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Patient mobility and financial sustainability of health systems

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&
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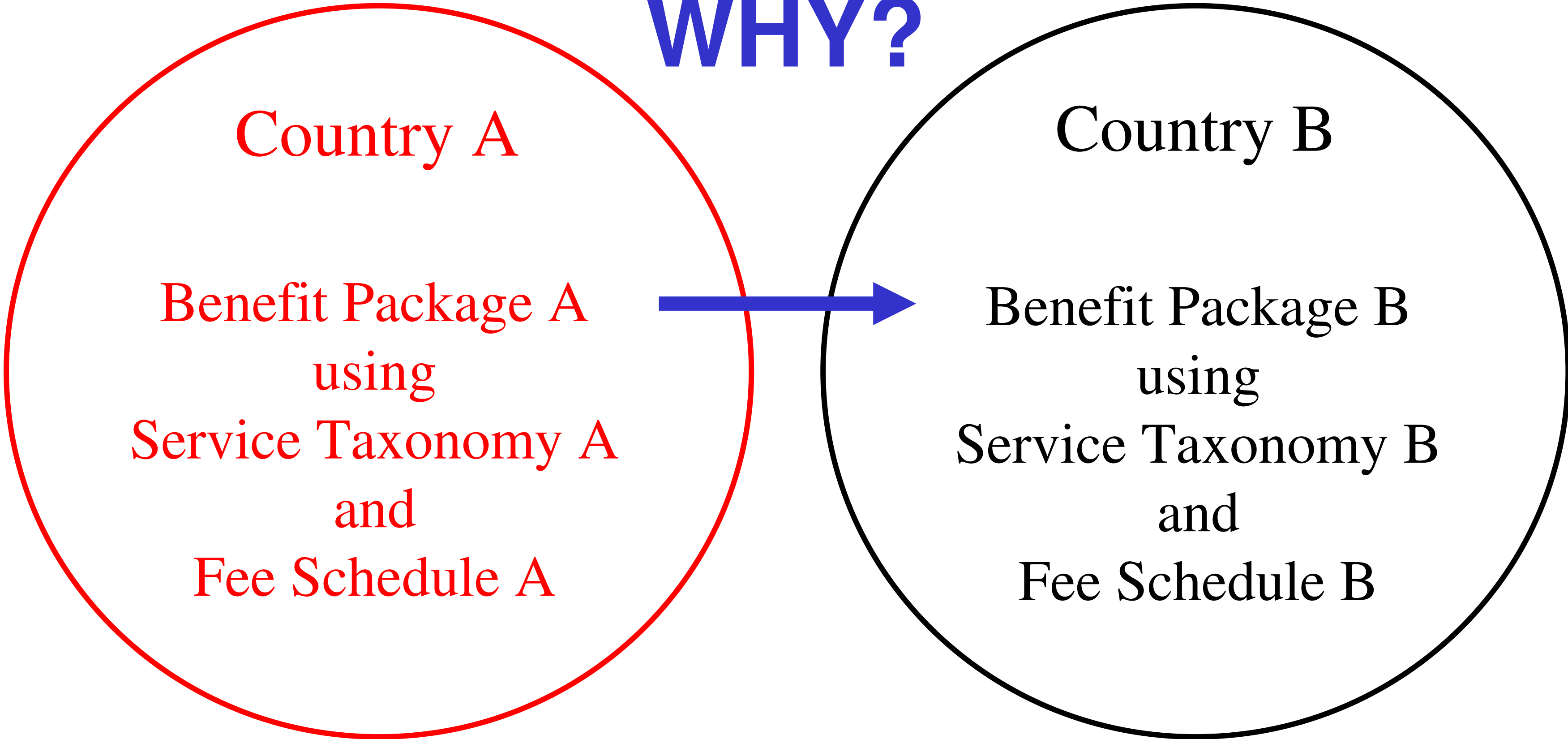
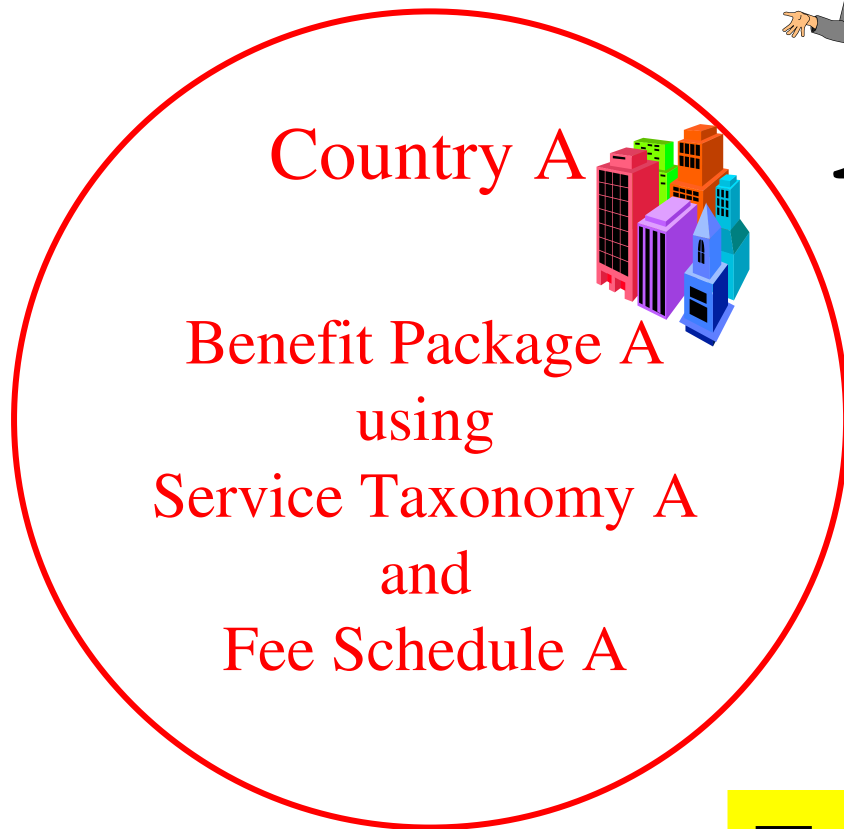
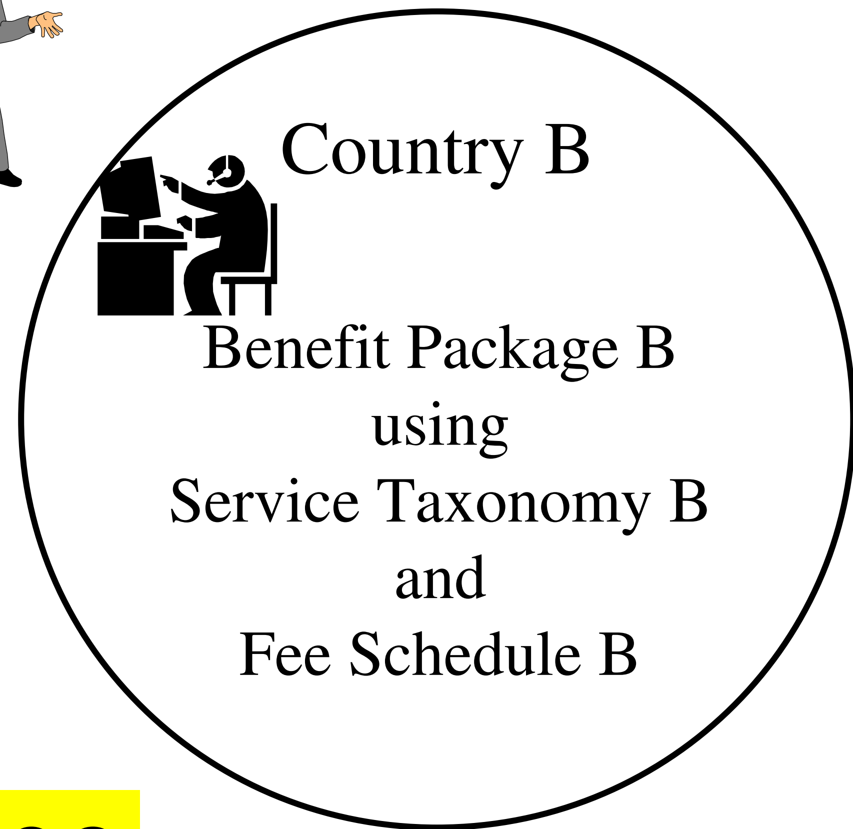
European Observatory on Health Systems and Policies

