THE WORLD BANK
UNICO – UNIVERSAL COVERAGE CHALLENGE PROGRAM
QUESTIONNAIRE FOR THE NUTS AND BOLTS OF THE PROGRAM EXPANDING HEALTH COVERAGE TO THE POOR (HCP)

In most countries, UC is achieved through a patchwork of various programs. This questionnaire asks about the most important program which is today expanding coverage to the poor – below we refer to this program as Health Coverage for the Poor (HCP).

I. General Information

Name of Author (person completing the questionnaire)	
Name of Task Manager for Case Study	
Name of Country	
Name of Heath Coverage Program (HCP)	
Acronym of HCP	
Date of completing this questionnaire	
Was this the First draft? Final draft?	

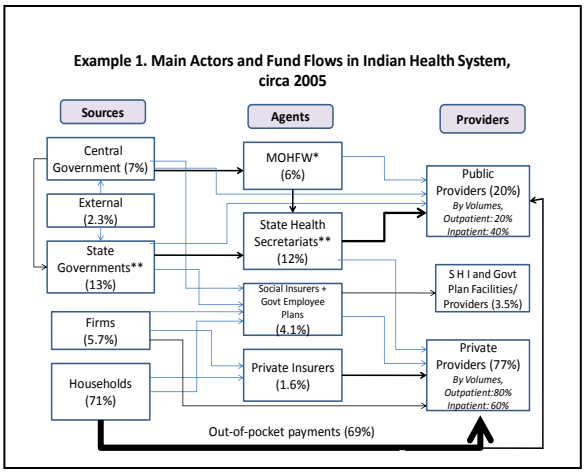
II. National Health System Overview

Please notice: This section (roman II) deals with the National Health System and not with the HCP. All later sections deal only with the HCP.

A. National health system Financing Flows

1. Make a diagram of the main financing flows in the country's health system showing Sources, Agents and Providers. If available include percentages. Feel free to scan a hand-drawing.

Methodological Note: Use National Health Accounts definitions. Please ensure that: (i) At the source level "donor financing" is accounted under 'external' whether funds are grants or loans; (ii) Social health insurance is an entity at the 'agent' level. Contributions to social health insurance should be categorized under the appropriate source-level entity (iii) The diagram captures the flow of funds used for the purpose of health. That is, funds transferred from the federal to state government for general purposes and allocated by the state



to health should appear as a 'state' fund at the source level. Conversely, transfers made from the federal government to the state government for the explicit purpose of health should be classified as a 'federal' fund.

B. Provision

1. Briefly describe Public/Private mix by level.

2. For the public sector briefly describe primary, secondary and tertiary care providers. Within the public sector, is there effective coordination of care? Are referrals, networks or gate-keeping strong?

3. Refer to the largest Social Security subsystem: Does it run its own providers or does it mostly purchase health services from others?

4. Refer to the hospital providing the most sophisticated cardiac services in the country: How is it owned and financed?

C. Primary Care and public health services to individuals

1. Refer to each of the following Programs in primary care settings:

	TB[1] Y/N	Child Health Y/N	Birth deliveries[2] Y/N	Diabetes[3] Y/N	Comments
Do health workers use a population-based list of names to monitor program implementation?					
Has earmarked funding from central source?					
Funding is more predictable than for the rest of the public health system?					
Requires co-payment by user?					
Often requires informal payments to obtain medications/service?					
Often is out of stock of medications					
Has below average worker absenteesm?					
Is commonly perceived as a					

[1] Tuberculosis, we use this as a tracer for communicable disease programs
[2] Please reply based on birth deliveries at the primary care level, not at higher complexity settings
[3] We use this as a tracer for programs dealing with NCDs

"strong program"					
Use of technical protocols is effectively enforced in most primary care clinics?					
Reports for 2010 have already been issued based on **administrative** data?					

2. Many of the questions in the table above required an opinion. Did you arrive at this experience based on your experience in the country, interviews with health workers, other?

