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Cross-border Purchases of Health Services

A Case Study on Austria and Hungary

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Abstract

This paper explores the structure of cross-border health purchasing between Austria and Hungary and determines the size of this phenomenon as well as the barriers to a further increase. Austrian patients may receive health care treatment in Hungary in three different ways. First, patients may receive benefits in the context of the European Community Regulations 1408/71 and 574/72 (Category I patients). Second, outside those regulatory structures, Austrian patients travel to Hungary to receive medical treatment, especially dental treatment, and then seek reimbursement from their Austrian insurance (Category II patients). Third, some patients receive medical treatment in Hungary outside both schemes (Category III patients). There are about 42,500 Category I patients per year; and 58,000 Category II patients world-wide per year. An unknown but supposedly greater number of patients travel to Hungary to receive mainly dental treatment and cosmetic surgery (Category III). Most health actors in both Austria and Hungary do not regard cross-border purchasing of health services as having cost-saving effects. They put forward major legal, institutional, political, and psychological barriers, which inhibit public and private Austrian providers, to facilitate trade in health care and which inhibit individual patients to realize cost savings through capitalizing on lower health care prices in Hungary. Therefore, for the time being, trade in health care and patient mobility between Austria and Hungary is a circumscribed phenomenon in terms of quantities, and it will most probably remain so in the near future.

This paper—a product of the Trade Team, Development Research Group—is part of a larger effort in the department to improve our understanding of international trade in services. Policy Research Working Papers are also posted on the Web at http://econ.worldbank.org. The author may be contacted at Andreas.Obermaier@oeaw.ac.at.

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by
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INTRODUCTION

The widespread vague narrative about cross-border purchasing of health services is as follows: Increasing numbers of patients receive planned or urgent medically necessary health treatment outside their own country. This outflow of patients happens for various reasons. In Austria, one cause is that the cost of less expensive but more frequent health services – such as dental care – are not entirely reimbursed by the statutory health care system.[1] Rising out-of-pocket expenditures in the past years have been driving patients to countries with lower health care prices, such as Hungary.[2]

This paper explores the empirical reality of this narrative with evidence for the country pair Austria/Hungary. What legal provisions exist in Austria to import health care from Hungary? In turn, what provisions are in place in Hungary to receive Austrian health care consumers? What is the quantitative size of this phenomenon? What are the views and future plans of the main health care actors in Austria and Hungary on trade in health care? Do health care actors facilitate cross-border purchasing of health care, or do they obstruct it? If the latter is the case, what are the major obstacles?

The concepts of "trade in health services" and "cross-border purchasing of health services" are used in this paper according to the definition of the General Agreement on Trade in Services (GATS, mode 2).[3] "Trade in health services" is used when referring to health organizations contracting health providers abroad in order to deliver health services outside their territory. The concept of "cross-border purchasing" is used for individual patients who travel abroad to purchase a health service.

Even though there is a growing body of literature, little is known about the extent and shape of the phenomenon of health care purchased in another country. We do not have accurate data on how many patients travel to another country to receive health care and we know little about the barriers to trade in health services. However, there are singular case studies on trade in health services in the United States, Canada or the ASEAN region (see e.g. Katz et al. 2002, Mattoo and Rathindran 2006, Arunanondchai and Fink 2007). This paper aims at improving our knowledge about the phenomenon of cross-border purchasing of health care with the example of Austrians traveling to Hungary to receive health care.

In the first section, the fundamental principles as well as the provisions on the importability and exportability of health care of the Austrian and Hungarian health care systems will be outlined (1). Second, the European Community provisions on cross-border health care will be presented (2). In the third section, the differing views of Austrian and Hungarian health care stakeholders will be summarized (3). Fourth, the available quantitative data on cross-border health care between Austria and Hungary will be presented (4). In the fifth section, the potential financial benefits for three health care areas will be shown (5). Finally, the case study will discuss the major legal, institutional,

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[1] On the reduction of mandatory health risk coverage in Bismarckian health insurance systems, see e.g. Hassenteufel and Palier (2007: 581–84).

[2] Recent data from Hofmarcher and Rack (2006: 71–72) suggest that the proportion which private households (private health insurance, indirect and direct cost-sharing, private non-profit organizations) contribute to social health insurance fell from 1995 to 2004. However, direct cost-sharing, defined as co-payments of private households for benefits covered by social health insurance, rose from 6.5 percent in 1995 to 7.6 percent in 2004 (as a percentage of total health expenditure). The nominal value of private health expenditure rose from 4,210 million Euro in 1995 to 5,339 million Euro in 2004 (ibid: 90).

[3] On the definition of consumption of health services abroad, see e.g. Chanda (2002).

political and psychological barriers which inhibit cross-border purchasing between Austria and Hungary (6), before concluding the paper.

CASE SELECTION AND METHODOLOGY

Austria and Hungary were chosen as a country pair because of various reasons: health care standards and prices differ between these countries; they have a long common history; and, cross-border contacts are a common phenomenon between the two countries.

The parts on the (legal) national and European structures of receiving health care services abroad have been done through a literature survey, a legal analysis, and interviews with representatives of ministries of health and social affairs, social security institutions, public health care providers, and private health care providers. The third section is based exclusively on the information provided in the expert interviews. The fourth section presents the available public and unpublished statistics provided by Austrian and Hungarian health care institutions. The fifth section relies mainly on an analysis of public health care documents as well as explorative information provided in telephone and email inquiries. Finally, the sixth section on the barriers to cross-border health purchasing is again mainly based on analysis of the expert interviews.

1 THE AUSTRIAN AND HUNGARIAN HEALTH CARE SYSTEMS

1.1 Austria

1.1.1 Fundamental Principles

In Austria, all employed persons, their family members, and most social assistance claimants (thus 98.7 percent of the population in 2007) are covered by statutory health insurance (see Federation of Austrian Social Security Institutions 2008b: 25). Persons who are not covered have the possibility of voluntary insurance within statutory health insurance. In 2001, 112,000 persons were voluntary insured (see Wörister and Rack 2003: 45).

In addition to the statutory health insurance, there is the option of private health insurance that offers supplementary benefits and betterments. In 1999, approximately 32 percent of the population had private health insurance (see Loy 2002: 53).[4] The main motives for patients to buy private health insurance are threefold. First, it covers the costs of better accommodation in hospitals. A second motive is to cover the costs of treatment by a non-contracted physician of choice. And third, it shortens the waiting times for examinations (see Hofmarcher and Rack 2006: 96).

Austria's non-competing self-governing health insurance funds (HIFs) are classified by occupational groups (miners, self-employed persons in trade, commerce and industry, farmers, railway employees, civil servants, blue-collar workers, white-collar workers, etc.), by region, and by employer.[5] There are sub schemes for workers and employees,

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[4] Hofmarcher and Rack confirm that around a third of the population has private health insurance (2006: 96).

[5] For a more detailed overview of the structure of the Austrian HIFs, see e.g. Federation of Austrian Social Security Institutions (2008a), Hofmarcher and Rack (2006), and Köttl (2008).

civil servants, self-employed in industry and business, and farmers.[6] In 2003, 77.0 percent of all insured persons were covered by the General Social Security Act, 8.5 percent by the Civil Servants Health Insurance Act, 6.8 percent by the Social Security Act for the Self-employed, and 4.6 percent by the Farmers Health Insurance Act (see Hofmarcher and Rack 2006: 73).

The overall 21 HIFs (nine regional funds, four occupational funds, six company funds, as well as the General Work Accident Insurance Institution and the Pension Insurance Institution) are united within an umbrella organization, the Federation of Austrian Social Security Institutions (*Hauptverband der Österreichischen Sozialversicherungsträger*, HVSV). The main tasks of the HVSV are: long-term planning; drawing up guidelines for uniform implementation; central data management; contracts with physicians and dentists; publication of a list of pharmaceuticals; comparison of key indicators for the social insurance institutions; representation of the social insurance institutions in the public arena; and acting as a liaison office in the international arena (see Federal Ministry for Social Affairs and Consumer Protection 2008: 12).