- 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?


WHY?
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

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





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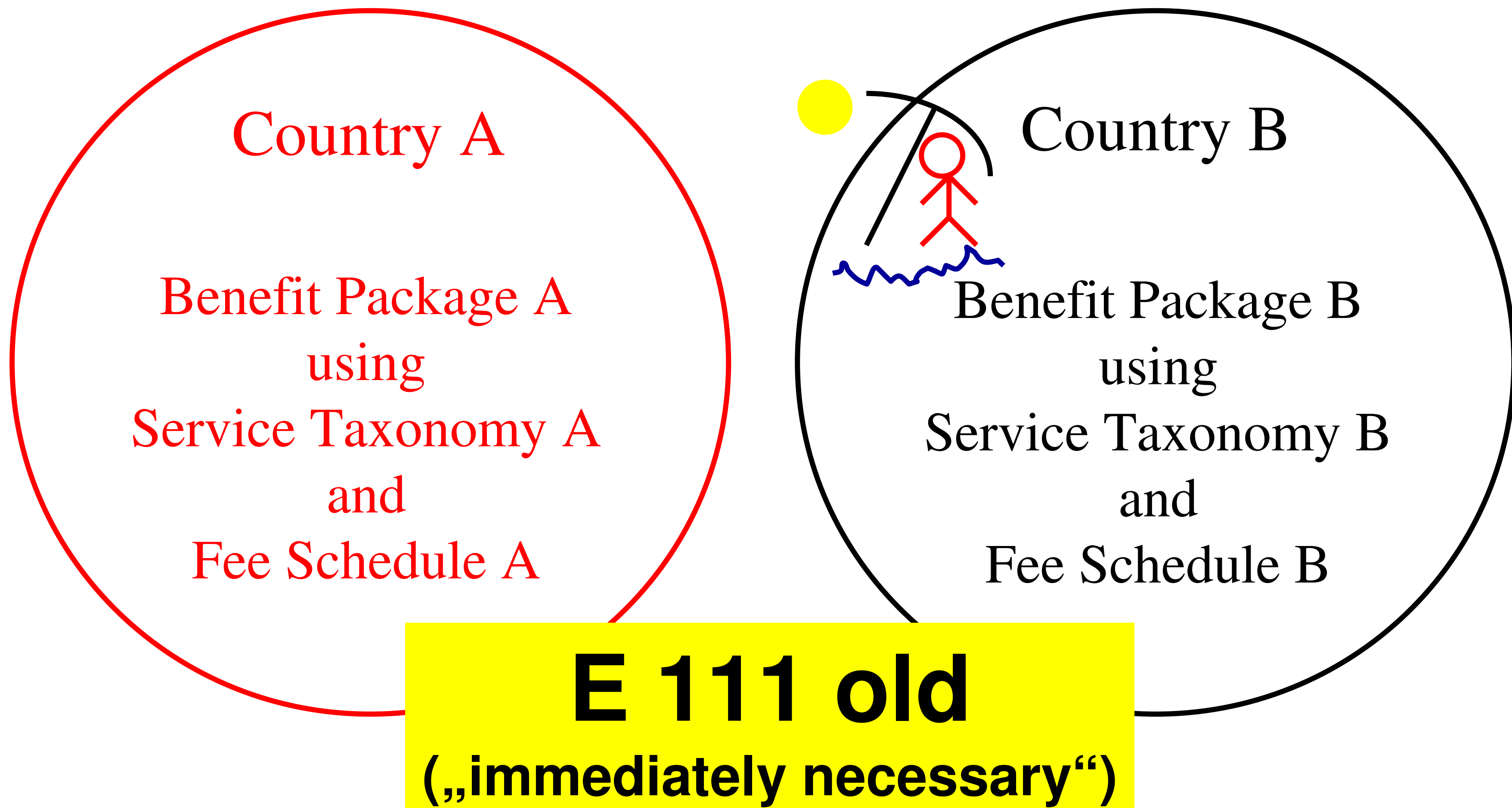
