

Chapter 11

Conclusions

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Who, how and where?

As the case studies in this book reveal, mobility of patients across Europe's borders is a somewhat marginal phenomenon as most patients prefer to be treated as near to home as possible, close to their relatives, in a system they are familiar with, and with providers who speak their language, where they know what they can ask for and what they can expect to receive. Going abroad for treatment is almost never the first option, but is rather the result of specific circumstances.

Nevertheless, as the case studies also demonstrate, patient mobility can be an important phenomenon in certain areas and contexts, such as in tourist areas and border regions, and where providers have developed specific strategies to attract foreign patients. Furthermore, while the overall level of activity may be small, it can entail large expenditures for some economic units within health care systems because of the extra costs incurred for transport and accommodation, and the transaction costs involved in ensuring cooperation between providers to facilitate quality and continuity of care. In some settings, therefore, there is a need for enhanced mechanisms to support planning, implementation and monitoring of the process, with actions to ensure transparency and to reduce legal ambiguity.

What are the characteristics of the mobile patient? The case studies have confirmed that the available data are fragmentary and incomplete but they do indicate that elderly people make up a significant element of the patient population, especially in the tourist regions or in areas that are particularly attractive for long-term residents (mainly regions bordering the

Mediterranean). This is a group that is now numerically much more important than in the past and that now commands the necessary financial resources and can avail of new opportunities to travel extensively. They are, however, more likely to need health care, not least because modern health care has enabled many of them to lead normal lives despite the presence of often multiple chronic diseases. This has led to an extension of the formerly narrow interpretation of emergency care for a condition occurring while abroad to include exacerbations of pre-existing diseases. This, coupled with growing awareness of the right to care, is likely to increase the demand for health care by patients from other countries, especially in regions attracting larger numbers of older people. Furthermore, those people who, in the past decade, have chosen to spend their retirement in southern Europe are continuing to age and, when one partner dies, may lack the support that enabled them to remain independent. This can be expected to create a growing need for long-term care facilities, home care and other types of end-of-life care.

The situation is different for those patients who are sent abroad by their health care systems within the framework of an organized programme. This care is usually specialized and the package is very specific and clearly defined. Patients must meet certain conditions such as being fit to travel. As the case studies reveal, patients may be required to bear some of the additional costs associated with obtaining the treatment abroad.

Where patients cross the borders on their own initiative, the picture is much less clear. The type of treatment that these patients obtain abroad is often influenced by the ease with which the service in question can be accessed in their home country. Even when the cost of obtaining care is higher abroad than at home, some patients still prefer to cross the border to obtain care that is perceived to be of better quality or more convenient. Those taking this course seem likely to be younger, better educated, and with higher incomes. Proximity is clearly important, with those living in border areas more likely to go abroad for a wider range of treatments. As the Slovenian example shows, there are particular factors related to price differentials across borders between “old” and “new” Member States, especially where the treatment is not or only partially covered by their domestic benefit package, such as spa treatments, dental care and cosmetic surgery.

In the case studies we identified a wide range of *ways in which cross-border care is organized, managed and funded*. In tourist areas, procedures based on Council Regulation (EEC) No. 1408/71 are common, with patients using E111 and E121 forms and, more recently, the new European Health Insurance Card. However, it is apparent that, in reality, these procedures do not always work as efficiently as they should, both for patients and care providers.

In some cases providers do not accept the forms and demand the patient should pay out of pocket, as was reported in the Netherlands in the German case study. Spanish health care providers obtain no tangible benefit from completing the paperwork associated with the E111 as the foreign reimbursements remain at the national level. As a consequence, some ask patients to pay out of pocket and reclaim from their travel insurance policy.

Some funding organizations, such as German health insurance funds, have begun to agree contracts with providers in tourist areas abroad, for example with German physicians based in Majorca. This is of particular interest because it creates a precedent whereby the insurance funds engage directly with practising physicians, without the German physicians' association playing an intermediary role. This could potentially have implications for governance mechanisms in place in Germany and it would not be the first time that arrangements put in place to facilitate cross-border care have stimulated changes in domestic policies.

