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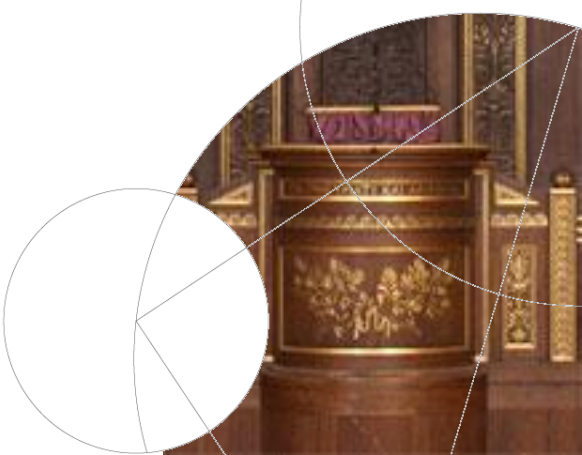
The Cross Border Healthcare Directive as a policy driver: Experience from Member states

Karsten Vrangbæk
Political Science and Public Health
University of Copenhagen



Theoretical model

Independent variable	Intermediate variable	Dependent variable
Developments in EU regulation of cross border care (ECJ and Directive) (examined in part 1) →	National institutional legacies and configuration of health systems (see below and appendix) →	Variation in national implementation strategies for cross border care

Explanatory variables

1. Institutions (fit/misfit)

- Implementation af ECJ case law
- Domestic ”market” for HC , contracting and choice
- transparent pricing, information on quality etc.
- defined benefits package,
- Experience with in- and outflow of patients. – Regulatory structures to deal with this?

Explanatory variables

2. Resources:

- General: Overall economic outlook
- Administrative: experience and capacity
- Sector: Excess capacity. State of the art technology

3. Domestic politics:

- Salience: Strong opposition/veto points
- Stakeholders interests (opportunity/threat)

Dependent variable: Implementation

1. Timeliness, ”quality” of preparation, stakeholder involvement

2. Policy developments: National strategies, policy choices

Dependent variable: Implementation

3. Strategic outlook: *(ideal types)*

I. ***Protectionist:*** Minimalistic implementation aimed to maintain control over out- and in-flows

II. ***Mercantilist:*** minimize costs of outflow/maximize gains of inflows

III. ***Free trade:*** As few restrictions as possible. Let the market develop!

Results:

Looking for systematic patterns……

….finding complexity and national variation based on legal uncertainties in the Directive.

Some general trends emerging…….

Results: Domestic politics

Salience:

- ”Technical/legal complexity” gives a strong role for national governments and administrations.
- Often limited involvement of opposition

Stakeholder involvement:

- Private providers: Use the Directive as a strategic platform to increase market share.
- Patient organizations: Positive, but concerned about risks of diverting resources to ”choice exposed” activities and from areas that are less exposed (but make up the majority of health service consumption)
- Professionals: mixed

Results: Resources

General, administrative and sector resources matter for national strategy building.

– But it is challenging to operationalize resources, - and the impact appears closely linked with institutional and political factors

(Implementing in a situation with a high degree of misfit requires more administrative and general resources and more political commitment: Borghetto, Franchino, & Giannetti, 2006)

Results: Resources

- ***General ressources*** are important particularly in Southern and Eastern Europe, but most countries are concerned about losing control over expenditures (gatekeeping, planning etc)
- ***Sector resources*** are important for the strategic outlook (excess or limited capacity, public/private)
- ***Administrative resources*** play a role for the comprehensiveness of impact assessments and level of detail in transposition

Results: Institutional fit

- Institutional structures are important for domestic policy choices. They set the conditions, enable some policy choices and restrict others

- Institutional fit and prior exposure makes it easier for some countries (eg. NL, Luxembourg) to conform to the directive

Results: Institutional fit

- Nordic public integrated systems and several Eastern and Southern European systems have issues with pricing, defining benefits packages and controlling access to private providers (Finland, DK, Poland, Spain)

- Quality information availability varies significantly across Europe giving very different starting points for patient choice. – No common EU framework or minimal standards.

Results: Institutional fit

- National contact points tend to be add-ons to existing structures (in some cases only e-mail address) and with limited information for patients from other member states (except Germany and Ireland).

- The role of domestic private (non-contracted) providers create issues in some countries (Poland, Spain, Denmark, NL)

	Denmark	The Netherlands	Poland	Spain
Does information exist on prices? Are there transparent mechanisms for the calculation of costs ?	DRG prices administratively determined based on estimated average costs.	Yes; DRC-based pricing system on websites hospitals ("walk-in tariffs for non-contracted care); not really transparent	Different prices in different regions. Not transparent mechanisms for the calculation of prices	Prices vary across regions. And they exist at different levels (hospitals/regions etc). And hard to get access to prices. This means that reimbursement levels will vary depending on which region citizens reside in. Maybe standardization of prices later

	Denmark	The Netherlands	Poland	Spain
Contact points	Five. One in each region. So far no further resources will be added. Coordinating function by 'Patientombud det'	One; at the Health care insurance board	One	One in each region.- But more specific details undetermined yet (what is the level of service etc)

	Denmark	The Netherlands	Poland	Spain
Prior authorization for which treat-ments?	Hospital care + specialized care Based on characterization of level of specialization by the Agency for Health and Medicine. – Discretion to add additional treatments temporarily	Prior authorization not in basic health insurance law (but yet in many health insurance policies). Prior authorization in law on costs for long-term care	Hospital and specialized care. Considerable discretion for authorities. – Plans of developing a "positive list"	Hospitals and specialized care. – and relatively extensive list of treatments requiring PA

Results: Strategic outlooks

Cautious (*"protectionist"*) strategies dominate,

…but perhaps "involuntarily" reflecting institutional misfits or lack of infrastructure

Some *"mercantilist"* thinking (using the directive to further national provider interests)

A few countries adopt mostly *"free trade"* strategies (Sweden, NL)

Towards a general theory about transposition probability?

Implementation is most likely to be flawed/problematic, if there is:

high degree of institutional misfit +

low level of resources +

limited commitment from ruling domestic coalitions (diverging preferences)

"*Interaction effects*" in different country cases