



# TK in Europe

**TK Europe Survey 2009**

German Patients en  
route to Europe

**Techniker Krankenkasse**  
Gesund in die Zukunft.



## TK-contracted institutions in other EU countries



**TK in Europe** – German Patients en route to Europe. Issued by Techniker Krankenkasse, Hamburg; Internet: [www.tk-online.de](http://www.tk-online.de); Corporate Development Department (UE) and the Scientific Institute for Benefit and Efficiency in Healthcare (WINEG) at TK; Authors: Dr Caroline Wagner (WINEG), Dr Frank Verheyen (WINEG); Analysis: Dr Caroline Wagner (WINEG), Julia Weller (UE), Malte Höhle (UE); Data selection: Martin Zieger; Design: Wolfgang Geigle; Production: Christian Nickel; Printing: TK in-house print shop

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## Foreword

German patients are en route to Europe – to be more precise, to the European healthcare market. This is also true of TK insurants. What makes German patients cross borders in order to receive planned medical treatment in other EU healthcare systems? What distinguishes this group of patients? And how many people actually opt to do this? TK's Scientific Institute for Benefit and Efficiency in Healthcare Systems (Wissenschaftliches Institut der TK für Nutzen und Effizienz im Gesundheitswesen – WINEG) has looked into this and other questions in the present study.

The 2008 Europe Study depicted an initial overall picture of demand among TK members for treatment in other EU countries. The crucial finding was the surprisingly strong increase of TK members receiving planned treatment in other EU countries in the total number of TK members treated in other EU countries. Consequently, the present 2009 Europe Study focuses on this phenomenon.

Some aspects of cross-border medical care are still not sufficiently regulated for patients, such as the question of their rights in the event of their needing subsequent treatment or their receiving medical malpractice. The proposed directive by the European Commission on cross-border healthcare, on which the EU health ministers were unable to reach political agreement, would basically be a requisite European political milestone in strengthening patients' rights in the European healthcare market. However, the fact that people insured under the German statutory health insurance system are reimbursed the costs of receiving medical treatment in other EU countries based on statutory provisions has at least been embodied in German law since the 2004 Healthcare Modernisation Act (Gesundheitsmodernisierungsgesetz).

TK has started concluding direct selective contracts with service providers in other EU member countries for its insurants. The main motives for doing this are to spare insurants the bureaucratic burden of a protracted reimbursement procedure and to offer them high-quality treatment offering German-speaking personnel. Today, this TK Europe Service encompasses 88 contracted clinics in the Netherlands, Belgium, Austria and Italy. In addition, there are 28 contracts with health and spa institutions in Austria, Italy, the Czech Republic, Hungary, Poland and Slovakia.

The present study has shown that the two key reasons for opting specifically for treatment in another European country are to save money and to combine treatment with a holiday. The latter reflects the trend towards healthcare tourism even among TK members. The vast majority of the members involved are senior members over the age of 60. In future, we would like to provide this group of members with an even greater level of professional advice on their way to the European healthcare market. This is why we are planning a further Europe Study which will concentrate on analysing the needs of these TK members and their experiences in other EU countries.



Prof. Dr. Norbert Klusen

Chairman of the Management Board

# Table of Contents

|   |           |
|---|-----------|
| <b>Tables and Figures</b>   | <b>5</b>  |
| <b>1 Objective, Summary of Results, Data Basis and Methodology</b>                              | <b>6</b>  |
| <b>2 Comparison of Planned and Unplanned Treatment in Another EU Country</b>                    | <b>10</b> |
| <b>2.1 Characteristics of the Typical German Patient in Another EU Country</b>                  | <b>10</b> |
| 2.1.1 Patients Receiving Planned and Unplanned Treatment.....                                   | 10        |
| 2.1.2 The Most Important Socio-Demographic Factors.....   | 11        |
| 2.1.3 The Most Frequent Underlying Illnesses .....  | 17        |
| 2.1.4 The Most Popular EU Countries .....   | 17        |
| <b>2.2 Characterisation of the Use of Planned and Unplanned Treatment in Another EU Country</b> | <b>18</b> |
| 2.2.1 Demand, Broken Down by Types of Treatment.....  | 18        |
| 2.2.2 Reasons for Choosing Treatment in Another EU Country .....                                | 20        |
| 2.2.3 Level of Satisfaction with Treatment in Another EU Country .....                          | 21        |
| 2.2.4 Method of Choosing the Service Provider .....   | 23        |
| 2.2.5 Sources of Finance for Treatment in Another EU Country .....                              | 23        |
| 2.2.6 Need for and Location of After-Treatment .....  | 24        |
| <b>3 Knowledge, Attitude and Experience of Patients</b>   | <b>25</b> |
| <b>3.1 Exchange of Information between Service Providers and Reimbursement</b>                  | <b>25</b> |
| <b>3.2 Legal Framework and Expectations of the European Healthcare Market</b>                   | <b>27</b> |

## Tables and Figures

- Table 1: Total Utilisation of Cross-Border Care by EU Country (Members and Treatments)
- Table 2: Total Utilisation of EU Cross-Border Care by Federal States (Members)
- Table 3: Planned and Unplanned EU Cross-Border Treatments by Federal States (Cases)
- Figure 1: Planned and Unplanned EU Cross-Border Care Treatments
- Figure 2: TK Members with EU Cross-Border Treatments by Age
- Table 4: TK Members by Age
- Figure 3: TK Members with EU Cross-Border Treatments by Profession
- Figure 4: TK Members with EU Cross-Border Treatments by Monthly Gross Income
- Figure 5: TK Members with EU Cross-Border Treatments by State of Health
- Figure 6: TK Members with EU Cross-Border Treatments by Insurant Status
- Figure 7: TK Members with EU Cross-Border Treatments by Illness
- Figure 8: TK Members with EU Cross-Border Treatments by Country
- Figure 9: TK Members with EU Cross-Border Treatments by Type of Treatment
- Figure 10: Reasons for TK Members for EU Cross-Border Treatments
- Figure 11: Satisfaction Felt by TK Members with EU Cross-Border Treatments Compared with Germany
- Figure 12: Choice of Providers by TK Members with EU Cross-Border Treatments
- Figure 13: Coverage of Costs for EU Cross-Border Treatments
- Figure 14: Need for After-Treatment in the Case of EU Cross-Border Treatments
- Figure 15: Did the Foreign EU Doctor have Access to the Patient's Records in Germany?  
Are the Costs to be Paid so High as to be a Reason for Avoiding EU Cross-Border Treatments?
- Figure 16: Are You Familiar with the European Health Insurance Card (EHIC)?  
Have You Tried to Use the EHIC?
- Figure 17: Are You Aware that You are Entitled to Have the Costs of Outpatient Treatment in EU Cross-Border Care Reimbursed?
- Figure 18: What is Your Assessment of the Effects of the Emerging EU Healthcare Market and the Trend Towards Healthcare Tourism?
- Figure 19: Have You Heard About the Planned EU Directive on Patients' Rights?
- Figure 20: How Do You Feel About a European Legal Framework which would Strengthen Patients' Rights and Safety in EU Cross-Border Care?

# 1 Objective, Summary of Results, Data Basis and Methodology

## Introduction

Increasing patient mobility and the emergence of the European healthcare market are leading to increased use of cross-border EU treatment. In addition to acute and emergency cases, which occur on holiday or during business trips, there is a growing group of patients who increasingly undertake research into their options of being treated in other EU countries in a targeted manner and make use of this option.

TK members who are treated on an unplanned basis are a relatively heterogeneous group of patients. In contrast to this, TK members receiving planned treatment in other EU countries can be identified by specific socio-demographic characteristics, diseases, types of treatment and motives.

## Summary of the Results

Compared to the demand for unplanned treatment, demand for planned cross-border treatments comes from a different group of TK members, requiring different advice and timescales. Because of the element of chance involved in acute or emergency treatment, a vast range of TK members are affected here, whose need for advice occurs very rapidly and is very short-term. In contrast to this, TK members receiving planned treatment require more detailed advice over a longer period before availing themselves of cross-border care options. Despite this, the majority still choose their service providers on the basis of recommendations from friends with experience of these services, from their tour guide or from the hotel as well as from their own Internet research. In this regard, there is a demand for TK to provide its members with more support.

TK members who have consciously opted for treatment in another European country instead of treatment in the German healthcare system share certain socio-demographic characteristic values: the majority fall within the over-60s TK member group (79 per cent), they are largely pensioners (79 per cent), on lower incomes, who are aiming to combine holiday and treatment (45 per cent) and/or save money on the costs which they have to bear themselves (33 per cent) and on co-payments (24 per

cent). This supports the theory that senior members are already the dominant, trendsetting target group with the greatest patient mobility in the consumption of cross-border treatment on the European healthcare market.

The fact that illnesses of the musculoskeletal system and cardiovascular system occur most frequently and remedies (55 per cent) and spa treatments (37 per cent) are, accordingly, most in demand, fits this picture. A further theory which bears out the results is the fact that the use of planned treatment in other EU countries is greater among those in the former West (65–84 per cent) than in the former East Germany (33–48 per cent). The reasons for this could be the geographical proximity to the traditional Eastern European spas and the historical link between the former GDR and Eastern-bloc countries. Further analyses have shown that a higher than average number of TK members from the former East Germany travel to the Czech Republic (29–40 per cent) and Poland (31–45 per cent) in order to receive medical treatment. By contrast, the use of such treatment by TK members from the former West Germany in the Czech Republic (11–25 per cent) and Poland (0–18 per cent) is much lower. The demand for receiving medical treatment in Hungary, however, is comparable in the former West Germany (8–22 per cent) and the former East Germany (7–17 per cent). In this respect, an examination would have to be carried out to see whether this could be due to attractive offers for dental cross-border treatment that exist throughout Germany.

## Objective

The aim of the TK Europe Survey 2009 was to obtain findings regarding the characteristics and needs of those TK members (not TK insurants, i.e. excluding dependent family insurants) who had received planned medical treatment in another EU country in 2008. These new findings are to be used to specifically enhance TK's range of services, advice and care options for this specific group of members. The results reflect the particular features of TK members and no claim is therefore made to have generated a generally representative study. The results are presented in a mainly descriptive manner. Those results which are not shown in the graphics selected here are also described.

## Data Basis and Methodology

The start of the written survey project was January 2009. Those persons selected were all TK members not resident abroad and over the age of eighteen at the qualifying date and who had received treatment in another EU country on at least one occasion in 2008, whether this was outpatient spa treatment, hospital treatment, treatment in a clinic which has a contract with TK (TK Europe Service) or another kind of treat-

ment in another EU country, the costs of which were settled either with the European Health Insurance Card (EHIC) or reimbursed.

In the survey, account was taken of all cases of treatment abroad – both planned and unplanned – in all countries where the social security agreement as a result of EEC Regulation 1408/71 applies. This covers all member states of the EU, the European Economic Area (EEA) and Switzerland. Iceland, Liechtenstein and Norway were also included as a result of the EEA's agreement with the member states of the European Free Trade Association (EFTA). The survey therefore included all cases of treatment in all European countries where the European Health Insurance Card (EHIC) – which replaced the E111 form in 2004 – is valid. For convenience, these are grouped together under the term „EU countries“.

Accordingly, in May 47,038 questionnaires, each containing 42 questions, were sent out by post. Members had eight weeks to complete the form based on their experiences. By the end of June, 16,446 questionnaires had been returned to the TK. This corresponds to a response rate of 35 per cent which, based on TK's experience of member surveys reflects the clear interest members have in receiving treatment abroad. Once the dataset was recorded and its quality adjusted, 15,540 questionnaires remained which related to 30,000 cases of treatment and which were analysed for this results brochure.

The questionnaires returned were examined to assess how representative they were of the basic population of TK members contacted.

Measured in terms of the most important characteristics, the forms returned were indeed found to be representative. The results were then presented to an expert panel – comprising Prof. Dr med. Reinhard Busse, MPH FFPH, Healthcare Management, Technische Universität Berlin; Jeni Bremner, Director of the European Health Management Association (EHMA), Brussels, which assessed them with regard to their impact.

### Use in EU countries

Table 1 shows the demand among TK members for treatment in other EU countries, broken down by country. Generally speaking, and irrespective of whether planned or unplanned, most TK members were in Austria, Spain, Italy, the Czech Republic and Poland when receiving their treatment abroad. This is not surprising as the countries in question are both popular holiday destinations and neighbouring countries, partly with attractive cost structures. There are also TK members who have received treatment several times in other EU countries. If the number of treatments is considered instead of the number of members, the ranking order is different. Most treatments in other EU countries were received in the Czech Republic, Poland, Austria, Spain and Italy, with the focus being on Eastern European countries.

