Patient mobility and financial sustainability of health systems

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&
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• Why do patients move? What are the push factors, what are the pull factors?
• Has this led to unsustainable expenditure in the past? Might this change?
• What should we in the EU do about it?
Country A

Benefit Package A
using
Service Taxonomy A
and
Fee Schedule A

Country B

Benefit Package B
using
Service Taxonomy B
and
Fee Schedule B

WHY?
Situation 1: Person wants to live (with his/her family) in Country A but to work in Country B.

Country A

Benefit Package A
using
Service Taxonomy A
and
Fee Schedule A

Country B

Benefit Package B
using
Service Taxonomy B
and
Fee Schedule B

E 106
Situation 2: Person from Country A happens to be in Country B (for tourism, business ...) when he/she falls ill and needs treatment.
Situation 3: Patient from Country A needs to go to Country B for treatment as it is not available in Country A.
New Situation 1: Retired person from Country A wants to live in Country B (including receiving health care there).

Country A

Benefit Package A using Service Taxonomy A and Fee Schedule A

Country B

Benefit Package B using Service Taxonomy B and Fee Schedule B

E 111 new
New situation 2: Patient from Country A wants to go to Country B for treatment – to bypass waiting lists in A, because of perceived higher quality ...

Country A

Benefit Package A using Service Taxonomy A and Fee Schedule A

Country B

Benefit Package B using Service Taxonomy B and Fee Schedule B

Kohll/Decker et al.
The 6 leading questions in regard to access hurdles

• Who is covered?
• What benefits are included under this cover?
• Do accessible providers offer services when they are needed/ appropriate?
• Do cost-sharing regulations impact on the demand for, and therefore access to, these services?
• Do their capacities allow the actual delivery of the appropriate services?
• Are the available appropriate services acceptable?

HealthAccess Project
(funded under Public Health Programme)
Phase I
Insustainable?

Trans-border care (here: imported goods and services in €/capita): negligible or under-counted?

Source: Palm et al. 2000

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<td>Sweden</td>
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<td>1.31</td>
<td>2.95</td>
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Foreign EU patients treated annually in 2000/01: exports

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<td>14 061</td>
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<td>DK</td>
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<td></td>
<td>2 401</td>
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<td>E</td>
<td>20 559 825</td>
<td>3 156</td>
<td>133 958</td>
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<td>F</td>
<td>297 200 000</td>
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<td>435 856</td>
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<td></td>
<td></td>
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<td>4 101</td>
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<tr>
<td>NL</td>
<td></td>
<td></td>
<td>3 316</td>
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<td>AT</td>
<td>5 160 000</td>
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<td>1 000</td>
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<td>FIN</td>
<td>951 000</td>
<td>9</td>
<td>11 483</td>
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<tr>
<td>SW</td>
<td>9 504 411</td>
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<tr>
<td>UK</td>
<td>8 720 428</td>
<td>871</td>
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</table>

No data: D, GR, P

Commission staff working paper, July 2003
Germany: Imported goods and services = best contained area of health expenditure!

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<td>99</td>
<td>108</td>
<td>113</td>
<td>117</td>
<td>116</td>
<td>118</td>
<td>122</td>
<td>124</td>
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<td>133</td>
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<tr>
<td>in % GDP</td>
<td>6.14</td>
<td>6.00</td>
<td>6.20</td>
<td>6.27</td>
<td>6.36</td>
<td>6.18</td>
<td>6.13</td>
<td>6.15</td>
<td>6.13</td>
<td>6.21</td>
<td>6.32</td>
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<tr>
<td>Outside the country in € bn</td>
<td>0.36</td>
<td>0.35</td>
<td>0.33</td>
<td>0.36</td>
<td>0.40</td>
<td>0.35</td>
<td>0.34</td>
<td>0.35</td>
<td>0.37</td>
<td>0.37</td>
<td>0.41</td>
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<tr>
<td>as % of SHI expenditure</td>
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<td>0.36</td>
<td>0.31</td>
<td>0.32</td>
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<td>0.29</td>
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<td>0.30</td>
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<td>as % of GDP</td>
<td>0.02</td>
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<td>0.02</td>
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<tr>
<td>Total expenditure in €bn</td>
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<td>168</td>
<td>180</td>
<td>194</td>
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<td>204</td>
<td>208</td>
<td>214</td>
<td>219</td>
<td>227</td>
<td>234</td>
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<tr>
<td>in % GDP</td>
<td>10.1</td>
<td>10.2</td>
<td>10.4</td>
<td>10.8</td>
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<td>10.9</td>
<td>10.8</td>
<td>10.8</td>
<td>11.0</td>
<td>11.1</td>
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<tr>
<td>Outside the country in € bn</td>
<td>0.38</td>
<td>0.37</td>
<td>0.35</td>
<td>0.38</td>
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<td>0.37</td>
<td>0.37</td>
<td>0.38</td>
<td>0.40</td>
<td>0.41</td>
<td>0.44</td>
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<tr>
<td>as % of total expenditure</td>
<td>0.23</td>
<td>0.23</td>
<td>0.19</td>
<td>0.20</td>
<td>0.21</td>
<td>0.18</td>
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<tr>
<td>as % of GDP</td>
<td>0.02</td>
<td>0.02</td>
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<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
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</table>