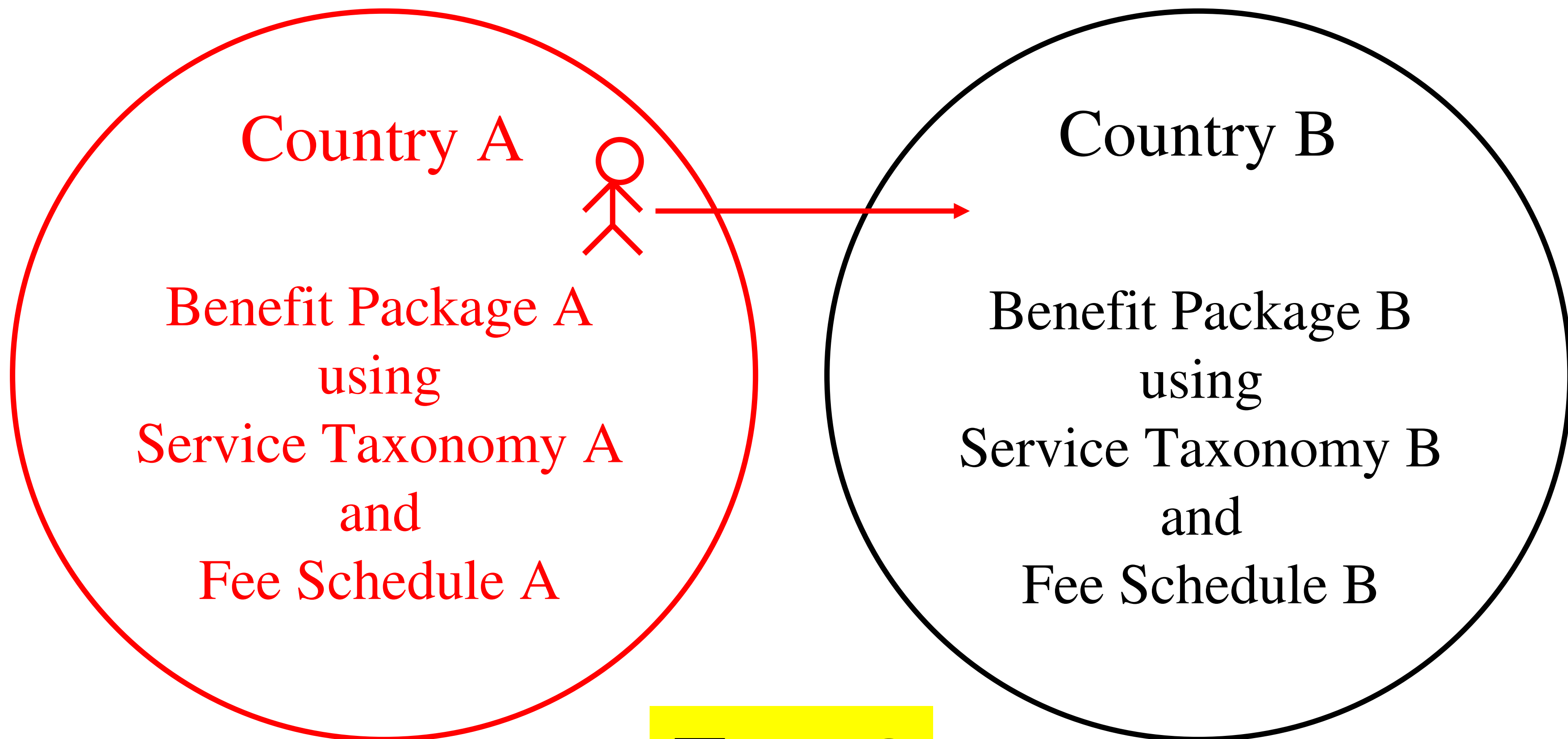
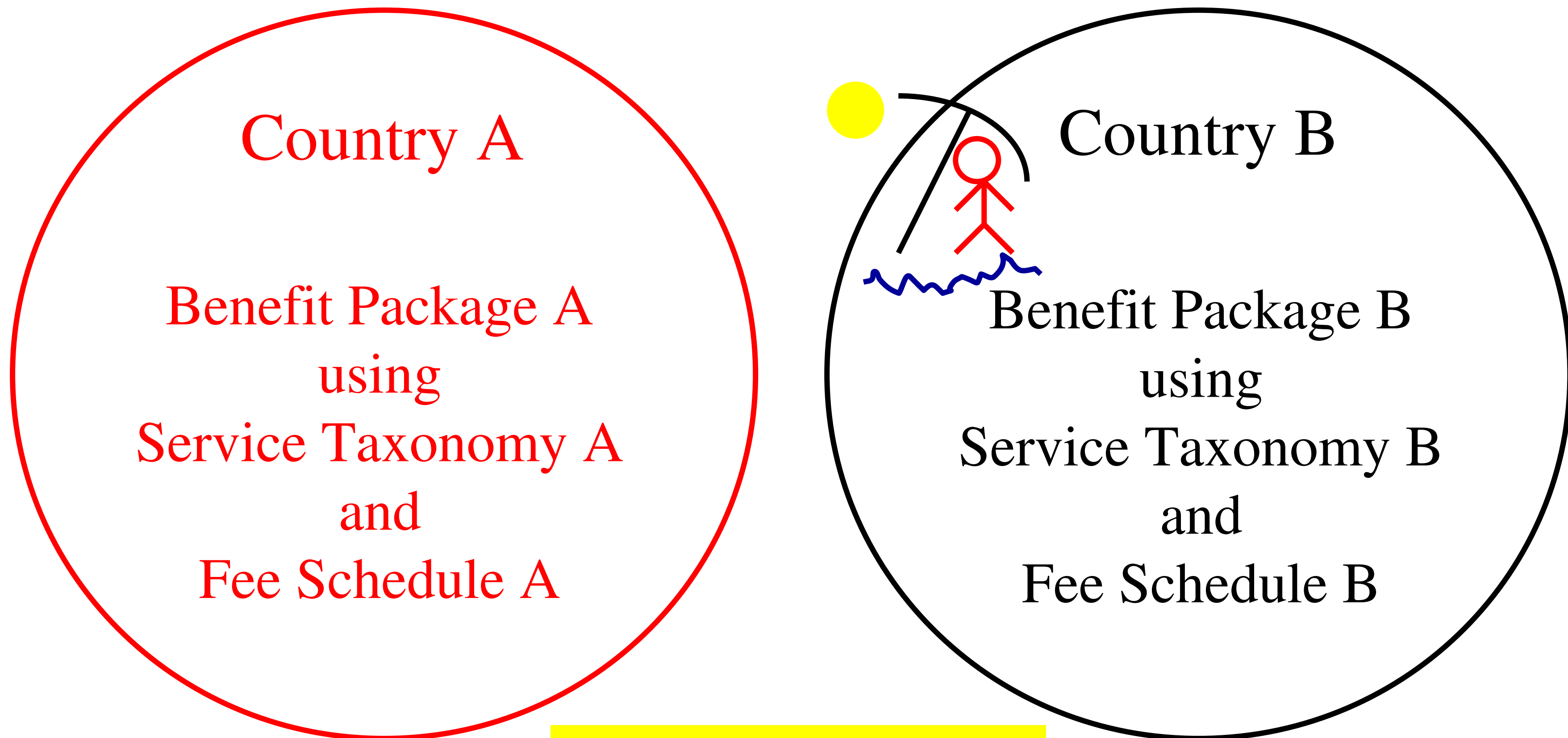
Situation 2: Person from Country A happens to be in Country B (for tourism, business ...) when he/she falls ill and needs treatment.