## Total Utilisation of Cross-Border Care by EU Country (Members and Treatments)

| EU Member State | TK Members    | %           | Treatments    | %          |
|-----------------|---------------|-------------|---------------|------------|
| Austria         | 3,013         | 19          | 3,711         | 12         |
| Spain           | 2,795         | 18          | 3,577         | 12         |
| Italy           | 1,724         | 11          | 2,420         | 8          |
| Czech Republic  | 1,662         | 11          | 5,467         | 18         |
| Poland          | 1,438         | 9           | 4,512         | 15         |
| Switzerland     | 980           | 6           | 1,200         | 4          |
| France          | 906           | 6           | 1,134         | 4          |
| Hungary         | 874           | 6           | 2,522         | 8          |
| Other Countries | 3,020         | 19          | 5,341         | 18         |
| <b>Total</b>    | <b>15,540</b> | <b>106*</b> | <b>29,884</b> | <b>100</b> |

\* Multiple Responses

Table 1

## Total Utilisation of EU Cross-Border Care by Federal States (Members)

| Federal States           | TK Member with Treatment | %          | TK Member (2008) | %          |
|--------------------------|--------------------------|------------|------------------|------------|
| North Rhine-Westphalia   | 3,652                    | 24         | 1,092,199        | 26         |
| Baden-Württemberg        | 1,832                    | 12         | 501,294          | 12         |
| Bavaria                  | 1,764                    | 12         | 503,536          | 12         |
| Hesse                    | 1,313                    | 9          | 388,522          | 9          |
| Berlin                   | 1,286                    | 8          | 310,234          | 7          |
| Lower Saxony             | 1,161                    | 8          | 411,712          | 10         |
| Saxony                   | 1,000                    | 7          | 126,653          | 3          |
| Rhineland Palatinate     | 578                      | 4          | 199,490          | 5          |
| Hamburg                  | 523                      | 3          | 157,810          | 4          |
| Schleswig Holstein       | 501                      | 3          | 179,853          | 4          |
| Brandenburg              | 491                      | 3          | 113,580          | 3          |
| Saxony Anhalt            | 349                      | 2          | 76,497           | 2          |
| Thuringia                | 270                      | 2          | 70,381           | 2          |
| Mecklenburg-Western Pom. | 213                      | 1          | 65,502           | 2          |
| Saarland                 | 148                      | 1          | 48,126           | 1          |
| Bremen                   | 108                      | 1          | 35,465           | 1          |
| <b>Total</b>             | <b>15,189</b>            | <b>100</b> | <b>4,280,854</b> | <b>100</b> |

Table 2

### Use Broken Down by Federal States

As shown in table 2, within the population, most TK members who received treatment in other EU countries live in North Rhine-Westphalia (24 per cent), Baden-Württemberg and Bavaria (12 per cent each). This is due to the fact that these are the three most heavily populated states and at the same time the states with the highest number of TK members. The

rest of the ranking in terms of use of treatment broken down by federal state also reflects this context. Furthermore, the three federal states where the highest use of cross-border treatment is recorded are also those federal states with regions bordering the Netherlands, Belgium, Luxembourg, France, Switzerland and Austria. This supports the theory that the geographical proximity of federal states to other EU countries leads to a higher use of treatment in other EU countries.

## Planned and Unplanned EU Cross-Border Treatments by Federal States (Cases)

| Federal States            | Elective Treatments | %  | Acute and Emergency Treatments | %  |
|---------------------------|---------------------|----|--------------------------------|----|
| <b>Old Länder</b>         |                     |    |                                |    |
| Berlin                    | 2,705               | 73 | 1,013                          | 27 |
| Schleswig Holstein        | 440                 | 48 | 479                            | 52 |
| Baden-Württemberg         | 1,373               | 47 | 1,557                          | 53 |
| Bremen                    | 74                  | 46 | 87                             | 54 |
| Lower Saxony              | 755                 | 42 | 1,027                          | 58 |
| Northrhine-Westphalia     | 2,489               | 42 | 3,429                          | 58 |
| Bavaria                   | 1,095               | 39 | 1,718                          | 61 |
| Hesse                     | 735                 | 37 | 1,235                          | 63 |
| Rhineland-Palatinate      | 272                 | 36 | 494                            | 64 |
| Saarland                  | 70                  | 36 | 124                            | 64 |
| Hamburg                   | 234                 | 33 | 474                            | 67 |
| <b>New Länder</b>         |                     |    |                                |    |
| Saxony                    | 2,890               | 84 | 536                            | 16 |
| Saxony-Anhalt             | 1,301               | 81 | 315                            | 19 |
| Brandenburg               | 1,016               | 77 | 299                            | 23 |
| Mecklenburg-Western Pomm. | 388                 | 77 | 118                            | 23 |
| Thuringia                 | 399                 | 65 | 215                            | 35 |

Table 3

A comparison of planned and unplanned cases of treatment, broken down by federal states, quite clearly shows that there is a greater demand for planned treatment in other EU countries in the former East Germany. As illustrated in table 3, the percentages here vary between 65 per cent (Thuringia) and 84 per cent (Saxony) depending on the federal state. In contrast, the proportion of planned

treatment in other EU countries is much lower in the former West Germany, at between 33 per cent (Hamburg) and 48 per cent (Schleswig Holstein). An exception, though, is Berlin with 73 per cent, certainly also as a consequence of the geographic location.

## 2 Comparison of Planned and Unplanned Treatment in Another EU Country

### 2.1 Characteristics of the Typical German Patient in Another EU Country

#### 2.1.1 Patients Receiving Planned and Unplanned Treatment

Cross-border care has changed in recent years. In 2003, for example, planned treatment and health tourism had not yet begun to play a role: in a TK survey of a sample of 2,100 members, fewer than 7 percent indicated that they had received planned treatment in another EU country. Initially, cross-border treatment tended to be unplanned medical treatment, i.e. acute and emergency treatment which became necessary by chance during a holiday or business trip. Now, a European market for planned medical treatment has developed, and is also being used increasingly by TK members.

The European Health Insurance Card (EHIC) entitles insured persons to acute and emergency treatment under the statutory health insurance system in the countries mentioned, but not to planned treatment. Where acute and emergency treatment is required (e.g. on holiday, on a business trip, when having been sent abroad to work), the costs of treatment are settled by the EHIC. Where

the insured undergoes a planned course of treatment in the same countries, he pays a private invoice. The costs are then reviewed by the responsible German health insurance fund and generally reimbursed to the amount which would have been incurred for corresponding treatment in Germany.

Among the 15,540 TK members whose questionnaires were analysed, some underwent both planned and unplanned treatment in the course of the year. In this slightly differentiating consideration, a TK member who, for example had undergone one planned and one unplanned treatment, was considered once in each case. Due to this the data basis overall amounted to 17,285 TK members receiving planned and/or unplanned treatment. Of these, more than two-thirds had to receive treatment in other EU countries due to acute and emergency cases; 40 percent opted quite consciously to receive treatment in another EU country, enquired about these options and planned treatment in another EU country in advance.

An analysis of the number of cases instead of the number of TK members results in a much larger basic population, since there are members who have caused several cases of treatments. Of these 29,884 cases of treatments more than half (16,476) were planned and only still 45 per cent were unplanned. These results show that in EU cross-border care by now selective treatments play a more important role than acute and emergency treatments. The typical TK member travels predominantly to other European countries in order to receive planned treatments.

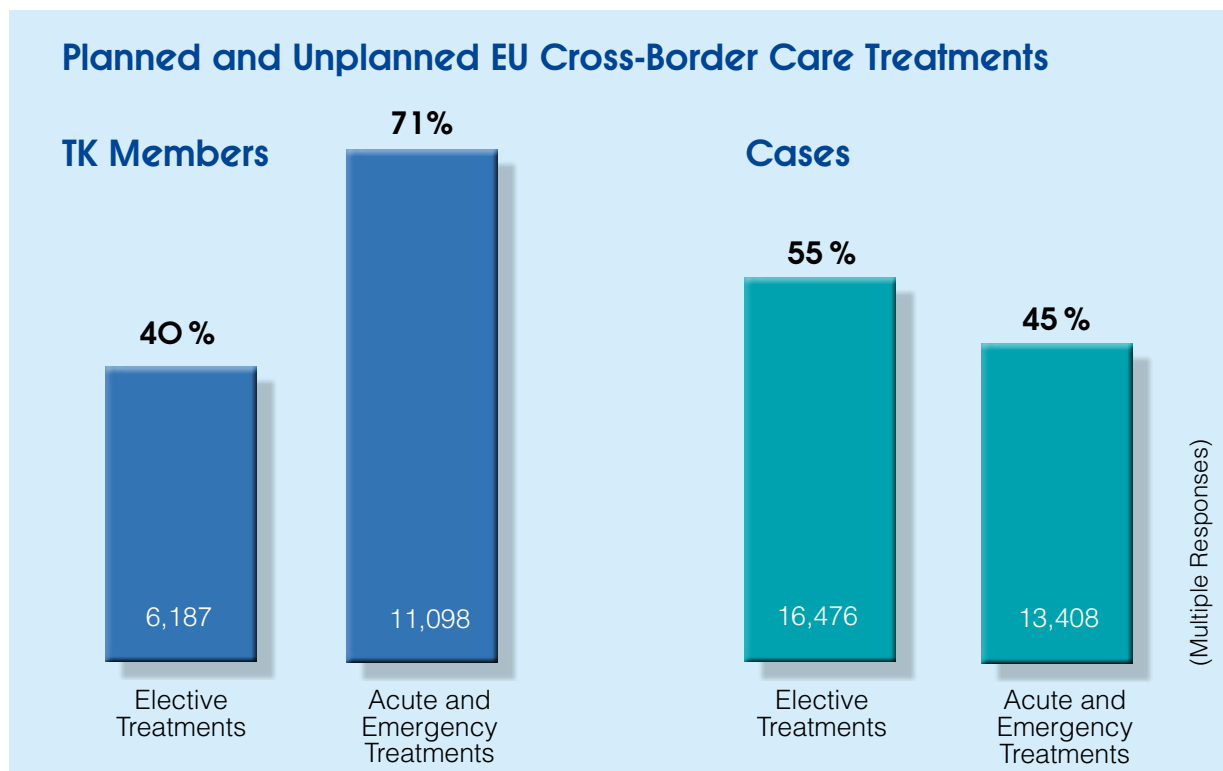


Figure 1

## TK Members with EU Cross-Border Treatments by Age

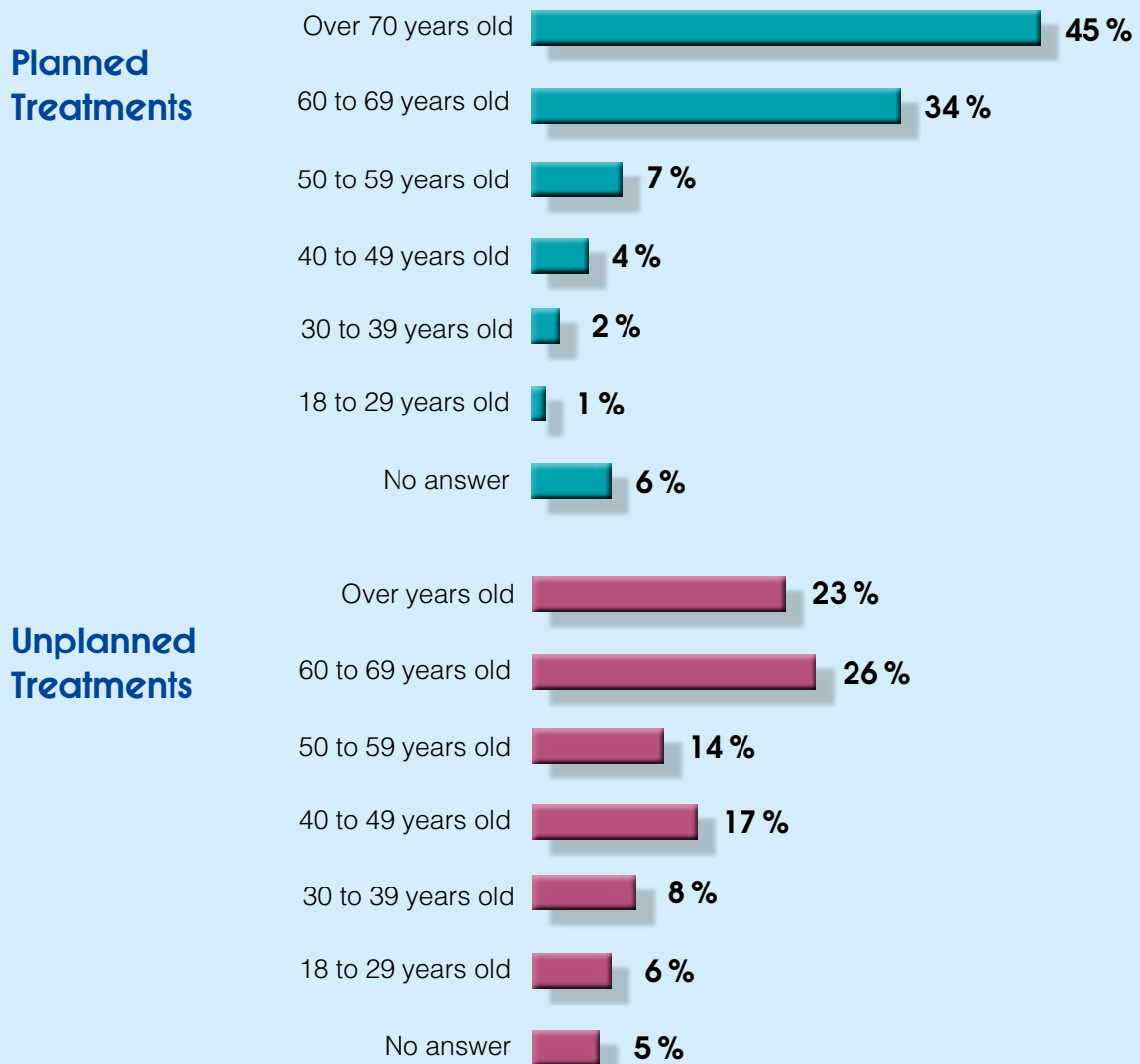


Figure 2

### 2.1.2 The Most Important Socio-Demographic Factors

#### Age and Gender

An examination of the age structure of those TK members responding to the survey reveals that it is mainly those TK members aged over 60 who deliberately choose to be treated in other EU countries. 34 per cent of respondents were in the 60–69 year age group, while the over 70-age group accounted for as many as 45 per cent of the respondents. Overall, these two groups make up almost 80 per cent of TK members using treatment in another EU country. Younger age groups are only weakly represented which is also undoubtedly due to the fact that they are healthier on average and therefore require treatment less, but also have less time.

