*Health*BASKET

WP 3 / WP 4

Synthesis Report

(Deliverables 11 and 12)

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1. Acronyms

AR-DRG	Australian refined DRG
AWBZ	Insurance for Exceptional Health Care Costs
CCAM	Common Classification of Medical Procedures
DAGS	Danish Ambulatory Grouping System
DEN	Denmark
DES	Drug eluting stent
DRG	Diagnostic Related Groups
GER	Germany
HCFA	Health Care Financing Administration
HUN	Hungary
ICD-9-CM	International Classification of Diseases 9th Version, clinical modification
ICD-10-GM	International Classification of Diseases 10th Version, German modification
ICPM	International Classification of Procedures in Medicine
ITA	Italy
NHS	National Health Service
NSF	National Service Framework
OPS	Operations and Procedures Nomenclature
OR	Operating room
SHI	Social Health Insurance
ZFW	Health Insurance Act

2. Introduction

The Kohll/Decker judgments of the European Court of Justice and more recently the Geraets-Smits/Peerbooms cases, have demonstrated that health services can no longer be regarded as operating in isolation from other EU Member States [1]. Increasingly, patients are flowing to seek care from one member state to another, sometimes due to individual choice, sometimes induced by sickness funds or even by Ministries of Health. Such movements have the potential to stimulate competition between health care systems of the member states. However, the average volume of imported health care services in the EU has been rather small at approximately €1.99 per person (1998) [2]. One major reason for this low volume of cross country flows is the lack of accurate information as the basis for competitive behaviour. Actors in one health care system, e.g. sickness funds, do not have sufficient information on benefit catalogues and prices for benefits in other health care systems in order to induce in- or exports of health services. So far research has mainly focused on health services for selected indications or on the comprehensiveness of services, but information on the benefit catalogues, their taxonomy and inclusion criteria in each country is widely lacking [3,4,5,6,7].

The definition of *health* subscribed by the World Health Organisation in 1946 as a state of complete physical, psychological and social well-being implies that a very broad spectrum of services could be described as “health services” (as well as goods). One can argue that any kind of activity or service aiming at the preservation or restoration of such an (ideal) state of well-being belongs to health care, that is, any activity or service which aims at preserving or even improving the physical or mental state, or the social functioning of an individual. Taking this reasoning to an extreme, health care could encompass anything ranging from medical care in case of illness to any leisure activities which may contribute to psychological and social well-being, as well as any kind of cosmetic or so called wellness activities. However, the spectrum of activities or services financed with public money within health systems is much more restricted than this range in services. Only a part of the activities, services or goods, which may lead to conservation, improvement or restoration of health are under the scope of publicly funded health care. This more or less limited set of services, activities and/or goods constitutes the benefit basket.

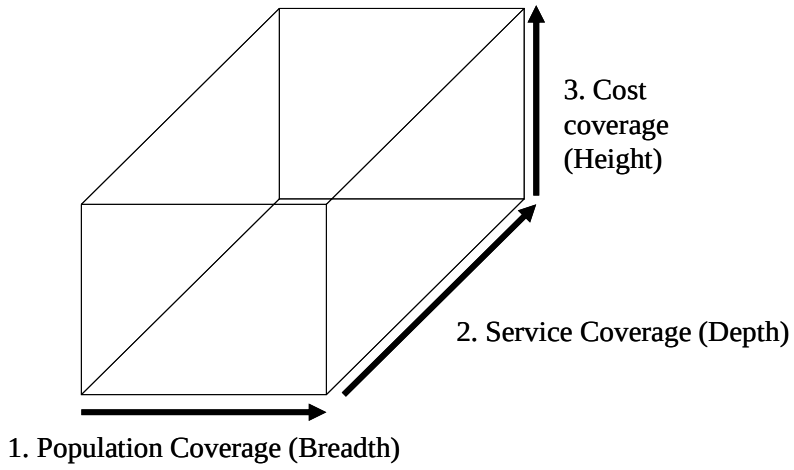
The aim of this part of the project is to produce an in depth insight on the issue of the benefit basket in the participating countries: Denmark, England, France, Germany, Hungary, Italy, Poland, Spain and The Netherlands.

3. Terminology and Conceptual Framework

The common terminology used in the project (i.e. in this report as well as in the country reports) and the conceptual framework followed to explore the benefit package issues in a standardized way in the participating countries will be briefly presented in the following lines.

We differentiate between the terms "benefit basket" (also "benefit package") and "benefit catalogues". The *benefit basket* refers to the totality of services, activities and goods covered by publicly funded statutory or mandatory insurance schemes or covered and/or provided by national health services. Coverage of a given population for health services can be characterised by three dimensions: breadth, depth and height (Busse et al. 2005). While "breadth" can be defined as the extent of covered population and "depth" as the number and character of covered services, "height" specifies the extent to which costs of the defined services are covered by pre-paid financial resources as opposed to cost-sharing requirements. Services, activities or goods which are not covered at all (i.e. with a "co-payment" of 100%) are consequently not considered to be part of the benefit basket. Figure 1 summarizes the three dimensions of a benefit basket. The project mainly focused on the coverage of services (depth of benefit coverage).

Figure 1: Three dimensions of coverage



In contrast, *benefit catalogues* are defined as the document(s) in which the different components of the benefit basket are stated in detail, i.e. which enumerate the services, activities or goods in a more detailed way, listing single interventions (i.e. specific technologies[1]). Thus a benefit basket might be further defined (i.e. operationalised) through one or more benefit catalogues.

[1] Technologies include devices, drugs, manouvres, organisational interventions, etc.

In order to explore the issue of the benefit basket, and especially the benefit catalogues, an open questionnaire was developed, and served as guide for the compilation of standardised country reports. As already stated above, our definition of benefit basket focuses on services provided under public financing, that is where the main source of funding comes from taxes or from social security funds. To scan the different health systems in search for existing benefit catalogues we followed the framework of functional categories of "health care services and goods" proposed by the OECD in its system/classification for Health Accounts (OECD 2000) (see Table 1). The researchers in each country were asked to identify and to provide a detailed description of the existing benefit catalogues for each functional category, the actors involved in decision-making and the decision criteria.

In this synthesis report, we will attempt to provide an overview of the existing benefit basket and catalogues. For details on each country we recommend to refer to the in-depth country reports.

Table 1. Framework of Health Care Functional Categories, System for Health Accounts (OECD 2000).

HC.1 Services of curative care	**HC.5 Medical goods dispensed to out-patients**
HC.1.1 In-patient curative care	HC.5.1 Pharmaceuticals and other medical non-durables
HC.1.2 Day cases of curative care	HC.5.1.1 Prescription medicines
HC.1.3 Out-patient care	HC.5.1.2 Over-the-counter medicines
HC.1.3.1 Basic medical and diagnostic services (primary health care)	HC.5.2 Therapeutic appliances and other medical durables
HC.1.3.2 Out-patient dental care	HC.5.2.1 Glasses and vision products
HC.1.3.3 All other specialised care	HC.5.2.2 Orthopaedic appliances and other prosthetics
HC.1.3.9 All other out-patient curative care	HC.5.2.3 Hearing aids
HC.1.4 Services of curative home care	HC.5.2.4 Medico-technical devices (including wheelchairs)
HC.2 Services of rehabilitative care	HC.5.2.9 All other miscellaneous medical durables
HC.2.1 In-patient rehabilitative care	**HC.6 Prevention and public health services**
HC.2.2 Day cases of rehabilitative care	HC.6.1 Maternal and child health; family planning and counselling
HC.2.3 Out-patient rehabilitative care	HC.6.2 School health services
HC.2.4 Services of rehabilitative home care	HC.6.3 Prevention of communicable diseases
HC.3 Services of long-term nursing care	HC.6.4 Prevention of non-communicable diseases
HC.3.1 In-patient long-term nursing care	HC.6.5 Occupational health care
HC.3.2 Day cases of long-term nursing care	HC6.9 All other miscellaneous public health services
HC.3.3 Long-term nursing care at home	
HC.4 Ancillary services to health care	
HC.4.1 Clinical laboratory	
HC.4.2 Diagnostic imaging	
HC.4.3 Patient transport and emergency rescue	
HC.4.9 All other miscellaneous services	

4. Establishing and Shaping Benefit Baskets

The establishment of a clear boundary between the concepts of benefit basket and benefit catalogue as described in Section 3 results sometimes have been difficult to separate since in reality the documents which provide the definition of the basket also function as catalogues, in the sense that they also refer to specific technologies (for example oxygen therapy at home in Spain, or abortion in Germany), in order to explicitly include or exclude them. Acknowledging these exceptions, a generic pattern of establishing and shaping the health basket can be observed across most of the countries consisting of two levels: a high level and a low level (see Figure 2). On the higher level, legislation passed by the national parliaments (sometimes even the country's Constitution, like in Poland) establishes the general framework by enumerating the areas of health care (which to some extent correlate with the OECD categories) included in the benefit basket. On the lower level, the benefit basket is further shaped by specifying certain procedures provided within each area of health care as part of the benefit catalogues. These catalogues contain recommendations as well as explicit in- or exclusions of services. The extent to and the way in which this shaping actually takes place varies considerably from country to country and within each country, from functional category to functional category of health care. There are several possible ways to establish benefit catalogues: legislation passed by central or regional parliaments, decrees issued by national or regional governments, directives issued by self-governing bodies or by national and/or local authorities, and other documents considered as "quasi-laws"[2] (like for example clinical guidance). All of these methods, belong to the repertoire of instruments (*benefit catalogues*) used in the shaping of the health basket[3].

Figure 2. Establishing and shaping a health basket

Higher Level "*establishing the health basket*"	Laws passed by the national parliaments, which provide the overall framework of the benefit basket.	Enumeration of categories of health care, (correlating to some extent with OECD categories)
Second Level "*shaping the health basket*"	Laws passed by national or regional governments, decrees issued by national or regional governments, directives issued by self-governing bodies, national, regional or local authorities, quasi-laws	Lists of specific technologies included or excluded, or recommended / not recommended

[2] Rules that are not absolutley legally binding, although they have some legal force, but which will in practice determine the way in which people act.