In Austria, health care is essentially provided through benefits in kind, either by special facilities (above all out-patient clinics) or—to a much larger extent—by institutions under special contract (hospitals) or physicians under special contract (in-network facilities and physicians). The HVSV and the regional medical associations conclude regional agreements. The sub schemes for self-employed, farmers and railway workers have contracts on a national level. There are national dental care tariffs for all insured persons. If patients receive health services from out-of-network physicians or institutions, they have to advance the charged fees and are then partially reimbursed by their insurance institution.

1.1.2 Provisions on Cross-border Purchasing of Health Care

The Austrian statutory health insurance, in contrast to for example Germany, does not have suspension regulations any more.[7] This means that the right to health care is not suspended while an insured person stays abroad. Consequently, there are no explicit domestic provisions which provide for obtaining health care abroad. If health care is received abroad, Paragraph 131-1 General Social Security Act (ASVG) which concerns the reimbursement of health care treatment costs is taken as a reference point. This paragraph states that if an insured person does not make use of the contractual partners according to Paragraph 338 ASVG or the facilities of her HIF, she has the right to a reimbursement of 80 percent of the amount the health insurance institution would have had to pay for a treatment by a physician who has a permanent contract with that institution. Paragraph 131-2 provides that the reimbursement of expenses may be excluded if the insured has consulted an in-network facility for the same insurance case.

[6] See Allgemeines Sozialversicherungsgesetz/ASVG – General Social Security Act, Federal Law Gazette 1955/189, last amendment I-2003/71; Beamten-Kranken und Unfallversicherungsgesetz/B-KUVG – Civil Servants Health Insurance Act, Federal Law Gazette 1967/200, last amendment I-2003/71; Gewerbliches Sozialversicherungsgesetz/GSVG – Social Security Act for the Self-employed, Federal Law Gazette 1978/560, last amendment I-2003/71; Bauern-Sozialversicherungsgesetz/BSVG – Farmers Health Insurance Act, Federal Law Gazette 1978/559, last amendment I-2003/71.

[7] In Germany, according to Article 16-1-1 Social Code Book V, benefit claims are suspended as long as an insured person stays abroad.

The same provisions exist in the other sub schemes.[8] According to Austrian health care law, a foreign physician is thus treated like any other Austrian out-of-network physician. The financial cut of 20 percent has been justified with the additional administrative burden caused by bills of out-of-network physicians. The individual calculation of the billing of out-of-network physicians does increase considerably the administrative expenditure in contrast to the computer-based billing of in-network physicians. In 2000, the Austrian Supreme Constitutional Court confirmed this procedure.[9]

1.2 Hungary[10]

1.2.1 Fundamental Principles

In Hungary, health care coverage is universal and provides access to all out-patient and in-patient benefits. The autonomous Hungarian National Health Insurance Fund (*Országos Egészségbiztosítási Pénztár*, NHIF) covers all insured persons. It collects contributions at the national level and then allocates the funds to 20 county branches. The NHIF contracts freely with providers. Most Hungarian hospitals are public, whereas in out-patient care most health care services are provided through in-network private providers. Out-of-network physicians are rare and especially concentrated in the dental sector.[11] Patients have to make co-payments to certain health services, such as dental care, rehabilitation, and stays at health resorts.

There is a very heterogeneous and expanding private health care sector in Hungary, mainly because the state and local governments lack financial resources. The private sector ranges from physicians working individually to foreign companies with an international network. The majority of private medical care is financed by direct payments by the patients.

1.2.2 Provisions on Cross-border Purchasing of Health Care

Treatment of Austrian patients within the Hungarian NHIF system mainly takes place in the context of EC Regulation 1408/71 (see Section 2). In the course of a short temporary stay, Austrian insured persons have to carry their European Health Insurance Card with them and may receive every medically necessary treatment. The Hungarian physicians have to check how long the patient has been in Hungary and in which medical condition she is in. As long as the patient cannot go home in order to receive treatment, the Hungarian physician has to treat her within the framework of EC Regulation 1408/71. In this case, there is no difference in treatment between Austrian and Hungarian patients. If a patient travels to Hungary for treatment outside EC Regulation 1408/71, she has to pay out-of-pocket for the treatment. Since Hungarian physicians have a lot of leeway for their pricing, foreign patients might have to pay a higher price than Hungarians. Most Austrian patients travel to Hungary for dental treatment, which is to a very low extent covered by the Hungarian and Austrian health care systems.

[8] See Paragraph 59 B-KUVG, Paragraph 80 BSVG, and Paragraph 96 GSVG.

[9] See Austrian Supreme Constitutional Court, 18 March 2000, G 24/98, V 38/98.

[10] For a more detailed overview of the Hungarian health care system, see e.g. Gaál (2004).

[11] According to information provided by the NHIF, from 4,122 providers in the dental sector, 3,439 have a contract with the NHIF. This means that 683 providers in the dental sector do not have a contract with the NHIF.

2 EUROPEAN COMMUNITY PROVISIONS ON CROSS-BORDER PURCHASING OF HEALTH CARE[12]

The major part of cross-border purchasing of health care between Austria and Hungary is regulated by European Community (EC) regulations, which will be outlined in detail in the following section.

2.1 Regulations 1408/71/EEC and 574/72/EEC

The EC coordination Regulations 1408/71 and 574/72 are of great importance for cross-border medical care.[13] Regulation 883/2004 is going to replace 1408/71. It is not yet applicable, though, because it does not have a procedure regulation and several important annexes are missing. In the meantime, Article 22-1 of Regulation 1408/71 determines that an insured person and her family members staying or residing in another Member State are entitled to receive benefits in kind according to the legislation of this Member State as if they were insured there, at the expense of their insurance institution. This entitlement concerns "benefits in kind which become necessary on medical grounds during a stay in the territory of another Member State, taking into account the nature of the benefits and the expected length of the stay" (Article 22-1-a).

For planned treatment abroad, Article 22-2 of Regulation 1408/71 determines that authorization for such a treatment

> may not be refused where the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resided and where he cannot be given such treatment within the time normally necessary for obtaining the treatment in question in the Member State of residence taking account of his current state of health and the probable course of the disease.

If authorization is granted, the treatment is provided according to the legislation of the Member State where the treatment takes place, at the expense of the insurance institution in the state of insurance.

The provisions of Article 22 of Regulation 1408/71 apply to all persons insured under the legislation of a Member State and to the members of their families residing with them.

The innovative *Kohll/Decker* jurisprudence of the European Court of Justice, based on the free movement of services and goods, has abolished the prior authorization procedure in the case of out-patient care.[14] Now, patients may consume health care abroad

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[12] On the problems of implementation and application of the EC provisions, see e.g. Jorens and Hajdú (2005).

[13] Detailed information on EC Regulations 1408/71 and 574/72 can be found, for instance, in Cornelissen (1996), Schulte and Barwig (1999), or Spiegel (2006). Regulation (EEC) N° 1408/71 of the Council of 14 June 1971 applies social security schemes to employed persons and their families moving within the Community, Official Journal L 149, 5 July 1971, pp. 0002–0050. Regulation (EEC) N° 574/72 of the Council of 21 March 1972 fixes the procedure for implementing Regulation (EEC) N° 1408/71 on the application of social security schemes to employed persons and their families moving within the Community, Official Journal L 074, 27 March 1972, pp. 0001–0083.