The examples in which care is provided to a population that straddles a national frontier provide many interesting experiences. These have often emerged from grass-roots cooperation based on local agreements between providers and purchasers, as seen in the cases of Belgium, France, Ireland and Slovenia. These forms of cooperation are often within a broader framework of cross-border cooperation, often supported by EU Interreg funds (or in Ireland, Peace and Reconciliation Programme funds). These projects often seek to achieve optimal use of capacity on both sides of the border, with patients and health professionals crossing in both directions.

While these projects frequently provide pragmatic solutions to specific local problems, there may be problems once the exchange of patients takes place, often because of a lack of a sound legal basis. This observation highlights the importance of establishing ways by which those involved in cross-border collaboration can communicate their difficulties to legislators and ways by which legislators can respond appropriately to these difficulties. In many cases those involved have taken advantage of the provisions of Council Regulation (EEC) No. 1408/71, even if the precise mechanisms related to the E112 are not used. Difficulties also relate to the development of shared approaches to quality assurance, continuity of care, information sharing, or compliance with regulatory systems.

Particular issues arise in cases where administrations seek to share common infrastructure in a border area. This volume includes several examples: one from the north of Europe, on the Estonian-Latvian border; a second from the south, on the French-Spanish border; and a third from the east, on the Italian-Slovenian border. In all these cases the process of establishing cooperation was

protracted and complex. Problematic issues included matters related to ownership and legal authority, for example as applied to employment contracts. Thus, on the Slovenian-Italian border an attempt to invest jointly in a magnetic resonance scanner failed because of unresolved administrative problems. Eventually one of the hospitals proceeded with the investment and offered access to radiologists on the other side of the border.

More recent developments include direct contracting by public purchasers, for example where sickness funds enter into agreements with foreign health care providers. Examples are drawn from Germany and the Netherlands. While initially these were concentrated in border areas, their coverage is now extending further afield. These contracts are often based on an interpretation of European Court of Justice rulings that care provided abroad should be under the same terms and conditions as that provided domestically. Thus, a Czech provider contracting with a German sickness fund is expected to apply German quality standards.

The principle of exporting domestic standards is also apparent in the case of English patients treated in Belgium and France, as part of a short-lived attempt to reduce waiting lists. Thus, the English NHS undertook a separate, thorough assessment of the quality of providers, with contracts prescribing the care to be delivered in great detail, with the result that Belgian providers viewed the assessment procedures as unnecessarily bureaucratic and, in frustration, some withdrew from the process. In passing, it should be noted that while there was undoubtedly an element of media presentation, with English ministers reassuring patients that they would be able to get cups of tea and English newspapers, this may also reflect an important cultural difference in relation to the acceptability of different degrees of state involvement in the detailed delivery of health care.

The English Department of Health strove to maintain tight control over this process, portraying it as quite distinct from the mobility permitted by the rulings of the European Court of Justice. Indeed, in the one case where a British patient cited the precedents established by the Court she received treatment before the case could be heard. As a consequence, the precise interpretation of “undue delay” set out in the directive remains unclear in the British context.

An interesting phenomenon to emerge in some settings is the use of brokers. These can have different functions; in general they are actors familiar with the system in the providing country and function as a kind of “system translator”. This can help to ease negotiations, clarifying tariff-setting systems, and managing invoices. The involvement of such brokers seems especially useful when the health care systems involved are very different.

Experiences and expectations

This section examines the *experiences and expectations* of those involved in the processes whereby patients receive treatment abroad. It is, however, necessary to reiterate an observation made earlier. There is remarkably little systematic information about the perspectives of those involved, and in particular of patients, as there are few surveys of their views. However, what evidence does exist is fairly consistent.

The available, albeit limited, evidence suggests that *patients* obtaining care abroad tend to be reasonably satisfied with what they receive, although the evidence relates largely to those whose care is obtained within the framework of specific purchasing agreements, in which an informed purchaser is acting on their behalf to ensure the quality of care provided. Patients describe the importance of access to information at all stages in obtaining care. This is particularly great before they go abroad, with questions about the available options for care, their rights and entitlements, cost implications, administrative procedures involved, transport arrangements, and management before and after the main treatment. During their stay they seek information on their progress, in a language that they can understand. After discharge they seek information on follow-up arrangements.

While the available information is even patchier, it does seem that the situation is much less satisfactory for those obtaining care as tourists. Here there is no informed purchaser to act on their behalf. They are faced with the difficulty of selecting a provider in the public scheme who will accept their E111 or European Health Insurance Card. Their difficulties are exacerbated by the many individuals with vested interests in diverting them to private providers.

