Access to Healthcare Services Within and Between Countries of the European Union

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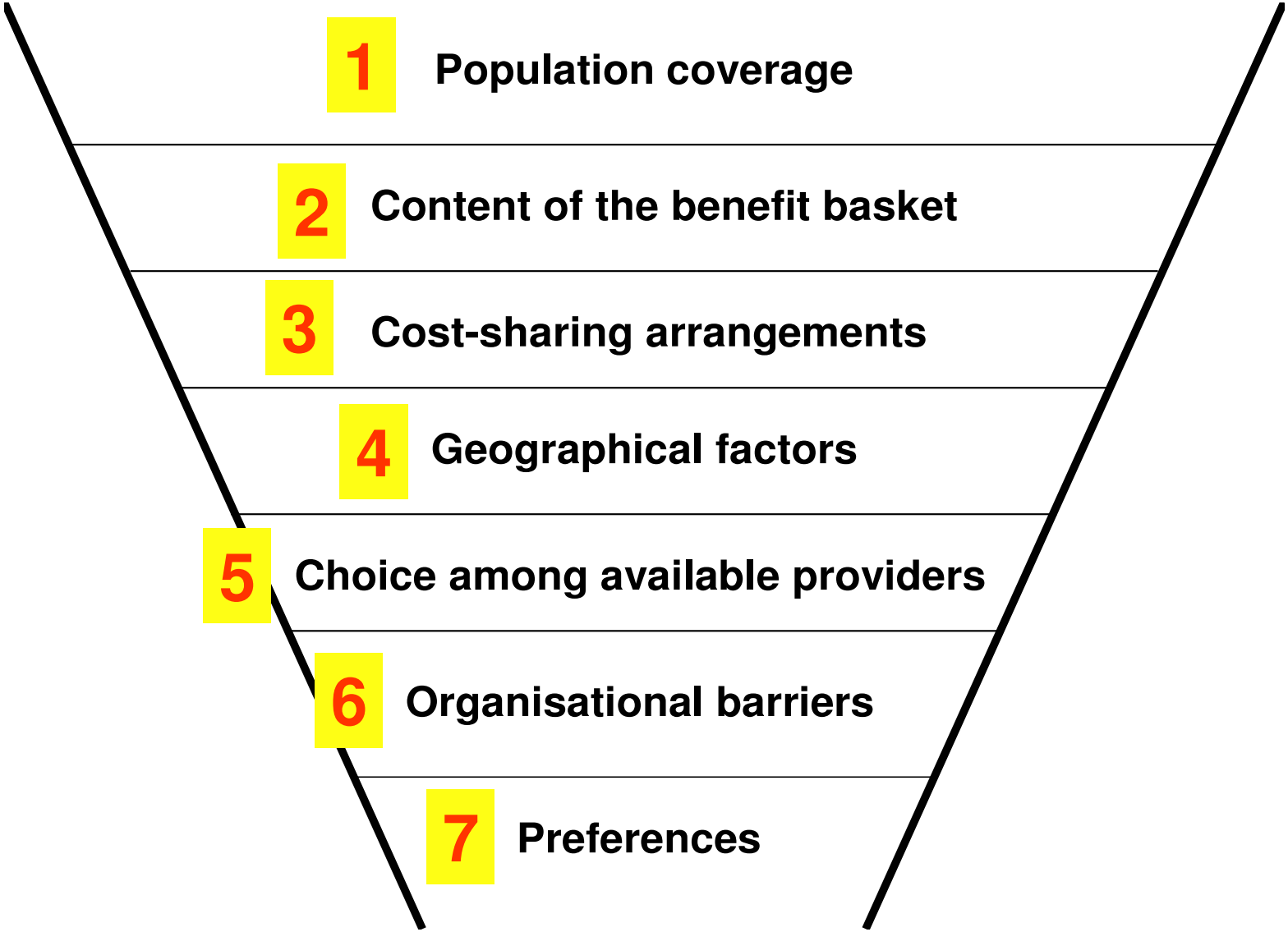
Introduction

- Access to health care services is regarded as an essential right in the Member States of the European Union.
- “Everyone has the right of access to preventive health care and the right to benefit from medical treatment *under the conditions established by national laws and practices*. A high level of Human health protection shall be ensured in the definition and implementation of all Union policies and activities” (Article 35 of the Charter of Fundamental rights)

Structure

- Access to healthcare within countries
  - Barriers or preferences that force people abroad?
- Access to healthcare between countries
  - Can national access problems be overcome/ easened through cross-border care?
  - Problems?

The Filter Model: the seven steps of accessing healthcare services



1

Step 1: population coverage (who is covered?)

- Most of the countries in the European Union have de facto universal coverage – but even this will exclude, depending on the country, certain groups (such as refugees and illegal immigrants)

2

Step 2 Content of the benefit basket

- Huge differences in definition, but minor variations exist between countries if statutorily covered benefits are analysed by categories (main exceptions: dental services; exclusions on the basis of bio-ethical legislation)
- However, since applied taxonomies differ widely between (and sometimes within!) Member States, huge differences may exist in how patients with identical conditions are treated, reflected in the choice of technologies, procedures, staffing mix and usage intensity

3

Step 3 Cost sharing

- Cost sharing requirements represent a visible problem in only a handful of countries – though a minority seems to be negatively affected in each country
- But: no data available on individual sub-sectors or services (except dental care for which money is THE reason for unmet need)