[14] On the *Kohll/Decker* jurisprudence, see e.g. Hatzopoulos (2002), Jorens (2004), or Sieveking (2007). See Case C-158/96, *Raymond Kohll vs. Union des Caisses de Maladie* [1998] ECR I-1931; Case C-120/95, *Nicolas Decker vs. Caisse de Maladie des Employés Privés* [1998] ECR I-1831; Case C-368/98, *Abdon*

independently from prior authorization. They have to advance the payment for the treatment and are then reimbursed by their state of insurance according to the current reimbursement rates. For in-patient care the prior authorization procedure remains in place under the following conditions:

- there have to be objective, non-discriminatory criteria for authorization which are known in advance;
- considered should be what has been sufficiently tried and tested by international medical science;
- the prior authorization scheme has to be based on a procedural system which is easily accessible and capable of ensuring that the request for authorization will be dealt with objectively and impartially within a reasonable time; and
- there has to be the possibility to challenge a refusal to grant authorization in judicial or quasi-judicial proceedings.

In the following parts, the procedures for the different categories of persons entitled to health care benefits abroad within the EC regulatory structure will be examined in more detail.

2.1.1 EHIC: Medically Necessary Treatment While Staying Abroad

If patients are staying temporarily in Hungary, they may use the European Health Insurance Card (EHIC) in order to receive all medically necessary treatments (see Article 22-1 Regulation 1408/71). EHIC has replaced the old E111 Form in 2004 (see European Commission 2003). With EHIC all benefits in kind, out-patient as well as in-patient, are covered which become medically necessary in the event of a short-term visit in an EU/EEA[15] country and Switzerland, taking into consideration the type of treatment and the expected duration of the stay. EHIC has to be submitted to the service provider abroad (physician or hospital) who then has to check its validity. In individual cases physicians do not accept EHIC, but in general it seems that there are no specific problems concerning EHIC between Austria and Hungary. In 2005, about 41,000 Austrian EHIC-cases were registered in Hungary (see Section 4).

2.1.2 E112 Procedure: Authorization for Planned Treatment Abroad

If patients cannot be treated in Austria in time, they have to be referred abroad under the E112 Procedure (see Article 22-2 Regulation 1408/71). This procedure provides for the consumption of a specific planned treatment in an EU/EEA Member State and

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Vanbraekel and Others vs. Alliance Nationale des Mutualités Chrétiennes [2001] ECR I-5363; Case C-157/99, *B.S.M. Geraets-Smits vs. Stichting Ziekenfonds VGZ and H.T.M. Peerbooms vs. Stichting CZ Groep Zorgverzekeringen* [2001] ECR I-5473; Case C-385/99, *V.G. Müller-Fauré vs. Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA and E.E.M. van Riet vs. Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen* [2003] ECR I-4509; Case C-56/01, *Patricia Inizan vs. Caisse primaire d'assurance maladie des Hauts-de-Seine* [2003] ECR I-12403; Case C-08/02, *Ludwig Leichtle vs. Bundesanstalt für Arbeit* [2004] ECR I-2641; Case C-145/03, *Heirs of Annette Keller vs. Instituto Nacional de la Seguridad Social* [2005] ECR I-2529; Case C-372/04, *The Queen on the application of Yvonne Watts vs. 1) Bedford Primary Care Trust 2) Secretary of State for Health* [2006] ECR I-4325; Case C-466/04, *Manuel Acereda Herrera vs. Servicio Cántabro de Salud* [2006] ECR I-5341.

[15] The European Economic Area (EEA) was founded in 1994. It comprises the EU Member States and the three EFTA Member States: Iceland, Liechtenstein and Norway.

Switzerland if the health insurance institution after consultation of the head doctor has authorized it. The E112 Form is only displayed in very specific circumstances, if the treatment cannot be provided in Austria itself in appropriate time. In the foreign country, the E112 Form has to be transferred into a domestic proof of claim.[16] In general, Austria is very restrictive in authorizing treatment abroad. The E112 cases concern very specialized treatments, which cannot be offered in Austria, e.g. therapy for children with dolphins. Up to now, no case has been referred to Hungary.

2.1.3 Pensioners Resident in Another EU Member State

Pensioners who are insured in Austria but resident in Hungary may receive an E121 Form from their insurance institution and submit it to the Hungarian NHIF (see Decision 153). The NHIF provides them in the following with an insurance card that entitles them to all domestic health care benefits in kind. In 2005, only about 40 pensioners insured in Austria but resident in Hungary took up this opportunity (see Section 4).

2.1.4 Regular Cross-border Commuters

Insured persons who—on a regular basis—cross the border to Hungary may receive an E106 Form from their insurance institution and submit it to the NHIF (see Decision 153). The NHIF then provides them with a Hungarian insurance card with the right to have the same treatment as a Hungarian insured person. In 2005, 1,592 Austrian commuters were registered in Hungary to these conditions (see Section 4).

2.1.5 Co-insured Family Members

Co-insured family members who live in Hungary may receive an E109 Form from their insurance institution and submit it to the NHIF who then provides them with a Hungarian insurance card with the right to have the same treatment as a Hungarian insured person (see Decision 153). In 2005, only about 50 co-insured family members made use of this opportunity (see Section 4).

2.1.6 Calculation of Costs

The costs resulting from the benefits in kind delivered in the framework of EC Regulation 1408/71 are calculated between the so-called connecting institutions, on the Austrian side the Federation of Social Security Institutions and on the Hungarian side the National Health Insurance Fund. Both fulfill only a mailbox function between the Hungarian providers and the responsible Austrian HIFs (see Article 36 Regulation 1408/71).

The reimbursement mechanism works as follows: A person insured in Austria needs medically necessary treatment in Hungary on the occasion of a short term stay. She presents her EHIC to the Hungarian service provider and receives benefits in kind. The

[16] See Decision N° 153 of 7 October 1993 of the Administrative Commission on Social Security for Migrant Workers on the model forms necessary for the application of Council Regulation N° (EEC) 1408/71 and (EEC) N° 574/72 (E 001, E 103 to E 127) (Text with EEA relevance) (94/604/EC), Official Journal L 244, 19 September 1994, pp. 0022–0122.
The Administrative Commission on Social Security for Migrant Workers is composed of Member State representatives of the ministries for social affairs, employment and health. It has been set up with reference to Article 80 of Regulation 1408/71 and is concerned with the correct application of EC Regulations 1408/71 and 574/72.

Hungarian provider has to check whether the treatment is medically necessary taking into account the nature of the benefits and the expected length of the stay (see Article 22-1-a Regulation 1408/71). The Hungarian benefit provider then has to fill out Form E125 (see Decision 179 of the Administrative Commission on Social Security for Migrant Workers) to assert her claim for reimbursement. The Hungarian NHIF collects these invoices from the Hungarian physicians and hospitals and transmits them to the HVSV. The HVSV then asks the Austrian HIFs for their acceptance to cover the costs. In case of approval, the HVSV transfers the money directly to the Hungarian NHIF that distributes it among the Hungarian providers. The Austrian HVSV finally reclaims the money from the HIFs.

In the case of short stay treatments, E112 Procedures and regular cross-border commuters, the actual costs are calculated; for pensioners and co-insured family members, lump-sums are paid that have to be determined every year anew in the Administrative Commission on Social Security for Migrant Workers (see Articles 93 to 95 EC Regulation 574/72).

According to the Hungarian NHIF, the Austrian Ministry for Social Security and the HVSV, there are no specific problems with the above presented reimbursement mechanism between the two countries. However, there is a percentage of cases—though being low—in which payment is declined for several reasons; for instance the person is not an Austrian citizen or the amount has been charged already. The promptness of the reimbursement depends on the amount, i.e. for small sums it takes between two to four months, for higher sums between six to nine months.

If a Hungarian health care provider refuses the EHIC of an Austrian patient who then has to pay cash in advance—which is sometimes the case—the Austrian insurance institutions dispose of an unbureaucratic method of reimbursing claims up to the amount of 1,000 Euro. The legal basis for that is Article 34 of EC Regulation 574/72.

3 DIFFERING POSITIONS ON CROSS-BORDER HEALTH CARE[17]

This third section will reproduce the views of health care actors in Austria and Hungary on cross-border purchasing of health services and trade in health care.

3.1 Austrian Health Actors

The following parts will shortly summarize the views of Austrian health care actors along three issues: What do Austrian health care actors think about cross-border purchasing (with a special focus on Hungary)? Do they expect financial cost savings? What do they regard as the main problems?

