Implications of the EU Patients' Rights Directive in Cross-Border Healthcare on the German Sickness Fund System

Mathias Kifmann and Caroline Wagner

Abstract We examine the implications of the EU directive on the application of patients' rights in cross-border healthcare on the German sickness fund system. Since Germany implemented most requirements of the directive already in 2004, we first review Germany's experience with EU cross-border healthcare. We then focus on the possible effects of increased EU cross-border healthcare. While this gives patients more choice, the German sickness fund system faces a number of challenges. EU cross-border care may undermine efforts to keep healthcare expenditure under control. Cross-border care can also increase inequality of access. Furthermore, promoting cross-border care can be a means for sickness funds to attract good risks. We discuss these challenges and point out possible policy responses.

Keywords EU patients' right directive · EU cross-border healthcare · Physician payment · Expenditure control

JEL Classification F15 · H51 · I13 · I18

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1 Introduction

By October 2013, all EU member states are required to implement the EU patients' rights directive in cross-border healthcare. After the European Court of Justice Kohll and Decker decisions in 1998, it is the second milestone in facilitating medical treatment in a member state different from the state where patients are insured. With few exceptions, individuals now have the right to obtain treatment in other member states if they have the right to this treatment in their home country. The healthcare system which covers the individual must reimburse up to the amount which it would have paid for the same treatment in the home country.

From the point of view of patients, the EU patients' rights directive offers new opportunities. Quality of treatment may be perceived as higher in other member states. Also waiting times may be shorter. Furthermore, if treatment in the home country involves considerable copayments, traveling to other member states can be financially attractive. Increased patients' mobility can also encourage competition between healthcare providers leading to higher quality and lower costs in the home country.

However, the EU patients' rights directive also poses a challenge to national healthcare systems. National systems of treatment allocation may be undermined as in the case of waiting lists. In particular, it may be regarded as unjust when those who can afford to travel to other member states get better access to healthcare. This also holds for national systems of planning and financing which need to be revised when a considerable number of patients obtain their treatment in other member states. The directive here allows member states to ask for prior authorization which can be refused if treatment can be provided in the home country within a time limit which can be medically justified.

Furthermore, national systems of expenditure control are challenged by the EU directive. At first sight, the procedure for reimbursing cross-border care appears to have no impact on expenditure or even help to reduce expenditure because the amount of the reimbursement should not be larger than in the home country and must not exceed actual costs of care. Yet, it can be costly to determine this amount since the corresponding treatment and its reimbursement in the home country must be clarified. In particular, the latter may prove difficult unless the country uses a fee-for-service system. Many states, however, use budgets or put caps on the amount of reimbursement which causes nominal fees to be higher than what is effectively reimbursed.

In countries with competing health insurers like Germany, cross-border care also raises the issue of risk selection. Specifically, users of planned cross-border care may on average be good risks since they are still able to travel. Health insurers may therefore excessively promote cross-border care. This can be at the expense of those who are dependent on treatment in the home country.

For Germany, the implementation of the EU patients' rights directive required only a minor change in law—the formation of a national contact point for cross-border healthcare. All other requirements were already met by the Health

Modernization Act of 2004 ("Gesetz zur Modernisierung der gesetzlichen Krankenversicherung") which allowed members of sickness funds to obtain treatment in all EU member states and the four members of the European Free Trade Association. Treatment costs are reimbursed up to the amount paid for the same treatment in Germany.

For outward patient mobility, Germany therefore provides an interesting case study for possible impacts of the directive. In our contribution, we discuss the German experience with patient mobility. We present the results of a survey commissioned by Techniker Krankenkasse, one of Germany's largest sickness funds. Furthermore, we point out the challenges posed to the German sickness fund system by cross-border healthcare and discuss policy implications.

We proceed as follows. In the following Sect. 2, we describe the German sickness fund system and the legal framework for cross-border healthcare. Section 3 presents data on Germany's experience with EU cross-border healthcare. Possible effects of increased EU cross-border healthcare for the German sickness fund system are analyzed in Sect. 4. Building on our results, we discuss possible policy implications in Sect. 5. A final section concludes.