3 Main reasons for unmet need for medical examination and treatment

Country	Hurdle 3: Could not afford (too expensive)	Hurdle 4: Too far too travel / no means of transportation	Hurdle 6: Waiting list	Other	No unmet need
Austria	0.23%*	#	#	1.57%	98.04%
Belgium	0.68%	#	#	0.24%*	99.04%
Cyprus	2.95%	#	#	2.76%	94.13%
Czech Rep	0.32%*	0.47%*	0.40%*	5.95%	92.86%
Germany	6.69%	0.14%*	1.74%	7.93%	83.49%
Denmark	#	#	#	0.81%*	98.94%
Estonia	2.74%	0.81%	2.15%	2.55%	91.75%
Spain	0.41%	0.19%	0.70%	4.87%	93.84%
Finland	1.41%	#	0.98%	0.93%	96.62%
France	1.24%	#	0.21%*	2.10%	96.42%
Greece	3.44%	0.45%	0.62%	1.66%	93.83%
Hungary	2.44%	0.37%	0.73%	12.56%	83.90%
Ireland	1.06%	#	0.65%	0.51%	97.67%
Italy	3.14%	0.09%*	1.36%	2.11%	93.30%
Lithuania	3.65%	0.39%*	2.32%	2.89%	90.75%
Luxembourg	0.35%*	#	#	4.30%	95.23%
Latvia	17.01%	0.62%*	1.72%	10.27%	70.38%
Malta	1.01%	#	0.50%*	2.12%	96.35%
Netherlands	#	#	0.28%*	0.97%	98.57%
Poland	7.13%	0.44%	2.26%	6.32%	83.85%
Portugal	3.77%	#	0.77%	0.77%	94.56%
Sweden	0.50%*	#	2.02%	12.38%	85.00%
Slovenia	#	#	#	0.19%*	99.48%
Slovakia	2.52%	0.19%*	0.34%*	4.80%	92.15%
UK	#	#	2.14%	2.96%	94.77%

EU-SILC (2005)

3 Main reasons for unmet need for dental examination and treatment

Country	Hurdle 3: Could not afford (too expensive)	Hurdle 4: Too far too travel / no means of transportation	Hurdle 6: Waiting list	Other	No unmet need
Austria	0.85%	#	0.23%*	1.38%	97.48%
Belgium	1.56%	#	#	1.14%	97.20%
Cyprus	5.92%	#	#	6.99%	86.84%
Czech Rep	0.51%*	#	#	4.34%	94.84%
Germany	6.13%	0.12%*	0.54%	5.47%	87.75%
Denmark	1.76%	#	#	2.54%	95.48%
Estonia	11.63%	0.32%*	0.29%*	1.28%	86.48%
Spain	4.07%	0.11%*	#	4.59%	91.20%
Finland	2.82%	#	1.39%	2.30%	93.42%
France	3.24%	#	0.14%*	2.76%	93.77%
Greece	5.00%	#	0.17%*	1.83%	92.84%
Hungary	6.51%	#	0.38%	7.83%	85.18%
Ireland	1.64%	#	0.25%*	1.48%	96.58%
Italy	6.03%	#	0.75%	3.43%	89.71%
Lithuania	8.85%	#	1.00%	1.49%	88.53%
Luxembourg	0.69%	#	#	3.55%	95.71%
Latvia	22.60%	#	0.57%*	5.78%	70.85%
Malta	1.19%	#	#	2.73%	95.93%
Netherlands	1.25%	#	#	5.24%	93.28%
Poland	9.77%	0.15%	1.52%	5.05%	83.51%
Portugal	7.85%	#	0.27%*	2.21%	89.58%
Sweden	6.16%	#	0.39%*	5.95%	87.44%
Slovenia	#	#	#	#	99.37%
Slovakia	4.03%	#	0.26%*	3.23%	92.43%
UK	0.73%	#	4.09%	1.35%	93.75%

EU-SILC (2005)