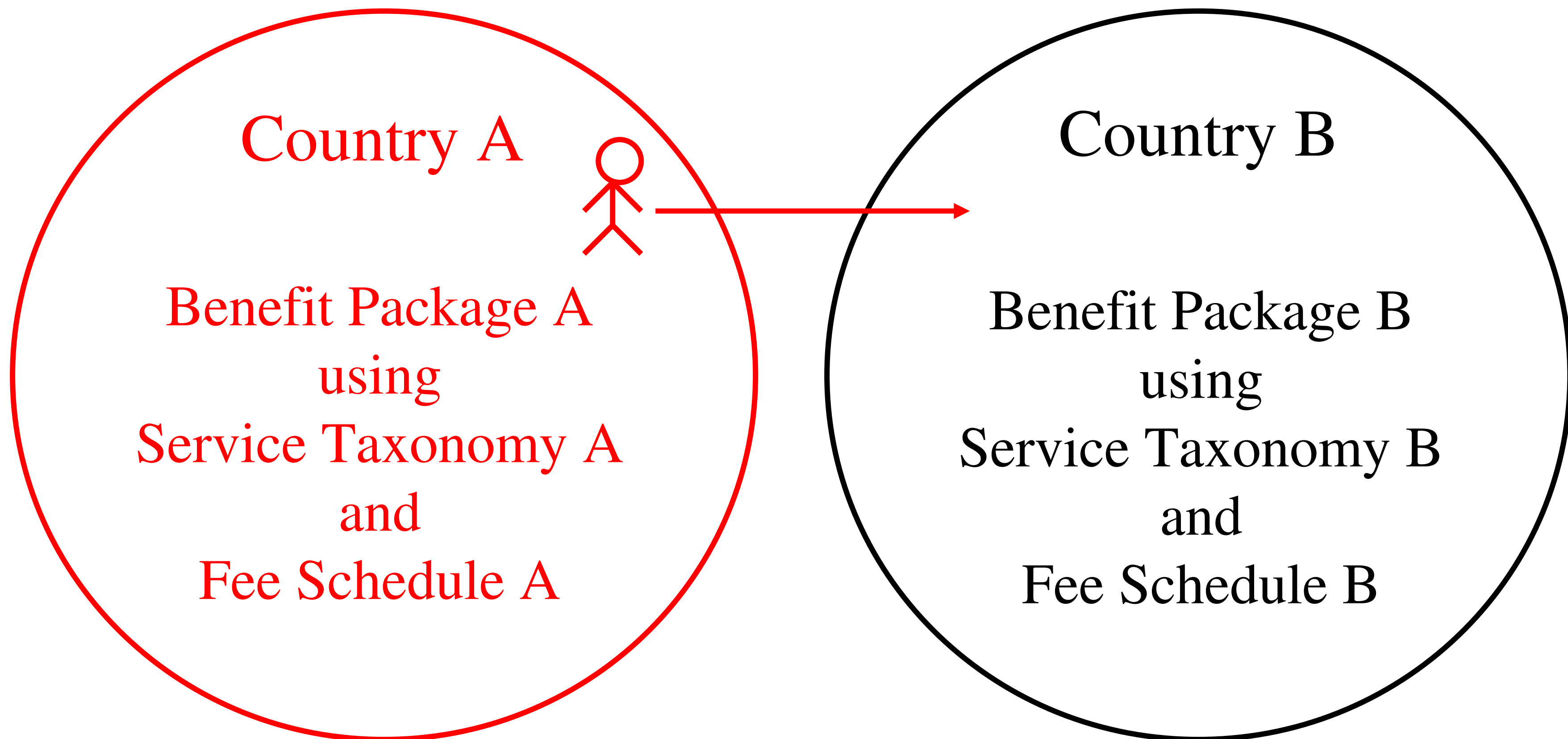
Situation 3: Patient from Country A needs go to Country B for treatment as it is not available in Country A.



