Technische Universität Berlin

The contribution of the *Health*BASKET and *Health*ACCESS projects

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European Observatory on Health Systems and Policies

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Expenditure for cross border care

(here: imported goods and services in €/capita)

negligible or under-counted?

Source: Palm et al. 2000

	1989	1993	1997	1998
Belgium	3.62	8.93	8.93	4.38
Denmark	-	0.16	0.83	0.63
France	0.79	1.87	1.21	1.05
Germany	1.77	1.83	2.08	2.21
Greece	0.95	2.51	2.68	3.15
Ireland	0.18	0.65	1.68	0.93
Italy	2.99	8.36	3.52	2.89
Luxembourg	58.01	149.55	135.29	116.00
Netherlands	1.95	0.26	1.98	2.85
Portugal	0.82	3.76	6.81	7.00
Spain	0.33	1.48	1.03	1.11
United Kingdom	0.33	1.61	1.92	0.36
Austria	-	-	0.48	1.87
Finland	-	-	0.49	0.52
Sweden	-	-	0.65	0.96
AVERAGE	1.31	2.95	2.37	1.99

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Foreign EU patients treated annually in 2000/01: exported goods and services

<table>
<tr><th></th><th>total invoice (€)</th><th>E112 persons</th><th>E111 persons</th></tr>
<tr><td>B</td><td>168 790 871</td><td>14 061</td><td></td></tr>
<tr><td>DK</td><td></td><td colspan="2">2 401</td></tr>
<tr><td>E</td><td>20 559 825</td><td>3 156</td><td>133 958</td></tr>
<tr><td>F</td><td>297 200 000</td><td colspan="2">435 856</td></tr>
<tr><td>I</td><td></td><td colspan="2">1 022</td></tr>
<tr><td>IRL</td><td></td><td colspan="2">1 ?</td></tr>
<tr><td>L</td><td></td><td>4 101</td><td>250</td></tr>
<tr><td>NL</td><td></td><td colspan="2">3 316</td></tr>
<tr><td>AT</td><td>5 160 000</td><td colspan="2">1 000</td></tr>
<tr><td>FIN</td><td>951 000</td><td>9</td><td>11 483</td></tr>
<tr><td>SW</td><td>9 504 411</td><td></td><td></td></tr>
<tr><td>UK</td><td>8 720 428</td><td>871</td><td></td></tr>
</table>

No data: D, GR, P

Commission staff working paper, July 2003

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Germany: Imported goods and services = best contained area of health expenditure!

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
SHI expenditure total in € bn	99	99	108	113	117	116	118	122	124	129	133
in % GDP	6.14	6.00	6.20	6.27	6.36	6.18	6.13	6.15	6.13	6.21	6.32
Outside the country in € bn	**0.36**	**0.35**	**0.33**	**0.36**	**0.40**	**0.35**	**0.34**	**0.35**	**0.37**	**0.37**	**0.41**
as % of SHI expenditure	**0.36**	**0.36**	**0.31**	**0.32**	**0.34**	**0.30**	**0.29**	**0.29**	**0.30**	**0.29**	**0.31**
as % of GDP	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**
Total expenditure in €bn	163	168	180	194	203	204	208	214	219	227	234
in % GDP	10.1	10.2	10.4	10.8	11.1	10.9	10.8	10.8	10.8	11.0	11.1
Outside the country in € bn	**0.38**	**0.37**	**0.35**	**0.38**	**0.42**	**0.37**	**0.37**	**0.38**	**0.40**	**0.41**	**0.44**
as % of total expenditure	**0.23**	**0.23**	**0.19**	**0.20**	**0.21**	**0.18**	**0.18**	**0.18**	**0.18**	**0.18**	**0.19**
as % of GDP	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**

Federal Statistical Office, 2004.