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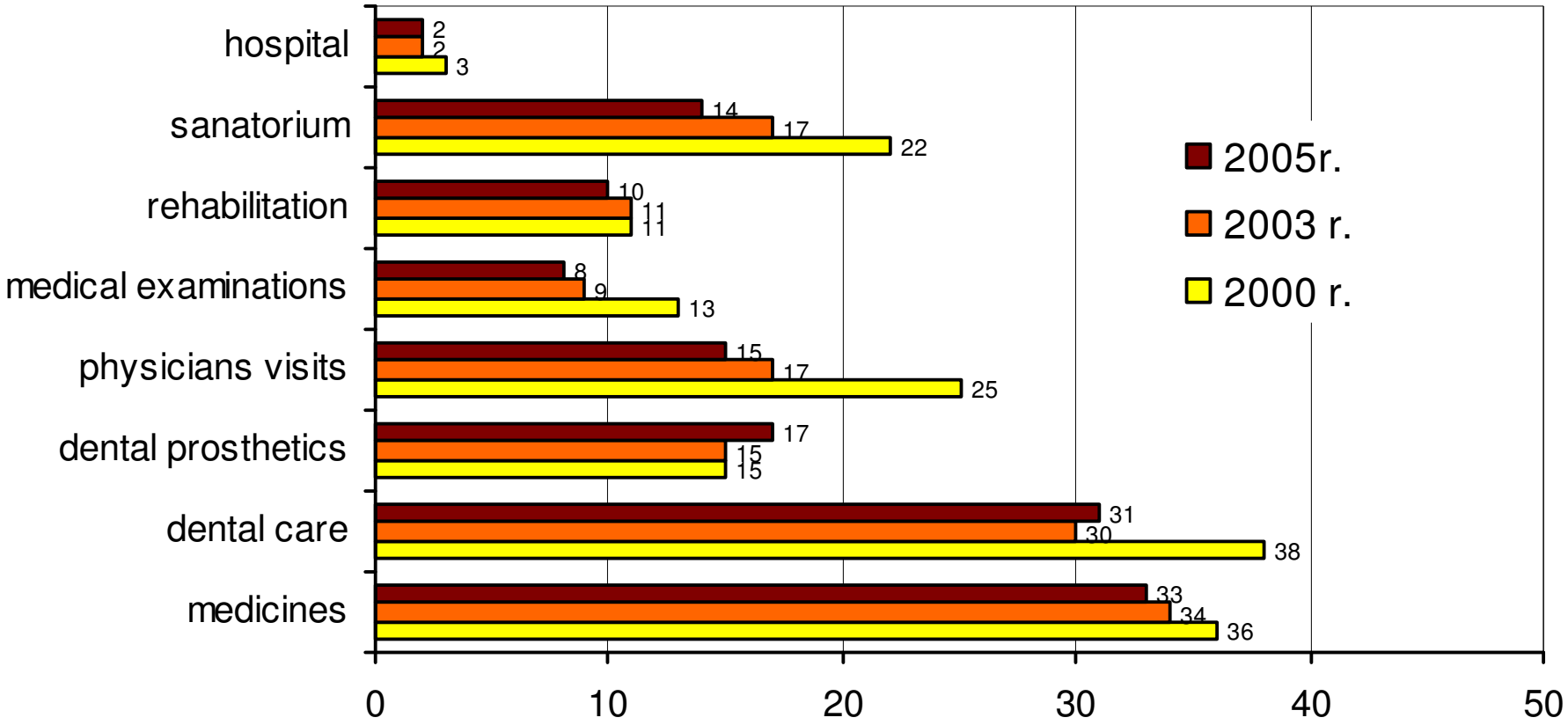
Access problems due to financial difficulties in Poland 2000-05



… very little data from other countries!

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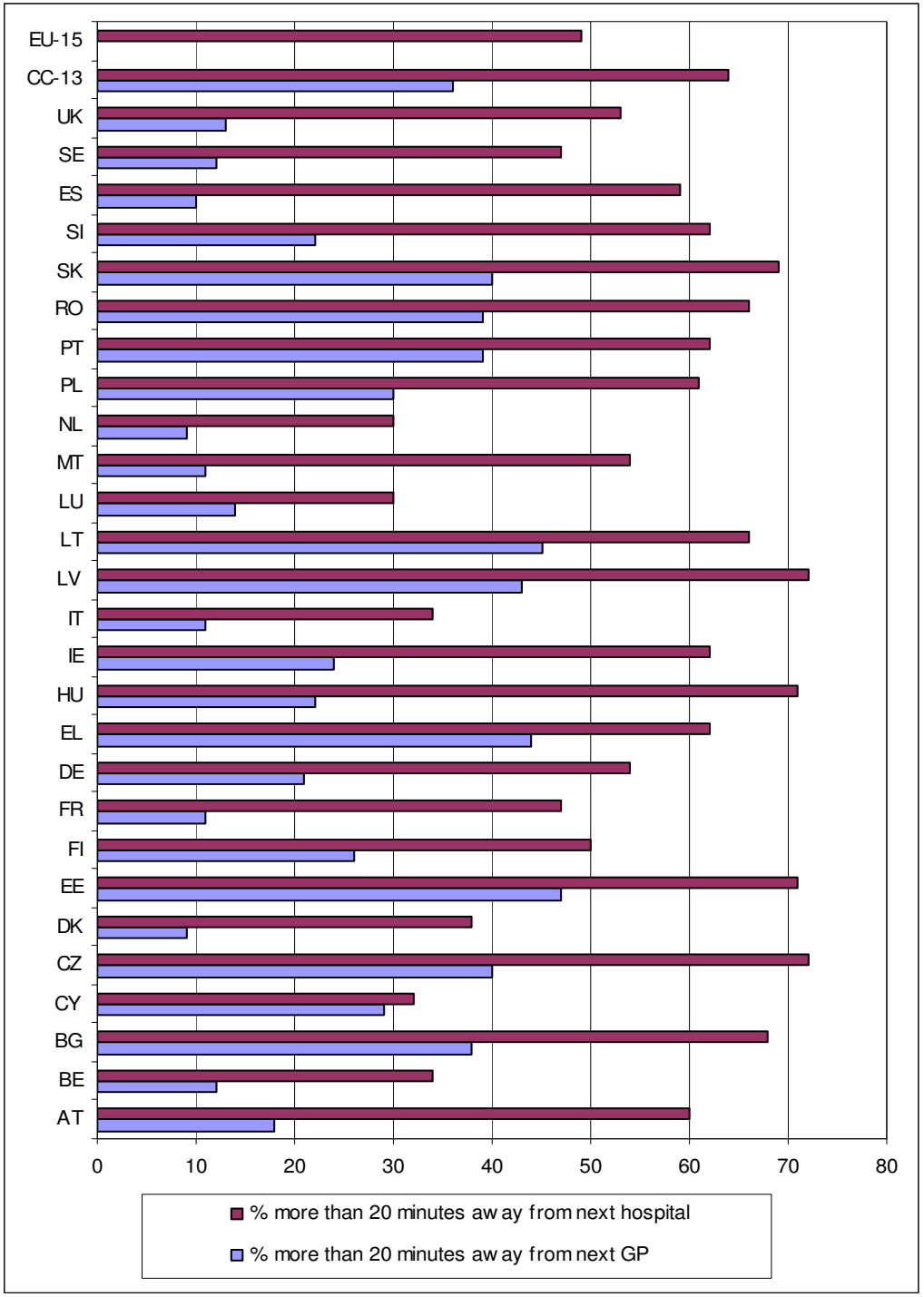
Step 4: Geographical factors