A comparison of these age groups with the age structure of TK members on the whole reveals that the 60–69 year age group and senior members aged 70 and over constitute much smaller proportions of the total number of TK members, at 14 and 10 per cent respectively. The high degree to which planned treatment in other EU countries is used is not therefore based on the high number of TK members who are aged 60 and over. This is a particular feature of cross-border care which is not representative of the TK membership structure on the whole.

An examination of the characteristic „Gender“ has shown that there are slightly more male (52 per cent) than female (42 per cent) members who receive planned treatment in other EU countries.

### TK Members by Age

| Age          | Members*         | %          |
|--------------|------------------|------------|
| 0 – 19       | 70,879           | 2          |
| 20 – 29      | 633,384          | 15         |
| 30 – 39      | 705,622          | 17         |
| 40 – 49      | 1,077,923        | 25         |
| 50 – 59      | 742,614          | 17         |
| 60 – 69      | 613,773          | 14         |
| 70 –         | 439,894          | 10         |
| <b>Total</b> | <b>4,284,089</b> | <b>100</b> |

\*TK Members 2008.

### Occupation and Gross Monthly Income

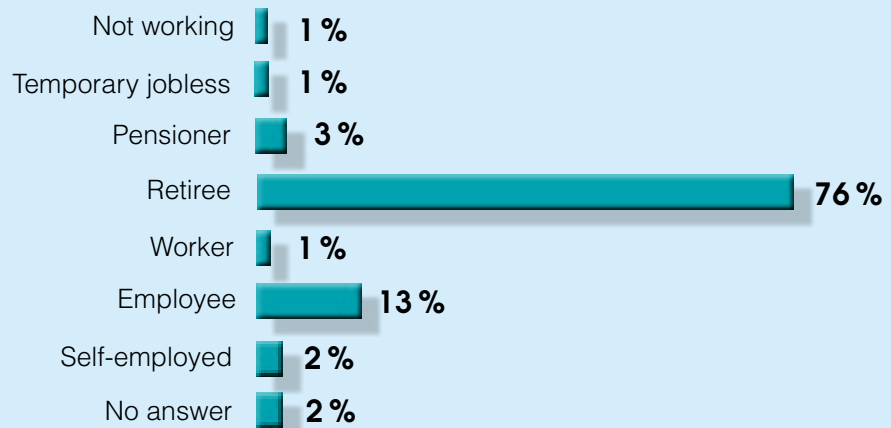
According to the results on the age structure of TK members who have received planned treatment in another EU country most frequently, 76 per cent are standard pensioners and 3 per cent are retired civil servants. A further 13 per cent are employees.

In a further examination of the four EU countries where the degree to which planned treatment is used is the highest, pensioners were represented to a disproportionately strong degree: in the Czech Republic, the proportion was 86 per cent, in Hungary 84 per cent, in Poland 82 per cent and in Italy 77 per cent.

Table 4

### TK Members with EU Cross-Border Treatments by Profession

#### Planned Treatments



#### Unplanned Treatments

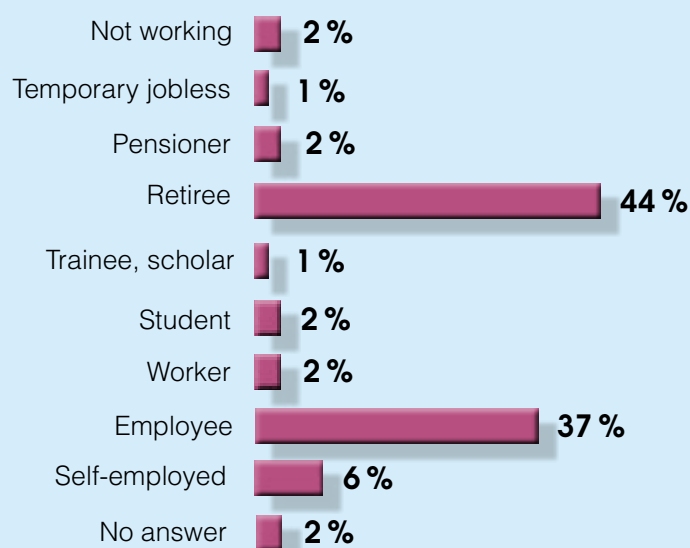
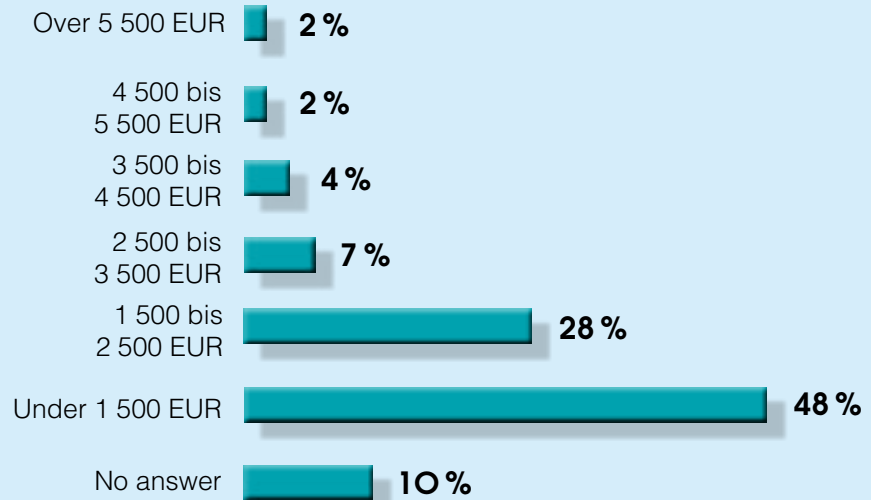


Figure 3

## TK Members with EU Cross-Border Treatments by Monthly Gross Income

### Planned Treatments



### Unplanned Treatments

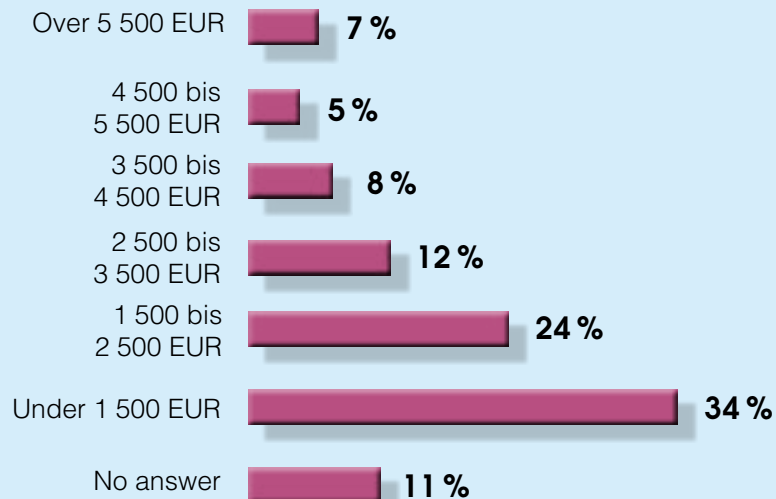


Figure 4

An examination of gross monthly income shows that it is mainly TK members on a lower income who travel to other EU countries to receive planned treatment.

Almost half have a monthly income of less than EUR 1,500, while a further third have a monthly income of between EUR 1,500 and EUR 2,500. This is also certainly due to the fact that higher incomes (2006: high income levels 9.5 per cent of the German population) are generally rarer than lower incomes (lower to medium income levels: 25 per cent of the German population). On the other hand, it can also be assumed that planned treatment in other EU countries

is chosen by pensioners receiving small pensions (old-age pension in 2008: EUR 970 for men in the former West Germany and EUR 999 in the former East Germany; respectively EUR 485 and EUR 811 for women) in order to save costs. This theory is confirmed by the high proportion of those TK members stating cost savings as a reason for receiving planned treatment in another EU country.

The ratio is somewhat more balanced among TK members receiving unplanned treatment in other EU countries: 44 per cent are pensioners and 37 per cent are employees.

## State of Health

The state of health is „satisfactory“ in 46 per cent of TK members receiving planned treatment and „less good“ in 21 per cent of members. 23 per cent of TK members gave their state of health as being „good“. The low proportion of 3 per cent shows that very little treatment in other EU countries is planned if the state of health is bad.

However, members with chronic illnesses go abroad more often to receive treatment than healthy members: two-thirds responded „yes“ to the question of whether they had a chronic illness, and only one-third responded „no“.

These results also reflect the presence of senior members among those persons receiving planned treat-

ment in other EU countries, since the likelihood of being chronically ill or not being in a state of health which ranges from good to very good increases with age.

Cases of unplanned treatment in other EU countries reveal a different picture: here the focus was more on TK members with a better state of health. 40 per cent described their state of health as being „good“ and 12 per cent described it as being „very good“. This is natural since emergency and acute cases such as accidents and injuries occur irrespective of the state of health. This result is also confirmed in the answers received to the question on chronic illnesses: more than half of TK members receiving unplanned treatment stated that they were not chronically ill.