Ca. €4.70/capita

Ca. €5.40/capita

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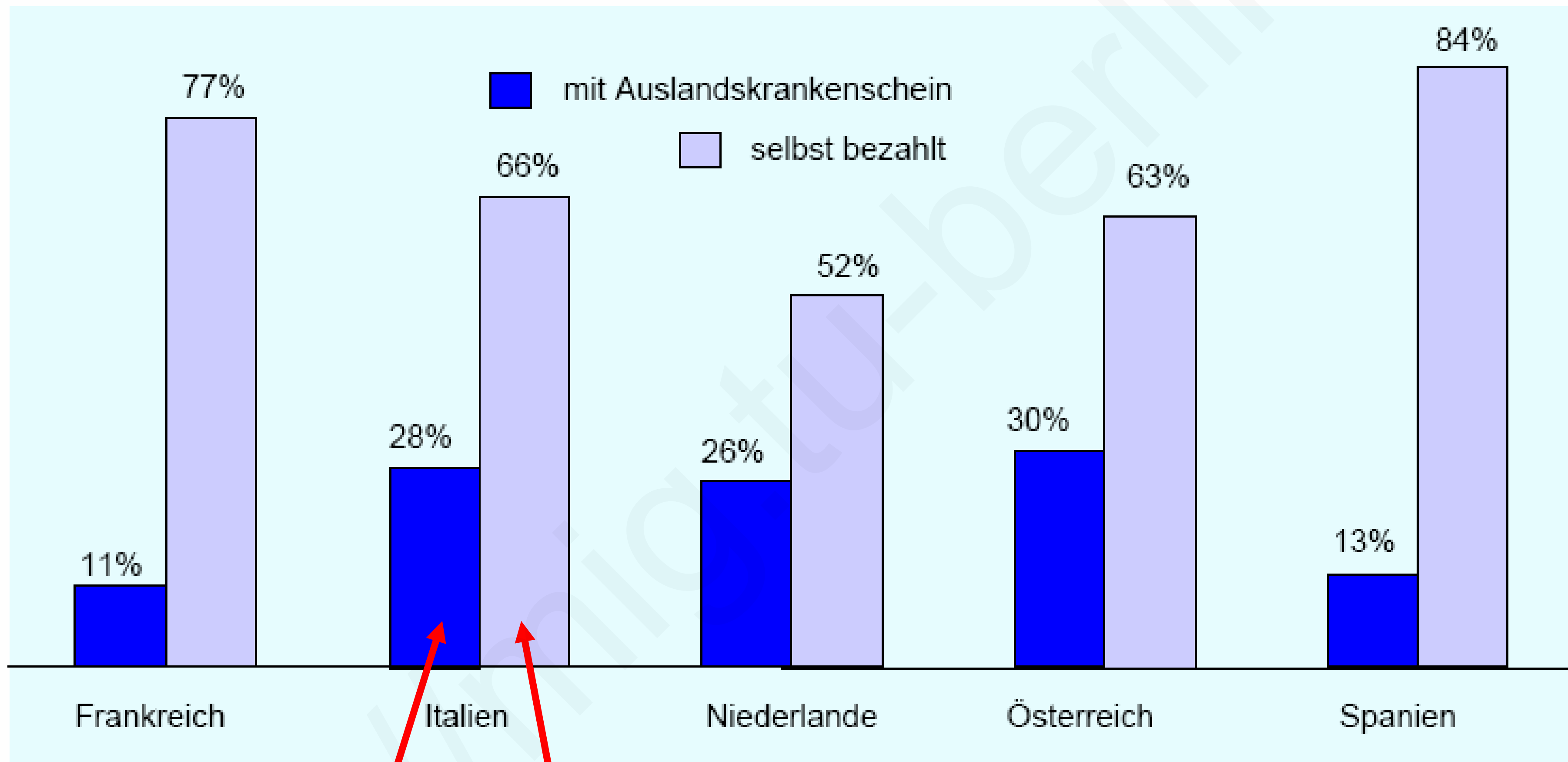
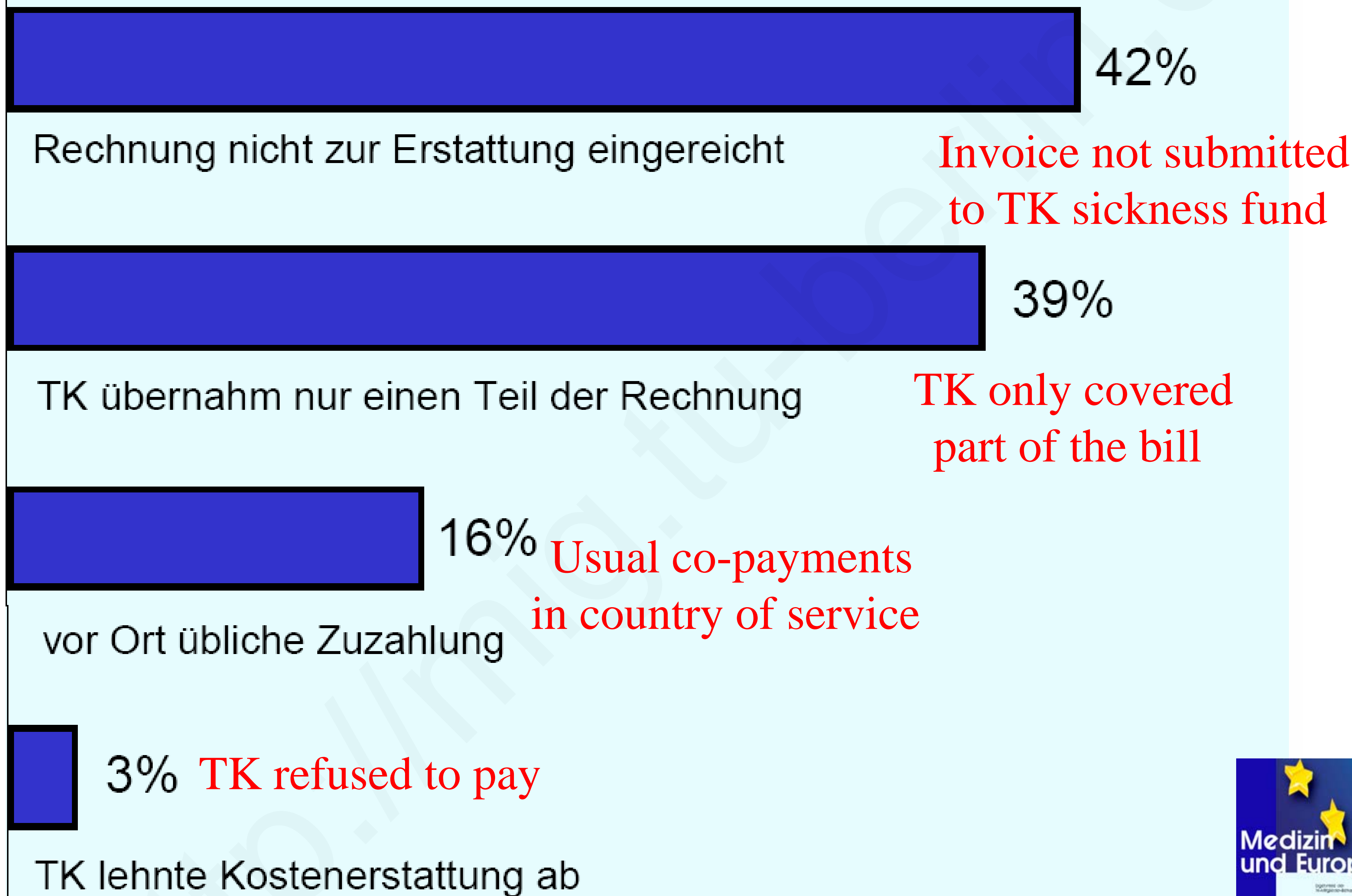
Is this the whole truth? Most likely not …



