3	4	5	6
5	D 1	<i>Cancer (C00-D48, Neoplasms)</i>						
5	D 2	<i>Diseases of the circulatory system (I00-I99) (including ischaemic heart disease)</i>						
5	D 3	<i>Diabetes (E10-E14, Diabetes mellitus)</i>						
5	D 4	<i>Chronic lower respiratory diseases (J43-J47) (including asthma)</i>						
5	D 5	<i>Dementia and other degenerative diseases of the nervous system (F00-F03, G30-G32) (including Alzheimer's Disease)</i>						
5	D 6	<i>Multiple pathologies</i>						
5	D 7	<i>Other important conditions (please specify): .....</i>						

2) Cost of illness is defined in the glossary.

5 E		Please indicate the <u>budgetary cost</u> of any public policies that directly or indirectly support care coordination. Countries should identify the programmes themselves. <sup>(3)</sup>	Total
			6
5	E 1	<i>Programme (please specify)</i>	
5	E 2	<i>Programme (please specify)</i>	
5	E 3	<i>Programme (please specify)</i>	
5	E 4	<i>Programme (please specify)</i>	
5	E 5	<i>Programme (please specify)</i>	

3) These could include, for example, measures to enhance the electronic transfer of information.

**5 F Any clarifying comments to the questions presented in Section 5 and any information on other programmes**

