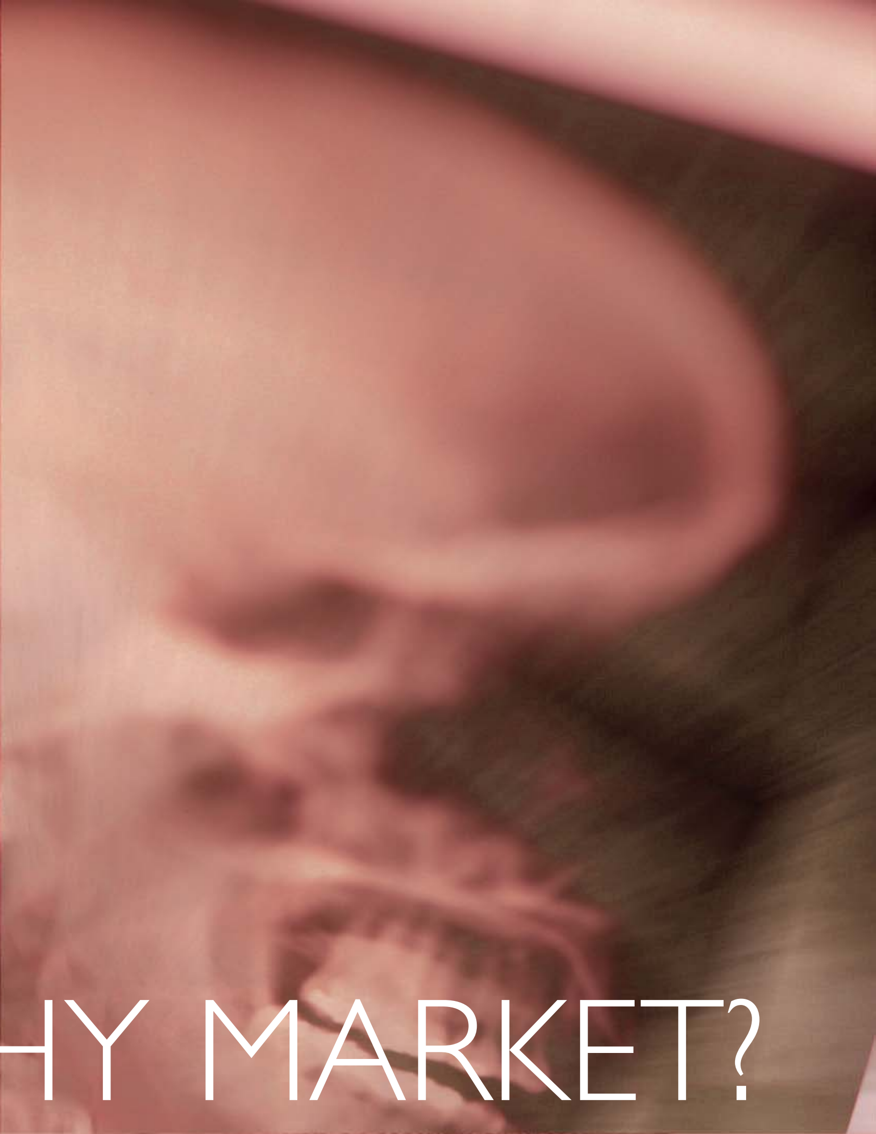
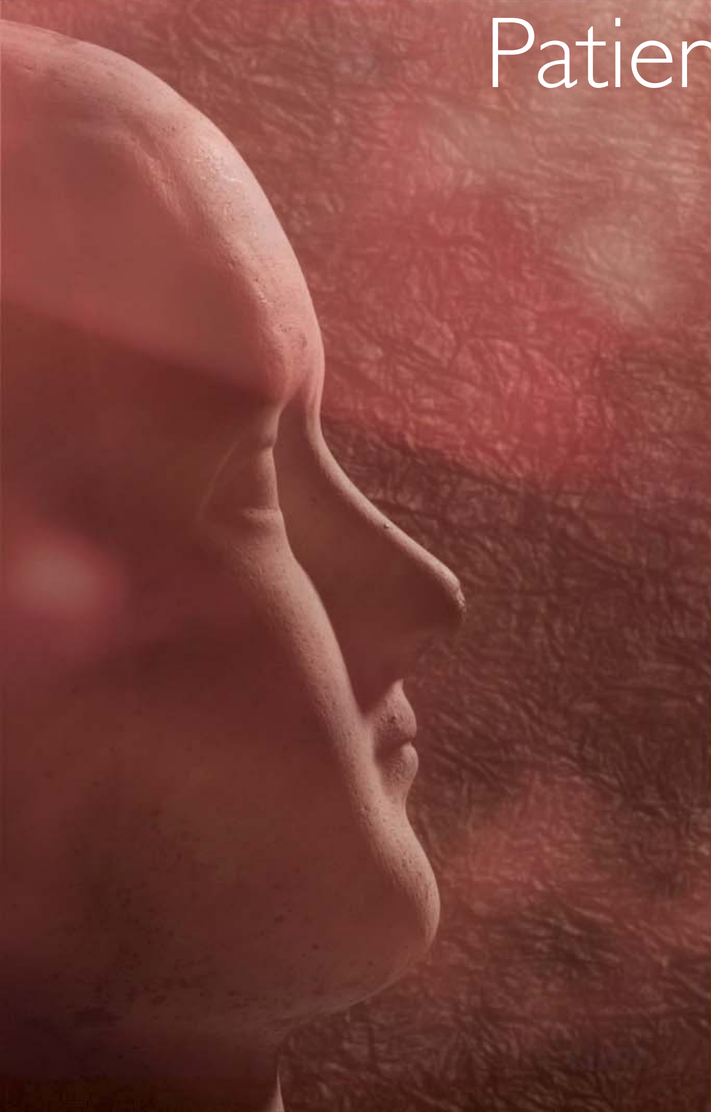