2 The German Sickness Fund System and Cross-Border Healthcare

2.1 The German Sickness Fund System

In Germany, about 88 % of the population is insured by the social health insurance (SHI) system ("Gesetzliche Krankenversicherung"). About 12 % of the population obtains coverage through the private health insurance system (PHI, "Private Krankenversicherung"). These are mainly individuals who opted out of the SHI system and civil servants. The SHI system is largely financed by the contributions which are shared by employees and their employers unless members are self-employed. The contribution rate is automatically deducted from monthly salaries. Currently, the universal contribution rate amounts to 15.5 %, with the members sharing 8.2 % and employers 7.3 % of the contribution rate. Total contributions of all members are collected in a central fund ("Gesundheitsfonds") and distributed to sickness funds in form of risk-adjusted capitations.[1]

The remuneration of the health service providers is negotiated in complex corporatist social bargaining processes between SHI funds and provider organizations mainly on the state level ("Bundesländer"). For outpatient care, sickness funds pay a capitation to physicians' associations to cover most expenses. These

[1] The German risk-adjustment scheme differentiates capitations according to 40 age and gender groups, 6 reduced earning capacity groups and 155 hierarchic morbidity groups which are based on 80 diseases.

associations distribute their total revenue to physicians according to a complex catalog which specifies fees for cases as well as for specific services. Physicians face a reduction in their fees once they have treated more than a predefined number of cases in a quarter. Hospital reimbursement is mainly based on Diagnostic Related Groups (DRGs). Similar to physicians' reimbursement, target budgets limit total expenditure. If a hospital treats more cases than agreed upon in negotiations, it faces reductions in its DRG payments for additional patients.

Presently, the SHI system consists of around 130 sickness funds. These are corporations under public law and have historically the right to self-government. The key principles are solidarity (everyone is covered and pays a contribution unrelated to the health status) and subsidiarity (local decision-making and personal responsibility). Sickness funds compete for SHI members with their services and with their cost management. In particular, they try to avoid that they have to charge additional premiums to cover their expenses.

SHI members can obtain treatment from physicians which belong to a physicians' association. Access to medical care is mainly free. Copayments exist for prescription drugs and for inpatient care. They cannot exceed 2 % of household income. Traditionally, general practitioners have no gatekeeping role[2] and patients are free to go directly to an SHI-affiliated specialist doctor of their choice. Importantly, members generally receive benefits in kind ("Sachleistungsprinzip"), implying that they are not billed for services.

2.2 Regulation of Cross-Border Healthcare

Until 1998, the Council Regulation (EEC) No. 1408/71[3] provided the sole basis for EU cross-border care. This regulation gave EU citizens the right to the same emergency treatment in EU member states as residents. Patients from other EU member states are entitled to claim the same benefits as domestic patients. In 1998, patients' rights in cross-border care were considerably extended by the European Court of Justice. In its Kohll and Decker decisions it ruled that healthcare services provided in another EU member state on a remunerated basis constitute services as defined in the EU Treaty. Measures rendering the reimbursement of amounts paid contingent upon prior consent are obstacles to the free movement of services which need to be justified. These and later rulings were fundamental in that they placed limits on the provisions of the national EU healthcare systems which up to then were exclusively framed by the EU member states.

Germany was one of the first EU member states to implement the decisions of the European Court of Justice on patient mobility into national law by passing the

[2] See Chambers et al. (2010, p. 3).

[3] Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community.

Statutory Health Insurance Modernization Act of 2004.[4] It explicitly allows SHI members to claim inpatient and outpatient treatment in all EU member states and in the additional four member states of the European Free Trade Association (EFTA), i.e. Iceland, Liechtenstein, Norway and Switzerland.[5] Furthermore, the legislation allows sickness funds to directly enter into contracts with healthcare providers in the European Economic Area (EEA) and Switzerland.[6]

The following principles on EU cross-border care are legally implemented[7]:

- All SHI members can claim outpatient treatment to which they would be entitled in Germany in any other EU member state without prior permission.
- All SHI members can claim inpatient treatment to which they would be entitled in Germany in any other EU member state subject to prior permission. This permission must be granted if the German healthcare system cannot provide the treatment within the medically necessary period.
- In both cases, the costs must generally be reimbursed up to the amount which would be reimbursed in Germany if the domestic preconditions for treatment are fulfilled.

These principles are in full accordance with the EU directive 2011/24/EU on the application of patients' rights in cross-border healthcare. The only change in German law necessary to meet this directive was the legal establishment of a national contact point for cross-border healthcare.

The EU patients' rights directive complements the existing regulation (EC) No 883/2004[8] on the coordination of social security systems. This regulation replaced the Council Regulation (EEC) No. 1408/71 and is particularly relevant for frontier workers who are members of the EU healthcare system in the country in which they work but who reside in another EU country. It specifies the access to healthcare in both states.

The directive differs from regulation (EC) No 883/2004 in three aspects: only planned cross-border care treatments are affected; there is no need for an approval for outpatient care prior to the planned treatment; costs of the planned EU cross-border treatment are only borne up to the amount a comparable treatment would have cost in the home country less a deduction for administration.

According to the regulation (EC) No 883/2004, by contrast, cross-border patients obtain healthcare as if they would be insured in the country they visit. If this coverage is more generous than in Germany, sickness funds must therefore

[4] Gesetz zur Modernisierung der gesetzlichen Krankenversicherung dated 14 November 2003 | Bundesgesetzblatt 2003 Part 1 No. 55.