New Situation 1: Retired person from Country A wants to live in Country B (including receiving health care there).



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 ...



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 al[...] appropriate serv[...]
- Are the available ap[...]

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

	1989	1993	1997	1998
Belgium	3.62	8.93	8.93	4.38
Denmark	-	0.16	0.83	0.63
France	0.79	1.87	1.21	1.05
Germany	1.77	1.83	2.08	2.21
Greece	0.95	2.51	2.68	3.15
Ireland	0.18	0.65	1.68	0.93
Italy	2.99	8.36	3.52	2.89
Luxembourg	58.01	149.55	135.29	116.00
Netherlands	1.95	0.26	1.98	2.85
Portugal	0.82	3.76	6.81	7.00
Spain	0.33	1.48	1.03	1.11
United Kingdom	0.33	1.61	1.92	0.36
Austria	-	-	0.48	1.87
Finland	-	-	0.49	0.52
Sweden	-	-	0.65	0.96
AVERAGE	1.31	2.95	2.37	1.99

Foreign EU patients treated annually in 2000/01: exports

	total invoice (€)	E112 persons	E111 persons
B	168 790 871	14 061	
DK		2 401	
E	20 559 825	3 156	133 958
F	297 200 000	435 856	
I		1 022	
IRL		1 ?	
L		4 101	250
NL		3 316	
AT	5 160 000	1 000	
FIN	951 000	9	11 483
SW	9 504 411		
UK	8 720 428	871	

No data: D, GR, P

Commission staff working paper, July 2003

Germany: Imported goods and services = best contained area of health expenditure!

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
SHI expenditure total in € bn	99	99	108	113	117	116	118	122	124	129	133
in % GDP	6.14	6.00	6.20	6.27	6.36	6.18	6.13	6.15	6.13	6.21	6.32
Outside the country in € bn	**0.36**	**0.35**	**0.33**	**0.36**	**0.40**	**0.35**	**0.34**	**0.35**	**0.37**	**0.37**	**0.41**
as % of SHI expenditure	**0.36**	**0.36**	**0.31**	**0.32**	**0.34**	**0.30**	**0.29**	**0.29**	**0.30**	**0.29**	**0.31**
as % of GDP	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**
Total expenditure in €bn	163	168	180	194	203	204	208	214	219	227	234
in % GDP	10.1	10.2	10.4	10.8	11.1	10.9	10.8	10.8	10.8	11.0	11.1
Outside the country in € bn	**0.38**	**0.37**	**0.35**	**0.38**	**0.42**	**0.37**	**0.37**	**0.38**	**0.40**	**0.41**	**0.44**
as % of total expenditure	**0.23**	**0.23**	**0.19**	**0.20**	**0.21**	**0.18**	**0.18**	**0.18**	**0.18**	**0.18**	**0.19**
as % of GDP	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**

Federal Statistical Office, 2004.