D. Reach into poor and remote areas

1. Is there a program that encourages or requires doctors and other health workers to spend part of their career in poor and/or rural areas? What types of health workers does this program cover? At what stage in the health worker's career is this program applied?

2. What are the incentives / penalties used under this human resources program?

INCENTIVES	**Y/N**	**PENALTIES (FOR FAILING TO TAKE UP RURAL POSTING)**	**Y/N**
FINANCIAL – HIGHER SALARY		GRADUATION CONDITIONED ON SERVICE	
FINANCIAL – OTHER BENEFITS		PUBLIC SERVICE JOB CONDITIONED ON SERVICE	
ENHANCED TRAINING OPPORTUNITIES		LOSS OF SENIORITY	
INCREASED CAREER OPPORTUNITIES		NO PENALTY	
GOOD HOUSING			
OTHER (DESCRIBE)			

3. Describe any large-scale programs to incentivize institutional birth deliveries in rural or poor areas. Does it include subsidies for transport, family travel, others? Exemptions from fees? Quality assurance of participating providers?

4. Is there a capital investment program to expand access to emergency obstetric care (including safe blood transfusions) in rural or poor areas? Describe financing and execution of capital investment.

.

5. Are there systematic capital investment programs to expand the supply of services in secondary towns? Describe financing and execution of capital investments.

III. History and Institutional Architecture of HCP

A. Brief history of HCP

1. Motivations, precursors, issues when started, how evolved, domestic political context, donor role

2. FORMAL CREATION OF HCP

Date and main legal instrument creating the HCP. Also describe the type of legal instruments setting implementation rules.

3. Program objectives. Please quote literally from the document of creation.

B. Institutional architecture of HCP

1. Who is the HCP directly accountable to?

Is HCP under a Ministry or other Government agency? Does HCP regularly report to a higher authority (e.g. Presidential or Parliamentary Comission)? Who appoints the Head of HCP?

2. What is the role of the Ministry of Health in relation to the HCP (e.g. policy setting, financing, delivery, monitoring, other)? Is MoH perceived as supportive or not supportive of HCP?

3. What are the sources of revenue of HCP?

	YES/NO
Central Government	
Regional Government	
Local Government	
Social Security Contributions	
External Donors	
Beneficiaries	
Others (describe)	

4. Who are the Financial Agents of HCP?

List all Financial Agents by name and acronym. Also describe the affiliation (e.g. Central Government Agency, Regional or Local Government, Social Security, Autonomous governmental institution, philanthropic, private). Note: "Financial Agents" are all flow-through agencies that incur expenditures for HCP and include among others the following concepts: Fund holders, pooling agents, purchaser, payor. It does not include "Sources of financing" or "Providers of care"

Name of Financial Agent	Acronym	Affiliation

5. Make a drawing of the flow of funds.

Include Sources, Financial Agents and Providers. The main objective of the drawing is to understand the role of the financial agents in the HCP (so please include details about the Financial Agents, no need to be detailed about sources or providers in this drawing.

6. For each Financial Agent in #4 above, describe the type of payment it makes (e.g. budget transfer, insurance premium, provider payments) and the type of proof of execution that it requires (e.g. inputs purchased, outputs purchased, budget distributed according to population size).

The objective of this question is to understand the role of the financial agent and the type of incentives it helps generate.

7. Who are the health care providers for the HCP?

	Private	Philanthropic	Public	Is there choice of provider for HCP

	Yes/No	Yes/No	Yes/no	beneficiaries?
Primary				
Secondary				
Tertiary				

8. Do providers need to be approved (or accredited) to participate in HCP? Who approves/regulates providers? How many providers lost the right to participate in HCP in recent years?

C. Interaction of HCP with rest of the health system.

1. In addition to improving access for the poor, does the HCP "improve the way the health system works"? Is it designed in a way that improves regulation of providers (or of insurers)? Does it increase choice or strengthen competition?