3.1.1 Federal Ministry for Social Affairs

In general, the Federal Ministry for Social Affairs and Consumer Protection is ambivalent regarding cross-border purchasing of health care. On the one hand, it wants to be prudent

[17] The following section is based on interviews with representatives of various health care actors in Austria and Hungary (ministries for health and social affairs, social security institutions, public health care providers, and private health care providers). The author would like to thank all experts contacted during the research. Patients or consumer groups were not interviewed because of organizational and financial restrictions.

with the opening of borders, because health care is a sensitive issue in Austria. On the other hand, it does not want to lag behind European developments.

According to an official of the Federal Ministry, foreign providers could exert considerable pressure on Austrian service providers (dentists and physicians). For dentists, the main sources of income are private additional treatments, i.e. jaw adjustments, dentures and the like. If patients would migrate in masses abroad, Austrian dentists would lose their main source of income. For the moment, however, the Federal Ministry does not perceive a major effect of patient mobility.

From a legal perspective, the Ministry does not see problems for the regional HIFs to contract with foreign health care providers.[18] The main question would be which tariffs apply. If Austrian HIFs would offer Hungarian dentists the Austrian tariffs, Austrian dentists would probably not object. However, this would create tensions in Hungary, with a small number of well-off dentists. If the HIFs would offer Hungarian dentists more reasonable tariffs—which would be more interesting for the funds—it is very likely that Austrian dentists would object to this, regarding it as price dumping. Another important question for the Ministry is to secure the quality of treatments in Hungary. However, up to today these questions have been treated as a taboo in Austria.

According to the Federal Ministry, in practice Austrian HIFs do not save money by reimbursing patients having had treatment in Hungary. In general, the replacement rates for dental treatments are extremely low. The costs (the nominal value) for the HIFs remain the same whether a patient pays a treatment in Austria or abroad. If, for example, a treatment costs 1,000 Euro in Austria with the HIF paying 100 Euro, and the treatment costs 300 Euro in Hungary, the HIF would still reimburse 100 Euro. The saving effect for the HIF would therefore be zero.

According to the Federal Ministry, EC Regulation 1408/71 functions quite well in practice, especially in hospitals. There are no specific problems with Hungary, leaving the impression that the "new" Member States try to apply EC law correctly.

3.1.2 Viennese HIF

Currently, trade in health care does not concern the Viennese HIF, neither in positive nor in negative terms. However, the Viennese HIF perceives Hungarian providers as a potential concurrence for its own health facilities.

The Viennese HIF does not see cost savings resulting from trade in health care. As far as dental treatment is concerned, a representative states, that the HIF always has to pay the same amount. In principle, it does not make a difference, whether a patient submits a receipt from an out-of-network physician from Vorarlberg, i.e. a Western region of Austria, or from Hungary.

At present, the Viennese HIF has no contracts with foreign providers. There are no intentions for the near future to change this status quo, for various reasons: the question

[18] One way of dealing with cross-border treatment would be to in-source certain treatments on a contractual basis. At the moment there are no contracts between Austrian HIFs and Hungarian health care providers. In general, according to the Austrian Ministry for Social Affairs, there are only very few contracts between Austrian HIFs and foreign providers in place. There are few efforts to improve this situation. Nevertheless, in 2006 the HVSV set up a working group on the issue of cross-border contracts. The reason was that the Bavarian *Allgemeine Ortskrankenkasse*—one of the main German insurance funds—wanted to contract with Upper Austrian and Salzburg providers. Therefore, the Upper Austrian HIF encouraged the HVSV to discuss this matter in principle.

of the applied tariff is not resolved, there are concerns about quality control in Hungary, the influence on domestic contracts and tariffs is contested, and issues such as follow-up treatments and claims for compensation are not resolved. According to the Viennese HIF, cooperation contracts with foreign providers would only cause additional costs, because the HIFs currently pay a fixed lump-sum to the regional hospital funds, out of which the hospitals are financed. Foreign providers would have to be paid in addition. However, in principle it would make sense for the Viennese HIF to have contracts with cheaper Hungarian dental laboratories for their own medical facilities. This is a very sensitive political issue, though. In theory, the Viennese HIF regards contracts in the hospital sector as possible, especially for those treatments which are not available in Austria. The HIF would thus be able to exert some influence on pricing within the E112 Procedure. However, according to the Viennese HIF, it is difficult to settle such contracts, because the Austrian Medical Association has got a say in this as well and is strictly opposed to such contracts.

3.1.3 Salzburg HIF

The Salzburg HIF identifies one major problem with facilitated "health tourism": the difficulty to control the quality of the benefits and its cost effectiveness.

According to the Salzburg HIF, treatment purchased abroad would not produce cost savings, but in the contrary would lead to additional spending. Cost saving effects could be achieved only if the reimbursement for foreign providers would be below that of domestic contracts and reimbursement tariffs and if the necessary treatment would only be claimed abroad. That would be possible in the cases of permanent stays abroad or specific treatments.

3.1.4 Medical Association

In a statement delivered to the author[19], the Austrian Medical Association stands in general for mobility and flexibility of physicians and medical services, under the condition that the same quality written down in domestic law is being delivered. The association states that generally the training of physicians in Hungary fulfills the minimal requirements of EEC Directive 93/16.[20] Nevertheless, according to the association, due to transitional provisions, some physicians in Hungary do not have diplomas in conformity with the directive.

3.1.5 Private Health Insurance Provider

According to one of the leading private health insurance companies in Austria and Europe, it does not discriminate between the usage of health care in Austria and abroad with the sole exception of the United States, because of its extraordinary high health care costs. Whether a patient submits an invoice from Hungary or from an Austrian region, the additional payment of the private insurance is the same. In general, it neither encourages patients to purchase health care abroad nor does it discourage them. The private provider sees a considerable number of patients traveling abroad, especially in the Eastern parts of Austria, concerning dental care. The private provider supports cross-border purchasing in

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[19] In possession of the author.

[20] This EU Council Directive from April 1993 seeks to facilitate the free movement of physicians and the mutual recognition of their diplomas, certificates, and other evidence of formal qualifications in medicine.

general, because it is perceived as being cheaper. The main issue according to the private provider is the interplay between public and private social health care insurance. As long as there is no harmonization of social security systems in the EU, the private insurer cannot offer standardized solutions. Instead, costly single case examinations are perceived as disincentive for cross-border purchasing of health care.

3.1.6 Hospital Operator

According to a big Austrian hospital operator, there is no significant "health tourism" in the in-patient sector, except for tourists receiving treatment in the framework of EC Regulation 1408/71. Not more than 2 or 3 percent of all its patients are from abroad. The hospital operator does not have contracts with foreign insurance institutions, although it has received inquiries from the United Kingdom and an international company for wealthy Russian patients. The hospital operator would welcome the possibility for such contracts for border regions, but there are many problems involved, regarding the tariffs and legal uncertainties. According to the operator, an EU-wide harmonization of health systems, which is regarded as being very unlikely, should be discussed first. In general, the hospital operator thinks that trade in health care is only feasible and reasonable for very specific areas, such as specialized surgeries, even in the case of increased inner-EU mobility. Trade in health care apart from specialized sectors will be at most a temporary phenomenon. The hospital operator thinks that it is much more likely that specialized surgeons move instead of patients. Either the surgeons travel to the patient or high technology allows them to follow the surgery over a distance.

According to the hospital operator, domestic and EC law make it near to impossible to profit from foreign patients, because they have to be treated like Austrian patients. Prices paid for surgeries for the Austrian population, however, are mostly not cost-covering and additional tax funds have to be used to cover the incurred "deficits".

Table 1 summarizes the views of Austrian health care actors on the questions of what they think about cross-border purchasing of health care, whether they expect financial cost savings, and what they consider the main problems.