A key issue is continuity of care. While some minor disorders can be managed as a single episode of care, many, especially where they involve an aggravation of a pre-existing condition, require communication with the individual's usual health care provider. This means that medical records must be accessible and understandable by different providers, there must be access to prescribed pharmaceuticals, and arrangements must be in place for follow-up assessments and rehabilitation. This provides another justification for active management of the process.

The case study also revealed the needs of *providers*. Providers treating foreign patients must be reimbursed appropriately, where relevant taking account of any extra workload and costs involved. They also require ready access to patients' past medical history. These require effective systems for data management. Furthermore, there is a consistent demand from providers involved in cross-border contracts for more legal certainty about what they are

allowed to do, which procedures they should use, what prices they can charge, and what happens when things go wrong.

Referring providers play a crucial role in guiding patients in their choice of treatment abroad. The information needs of the referring providers are thus similar to those of patients. They need to be involved actively and positively in cross-border cooperation. When domestic providers feel they are insufficiently involved, they can obstruct arrangements for cross-border care. Also, domestic providers may complain about unfair competition when prices charged for care abroad are lower than those at home. In some cases this arises because governments explicitly use the potential to send patients abroad as a means of challenging domestic providers that are perceived as inefficient (whether or not this is actually the case), as happened with the short-lived overseas treatment initiative developed by the English Department of Health. In some cases, such as in the Netherlands, providers may be concerned because they must fund capital investments from their income, while in their neighbours', as in Germany, these costs are borne by regional governments and are thus excluded from the pricing formula.

Purchasers are concerned about transparency of tariff-setting, guarantees of accuracy of invoicing, and systems to assure quality. This will often require specific mechanisms to be put in place but, as in the Netherlands, one possibility is to establish brokers who can concentrate this experience and make it available to multiple smaller purchasers.

Potential impact on health care systems

Public health care systems aim to guarantee high-quality care accessible to all citizens in the most efficient way. Patient mobility can provide additional *opportunities* to achieve this objective. Patients can be treated close to home, but on the other side of a border, or treated abroad when on holiday. For smaller countries, or regions with low population densities, it can make available treatments that would otherwise be unavailable. In border regions it facilitates a more rational use of scarce capacities. The country providing care will have the opportunity to make use of spare capacity, so generating additional income to cover their fixed costs or to support new capital investments.

Patient mobility can provide an incentive for improvements in health care delivery in both sending and receiving countries, for example by creating pressure to reduce waiting times. Patient mobility can also reveal weaknesses in administrative processes, such as patient registration and data flows.

On the other hand, patient mobility can also entail *risks* for health care systems, especially if the process is not managed effectively and if authorities in both countries are insufficiently involved. The principle of equity can be jeopardized if patients going abroad on their own initiative thwart domestic priority-setting systems. Patients unable to meet additional costs for treatment abroad may have reduced access to care.

For the receiving country, there is a risk that foreign patients will be given priority over domestic patients if foreign purchasers are willing to pay above official tariffs. This could also exert upward pressure on tariffs and increase waiting times in the receiving country.

Where cost-containment policies are based on restriction of supply (leading to waiting lists), patient mobility can threaten cost-containment policies in the sending Member State by circumventing constraints on supply. Patient mobility can also put pressure on established organizational arrangements, with unpredictable consequences. Examples include the corporate system of contracting in Germany, referral systems in the Netherlands, collective agreements between providers and purchasers in Belgium, and relationships between local and national authorities in France, Spain and Italy. Additionally, patient mobility can lead to pressure for a greater role to be played by the private/commercial sector.

While patient mobility can clearly bring benefits, it can also be very expensive, for example for small countries such as Malta. It can also delay the inclusion of new treatments when patients can receive them abroad. In all these cases, it is important that public authorities ensure that benefits from patient mobility are realized, while challenges are dealt with.

Realizing the scope for all to benefit

If the potential benefits from enhanced patient mobility are to be achieved, we argue that there is a need for a shared view on certain issues. As a starting point for achieving consensus among Member States, we propose the following potential principles.

- 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. We 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, synthesized, 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, etc., 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 we have not yet touched upon is the involvement of the 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.