[3] The benefit catalogues are summarized in Chapter 5 following the OECD categories.

In all countries studied a general definition of a benefit basket could be identified at the higher level (see Table 2). Depending on the organisation of the health system (NHS or SHI) the logic underlying the general definition of the benefit basket differs. Whereas in NHS-countries the definition of a benefit basket refers to the specification of the *duties and obligations* of the Health Services (acting as purchaser or direct provider), in SHI-countries the issue of the benefit basket is more related to the specification of *entitlements* of the insured persons. However, it cannot be said that either NHS- or SHI-countries generally define their benefits more explicitly than the other. As shown by Table 2 and Table 3 the level of detail in the higher level varies considerably from country to country and within the same country ranging from broad functional categories to specific technologies to be included or excluded.

In countries with a NHS we interpret the legislation (i.e. Acts, Laws) establishing the tasks of the respective health services as the one providing the overall/general definition of the benefit basket. In most of the countries these documents provide a list of the kind of services (i.e. areas of care) to be provided or financed within the respective NHS (including "regional-NHS"[4]). The vaguest definition of a benefit basket might be the one provided in the English-NHS foundation Act (1946) and related posterior documents where the Secretary of State for Health is legally required to provide services "*to such an extent as he considers necessary to meet all reasonable requirements*". In contrast, the framework of the Italian and Spanish benefit basket, which both has been established in more recent legal documents, has been structured with more detail. Within the NHS countries, Denmark represents an exception, a single document stating the framework of the benefit basket could not be identified. This framework however is provided by separate Acts, concerning the categories of hospital, primary and long-term care and pharmaceuticals, which all together represent the higher level of regulation.

Common to all four, however, is the differentiation between hospital care and primary health care, including specialist outpatient services, as well as preventive or health promotion services. Interestingly, the level of specificity at this level of regulation of the benefit basket is not only heterogeneous across different countries, but also within the same country. In the same document, some areas of care might be further shaped by mentioning specific services or in some cases even specific technologies for its inclusion or exclusion in the benefit basket (see Table 2 and Table 3) whereas other do not seem to deserve further detail. Thus, the definition of the benefit basket does not seem to follow always a systematic approach of

[4] We use this expression for referring to the regional health services of decentralized (i.e. regionalized) NHS-systems like the ones in Italy or in Spain.

shaping a general framework by going into further detail. It rather seems to reflect the identification of specific needs or shortcomings of the health care system at the moment of elaborating the documents mentioned. For example ophthalmic services are emphasized over other specialist attention as part of the duties in the UK NHS-Foundation Act of 1946 and the inclusion of oxygen home therapy in Spain is explicitly mentioned in the Royal Decree 63/1995.

Concerning the origin of more detailed benefit catalogues, some similarities can be observed across countries with a similar organisation of the health care system or with similar organisational demands (i.e. need to reimburse providers in free practice). In Italy and Spain, the two countries with a completely regionalized NHS, the motivation for the formulation of a benefit catalogue is to be seen in the fear that regions would not provide "enough" services. The national benefit basket in these two countries can be regarded as a minimum basket of health services that has to be provided by the regional health authorities. In both countries it is left to the regional (autonomous) authorities, to provide or finance services explicitly excluded from the national benefit basket, as long as the minimum set of services is guaranteed. In this case, the exclusion means that these services must be financed from regional resources and not from the resources centrally allocated for the health system.

Health baskets in SHI-countries stem from two different roots. According to the first root, SHI-countries formulate the basket as an entitlement for persons insured under the respective statutory health insurance schemes. The main reason for this lies in the fact that SHI schemes have evolved from fragmented voluntary/statutory health insurance schemes not covering the whole population and only covering certain services, e.g. sickness benefits. Statutory Health Insurance in Germany as well as in the Netherlands does still not cover the whole population. Therefore in SHI-countries the health basket is also used to indicate the boundaries between those insured under the statutory health insurance and those insured under other schemes. The second root is fee catalogues which were originally more prevalent in SHI- than in NHS-countries due to the frequently used fee-for-service reimbursement system – at least in ambulatory specialist care.

Another common characteristic of decision-making on health baskets in most SHI-countries is the role of the self-governing institutions. Within a general framework stipulated by laws, self-governing institutions (e.g. sickness funds, physician associations etc.) specify the rules to explicit benefit catalogues or remuneration schemes with the character of benefit catalogues, limiting the scope of service provision.

As observed in NHS-countries, the level of explicitness at the higher level also varies considerably among SHI-countries. Again, the documents which establish the general framework of the benefit basket refer mostly to broad categories of services (such as in-patient, out-patient, pharmaceuticals, other). However in some cases, for example infertility treatment in Germany, specific technologies are also mentioned at the higher level of regulation.

In both types of countries it is also interesting to observe, that some explicit exclusions are already made at this higher level of definition of the benefit basket (Table 3), which is complemented by further exclusions or further specifications of the exclusions at lower levels. Despite the differences in the level of detail (i.e. mentioning of specific procedures or technologies) it can be observed (as shown by Table 3) that across the studied countries a considerable level of consensus exists regarding what kind of services are to be excluded from the benefit basket. For example, broad agreement seems to exist concerning the exclusion of cosmetic interventions (without previous accident or congenital malformation), medical certificates not relevant to patient care (i.e. for driving license), most of the therapies belonging to so called alternative (or non-conventional) medicine and prescription-free pharmaceuticals. It is also to be noted, that in some cases selected groups (like “disabled, children, elderly, chronically ill”) may be provided access to services that are excluded for the rest of the population. Also, in many of the studied countries, it is possible to cover (or provide) services otherwise excluded, when “medical necessity” is proven. This is mainly the case for cosmetic interventions, but is also possible for some drugs. This form of exception to the exclusions may leave an open door to litigation when an individual considers him/herself to have a medical necessity, which would justify the exception as no clear criteria for the definition of “medical necessity” have been established.

In summary, the documents identified as the ones establishing the general framework of the benefit basket mainly describe broad categories of services included, going into more detail for a variety of them, and specify exclusions with different levels of detail or explicitness. A very gross taxonomy can be identified underlying to all countries, which divides the benefit catalogue into hospital (in-patient) care, primary care (out-patient, general and specialised), pharmaceuticals, other (preventive services, allied professions, etc.).

Table 2. Benefit Basket. Level of framework regulation (Higher Level Regulation), different levels of detail.

Country	Document	Purpose	Inclusions		
			General	Specific	Specific++
Denmark	No single document				
	Hospital Act	Regulation of Hospitals	Hospital care		
	Public Health Insurance Act	Entitlement to services of Primary Care	Primary Care and prevention		
	Medicines Act	Regulation of access to pharmaceuticals	Pharmaceuticals		
	Social Services Act	Regulation of Rehabilitation and other	Rehabilitation and other		
France	SSC. Art. L.321-1	Definition of entitlements	Hospital Care	Health care at private and public institutions	
				Rehabilitation at private and public institutions	
				Physiotherapy at private and public institutions	
			Out-patient care	General practitioners	
				Specialists	
				Dentists	
				Midwives	
			Diagnostic Services and care prescribed by physicians	Laboratories	
				Speech therapy	
				Nursing	
				Physiotherapy	
			Drugs, medical appliances and durables	Included in positive list	
			Health care related transport	-	
Germany	SGB V	Definition of entitlements for insurees in the statutory health insurance	Prevention of disease and its worsening	Primary prevention	
				Dental prevention	
				Mother-Child / Father-Child Spa	
				Disability prevention	
				Contraception	
				Abortion	Anaesthetics
					Surgical or medical intervention
					Vaginal intervention, incl. drug injection

					Delivery of labor inducing drugs
			Screening	Health check-up	Hypertension-Screening
					Hypercholesterolemia-Screening
					Diabetes Screening
					Cancer Screening
				Children Screening	Health and development assessment
			Treatment of disease	Treatment	In- and out-patient, incl. Drugs, devices and medical products
					Rehabilitation
				In-vitro Fertilisation	
				Medical and dental treatment	
				Maxilofacial treatment	
				Drugs and medical products	
				Medical aids	
				Soziotherapie	
				Rehabilitation	
Hungary	Act LXXXIII 1997 Services of Compulsory Health Insurance	Definition of entitlements	Services for prevention and early detection		
			Curative Services	Family doctor services	
				Dental care	
				Outpatient specialist service	
				In-patient care	
			Other services	Deliveries	
				Infertility treatment	
				Medical rehabilitation	
				Patient transportation	
				Emergency ambulance services	
Italy	DCPM 29th 2001	Definition of national standards of care (Levels of Essential Care, LEAs)	Public and Occupational Health Care Services	Hygiene and Public Health	25 Services divided in 3 Groups
				Food Control an Hygiene Surveillance	8 Services
				Occupational Security and prevention	14 Services
				Public Health and Veterinary Services	31 Services in 3 Groups
				Individual Prevention Care	3 Services
			Community Care Services	Primary Care Services	
				Territory Emergency Services	

				Pharmaceutical Services	
				Integrative Care	
				Specialist Outpatient Services	
				Prosthesis Care	
				Ambulatory Home Care	
				Residential and semi-residential care	
				Thermal (Spa) care	
			Hospital Care Services	-	7 Groups
Netherlands	ZFW	Entitlements to health insurance	General practitioner care		
			Paramedical care		
			Obstetric care		
			Maternity care		
			Pharmaceutical care		
			Medical devices		
			Dental care		
			Specialist medical care	Hospital in-patient	
				Hospital out-patient	
				Other	
			Audiological assistance		
			Out-patient haemodialysis		
			Rehabilitative care		
				Genetic testing	
				Thrombosis prevention	
				Chronic intermittent ventilation	
			Transportation		
	AWBZ	Entitlements to health insurance in exceptional circumstances	Preventive services	Antenatal Care	
				Tests in connection with congenital metabolic dysfunction	
			Long-term medical treatment, nursing or personal home care		
Poland	Constitution of the Republic of Poland	Definition of citizens' rights	Health protection	-	
			Health care services	Special services for pregnant woman, children, disabled and elderly people	
			Prevention of epidemic diseases and environment degradation	-	