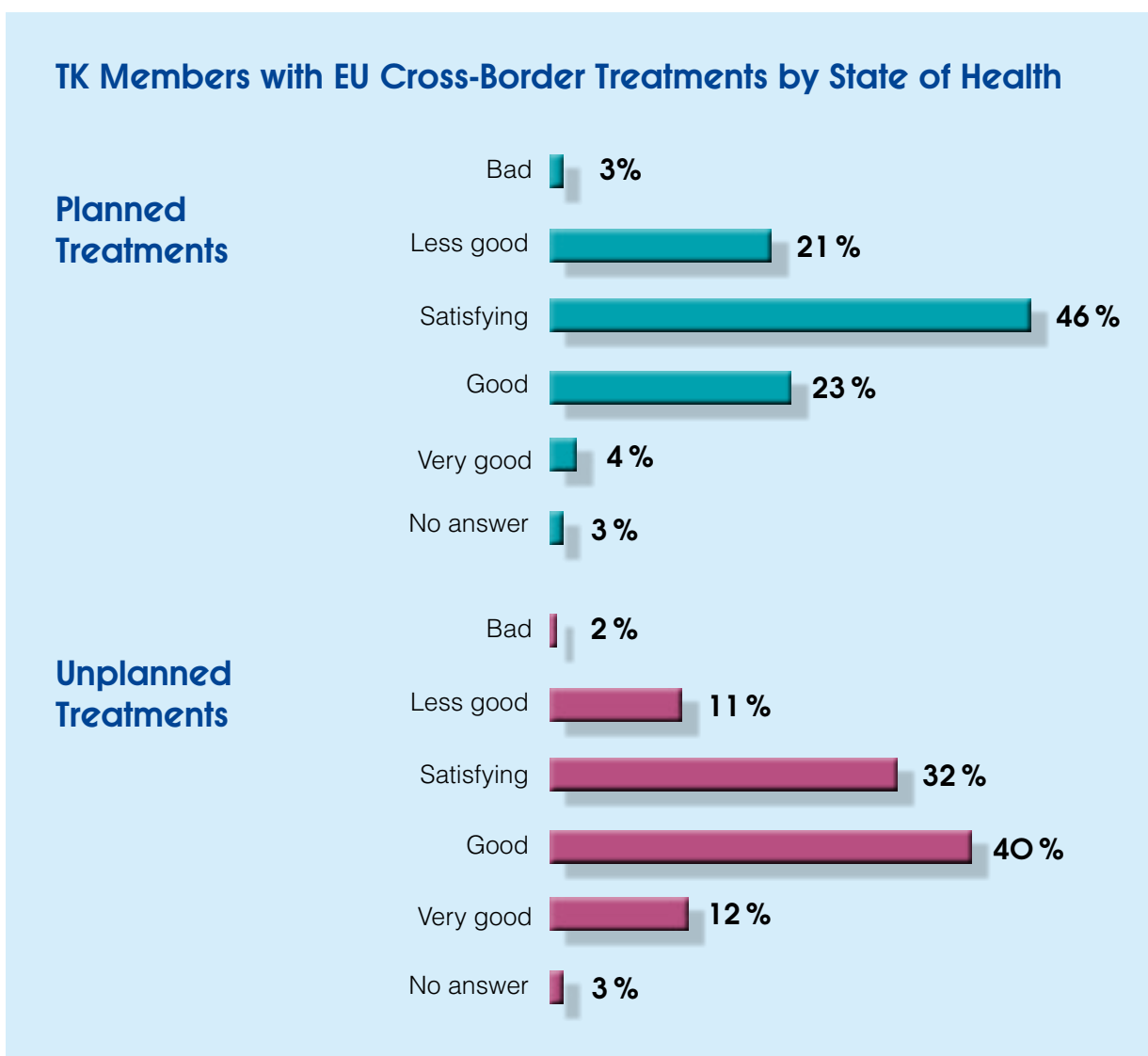


Figure 5

## TK Members with EU Cross-Border Treatments by Insurant Status

### Planned Treatments

### Unplanned Treatments

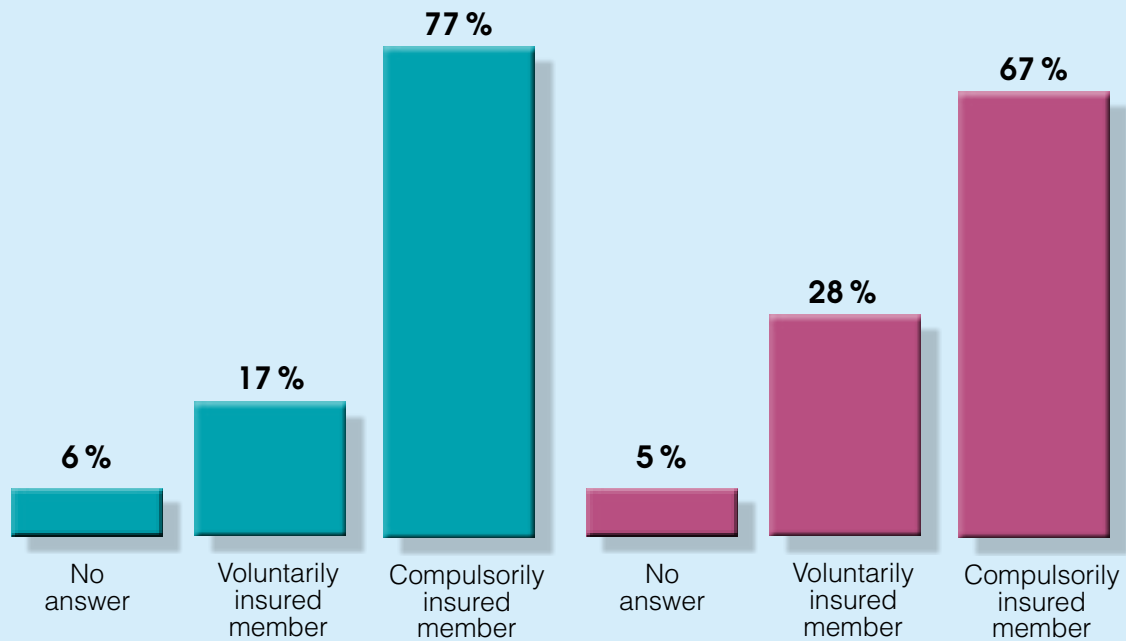


Figure 6

### Insurant Status

In line with the results regarding income distribution, in terms of insurant status too, it is clear that TK members receiving planned treatment in other EU countries are those whose income tends to be lower: 77 per cent are compulsorily insured TK members and just 17 per cent are voluntarily insured members. Only the latter have income levels which exceed the limit for which insurance is compulsory. This result is also consistent with the finding that the TK members receiving treat-

ment in other EU countries are mainly pensioners since these, generally speaking, are subject to compulsory insurance.

The chance nature of acute and emergency cases of treatment mean that the distribution between those members with compulsory insurance and those with voluntary insurance is more even among TK members who had to receive unplanned treatment in other EU countries: even though more than two-thirds are compulsorily insured, almost one-third remains insured on a voluntary basis.

## TK Members with EU Cross-Border Treatments by Illness

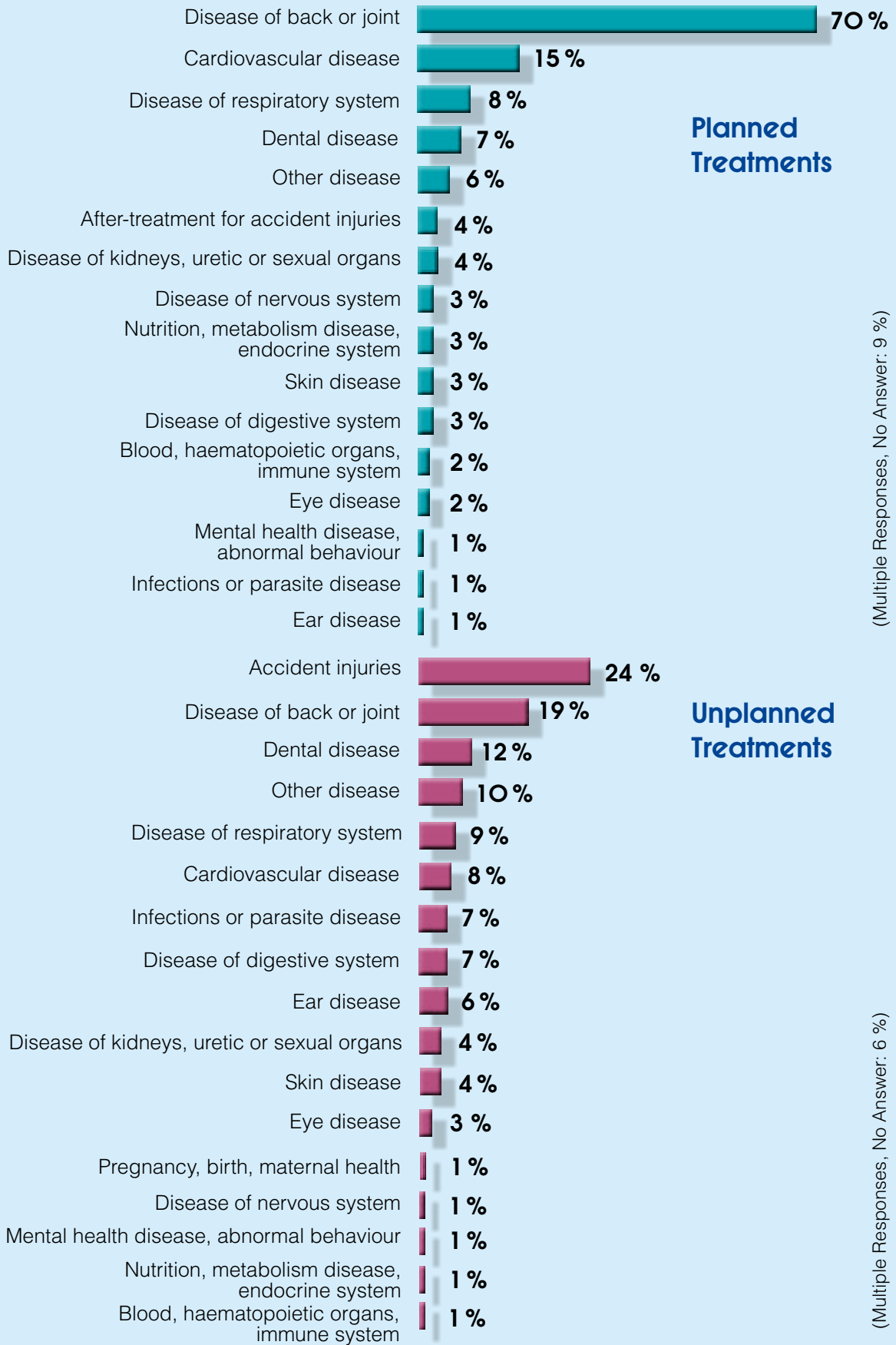


Figure 7

### 2.1.3 The Most Frequent Underlying Illnesses

An examination was also carried out into the illnesses for which planned treatment in other EU countries was received: more than two-thirds of TK members receiving planned treatment in other EU countries suffered from illnesses of the back or joint. 15 per cent had an illness of the cardiovascular system and a further 8 per cent had an illness of the respiratory system. These three most common illnesses would suggest that the proportion of spa treatments among the types of treatment is correspondingly high. This theory is confirmed in section 2.2.1.

Illnesses of the musculoskeletal system (joint, disc, bone and back problems), cardiovascular illnesses as well as pulmonary illnesses are, at the same time, widespread illnesses among more elderly groups. These results reflect the higher proportion of senior members receiving planned treatment in other EU countries.

A further 7 per cent reported dental illnesses. This

confirms to a moderate degree the trend towards dental tourism. All other illness patterns played a somewhat less important role.

As expected, the variety of illness types among TK members who had to receive unplanned treatment in other EU countries is much greater. At just under 25 per cent, accident-related injuries (e.g. open wounds, burns, broken bones and cases of poisoning) head the list, followed by 19 per cent back or joint illnesses. Dental illnesses, respiratory and cardiovascular illnesses, typical illnesses arising while on holiday (e.g. infectious or parasitic illnesses), as well as illnesses of the digestive system or the ears, were each represented at between 6 and 12 per cent respectively.

### 2.1.4 The Most Popular EU Countries

Among the TK members who have received planned treatment in other EU countries, Eastern European destinations are the most popular: almost a quarter of these members went to the Czech Republic, a fifth went to

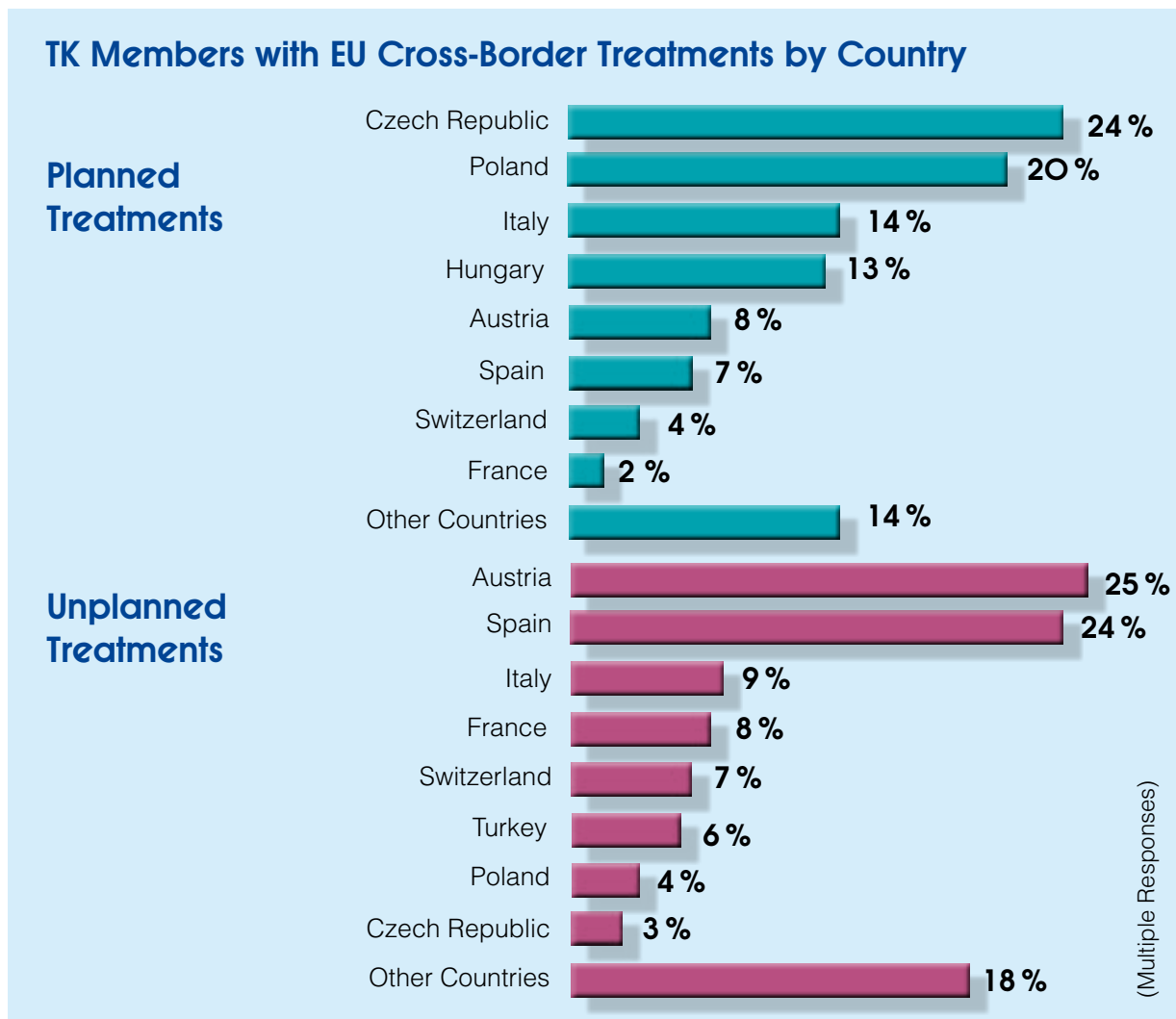


Figure 8

Poland, 14 per cent to Italy and a further 13 per cent went to Hungary. The Czech Republic, Poland and Hungary are, primarily, countries which are attractive as a result not only of the potential cost savings that treatment here can provide, but also because of the old historical association in the form of the German tradition of spa treatments in Eastern Europe. Further analyses broken down by federal states have shown that this relates in particular to TK members from the former East Germany; certainly also as a relic of the close relations with neighbouring Eastern European countries during GDR times.