[5] In the following "EU member States" or "EU cross-border care" also includes these European countries.

[6] Social Code Book V, Sect. 140e.

[7] Social Code Book V, Sect. 13 para. 4–6.

[8] Regulation (EC) No 883/2004 of the European Parliament and of the Council on the coordination of social security systems of 29 April 2004.

reimburse it. On the other hand, if copayments or other out-of-pocket-payments apply to patients in that country, the SHI member would have to pay them as well. The German SHI members are allowed to choose between reimbursement according to the EU patients' rights directive and the regulation No. 1408/71 which improves the situation for SHI members for planned cross-border care treatments.[9]

2.3 Sickness Funds and Cross-Border Healthcare

European legislation on cross-border healthcare implies for sickness funds that they must reimburse treatments in other member states. In case of inpatient treatment, sickness funds must also authorize treatment. This can involve considerable administrative costs.[10] To cover these costs, funds are allowed to deduct an administrative surcharge when they reimburse treatment. German legislation also gives funds a potential active role in cross-border healthcare. They are allowed to directly enter into contracts with healthcare providers in the European Economic Area (EEA) and Switzerland.

The currently second largest German statutory health insurance fund, Techniker Krankenkasse (TK) with approximately 8.3 million members in 2013 has taken the most pro-active strategy towards cross-border healthcare. Following the Kohll and Decker rulings of the European Court of Justice, TK started to offer a range of individual services regarding EU cross-border care. TK members who plan to receive medical care in another EU member state have the possibility to be consulted concerning quality, costs, billing, entitlement and SHI-benefits. The consulting on EU cross-border care at TK predominantly takes place in customer consulting offices or by telephone and email through the call and specialist service centers.[11] TK offers a free travel hotline to support its members before and during their stay abroad. Consultation is offered by doctors who are trained in travel and tropical medicine for all questions on cross-border care, both planned and unplanned.

What distinguishes TK from competing sickness funds is its strategy to contract directly with qualified service providers in other EU member states.[12] TK monitors quality of contractual partners and requires, for example, care by physicians and nurses who speak German fluently. Billing directly takes place between the contractual partners and TK, which is to benefit of both SHI members, who do not

[9] See Federal Ministry of Health in Germany (2013).

[10] For cross-border care in the Meuse-Rhine eurogio based on regulation No. 1408/71, the additional administrative cost was estimated to be 5 % (Grunwald and Smit 1999).

[11] See Wagner et al. (2011), p. 14.

[12] To some extent, other sickness funds have also contracted with foreign providers. See Nebling and Schemken (2006) for further examples.

have to pay cash in advance, and TK, which does not have to check bills from unknown providers. TK is also able to negotiate prices in exchange for giving the contractual partners better access to its members.

Currently, the TK European Service for Clinics comprises around 135 clinics in eight member states (Austria, Belgium, Czech Republic, Italy, Netherlands, Poland, Portugal and Spain). This service was originally initiated in co-operation with another sickness fund[13] in regions in which a large number of unplanned acute and emergency EU cross-border treatments of TK members occurred like ski injuries in Austria. Furthermore, there are other additional single contracts between TK and EU cross-border healthcare service providers. In all TK partner clinics, it is possible to receive planned inpatient and outpatient cross-border care. Moreover, TK has lately entered contracts with four dental clinics in Hungary and Poland. Finally, TK has contracted with nearly forty spa and rehabilitation facilities which are located in six member states, predominantly in Eastern Europe (Austria, Czech Republic, Hungary, Italy, Poland and Slovakia). TK members receive special conditions, e.g. regarding the accommodation. TK reimburses all the contractually declared therapy costs. On top wellness treatments like e.g. additional massages have to be borne out-of-pocket by the members. These additional treatments tend to be less expensive than in Germany, in particular in Eastern European Countries. Furthermore, TK pays a one-time extra payment of 100 Euro for a cure or rehabilitation treatment which lasts for at least two weeks.

TK has carried out surveys on experiences and expectations concerning EU cross-border care among its members, particularly focusing on patient satisfaction with regard to planned treatments. Its key results are presented in the following section.

3 Germany's Experience with EU Cross-Border Healthcare Prior to the Directive

TK has carried out several EU cross-border surveys. In the following, we present important findings of the two latest surveys published in 2010 and 2012.[14] For the first survey, questionnaires were sent to randomly chosen individuals who used cross-border care in 2009. The second survey asked a random sample of those who obtained cross-border care in 2010. For the 2010 survey, the response rate was 31 %, for the 2012 survey it reached 41 %. About 1 % of TK members claimed reimbursement for cross-border care in a year. The 2010 survey reveals that about 26 % of these had planned to use EU cross-border care. For the 2012 survey, the corresponding share is 19 %. We focus on this group in the following.