2. Does HCP improve incentives (or reduce rigidities) for public sector…

	Y/N	If yes, How?
hospital managers		
primary care clinic managers		
physicians		
other health workers		

3. Is HCP designed to reduce problems associated with informal payments? If yes, please explain if it is succeeding and what is the evidence?

4. In relation to the HCP, who is the "champion for the poor

5. In relation to the HCP, who is the "champion for improved health outcomes" "? (something or someone in the system whose main interest is to champion the interests of health outcomes– over say the interest of health providers). Does this champion periodically report on indicators measuring how well the HCP serves health outcomes? If yes, describe the indicators. and how is its effectiveness monitored?

6. How independent are the payers from the providers? Is there a planned transition from supply subsidies to demand subsidies? If yes, what progress has been achieved in said transition?

IV. Beneficiaries, Targeting and Enrolment

A. The national system to identify the poor (SIP)

1. Does the country have a SIP (national system to identify the poor)?	
2. What agency runs the SIP?	
3. What mechanism is used to identify the poor? Geographic? Demographic? Income? If income, how is it measured? Proxy-means test?	
4. Is there a national data-base/list of the poor?	
5. Are the poor identified by name? By number? Do children have a number to identify them?	
6. What uses are made of the system to identify the poor? (e.g. CCT, food support, education grants)	

B. Eligibility to the HCP

1. What is the target group of the HCP?

The poor? Does it also include the near-poor? Are there special rules for people with disability, the unemployed, people with special illnesses, "war heroes", the elderly?

2. Does the HCP use the SIP (national system to identify the poor) or does it have a separate system to determine eligibility?

3. How long does eligibility last? Does it need to be recertified?

C. Enrolment

1. Do you have to be "enrolled" in the HCP or is enrolment automatic for those who are eligible? Are there fees to enroll? How often do beneficiaries need to reapply?

2. What agency is in charge of enrolling beneficiaries for HCP? The administrator of HCP? A separate agency? Local Governments? Does enroller have flexibility deciding who to enroll? Community participation? Mechanisms of redress?

3. What are the incentives facing the enroller? To maximize enrolment? To cream-skim? To minimize its costs by minimizing enrolment?

4. Is voluntary enrolment by the non-poor allowed in HCP? Is it subject to a fee? Is it subsidized or is an actuarially fair price being charged? Do the non-poor enroll as groups or individually?

5. How is the enrolled person identified by the health care providers?

D. Targeting Issues

For these questions please try to be as quantitative as possible or provide specific examples.

1. Have there been evaluations of the accuracy of targeting of the HCP? Describe inclusion and exclusion (i.e. Type I and Type II error) found by evaluations. Please scan and provide copy of the evaluation.

2. Is there much alleged fraud? Political clientelism?

3. If the system is designed to be also open to the non-poor with a partial subsidy, does this create problems? Do they absorb a significant fraction of the public subsidies? Are there signs of adverse selection? Do they enrol only once they are sick and need high-cost treatment?

4. Is there stigma? Is there conflict in small communities where some individuals are eligible and others are not?

E. Numbers measuring targets and achievements

1. Target, Enrolment and Utilization

	2010		Comments/Observations
	Administrative Source	Household Surveys	
Target population for HCP[4]			
Enrolment (number of enrolled)			
Utilization: % of enrolled who used inpatient services			
Utilization: % of enrolled who used outpatient services			
Utilization: Number of physician contacts per year per enrollee			
Memo items for comparison: % of non-enrollees who used inpatient services % of non-enrollees who used outpatient serv. Number of physician contacts per year for non-enrollees			

2. Evolution of enrolment during the last decade[5]

2012 estimate	
2011	
2010	
2009	
2008	
2007	
2006	
2005	
2004	
2003	
2002	

[4] If there is no official target number, please estimate the number in the category e.g. if the program aims to provide coverage "to the poor" or "to mothers in poor geographical regions" please estimate the total number of people in that category.

[5] If this information is hard to obtain provide the numbers for the last 5 years only.