	Health insurance Law	Definition of services funded from public money	Diagnostic tests	Laboratory tests	
			Protection of health, prevention of disease and injury, screening.	Vaccinations	
			Primary health care		
			Specialist out-patient		
			Medical rehabilitation		
			Dentistry services		
			Hospital treatment		
			Highly specialized services		
			Psychology	Examination and treatment	
			Logopedy	Examination and treatment	
			Nursing care	Hospices and palliative care	
			Antenatal care and newborn care	Newborn's health and development assessment	
			Care during breastfeeding period		
			Healthy Child care	Health and development assessment	
			Spa		
			Medical products and aids		
			Medical transport		
			Emergency care		
Spain	RD 63/1995 / Law 16/2003	Organization of the health services provided by NHS Definition of minimum benefits to be provided by all autonomous communities	Public health services	Epidemiological information and surveillance	
				Health Protection	
				Health Promotion	
				Diseases and disability prevention	
				Surveillance and control of risks from imported goods	
				Environment health promotion and protection	
				Occupational health promotion and protection	
				Food security promotion	
				On demand out-patient services (elective and urgent), office-based and home-based	

			Primary Care Services	Indication , prescription and delivery of diagnostic and therapeutic interventions	
				Prevention, health promotion, family health and community health interventions	
				Information and surveillance	
				Out-patient rehabilitation	
				Specific services for women, children, adolescent, elderly, special risk groups and chronically ill	
				Palliative care for terminally ill	
				Mental health care	
				Dental health care	
				Out-patient specialised health care	
			Specialised Care	Specialised ambulatory care in day-hospitals	
				Specialised in-patient care	Medical, surgical, obstetric and paediatric
				Co-ordination with out-patient care and home hospital	
				Indication, prescription and delivery of diagnostic and therapeutic interventions	
				Organ, tissue and cell transplantation	
				Palliative care for the terminally ill	
				Mental health care	
				Rehabilitation	
				Long-term health care	
			Socio-sanitary care	Convalescence care	
				Rehabilitation	
			Pharmaceuticals		
			Health Care Information and Documentation		
UK	NHS Acts 1946 and 1977	Definition of the general duties of the NHS (“comprehensive health services”)	Hospital accommodation	Medical services	
				Nursing services,	
				Specialist services	
				Other services	
				High security psychiatric services	

			Family planning services		
			Dental inspections in scholars		
			Primary care	General medical services	
				General dental services	
				Pharmaceutical services	
				Ophthalmic services	
				Other specialist outpatient services	
				Mother and children care	
				Home nursing	
				Vaccinations and immunisations	
				Ambulance services	
			Aftercare of persons who have suffered from illness		

AWBZ: Algemene Wet Bijzondere Ziektekosten, DCPM: Decreto del Presidente del Consiglio dei Ministri, RD: Royal Decree, SGB V: Sozialgesetzbuch V, SSC: Social Security Code, ZVW: Ziekenfondswet

Table 3. Explicit Exclusions from the Benefit Basket.

Country	Documents	Level*	Exclusions**	Exceptions
Denmark	-	-	No explicit exclusions	-
France	Mandatory clinical practice guidelines	Lower	May explicitly exclude specific procedures, drugs or devices	Exceptions based on clinical situations
Germany	SGB V	Higher	Prescription-free (OTC) drugs, explicitly: analgesics, antitussiva and other drugs used in the treatment of common cold, laxatives, motion-sickness drugs. Life-style drugs: for the treatment of erectile dysfunction, for supporting smoke-cessation, for promoting weight lose, for promoting hair growth.	Children up to 12 years People up to 18 years and developmental impairment Drugs used in the therapy of severe illness listed in the OTC-Exception-List (e.g. ASS for CHD, laxatives for chronic intestinal diseases, mistletoe for palliative treatment of cancer, water soluble vitamins for dialysis, etc.)
			Prescription-free (OTC) medical aids	
	Directives and decisions of GBA	Lower	Explicit exclusion of several technologies (ca. 50), such as Screening for Glaucoma, Uterus-Ballon, refractive surgery, oxygen-therapy, osteodensitometry, ozone therapy, etc. All together can be considered an explicit negative list. Most of them can be considered unconventional therapies	Exceptions for some indications might be stated in each directive
Hungary	Act LXXXIII 1997 Services of Compulsory Health Insurance	Higher	Non curative treatments for aesthetic or recreational purposes	
			Medical examinations required for certifications	Those required when applying for social benefits
	MD 46/1997	Lower	Abortion	Medical indication
			Sterilization	Medical indication
			Prostate specific antigen for screening	
			Manual therapy	
			Correction of the shape of the outer ears, nose correction, muscle reconstruction, face wrinkles plastic surgery	
			Nipple, breast and breast skin plastic surgery	
			Excision of scars or constrictions	
			Hair transplantation, removal or depilation	
			Tattoo removal	
			Dermabrasio	

	MD 284/1997	Lower	Medical examination for firearms permission, driving license and forensic purposes	
			Blood alcohol test	
			Detoxification of drunk person	
Italy	DCPM 2001	Higher	Plastic Surgery	Accident, disease or congenital malformations
			Ritual male circumcision	
			Acupuncture, phyto-therapy, ayurvedic medicine, homeopathy, chiropractic care, osteopathy and all other non-conventional care	
			Vaccinations for travelling purposes	Obligatory vaccinations
			Medical certifications	Scholars
			Hydromassotherapy, short-wave diathermy, hypothermia NAS, pressotherapy, antalgic electrotherapy, ultrasound therapy, iontophoreses, laser antalgic therapy, photophoreses, extracorporeal photochemotherapy.	
			Bone densitometry	Conditions for which there is proven efficacy
			Refractive Laser Surgery	Patients who cannot wear glasses or contact lenses
		Lower	List of excluded pharmaceuticals (includes both OTC and prescription drugs)	
Netherlands	-	Higher	No explicit exclusions	
	Regulations on medical specialist care in the health insurance Act 2000	Lower	Plastic surgery	Accident, disease or congenital malformations
			Contact lenses	Special clinical circumstances
			Eyelid, ear or body sculpturing	
			In vitro fertilisation	2nd and 3rd attempt included
			Treatment of snoring by uvoloplasty	
			Sterilisation and undoing sterilisation	
			Circumcision	
	Regulations governing the pro-vision of para-medical assistance 1996	Lower	Speech therapy for the treatment of dyslexia	
			Physiotherapy, Mensendieck, Cesar remedial therapy	People up to 18 years (9 sessions) Chronic conditions

	Health Insurance Fund Provision of Pharmaceuticals Regulation 1996	Lower	Prescription-free (OTC) drugs	For chronic patients, laxatives, calcium, anti-allergics, anti-diarrhoea, anti-emetics.
Poland	Act on Health Care Services	Higher	Medical certifications for driving license and other	Related to continuity of care, work incapacity, related to continuity of education.
	Negative List	Lower	Not compulsory vaccinations	
			Plastic and cosmetic surgery	Injury, disease or congenital malformation
			Sex-change operations	
			Acupuncture	Chronic pain management
			Spa	
			Counselling on sexual and reproductive health	Highly disabled persons
			Psychoanalysis	
			Ozone therapy	
			Auto-immunisations	
			Magnetic filed therapy	
			Laser-puncture	
			Acupressure	
			Zoo therapy	
			Diagnostic and therapy within the framework of unconventional, traditional or oriental medicine	
			Further 17 procedures such as PET or Obesity treatment, which may be provided depending on different clinical circumstances	Exceptions based on clinical judgement
Spain	RD 63/1995	Higher	Medical Certifications	Birth, Death, work incapacity, discharge from hospital, related to continuity of care
			Examination or diagnostic procedures at one's own request or by request of thirds	
			Cosmetic Surgery	Accident, disease or congenital malformations
			Sex-change surgery	Pathological intersexual states
			Psychoanalysis and Hypnosis	
			Thermal medicine, Spa	
	RD 1348/2003 (MD 06/04/1993)	Lower	List of excluded pharmaceuticals (following ATC-classification)	

UK	NHS Trust purchasing contracts	Lower	Cosmetic surgery (e.g. tattoo removal, buttock lift, breast augmentation, procedures for pinning back ears	Exceptional clinical circumstances (i.e. "blanket bans" are illegal, assessment of exceptional cases is to be ensured)
	Black List	Lower	List of excluded pharmaceuticals (OTC drugs, perfumes, food, drinks)	
	Grey List	Lower	List of excluded pharmaceuticals	Specific clinical circumstances
	NICE Appraisals	Lower	Exclusion of specific drugs or devices (e.g. wisdom teeth removal, ultrasound devices for placement of central venous catheters, electroconvuls	Exceptions for some indications might be stated in each appraisal
	Decisions of UK National Screening Committee / NSF's	Lower	Prostate Cancer Screening	
			Pregnant Women: Screening for Chlamydia, cystic fibrosis, hepatitis C and diabetes.	
			Newborn: Screening for Duchenne muscular dystrophy, neonatal alloimmune thrombocytopenia and neuroblastoma	
			Children: Screening for autism, hypertension, speech and language delay, iron deficiency anaemia, lead poisoning, obesity and vision defects	
			Adults: Screening for Alzheimer disease, cancer (anal, bladder, lung, oral and ovarian), depression, hepatitis C and osteoporosis	
			Vaccines: small-pox, single vaccine for measles, mumps and rubella	
	Other	Lower	Glasses for working adults	Based on age and income

*Level as defined in Figure 1: Higher: Framework regulation, Lower: Benefit specification

**Compiled with data from the country reports. Only explicit exclusions are included here. Implicit exclusions (i.e. services, technologies not included in positive lists, or not supplied) are not stated here

5. Benefit Catalogues of services

In this section, we summarize the different types of benefit catalogues across our study countries following the system of functional categories of health services provided by the OECD (see Table 1).