Four factors regarding access:

- Remoteness
- Density of providers
- Size of the country
- Proximity to a national border



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SILC and Eurobarometer (1999 and 2002) data support the view that remoteness is generally not a major access bottleneck in the European Union

4

Aggregate data can conceal regional variation in density within countries

	Acute hospital beds per 100,000 inhabitants			active physicians per 100,000 inhabitants			GPs per 100,000 inhabitants			Nursing home beds per 100,000 inhabitants		
	Min	Max	Av.	Min	Max	Av.	Min	Max	Av.	Min	Max	Av.
Austria	564	1.171	834	-	-	-	87	169	142	-	-	-
Belgium	497	819	536	366[a]	597[a]	404[a]	-	-	144	-	-	-
England	-	-	223[1]	-	-	-	53	69	61[2]	-	-	-
France	343	488	390	256	426	340	137	194	166	-	-	-
Germany	518	860	627	317	548	368	49	60	52	744	1,161	864
Ireland	238[c]	383[c]	337[c]	-	-	283[d e]	51[c f]	94[c f]	63[c f]	491[c]	850[c]	608[c]
Italy	340	490	430	-	-	600[3]	62	108[4]	95[5]	31[6]	904	294[7]
Poland	413	581	491	160	280	230	-	-	-	8	72	41
Hungary	445	975	-	225,1	424,5	284,9	47,6	55,0	50,4	-	-	-
the Netherlands	180[a]	430[a]	330[a]	174[a]	499[a]	327[a]	41[a]	44[a]	42[a]	180[a]	540[a]	380[a]

Source: Data provided by the country experts

Factor 2.4 **Factor 2.9** **Factor 1.9** **Factor 33**

Geographical factors (continued)

- Geographical access to health care providers can be more difficult in smaller Member States (e.g. Luxembourg, Malta, Cyprus) – which do not have enough patients to justify having certain institutions or technologies available in the country.
- That “smallness” of a country is relative, can be shown for the case of orphan diseases which, for the purpose of the EU Orphan drug regulation, are defined as diseases which are present in a maximum of 1 per 2000 persons
- The fourth geographical aspect is the proximity of a national border. A similar situation to may also arise at the periphery of larger countries where the nearest appropriate health care provider may be located across the border.

4 ountry	Erythro-poetic proto-porphyria (50/ 100000)	Marfan syndrome (30/ 100000)	Systemic sclerosis (20/ 100000)	Cystic fibrosis (12/ 100000)	Huntington disease (6/ 100000)	Gaucher disease (1/ 100000)	Factor VII deficiency (0.25/ 100000)
Austria	4050	2430	1620	972	486	***81***	***20***
Belgium	5200	3120	2080	1248	624	***104***	***26***
Bulgaria	3900	2340	1560	936	468	***78***	***20***
Cyprus	400	240	***160***	***96***	***48***	***8***	***2***
Czech Rep	5100	3060	2040	1224	612	***102***	***26***
Germany	41250	24750	16500	9900	4950	825	206
Denmark	2700	1620	1080	648	324	***54***	***14***
Estonia	700	420	280	***168***	***84***	***14***	***4***
Finland	2600	1560	1040	624	312	***52***	***13***
France	29900	17940	11960	7176	3588	598	***150***
Greece	5400	3240	2160	1296	648	***108***	***28***
Hungary	5050	3030	2020	1212	606	***101***	***25***
Ireland	2000	1200	800	480	240	***40***	***10***
Italy	28800	17280	11520	6888	3444	576	***144***
Latvia	1150	690	460	276	***138***	***23***	***6***
Lithuania	1750	1050	700	420	210	***35***	***9***
Luxembourg	***200***	***120***	***80***	***48***	***24***	***4***	***1***
Malta	***200***	***120***	***80***	***48***	***24***	***4***	***1***
Netherlands	8100	4860	3240	1944	972	***162***	***41***
Poland	19100	11460	7640	4584	2292	382	***96***
Portugal	5200	3120	2080	1248	624	***104***	***26***
Romania	10850	6510	4340	2604	1302	217	***54***
Slovenia	1000	600	400	240	120	20	***5***
Slovakia	2700	1620	1080	648	324	54	***14***
Spain	20550	12330	8220	4932	2466	411	***103***
Sweden	4500	2700	1800	1080	540	90	***23***
UK	29650	17790	11860	7116	3558	593	***99***

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Step 5: Choice of available providers

- The right to choose care is – officially – a common element in all EU Member States
- But: in some countries restricted to primary care, to public or/and contracted care or only within one region (or in combination)
- Therefore, the formally ‘free’ choice is often quite restricted as Missoc data show. But even these data overstate the degree of choice as non-contracted providers are not “seen”.