The Eastern European focus becomes even clearer if the number of cases of treatment are considered, as in a further analysis, and not the TK members. In this respect, Hungary is in third, not fourth position. The percentage figures with regard to the degree of use are even higher: 29 per cent of planned treatment in other EU countries took place in the Czech Republic (4,819 cases of treatment), 23 per cent in Poland (3,756 cases of treatment) and 13 per cent in Hungary (2,219 cases of treatment).

In addition to Italy, Austria (8 per cent) and Spain (7 per cent) are popular holiday destinations for Germans, for whom the motive of combining holiday and treatment will certainly have played a greater role than cost savings.

A different picture emerges among TK members who received unplanned treatment in other EU countries. The countries in question here are exclusively the most popular holiday destinations among the German people, which are also almost all of its neighbouring countries: 25 per cent of members travelled to Austria and Spain, followed by Italy (9 per cent), France (8 per cent), Switzerland (7 per cent) and Turkey (6 per cent). The analysis of treatment cases did not lead to noticeable differences to these results.

## 2.2 Characterisation of the Use of Planned and Unplanned Treatment in Another EU Country

### 2.2.1. Demand, Broken Down by Types of Treatment

At 55 per cent, remedies are the most popular form of treatment among TK members receiving planned treatment in other EU countries.

Remedies include, for example, massages, physiotherapy, chiropractic exercises, inhalations, baths as well as heat and cold applications. Part of the costs is covered by TK members who make a supplementary payment in the amount of 10 per cent of the costs plus 10 euro for each prescription, however no more than the actual costs incurred.

In the four separate countries where the degree to which planned treatment is used is the highest, the proportion of remedies was as much as higher than average: Czech Republic (67 per cent), Poland (65 per cent), Italy (68 per cent) and Hungary (73 per cent).

The second most frequent treatment (37 per cent) chosen by TK members receiving planned treatment in other EU countries was spa treatments. If, here too, the most popular countries are considered, the degree to which the treatment is used is once again shown to be above-average in Eastern European countries: Czech Republic (52 per cent), Poland (43 per cent), Italy (38 per cent) and Hungary (43 per cent).

The strong demand for remedies and spa treatments is also a result that matches the high proportion of senior TK members receiving planned treatment in other EU countries.

General practitioners (22 per cent) and specialists (14 per cent) were also specifically sought by TK members on a very regular basis in other EU countries. In terms of demand, medicines are in fifth place with 11 per cent, followed by dental treatment with 8 per cent.

Further analyses show that medicines were specifically bought in the Czech Republic (11 per cent), Poland (7 per cent), Italy (6 per cent) and in Hungary (10 per cent). Demand for dental treatment among TK members was strongest in Hungary (11 per cent).

## TK Members with EU Cross-Border Treatments by Type of Treatment

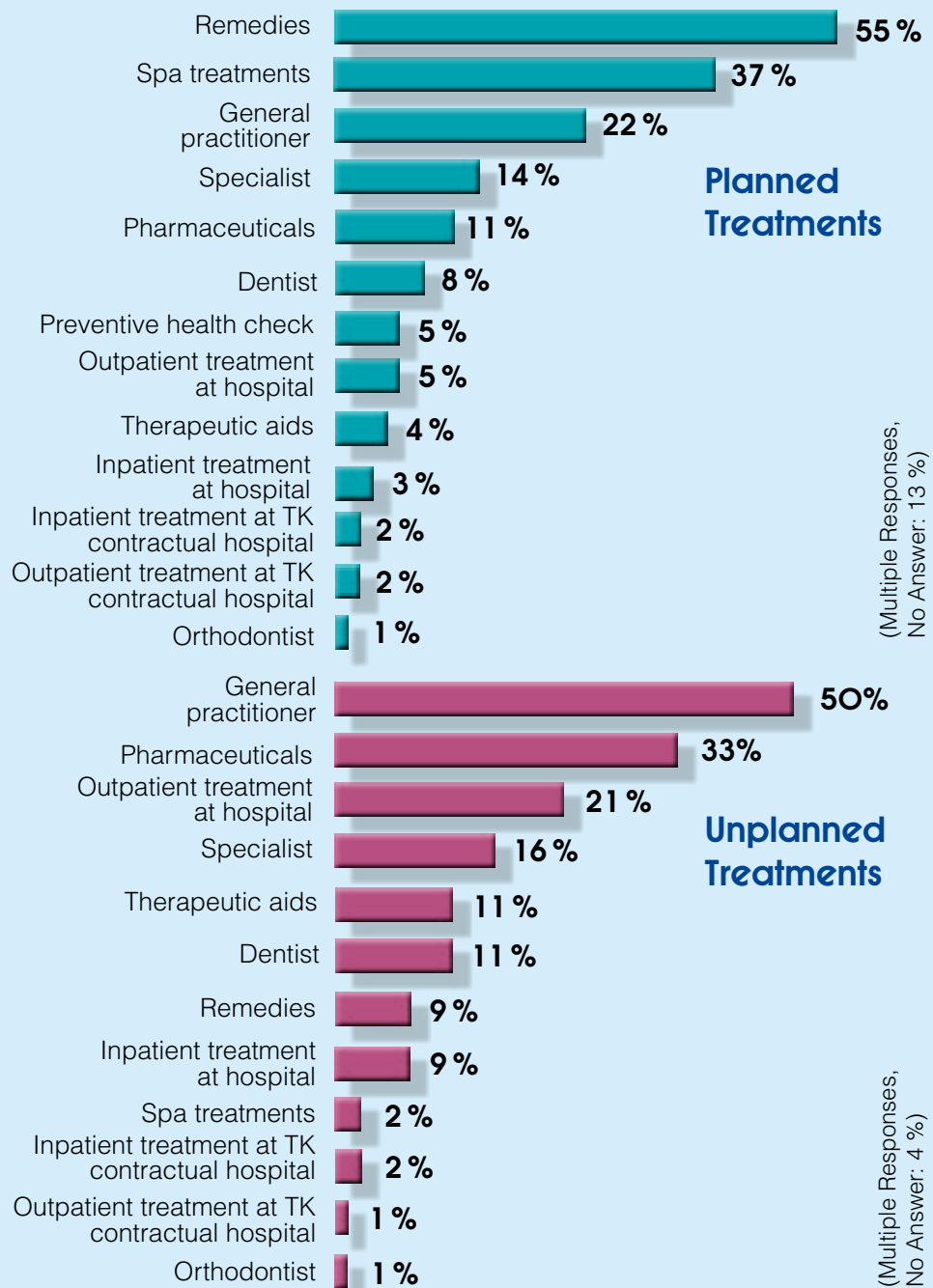


Figure 9

At 5 per cent, 7 per cent and 2 per cent respectively, the proportions of members seeking dental treatment in the Czech Republic, Poland and Italy were comparatively lower.

50 per cent of TK members who had to receive unplanned treatment in other EU countries most frequently sought a general medical practitioner. A further 33 per cent used medicine as part of their acute or emergency treatment and 11 per cent used

therapeutic appliances. The demand for treatment from specialists and dentists was 16 and 11 per cent greater respectively than cases where treatment was planned.

In contrast to planned treatment in other EU countries, in the case of acute and emergency cases in particular, outpatient treatment in hospital (21 per cent) and inpatient treatments in hospital (9 per cent) naturally played a much greater role.

## Reasons for TK Members for EU Cross-Border Treatments

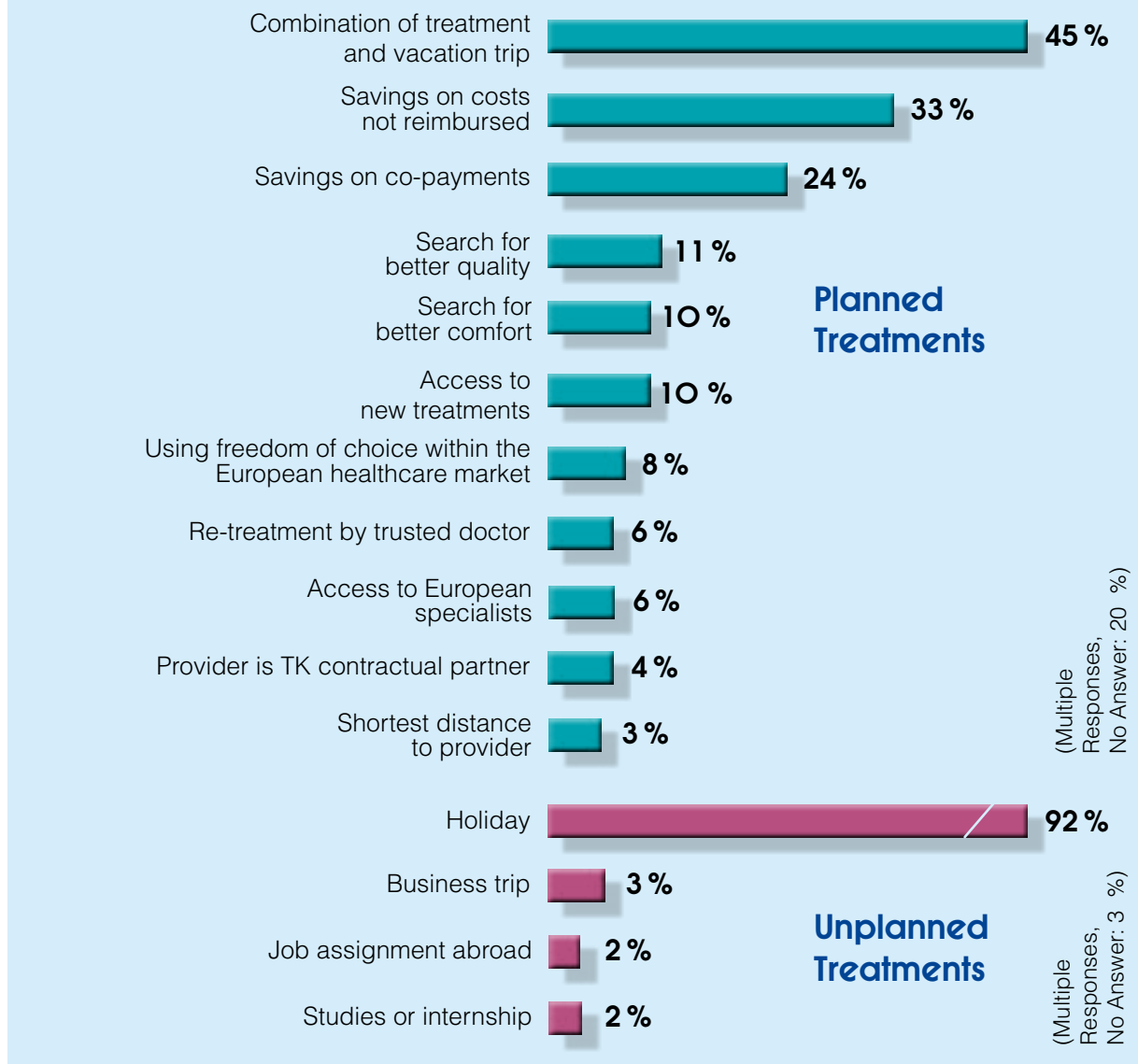


Figure 10

### 2.2.2. Reasons for Choosing Treatment in Another EU Country

At 45 per cent, the main reason given by TK members for receiving treatment in other EU countries is to combine treatment with a holiday. This result is a clear reflection of the fact that TK members are also part of the trend towards health tourism.