5.1. Catalogues for services of curative care (HC.1)

Together with the category of "Medical goods dispensed to out-patients", (see Chapter 5.1.2) the category of services of curative care is the one for which more explicit and detailed catalogues were identified in the participating countries.

5.1.1. In-patient services (HC.1.1)

As in other sectors of the health care system, provided inpatient services can either be listed as procedures being part of an explicit benefit catalogue or indirectly determined by grouping systems that serve remuneration purposes, e.g. DRGs.

France, Poland and Spain have defined explicit benefit catalogues, grouped according to medical specialties and/or anatomical-functional classifications for inpatient services (see Table 4). The benefit catalogue's level of detail in Spain is very limited since the catalogue is reduced to the mentioning of broad categories of hospital services in the Decree establishing the framework of the health services (see also Table 2). However the same decree encourages the definition of a more specific catalogue. In contrary France and Poland have defined a detailed and itemized benefit catalogue in which items correspond to procedures or cases. The items usually leave it up to hospital managers and/or clinicians on which technologies to apply in order to provide a specific service. Clear decision criteria have been established for the inclusion of benefits into the benefit catalogue in France and Spain, namely safety, effectiveness, and economic aspects. In both countries, HTA-Agencies (national in France, national and regional in Spain) function in order to formally support the process of decision-making with evidence from research. In contrary, no transparent criteria are applied in Poland.

In all other countries, DRG- and other grouping-systems serve as a tool for estimating resource consumption, supporting budget assignations or providing the basis for remuneration (see

Table 5). In general, these systems classify a single episode of care according to main diagnoses, co-morbidities and main surgical interventions, into one of a limited number of groups. It is assumed that single episodes of care within each group require more or less homogeneous resource consumption, independent of whether exactly the same items (i.e. drugs, diagnostics, etc.) were provided. Based on the rationale of homogeneous resource consumption, each group is linked to a standard monetary value (average), which is the reimbursement received by the hospital for that case and is independent of whether the single patient consumed more or less resources than the average. The monetary values attached to the different groups may limit the use of drugs, diagnostics etc. in single episodes of care.

In our study, four countries have introduced DRG-systems: Italy, Germany, Hungary and Denmark. The UK is on the way of adopting a DRG-like grouping system, called Health Care Resource Groups (HRG's). The main features of the DRG systems being used in the countries under study are very similar (

Table 5). This is not surprising since all DRG-systems share a single common origin. In all countries the division into Major Diagnostic Categories (MDC) follows a similar logic as the ICD-10 does; some MDCs refer to body systems, some to aetiological agents and some to special situations (e.g. pregnancy, newborns). In addition, exceptional DRGs and/or so called pre-MDC categories for cases with very intensive resource consumption are defined in all systems. Although there are minor differences in the denomination (i.e. as "exceptional categories", as "pre-MDC") all systems agree on what are considered special or exceptional DRGs. HIV Infection /AIDS, multiple trauma, tracheotomy/ long-term ventilation and transplantation regularly belong to what are considered exceptional cases in the four countries and in Denmark, chemotherapy and radiotherapy add to this category. Considering the case-characteristics used for grouping, all systems consider the same case-characteristics and only minor differences in the coding systems used can be identified (i.e. ICD-9 vs. ICD-10, use of national procedure nomenclatures).

The scope of application of the DRG-systems varies slightly across the four countries. In all the four countries, the DRG-system is applicable in the area of inpatient curative care. In Italy and in Germany it also applies to hospital day cases, whereas in Hungary this is not the case. In Denmark a specific grouping system for day cases has been developed, the so called Danish Ambulatory Grouping System (DAGS), which follows a similar principle as the DRG system. In Germany psychiatric departments are explicitly excluded, but some in-patient rehabilitation DRGs have been developed. In Italy rehabilitation is explicitly outside the scope of the DRG system as well as long term care.

The most striking difference can be seen in the number of DRGs in each system. In Italy, depending on the region, the system contains between 489 and 506 DRGs, in Denmark 589, in Hungary 786 and in Germany, the system lists 878 different DRGs in 2005. In all systems, the MDCs with the highest number of DRGs are "Diseases of the circulatory system" (GER: 102, HUN: 91, DEN: 60, ITA: 44) and "Diseases of the musculoskeletal system and connective tissue" (GER: 88, HUN: 107, DEN: 59, ITA: 50). In each country the DRG system has been empirically developed and is updated according to further data collection. Data on resource consumption are collected and homogeneous resource consumption groups have been built on this data basis. The observed variability in the number of DRGs in each system might be explained through the use of different criteria to determine the homogeneity of resource consumption that is, to determine when a type of case is split. Another possible explanation, is the creation of extra DRGs with the aim of allowing specific reimbursement for the use of special technologies (devices, procedures and theoretically even

drugs), which are considered worth their promotion (i.e. because of higher efficacy). This has been the case in Italy, where the regional health authority of Lombardy added three new DRGs to its system in order to specifically consider the use of drug eluting stents (DES) and to encourage its utilisation. A similar (even more accentuated) situation can be observed in Germany, where an increasing amount of DRGs reflects the use of specific technologies.

The fact that specific procedures and technologies drive the development of DRG-systems confirms our hypothesis that they have the character of a benefit catalogue. On the one side, in all systems a part of the DRGs is defined through specific procedures (specially the so called surgical DRGs) or, as shown in the case of DES, through specific technologies. These DRGs can be considered a kind of positive and explicit formulation of included benefits. On the other side, technologies which are not object of a specific DRG might not be used when less resource consuming alternatives are available (the creation of specific DRGs for effective technologies with high resource consumption represents actually an acknowledgement of this effect of the DRG-system, which in some cases can be considered a limitation). In this way, a less specific DRG-system may act like a hidden negative list of technologies, which de facto are not available for beneficiaries of publicly funded care (be it social health insurances or national health systems) since the reimbursement offered by the DRG-system does not cover the actual resource consumption associated with its utilization.

The Netherlands has developed its own grouping system, which clearly differs in its principles from existing DRGs to date: the Diagnose Behandeling Combinaties (DBC's). The starting point of DBC is the initial need of care of the patient, the kind of visit (i.e. emergent, scheduled) and the speciality of the provider. For each combination of these features, a set of "allowed" procedures (diagnostic, therapeutical, etc.) are listed, as well as a set of procedures "not-allowed" (excluded) and a list of procedures whose use is limited to special conditions. The DBC-system is thus a combination of positive and negative benefit catalogue for in-patient care, organised by medical speciality (24 categories). A total of 109,375 items are explicitly included (3649 only under certain conditions) and 1511 items are explicitly excluded. The DBC system is thus considered to be one of the most explicit and detailed catalogues for in-patient care developed to date. The application of the DBC-System is not only limited to in-patient care, it also functions as the benefit basket for out-patient specialist care.

Table 4. Explicit In-Patient Benefit Catalogues.

Country	Name of Taxonomy / Year of introduction	Applied Geogra-phical area	Taxonomy (and grouping criteria)	Actors involved in decision - making	Criteria for in-/ exclusion of benefits
France	Common Classification of Medical Procedures (CCAM) 2005	National	17 Chapters according to anatomic-functional classification (ICD-like) Items are medical procedures, each implies all manoeuvres and materials needed for the performance of the procedure CCAM Lists reimbursable and excluded medical procedures thus being a positive and negative list	National level (law, general framework) Ministry of Health (approval) National Union of Health Insurance Funds (in- and exclusion of services) High Health Authority (advisory body on in- and exclusion of services)	Effectiveness, safety
Poland	National Fund Catalogue of Products Regularly updated, 2005	National	Overall benefit catalogue of all services covered by NHF In-patient services (>1500) can be grouped into following categories: Hospital Care (General/ Radiology, Nuclear medicine/ Oncological therapy/ Non-oncological therapy), Psychiatric and substance abuse therapy. No uniform systematic Items represent cases or procedures	Legislation at the national level (law, general framework) Ministry of Health (regulations) National Health Fund (inclusion or exclusion in the catalogue)	Not transparent
Spain	Royal Decree 63/1995	National with regional differences	Categories (area of care, medical specialty) of in-patient care are listed explicitly in decree (higher level legislation, see also Table 2) Generally, no single items (procedures or technologies listed). In some cases, services are restricted to specific patient groups	Legislation at the national level (law, general framework) Central Government (decree) Inter-territorial Council and Council of the State (inclusion of new benefits) Clinicians (choice of technologies, provision of services within the broad areas of care)	Safety, efficacy, efficiency (for single technologies)

Table 5. Resource Consumption related Benefit Catalogues

Country	Name of Taxonomy / Year of introduction	Source System	Applied Geographical area	Taxonomy	Grouping Criteria	Actors involved in decision - making	Criteria for in- / exclusion of benefits
Denmark	Dk-DRG 1998	Nordic-DRG	National Acute in-patient Not applicable to day cases (DAGS system used)	25 MDC (anatomical/ etiological/ other) with 589 DRG 1 outside MDC Special category for Chemotherapy and Radiotherapy	Principal diagnosis at discharge (ICD-10) Surgical Procedure (Nordic Classification of Surgical Procedure) Other procedures (SKS) Sex, Age, Discharge status	Legislation at the national level (law, general framework) Central level (national DRG – Catalogue) Regional level (redefines DRG-Catalogue, sets tariffs) Clinicians (priority setting in hospital)	Effectiveness, costs
Germany	G-DRG Stepwise 2003-2009	AR-DRG 4.1	National Acute in-patient care / day cases urative care / in-patient rehabilitation Not applicable to care in psychiatric departments	25 MDC (anatomical/ etiological/ other) with 876 DRG 1 Pre-MDC (special cases, including long-term assisted ventilation, transplantation)	Principal diagnosis at discharge (ICD-10-GM) Procedure (OPS-301) Age Co-morbidity / Complications Status at discharge	Legislation at the national level (law, general framework) Ministry of Health (approval) Federal Joint Committee (exclusion of benefits) Institute for the Remuneration of Hospitals with assistance of the Committee of on Hospital Payment (DRG – Catalogue) Clinicians (priority setting in hospital)	Services can be provided as long as they are not explicitly excluded Adequate, expedient and cost-effective
Hungary	DRG-System 1993	US-DRG	National Acute in-patient care	26 MDC (anatomical/ etiological/ other) with 786 DRG	Principal diagnosis at discharge (ICD-10) Procedure (ICPM) Age Co-morbidity / Complications	Legislation at the national level (law, general framework, budgeting) Ministry of Welfare, Health division (DRG – Catalogue) National Health Insurance Fund Administration, especially (prepares decisions) Clinicians (priority setting in hospitals)	Costs, effectiveness