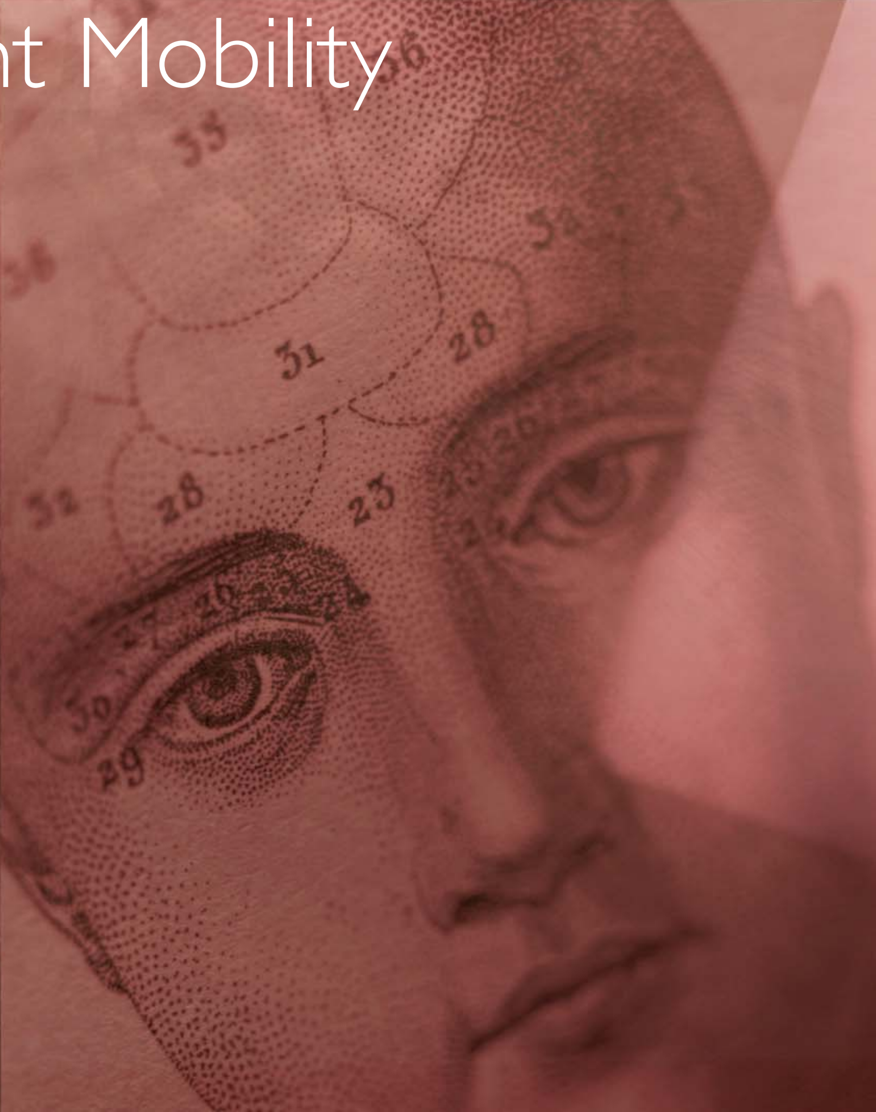
A HEALTHY MARKET?

