Patient mobility

*Framework and typology*

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Outline of the presentation

• The evidence: sources and limits
• An analytical framework
• A typology of patient mobility
• Impact on healthcare systems
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The evidence: sources

✓ 6 (+3) case studies

- Ireland/Northern Ireland
- Belgium/Netherlands and UK
- Slovenia/Austria and Italy
- Estonia/Finland and Latvia
- Spain: LT residents
- Italy, Veneto: tourists

- Malta/UK
- Germany: cb contracting
- France: hospital co-operation

✓ 2 Literature reviews
The evidence: limits

- Lack of (statistical) data: availability, quality, reliability, comparability;
- Poor willingness to co-operate from the private, commercial sector;
- Diverse material: quality, purposes, representativeness.
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Conceptual framework on cross-border health care

**Institutional frameworks**
- Organisation of health care systems
- European Union framework
- Legal frameworks
- Financial frameworks
- Contractual frameworks
- Quality assurance frameworks
- Tariffs, costs and pricing structures
- Patients’ rights

**Actors**
- Patients
- Providers
- Purchasers
- Brokers and facilitators
- Public authorities

**Contextual factors**
- Political factors
- Health Policy factors
- Economic factors
- Cultural and linguistic proximity
- The nature of borders
- Cultural factors
- Seasonal factors

**Processes**
- Phase 1:
  How is the arrangement initiated, developed, implemented and evaluated?
- Phase 2:
  How is the process changing, and why?
  What factors have stimulated/ inhibited it?
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A typology of patient mobility

- Types of borders: where
- Types of patient flows: why
- Types of arrangements: how
- A matrix of patient mobility
Types of borders

Mobility between neighbouring countries?

– If do share a border:
  • Rigid border?
  • Fluid border?
Types of patient flows

A. Being abroad when in need for care
   • First mobile, then patient

B. Going abroad to receive care
   • First patient, then mobile
A. Being abroad when in need for care

• **Short-term visitors**
  – Tourists, road accidents, professional travellers etc.
    ➢ Emergency assistance, chronic conditions

• **People with double residence**
  – Students, workers, pensioners
    ➢ Access arrangements?

• **Long-term residents**
  – Migrants, pensioners
    ➢ Long term care
    ➢ Going back home?
A. Going abroad to receive care

• As close to home as possible
  – Language, culture
  – Knowledge of the system
  – Surrounded by relatives, friends

• But: willing to go when “abroad” is:
  – More familiar (*pull factor*)
  – Relative weakness in the home system: availability, financial cost, perceived quality, legal provisions (*push factors*)
Going abroad to receive care: pull

**Familiarity**

- Border regions
  - Across “fluid borders”: multi-dimensional proximity
  - Spontaneous
  - Distances, language, culture

- Going back “home” for treatment
Going abroad to receive care: push

- **Availability**
  - Waiting lists
  - Small countries
  - Highly specialised treatments, experimental treatments

- **Financial costs**
  - Not in the domestic benefit package
  - High out of pocket payments

- **Perceived quality**
  - Some Southern and Eastern European MS

- **(Bio)-ethical legislation**
  - Reproductive health and genetics
  - Abortion, euthanasia,...
types of arrangements

1. Regulation 1408/71
2. Institutionally arranged care
3. “Self managed” care
1. Regulation 1408/71

- **In need for care when temporarily abroad**
  - Medically necessary treatments
- **Planned care abroad**
  - Prior authorisation
1. Regulation 1408/71

**Characteristics**

- Patient integrated in the public care system of receiving Member State
- Content, price, quality, reimbursement level of country of treatment
2. Institutionally arranged care

Institution takes responsibility for the care period abroad

- Cross border contracting
- Provider co-operation
- Common infrastructure
2. Institutionally arranged care

**Characteristics**

– Foreign supply integrated into the system of exporting country

– Content, price, quality agreed in negotiations
3. “Self managed” care

• Patients’ private initiative

• Situations
  • Waiting lists, not publicly covered care, patients without coverage, “diverted” patients

• Funding
  • Out of pocket, travel insurance, private health insurance
  • Public money (“Kohll and Decker” procedure)
3. “Self managed” care

Characteristics

– Providers not always integrated in the public system of the receiving country
– Content, price, quality poorly regulated/supervised by purchasers/public authorities
## Typology of patient mobility

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<th>Types of patient flows</th>
<th>Types of arrangements</th>
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<td>Reg. 1408/71</td>
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<td>Institutionally arranged care</td>
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Extent of patient mobility

• Marginal phenomenon
• Can be concentrated
  – In certain regions
    ➢ Tourist regions
    ➢ Border regions
  – Among providers with specific strategies
  – For specific treatments
• Can have important impact
Impact on healthcare systems

• Not only patients move, but interaction between healthcare systems.

• Different impact for
  – Exporting and importing system
  – Different arrangements
    1408/71, institutional purchasing, “self managed” care
  – Characteristics of the systems.

• Impact:
  + Supporting basic objectives
  - Putting pressure on basic objectives
  +/- requires adaptation, neutral or unclear direction
Impact exporting system

+  
  • Better, faster access to care  
  • Breaching monopolies of providers  
    – Better performing providers  
    – Reduced prices  
  • Pressure to improve domestic system  
  • More explicit procedures (eligibility criteria)  
  • Lower costs: investment, lower prices
Impact exporting system

- Pressure to include private providers in public scheme;
- Bypass cost containment measures;
- Delay of new treatments in benefit package;
- Unfair competition;
- Bypass GP gatekeeper system;
- Bypass priority setting mechanism;
- Pressure on national regulation if not applicable abroad.
Impact exporting system

+/-

- Additional costs if managed;
- Purchasers positioning on the international market;
- Supply control *versus* demand control;
- Introduction of fee-for-service payment methods;
- Pressure on collective agreements between providers and purchasers;
- Increasing expectations of population.
Impact importing system

+  
  – Rational use of spare capacity  
  – Extra income for providers  
  – Incentive for better registration, more transparent budget setting, financial flows and tariff setting
Impact importing system

- Multiple systems of contracting, price setting, treatment procedures in parallel
  - Selective/collective contracting
  - Relationship hospital / hospital doctor
  - Relationship insurer / provider
  - Upward pressure on prices
- Incentives for more commercial behaviour of providers (patient selection)
- Waiting times
- Pressure to create a private system outside publicly funded system
- High investment costs not shared
Impact importing system
  +/-

- Need for adapted planning policies
- Need for appropriate cost calculation/investment costs
- Changing relationship between regional and national authorities;
- Providers positioning on the international market
Conclusions

• Patients are in a vulnerable position when they “self manage” their care abroad;

• “Institutionally arranged” care provides guarantees for purchasers and providers;
  – Institutionalised provider co-operation;

• ... But can have adverse effects in the receiving country when not monitored appropriately

• Can lead to more commercial behaviour
  – ! Patient selection
  – Actors positioning on the international market instead of national market

• If it has to work, involvement of all players;