Italy	Reference-DRG 1995	HCFA n.10 (HCFA n.14 HCFA n.19)	National reference list and regional lists Acute in-patient care / day cases of curative care Not applicable to rehabilitation and long-term care	23 MDC (anatomical/ etiological/ other) with 489 to 506 DRG, 2 Pre-MDC (multiple trauma / HIV), exceptional DRG (liver and bone marrow transplantation, tracheotomy)	Principal diagnosis at discharge (ICD-9-CM) Procedure Age Co-morbidity / Complications Status at discharge	Legislation at the national level (law, general framework) Ministry for the Interior and Health (approval) National Board of Health (DRG – Catalogue) County level (budgeting, hospital plan) Clinicians (priority setting in hospital)	Need, budget
Netherlands	Diagnose Behandeling Combinaties [DBC]) 2005	No source since innovation	National In and out-patient specialist care	24 Categories (specialities) 641 product groups (DBC) Positive list of allowed procedures regarding diagnosis and therapy. Negative list of excluded procedures	Medical speciality Type of visit Initial need for care Diagnosis Activities performed	Legislation at the national level (law, general framework) Ministry of Health (decrees) DBC-Maintenance Organization (DBC-System) Clinicians (priority setting hospital)	Costs, effectiveness,
UK	Health Care Resource Group (HRG) stepwise 2004-2009	DRG-like System	National	In April 2004, there were only 48 HRGs in use	Diagnosis Case complexity Procedure	Legislation at the national level (law, general framework) Ministry of Health (catalogue) Primary Care Trusts (negotiate with providers on quantity and tariffs)	Costs, budget

5.1.2. Out patient curative services

In the outpatient sector, benefit catalogues are again often substituted by grouping systems, serving remuneration purposes. Although they generally seem to be more explicit than the inpatient catalogues, the explicitness and level of detail varies even larger than in the in-patient sector (see Table 6). These different degrees of explicitness are mainly due to the applied remuneration schemes in each country. If physicians receive fixed budgets or capitations, the benefit "catalogue" (i.e. the procedures they can offer) is indirectly restricted by the amount of money allocated to them. Therefore in these countries, the benefit package for outpatient care is regulated rather implicitly through decrees issued by national or regional health authorities describing the obligation of physicians to provide those benefits that are considered necessary. Examples for these kind of implicit benefit catalogues are the "Health Insurance Treatment and Services Decree" for care provided by GPs in the Netherlands or the "General Medical Services Contract" in the UK. These decrees do not mention specific procedures, (with the exception of vaccination and cancer screening in the UK) however in the case of The Netherlands, the GP association - the *Landelijke Huisartsen Vereniging* - defined a basic GP benefit package in the 1980s (Groenewegen & Greß 2004).

In contrast, those countries remunerating providers on the basis of fee-for-service-schemes need detailed lists of procedures, or at least of service complexes (aggregated multiple procedures), to be able to negotiate on price and/or volumes. These lists can therefore be interpreted as substitutes for benefit catalogues, as physicians are usually reimbursed only for those items listed. The explicitness of these lists differs largely. Some countries issue detailed lists of all procedures to be performed by physicians (e.g. the "Catalogue of Benefits" in Poland or the "Common Classification of Medical Procedures" in France) while other countries are listing service complexes making physicians responsible for the priority setting within such a service complex (e. g. SHI – EBM or SHI – BEMA in Germany or the Health Care Reimbursement Scheme Fee Schedule in Denmark).

Interestingly, the taxonomy and structure are very similar among all countries. For example in Denmark, France, Germany, Hungary and the Netherlands, services are grouped according to medical specialty. Certain outpatient benefits are also linked to indications or special patient groups in Poland and Spain. The high degree of explicitness regarding the definition of the benefit package is also underlined by the diverse lists of excluded services, common in all countries (see Table 3).

Table 6. Benefit Catalogues in out-patient care

Country	Name of Taxonomy	Applied geographical area	Taxonomy (and grouping criteria)	Actors involved in decision - making	Criteria for in-/exclusion of benefits
Denmark	Health Care Reimbursement Scheme Fee Schedule	National	Services are grouped according to medical specialty and for GPs additionally in basic, supplementary, laboratory and miscellaneous services. Each service has an item number. It is referred to the respective legislation decree specifying the benefit, certain goods, and procedures or in rare cases indications.	National level (law, general framework) Ministry for the Interior and Health (approval) Counties (budgeting, health plan) Health care Reimbursement Negotiating Committee and health professional associations (negotiate catalogue)	Need
France	Common Classification of Medical Procedures (CCAM)	National	Lists all medical procedures reimbursable and excluded. Grouping criteria: anatomic classification, medical specialties, 17 chapters	National level (law, general framework) Ministry of Health (approval) National Union of Health Insurance Funds (in- and exclusion of services) High Health Authority (advisory body on in- and exclusion of services)	Effectiveness, safety
Germany	SHI-EBM SHI-BEMA SHI-BEL-II	National	Services are grouped according to the medical specialty allowed to provide the service. Each service is assigned a numeric code in accordance with the subjection of the catalogue.	National level (law, general framework) Federal Joint Committee (approval of new benefits) Valuation Committee (negotiates EBM) Dental Valuation Committee (negotiates BEMA, BEL-II)	Diagnostic and therapeutic expedience, medical necessity and cost-effectiveness
Hungary	Governmental decrees and reimbursement catalogues	National	Similar services are listed in groups. Governmental decrees relate to different areas of care (e. g. dental care, specialist services) Items in reimbursement catalogues are listed with the respective ICPM code and a point value.	Legislation at the national level (law, general framework, budgeting) Ministry of Welfare (decrees, approval) National Health Insurance Fund Administration, especially (prepares decisions) Payment Codes Updating Committee(reimbursement catalogues)	Costs, effectiveness
Italy	National contract for Primary care Decree on specialist outpatient services	National benefit package, regions include additional services	Contract for primary care describes obligations of GP. Individual services are not further itemized. Decree on specialist outpatient services lists services in three sections: available, availability restricted to specific indications, excluded. Some services can only be provided in special settings (i.e. out-patient services in hospitals). 16 categories based on anatomical site, each subdivided into different chapters containing several items (single services)	Government at national level (sets decree, negotiates contract) Representatives of GPs (negotiate contract) Ministry of Health (transfers contract into law) government at regional level (negotiates additional contracts)	Effectiveness, costs

Netherlands	Health Insurance (Treatment and Services) Decree Diagnose Behandeling Combinaties [DBC] (DRG-like system)	National	GP services are regulated in generic terms only by decree. DBC-catalogue (see Table 5) also relevant for hospital out-patient services Grouping criteria: medical specialty, product group	Legislation at the national level (law, general framework) Ministry of Health (decrees) DBC-Maintenance Organization (DBC-System) Physicians (priority setting)	Costs, effectiveness,
Poland	Governmental decrees and Catalogue of Benefits	National	Overall benefit catalogue of all services covered by NHF Services listed include consultation, diagnostic tests and also separate group of imaging techniques	Legislation at the national level (law, general framework) Ministry of Health (regulations) National Health Fund (catalogue)	/
Spain	Royal Decree 63/1995 Law 16/2003	National with regional differences	Services are listed explicitly in decree under “Primary Care”-category, with 9 subdivisions (ranging from prevention and health promotion to palliative care for the terminally ill) In some cases, services are restricted to specific patient groups.	Legislation at the national level (law, general framework) Federal Government (decree) Inter-territorial Council and Council of the State (inclusion of new benefits) Clinicians (provision of services relating to entitlements defined by decree)	Safety, efficacy, efficiency
UK	National Service Framework General Medical Services Contract Clinical Guidelines	National National, with possible variation at PCT-level National	General medical services contract Taxonomy based on specific conditions Some individual items listed (e.g. vaccinations)	Legislator at national level (law, general framework) NHS Confederation and General Practitioners Committee (negotiate contract) Primary Care Trusts [PCT] (negotiate additional contracts) NICE (clinical guidelines)	Need, effectiveness Need, costs Need, costs, effectiveness

5.2. Services of rehabilitative care (HC.2)

Rehabilitation is part of the benefit package in all the countries studied. It is explicitly mentioned in all the documents establishing the overall framework of the benefit basket (see Table 2 and Table 7) either as an entitlement for the patients or as duty to be fulfilled by the health services.

There are specific benefit catalogues beneath the level of framework regulation for rehabilitation, however not these specific benefit catalogues are not found everywhere. In France, Germany, Netherlands, Spain and the UK there is no specific catalogue for rehabilitative services, which further elaborates the overall statements given in the framework documents. In contrary the other countries (Denmark, Hungary, Italy and Poland) do have a specific catalogue for rehabilitation. In Hungary two catalogues specific to rehabilitation are in use. The first one, unlike other catalogues described in this project, does not specify services *that* might be provided within the benefit package framework but specifies indications *for which* rehabilitation (otherwise not further itemized) is part of the basket. The taxonomy is based on age groups (adult/child) and differentiates between cardiovascular, locomotor, lung, endocrine and other diseases. The catalogue lists about 15 indications for which rehabilitation might be provided, also specifying the providers (i.e. clinics/ "*sanatoria*") licensed to provide rehabilitative services covered in the benefit package. The second Hungarian catalogue differentiates between two different types of rehabilitation (balneotheray and physiotherapy services) which are further itemized into specific services (10 respective 13). Other country catalogues differentiate among broad categories of services, according to the aim of rehabilitation (Denmark), the intensity of the rehabilitative intervention (Italy) or the kind of services (Poland). Common to all of them is its vagueness in contrast to the Hungarian case. Beneath the broad categories (which range from 2 to 6) no further specification to the level of items included in each category has been done yet.