Patient Mobility







A Healthy Market?

Patient Mobility in Europe: Filling the void where public systems fail

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Patient Mobility in Europe: Filling the void where public systems fail

If up to this point you thought that the concept of patient mobility had a somewhat old, administrative and out-of-date feel and that it was merely a headache for European health policy makers, attempting to unravel insoluble issues in working groups and sessions, you were wrong. It turns out that patient mobility is, in various exciting ways, fostering innovations in the way healthcare is provided and managed in European health systems. It is, paradoxically, the constraints inherent in the systems, exposed as they have been in the cross border context, that are the particular impetus towards new ways of thinking in terms of the provision, organisation and financing of health care. This is especially pertinent for the relationship between private and public systems. Often cross-border arrangements reflect back on the national systems and offer interesting ideas for change and improvement. Examples of this are to be found in a series of very different settings, such as in the *euregios* (co-operative insurance in Germany, Netherlands and Belgium), tourists and long-term residents in Spain, German-Czech cross-border contracting, or hospital cooperation on the French-Spanish border.

But there also remain some issues to be tackled, such as the inability of some European health systems to cope in a satisfactory manner with patients from other countries. This happens when special needs and expectations of European citizens are not taken into account - as in the case of long-term residents in Spain. It is also due to inflexible and poorly thought-out underlying administrative systems. European health systems are not usually designed to take care of foreign patients: old and uncoordinated administrative systems do not allow for proper management, and this has significant consequences. For example, Spain is losing substantial sums of money through invoices, for care provided to European tourists in hospitals in the different autonomous regions, that are not duly processed. It seems that the problem has not been actively addressed. Some ideas for improvement do exist, however. There are alternatives to the public system – in the direct contracting of (statutory – public) health insurances with private providers in the tourist areas, for example. This use of the private sector could potentially bring substantial benefits to patients/citizens and policy-makers, as well as other key players in the health sector.

Patient Mobility – a European Issue

What is understood by patient mobility at the European level? And how did it become such a fashionable issue on the European health policy agenda? A decade ago, there was very little discussion of patient mobility at European level, health systems being not a European competence but a matter for national governments. The '*free movement of people*', one of the basic principles of the European Union prompted, in the early 1970s, the issuing of regulation 1408/71, establishing the E111 system, to ensure that European citizens are covered under the public health (and social security) system when travelling abroad in Europe. A survey undertaken by the German Techniker Krankenkasse (2001) found that its members were highly mobile, with 80% travelling to another country at least once a year. Most of those who did travel were unlikely to need health care and some 2–5% did mainly for ambulatory services whose costs represented less than 0.5% of the fund's overall expenditure.

So why focus on patient mobility? There are several reasons. Firstly, there is a substantial amount of (so far largely anecdotal) evidence suggesting that cross-border care sometimes falls outside the mechanisms designed to ensure that the care provided is of high quality and responsive to the needs of the patient, especially where the patient does not speak the language or lacks understanding of the functioning of the country's health system. Secondly, given the continuing imbalance between supply and demand in Europe's health systems, it may be that there is scope for greater mobility that would benefit both patients and health care providers within Europe. Thirdly, the extent of mobility within Europe has increased markedly. As in the Spanish example, many people from northern Europe have decided to spend their retirement years in the warmer climates in the south. The growth of budget airlines means that many people whose parents might never have travelled beyond the nearest large city may take several short breaks each year in a different part of Europe. These same airlines allow a growing number of people to commute weekly between a home in one part of Europe and work in another. This new European generation, accustomed to crossing frontiers with ease and able to purchase goods and services from any part of the European Union, is less likely to accept constraints on where it can obtain health care.