[13] The sickness fund "AOK Rheinland Hamburg" .

[14] See Wagner et al. (2011, 2013).

3.1 *Users of Planned EU Cross-Border Healthcare and Destinations*

TK members with planned cross-border treatment are comparatively old on average (see Fig. 1). Nearly 80 % were over 60 years, out of which half were aged 70–79 years, and another 8 % were older than 80 years. Accordingly, the majority are retirees (70 %). The remaining members are employees (16 %), housewives and house husbands (10 %), and self-employed persons (4 %). Both genders are equally represented with 50 %. The level of education of planned cross-border care consumers at TK is high with a share of 54 % having passed their A-levels ("Abitur"), out of which 32 % are university graduates and another 3 % have a doctorate in addition. Since most cross-border care users are retired, the income level is comparatively low: 50 % had a gross income of 1,000–2,500 Euros, another 10 % of 750–1,000 Euros.

Living in border regions is not crucial for planned EU cross-border care: only 7 % of the surveyed TK members stated this as a reason. Only 16 % of TK cross-border care consumers live in border regions, i.e. at a distance of less than 30 km. Another 13 % live more than 30 but less than 60 km from the border. The majority of 71 % live more than 60 km from the border.

One of the main survey findings is that a certain degree of continuity and regularity has emerged: 53 % of the TK members surveyed consume planned EU

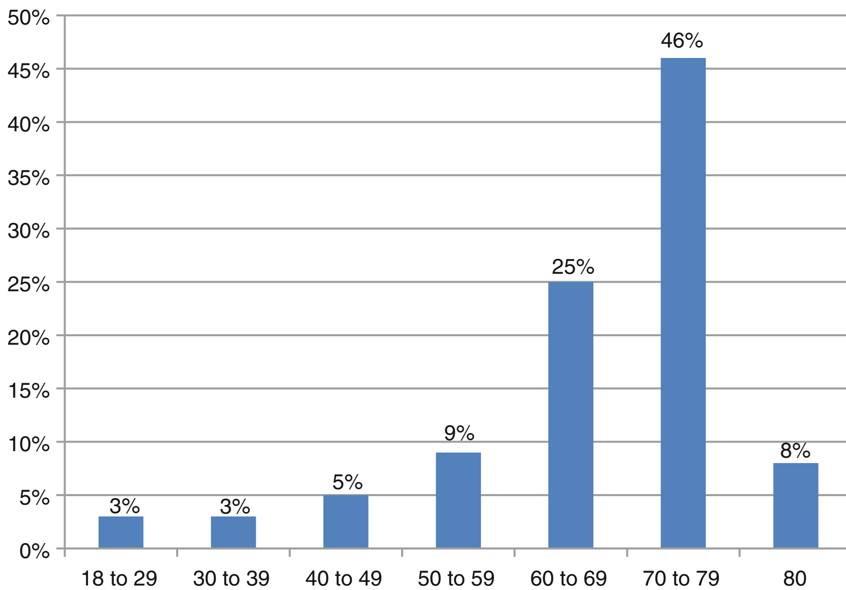

Fig. 1 Age distribution of TK members with planned cross-border treatment. *Source* Wagner et al. (2013)

cross-border care regularly, out of these 39 % regularly do so each year. Another 73 % stated that they get treated deliberately once a year, 12 % twice a year and 16 % three times a year or more.

According to the 2012 survey, Italy is the most popular destination for planned EU cross-border treatment of TK members (16 % in 2010 and 2012). In 2010, this has been Czech Republic (2010: 27 %, 2012: 14 %) and Poland (2010: 20 %, 2012: 15 %). Hungary had a share of 12 % in both surveys. Overall, the Eastern European States including Hungary have slightly lost in popularity. Austria (2010: 6 % to 2012: 10 %) and Switzerland (2010: 5 % to 2012: 8 %), but also Spain (2010: 2 % to 2012: 6 %) and France (2010: 1 % to 2012: 3 %) have gained popularity.

3.2 Treatments Provided

With 51 %, preventive cure and spa treatments were the most frequently demanded types of EU cross-border care. These are, quite uniquely as compared to the other EU healthcare systems, part of the statutory benefits catalog covered by sickness funds in Germany. A trend is the growth in the demand for planned treatments in clinics: the share of members who sought them rose considerably from 4 % in 2010 to 16 % in 2012. Planned dental and orthodontic cross-border treatments ranked third among TK members and grew, too (2010: 7 % and 2012: 11 %). Specialists and general practitioners were noticeably less, but equally often consulted (Fig. 2).