Ca. € 4.70/capita

Ca. € 5.40/capita

What is the money spent on? Ratios vs. overall expenditure (2002)

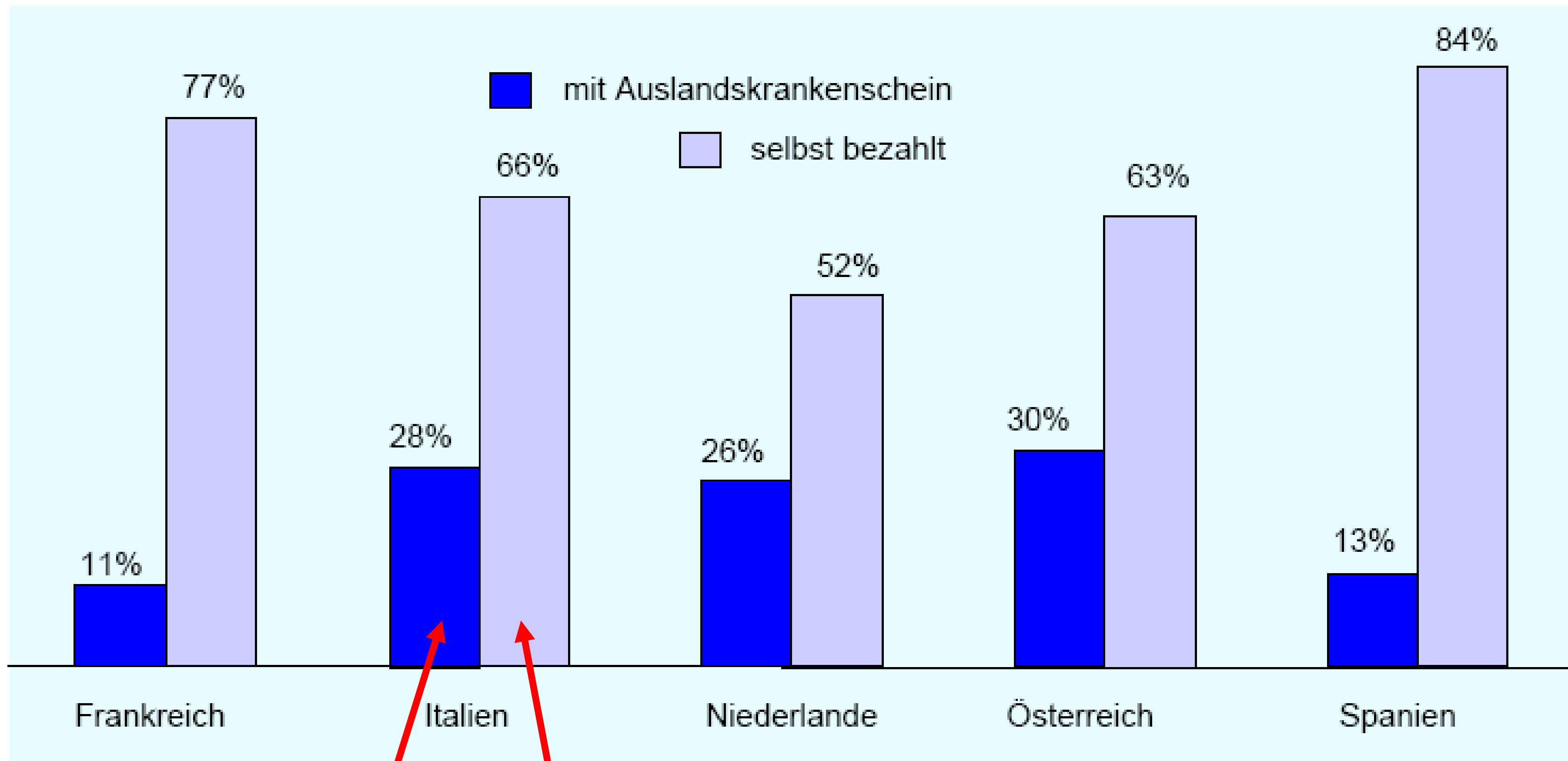
- Transport 1.3
- Physician services 1.25
- Goods 1.15
- Care/ accomodation 0.8
- Prevention 0.65

