

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



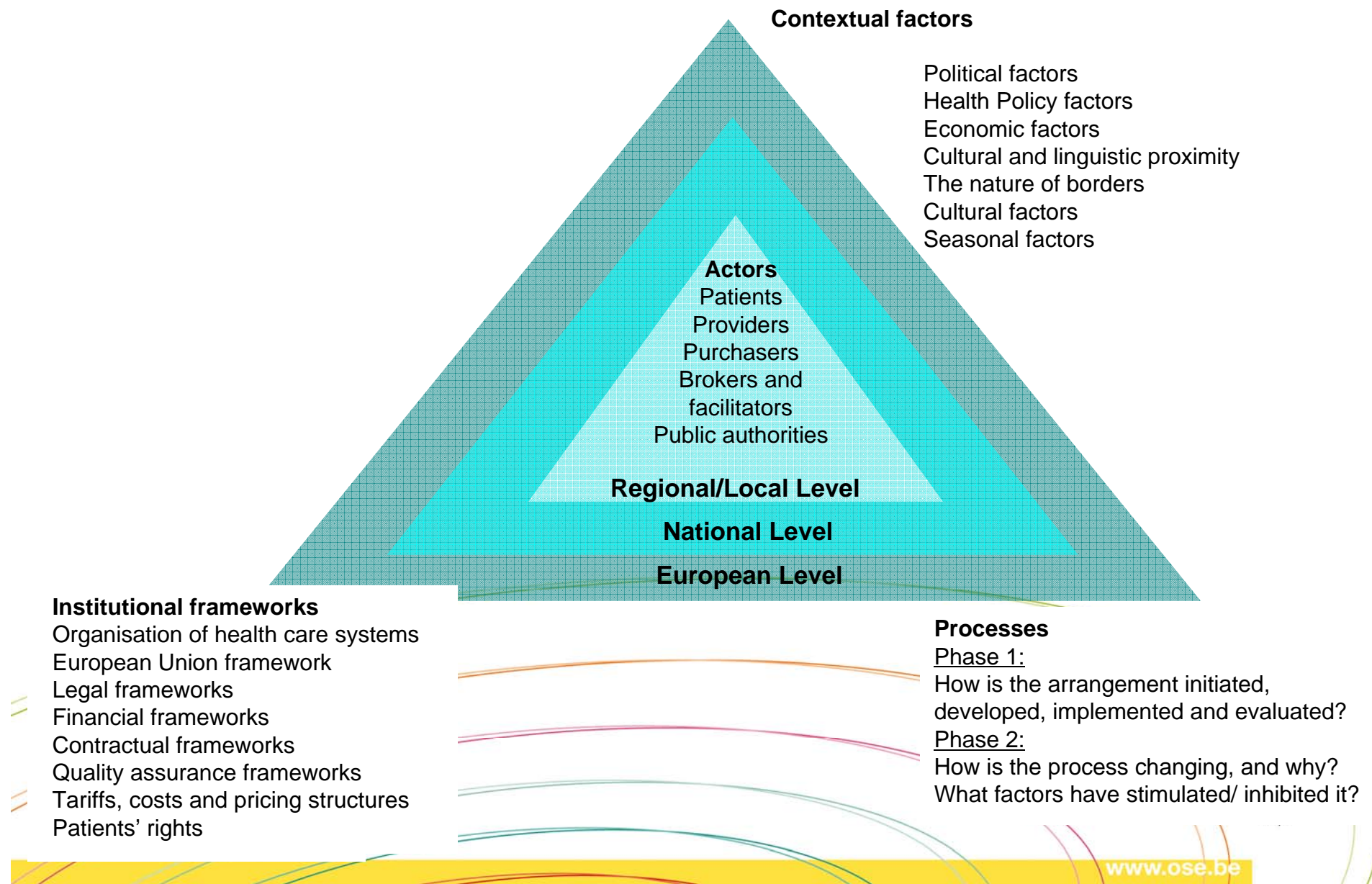
The evidence: limits

- 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



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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:

- **Availability** push
 - 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

		Types of arrangements			
			<i>Reg. 1408/71</i>	<i>Institutionally arranged care</i>	<i>“Self-managed” care</i>
Types of patient flows	<i>abroad when in need for care</i>	Short-term			
		double residence			
		Long-term			
	<i>Going abroad for care</i>	Familiarity			
		Availability			
		Financial costs			
		Perceived quality			
		(Bio)ethical legislation			

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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

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- 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

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- 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;