# The Cross Border Healthcare Directive: Transposition strategies and institutional legacies

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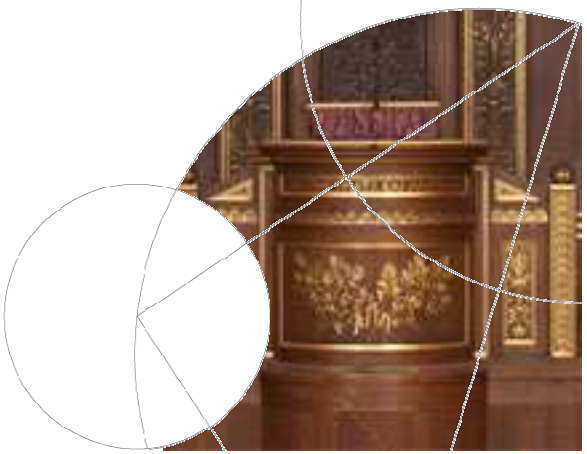
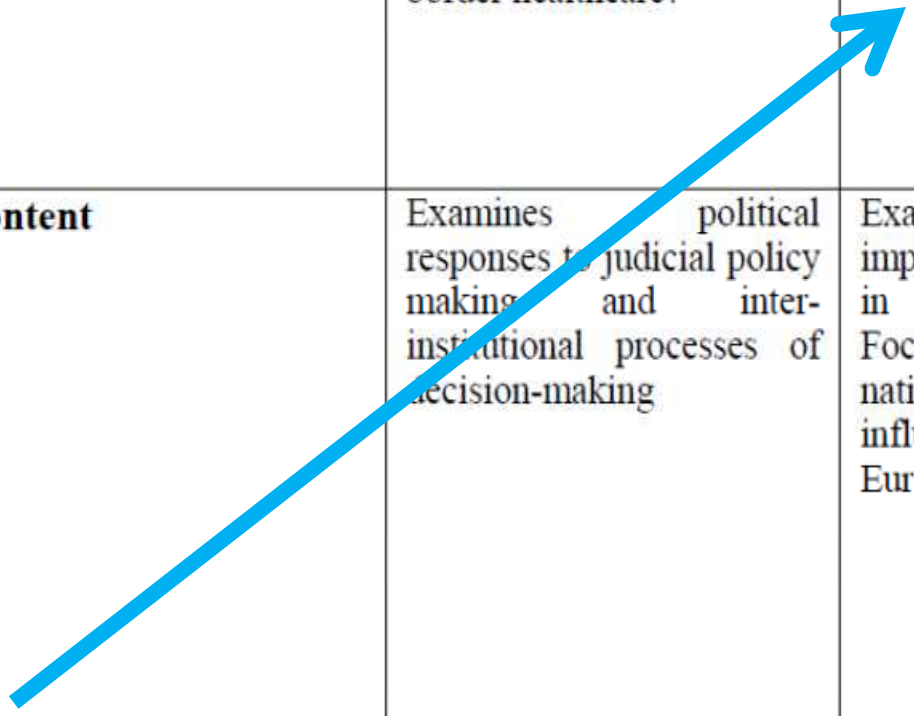


# Theoretical model

| 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 |

| | Project 1 | Project 2 | Project 3 |
|---|---|---|---|
| **Research question** | How do politics respond to judicial activism in policy-making and how may inter-institutional dynamics drive or hinder political regulation of EU cross-border healthcare? | How may different national healthcare institutions and their legacies explain variation in national implementation strategies for EU cross border care? | How may different national healthcare institutions and organisations explain variation in national implementation processes in Southern and Eastern member states expected to have relatively weak institutional capacity for implementation |
| **Content** | Examines political responses to judicial policy making and inter-institutional processes of decision-making | Examines the implementation processes in 5 member states. Focuses on how established national institutions may influence processes of Europeanisation | Examines implementation processes in 3 member states. Apart from focusing on the impact of national institutions on Europeanisation, the Ph.D. project is encouraged to pay attention to the role of interest organisations for the national implementation processes |
| **Theory** | Law and politics theoretical discussion and integration theory on complex decision-making | Informed by theoretical studies on integration, Europeanisation and comparative healthcare research | Informed by theoretical studies on integration, Europeanisation and comparative healthcare research |



# Dependent variable: transposition
## (*not implementation!)*

**1. Timeliness:** on time or not?

**2. Quality:** To which extent have all relevant details been addressed? What is the likelihood of judicial challenges (domestic/EU)? Assessments of impact? Involvement of relevant stakeholders?

# Dependent variable: transposition
## (*not 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!

# Explanatory variables

**Institutions (fit/misfit) – *(More on following slide)***

- 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?