The second most important motivation is to save costs, whether it be for treatment which is not covered by statutory health insurance schemes (33 per cent) or for co-payments (24 per cent). This result explains the strong demand for spa treatments, remedies and dental treatments.

Included among other relevant reasons for planned treatment in other EU countries is the search for better quality (11 per cent) or a higher level of comfort (10 per cent) abroad due to negative experiences with the domestic system, the use of new treatment procedures (10 per cent) or the freedom to choose between the variety of European healthcare systems (8 per cent).

For almost all TK members who required an acute case of treatment or emergency treatment in other EU countries (92 per cent), this occurred while on holiday. Business stays or education-related stays only played a minor role.

For 59 per cent of TK members, the unplanned treatment in other EU countries was necessary due to a minor to semi-serious illness or a minor to semi-serious accident, while for 19 per cent the treatment was required due to a serious accident or emergency and, in the case of 14 per cent, due to a deterioration of a chronic illness.

### 2.2.3. Level of Satisfaction with Treatment in Another EU Country

Of the TK members who specifically received treatment, almost half were a little more or much more satisfied with the treatment in other EU countries than with that in Germany. A further 29 per cent were equally satisfied and only 4 per cent were a little to a lot more dissatisfied.

The subjective reasons given by TK members for the higher level of satisfaction with the treatment in other EU countries were primarily the absence of waiting times or shorter waiting times until receiving a treatment date.

At 47 per cent, a further key reason was the more friendly and more polite care provided by the staff; other relevant reasons also included the lower costs to be borne by the patient himself (41 per cent), a subjectively better quality of treatment (39 per cent), absence of waiting times or shorter waiting times in the

waiting room (36 per cent) and a longer, more personal course of treatment as a result of less time pressure on doctors (32 per cent). Among the 4 per cent of comparatively less satisfied TK members, the main reasons given were a subjectively poorer quality of treatment (43 per cent), less comfort, e.g. as a result of outdated technology and buildings (28 per cent), greater time pressure on doctors (20 per cent), unexpected costs to be borne by the patients themselves (16 per cent), a lack of serious preliminary information (15 per cent), no German or English-speaking contact person (15 per cent) and less friendly and less polite service provided by the staff (13 per cent).

Among the TK members who had to receive unplanned treatment in other EU countries, a majority of 52 per cent was just as satisfied with the treatment received in the other EU countries as in Germany and a further 32 per cent were a little to a lot more satisfied. The proportion of those who were less satisfied was with 13 per cent higher than among TK members who received planned treatment in other EU countries.

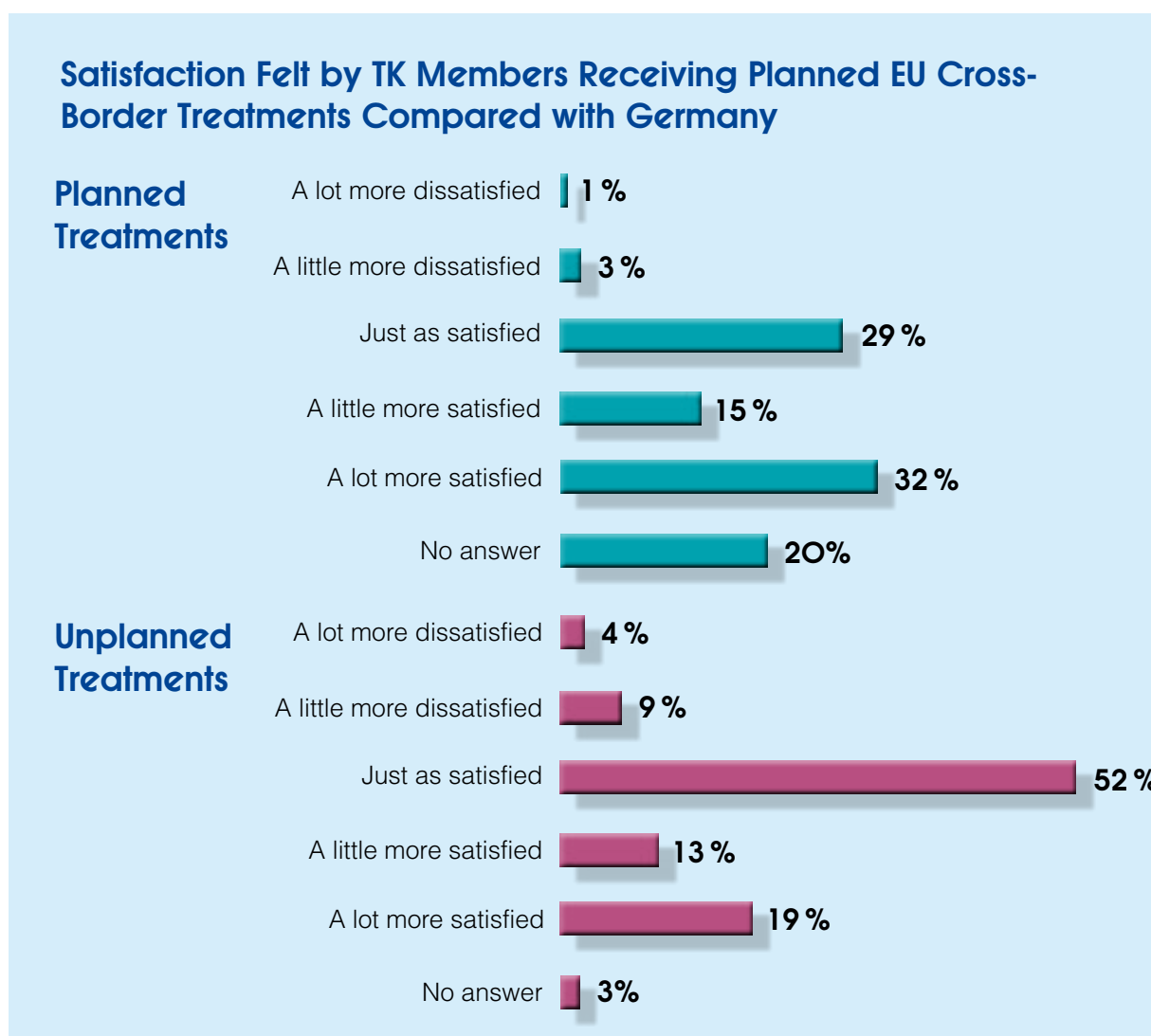


Figure 11

The five main subjective reasons given by more satisfied TK members were the absence of waiting times or shorter waiting times until receiving a treatment date (53 per cent), the longer, more personal treatment as a result of less time pressure on doctors (49 per cent), the absence of or shorter waiting times in the waiting room (48 per cent), the more friendly and polite service provided by staff (46 per cent) and the better quality of treatment (33 per cent). The six main reasons given by

TK members who were comparatively less satisfied when receiving unplanned treatment in other EU countries are as follows: a subjectively poorer quality of treatment (43 per cent), unexpected costs to be borne by the patients themselves (40 per cent), less comfort, e.g. as a result of outdated technology and buildings (31 per cent), no German or English-speaking contact person (25 per cent), longer waiting times in the waiting room (18 per cent) and a lack of serious preliminary information (17 per cent).

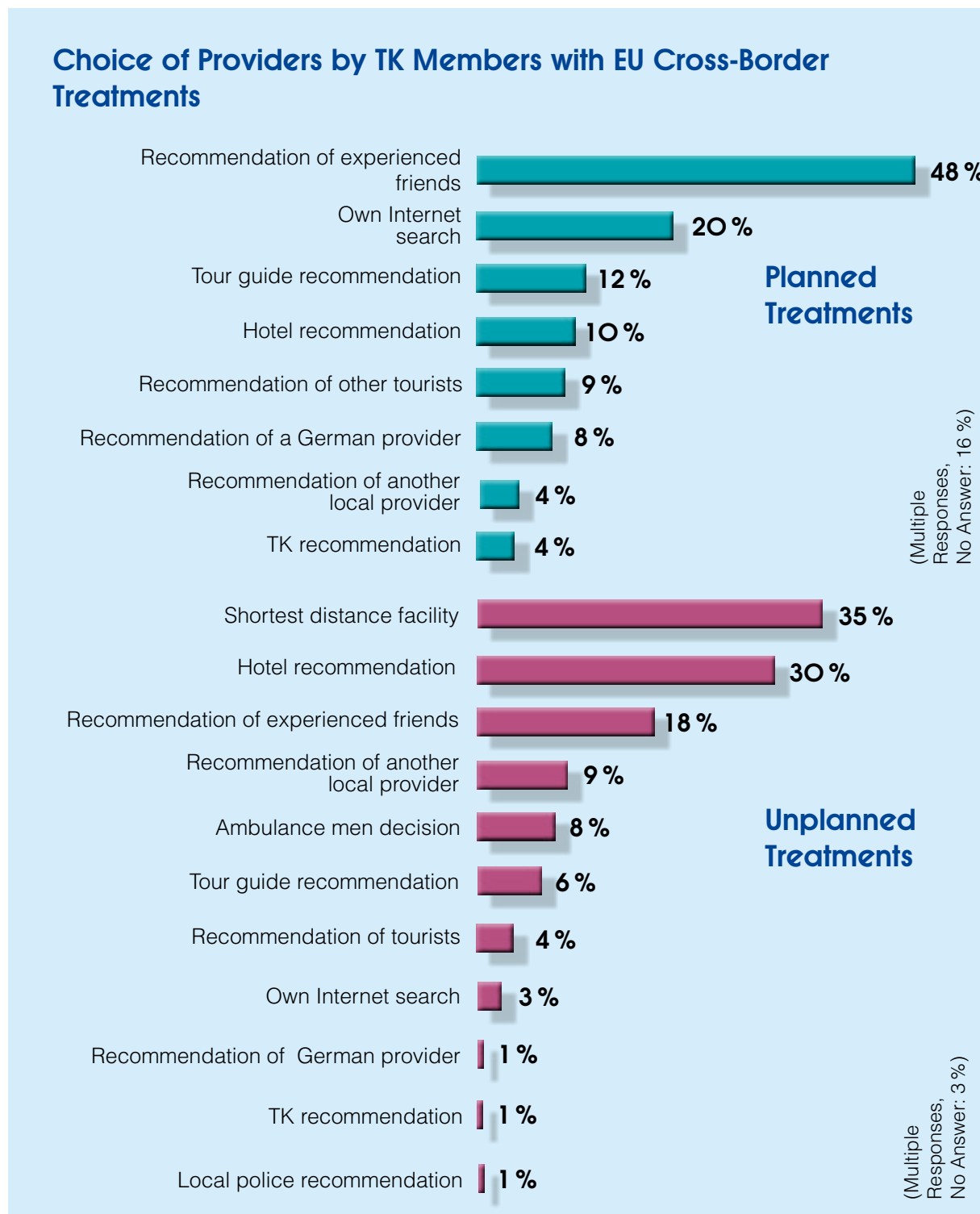


Figure 12

## 2.2.4 Method of Choosing the Service Provider

Almost half of the TK members who specifically travelled to a healthcare system in another EU country in order to receive medical treatment there did so on the basis of a recommendation from friends or acquaintances.

A further 20 per cent stated that they had carried out research themselves on the Internet, whereas 12 per cent went on a recommendation from the tour organiser, 10 per cent on a hotel recommendation and 9 per cent on the recommendation of other tourists.

Practice has also shown that, when selecting a service provider in other EU countries, there is still a

need for TK employees to advise TK members with their expertise.

In cases of acute and emergency treatment of TK members in other EU countries, 35 per cent selected the closest service provider, 30 per cent also consulted the hotel for their decision and 18 per cent consulted friends and acquaintances.

However, the recommendation of local doctors, medical staff or the tour guide (9 per cent, 8 per cent and 6 per cent respectively) also influenced the selection decisively. Here too, it is clear that the existing advice options from the TK are only used to an insufficient degree by TK members in the event of acute and emergency cases in other EU countries.