Common to both are countries which have a specific rehabilitation catalogue and those countries who not have one, is that rehabilitative services are included as part of other catalogues, mainly the ones concerning out-patient and in-patient care. Thus, even where no specific catalogue for rehabilitation exists, a detailed list of rehabilitative services included in the basket might be available (e.g. Italy or France) elsewhere.

In countries without a specific catalogue for rehabilitation services, different forms of guidelines may play an important role in the specification of the kind of rehabilitative services included the basket. In France for example, mandatory clinical practice guidelines link services to specific clinical conditions. In UK, both National Service Frameworks and clinical

guidelines specify on the one side indications for which rehabilitation belong the basket and, on the other side types of rehabilitative services.

In summary, rehabilitation is a component of the benefit basket in all studied countries. Some specific catalogues for rehabilitation could be identified, however most remain very vague (i.e. stating only broad groups of services without further itemisation). Rehabilitative services, however, are frequently included in other catalogues (i.e. for out-patient care), or specified in clinical guidelines.

Table 7. Rehabilitation. Catalogues and Specification of Services

Country	Explicit Mention in Benefit Package	Specific Benefit Catalogue /Taxonomy	Other relevant catalogues / categories	Other form of specification of services*
Denmark	Yes Social Services Act	Social Services Act 3 Main Categories, no further itemized -Rehabilitative care to improve functioning as part of or following hospital treatment -Rehabilitative care to improve or maintain functioning not following hospital treatment -Rehabilitative care to prevent deterioration of already decreased functioning	In-Patient: Hospital Act (partly DK-DRG) Out-patient: Health Care Reimbursement Scheme Fee Schedule	-
France	Yes	No	Out-patient: General Fee Schedule (NGAP), Chapter 14 "Rehabilitation and functional recovery"	Mandatory clinical practice guidelines link some services to indications (i.e. "Low-Back-Pain")
Germany	Yes	No	Social Code Book IX (Rehabilitation and participation of disabled persons) In-patient: G-DRG (e.g. „Geriatric Rehabilitation") Out-patient: Directive on care by non-physicians, lists procedures of Physical Therapy, Ergotherapy and Logopaedics (among others), single procedures linked to indications (following anatomical classifiacation), also includes a negative list.	-
Hungary	Yes	Decree 20/1996 Treatment in Sanatoria in the Frame of Medical Rehabilitation 3 Main categories with subcategories of indications. No procedures listed. Itemized by providers. Adults Cardiovascular disease (11 indications) Locomotor disorders (4 indications) Lung and endocrine diseases (6 indications)	-	-

		Children (3 providers) Outpatient rehabilitation Cardiovascular disease Locomotor disorders Other diseases Decree 5/2004 on Balneotherapy for medical rehabilitation Balneotherapy (10 items) Physiotherapy (13 items).		
Italy	Yes	Guidelines for Rehabilitative Care 2 Types of rehabilitative care Extensive and Intermediate rehabilitative care Intensive rehabilitative care No further detail given	In-patient: Italian DRG Out-patient: DM 1996 Specialist out-patient services, Chapter 16, Subchapter on "Physical therapy, respiratory therapy, rehabilitative care and correlated procedures" (99 services)	-
Netherlands	Yes	No	No	Regional Indication Bodies: Decide on appropriateness of rehabilitation for patient needs.
Poland	Yes	Social Insurance Institution Rehabilitation Services (6 categories) Physical rehabilitation Psychological Rehabilitation Health Education Dietary Education Prevention No further detail given	National fund catalogue of products Appendices concerning rehabilitation services provided by physicians and physiotherapists	-
Spain	Yes	No	No	No definition of rehabilitation available Resources and clinical guidelines may determine what is done in each hospital or primary care unit
UK	Yes	No	No	National Service Frameworks (Elderly,

				Mental Health, Coronary Heart Disease) Clinical Guidelines (e.g. "Stroke in Childhood")

*Documents which explicitly mention services to be included/excluded (with different levels of detail).

5.3.Services of long-term nursing care (HC.3)

Long-term nursing care, as defined by the OECD in its system of health accounts, refers to ongoing health care and nursing given to patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. According to the OECD definition, this category explicitly excludes "social care". The studied countries show however, that in this category, the boundary between what is included in the benefit basket of the health system and the benefits rooting in social protection legislation might not always be as straightforward. This might be due to the fact that these kind of services are provided initially within the health services but when due to specific circumstances, these same services may end up falling within the scope of social services instead. In England, the Beveridge report (1942) already recommended the separation of the responsibility for health and social care. Since then this issue has been subjected to controversy. The circumstances in which a person loses his/her status as "patient" (i.e. under health care services responsibility) to become a "resident" (i.e. under social care services responsibility) seem to be difficult to define.

In Germany, this boundary has been clearly set by means of creating a special statutory insurance for long-term care, while short term-care continues to be a benefit of the health basket (i.e. under SGB-V). The boundary has been set at six months, so patients whose need of nursing care is under six months will be covered by the health insurance and patients, whose need of care is expected to last six months or longer, will be covered by the long-term care insurance. Similarly in the Netherlands a specific insurance scheme for long-term care exists (AWBZ), which covers both nursing as well as social care (i.e. household help). In both countries the need for long-term care is assessed after application.

Another way has been taken in Italy, where an explicit and detailed catalogue of long-term care services has been formulated (Governmental Decree Nov. 2001 on the coordination of health and social services) and has been organized into four main categories of services (community out-patient and home care, semi-residential community care, residential community care and penitentiary care) for which subcategories and specific services have been further differentiated. The catalogue also clearly defines the financial responsibilities of the health and social services. This is similar in France, where the nursing components of care (home or in-patient) are part of the health benefit basket and other components of care such as catering, accommodation, or household help are financed by the social services. Also in Spain, long term care has been defined as a component of the benefit basket, however it has not yet been developed in detail and the division of responsibilities between social and health

services is still not very clear. In Denmark, a separation of responsibilities between health care services and social services (municipality) has been established, by differentiating among "specialised" long term care (health services' responsibility) and "general/ less specialised" long-term care (social services' responsibility). However the borderline is usually made on an individual case basis.

5.4. Ancillary services to health care (HC.4)

According to the OCED classification, ancillary services to health care comprises of services performed by paramedical or medical technical personnel with or without the direct supervision of a medical doctor, such as laboratory tests, diagnosis imagery and patient transport.

The benefit basket of all studied countries includes services of this category. However, this inclusion is not always explicit (Table 8). There is no common pattern among NHS or SHI countries on the issue of explicitness for this category of care.

Table 8. Mention of HC.4 in benefit basket.

Country	Diagnostics (Laboratory, HC.4.1 and/or Imagery, HC.4.2)	Transport (HC.4.3)
Denmark	Implicit	Implicit
France	Explicit	Explicit
Germany	Implicit	Implicit
Hungary	Implicit	Explicit
Italy	Implicit	Explicit
Netherlands	Implicit	Explicit
Poland	Explicit	Explicit
Spain	Explicit	Implicit
UK	Implicit	Implicit

Diagnostic services (laboratory or imaging) are included in the benefit basket of all studied countries however, only one specific benefit catalogue could be identified. In France, the so called *Nomenclature des Actes de Biologie Medicale* lists specific laboratory procedures covered by the SHI. Diagnostic imagery however is not part of this catalogue. The taxonomy of the laboratory tests catalogue is organised around types of procedures and includes 17 groups of diagnostic procedures ranging from pathology to prenatal diagnosis. Each of the categories is then further itemized. However, this list will be integrated in the overall French catalogue (CCAM).

In the rest of the countries, laboratory test or diagnostic imagery are either items within other catalogues, i.e. out-patient or in-patient service catalogues, or implicitly included within broader definitions of services. The level of detail and the taxonomy concerning laboratory or diagnostic imagery services depends on the way the catalogues for HC.1 are

built. In some situations guidelines may explicitly mention specific tests to be made by clinicians (e.g. NSF), while in other countries, the availability of diagnostic technologies may lead a *de facto* definition of benefits, like in the case of Denmark or Spain. The availability of technologies depends thus on the priority setting for resource allocation.

Overall, transport of ill people and emergency rescue are included in the benefit basket of the studied countries. In this subcategory, however, no specific catalogues have been defined. Usually the relevant regulations describe situations for which transport or rescue are covered, but no catalogues (in the sense of lists of services) are in use. The entitlement to transport depends mainly on medical need and socioeconomic situation of the individual. As with the other two subcategories in HC.4, explicit mention of the service in the overall benefit framework is not related to type of health system.

5.5.Medical goods dispensed to out-patients (HC.5)

5.5.1. Pharmaceuticals and other medical non-durables (HC.5.1)

In the category of pharmaceuticals, the greatest homogeneity across the studied countries can be identified. As shown by Table 2, in all countries this category is explicitly included in the benefit package. In addition, all countries also have some kind of itemized benefit catalogues for pharmaceuticals.

The majority of the countries have established a general catalogue of explicitly included drugs (positive list), which might be organized following the ATC-Classification (or a similar systematic) (Denmark, France, Netherlands and Spain) or a catalogue, which contains an alphabetical list of the pharmaceutical preparations included (Italy, Hungary, Poland). The majority of these catalogues provide information on the level of co-payment and link the inclusion of some drugs to specific clinical conditions or patient characteristics. Interestingly, the general benefit catalogues of drugs are applied at the national level, even in such health systems with a high level of decentralization (Italy, Spain). This is in contrast to other categories of health services, where regional variations in the content of the benefit basket are possible.

