



The contribution of the *HealthBASKET* and *HealthACCESS* projects

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&

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Patient mobility

Country A

Benefit Package A using
Service Taxonomy A and
Fee Schedule A

Accessibility A_x

Quality of service A_x

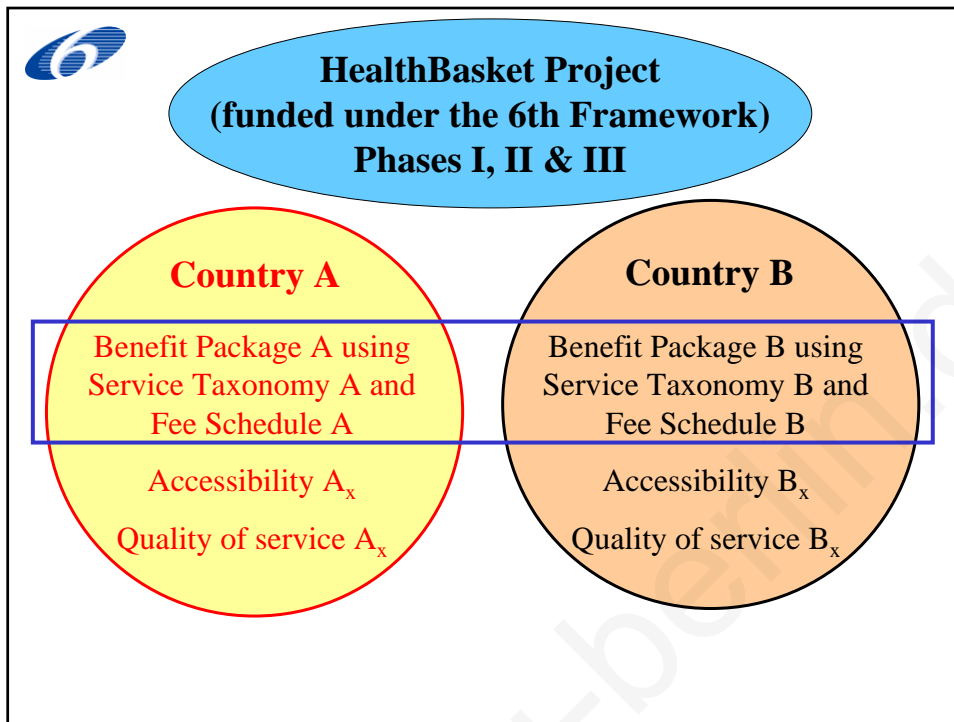
Country B

Benefit Package B using
Service Taxonomy B and
Fee Schedule B

Accessibility B_x

Quality of service B_x

HOW
MANY?
WHY?



- HealthBasket Project
(funded under the 6th Framework)
Phase I**
- I. Overview on benefit basket in country**
1. On which level are entitlements to which service groups of health services/ goods regulated? Constitution? Law? Governmental decree? Health services administration order? Bi-/tri-lateral negotiations? Contracts?
 2. For how many different sectors of health care (and/ or how many regions and/ or how many statutory schemes) exist different regulatory regimes? How many different catalogues exist?
 3. Which is the role of the central government in cases of delegation/ devolution to local and/ or self-regulating actors (e.g. whether pure supervision of process, formal approval of result, or need to transform into governmental decree or similar)?
 4. Which types of benefit categories are excluded (esp. around the edges, e.g. physiotherapy, psychotherapy, dental care, rehabilitation)?

HealthBasket Project - Phase I

II. Definitions of entitlements and benefits by sector

1. Who are the actors responsible for defining benefits for this sector and what is their respective role?
2. Are the benefits defined explicitly (i.e. existing in a written form), implicitly (i.e. based on tradition) or as mixture of both? Is the definition of benefits specific or rather vague? Are they defined in a positive or negative way (i.e. listing the included or excluded services)? Are the included benefits simple enumerations of procedures or goods or are they linked to patients' conditions/ indications?
3. How are benefits classified, i.e. itemised by service delivered or individual good (e.g. for pharmaceuticals), case-based per time-period ("all necessary services", e.g. in primary care), case-based per diagnosis etc., per provider per time period?
4. Are positive or negative, implicit or explicit definitions uniform for all payers? If not, is there a certain core uniform for all payers? How and by whom is that defined? If benefit catalogues vary, what are the deciding entities (e.g. insurance scheme, sickness funds within one scheme, regional/ local health authorities) and how many of them are there?