Patient Mobility on the European Policy Agenda

Patient mobility has emerged only slowly on the European health policy agenda. It was the 1998 ECJ cases of *Kohll* and *Decker*, which unleashed a flurry of political and academic discussion about the precise implications of these rulings, that established an important principle while offering very little detail of what patient mobility in the European Union meant in practice (Busse, Drews et al. 2002). The start in 2002 of a high-level process of reflection on patient mobility and healthcare developments in the European Union led to a series of recommendations on areas of cooperation, such as cross-border cooperation, centres of reference; technology evaluation; quality of care, and the role of Europe in supporting these developments. The European Commission responded with a policy paper (2004) and the creation of the High Level Group on Health Services and Medical Care with working groups on some of the identified issues. They are likely to produce very concrete solutions to existing challenges, while the Europe for Patients and other related research projects[1] contribute evidence and insights, such as the publication on patient mobility case studies (Rosenmöller, McKee et al. 2006).

Learning from Patient Mobility

An interesting starting point is with the *euregios*, the German health insurance bodies set up with Dutch providers on the other side of the border at a time when this had not really been foreseen by the German legal framework. The arrangement allowed patients on both sides to have a better choice and often to travel shorter distances for much better access. Since then numerous contractual arrangements with public and private providers have increased access and quality for the citizens living in these border regions. It is interesting that often there is support from broker institutions of both a public and a private nature, which ensures that contractual arrangements are being respected on both sides.

In the typical tourist regions, there are significant variations in demand between winter and summer. To respond to this fluctuation in demand, the authorities of the Veneto region started to employ Slovenian nurses on a short contract basis in the summer (Scaramagli, Zanon et al. 2006). Interestingly, the same nurses then move to the Austrian ski resorts in winter. The topic of professional mobility usually focuses narrowly aournd the brain drain phenomenon, but here we see an interesting aspect of professional mobility. Professionals improve their skills and knowledge because they are required to adapt in a flexible manner to different demands and environments. This constitutes a much more efficient use of human resources. In order to make an optimal use of such opportunities, it might be desirable to have some kind of European coordination or EU supporting function: ie gathering data on the availability of health professionals on one side and the demand for them on the other, and trying to match the two.

Another aspect of patient mobility is that it is likely to have a profound impact on the way health care is provided at the national level, and will therefore engender change. Arrangements made out of necessity across a border are suddenly reflecting back on national systems. One example is German statutory (public) health insurance companies establishing direct contracts with German doctors installed in Mallorca, to take care of their German insurees on holiday on the island. This was made possible after the German law was amended to allow cross-border contracting, prompted by the very active *euregios* on the German/Dutch/ Belgian border. This raises in the first instance a series of organisational questions: how will this care be supervised? What is the planning and regulatory role of the Spanish or regional (Balearic) government? In case of medical error or litigation will this to be cleared in Spanish or German courts?

Secondly there are likely to be effects on the Spanish system. Balearic public hospitals could start to contract directly with German public funds – difficult within present arrangements, but possible when hospitals gain a more autonomous status as in other Spanish regions –allowing them to follow a private legal framework, particularly concerning the employment of professionals. This would certainly benefit the (numerous German) patients by facilitating better access, quality and service, and would be of advantage to the health system in that it would provide additional income opportunities. Thirdly, and rather unexpectedly, there is a potential impact on the German system back home, where doctors are usually compulsorily contracted through the physician associations, which is somewhat hindering reform and innovation. Thus, it is likely to open doors for change at a time when further reforms of the very rigid German system are being hotly debated. Similarly, in Ireland we found an impact of patient mobility on the home system (Jamison, Legido-Quigley et al. 2006). In the light of waiting lists for some specific conditions, the Irish NHS started to contract out services – mainly to the UK. All of a sudden private Irish hospitals raised their voices: if contracting was done, why go abroad? This is likely to break the long established monopolies of public hospitals in Ireland – and make way for more innovative arrangements.