2001	

V. Management of the Benefit Package (BP)

A. What are the mechanisms for the setting and revision of the Benefit Package?

1. How is the Benefit package described?

TYPE OF DESCRIPTION	Yes/No[6]	Comments
Positive list		
Negative list		
By health condition		
By clinical procedure		
By broad categories		
By detailed categories		
Based on ICD-10 codes		

2. Describe the institutions and political actors involved in setting or revising the BP. Is there a role for the scientific community?

3. What are the criteria for inclusion of benefits?

Criteria	Yes/No	Comments
Cost Effectiveness		
Affordability		
Financial Protection		
Opinion of scientific community		
No criteria are formally specified		

[6] You may mark YES in more than one category

4. Does the modification of the BP need to explicitly take into account fiscal impact/budget availability? Please provide examples from recent years.

B. How was the cost of the benefit package/HCP defined?

1. Was the initial budget defined based on …Actuarial studies? Guesswork? Examples from previous programs? An amount government was willing to spend?

2. After the HCP began implementation, have there been attempts to estimate the cost of the Benefit Package? Describe the methods used.

C. Benefit Package covered by HCP and cost-sharing by beneficiary

Benefit Package covered by HCP	Covered by HCP? Y/N	Cost-share by beneficiary? Y/N	Comments
Inpatient Services			
Birth delivery			
Emergency Services			
Other Inpatient hospital services			
- Hospital component (hotel services, nursing care, disposables, tests)			
- Physician service components			
- Pharmaceuticals			
- MRI			
Outpatient Services			
Public health services, such as immunizations[7]			
Outpatient primary care contacts			
Outpatient specialist contacts			
Pharmaceuticals for outpatient services			
Clinical laboratory tests for outpatient services			
Diagnostic imaging for outpatient services– basic (X rays and ultrasound)			
Diagnostic imaging for outpatient services – beyond X-rays and ultrasound (e.g. MRI, Cat Scan)			
Other services			
Eyeglasses			
Dental care – basic			
Dental prostheses			
Mental health/behavioral			
Prosthetics and orthotics			
Dialysis or Transplants			
Home-care services			
Paid Maternity Leave (cash benefit)			
Sick leave (cash benefit)			
Funeral Expenditures (cash benefit)			

[7] If public health services are available free of charge but are paid by another program mark "no"

D. Are the following Cost Containment instruments used to manage the BP?

1. Caps on the benefits provided to beneficiaries. Are there caps per beneficiary? Per family? What were the caps in local currency for 2011. If easily available, can you also express this cap as a % of household non-food expenditures?

2. Eligibility and Enrollment criteria (are they manipulated to manage costs?)

3. Limits in type, scope, duration, service coverage conditions and service exclusions

4. Cost sharing by beneficiary (copayments, co-insurance, extra-billing, etc.)

5. Restrictions on freedom of choice of provider. Can beneficiaries chose a private provider? Can they chose a public provider?

6. Price and quantity contracts with providers that specify a maximum expenditure by the program. If this method is used, please discuss how rigorously it is enforced, especially if providers exceed the contracted quantities.

7. Other Macro (expenditure and budget caps) and/or micro provider payment and cost containment policies for HCP.

E. Payment Systems

1. Briefly describe payment systems used by HCP.

2. Who sets prices/rates? Does HCP have autonomy and market power to set prices or is it a price-taker?

3. Are prices/rates different for different types of provider? (e.g. public/private or teaching hospital vs. other)

F. Payment Systems and Cost containment measures

Payment Systems and Cost containment instruments for HCP	Payment System[8] (use codes below)	Utilization Controls[9] (Use Codes below)	Comments
Inpatient Services			
Birth delivery			
Emergency Services			
Other Inpatient hospital services			
- Hospital component (hotel services, nursing care, disposables, tests)			
- Physician service components			
- Pharmaceuticals			
- Diagnostic imaging			
- Adjustments (e.g. teaching, disp. share of poor, capital)			
Outpatient Services			
Public health services, such as immunizations			
Outpatient primary care contacts			
Outpatient specialist contacts			
Pharmaceuticals for outpatient services			
Clinical laboratory tests for outpatient services			
Diagnostic imaging for outpatient services– basic (X rays and ultrasound)			
Diagnostic imaging for outpatient services – beyond X-rays and ultrasound (e.g. MRI, Cat Scan)			
Other services			
Eyeglasses			
Dental care			
Prosthetics and orthotics			
Dialysis or Transplants			
Home-care services			