Table 1: Views of Austrian Health Actors

	What do you think about cross-border purchasing?	Do you expect financial cost savings?	What are the main problems?
Federal Ministry for Social Affairs	Ambivalent	No	Domestic tensions (income pressure on Austrian service providers); tariffs
Viennese HIF	Minor concerns (concurrence for Viennese health facilities)	No (in the contrary expects additional costs)	Tariffs; quality control; influence on domestic contracts and tariffs; follow-up treatments; claims for compensation
Salzburg HIF	Only for specific treatments	No (in the contrary expects additional costs)	Quality of the benefits; cost effectiveness
Medical Association	Only if same quality is being delivered	-	Conformity with Austrian standards
Private health insurance provider	In principle cheaper but structures are missing	Not under the current conditions	Interplay between public and private health insurance; lack of EU harmonization
Hospital operator	Cross-border contracts would be welcome; only in specific areas; will be a temporary phenomenon	No	Tariffs; legal uncertainties; lack of EU harmonization

3.2 Hungarian Health Actors

The following paragraphs will shortly summarize the views of Hungarian health care actors along two issues: What size does the phenomenon of cross-border purchasing have, and is it growing? Are foreign patients perceived to be a good business opportunity?

3.2.1 National Health Insurance Fund (NHIF)

According to the Hungarian NHIF, 99 percent of Austrian patients who receive dental treatment in Hungary do it via the out-of-network way, as private patients. There are endeavors—though not yet very concrete—to increase cross-border cooperation in health care with Slovakia, i.e. cooperation between Northern Hungary and Southern Slovakia. There are few efforts to encourage trade in health care (e.g. spa treatment), but those benefits do not fall under the EC regulations or are not financed by the NHIF. For spa treatment, more German than Austrian patients travel to Hungary.

3.2.2 Association of Human Private Health Care Providers

According to the Hungarian Association of Human Private Health Care Providers, the main obstacles to cross-border purchasing are on the one hand the immobility of patients and on the other hand the lack of public financing. The association assumes that the public sector would be in principle interested in cross-border care, because the health sector in Hungary is structurally underfunded. Therefore, patients from abroad could generate additional resources. However, the Hungarian NHIF cannot calculate a higher

invoice for foreigners, due to EC anti-discrimination regulations. Therefore, the public sector lacks an incentive to trade health care.

For the private sector the problem is, according to the association, of a different nature. Most big private health care companies are concentrated in the Budapest area and are not near the border, which creates a disincentive for Austrian patients.[21] Budapest locates some specialized hospitals which provide primarily out-patient care and whose clientele is mainly Hungarian. However, a major percentage also comes from abroad. Due to cost and marketing considerations, these specialized hospitals offer only very few profiles on a very high level, e.g. eye treatment or rheumatology (see e.g. the clinic "Focus Medical Margitsziget"). According to the association, the private providers view foreign patients in principle as a good business opportunity, however primarily for marketing considerations.

The biggest problem identified in Austria itself is the widespread belief that the quality of Hungarian health care is lower. Therefore, patients do not want to travel to Hungary.

3.2.3 Buda Health Center

According to the director of the Buda Health Center, a private clinic in Budapest with 140 beds and about 12,000 patients in 2005, the number and share of its foreign patients have been growing over the years. In 2005, the share of foreign patients in out-patient treatment was about 20 percent: about five percent were patients from outside Hungary; and about 15 percent were foreigners living in Hungary. The share of foreign patients of the overall business for the Buda Health Center was about 30 percent.

The patients of the Buda Health Center have to pay in cash. The clinic has contracts with the Hungarian NHIF (a very limited volume, 3,700 DRG[22] points, with a waiting list) as well as with Croatian and Slovak insurance companies. The clinic does not price-discriminate between foreign and Hungarian patients concerning the medical treatment. Nevertheless, foreign patients receive a different service level. They are offered more comfortable single rooms, better food, and private nurses in their native language. Therefore, foreign patients on average have to pay more. The clinic perceives foreign patients as a good business opportunity. The facility for spinal disorders, that belongs to the Buda Health Center, is even dependent on foreign patients, because of the overall low number of potential patients. The clinic therefore tries to attract patients on the occasion of conferences of medical societies and through foreign doctors who know the expertise of the Buda Health Center.

Table 2 summarizes the views of Hungarian health care actors on the questions of whether cross-border purchasing has been growing, and whether foreign patients are perceived as a good business opportunity.

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[21] The majority of Austrian patients who travel to Hungary go to the border region (Sopron, Györ, Mosonmagyaróvárn, and Szombathely).

[22] Diagnosis Related Groups (DRG) designate a system of classification for groups of in-patient care.

Table 2: Views of Hungarian Health Actors

	Has cross-border purchasing been growing in the last years?	Do you perceive foreign patients as a good business opportunity?
NHIF	Moderate	No (at least not for the public sector)
Association of Human Private Health Care Providers	Moderate	Yes (though primarily for marketing considerations)
Buda Health Center	Number and share of foreign patients has been growing considerably	Yes

4 QUANTITATIVE DATA ON CROSS-BORDER PURCHASING OF HEALTH CARE

There are few reliable data available on cross-border purchasing of health care between Austria and Hungary. The regional Austrian HIFs and the HVSV did not provide statistics that differentiate between the countries to which insured persons travel in order to receive health care treatment. The Hungarian NHIF, however, was able to deliver some differentiating data.

The gathered data do not provide a satisfying picture of the phenomenon of cross-border purchasing of health services. The number of Austrian patients seeking health care in Hungary within the EC regulatory structure is about 42,500. The number of Austrian patients seeking health care abroad world-wide and then claiming (partial) reimbursement from Austrian social insurance—estimated by the Austrian Federal Ministry for Social Affairs—revolves around 58,000 per year. An unknown number of patients travel to Hungary to receive mainly dental treatment and cosmetic surgery outside these established structures. Overall, it can be said that the number of Austrian patients treated in Hungary is quite modest.[23]

4.1 Data for Austria

According to reports of the Administrative Commission on Social Security for Migrant Workers, in 1997, Austria spent 0.48 Euro per inhabitant on medical benefits consumed in other countries on average. A year later, this value rose to 1.87 Euro and amounted to 8.90 Euro in 2004.[24]

According to rather old data from the Austrian Ministry for Social Affairs presented in Table 3 (1997–1998), very few patients, i.e. an estimated 850, travel each year to another country under the E112 Procedure (see Section 2.1.2), for the average costs of 5,523 Euro. The E112 authorization procedure is mainly used for hospital treatment.

[23] Albreht, Pribaković and Štalc (2006) find the same for Austrians traveling to Slovenia to receive health care.

[24] However, according to a representative of the Austrian Federal Ministry for Social Affairs, these data are highly questionable.

Table 3: Authorization for Treatment Abroad (EC-wide), 1997–1998

Estimated number of cases	Estimated total amount (Euro)	% of persons in relation to total number of insured persons	% of the general costs of Austrian health insurance and hospital care	Estimated average costs per case (Euro)
850	4,700,000.00	0.0154	0.04	5,523.00

Source: The author assembled these figures from an internal report of the Austrian Ministry for Social Affairs and a report of the *Association Internationale de la Mutualité*. The figures represent only estimates.

In 1997/1998 about 58,000 people traveled abroad and sought (partial) reimbursement for mainly non-hospital treatment, for the average costs of only 58 Euro (see Table 4). There is no reason to believe that these figures have changed substantially since then. It can be assumed that a large percentage of the reported cases concerned patients that purchased dental treatment in Hungary. From the 4,715 cases reported by the Lower Austrian HIF, 1,200 cases concerned reimbursement of dental treatment outside the "old" EU/EEA Member States.[25]

Table 4: Reimbursement for Treatment Abroad (World-wide), 1997–1998

Institution	Number of cases (per year)	Amount of reimbursement per year (Euro)	% of persons in relation to total number of insured persons		
Lower Austrian HIF	4,715	271,549.00	0.6559		
	Estimated number of cases (per year)	**Estimated amount of reimbursement per year (Euro)**	**% of persons in relation to total number of insured persons**	**% of the general costs of Austrian health insurance and hospital care**	**Average costs per case (Euro)**
Austria (total)	58,030	3,445,470.00	1.0517	0.03	58.00

Source: The author assembled these figures from an internal report of the Austrian Ministry for Social Affairs and a report of the *Association Internationale de la Mutualité*. The figures represent only estimates.