The most frequent medical reasons for TK members to travel abroad for care in 2012 were muscular, bone, and joint diseases (55 %), though the share of members stating this has considerably fallen from a level of around 70 % in 2010. The next most frequent diseases affected the cardiovascular system (11 %), teeth (10 %), respiratory diseases (8 %), cancer (4 %), follow-up treatments of injuries caused by accidents or intoxications (4 %), diabetes (3 %), and skin diseases (3 %).

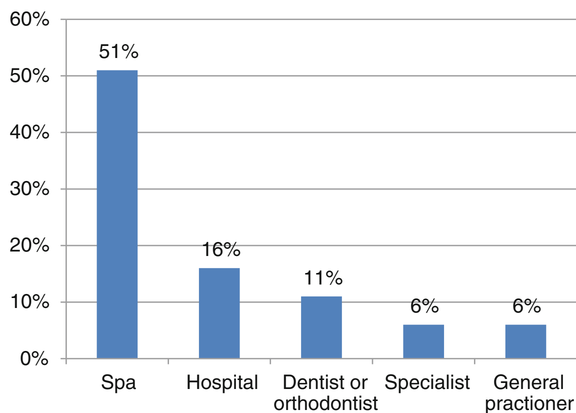

Fig. 2 Treatments by provider, 2012 Survey. *Source* Wagner et al. (2013)

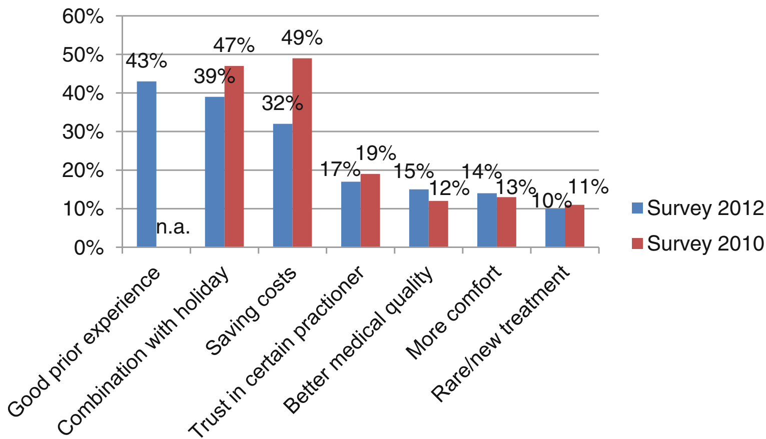

Fig. 3 Motivation for planned cross-border care. Multiple responses possible. *Source* Wagner et al. (2011, 2013)

3.3 Motivation for Planned Cross-Border Treatment

When asked about the motivation to deliberately seek cross-border care, the most common reason in the 2012 survey was good experience with former treatments (43 %, not asked in the 2010 survey). Combining treatment with holiday (2012: 39 %, 2010: 47 %) and cost savings are also important motives (2012: 32 %, 2010: 49 %). A frequently stated reason was also confidence in a cross-border doctor (2012: 17 %, 2010: 19 %). Moreover, in the 2012 survey, 15 % of the surveyed TK members stated to search for better quality and 14 % for better comfort in other EU healthcare systems (Fig. 3).

3.4 Satisfaction with Planned Cross-Border Care

Planned cross-border care among TK members is marked by a high level of satisfaction. This concerns the facilities, the doctors and dentists as well as the therapies and treatment results. The proportion of members who were very satisfied with the facilities amounts to more than 70 % regarding short waiting times for appointment, the cleanliness of rooms, the efficiency of the working processes and the agreeable atmosphere.

The evaluation of the doctors, dentists and quality of the treatment was similarly positive. According to the subjective assessment of the treatment results by the 2012 survey respondents, planned cross-border care in those EU healthcare systems frequently visited by the TK members is of high quality. This is also supported by the fact that less than 2 % stated to have had to undergo a follow-up

or further treatment because of unexpected complications or maltreatment. TK members were most satisfied with the medical competence of the doctors (78 %), with the doctors' thoroughness in examination and in treatment (74 %), as well as the comprehensibility of the information given by them (73 %). Up to 85 % were very satisfied with the treatment results from dentists and orthodontists, 79 and 78 % respectively with the treatment results from general practitioners and specialists. Less than 1 % stated throughout the different groups of doctors to be very dissatisfied with the treatment results. Even if some respondents are looking for better treatment and comfort in cross-border care, the high level of satisfaction does not seem to be a consequence of dissatisfaction with German healthcare. 59 % indicated to be rather satisfied with German healthcare, another 15 % were very satisfied. Only 23 % were rather dissatisfied and just 3 % expressed extreme dissatisfaction.