Codes for Payment Systems and Utilization Controls

Payment Systems:	Utilization Controls
Fee-For-Service=FFS Per Diem=PD Case Payment (e.g. DRG)=CP Performance-Related Pay=P4P Capitation(all services for an individual for a fixed period of time)=CAP All services by a provider for a fixed period of time (i.e. salary or global/line item budget)=SAL Reimbursement to patient for payments= REIM Reference price system to subsidieze medical goods and pharmaceuticals purchased by patients= RP	Cap on reimbursements for this category = CAP Prior Authorization= PA Gatekeeper (referral from gatekeeper required to access a certain service) = GATE Concurrent Review (hospital visit while patient is present) = CONR Utilization Review and Control (statistical review of outliers and follow-up)= URCO Copayments paid by patient=COPAY Deductibles paid by patient=DED

[8] More than one may be used
[9] More than one may be used

G. Enforcement of the right to the HCP benefit package

	Yes/no	Comments
Are rules regulating access to the benefit package widely publicized?		
Is it clear to which public official or agency patients should go if they want to file a complaint about access or quality of the services?		
Does HCP have a system for providing i) acknowledgement of a complaint; ii) a deadline by which redress or an explanation will be given; and iii) written explanations regarding the alleged sub-standard service?		
Is redress available to patients? Does it include an apology and medical treatment?		
Can complaints be filled via internet?		
Are the complaint forms easily understood and available in local languages?		
Are there fees or other costs associated with filing complaints?		
Can NGOs file on behalf of individuals?		
How strong are the appeals procedures for grievance redress? Do claimants have access to genuinely independent agencies (e.g., strong and independent courts, political autonomy and effective ombudsman) if the Ministry's decisions fail to satisfy them?		
Are statistics about complaints released to the public?		
Does the HCP have a system to capture information from the grievance redress system for the purposes of organizational learning?		
Does HCP have a patient advocate or Ombudsman function?		

VI. Public financing for HCP

1. Expenditures of HCP during the last ten years (in local currency)

	Total HCP expenditures in local currency	As % of Public health expenditures	As % of Total Public expenditures	As % of GDP
2012				
2011				
2010				
2009				
2008				
2007				

2006				
2005				
2004				
2003				
2002				

2. Financing of HCP expenditures in 2011 or most recent year available

	Local Currency	Percent of Total
Total expenditures of HCP in 2010		
Government Funding		
- Of which		
- Central Government		
- Payroll taxes/Social Security contributions		
- Sub-National Government		
- Arrears		
Beneficiaries		
- Of which		
- Point of service payments (includes co-payments, user fees, etc.)		
- Registration fees		
- Premium contributions		
- Others (describe)		
External Donor Contributions		
Others (describe)		

3. Are part of the Central Government contributions listed above obtained from taxes earmarked for health (e.g. Sin Taxes) Describe.

4. How is the budget determined ex ante?

	Yes/No	Comments
Cost of inputs for direct provision?		
Estimated cost of reimbursing providers for services?		
Insurance “premiums” for public or private insurance entities?		

B. Is actual spending subject to fixed caps or is health care an entitlement (that is, do patients have a right to care and spending is not subject to appropriation)?

1. If budget caps are fixed and immutable, what happens if demand is greater than what has been budgeted? Are patients turned away? Are there provisions for supplemental appropriations? Do providers perform services expecting to be reimbursed later? In the next year's budget?

2. If spending is an entitlement, are there any controls over total spending? Does spending over budget estimate require legislative approval? What ensures resources are available to pay providers when demand is high? Is there a reserve fund?