Ca. € 4.70/capita

Ca. € 5.40/capita
What is the money spent on?
Ratios vs. overall expenditure (2002)

- Transport 1.3
- Physician services 1.25
- Goods 1.15
- Care/ accomodation 0.8
- Prevention 0.65

- Eye diseases 3.2
- Ear diseases 3.0
- Infections 2.0
- Injuries 1.3
... 
- Psychiatric diseases 0.4
- Pregnancy/ birth 0.4
- Cancer 0.35
Is this the whole truth? Most likely not …

E111 self-pay
<table>
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<tr>
<th>Reason</th>
<th>Percentage</th>
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<td>Invoice not submitted to TK sickness fund</td>
<td>42%</td>
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<tr>
<td>TK only covered part of the bill</td>
<td>39%</td>
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<tr>
<td>Usual co-payments in country of service</td>
<td>16%</td>
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<tr>
<td>TK refused to pay</td>
<td>3%</td>
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</table>

**Reasons for not being (fully) reimbursed**

- Invoice not submitted to TK sickness fund
- TK only covered part of the bill
- Usual co-payments in country of service
- TK refused to pay
Pull?

- Österreich: 56% besser, 4% gleichwertig, 12% schlechter
- Niederlande: 41% besser, 5% gleichwertig, 11% schlechter
- Frankreich: 40% besser, 38% gleichwertig, 18% schlechter
- Italien: 39% besser, 38% gleichwertig, 18% schlechter
- Spanien: 41% besser, 39% gleichwertig, 15% schlechter

Differenz zu 100% = keine Angaben
• Why do patients move? More push than pull … and a lot of need arising when abroad.

• Has this led to unsustainable expenditure in the past? No, but there is probably a lot of expenditure not accounted for. Might this change? Not imminently …

• What should we in the EU do about it?
EU health policy

Article 152 (5) TEC
BUT:

• Article 152(5) only relates to Public Health measures

• Other EU policies do interfere with health systems, i.e. do not fully respect the responsibilities of the Member States:
  - occupational law (working times in hospitals!)
  - competition law
  - Single European Market (internal market) – especially as interpreted by the European Court of Justice
Health care outcome: satisfaction, complications etc.

Structures and organisation

Patients: demand, access

Nutrition/ agriculture

Other sectors

Environment

Population health status (need)

Process

Health care system

Health gain/ Outcome

EU health policy

Financial resources

Internal market

Competition law
“At European level, health services have to adapt to market rules, while at national level, health services are seen as part of a social model. To overcome this situation and to ensure the social status of health services, we need – possibly paradoxically – to develop a European health policy.”
Health care
outcome: satisfaction, complications etc.

Structures and organisation

Patients: demand, access

Process

Health care outcome: satisfaction, complications etc.

Other sectors

Environment

Nutrition/ agriculture

Health gain/ Outcome

Population health status (need)

Financial resources

Health care system

EU health policy

Internal market

Competition law

√√ √√ √√ √√ √ √ √√

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√√ √√
If we accept that conclusion, the question is:

Should European health policy be based mainly on the “regular” instruments (regulations, directives etc.) or on the “open method of coordination” (OMC)?
How could the open method of coordination be applied to health care?

Objectives in Commission Communication 4/04:

- **Accessibility of care** for all, based on fairness and solidarity, taking into account the needs and difficulties of the most disadvantaged groups and individuals, as well as those requiring costly, long-term care;

- **High-quality care** for the population, which keeps up with medical advances and the emerging needs associated with ageing and is based on an assessment of their health benefits;

- Measures to ensure the long-term **financial sustainability** of this care and aiming to make the system as efficient as possible.
What do we still need to know?

• In what areas/services do benefit baskets differ among EU countries, i.e. where can patients benefit by moving (under the E111 procedure)?

• How much do prices/reimbursement rates really differ? Or are they rather explained by systematic differences (e.g., capital costs included/not included) or differences in service intensity?
How could the application of such developments influence European health systems? (1)

Initially probably not directly, but
- **Comparability** of services, their access and quality will increase,

and thereby contribute to the *Europeanisation of health care systems*, already on the way through
- mobility of short- and long-term tourists,
- cross-border contracts/ Euregios,
- ECJ rulings on Kohll/ Decker, Peerbooms etc.,
- the EU-health insurance card.
How could the application of such developments influence European health systems? (2) This will in the medium-term probably lead to

- a European *benefit catalogue* (but not equal prices),
- Europe-wide rules/ standards for *accreditation* and *quality assurance*,
- Europe-wide diagnosis/ treatment *guidelines*.

This could make *Europe more concrete for its citizens* and help to remove the conflict between *markets and the social model*. 
This presentation and more material can be found on my department’s website

http://mig.tu-berlin.de