Preliminary findings

- Country approaches to benefit definition vary greatly
- Benefits vary within countries (e.g. Spain; creating possibly larger inequities than between countries as E-111 is not valid)

A supplement of the European Journal of Health Economics summarising the results will be available this autumn.

Taxonomy

theoretical study of classification,
including its basic principles,
procedures, and rules –
“the science of classification”

Diseases: ICD;
Functional impairments: ICF;
Health care providers: System of Health Accounts;
Health services and goods: ???

International Classification for Health Accounts (ICHA) – one- and (partly) two-digit level

| HP Code | Classification of Health Care Provider (HP) Description | HC Code | Functional Classification (HC) * Description |
|---------|---|---------|--|
| 1 | Hospitals *) | | <i>Personal Health Care Services and goods</i> |
| 2 | Nursing and residential care facilities *) | 1 | Services of curative care |
| 3 | Providers of ambulatory health care | 2 | Services of rehabilitative care |
| 31 | Offices of physicians | 3 | Services of long-term nursing care |
| 32 | Offices of dentists | 4 | Ancillary services to health care |
| 33 | Offices of other health practitioners | 5 | Medical goods dispensed to out-patients |
| 34 | Out-patient care centers | | <i>Collective health care services</i> |
| 35 | Medical and diagnostic laboratories | 6 | Prevention and public health services |
| 36 | Providers of home health care services | 7 | Health administration and health insurance |
| 39 | Other providers of ambulatory health care | HCR | Health-related functions |
| 4 | Retail sale and other providers of medical goods | 1 | Capital formation of health care provider institutions |
| 41 | Dispensing chemists | 2 | Education and training of health personnel |
| 42 | Retail sale and other suppliers of optical glasses | 3 | Research and development in health |
| 43 | Retail sale and other suppliers of hearing aids | 4 | Food, hygiene and drinking water control |
| 44 | Retail sale and other suppliers of other medical appliances | 5 | Environmental health |
| 49 | All other miscellaneous suppliers of medical goods | 6 | Administration and provision of social services in kind to assist living with disease and impairment |
| 5 | Provision and administration of public health programmes | 7 | Administration and provision of health-related cash-benefits |
| 6 | General health administration and insurance | HF | Classification of Health Care Financing (HF) |
| 61 | Government administration of health | Code | Description |
| 62 | Social security funds | 1 | General Government |
| 63 | Other social insurance | 11 | Gen. Gov. excluding social security funds |
| 64 | Other (private) insurance | 12 | Social security funds |
| 69 | All other providers of health administration | 2 | Private sector |
| 7 | Other industries (rest of the economy) | 21 | Private social insurance |
| 71 | Establishments as providers of occupational health care | 22 | Private insurance (other than social insurance) |
| 72 | Private households as providers of home care | 23 | Private households |
| 79 | All other industries as secondary producers of health care | 24 | Non-profit institutions serving households |
| 9 | Rest of the world | 25 | Corporations (other than health insurance) |

*) two and three digit level omitted ; Source: OECD (2000)

Functional Classification

HC.1 Services of curative care

HC.1.1 In-patient curative care

- HC.1.2 Day cases of curative care
- HC.1.3 Out-patient care
 - HC.1.3.1 Basic medical and diagnostic services
 - HC.1.3.2 Out-patient dental care
 - HC.1.3.3 All other specialised health care
 - HC.1.3.9 All other out-patient curative care
- HC.1.4 Services of curative home care

HC.2 Services of rehabilitative care

- HC.2.1 In-patient rehabilitative care
- HC.2.2 Day cases of rehabilitative care
- HC.2.3 Out-patient rehabilitative care
- HC.2.4 Services of rehabilitative home care

HC.3 Services of long-term nursing care

- HC.3.1 In-patient long-term nursing care
- HC.3.2 Day cases of long-term nursing care
- HC.3.3 Long-term nursing care: home care

HC.4 Ancillary services to health care

- HC.4.1 Clinical laboratory
- HC.4.2 Diagnostic imaging
- HC.4.3 Patient transport and emergency rescue
- HC.4.9 All other miscellaneous services