**Resources:**

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

**Domestic politics:**

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

| | |
|---|---|
| **Healthcare system** | NHS, SHI etc |
| **Governance** | Centralized – decentralized. Public-private. Coherent-fragmented. |
| **Planning and control** | Planning of health facilities. – Referral systems |
| **Financing** | Taxation, social insurance, private insurance, OOP |
| **Patient rights** | Choice, waiting times, benefits package |
| **Complaint procedure** | Administrative or court system |
| **Economic resources: Ability to reimburse** | Constrained/relatively good |
| **Implementation of CJEU case law** | Extensive/limited |
| **Experience with cross border treatment** | Outflow/inflow |
| **Information on healthcare standards, treatment options, quality and safety** | Which information, available to whom? |
| **Information on prices? Transparent mechanisms for the calculation?** | Administrative or market prices? – How are they calculated? |
| **Transposition by** | Law or decree |
| **Which actors have so far been involved in the transposition** | Ministries, health insurers, regions? |

# Transposition details

| | Denmark | The Netherlands | Poland | Spain |
|---|---|---|---|---|
| **Does information exist on healthcare standards, treatment options, quality and safety** | Yes, information exists. Publicly available at: www.sundhedskvalitet.dk (quality). www.venteinfo.dk (waiting times) og www.patientoplevelser.dk (patient satisfaction). | Yes, still somewhat limited; see kiesbeter.nl; reports Health Care Inspectorate; Consumer Quality Index (available on internet and in libraries) | Limited | Varies significantly across regions. (Spain is a model for how this will be in EU). More developed regions (Catalunya, Balaeric Islands) have them, but very sporadic and not very useful in other regions. No attempt to standardize due to the Directive. |

| | 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 (prices include first consultation to final check, as well as overhead such as education, research etc.) | 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.<br><br>This means that reimbursement levels will vary depending on which region citizens reside in.<br><br>Maybe standardization of prices later |

| | Denmark | The Netherlands | Poland | Spain |
|---|---|---|---|---|
| **The establishment of contact points** | Five. One in each region. So far no further resources will be added. Coordinating function by 'Patientombudet' | One; at the CVZ (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<br>Based on characterization of level of specialization by the NBoH. – With discretion to add additional treatments temporarily | Prior authorization not in basic health insurance law (ZVW): option of reimbursement (but yet in many health insurance policies) /<br>Prior authorization in law on costs for long-term care (AWBZ) | Hospital and specialized care.<br><br>Considerable discretion for authorities. – Plans of developing a "positive list" | Hospitals and specialized care. – and relatively extensive list of treatments requiring PA |

| | Denmark | The Netherlands | Poland | Spain |
|---|---|---|---|---|
| **Changed procedures regarding outflow** | The gatekeeper function of the GPs weakened. PA for fewer treatments. Positive list to be established , but with some discretion to adjust according to system needs<br><br>Waiting time guarantee (30 days to diagnosis, then 30 or 60 days to treatment) | Initiatives to limit cross-border healthcare (from Rutte governments and MinFin) may lead to stricter legislation on outflow (perhaps adopting prior authorization criteria in law?);<br><br>Outflow may be limited by allowing health insurers in future to refuse reimbursement for non-contracted healthcare | Strategy paper proposes a procedure based on assessment of "purpose" and "efficacy". Which leaves considerable discretion to authorities.<br><br>Treatments delivered within reasonable waiting time in Poland will not be granted PA (but no official definition of "reasonable waiting time" | Fundamental changes: Cross border choice, - but not choice across regions w/n Spain. Reference hospitals/catchment areas still exist.<br><br>Waiting time guarantee of 180 days. |

| | Denmark | NL | Poland | Spain |
|---|---|---|---|---|
| **Change in pro-cedures for inflow** | Public sector to open up for planned treatment of foreign treatments | No; except for NCP | The Polish government is criticized for not dealing sufficiently with this issue | Yes. Individual regions will now receive the payment. – previously money would go to Madrid, and they would reimburse. There has been a lack of admin capacity to collect this funding from abroad. Now money will be collected at the hospital/regional level. Probably with requirement to put up security up front.<br><br>There is a concern that the very long waiting lists in Spain will be further worsened by inflow of foreigners |

| | Denmark | The Netherlands | Poland | Spain |
|---|---|---|---|---|
| **Medicine purchased in other MS** | Less control with medicine use. Challenges the idea of the 'medical card' as insuring quality and safety | Not limited (but reimbursement only with GP referral, in basic health insurance basket, and generic – and according to domestic market prices) | Ordinary medicines will be reimbursed. Poland operates a list of special medicines. Medicines on this list will not be reimbursed | Yes, will be reimbursed. Not considered an issue as medicine is cheap in Spain relatively |