Member State	Primary Care	Secondary care
Austria	Only contracted doctors	Free among public hospitals, if no additional costs arise
Belgium	Free	Free among approved hospitals
Cyprus	Free choice of government doctors, not obliged to register with one GP	free, on referral to hospital where doctor is employed
Czech Rep.	Free	Free choice of contracted hospitals
Denmark	Group 1: Only GPs that joined 'collective agreement'; Group 2: Free	Free for public hospitals, if waiting time exceeds 2 months also private and abroad
Estonia	Free	On referral
Finland	Determined by district of residence	Determined by district of residence
France	Free	Free among public and private (approved) hospitals
Germany	Free among contracted sickness fund doctors	Free choice of licensed hospitals
Greece	In urban regions, the insured choose doctor according to a list. In rural areas, there is no free choice: the insured goes to the local insurance institute doctor	Only public hospital and registered clinic designated by the insurance institute, or in hospital of social insurance institute
Hungary	Free choice of contracted doctors	No free choice (only in case of emergency)
Ireland	Persons with full eligibility choose from list of local GPs	On referral
Italy	Free in region for approved GPs	Free for public hospitals and contracted private hospitals
Latvia	Free	On referral, patients can choose between contracted hospitals
Lithuania	Free	On referral
Luxembourg	Free	Free
Malta	Free	Free, however, due to size only limited number of hospitals available, e.g. only 2 general hospitals
Netherlands	Free	Free, but co-payment for uncontracted care may be needed in case of a benefits in kind policy
Poland	Free among contracted GPs	Free choice of contracted hospitals
Portugal	Free among contracted GPs	Free among public hospitals, and, if there is a waiting list, institutions approved by the Ministry of Health
Slovakia	Free for contracted GPs	Free, on referral
Slovenia	Free	Free choice of public hospital and contracted private hospitals
Spain	Free in area	No choice, according to region (except in case of emergency)
Sweden	Free	Free choice of regional public hospitals and approved private establishments
UK	Free	Patients can choose from a minimum of 4 local providers

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Choice and access of provider for primary and secondary care, Missoc (2006)

Step 6: Organisational issues

- According to 2005 EU-SILC data few patients had an unmet need for medical care or treatment and even less for dental care because of waiting lists:
  - Medical care: Lithuania (2.3%), Poland (2.3%), Estonia (2.2%) UK (2.1%) and Sweden (2.0%)
  - Dental care: UK (4.1%), Poland (1.5%), Finland (1.4%)
- Contrast to (older) 2003 OECD data which reports problems in e.g. Italy, Ireland, The Netherlands and Spain (= successful reduction in waiting lists?)

6 Main reasons for unmet need for medical examination and treatment

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Portugal	3.77%	#	0.77%	0.77%	94.56%
Sweden	0.50%*	#	2.02%	12.38%	85.00%
Slovenia	#	#	#	0.19%*	99.48%
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EU-SILC (2005)

7

Preferences and socio economic characteristics of the patient

- Even if the first 6 hurdles can successfully be conquered, the patient might still not access health services for a variety of reasons relating to socio economic status, or proactively, the preference a patient has to seek care abroad
- EU-SILC data contain a category other which includes factors (1) could not make time because of work, (2) fear of doctors/ hospitals/ examination/ treatment, (3) wanted to wait to see if problem got better on its own (4) did not know any good doctor or specialist and (5) Other
- Hence, there are more –unknown– reasons as a result of which European patients do not access the care they feel they need

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Slovenia	#	#	#	0.19%*	99.48%
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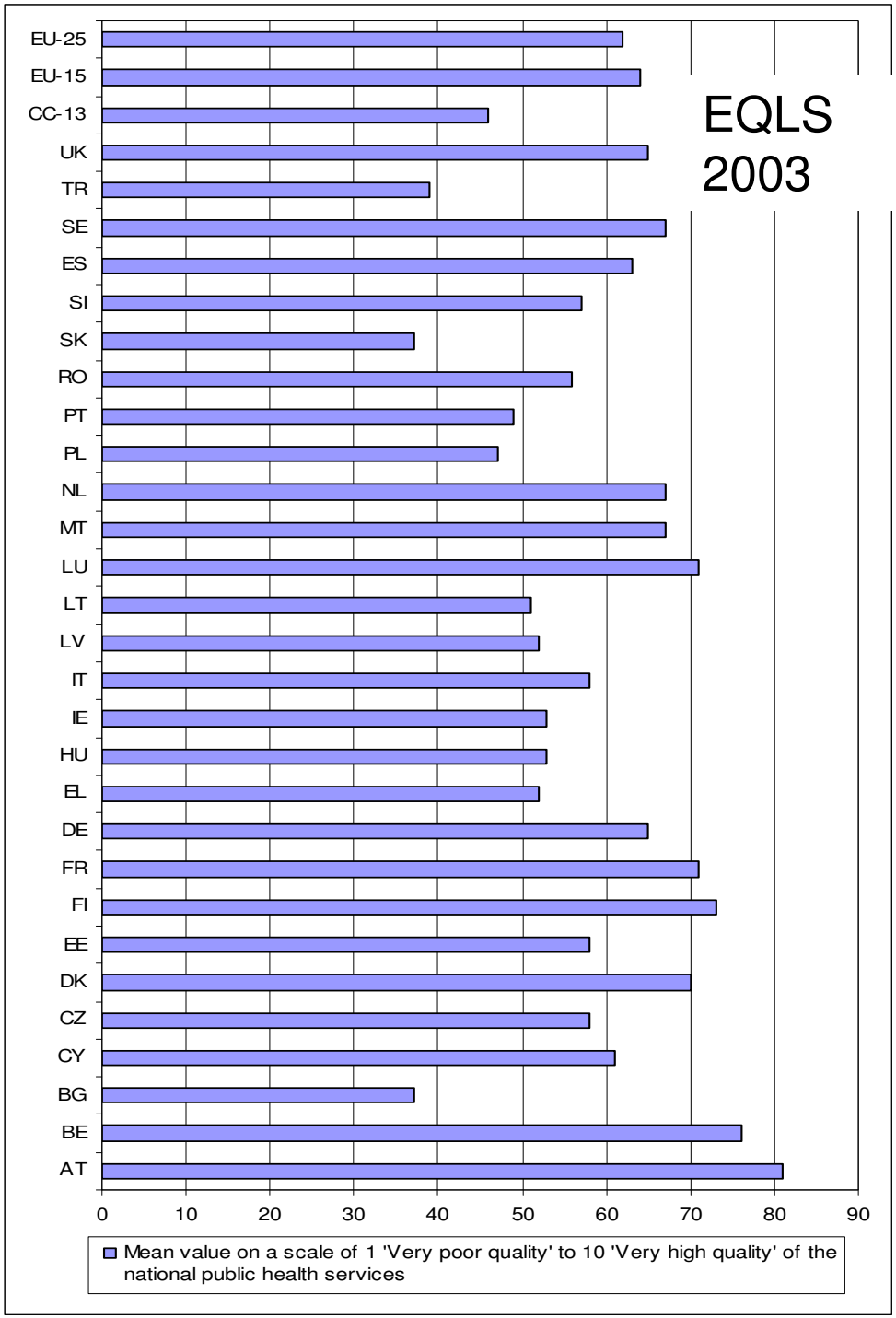
EU-SILC (2005)