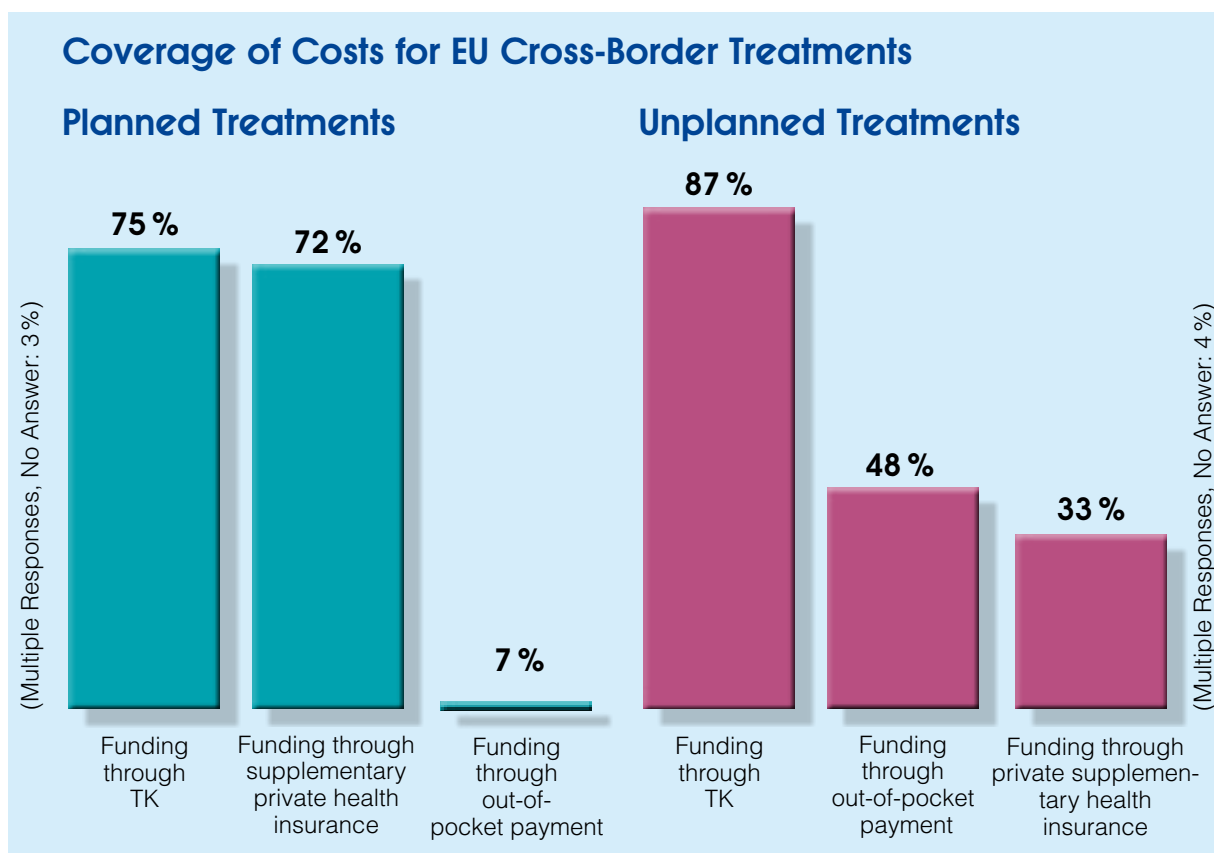


Figure 13

## 2.2.5 Sources of Finance for Treatment in Another EU Country

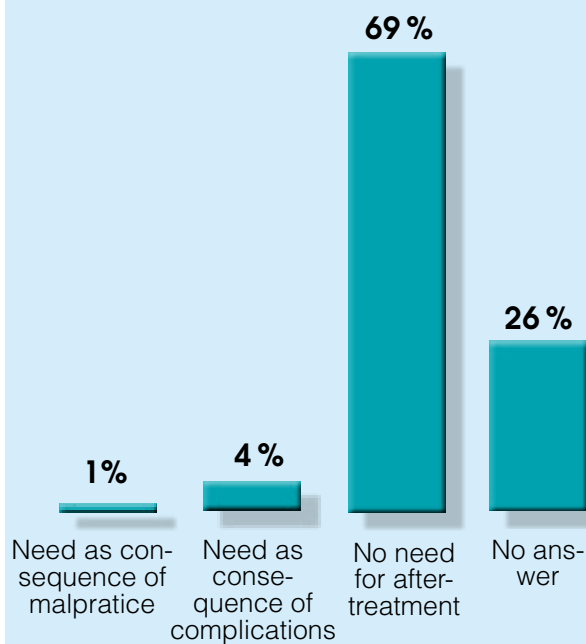
Among TK members who specifically travelled to other EU countries in order to receive medical treatment, 75 per cent stated that the costs were borne in full or in part by the TK and 72 per cent indicated that the supplementary private health insurance bore the costs in full or in part.

Only 7 per cent paid the costs in full or in part themselves.

At 48 per cent, the proportion of TK members who have borne the costs themselves in full or in part of unplanned treatment in other EU countries was significantly higher than in the case of planned treatment. This could be due to the fact that, in the event of cases of acute and emergency treatment, there is often no time available in advance or no need to clarify or discuss how the costs are to be covered, on a binding basis, prior to treatment. The majority of 87 per cent indicated that TK had reimbursed the costs in full or in part and 33 per cent indicated that these were borne by the supplementary additional private health insurance.

## Need for After-Treatment in the Case of EU Cross-Border Treatments

### Planned Treatments



### Unplanned Treatments

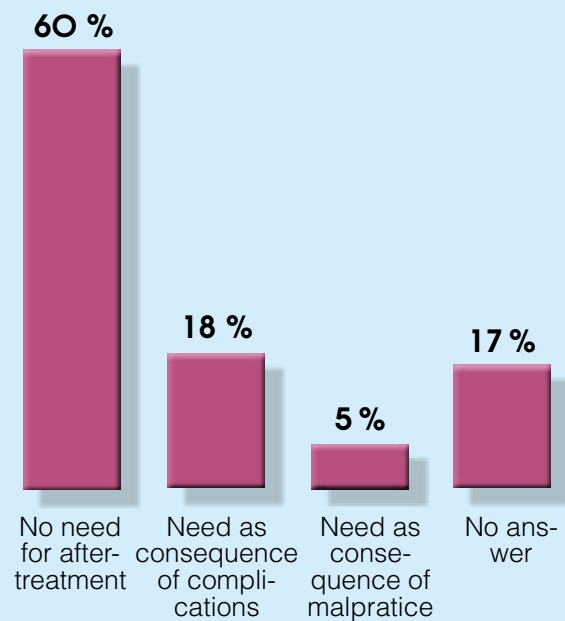


Figure 14

### 2.2.6 Need for and Location of After-Treatment

After-treatment was only required for a total of 5 per cent of TK members receiving planned treatment in other EU countries: in 4 per cent of cases this was due to complications and in 1 per cent due to medical malpractice.

76 per cent of these TK members indicated that the after-treatment was carried out in Germany and only 18 per cent stated that it was performed by a doctor abroad.

15 per cent returned to the doctor abroad who was responsible and 3 per cent visited a different doctor abroad.

A worse picture emerges among the TK members receiving unplanned acute and emergency treatment.

Here, at 23 per cent, after-treatment was required more than four times as frequently: in 18 per cent of cases this was due to complications and in a further 5 per cent due to medical practice.

The predominant majority of 93 per cent of these TK members then chose a German doctor to carry out the after-treatment, presumably as a result of these negative experiences or of greater proximity, since only 3 per cent were treated by the responsible doctor abroad and 1 per cent visited a different doctor abroad.

Claims for after-treatment as a result of cross-border treatment is not yet legally regulated. However, this is a matter of concern of the EU directive on patient rights for cross-border care. From the perspective of the TK, the aim should be to reduce the number of after-treatment cases which are required as a result of complications and medical malpractice.

# 3 Knowledge, Attitude and Experience of Patients

## 3.1 Exchange of Information between Service Providers and Reimbursement

In the European healthcare market, there is no regulation governing a structured process of exchange between domestic and foreign providers, not even electronically. Access to the information requires the organisational self-initiative of the patients and doctors, which does not always exist: over half of the TK members receiving treatment in other EU countries indicated that the foreign doctor did not have any access to the patient's records in Germany.

However, for 22 per cent of TK members receiving treatment in other EU countries, there was an ex-

change of information between the foreign and the German doctor.

Another picture emerges in terms of the exchange of data in the opposite direction: following the treatment in other EU countries, for 48 per cent of TK members, the German doctor had access to the foreign doctor's records on the patient. For only 31 per cent of members, this was not the case.

### The Influence of Costs

In the context of treatment carried out in other EU countries, patients often found themselves in situations where they themselves had to bear the costs which were then reimbursed to them later in whole or in part. Two-thirds answered „No“ to the question of whether the costs to be paid are so high as to pose an obstacle to receiving treatment in another EU country. Only 21 per cent saw the payment of such costs to be an obstacle.

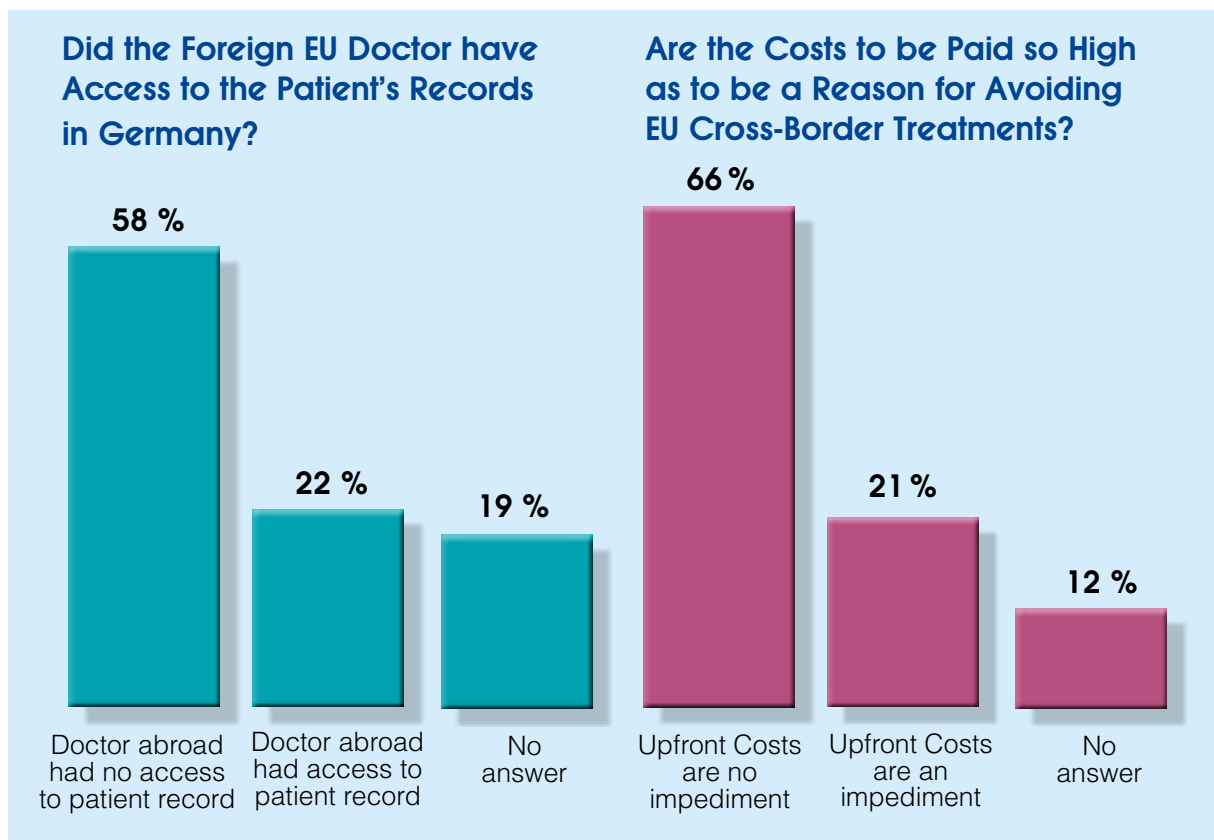


Figure 15

## The European Health Insurance Card (EHIC)

At present, 173 million EU citizens have the European Health Insurance Card (EHIC). This is 35 per cent of the EU population. The EHIC can currently be found on the reverse of the TK insured person's card and replaces the customary health insurance form for abroad (E 111) which has been used to date in the event of illnesses in other EU countries. It will also be able to be found on the planned electronic healthcare card.

In the event of a need for treatment in acute and emergency cases, the EHIC enables TK insured persons to obtain any treatment in EU member states, Iceland, Liechtenstein, Norway and Switzerland as if they were insured in those particular countries themselves.

42 per cent of TK members are familiar with the European Health Insurance Card. However, despite experiences with cross-border care, almost half of TK members are unaware of the card. 90 per cent of those TK members who are familiar with the EHIC also hold the card. 59 per cent of TK members who own an EHIC have tried to use it when receiving treatment in other EU countries. 35 per cent have not tried to use the card.

Of those who have tried to use the card, 50 per cent indicated that the EHIC was accepted without any problems, a further 5 per cent indicated that it was accepted, but unwillingly, and 42 per cent said that it was rejected. This clearly reflects the problems of the EHIC being accepted for cross-border care.