The figures presented above do not include cases in which people purchased health care abroad without being reimbursed. The number of these not reported cases is according to many sources much higher than the reported cases. In a report in 2005, the renowned consumer protection journal *Konsument* speculated about 160,000 Austrians traveling to Hungary for dental treatment every year.[26] In a small exploratory study in 2006, Österle

[25] These people supposedly went to the former Central European and Eastern European Countries.

[26] The findings of the journal *Konsument*, however, are based on anecdotal reports by patients, dentists, dental technicians, and dental companies. In addition, the findings are inconclusive. On the one hand, there is much praise primarily coming from the patients. They appreciated friendliness, language skills, time dedicated to patients, and prices. On the other hand, there was also much criticism, especially—yet not surprisingly—by Austrian dentists. They criticized that the time dedicated to the patients was too short, 90 percent of the edges of crowns would not fit the standard, 80 to 90 percent of the patients would have gum problems, and oral hygiene would not be a subject.

and Delgado found that about 80 percent of their respondents paid their dental treatment in Hungary out-of-pocket, while only 20 percent were partially reimbursed (2006: 134). These numbers suggest that the majority of cross-border cases take place outside the EC regulatory framework and Austrian reimbursement provisions. However, the exact number of this category of patients remains unknown.

UNIQA, a private insurance company, provided data on in-patient treatment of Austrian patients abroad (see Table 5). In 2003, UNIQA reimbursed 692 persons, world-wide, for the total amount of 2,349,754 Euro. In 2005, the numbers were still rather low and increased only modestly (937 persons; 2,985,412 Euro).

Table 5: UNIQA: In-patient Treatment Abroad, 2003–2005

	2003	2004	2005
Switzerland	60	81	75
Germany	271	266	293
Europe	229	201	305
Rest of the world	132	155	264
Total	692	703	937
Amount in Euro	2,349,754	2,033,337	2,985,412

Source: Data provided by courtesy of UNIQA, assembled by the author.

4.2 Data for Hungary

Within the regulatory structures of the EC, about 42,500 Austrian insured persons received Hungarian health treatment in 2005 for the total amount of 732,558 Euro (see Tables 6 and 7). These numbers cover several different groups: Austrian pensioners resident in Hungary, regular cross-border commuters, co-insured family members, and persons who stayed in Hungary only for a short term (see Table 6). The majority of cases concerned medical aid and visits paid to a general practitioner. Half of the overall costs were caused by expensive benefits in kind (see Table 7).

Table 6: Treatment in the Framework of EC Regulation 1408/71, 2005

Group of persons	Form	Number of cases	Type of calculation	Granted benefits
Pensioners (insured in Austria, resident in Hungary)	E121	40	Lump-sum	All benefits
Regular cross-border commuters	E106	1,592 (registered in Hungary, plus co-insured)	Actual costs	All benefits
Co-insured family members	E109	50 (registered in Hungary)	Lump-sum	All benefits
Short term stay	EHIC	About 41,000	Actual costs	Medically necessary treatment

Source: Data provided by courtesy of the Hungarian NHIF, assembled by the author.

Table 7: Treatment in the Framework of EC Regulation 1408/71 (Medically Necessary Treatment Abroad and Regular Cross-Border Commuters), 2005

Case	Number of cases	Euro	Euro/case
CT (computer tomography)/ MRI (magnetic resonance imaging)	197	16,051.2	81.47
Disposable instruments	3	1,626.3	542.10
Expensive benefits in kind	489	366,275	749.02
In-patient treatment	2,237	14,979.8	6.69
Dental treatment	156	6,183.01	39.63
Spa treatment	606	219,887	362.84
Medical Aid	23,453	17,052.7	0.72
Pharmaceuticals	196	385.378	1.96
Treatment at general practitioner	15,170	89,888.3	5.92
Care at home	3	229.791	76597
Total	42,510	732,558	17.23

Source: Data provided by courtesy of the Hungarian NHIF, assembled by the author.

Outside the structures provided by the EC Regulations 1408/71 and 574/72, 3,510 Austrians purchased health care in Hungary for the total amount of 262,370 Euro in 2005 (see Table 8). This number provides only an account of the reported cases from the in-network physicians and hospitals to the NHIF. Out-of-network actors do not have to report their cases, the overall number therefore being unknown.

Table 8: Treatment Outside the Framework of EC Regulation 1408/71, 2005

Treatment	Number of cases	Value in Euro (not actual price, according to NHIF provisions)	Euro/case
In-patient	705	249,240	353.53
Out-patient	2,805	13,130.9	4.68
Total	3,510	262,370	74.74

Source: Data provided by courtesy of the Hungarian NHIF, assembled by the author. The hospital/physician determines the price in advance. Only in-network hospitals/physicians have the duty to report to the NHIF.

5 POTENTIAL FINANCIAL BENEFITS FROM CROSS-BORDER PURCHASING FOR SELECTED HEALTH CARE SERVICES

The above presented data show that cross-border purchasing of health care is at the moment a minor phenomenon regarding health services covered by the statutory Austrian health insurance system. This section will look at the potential benefits for Austrian insurance institutions and individual patients regarding health services which are not always fully covered: cataract surgeries, dental treatment, and cosmetic surgeries.

In principle, the statutory health insurance in Austria covers all treatments that are medically indicated; only few areas are not covered such as specific cosmetic surgeries or fixed dentures. Each regional or occupational HIF has its own catalogue of benefits that are covered by it. The HIFs fund the public hospitals with lump sums without giving a limit regarding the treatments covered. Each hospital then decides independently whether

the treatment is medically indicated or not. Therefore, it cannot be determined in general whether a specific treatment is covered or not.

5.1 Cataract Surgeries

According to the Yearbook of Health Statistics of Statistics Austria, all public and private hospitals conducted 60,699 in-patient cataract surgeries in 2005 (see Statistics Austria 2007).[27]

There is a difference regarding prices for cataract surgeries between the Austrian LKF-point system[28] and the specialized Hungarian private clinic "Focus Medical Margitsziget" (see Table 9). Whereas a cataract surgery costs between 1,608 to 2,059 Euro in Austria, it costs between 960 to 1,500 in the Hungarian clinic. If a private patient purchases a cataract surgery on her own in Hungary instead of receiving it in Austria, the potential benefit would range between 559[29] and 648 Euro[30].

Table 9: Prices for Cataract Surgeries in Comparison

Treatment	Austria According to the LKF-System	Hungary "Focus Medical Margitsziget"	Potential Benefit
	Euro	Euro	Euro
Cataract surgery	1,608–2059[31]	960–1500	648/559[32]

Source: These data have been taken from the homepage of the Hungarian Private Clinic "Focus Medical Margitsziget" and the Austrian LKF-system, March 2007.

The above calculation has been made on the basis of the Austrian LKF-points, which require several remarks: The LKF-points are only an approximate value. They are composed of a benefit component (in the case of cataract 509 to 551 points) and a daily component (831 to 1165). The LKF-system has its roots in the 1980s and follows basically the DRG-system of the United States. The calculation for a benefit provided in an Austrian hospital is complex and consists of three stages. First, LKF-points are calculated nationally for each and every group of treatments. Second, every region determines a value that corresponds to one LKF-point. And third, every region determines a hospital factor for university or standard hospitals. These three components then determine how much a hospital receives for a certain benefit.