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# Preliminary interpretations

| | Overall strategic orientation | Transposition (timeliness, "quality", level of detail etc) |
|---|---|---|
| **DK** | Protectionist | Delayed (jan 1) Detailed assessments of impact, and very detailed legislation |
| **Pol** | Mercantilist/ Protectionist | Delayed (Jan 1). Some assessment of impact (but still uncertainty about practical, economic and judicial risks), formal proposal presented, but not yet accepted by parliament |
| **NL** | Mercantilist | Delayed: law providing CVZ tasks of NCP not adopted on time; legislative and regulatory changes regarding prescriptions presumable on time |
| **Sp** | Mercantilist/ protectionist | Delayed (jan 1): many practical issues not resolved |
| **Sw** | Free trade | On time |
| **Bu** | Free trade | On time: Close to the Directive text |

| | Key institutional variables (fit/misfit) |
|---|---|
| **DK** | NHI, public planning and financing, mostly public providers. (No OOP for treatment) |
| **Pol** | SHI, public planning and financing, public contracted providers, private non-contracted providers. (OOP for treatment) |
| **NL** | SHI, relatively good fit, but issues of health insurers ability to control access to non-contracted providers (cost containment). (some OOP for treatment) |
| **Sp** | NHI regionalized, public planning and control, but also significant private financing and delivery in some areas (OOP for treatment) |
| **Sw** | NHI, public planning and financing, mostly public providers. – But more private and international providers than DK (Limited OOP for treatment) |
| **Bu** | SHI, no significant issues with private providers.<br>Expect limited economic impact, as few will seek treatment abroad, and prices are rather low in Bulgaria (OOP for treatment) |

| | Resources |
|---|---|
| **DK** | General: relatively good<br>Administrative: strong<br>Sector: Very trimmed resource base. – no excess capacity |
| **Pol** | General: relatively poor<br>Administrative: constrained<br>Sector: Lack of capacity in some areas, excess in some (private) areas |
| **NL** | General: relatively good<br>Administrative: good, but more fragmented than NHI countries.<br>Sector: good |
| **Sp** | General: poor<br>Administrative: relatively limited. Center-region issues<br>Sector: varies b/n regions |
| **Sw** | General: relatively good<br>Administrative: Good, but center-region issues<br>Sector: good but very trimmed resource base. – no excess capacity |
| **Bu** | General: poor<br>Administrative: relatively limited<br>Sector: Oversupply in some areas, undersupply in others |

| | Previous experience |
|---|---|
| **DK** | Limited. Mostly due to agreements with neighboring countries (G and Sw). – (small net import: 1408, 2004) |
| **Pol** | Some inflow in selected areas (dentistry, rehabilitation services). Limited outflow (very small net import 1408: 2004) |
| **NL** | Relatively experienced with in/outflow (net import: 1408, 2004) |
| **Sp** | Many tourists and ex-pats needing care in Spain, or wanting care in their home countries (payment mechanisms insufficient) (large net export: 1408, 2004) |
| **Sw** | Limited exposure. - (Net exporter: 1408, 2004) |
| **Bu** | Very limited exposure. – Mostly Bulgarians working abroad (1408 n/a) |

# Politics of transposition

| | Denmark | The Netherlands | Poland | Spain |
|---|---|---|---|---|
| **Salience of the directive** | Some. – But limited parliamentary debate | Low in transposition phase | Low. – limited parliamentary debate | Low |
| **Transpo-sition by** | By amending law and ministerial decree | By law and ministerial decree | By law | Ministerial (royal) decrees. – I.e. parliament not involved |
| **Which actors have so far been involved in the transposition of the directive** | Mainly the Ministry of Health | Mainly ministry of health; and also Health Care Insurance Board (CVZ), and legal scholars | Ministry mainly, NHIF. Not very active regions. Hearing process generated critique, but no clear response from Ministry | Very centralized. But interregional committee has been consulted. – this led to expansion of list of treatments requiring PA.<br>Other stakeholders not very involved. – hearings, but low impact. |

| | stakeholders/interests (domestic politics) |
|---|---|
| **DK** | Maintain domestic capacity and planning. Limit financial exposure. |
| **Pol** | Maintain control over access/expenditures. Avoid access to domestic non-contracted providers.<br>Private: Attract patients from Germany and Scandinavia |
| **NL** | Protect the business strategy of health insurers.- limit access to "non contracted" providers.<br>Private providers: Attract patients from neighboring countries |
| **Sp** | Regions see an opportunity to secure payment for services rendered to foreigners. –Currently they do not always receive payment from Madrid.<br>Some private providers see this a business opportunity |
| **Sw** | More private and international providers than DK |
| **Bu** | Small private sector. Low impact expected |