HC.5 Medical goods dispensed to out-patients

- HC.5.1 Pharmaceuticals and other medical non-durables
 - HC.5.1.1 Prescribed medicines
 - HC.5.1.2 Over-the-counter medicines
- HC.5.2 Therapeutic appliances and other medical durables
 - HC.5.2.1 Glasses and vision products
 - HC.5.2.2 Orthopaedic appliances and other prosthetics
 - HC.5.2.3 Hearing aids
 - HC.5.2.4 Medico-technical devices, incl. wheelchairs
 - HC.5.2.9 All other miscellaneous medical durables

HC.6 Prevention and public health services

- HC.6.1 Maternal and child health; family planning ...
- HC.6.2 School health services
- HC.6.3 Prevention of communicable diseases
- HC.6.4 Prevention of non-communicable diseases
- HC.6.5 Occupational health care
- HC.6.9 All other miscellaneous public health services

Preliminary findings and conclusions

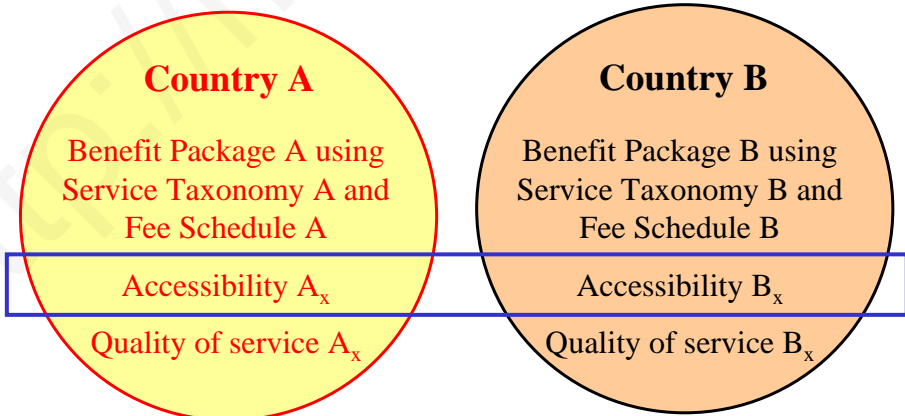
- No country has one uniform catalogue across sectors; it's rather a mixture of differently defined lists
- Taxonomy even within sectors differs from country to country (even if many use e.g. DRGs)
- A uniform taxonomy is urgently needed for both practical and scientific purposes

HealthBasket Project
(funded under the 6th Framework)
Phases II & III

- How do countries fix/ negotiate reimbursement?
- How much do prices/ reimbursement rates really differ?
 Or are they rather explained by systematic differences (e.g. capital costs included/ not included)?
 Or by differences in service intensity (e.g. pre-operative tests)?

Methodology:
Case vignettes

HealthAccess Project
(funded under the Public Health Programme)



Accessibility of health care

= A measure of the proportion of a population that reaches appropriate health services (WHO, 1998).



*WHO Regional Office for Europe (1998) Terminology –
A glossary of technical terms on the economics and
finance of health services; EUR/ICP/CARE0401/CN01*

The 6 leading questions in regard to access hurdles

**HealthAccess
Project - Phase I**

- Who is covered?
- What benefits are included under this cover?
- Do accessible providers offer services when they are needed/ appropriate?
- Do cost-sharing regulations impact on the demand for, and therefore access to, these services?
- Do their capacities allow the actual delivery of the appropriate services?
- Are the available appropriate services acceptable?

How could this influence European health systems? (1)



Initially probably not directly, but

- *Comparability* of available services, their costs and accessibility (and quality) *will increase*, and thereby contribute to the *Europeanisation of health care systems*, already on the way through
- mobility of short- and long-term tourists,
- cross-border contracts/ Euregios,
- ECJ rulings on Kohll/ Decker, Peerbooms etc.,
- the EU-health insurance card.

How could this influence European health systems? (2)



This might in the medium-term probably lead to

- a European *benefit catalogue* (but not equal prices),
- Europe-wide rules/ standards for *accreditation* and *quality assurance*,
- Europe-wide diagnosis/ treatment *guidelines*.

This could make *Europe more concrete for its citizens* and help to *remove the conflict between markets and the social model*.

This presentation and more
material can be found on my
department's website

<http://mig.tu-berlin.de>