E111 self-pay

Medizin und Europa

Reasons for not being (fully) reimbursed



Pull?

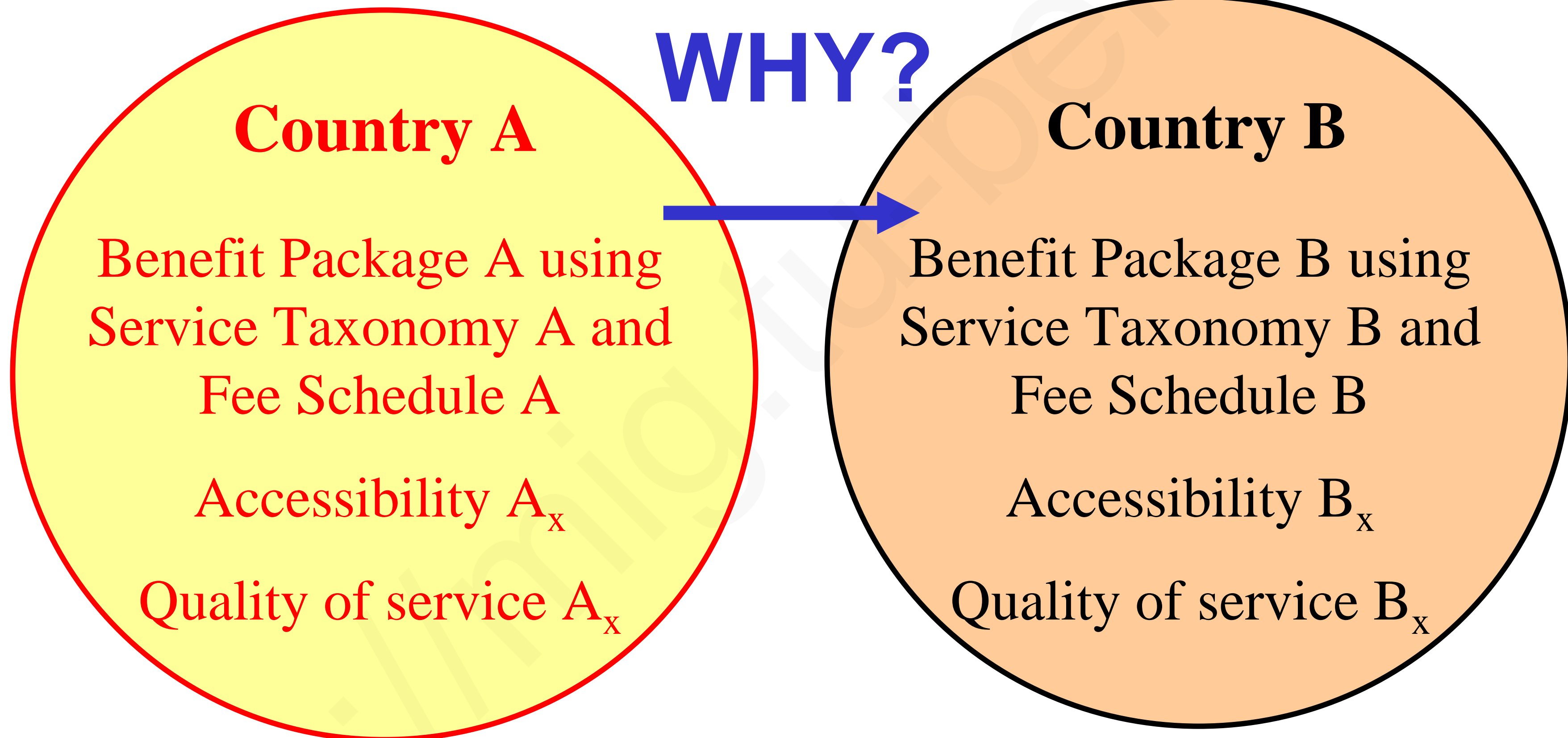
	Österreich	Niederlande	Frankreich	Italien	Spanien
schlechter	4%	5%	11%	38%	39%
gleichwertig	56%	41%	40%	18%	15%
besser		12%			

besser · gleichwertig · schlechter · Differenz zu 100% = keine Angaben

Better · Same · Worse

Patient mobility

HOW MANY?



WHICH SERVICES?

WHAT COSTS?
(SERVICES x REIMBURSEMENT)

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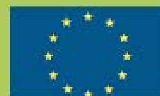
HEALTH BENEFITS AND SERVICE COSTS IN EUROPE

A European Research Project
April 2004 – March 2007



PROJECT PARTNERS ARE...

European Health Management Asssociation

Centre for Health Economics,
University of York, United Kingdom

Department of Health Care Management,
Berlin University of Technology, Germany

Health Services Management Training Centre,
Semmelweis University, Hungary

École Nationale de la Santé Publique,
France

Institute for Health Policy and Management,
Erasmus University Rotterdam, The Netherlands

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http://mig.tu-berlin.de

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

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

www.*Health*BASKET.org

http://mig.tu-berlin.de

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: ???

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What do we want to find out?

- In what areas/ services do benefit baskets differ among EU countries, i.e. where can patients benefit by moving (under the E111 procedure)?
- How much do prices/ reimbursement rates really differ? Are differences explained by systematic factors (e.g. capital), differences in service intensity or costs per service?
    - *We are not investigating expenditure (= number of patients x reimbursement)!*

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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)?

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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?

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Phase I 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)
- Taxonomy: inpatient care = diagnosis, then procedure; ambulatory care = speciality, then procedure (but huge variation in details)

A supplement of the European Journal of Health Economics summarising the results will be available in October.

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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

www.*Health***BASKET**.org

http://digital.tu-berlin.de

HealthAccess Project
(funded under the Public Health Programme)

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

http://mig.tu-berlin.de

The 6 leading questions in regard to access hurdles

HealthAccess Project - Phase I

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

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Phase I findings

- Hurdle 1 (population coverage) has been lowered by many countries (e.g. CMU in France, Netherlands from 2006)
- In many countries, hurdle 2 (benefits) has been lowered e.g. through new long-term care benefits; mixed results regarding equity through regionalisation with different e
- Hurdle 3 (cost-sharing): mu worry, hardly any sound sc
- Hurdle 4: growing in public
- Hurdle 5, especially waiting: s in many countries but actual problem

HealthAccess Project - Phase II: Does cross-border care help to overcome these hurdles?

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This presentation and more material can be found on the following websites:

http://mig.tu-berlin.de

www.*Health*BASKET.org

European Observatory on Health Systems and Policies

http://mig.tu-berlin.de