Cross-border hospital cooperation is another area where important benefits and learning opportunities are likely to take place. France in particular has a series of interesting cooperation schemes on its Belgian, German, Italian

[1] Europe for Patients, e4p is financed under the EU 6th Framework Research Programme strand of scientific support to policies. www.europe4patients.org

and Spanish borders, supported by central institutions (Harant 2006). The Puigcerda hospital is a remarkable example. Artificially divided by the "Pyrenees Treaty" in 1659, Cerdania has two communities which are historically, socially and culturally very close, sharing a common language, Catalan. The main hospital is in Puigcerda on the Spanish side, 1 km from the French border. It is under private management and has all the basic services. On the French side there are only general practitioners, specialists and some convalescence and rehabilitation facilities, but from the mountain plateau access to hospitals (in Perpignan) with surgery and obstetric care is difficult and slow. Emergency services, very frequently needed in this area with high tourism rates in both summer and winter, are not adequately covered.

This led the French authorities, in the 1990s, to develop initiatives with the hospital in Puigcerda, with the aim of improving services to their citizens. Since then the number of French patients visiting Puigcerda hospital has steadily increased, and the concepts have been developed further. The next step in the project is to create a new common health care organisation for the entire territory. It would employ staff from both sides, the first ever hospital to be planned, managed and funded jointly by two countries. Investment support will come from Catalonia, France and the European Union. But there are still several issues needing to be resolved, including the institutional and legal nature, the legal basis for cooperation, national planning schemes, labour laws, professional training, and organisational issues: control and supervision by authorities, management, organisation of patient care and structures. A particular challenge is the case of new-born babies, who need to be declared in the French consulate in Barcelona, some 90 km away, while the nearest French municipality, located just a few hundred metres from the border, is not allowed to issue birth certificates for babies born on Spanish territory. Despite and even because of all this, the collaboration will be worth following, as it is likely to give invaluable insights into how two completely different systems can find ways to collaborate.

There are other interesting examples of German health insurances contracting providers abroad (Nebling and Schemken 2006). Dutch hospitals on the coast of the North Sea coast have a direct agreement with German health insurances, bypassing the cumbersome 1408 procedure or the alternative of cash advances, a problem for many patients. Thus, it is a win-win for all concerned, patients are automatically recognised with their German insurance card – and a special webpage allows the Dutch provider to quickly check the terms of coverage directly with the German health insurer. Thus the patient gets a quick, easy and high quality service, while the providers know that they will receive payment within a reasonable period of time. As these are emergency services, it does not represent real competition to German providers. This is different from arrangements for spa treatment in the Czech Republic. Here one German health insurance company started contracting with rehabilitation facilities in different Czech cities through a broker institution - the DMZ – Deutsche Medizinisches Zentrum. The advantage is that they have built up long-term relationships and can guarantee the availability and quality of the service and that contractual arrangements are being adhered to.

All in all these experiences show that with innovative arrangements with private providers or outside the rigid public systems, it is possible to provide more choice, easier access, higher quality and a sense of security to patients, providing additional support to the search and choice of the patient. Increased competition has its potential downsides for national providers, but might push for better quality, a more consumer-orientated system and for greater efficiency. Here again there is new business potential not only for creative and high quality providers, but also for broker institutions.