3. Have there been issues with predictability of financing? Was money allocated for HCP, but not enough? Were HCP programs disproportionately affected as compared to other programs? Is HCP more or less vulnerable to variability and budget cuts than other budget items?

4. Does the government run arrears to providers? How are arrears addressed?

C. Fiduciary Issues

Refer to public health facilities…	Yes/No	Comments

Are they allowed to pay bonuses to health workers using earned income?		
Are they allowed to manage cash?		
Are there clear procedures for the financial reporting of output based payments received?		
Are there clear procedures for the auditing of output based payments received?		
Do they operate two budgets (one input based, heavily controlled, the other output-based, not controlled, even though funds are public),		

VII. Information Environment

A. Collection and use of HCP-related information

1. Is there a system that tracks use of health care by HCP enrollees? Is this used to improve the care they received in any way? If so, please explain.

2. Is information regularly collected on the following areas?

Information on HCP beneficiaries	**YES/NO**
Demographic information (age/sex/address etc)	
Occupation and Socio economic status	
Health status (e.g. pregnant, diabetic)	
Is there a consolidated National List of Enrollees?	
Information on HCP providers	
Infrastructure, facilities and capabilities	
Quality reporting (infection rates, readmission rates, outcome information etc)	
Provider output/ volume information (overall), case mix	
Provider performance data under the scheme	
Actual input cost data for a costing system	
Information on HCP internal processes	
Utilization statistics by beneficiary	
Utilization statistics by provider	
Payments and accounting information	
Prior authorization and claim status (where applicable)	
Grievance and redressal status	

3. Give examples of actions being taken based on routine analysis of payment and utilization information

4. Is the HCP required to make reports about its execution to a supervisory or parliamentary authority?

Is HCP required to specifically report on progress toward specific goals? Which person/ designation/ entity has the responsibility to examine specific aspects of information compiled by the HCP? Have there been any instances of policy change due to a higher level authority reviewing such information from the HCP?

5. What information is made publicly available?

Both passively (such as through a website) or actively (such as through social marketing campaigns or communication activities undertaken by the HCP). Is there any legal framework for disclosure of information by the HCP on demand by external entities (such as a right/access to information law)

B. Does the HCP have a regular system of onsite inspection or field visits? (e.g. physical verification, medical and/or claim audits)

1. If yes, what is the periodicity and frequency of such visits and who undertakes the same. If not a regular system, are any ad-hoc inspections or field visits undertaken (for example, in response to grievances). Are there clear guidelines and reporting formats whereby findings are systematically reported? How is the information analyzed and/or acted upon?

C. Impact evaluation.

1. Are there plans to evaluate the impact of the HCP? If yes, was there a baseline survey? Is there a clear strategy to define the control group? If an evaluation has been completed, describe the main findings (vis-à-vis scheme objectives, financial protection, health outcomes, quality etc). If no evaluation strategy is in place, explain if there were attempts to do one and the difficulties encountered.

Supplemental Questionnaire

UNICO – The Nuts and Bolts of the program expanding health coverage to the poor (HCP)

This is a supplement to the main Nuts and Bolts questionnaire. It incorporates questions that are necessary to complete or clarify the original questionnaire. We have chosen to issue this as a supplement instead of as a revised questionnaire to avoid potential mistakes originating from the cut and paste it would involve (all teams have already completed the main questionnaire and are working at revising it). The numbering in this supplement makes reference to the original numbering in the main questionnaire (for example, question "II.A.4" is a question that would be placed after question II.A.3 in the original questionnaire).

I. General Information

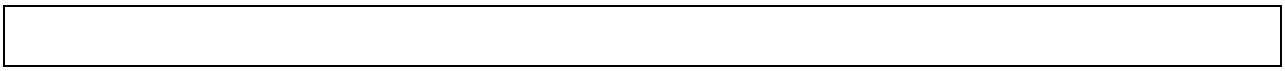
Name of Author (person completing the questionnaire)	
Name of Task Manager for Case Study	
Name of Country	
Name of Heath Coverage Program (HCP)	
Acronym of HCP	
Date of completing this questionnaire	

II.A.4. Brief description of the HCP.