3.5 Summary

The surveys reveal that a small but considerable share of sickness fund members make use of planned cross-border healthcare. The majority of these are retired and well-educated. Spa treatments are most popular but sickness fund members also plan to use hospital, dental and specialist services in other European countries. The three main motivations for obtaining treatment abroad are good prior experience, the possibility to combine the treatment with holidays and saving costs. Sickness fund members state a high satisfaction with planned cross-border care.

4 Possible Effects of Increased EU Cross-Border Healthcare for the German Sickness Fund System

Germany is a country with a fairly high standard of care. Currently, access to care is usually fast. Official waiting lists do not exist except for treatments with a natural shortage such as organ transplantations.[15] However, Germany is also a rapidly aging country. Several studies forecast a large increase in healthcare expenditure per capita, predicting increases in the contribution rate from currently 15.5 % of wage income to far above 20 % (see Postler 2010 for a survey). For example, the study by Breyer and Ulrich (2000), which predicted the current contribution rate quite accurately, states a contribution rate of 23.1 % in 2040. It is

[15] Nevertheless, waiting times exist in Germany. Roll et al. (2012) find that SHI patients have to wait on average 16 days to get an appointment with a specialist. Privately insured patients, by contrast, only have to wait 7 days on average. They also found that increased income had a negative effect on waiting time, pointing to an income gradient in the access to health care.

unlikely that this increase in the financial burden will not lead to stronger pressure to keep expenditure under control. Healthcare will probably be more rationed than today, either explicitly or implicitly.[16]

Given this scenario, EU cross-border care presents a challenge to the German sickness fund system in two related respects. First, expenditure control is made more difficult by the possibility of EU cross-border care which de facto introduces fee-for-service remuneration for treatment in foreign countries with little further restrictions. This is in contrast to remuneration in place inside Germany which relies on expenditure control mechanisms. Second, equal access to care may be undermined if those who are able to afford cross-country care can avoid rationing of healthcare in Germany. At the same time, cross-border care can also be a means of saving costs for the German healthcare system. In particular, sickness funds could be given a more active role in organizing and encouraging cross-border care. However, it must be ensured that cross-border care is not used for risk selection by competing sickness funds.

4.1 Cross-Border Care and Expenditure Control

The EU directive of the application of patients' rights and German law require that sickness funds must reimburse up to the amount which they would have paid for the same treatment in Germany. This regulation appears simpler than it is. Even though in Germany fees are specified for treatments, expenditure control measures lead to lower actual payments.

In the inpatient sector, hospitals are mainly paid based on DRGs. The German DRG catalog specifies a relative weight for each DRG.[17] Furthermore, for each federal state a "state basis value" ("Landesbasisfallwert") is specified which is to be multiplied by the relative weight to obtain the DRG payment. On average, about €3.050 are paid per standard case with weight one in 2013. If a person is treated in another country, this would suggest paying the state basis value multiplied by the relative weight of the corresponding DRG in Germany. This, however, would not take into account that there are also agreements on the total volume of services supplied by hospitals in Germany. These are broken down for each hospital in Germany, resulting in target budgets ("Erlösbudgets"). If hospitals exceed these target budgets, payments are considerably reduced. Currently, only 35 % of the DRG payment can then be kept by the hospital. In practice, this is frequently the case. Thus, sickness funds effectively pay less for hospital treatments per case than the payment according to the state basis value. This would

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[16] See Zweifel et al. (2009), Sect. 5.5 for a discussion of types of rationing of health care services.

[17] The German DRG system is managed by InEK (Institut für das Entgeltsystem im Krankenhaus). Information can be obtained on its website http://www.g-drg.de.

need to be considered for cross-border care. However, the exact amount paid on average for hospital treatment is known only retrospectively.

For the outpatient sector, the arrangement is even more complicated. For the most part, sickness funds pay capitations to regional physicians' associations. These distribute their total revenue to their members according to a complex catalog which specifies fees for cases as well as for specific services. Once again, these fees are overestimates of actual payments. This is a consequence of the target budgets for physicians ("Regelleistungsvolumina"). If this budget is exceeded, the reimbursement for additional cases is significantly reduced.

At the moment, sickness funds use official fees to calculate the maximum amount for reimbursement in case of cross-border treatment. On average, treatment in foreign countries can therefore be more generously reimbursed than in Germany itself. From the perspective of sickness funds, this is true in a double sense for the outpatient sector. They continue to pay the capitation to the regional physicians' association and pay the cross-border treatment on top. Since the treatment is not provided by the association, sickness funds could in principle claim back the expenditure for cross-border treatment. However, resistance from associations is strong and this has not yet been implemented.