[27] In 2005, there were 264 in-patient hospitals in Austria officially registered under the Federal Hospital Act, with a total of 63,248 available beds. Independent out-patient health care centers numbered about 1,000 (see Federal Ministry of Health and Women 2007a: 17)

[28] In 1997, Austria introduced the performance-oriented hospital financing system (*Leistungsorientierte Krankenanstaltenfinanzierung*, LKF) based on modified diagnosis-related groups (Austrian DRG System) (for a more detailed discussion see e.g. Hofmarcher and Rack 2006: 178–181).

[29] Comparing the highest price.

[30] Comparing the lowest price.

[31] 1340–1716 LKF-points: the benefit component is 509 (551); the daily component is 831 (1165); and the mean value of duration of stay is 2.9 (3.4). The LKF-points have been multiplied by 1.2 Euro.

[32] The lowest and the highest prices have been compared.

The Austrian LKF-system was calculated in 1999 and does not reflect any more the costs of the hospitals in 2007. Therefore, the Austrian Health Institute (ÖBIG)—in cooperation with the Ministry for Health and "SOLVE Consulting"—is at the moment (re-) calculating the reference points. According to "SOLVE Consulting", one LKF-point equals about 1.2 Euro today. In every region, the financing of the LKF-points is organized differently. For instance, whereas in Lower Austria one LKF-point equals about one Euro, in Upper Austria it equals around 55 Cents. There, the so-called *Abgangsfinanzierung*, i.e. tax money, covers the "deficit" of the hospitals. In the Austrian region of Tyrol the equivalent of one LKF-point is about one Euro. One of the reasons for this almost cost-covering approach in Tyrol is that there are many foreign tourists who are treated there.

These brief remarks on the LKF-system, which is in place in Austria, show that the price comparison between Austrian and private Hungarian hospitals can only be approximate, because the financing of Austrian hospitals usually is not cost-covering.

5.2 Dental Treatment

There are no statistical data on the market size of dental treatments in Austria and Hungary. Regarding the prices for dental treatment there is a big variation within and between Austria and Hungary. The *Konsument* in a rather anecdotal report in 2005 provided examples for prices: the average costs for simple crowns were 140 to 250 Euro in Hungary, whereas in Austria costs were between 378 and 713. The average costs for fillings in Hungary were 30 to 60 Euro, in Austria between 20 and 380.

There is some evidence that in the last years the price levels for dental treatment have been converging, i.e. they decreased in Austria and increased in Hungary. This effect is partly attributed to the pressure coming from Hungarian providers. Therefore, a partial relocation of "dental tourism" toward cheaper countries such as Romania has already taken place and will become even more pronounced in the future.

The available data (see Table 10) show that there is still a price incentive for Austrian patients to travel to Hungary for dental treatment. This is especially true for fixed dentures and crowns, because the Austrian health insurance institutions do not cover these treatments; less so for removable dentures because they pay half of the costs. According to Österle and Delgado, regarding fixed dentures the price differential between Austria and Hungary is still considerable; regarding preserving treatments it is much lower (2006: 151).

Table 10: Prices for Dental Treatment in Comparison

	Austria		Hungary			
Treatment	**According to a 2005 report of the *Konsument***	**Viennese HIF**	**According to a 2005 report of the *Konsument***	**“Rosengarten” Dental Group in Sopron**	**“Laserdent” Dental Clinic in Sopron**	**“Perfect Profiles” Dental Clinic in Budapest**
	Euro	Euro	Euro	Euro	Euro	Euro
Crown (metal)	378–713		140–250	-	149–169	255
Crown (porcelain)	378–713	Not disclosed[33]	140–250	200–300	360	420
Fixed denture	-		-	-	298–400	560
Removable denture	-	176 (352)[34] (plastics) 447 (894) (metal)	-	400 plus 50 per tooth (metal)	298–400	230

Note: These data have been taken from a report of the Austrian consumer protection journal *Konsument*, the homepages of the Dental Clinic “Perfect Profiles” in Budapest, the Dental Clinic “Laserdent” in Sopron, the “Rosengarten” Dental Group in Sopron, and the Viennese HIF, March 2007.

5.3 Cosmetic Surgeries

There are no reliable data on the number of cosmetic surgeries per year in Austria and Hungary. The clinics that were interrogated in the framework of this research did not want to (in the Austrian case) or were not able to (in the Hungarian case) disclose statistics about the number of surgeries per year.

The potential benefit for Austrian patients for receiving a cosmetic surgery in Hungary is difficult to calculate, because prices in the Hungarian clinic interrogated in this research depend on the clinical needs of patients, the number of days in the hospital, and the quality of the hotel.

If prices without accommodation are compared, the potential benefit oscillates between 710 and 1,710 Euro for various kinds of cosmetic surgeries (see Table 11). However, it has to be noted that travel costs to Budapest are not included in this calculation.

[33] The Viennese HIF and individual dentists did not disclose price information on crowns and fixed dentures via telephone. They referred to the necessity of seeing the patient first.

[34] The first figure signifies the amount that the insured person has to pay for the benefit. The figure in brackets provides the overall costs. The Viennese HIF covers half of the costs.

Table 11: Prices for Cosmetic Surgeries in Comparison

Treatment	Hungary “Perfect Profiles” Clinic in Budapest	Austria “EMCO” Private Clinic in Salzburg	Potential benefit
	Euro (including only an approximate value for anaesthesia and sedation)	Euro (all inclusive without stationary stay)	Approximate value in Euro
Face/Necklift	About 3,290[35]	4,000 (5,080[36])	About 710
Rhinoplasty	About 2,490	3,800–4,700 (4,880–5,780[37])	About 1,310
Mammoplasty (augmentation)	About 2,490	4,200 (4,920[38])	About 1,710
Mammoplasty (reduction)	About 2,990	4,700 (5,420–5,780[39])	About 1,710
Blepharoplasty (eyelid)	About 1,190	2,100 (2,820[40])	About 910
Blepharoplasty (undereye)	About 1,290–1,490	2,300 (3,020[41])	About 810–1,010
Abdominoplasty	About 3,290	4,700 (5,780–6,140[42])	About 1,410

Source: These figures have been taken from the homepages of the private Hungarian Clinic “Perfect Profiles” and the Austrian private clinic “EMCO” in Salzburg and verified by telephone, March 2007.

6 BARRIERS TO CROSS-BORDER PURCHASING OF HEALTH CARE[43]

Section 5 has shown that there are indeed, though modest, price differentials in selected health care sectors and resulting from that there are potential cost savings for Austrian HIFs and individual patients. However, for the time being, the number of persons traveling abroad to receive treatment is rather low. The reluctance of insurance funds and patients to purchase health care abroad can be explained with multiple barriers to trade in health services. This section will deal with the main factors that inhibit Austrian public and private health insurers as well as individual patients from realizing cost savings through capitalizing on lower health care prices in Hungary.

[35] The prices for the Hungarian clinic only refer to the actual price for the individual treatment. Anaesthesia costs about 330 Euro, sedation about 160 Euro, according to the needs. Accommodation etc. is not included.

[36] The clinical lump sum for a day in the private clinic “EMCO” amounts to 360 Euro. For face/necklift three days in the hospital have to be counted.

[37] A stay of three days is necessary.

[38] A stay of two days is necessary. The implants, which are not included in the price, cost between 500 and 600 Euro.

[39] A stay between two to three days is necessary.

[40] A stay of two days is necessary.

[41] A stay of two days is necessary.

[42] A stay between three to four days is necessary.

[43] For a more detailed discussion on the obstacles for trade in health care, see e.g. Brouwer et al. (2003), or Vollaard (2005).

6.1 Barriers Inhibiting Public Austrian Providers

Public Austrian health care providers face legal, institutional and political barriers which inhibit them to facilitate cross-border purchasing of health care.

6.1.1 Legal Barriers

According to a representative of the Austrian Federal Ministry for Social Affairs, the Austrian system does not differentiate between visiting a private physician in Austria or abroad. However, the fact that foreign physicians do not have contracts with Austrian insurance institutions constitutes an indirect health trade barrier. To remedy this disadvantage, contracts between regional Austrian HIFs and foreign providers would be needed, which determine regulations on the applied tariff, on legal issues such as claims to damages, etc. However, at the moment such contracts are nonexistent.