What does it do? What is the institutional set-up? How does it interact with the public providers and with the rest of the health system?

II.A.5. How does the HCP interact with the process of decentralization of health care?

This question is only for countries that have decentralized health care.



VIII. ISSUES FOR DISCUSSION

1. Pending Policy Agenda.

(This asks for the opinion of the authors of the Nuts and Bolts questionnaire. Please write it as you would in Bank ESW: based on where the country is, where it needs to go, and what is realistic)

Questionnaire Section	Pending Agenda
(i) HCP Architecture;	
ii) HCP Beneficiaries, Targeting, Enrollment;	
iii) HCP Management of the Benefit Package;	
iv) Public financing for HCP;	
(v) HCP Information environment and monitoring and evaluation.	
Pending agenda for primary care (based on discussion of II.c)	
Pending agenda for programs that reach into poor and remote areas. Base this discussion on ii.d	
Pending agenda for UC . Discuss here issues not included in the previous questions.	

2. **What special theme do you plan to discuss in your case study? Please choose one that you think other countries would value as lessons learned or because of their analytical value.**

IX. Please give your subjective impression/opinion about the following questions:

(This is to organize the discussion at the Authors' workshop; there are no claims that it has scientific validity)

A. WHAT DIMENSIONS OF "COVERAGE" DOES HCP AIM TO EXPAND? (BASED ON REAL LIFE IMPACT AND BASED ON HISTORY –NOT PROJECTIONS TO THE FUTURE)

Dimension	Yes/no	Strong/medium/weak	Ranking of achievement (Dimension with greatest achievement = 1)	Comments
Population (informal rural)				
Population (informal in towns and secondary cities)				
Population (informal in main cities)				
Population (other)				
User Satisfaction				
Benefit Package (so entire population has access to the full MDG 4,5 and 6 package)				
Benefit package (so benefits beyond the MDG package become available)				
Public financing of health care (first dollar)[1]				
Public financing of health care (last dollar)[2]				
Income loss due to illness or disability				

[1] Government subsidizes basic costs, but does not cover medical costs beyond a cap or a "basic package".

[2] Government assumes the cost of very costly interventions (such as dialysis, transplants, ARVs) and assumes the cost without a cap.

B. Is there a highly publicized benefit from HCP that is used for public relations purposes? (e.g. "All your needs for 20 bahts"; "all have access to transplants", "dental care")

C. There is a debate about the desirability of targeted programs (compared with "Universal" programs). Often politicians declare their programs to be targeted (or to be universal), but under scrutiny they are effectively different from the claims. Is your HCP declared to be targeted or universal? De facto, in your opinion is it targeted or universal?

D. There is a debate about the best way to get to "Universality". Does the experience of your country suggest the best way to travel the road to Universality is to…

a. Incrementally add "programs" to the health system, each of which gives access to new groups starting from the poor?
b. Incrementally add "programs" to the health system, each of which gives access to new groups starting from the better-off and cascading down?
c. Have a major reform to Create universal programs for all from the start
d. It is still too early to say

E. In your country – do the rich and the poor use the same or different….

Do rich and poor use the same….	Yes/no	Within the hospital, same access to high tech?	Within the hospital, same premises/hotel facilities?	Comments
Primary Care facilities				
Secondary hospitals				
Tertiary hospitals				

F. Section V of the main questionnaire describes the management of the benefit package of the HCP. Based on your answers we would like your opinion regarding the BP.

Is the benefit package….	Yes/No	Comments
Well-aligned with the burden of disease of the HCPs target population?		

Cost-effective?		
Well-aligned to provide the most urgent financial protection to the target population of the HCP?		
Revised and managed in a way that provides little fiscal risk? (i.e. it has strong controls)		