However, in two countries no general explicit and detailed benefit catalogue could be identified, both countries have positive lists of limited scope. In Germany a positive list exists that includes some OTC medicines for specific conditions, since OTC medicines are generally excluded at the higher level of framework regulation. The formulation of a general positive list was once planned in Germany but was never implemented. In England, local health authorities may issue positive lists of drugs available for prescription within their jurisdiction, thus representing a kind of local benefit catalogues.

There also seems to be a broad consensus on the criteria to be applied in the decision-making process of the pharmaceutical products' benefit catalogues. These criteria have been made transparent (at least on the paper) in most of the studied countries. Beside safety and effectiveness, the impact on overall expenses of the health systems plays an important role in the decision-making. In addition, a clear trend can be observed into the limitation of the inclusion of preparations which do not add any value (in terms of efficacy, cost-effectiveness, safety, etc.) to the ones already included. Thus new pharmaceuticals do not only need to prove they are "good", but they are being increasingly required to be "better than" in order to attain full reimbursement. The degree of innovation (i.e. challenging unsolved problems, treatment of orphan diseases, etc.) is also one of the criteria which are being increasingly used in the specification of the benefit package. In this context, the role of industry-independent health technology assessment will probably increase further in the next couple of years.

Table 9. Explicit benefit catalogues for Pharmaceuticals

Country	Name of catalogue / Year of introduction	Applied Geogra-phical area	Taxonomy (and grouping criteria)	Actors involved in decision - making	Criteria for in-/ exclusion of benefits
Denmark	Positive List of Medicines	National	Positive list of preparations reimbursable, contains information on level of co-payment Yearly updated Classification according ATC	Legislation at the national level (law, general framework) Danish Medicines Agency (approval of drugs, inclusion in positive list)	Evaluation of drug in clinical trial, cost-effectiveness, need, budgetary impact
France	List of reimbursable pharmaceutic als (LSPRAS	National	Positive list (around 4500 drugs included), classified into 18 chapters (ATC-like) Regularly updated	National level (law, general framework) Ministry of Health and <social Security (inclusion in positive list) Transparency Commission (advisory body)	Safety, effectiveness, degree of innovation, relative utility (compared to drugs already included): improvement of efficacy, cost.
Germany	SGB V OTC-List	National	Exclusion of OTC Drugs and drugs for minor conditions (antitusiva, cold remedies, laxativa, and mouth-throat infections), no further detail OTC-Exception List: Positive list of reimbursable OTC (active agents) linked to specific indications	Legislation at the national level (law, general framework, exclusions) Federal Joint Committee of Physicians and Sickness Funds (exception list for OTC, inclusions/exclusions and indication)	Efficacy, need
Hungary	Decree 1/2003 Annex 4 (2005)	National	Positive list (included drugs), however some available only under certain circumstances Drugs listed in alphabetical order	National health insurance fund administration (inclusion/exclusion) Technology assessment committee (advisory body)	scientifically proven safety and effectiveness, budget impact, health needs, cost-effectiveness and issues of equity and accessibility
Italy	National Pharmaceutic al Formulary 2005	National, regional variations possible	Positive list of generics, active agents and patented drugs. Itemized by commercial name (alphabetically), includes price information Some linked to specific indications / patient groups (prescription notes)	Legislation at the national level (law, general framework) National drug agency (establishes list of products) Minister of Health (may modify)	Cost, clinical effect, budgetary impact
Netherlands	Health	National	Positive list with 3 Categories	Legislation at the national level (law, general	Innovation-degree

	Insurance Fund Provision of Pharmaceuticals Regulation RFH 1996		1 A Drugs with reimbursement limit 1 B Drugs without reimbursement limit 2 Drugs without reimbursement limit under certain conditions Within each category ATC-Classification, clusters of similar drugs (436).	framework) Ministry of Health, Farmatec, (updating, inclusion/exclusion) Pharmaceutical Care Committee of the Health Care Insurance Board (advisory body to ministry of health) Regularly updated (monthly)	Cost-effectiveness Impact on overall budget
Poland	Ordinance on Drugs	National	Positive list 2 Categories: Basic Medicines and magisterial preparations, Complementary medicines (diff. levels of co-payment) Itemized, includes information on level of co-payment	Legislation at the national level (law, general framework) Minister of Health (determines list) Expert Committee (advisory body)	Costs (price)
Spain	Royal Decrees 83/1993, 1663/1998, Ministerial Decree 06/04/1993	National	Annexe I: Negative List (1692 pharmaceutical specialities) for personal hygiene, minor symptom relieve, minor dermatological symptom relieve, food supplements, slim-drugs, dietetic products. Annexe II: Positive List: Drugs partially reimbursed Classification according to ATC	Legislation at the national level (law, general framework) Directorate-General of Pharmacy (inclusions, exclusions)	Medical need, budgetary impact, therapeutic and social value (compared also to drugs already included)
UK	Black and grey list 1985	National	Black list: Negative list of preparations not to be prescribed in the NHS Grey list: List of drugs for which budgetary or clinical safety concerns exist Explicit, itemized.	Legislation at the national level (law, general framework) Secretary of State for Health (Black and grey list) Medicines and Health Care Products Regulatory Agency (authorisation /licensing of drugs) NICE (technology appraisal, influences availability in NHS)	Efficacy, safety and quality (not relative to already licensed ones) Budgetary impact Perceived medical need
	Drug Tariff and Local Formularies	National and local	Positive list of generic drugs available for prescription in NHS, regularly updated Formularies of drugs available in NHS-Trusts Explicit, itemized	Prescription pricing authority Local Health Authorities, NHS-Trusts	

5.5.2. Therapeutic appliances and other medical durables (HC.5.2)

In all studied countries, the higher level regulation establishes a duty of provision or an entitlement to the products of this category. Very explicit and detailed catalogues for products belonging to this category could be identified in all the countries studied. In these catalogues, the statements of the framework regulation are operationalised. The existing catalogues can be classified into two types according to its level of detail (see Table 10): The lower level of detail is given in some countries in which "only" types of products included are listed in the catalogue, organized in different groups according mainly to anatomical site of use and function of devices. The taxonomy of appliances and durables includes mostly around thirty different product types and ranges from prosthetics for surgical use to furniture for disabled people. In other countries (e.g. Germany, Hungary, Italy, UK), the level of detail of the benefit catalogues for this category reaches up to the level of individual products. Brandnames or manufacturers of individual articles are even mentioned in some catalogues, mostly according to ISO classification of medical devices and products.

The benefit catalogues of medical appliances and other durables are usually formulated in the form of positive lists. In Denmark however, positive lists are complemented by negative lists of products in some of the groups.

A common characteristic in almost all of the study countries is that the catalogues do not only state what is included but also under which circumstances inclusion applies. Many of the catalogues link the individual products to specific clinical conditions or to specific age or demographic groups. Further, in some of the identified catalogues the ability of prescription for a specific device is limited to specific groups of providers (i.e. medical specialities). The duration of use or the level of co-payment are usually regulated in several of the identified catalogues as well.

Concerning the criteria used to select technologies to be included in the catalogues, some differences are seen between the countries studied. In Spain, for example, new technologies are compared with ones already included in terms of effectiveness, quality and costs. According to the criteria stated in law, the inclusion of new technologies should be substitutive; older, less cost-effective technologies should be replaced by the ones included later. Similarly in France the relative improvement of a new technology in terms of effectiveness represents one of the relevant aspects to be taken into account in the decision-making process. In England, the so called Drug Tariff includes devices and appliances relying on their safety, effectiveness and budgetary impact.

In some countries, where only types of products are listed without mention of specific trademarks or manufacturers, the preferences of the user (i.e. of the patient) or the provider (e.g. insurance fund) may play an important role in the choice of the individual device. These preferences are mainly driven by differences in costs or quality between similar products.

In summary, the benefit catalogues concerning the category of therapeutic appliances and other medical durables are one of the most explicit and itemized across almost all of the study countries.

Table 10. Catalogues of therapeutic appliances and other medical durables

Country	Name of catalogue / Year of introduction	Applied Geogra-phical area	Taxonomy (and grouping criteria)	Actors involved in decision - making	Criteria for in-/ exclusion of benefits
Denmark	Several specific catalogues: BEK 19/2005, CIR 21/1975, VEJ 52/1998, VEJ 129/2004 LBK 708/1998	National	Explicit positive and negative lists for each of the following following categories: Glasses and vision products Orthopaedic Appliances Anatomical classification by site of use Hearing aids Medico-Technical devices	Legislation at the national level (law, general framework) Ministry for the Interior and Health (approval of devices) County and municipality level (supply of products) Users (selection of suppliers)	Utility to improve impairment
France	List of products and related benefits	National	4 sections (medical products for treatment and first aid, orthosis and external rosthesis, medical implants and grafts, vehicles for disabled). Each with several chapters (by anatomical site or type of product) Catalogue includes reference prices	National level (law, general framework) Ministry of Health (approval) Commission on medical devices and related services (advisory body)	Relative utility (compared to products already included)
Germany	Catalogue of medical aids (Directive of medical aids) 2004	National	34 product groups according to type of device, further divided by anatomic site of use. Lists individual products Contains instructions for prescription regarding conditions.	Legislation at the national level (law, general framework) Ministry of Health (establishes list) Federal Joint Committee (exclusion of benefits)	Functional effectiveness, quality and therapeutic utility
Hungary	Decree 19/2003	National	ISO Classification: 8 major categories (by type of device) each with several categories. Individual products listed Catalogue establishes rules of use (indication, provider prescription right, duration, maximum quantity, co-payment)	Legislation at the national level (law, general framework, budgeting) Ministry of Health, Social and Family Affairs (updating)	Not stated
Italy	Ministerial decree 332/1999	National	3 Main categories (appliances produced ad hoc, appliances produced in series, goods directly purchased by local health authorities)	Legislation at the national level (law, general framework) Central level (establishes list of products) upon	Need, costs