??: unknown reasons



Quality as a driver?

- EQLS (2003) and Eurobarometer (1999 and 2002) data on perceived quality and satisfaction seem to confirm observed patterns of patient mobility
  - New/accession countries rate their health system 4.6 compared to 6.2 for the EU-15
  - below EU15 average rating Greeks and Italians seek care in Northern European Countries

Cross border access

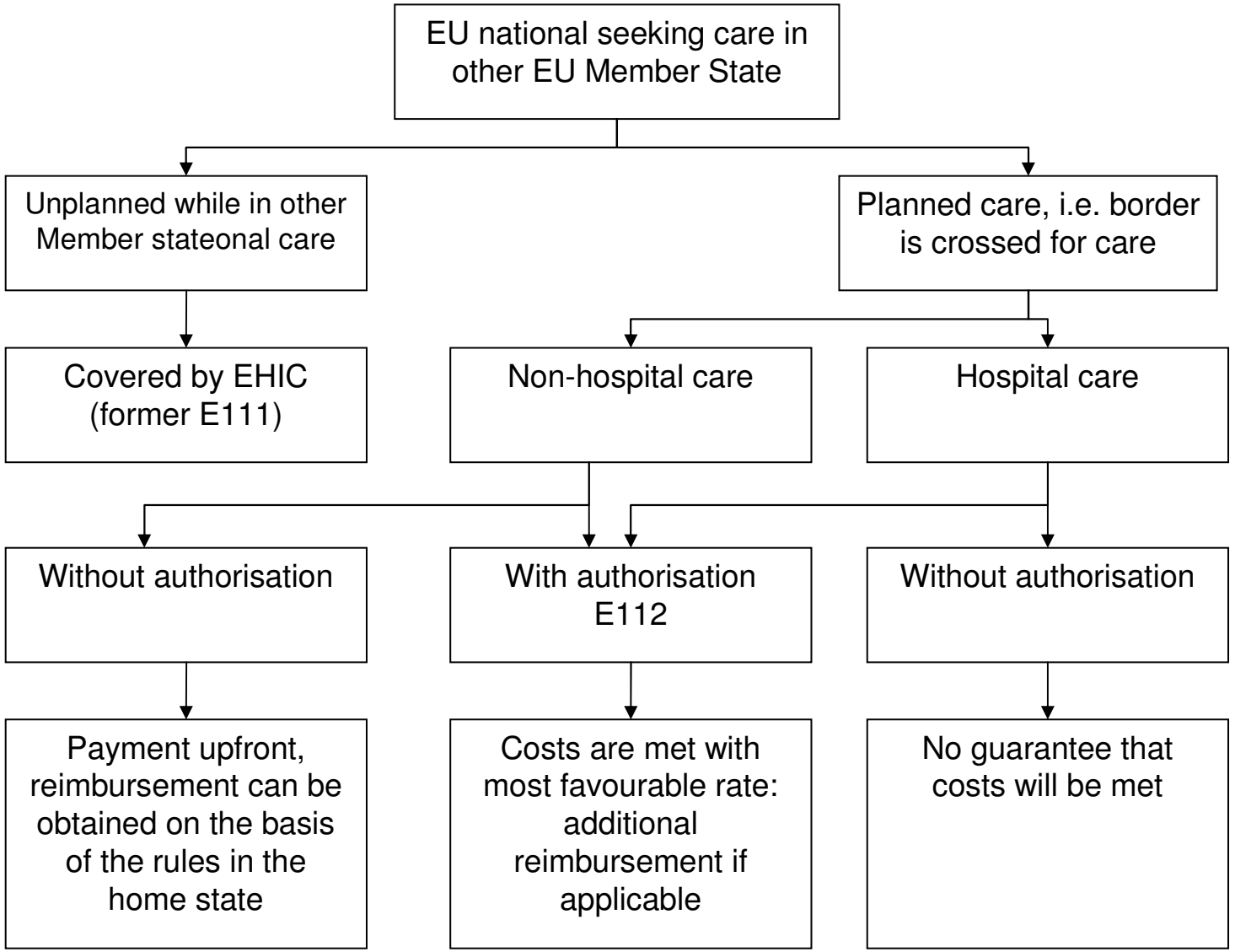
- Non-transparent and complicated – especially from the perspective of the patient – as three interrelated frameworks exist:
  - EC Regulation 1408/71 (EHIC and E112)
  - Cross-border arrangements
  - “Kohll/Decker” procedure
- These frameworks show differences with regard to benefits available, conditions for service, available providers (i.e. patient choice), quality assurance, prices, primary payer and cost-sharing