Achieving benefits for all

If the potential benefits from enhanced patient mobility are to be brought about – particularly in relation to the involvement of private, or non-public providers, there is a need for common ground on certain issues. As a starting point for achieving consensus among Member States, the following potential principles are proposed:

- Patient mobility should be **managed**. The scope for market failure in health care is well recognized, in particular because of the extent of information asymmetry. Even those purchasers who might be expected to be well informed, such as sickness funds, often find it helpful to employ brokers to ease the process. Except in the most straightforward of circumstances, there will be dangers in relying simply on market forces.
- Patient mobility requires **trust**. Purchasers must be able to rely on standards being upheld by providers. It is not always feasible simply to export national standards and this can provoke resistance from the providers and public authorities abroad. I believe that it will be necessary to establish some mechanism to ensure adequate standards of health care quality across the EU. In reality, the principle of mutual recognition, in which it is assumed that standards in place in any part of the European Union are universally acceptable, is not accepted by everyone involved in purchasing care. It would be unrealistic to advocate the same standards, not least because of the rapid pace of change in medical knowledge, but rather there should be systems in place that can ensure that this changing knowledge is identified, synthesised, disseminated and adopted.
- Patient mobility should clearly define specific arrangements necessary to support the mobile patient, in relation to matters such as transport, language and accompanying persons.
- Patient mobility should ideally be integrated into larger forms of cooperation involving providers of both countries. Referring providers may need to assume responsibility for care prior to and subsequent to travel.

- Patient mobility should be based on prices set in a manner that is transparent and which minimizes perverse incentives and distortions of the market. A more transparent system would address questions such as: how should prices be calculated in benefit-in-kind systems? Should they include costs of infrastructure or not? How does one reconcile exchanges between systems with and without fees-for-service? What is the role of state aid in this sector? How can extra costs, such as translation, accommodation for accompanying persons, be dealt with?
- The competent authorities or purchasers should define explicit eligibility criteria for patients who go abroad specifically to obtain treatment.
- The right to treatment abroad should be consistent with what is included in the benefit package of the Member State that funds the care. In other words, obtaining care abroad should not be a mechanism to circumvent restrictions of treatments unavailable on grounds of their lack of effectiveness.

These principles do not coincide precisely with either those in Council Regulation (EEC) No. 1408/71 or the procedure established by the Kohll and Decker cases. Instead, they propose creative answers to the new reality that is reflected in the case studies, which is a hybrid of both procedures.

For these processes to work, full involvement of the public authorities in the relevant countries is essential. There can be much flexibility in the systems adopted for cross-border purchasing of care, but an overall framework is essential. A system of cross-border contracts between providers and purchasers, based on the principles set out above, seems to offer a means of giving patients better access to high-quality care while at the same time providing greater certainty for providers.

One important point is the involvement of patients. In many European countries there is a move towards greater patient involvement in the planning of health services. In some regions experiencing mass tourism, such as the Veneto region or some parts of the Spanish coast, foreign patients can outnumber domestic ones. Yet tourists are, by definition, a transitory population, subject to seasonal fluctuations. There is a need to identify some way in which someone acting on their behalf could play a role in the planning process, although this will be far from easy.

The involvement of patients is equally important in border areas. This may involve establishing mechanisms to incorporate foreign patients into the planning exercise. However, this raises further questions, such as how this should be paid for. This process will also have to take account of public concerns that increased cross-border care could be an opportunity to close facilities in which local communities have a strong sense of ownership.

Enhanced patient mobility within the EU can bring benefits for all involved but to do so it requires an effective overall framework. Once established, it is important that its operation is evaluated and monitored regularly, although this is likely to require a substantial investment in data systems in many countries. We hope that, by bringing together these diverse experiences across Europe, we can stimulate the necessary discussions that will facilitate this process.

Conclusions

As we have seen, the introduction of market elements seems to make a lot of sense in cross-border collaboration. The use of direct cooperation and of private sector arrangements in the interplay between European health systems will be of tremendous advantage – providing it is introduced with the right legal and regulatory framework.

These arrangements can be on the *financing* side – as seen in the cooperation between German and Dutch health insurance bodies, or the use a German statutory health insurance fund made of a German private health insurance institution to take care of their insurees in Spain. They can also be on the *contracting* side – where publicly funded institutions use private providers in order to allow better access and service for their members, as is the case in Mallorca.

Concerning the *providers*, direct cross-border hospital cooperation is another interesting collaboration effort. The aim here is to share scarce capacities, provide better access and quality care to patients and to share the responsibilities to be covered in the region.

It would be desirable to see more of these promising initiatives around Europe, with increasing support from the European institutions, in terms of adequate legal and regulatory frameworks, and the facilitation of exchange of experiences and best practices.

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