			Within each category ISO 9999 Classification Individual products listed Catalogues defines groups of patients entitled	agreement with Regional authorities.	
Netherlands	Medical Devices Regulations	National	32 Categories systematized partly by anatomical site of use and partly by kind of device. No individual products listed Catalogue establishes rules for entitlement (conditions, circumstances of use)	Legislation at the national level (law, general framework) Ministry of Health (decrees updating categories) Health insurance funds (availability of devices) User (preferences)	No criteria stated, choice of individual device may depend on costs and preferences
Poland	Catalogue of Benefits of National Health Insurance Fund	National	Catalogue lists all services covered under social health insurance scheme. Chapter related to medical (incl. Orthopaedic) products.	Legislation at the national level (law, general framework) Ministry of Health (regulations) National Health Fund (catalogue)	Need, costs and "lobbying"
Spain	Ministerial Decrees 18/01/1996, 23/07/1999, 30/03/2000, 19/07/2001 Regional decrees (various)	National with regional differences	5 Major categories (fixed surgical prosthesis, external prosthesis, wheelchairs, orthesis, special prosthesis) each with several divisions and subdivisions mainly by anatomical site of use Catalogue establishes rules for prescription	Legislation at the national level (law, general framework) Federal Government (ministerial decree) Advisory committee of orthoprosthetic services (inclusion of new benefits, exclusion of outdated benefits) National and Regional HTA-Agencies (technical support)	*Inclusion* Therapeutic improvement (in terms of safety and effectiveness) Advantageous economic conditions (compared to existing benefits) *Exclusion*: Substituted by new (safer, more cost-effective) inclusions Advertised to general public
UK	Drug Tariff	National	Positive list of appliances and devices available for prescription in NHS primary care Explicit, itemized (individual devices /appliances)	Legislation at the national level (law, general framework) Medicines and Health Care Products Regulatory Agency (authorisation /licensing of devices) Prescription Pricing Authority (inclusion /exclusion) NICE (technology appraisal, advisory)	Efficacy, safety and quality (not relative to already licensed ones) Perceived medical need

5.6. Prevention and public health services (HC.6)

Preventive services targeting individuals (i.e. screening for disease, vaccinations, mother-child health programmes, family planning, etc.) are part of the benefit package of all studied countries, although differences may exist concerning the specific content of the services (i.e. technologies used for screening, target diseases to be screened for, specific vaccinations). Usually the inclusion of these services are made explicit at the higher level of framework regulation with different levels of detail and systematic (as previously shown in Table 2, Spain and Italy have one of the most developed catalogues at this level). Only Hungary and Poland have specific separate benefit catalogues for preventive services in the form of decrees, which specify and develop the benefit package in the area of preventive services. In Hungary, the Decree 51/1997 provides a list of conditions to be screened for in different age groups. Similarly in Poland, two decrees ("On preventive services" and "On prevention services at school") deal specifically with services from this category. The rest of the countries are similar in the fact, that a specific benefit catalogue for preventive services in the form of a single document could not be identified. The specification of the services included in the package takes place mainly through the mechanism of binding guidelines (such as the Directives of the Federal Joint Committee, in Germany), recommendations (as the ones issued by the National Screening Committee in UK) or its mention in specific preventive programmes (as for example in France or in the English National Services Frameworks). Since the majority of preventive measures targeted at individuals are provided by physicians and other health care personal in out-patient settings, the specific components of this part of the benefit basket are usually listed in the benefit catalogues for out-patient curative services (see Section 5.1.1).

The case of population health services is rather interesting, since major differences between NHS and SHI countries can be observed. Activities targeting population health through food and environmental protection, health promotion and education or epidemiological surveillance are explicitly included in the benefit package in countries like Italy and Spain (see Table 2). In the case of the UK part of these activities are included implicitly. In contrary, in SHI countries most of these kinds of activities do not belong to the scope of the benefit package (see Table 2), since they are not part of the health insurance schemes. The inclusion of population health services into the benefit package of an NHS roots probably in the close relation of the NHS to the State[5]. The underlying logic of National Health Service is the fulfilling of the State duties concerning health of its citizens or residents.

[5] At national or regional level

A NHS can be seen as the part of State administration related to health issues. Consequently, the benefit package has to include tasks of this category. The principle of SHI countries is to insure individuals against health risks. The activities of health protection, epidemiological surveillance, information, etc. are tasks assumed by State institutions (national /federal, regional, local) but, which do not fall into the insurance principle, since they are related to the whole population. Thus, despite the recognition across all countries of the State duties concerning health protection of its population, these services and activities are only part of the benefit package in NHS countries, which consequently results in a broader benefit package.

6. Discussion and conclusions

The analysis of benefits defined in the countries under study, reveals that there is a clear trend towards a more explicit definition of benefit baskets and benefit catalogues. Those countries which recently introduced new health care legislations, e.g. Italy, Poland and Spain, have more explicitly defined benefit catalogues. Other countries with older health care legislations e.g. the UK's English-NHS Foundation Act (1946) or Germany's Social Code Book (1988) have rather implicitly defined benefit catalogues. Despite different levels of explicitness, benefit baskets can be identified across European countries. NHS countries have usually broader packages, since they also include services for population health. These kind of activities are difficult to agree with the insurance principle, and thus the benefit basket of SHI countries do not include them. Concerning the kind of services explicitly excluded from the benefit package, a gross consensus seems to be given across the studied countries according to the exclusion of cosmetic surgery and products, medical certifications, or vaccinations not explicitly included. The field of complementary and alternative medicine however is explicitly excluded only in some countries.

Besides the more or less explicit formulation of the overall benefit basket framework, a series of more detailed benefit catalogues for different areas of health care have been identified. The benefit package needs to be filled up with specific activities, procedures, technologies, etc. To achieve this specification a number of different mechanisms are in use, which interestingly seem to vary more according to health care category than across health system model or country. Positive lists, mentioning single products, are being used by all countries in the category of pharmaceuticals, even if in some cases they do not comprehend all drugs covered. Positive lists are also present in the category of medical appliances and durables. Negative lists are also becoming more prominent in the area of pharmaceuticals, based on evidence provided by independent institutions such as the English NICE or the German IQWiG (Institute for Quality and Efficiency). Remuneration schemes like fee catalogues or DRGs function more and more as benefit catalogues. Fee catalogues act as a positive list of services covered since providers mostly will not deliver a service for which they will not be remunerated. The resource allocation through DRGs will probably limit the use of specific technologies as the example of DES shows.

These developments indicate that all the included countries are moving towards a more explicit and systematic definition of benefit catalogues. From the point of view of catalogues as classifications of services, many models of taxonomy have been identified by the project. These range from alphabetically ordered lists of trade-marks for devices or

pharmaceuticals to organisation along anatomical sites, ICD-like disorder systematics or medical specialities.

Explicitly defined benefit catalogues however, require clear and transparent decision criteria for the in- or exclusion of benefits. Most countries officially state that (cost)-effectiveness is an important decision criteria. However, further inquiries often lay bare that there is no rational process of reviewing the available evidence on specific procedures or technologies (Busse et al. 2002). In reality the decision-making process is rather guided by the lobbying activities of certain actors in the system. Especially those countries with very explicit benefit baskets, e.g. Poland, often lack transparency of decision-making criteria. In contrast to this, countries with rather implicitly defined benefit baskets, e.g. UK and Germany, define very transparent criteria for benefit exclusion, although lists with excluded services are minor compared to explicitly oriented countries. In addition, criteria such as cost-effectiveness or even effectiveness are often restricted to one or few sectors of the health care system, e.g. pharmaceuticals or medical devices, and not generalisable to all products or services (Gibis et al. 2004). In general, transparency of decision-criteria has to be improved in all countries in order to achieve accountability for all actors of the health care systems as well as for consumers in the countries. At this time, participation of the public in the shaping of the benefit catalogue seems to be nearly nonexistent in the European countries studied, although there is a recognition of the need to develop decision-making mechanisms in this direction, as the recent developments in some countries shows. However, European countries seem to be far away from the basic democratic experiment of participation in the shaping of the benefit like the Israeli “Health Parliament”.

The *Health*BASKET project has gathered useful information for health care providers and industrial companies willing to invest in EU-countries, but who do not have the necessary information on benefit baskets and their underlying decision-making processes. However, in order to improve the environment for investments and to provide confidence for foreign investors, public documents should be regularly prepared by each country giving a transparent overview of the health baskets and the decision-making criteria. This information is also relevant for citizens in both their role as users or clients and financiers of the health care system.

The information provided will especially be beneficial to decision makers on all levels of health policy enabling them to compare different approaches of benefit definitions in order to reveal their own position. The need for benchmarking will continue to grow in line with the further development of cross boarder flows as well as the establishment of coherent

benchmark criteria as part of the "Open Method of Co-ordination" triggered by EU-policy makers (Henke 2002, Wismar & Busse 2002).

However, the project results lay bare that the harmonisation of health baskets of the EU member States, which in the view of certain decision-makers could be the initial stage after identifying best practice in benchmarking, is not realistic in short of medium term. The definition of health baskets varies largely and reflects specific contexts (i.e. needs for, traditions of health care, etc). Additionally, as shown in the cases of Italy and Spain and especially in NHS-countries there is a trend towards more decentralisation of decision-making on benefits, giving regions the autonomy to offer certain benefits in addition to the nationally defined health baskets (Hurly et al. 1995, World Bank 2001). This could also mean that in the future a minimum basket of health benefits may be defined by all countries on the national level, which could be harmonised on the EU level at a certain stage due to systems' competition as a result of increased cross-border flows. Because of the major differences between SHI and NHS concerning services of public health (e.g. not targeting individuals), the harmonization of the benefit basket could be limited in an initial stage to the care of individual persons. Beyond this minimum basket, there could be regional variations reflecting differences of wealth, preferences and traditions.

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