EC Regulation 1408/71

- Occasional care: EHIC (E111, E110, E128 and E119)
  - Can only be used for contracted care! Visibility?
  - Many EU citizens do not have an EHIC

- Planned care (E112 form): pre-authorisation is required from payer (e.g. NHS, sickness fund), procedure is applied nationally and therefore shows variations. Cannot be refused if:
  - Treatment is covered in the country of insurance but cannot be given within a medically justifiable time limit

Flow chart summarising the ways in which costs may be met



E112 pre-authorisation procedure variations through national application

- GP as instigator, legally required in some countries
- Granting decision taken at regional or national level after consultation of technical committee or medical officers
- Deadlines for the decision? Urgent procedure? A posteriori decisions?
- Some national competent organisations require additional information, e.g. pathology, types of treatment envisaged and the hospital where the patient is likely to be treated

Pre-authorisation procedure variations through national application (cont.)

- Application of “medically justifiable time limit”
  - in order to refuse pre-authorisation on the grounds of waiting times, the public health services must establish that the waiting time does not exceed a medically acceptable period *having regard to the patient’s condition and clinical needs* (ECJ ruling in Watts case)
  - Denmark fixed limit of max 2 months
  - Other countries “voluntary commitment” e.g. Dutch health insurers (possible also for competitive grounds)

Pre-authorisation procedure variations through national application (cont.)

- Competent authority in country of treatment where E112 has to be submitted varies widely, e.g.
  - local sickness fund /insurer (e.g. Austria, Belgium, Greece, France, Slovenia)
  - (contracted) care provider (UK, Hungary)
  - GP (Denmark)
  - Ministry of health (Cyprus)
  - Local Administrational (NHS) units (e.g. Italy, Portugal, Ireland)
  - etc.

Cross-border Arrangements

- Collaborations between two actors from two countries
- Majority either between insurers and providers or between two providers
- Often function outside 1408/71
- Limited range of benefits
- Unique in nature, several forms

Kohll/Decker procedure

- “framework” established in the aftermath of the (ECJ) rulings in the Kohll/ Decker case, which stated that free movement of goods and services also apply to health care
- Hospital treatment: pre-authorisation (i.e. E112) needed, which can only be refused if the same or equivalent effective treatment could be obtained without ‘undue delay’ at home at a contracted institution.
- Non-hospital services: pre-authorisation not considered necessary, as the ECJ did not expect a substantial increase in cross border mobility to obtain non-hospital services since coverage would be limited to the levels and conditions of the country of insurance affiliation.

KohII/Decker procedure, problems in application

Mostly Definition problems:

- What is
  - undue delay/ medically justifiable time limit
  - non-hospital, outpatient and ambulatory care vs. inpatient and hospital care
- This can lead to valid differences in interpretation of the ECJ rulings, which could motivate patients (as seen before) to start legal proceedings in order to receive pre-authorisation for care that may not be covered or available and reimbursed at home.

Comparative analysis: available benefits

(CoI)	1. 1408/71, 22(1)a (E111)	2. 1408/71, 22(1)c (E112)	3. Cross-border arrangement	4. "KohII/Decker" procedure	
				Outpatient care	Inpatient care
Benefit basket of CoI (possibly regionally variable)	Benefit baskets of country of service provision (CoS), provided the condition necessitates care while in CoS	Legally benefit basket of CoS, de facto often that of CoI	As in CoI, possibly only for a limited range of those benefits	Benefits of CoI (with legal certainty for ambulatory benefits)	

Comparative analysis: conditions to get service

Inside CoI	1. 1408/71, (E111)	2. 1408/71, (E112)	3. Cross-border arr.	4. "KohII/Decker"	
				Out-patient	In-patient
Referral/ prescription / rationing measures if necessary/ existing in CoI	Referral/ prescription if necessary/ existing in CoS	Pre-authorisation for particular service by responsible CoI-payer in addition to "normal" conditions (but in certain situations in CoI, e.g. long waiting, patient has right to E112)	As in CoI	Referral/ prescription if necessary in CoI (if patient wants reimbursement)	

Comparative analysis: Service providers available (patient choice)

Inside CoI	1. E111	2. E112	3. Cross-border arrangement	4. "KohII/Decker" procedure	
				Out-patient care	Inpatient care
Those contracted by CoI-payers (all providers in Austria and Belgium)	Those contracted by CoS-payers	Those contracted by CoS-payers	Those contracted directly by CoI-payers (or indirectly by partnership with CoS-payer)	All (as no contracts with CoI- or CoS-payers necessary)	