Both in the inpatient and the outpatient sector, cross-border care therefore has the potential to increase overall expenditure of the German sickness fund system because it bypasses the expenditure control mechanisms. Currently, this does not matter too much because overall expenditures for cross-border care are still low. Furthermore, if treatment in other member states is less expensive than in Germany, then the potentially higher reimbursement is not a problem. This holds for most treatments in Eastern European countries but not for countries such as Austria or Switzerland. If cross-border care becomes more widespread with treatment in "expensive" countries, then measures would need to be taken.

4.2 Cross-Border Care and Equal Access to Care

One worry about cross-border care is that it can increase inequality of access to healthcare.[18] In particular, those which are physically and financially able to travel have an advantage over those with complex health conditions or little means.[19] Foreign providers can also have the incentive to attract easily treatable patients by offering spa and wellness treatments on top at a discount. Expensive and immobile patients with difficult and chronic conditions will probably remain in the home country.

This problem will be more severe, the stronger care is rationed in the home country. This holds for both explicit and implicit rationing as long as the treatment

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[18] See footnote 16 for evidence for unequal access in Germany.

[19] See Baeten (2011, p. 265).

is part of the benefit package of the public healthcare system.[20] In the case of explicit rationing with waiting lists, European cross-border care opens the possibility of jumping the queue. In particular, the rich and educated have an advantage. With implicit rationing through budgets, similar effects can arise. The EU directive effectively implements fee-for-service reimbursement for cross-border care. As pointed out in the previous section, this undermines standard expenditure control measures. Again, those able to use care in another country are privileged because they can claim fee-for-service remuneration.

The German sickness fund system so far relies mainly on implicit rationing.[21] In the inpatient and outpatient sectors, target budgets reduce the incentives of providers to treat patients by reducing reimbursement once the target budget is reached. With the aging of German society and the forecasted increase in healthcare expenditure per capita, the extent of implicit rationing is likely to increase. This creates the incentives to seek cross-border care and make use of the more favorable fee-for-service remuneration.

4.3 Cross-Border Care, Cost Savings and Risk Selection

The previous sections on expenditure control and access to care emphasized the problems created by cross-border care. However, cross-border care also has beneficial effects. The TK surveys showed that patients are very satisfied with cross-border care. They also tend to obtain care in Eastern European countries where healthcare is less expensive. According to the 2012 survey, 41 % of planned EU cross-border care took place in the Czech Republic, Hungary and Poland. This also saves costs for the German sickness fund system as the reimbursement for care in these countries is lower than for the same treatments in Germany.

These cost savings are more likely to arise if sickness funds take an active role in organizing cross-border care. First, sickness funds can assess the quality of foreign providers and thereby avoid costly follow-up treatments in Germany. Second, they can make sure that providers do not overcharge. This holds for the individual patients, who may face high copayments, and for sickness funds, which want to avoid that foreign providers try to extort the maximum payment from them. In particular, sickness funds can negotiate prices with foreign providers.

This approach has been taken by Techniker Krankenkasse. However, this has been observed with some scrutiny by other players in the German sickness fund system. As anywhere, domestic suppliers are not happy about competition from

[20] Explicit rationing may also exclude a treatment from the benefit package of the public health care system. In this case, however, cross-border care is not reimbursed either. Nevertheless, those with more financial means have an advantage because they can obtain this treatment either at home or abroad.

[21] Breyer (2013) argues that it would be desirable to limit implicit rationing and to move towards explicit rationing.

foreign suppliers who can produce at lower cost. Therefore, TK has been cautious in its cross-border operations and does not actively promote cross-border care but only offers assistance to those who seek it.

Cross-border care also has to be seen in the context of competition among sickness funds. Supporting cross-border care is a promising product differentiation strategy for sickness funds. In principle, this is to the benefit of individuals, who have more choice, and of sickness funds, which can save costs. A potential problem, however, is that promoting cross-border care may be a means of risk selection.[22] In particular, it can be a way to attract comparatively good risks. As the surveys have shown, users of cross-border care tend to be well-educated and in rather good health, a finding corroborated by the fact that they are still mobile. These characteristics are not directly considered in the German risk adjustment formula which uses information on age, gender, reduced earning capacity and morbidity. However, there is an easy way to avoid that cross-border care just pays off because cross-border care users tend to be healthier. The fact that a person uses planned cross-border care could be considered in the risk adjustment formula. If these individuals are less expensive compared to otherwise similar individuals, then the risk-adjusted payment for them should be reduced.

5 Policy Implications

The EU patients' rights directive not only creates new opportunities for patients but also raises problems for the German sickness fund system. The reason is that the directive de facto stipulates fee-for-service reimbursement for cross-border treatment while inside Germany reimbursement is limited by target budgets. Official fees are therefore overestimates of actual payments. This implies that the current system which uses official fees for cross-border care is potentially too generous. If cross-border care becomes more widespread, then sickness funds can face considerable expenditure increases. The fee-for-service reimbursement for cross-border care is also problematic for equity reasons. It puts those at an advantage who are able to seek cross-border care because they are still mobile and possess the means for traveling.