From a legal perspective, Austrian hospitals are not allowed to have direct contracts with the regional insurance funds. The HIFs pay an agreed amount of money into the regionally organized hospital financing funds[44], out of which the hospitals receive their revenue. In contrast to these provisions, in Germany, contracts between hospitals and insurance funds are the rule. To harmonize the health care systems would be, therefore, a precondition for cross-border contracts.

6.1.2 Institutional Barriers

There are also "constraints" coming from European Community rules: Regulations 1408/71 and 574/72 are a well-established structure to ensure that citizens receive health care whenever they cross borders (see Section 2). The well-established EC regulatory structure impedes Hungarian providers to attract Austrian patients, since they have to be treated like Hungarian patients in order to guarantee non-discrimination.

An additional institutional barrier is the expected negative effect of increased out-sourcing of health care on the health care facilities which are owned by Austrian HIFs. The case of the Viennese HIF facilities is most obvious, because of the proximity to Hungary.

Also, the out-sourcing of health care constitutes an additional financial burden for the regional HIFs. They have to pay a fixed amount into the hospital financing fund. If they out-source health care, they would have to face additional costs.

If specific treatments would be out-sourced to other countries, e.g. to Hungary, the Austrian hospitals would still be obliged to provide the full range of services. The Austrian health care system could realize cost savings only if entire parts of hospitals were to be closed down.

In general, Austrian hospitals do not receive a cost-covering remuneration for their services. Therefore, in all regions there are so-called *Abgangsdeckungssysteme* in place, i.e. systems which cover the "deficits" resulting from the financing shortfall. For

[44] In 1997, all Austrian regions set up proper funds which operate since then the financing of their public hospitals. For example, in Upper Austria the "Gesundheitsfonds – Geschäftsstelle für intramurale Aufgaben" administers about 1.4 billion Euro, with which the 20 hospitals within the fund, i.e. regional hospitals, religious order hospitals and Community hospitals, are financed through LKF-tariffs and subsidies for investment. The federal State, the Länder, the local authorities and social insurance institutions provide these resources. The 20 hospitals within the fund receive a certain amount of points for every treatment (about 1000 treatments). The catalogue for all benefits can be found in Federal Ministry for Health and Women (2007b).

example, the Upper Austrian HIF receives only about 60 percent of its budget from the hospital financing fund. The remaining 40 percent are compensated through so-called *Abgangsdeckungsmittel*, i.e. tax money to compensate for the non cost-covering remuneration of the hospitals. In principle, the tax money could also be transferred directly to the hospital financing funds, but the political will to do so is presently nonexistent. One reason for the reluctance to provide the hospital funds with adequate resources is that political actors lack an interest in a more transparent health system. A second reason is that the Länder and local authorities can strongly influence the health care system by financing it. They do not want to give away this political leverage.

6.1.3 Political Barriers

The Austrian Medical Association is fiercely opposed to the out-sourcing of health care with the aim to protect its clientele from unwelcome concurrence from foreign providers. The General Social Security Act (see Paras 338 and 339) determines that the association has a considerable say regarding contracts and a right to statement if the provision of services is changed. Therefore, public health insurance institutions shy away from a conflict with the Medical Association on the issue of cross-border purchasing of health care.

On a more general level, all relevant health care actors refuse to extend the private sector: the regional health insurance funds, the Federation of Austrian Social Security Institutions, the federal State, the *Länder*, and the local authorities. In Austria, there seems to be a "political consensus that a market-based provision of health care services is incompatible with the aims of the welfare state" (Hofmarcher and Rack 2006: 195). An out-sourcing of health care to foreign (private) providers would foil this consensus.

6.2 Barriers Inhibiting Private Austrian Providers

The barriers inhibiting potential trade in health care are quite similar for both public and private providers. However, there are also specific legal, psychological and institutional barriers which prevent private providers to engage in trade in health services.

6.2.1 Legal and Psychological Barriers

Private Austrian health insurers may only offer a supplement to the statutory health insurance. They consider themselves as the "cherry on the cake".[45] Their raison d'être consists of providing more choice than the statutory insurance. As a result, they have no interest in restricting the access to health care for their insured or steer them toward specific countries without losing this reputation.

6.2.2 Institutional Barriers

At the moment, the private insurers have to develop expensive individual schemes for cross-border cases. The fact that national social security schemes are not harmonized on the EU level prevents standardized schemes: If a person who is insured in Austria moves to another country and changes her status, i.e. becomes insured in another country, private insurers have to check case by case whether their insurance coverage is still suitable.

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[45] This expression was used by a representative of a private insurance company in an interview for this study.

6.3 Barriers Inhibiting Individual Patients

There are also various barriers for individual patients to take up the opportunities of cross-border purchasing of health care. They may have the (subjective) fear that they do not receive adequate quality of health care in Hungary, which prevents them from purchasing health care abroad. Also, claims to damages regarding Hungarian providers are difficult to enforce in case of a qualitatively bad treatment. There are further barriers, such as geographical distance, language issues, etc., which inhibit increased mobility of patients (for a more in-depth discussion on these issues, see e.g. Brouwer et al. 2003).

CONCLUSION

Cross-border purchasing of health services between Austria and Hungary takes place either within the well-established institutional framework of the European Community, and the domestic Austrian and Hungarian provisions, or—to a supposedly greater extent—outside these structures. EC Regulation 1408/71 provides a framework in which patients from Austria can be treated in Hungary at the expense of their insurance institution: the E112 Procedure, the EHIC procedure, provisions for commuters, pensioners, and co-insured family members all facilitate the utilization of health care in Hungary. The Austrian reimbursement provisions, which are applied outside the EC regulatory structures, do not differentiate between domestic and foreign out-of-network physicians. Therefore, health care received abroad is being reimbursed to the same amount as health care received by an out-of-network Austrian physician. These provisions—exceptional in the EC—have incited a considerable number of patients to go abroad, also to Hungary, to receive cheaper (in particular dental) treatment. Estimations assume that a higher but currently unknown number of patients travel to Hungary outside these established EC and domestic structures and pay their treatment out-of-pocket without receiving reimbursement.

However, for the time being, the available data indicate that trade in health care between Austria and Hungary is a circumscribed phenomenon in terms of quantities, and it will most probably remain so in the near future. In contrast to countries such as the UK or the US, in Austria there are fewer incentives for patients to purchase health care abroad: most treatments are provided by the statutory health care system and there are virtually no waiting lists (on this issue see e.g. Hofmarcher and Rack 2006: 86).

This paper has shown that most health care actors in both Austria and Hungary are skeptical or altogether reluctant toward increased trade in health services. However, this issue attracts more and more academic and political attention at all levels. At the domestic level, there are considerations within the Austrian administration to discuss the issue of contracts with foreign health care providers. For the time being, however, there are no improvements. At the EC level, patient mobility has become an issue too.[46] The so-called High Level Process of Reflection on Patient Mobility and Healthcare

[46] See for instance the following projects all funded by the European Commission:
HealthBasket project (http://www.ehma.org/projects/default.asp?NCID=112);
HealthAccess project (http://www.ehma.org/projects/default.asp?NCID=113);
and Europe for Patients project (http://www.iese.edu/en/events/Projects/Health/home/home.asp).

Developments entailed also talks about EU certified centers of reference.[47] These at the moment rather vague ideas could lead one day to specialized hospitals of reference in which patients from all over Europe are sent to receive health care treatment.

[47] In June 2002, an EU Health Council started a "High Level Process of Reflection on Patient Mobility and Healthcare Developments in the European Union", in which Health Ministers of the Member States and the European Parliament together with representatives of patients, professionals, providers and purchasers of health care discussed matters of health care, including the reconciliation of national health policy with EU obligations. The general results of this process of reflection were issued by the European Commission (2004).

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