Comparative analysis: Conditions for service provision/ quality assurance

Inside country of insurance affiliation (CoI)	**1. E111**	**2.E112**	**3. Cross-border arr.**	**4. "Kohll/Decker" procedure**	
				Outpatient care	**Inpatient care**
As regulated by law and/or contracts in CoI	As regulated by law and/or contracts in CoS	As regulated by law and/or contracts in CoS	As regulated by law in CoS plus those in contract with CoI-payer (possibly identical with those for contracted providers in CoS)	Only those which are legally regulated in CoS (not those which are regulated by contracts with payers)	

Comparative analysis: price and primary payer

	Inside CoI	**1. 1408/71, (E111)**	**2. 1408/71, (E112)**	**3. Cross-border arrang.**	**4. "Kohll/Decker"**	
					Out-patient care	**In-patient care**
Price	As set or negotiated in CoI	As set or negotiated in CoS	As set or negotiated in CoS	As negotiated between CoI-payer and CoS-provider	Freely set by provider (if legal in CoS)	
Pri-mary payer	Responsible CoI-payer	Responsible CoS-payer (will forward invoice to CoI-payer)	Responsible CoS-payer (will forward invoice to CoI-payer)	Responsible CoI-payer	Patient (ex post facto reimbursement)	

Comparative analysis: Cost sharing

Inside CoI	1. 1408/71, 22(1)a (E111)	2. 1408/71, 22(1)c (E112)	3. Cross-border arrangement	4. "KohII/Decker" procedure	
				Outpatient care	Inpatient care
As regulated by law (or payer) in CoI, with possible difference between contracted and non-contracted providers	As regulated by law in CoS	Normally as in CoI but if price or cost-sharing in CoS is lower than in CoI, actual cost-sharing may decrease or even turn into a "profit" for the patient	May differ, probably as in CoI	Price charged by provider minus reimbursement through CoI-payer based on/ limited to reimbursement in CoI ambulatory care	Potentially total amount

Comparative analysis: Main differences to provision in home country

1. 1408/71, 22(1)a (E111)	2. 1408/71, 22(1)c (E112)	3. Cross-border arrangement	4. "KohII/Decker" procedure	
			Outpatient care	Inpatient care
CoS conditions replace CoI conditions (may be better or worse for CoI patients)	Pre-authorisation = additional requirement	"Extension of CoI": for patients and CoI-payers relatively little differences	For patients more choice but less reassurance about quality and reimbursement	

CoS = Country of service provision; CoI = Country of insurance affiliation

Main Problems with 1408/71, 22(1)a (EHIC, previously E111)

- Confusing for patients as they need to know 26 different benefit/ cost-sharing regulations *(besides their own)*
  - Visibility problems of contracted institutions *(also often difficult inside country)*
- For CoI-payers: effects may be unsustainable
- For CoS-providers: reimbursement often does not reach them which in turn leads to refusal of E111

Main Problems with 1408/71, 22(1)c (E112)

- Pre-authorisation rules in CoI often unclear (who? what criteria? appeal?)

Country	Competent authority
Austria	the regional sickness fund
Belgium	Local sickness fund of choice
Cyprus	Ministry of Health
Czech Rep.	Health insurance fund of your choice
Denmark	Normally the general practitioner, who will refer to a specialist
Estonia	Sickness Insurance Agency
Finland	Local office of Social Insurance Institution. The form must be presented to the municipal health centre or the public hospital providing treatment.
France	Local sickness fund
Germany	Sickness fund of choice
Greece	Regional or local branch of Social Insurance Institute which issues a 'health book' without which no benefits in kind can be provided
Hungary	the treatment provider
Ireland	Local health office of the Health Service Executive
Italy	Local health administration unit
Latvia	Health Compulsory Insurance State Agency
Lithuania	Sickness and maternity institutions
Luxembourg	Sickness fund for manual workers
Malta	National Health Service establishment (doctor, dentist, hospital, health centre) providing treatment
Netherlands	Sickness fund competent for the place of residence or, in case of temporary stay, Agis Utrecht
Poland	the regional branch of the National Health Fund
Portugal	Metropolitan Portugal: the Regional Health Administration; Madeira and Azores: Health Centre of the place of stay
Slovenia	the regional unit of the Health Insurance Institute
Slovakia	Health insurance company of the insured person's choice. For cash benefits, the Social Insurance Agency.
Spain	Medical/ hospital services of the health system covered by Spanish social insurance
Sweden	Local Social Insurance Office. The form must be presented to the institution providing treatment.
UK	the medical service providing treatment
Iceland*	State Social Security Institute, Reykjavik
Liechtenstein*	Office of national economy
Norway*	Local insurance office
Switzerland*	Doctor or the hospital providing treatment

Competent auhority where E112 has to be submitted (back of E112 form!)

… often unclear especially from an individual patient's perspective!

Main problems with Cross-border arrangements

- Extension of network of contracted providers not an overall solution as transaction costs will limit this to border/ tourist areas

Main problems with Kohll/Decker procedure

- Outpatient care: Difficult to calculate for patients as they need information on CoI benefits and reimbursement; therefore no guarantee that the costs will be met. Which services fall under “outpatient care”? For which can CoI-payers refuse reimbursement?
- Inpatient Care: Difficult to calculate for patients; certainty only if they successfully apply for E112 which cannot be refused if treatment is covered in CoI and same effective treatment cannot be given within “medically justifiable time limit”

Can national access hurdles be overcome through cross-border mobility?