To avoid the adverse effects on expenditure and equity, an important step is to correct the official fees for treatment in Germany for the effects of expenditure control measures. A useful approach is to calculate what is actually paid for treatment in Germany considering that some treatments are reimbursed only partially because they have been provided when the target budget was already exhausted. Since this is known only retrospectively, data from previous years can be used to calculate a reduction due to budgeting restrictions. A problem of this

[22] This would be an instance of indirect risk selection where insurers use the design of the benefit package to attract favorable risks (see Zweifel et al. 2009, Chap. 7).

approach is that it may be regarded as a way of limiting patient mobility in the EU. However, it is in line with the requirement that only the amount must be reimbursed that is paid in the home country.

Cross-border care also requires adjustments within the German sickness fund system. One problem is that sickness funds now pay twice for a patient who seeks outpatient care abroad because they continue to pay the capitation to the regional physicians' association. Payments for cross-border care should therefore be deducted from the associations' budget. At the moment, however, this is difficult because the fees paid for cross-border care can be larger than the fees received by a physician when treating the patient at home. Again, this calls for a recalculation of the remuneration of cross-border care.

Furthermore, attention should be given to the potential of cross-border care as a means for risk selection. A simple approach is to include the fact that a person used planned cross-border care in the risk adjustment scheme. With this policy in place, sickness funds can be given an active role in organizing cross-border care. This is a promising way to ensure that the potential benefits of the EU patients' rights directive are not only to the advantage of the individual patient but also for the sickness fund system as a whole.

Overall, however, a fundamental problem remains. The coexistence of one sector of care which relies on expenditure control mechanisms and implicit rationing (domestic treatment) and an alternative sector of care which is reimbursed fee-for-service (cross-border treatment) is conflictive. If such a choice would exist within a country, the expenditure-controlled sector would likely suffer at the expensive of the fee-for-service sector. Fee-for-service, however, raises its own problems. In particular, it is vulnerable to both moral hazard by patients and supplier-induced demand by physicians. To counter these effects, copayments may have to be increased. It remains to be seen whether cross-border care will create such problems. Up to now, its impact has been limited.

6 Conclusions

Germany provides an interesting case study for possible impacts of the EU directive on the application of patients' rights in cross-border healthcare for outward patient mobility. Already in 2004, most of the directive's requirements were legally implemented in Germany. Since then, sickness fund members can claim treatment to which they would be entitled in Germany in any other EU member state and in the four member states of the European Free Trade Association. Only for inpatient treatment, prior permission is required. Costs must generally be reimbursed up to the amount which would be reimbursed in Germany.

Results from surveys by the German sickness fund with the most pro-active strategy towards cross-border care show that a small but considerable share of sickness fund members makes use of planned cross-border healthcare. The majority of these are retired and well-educated. Spa treatments are most popular but sickness

fund members also use hospital, dental and specialist services in other European countries. They are generally highly satisfied with planned cross-border care.

A problem for the German sickness fund system is that cross-border treatment is effectively reimbursed on a fee-for-service basis. By contrast, remuneration inside Germany is subject to expenditure control mechanisms. In particular, official rates used for cross-border care can be too high at the moment since they do not take into account reduction of fees due to targeted budgets. The discrepancy of rationing inside Germany and fee-for-service outside Germany can also be problematic for equity reasons. Those who are able to travel to foreign countries may get access to better treatment because it is more generously reimbursed. To avoid these adverse effects on expenditure and equity, the official fees for treatment in Germany should be corrected for the effects of expenditure control measures.

The problem of higher expenditure does not arise if sickness fund members obtain treatment in less expensive countries, in particular in Eastern Europe. Cost savings can be expected if sickness funds are given an active role in organizing these treatments and in contracting with local providers. To avoid that sickness funds use cross-border care to select healthier patients, the fact that a person used planned cross-border care should be included in the German risk adjustment scheme.

Overall, the German experience with cross-border care shows that patients make use of the possibility of being treated in other European countries and are usually satisfied. It also demonstrates that it is difficult to define the amount which would be reimbursed in Germany for the same treatment. On a fundamental level, there is a tension between resource allocation within Germany and the fee-for-service reimbursement for cross-border care. An open question is the effect of increased cross-border care on the healthcare systems of the countries in which German sickness fund members obtain treatment. On the positive side is the additional income created by patients from Germany. However, patients in these countries may have to wait longer than German patients, in particular in Eastern Europe. This has to be balanced against the incentives created by cross-border care for physicians to stay in their home country rather than to migrate to countries with higher income opportunities.

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