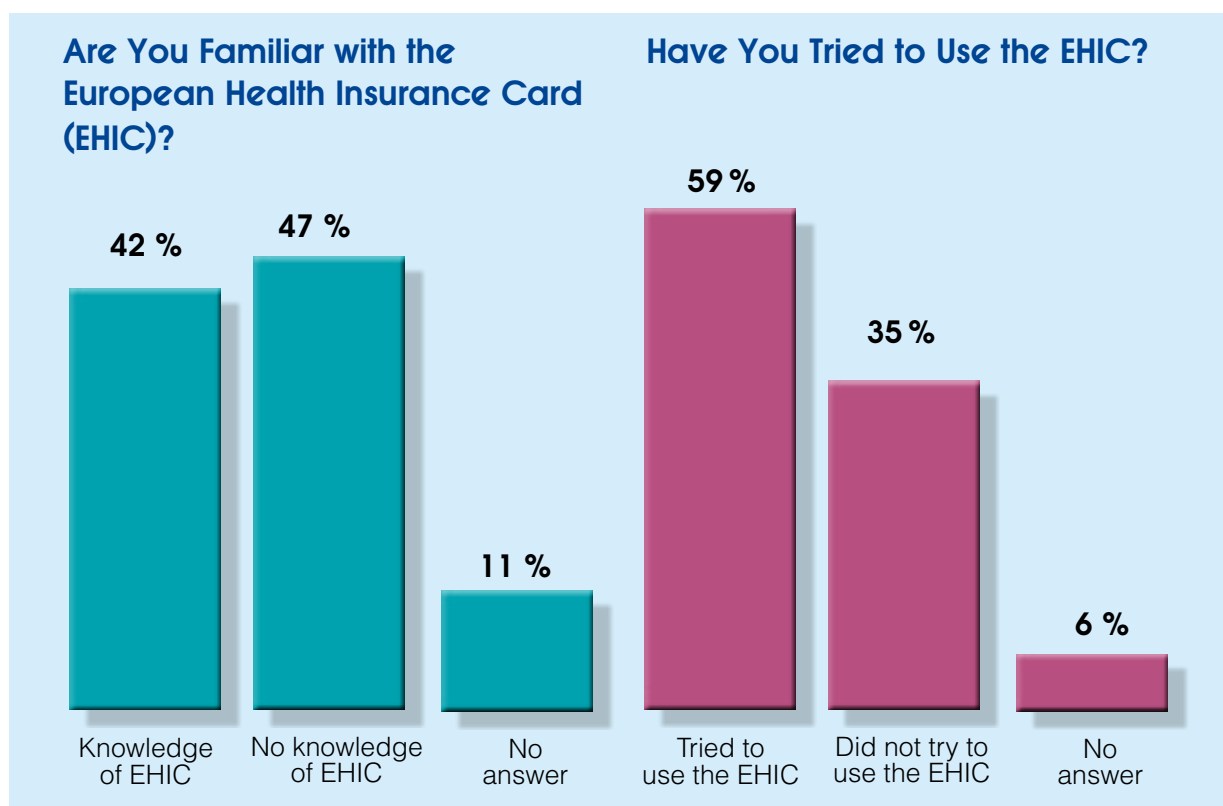


Figure 16

## Are You Aware that You are Entitled to Have the Costs of Outpatient Treatment in Another EU Country Reimbursed?

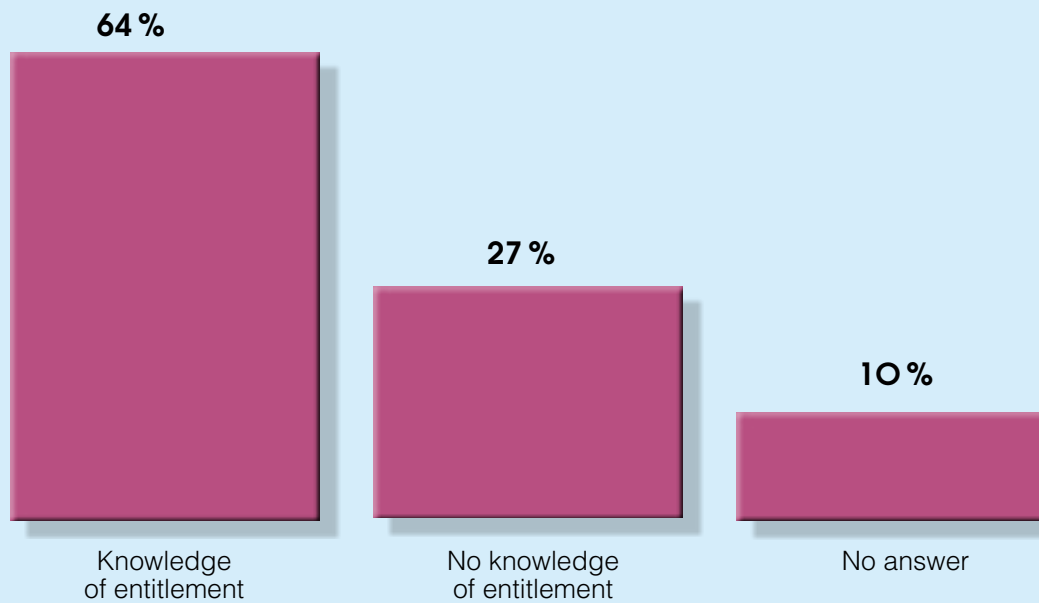


Figure 17

### 3.2. Legal Framework and Expectations of the European Healthcare Market

64 percent of TK members receiving treatment in other EU countries are aware that patients receiving outpatient treatment in other EU member states are entitled to have their costs reimbursed, as embodied in German law by the Healthcare Modernisation Act (Gesundheitsmodernisierungsgesetz), while 27 percent are unaware of this entitlement.

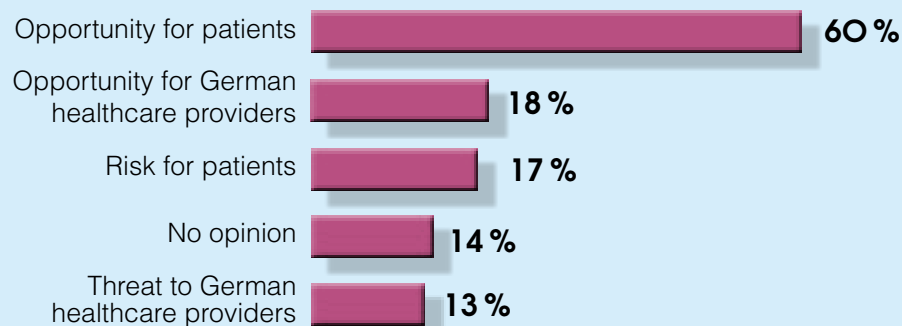
In contrast to this, inpatient services require prior approval by the statutory health insurance fund.

### Attitude Towards a European Healthcare Market

60 percent of TK members receiving treatment in other EU countries regard the emerging European healthcare market as an opportunity for patients while 18 percent also consider it to be an opportunity for German healthcare providers.

For a minority of 17 percent, the focus is on the risk for patients and for a further 13 percent the focus is on the threat to German healthcare providers.

## What is Your Assessment of the Effects of the Emerging EU Healthcare Market and the Trend Towards Healthcare Tourism?



(Multiple Responses, No Answer: 12%)

Figure 18

## Have You Heard About the Planned EU Directive on Exercising Patients' Rights?

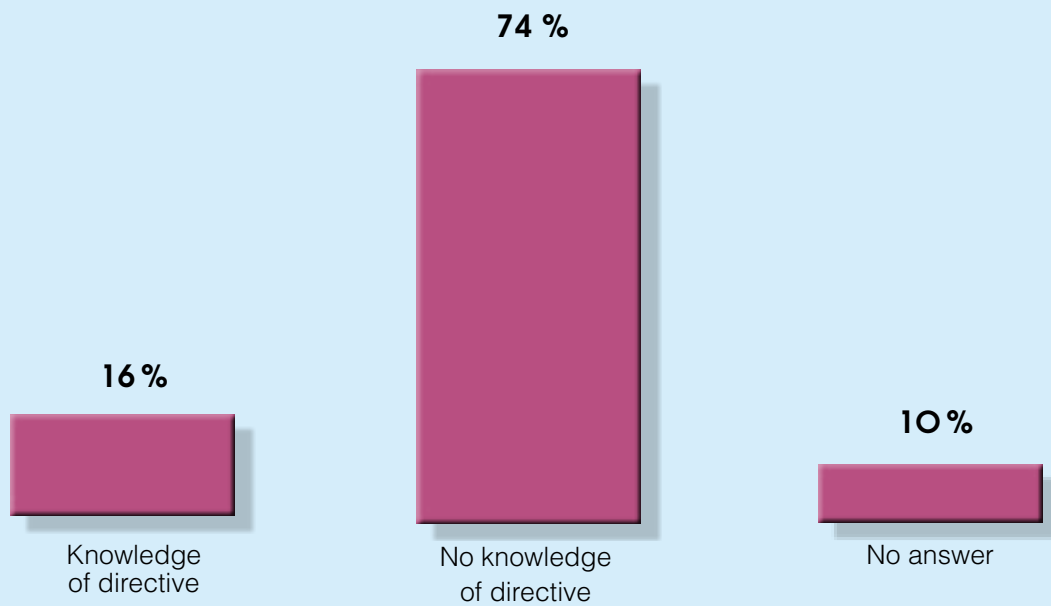


Figure 19

### The EU Directive on Patients' Rights

On 2 July 2008, the European Commission passed a proposed directive as part of a social package. The aim of the proposed directive is to strengthen patients' rights in cross-border care and to promote the free choice of healthcare providers in the European market.

The entry into force of this directive in this or another form would, for the first time, create a European legal framework whose measures would therefore directly affect the individual national healthcare systems. Although the aim of the directive is to strengthen patients' rights and patient safety, only 16 per cent of TK members receiving treatment in other EU countries have ever heard of this current directive.

The predominant majority of 74 per cent had not heard of the directive at all.

## How Do You Feel About a European Legal Framework which would Strengthen Patients' Rights and Safety in EU Cross-Border Care?

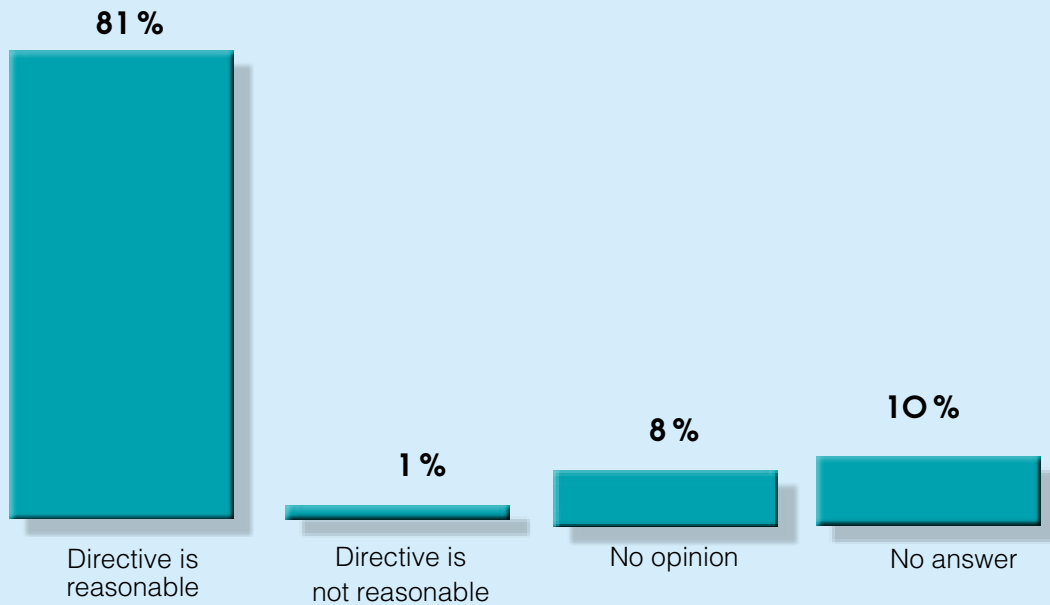


Figure 20

Asked about their attitude to such a patient directive, 81 per cent of TK members receiving treatment in other EU countries responded that they found it reasonable.

Only 1 per cent of TK members receiving treatment in other EU countries did not find the directive to be reasonable.

## **Contact**

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## **Acknowledgements**

We would like to express our particular thanks to the expert panel for the professional support in developing the questionnaire as well as in the constructive-critical discussion on the results of the survey and their implications.

We would therefore like to thank Prof. Dr med. Reinhard Busse, MPH FFPH, Healthcare Management, Technische Universität Berlin, and Jeni Bremner, Director of the European Health Management Association (EHMA), Brussels, for contributing their valuable expertise from a scientific and European political perspective.



# Techniker Krankenkasse (TK)

is a nationwide statutory health insurance fund with approximately 5.1 million members and nearly 7.3 million insureds altogether.

Its headquarters are located in Hamburg. TK was established on 27 of October 1884 in Leipzig as the „Registered Aid Fund for German Architects, Engineers and Technicians“.

As a statutory health insurance fund, TK is a self-administered corporation under public law. It is run by a full-time board. The 30-strong voluntary administrative board represents one-half each the employers and the insureds of TK. The members of the administrative board are elected every six years through a social election.

Further information: [www.tk-online.de](http://www.tk-online.de)



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