

The HealthBASKET Project: documenting the benefit basket and evaluating service costs in Europe

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Introduction

Valid international comparisons are amongst the most powerful devices for securing health system improvement. To inform rational decision-making, national and EU policy-makers need reliable comparisons about available health services, how these are defined, what their costs are and which prices they will have to pay for them.

Funded under the European Commission's 6th Framework programme, HealthBASKET was a three-year project that sought to identify which data are required to engage in meaningful international cost comparisons and to lay the basis for the development of methodological guidelines for future cross-border cost-auditing systems. Issues of access and quality of care were outside the project scope. The research began in April 2005 and involved partners from nine European countries that covered both National Health Service (NHS) (Denmark, England, Italy and Spain) and Social Health Insurance (SHI) systems (France, Germany, Hungary, the Netherlands and Poland).

What is a 'benefit basket'?

A distinction needs to be drawn between the 'benefit basket' (the general content of the coverage, which may vary in its precision and detail) and the 'benefit catalogue' (the list of the detailed services, activities and goods (possibly with sub-specifications) included in the coverage). Benefit baskets may be defined in terms of 'negative lists'. For example, the Drug Tariff in England contains lists of drugs that may not be prescribed on the NHS under any circumstances ('black list' drugs) or that may be prescribed only under special circumstances ('grey list' drugs). However, the NHS has no 'positive list' for drugs: instead, entitlement to the drugs that are not black- or grey-listed is implicit, inferred from their absence from the 'negative' lists.

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What methods did HealthBASKET use?

The research was undertaken in four phases:

- **Phase 1** involved the definition of services: each partner described how their own country defines the services provided within the system, analysing the structure and contents of benefit ‘catalogues’ (or ‘baskets’) as well as the process of defining these catalogues. Informed by this analysis and other relevant classifications, options for building a European taxonomy of benefits to enable a common language for cost comparisons were explored.
- **Phase 2** reviewed the methodologies used to assess costs and prices of individual services in the nine partner healthcare systems. In addition, a literature review identified ‘best practices’ for analysing micro-level costs when making international comparisons.
- In **Phase 3**, all partners participated in an empirical micro-costing study using a selection of ten ‘case-vignettes’ that covered inpatient and outpatient settings (Box 1 summarises these vignettes). For each vignette, partners sought to collect data on resource use, cost and price (reimbursement) from (ideally) at least five providers. A preliminary analysis of possible reasons for variations within and between countries was undertaken (see below, Dissemination).
- **Phase 4** summarised the main findings from the whole project and formulated recommendations for policy and further research.

Box 1: Overview of the ten vignettes costed the HealthBASKET project

Vignette 1	appendectomy; male aged 14-25; inpatient; emergency
Vignette 2	normal delivery; female aged 25-34; inpatient; elective
Vignette 3	hip replacement; female aged 65-75; inpatient; elective
Vignette 4	cataract; male aged 70-75; outpatient; elective
Vignette 5	stroke; female aged 60-70; inpatient; emergency
Vignette 6	acute myocardial infarction; male aged 50-60; inpatient; emergency
Vignette 7	cough; male aged ~2; outpatient; emergency
Vignette 8	colonoscopy; male aged 55-70; outpatient; elective
Vignette 9	tooth filling; child aged ~12; outpatient; emergency
Vignette 10	physiotherapy; male aged 25-35; outpatient; elective

A series of workshops provided opportunities to discuss issues with the project Advisory Board, which included representatives from associations of hospitals (HOPE) and ambulatory care physicians. A final conference, held in Berlin in February 2007, brought together policy-makers, academics, provider organisations and representatives from key European organisations including the European Observatory on Health Care Systems, the OECD and the World Bank.

What were the key findings from HealthBASKET?

Phase 1 found that all countries had fragmented benefit catalogues — no country had a single document defining entitlement. Decision making processes and approaches to benefit definition varied widely. Generally, in NHS systems the benefit catalogue was defined by obligations on government organisations while in SHI systems, insurance entitlements determined the catalogue. The degree of explicitness varied between countries in both NHS and SHI systems: for example, Poland had the most explicit catalogue of the SHI system countries and Germany’s catalogue was the least clear. Overall, there was a trend to greater

explicitness, with increasing (though still limited) use of evidence on costs and benefits to inform eligibility criteria.

Phase 2 found that most countries have installed performance-based remuneration schemes for in- and outpatient services, but these are often lacking for long-term care or rehabilitation. There was a clear trend towards the use of micro-costing data (especially for inpatient services) to determine remuneration. However, the quality of data delivered by providers remains problematic, with many countries having accounting and reporting systems that are neither nationally uniform nor mandatory.

Emerging findings from **Phase 3** suggest that there are significant between-country differences in mean cost for all vignettes. Visual inspection of the 95 per cent confidence intervals for each country showed that for the inpatient vignettes, Denmark, England France and Germany and Italy were consistently either at or above the mean, whereas Hungary, Poland and Spain were consistently at or below the mean. Length of inpatient stay was a significant factor associated with differences in cost between hospitals only in the stroke vignette. The vignette approach appeared to be both feasible and low cost: vignettes were readily transferred between health systems, and the exercise delivered valuable information beyond costs. However, differences in the treatment of overheads and capital costs are a cause for concern and limit the comparability of findings. The optimal choice of methodology for currency conversion also remains unresolved.

Recommendations and Conclusions

HealthBASKET documented, and helped to develop an understanding of, the very large variations in treatments and costs within and between countries. International comparison is a powerful instrument for improvement, but there is a need for consistent costing rules to facilitate comparison, and currency conversion remains an unresolved issue. However, a standardised 'European' accounting methodology conflicts with the principle of 'subsidiarity', which advocates the devolution of decision making wherever possible. Further work could integrate quality issues, assessing both the processes and outcomes of health care. The vignette methodology could be validated across a broader range of conditions. Finally, a uniform taxonomy ('European Classification of Health Services') to explore and describe differences — but not to standardise the baskets — is urgently needed for both practical and scientific purposes.

Dissemination

Country reports and presentations from the workshops and conference are available on the project website: <http://www.ehma.org/projects/default.asp?NCID=112>.

Articles describing country-level benefit baskets for inpatient care were published in the *European Journal of Health Economics*, December 2005, suppl. 1, 6.

Articles on the methods used to assess costs and prices for inpatient care were published in a special issue of *Health Care Management Science*, August 2006, 9, 3.

Articles synthesising findings for a selection of the case vignettes are to be published in a special issue of *Health Economics* (expected late 2007/early 2008).

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