- 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

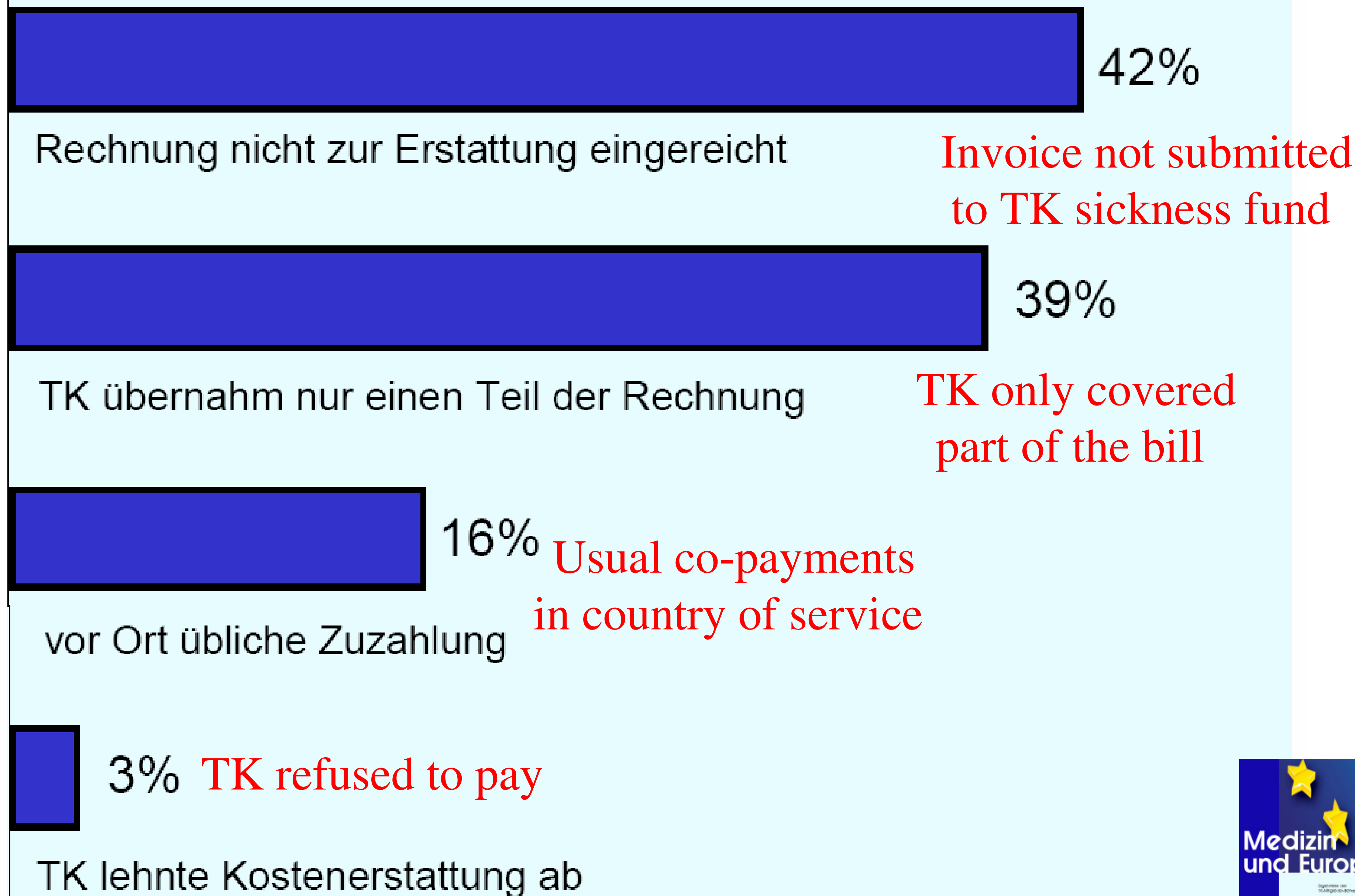
Is this the whole truth? Most likely not …



E111 self-pay

Medizin und Europa

Reasons for not being (fully) reimbursed



Pull?

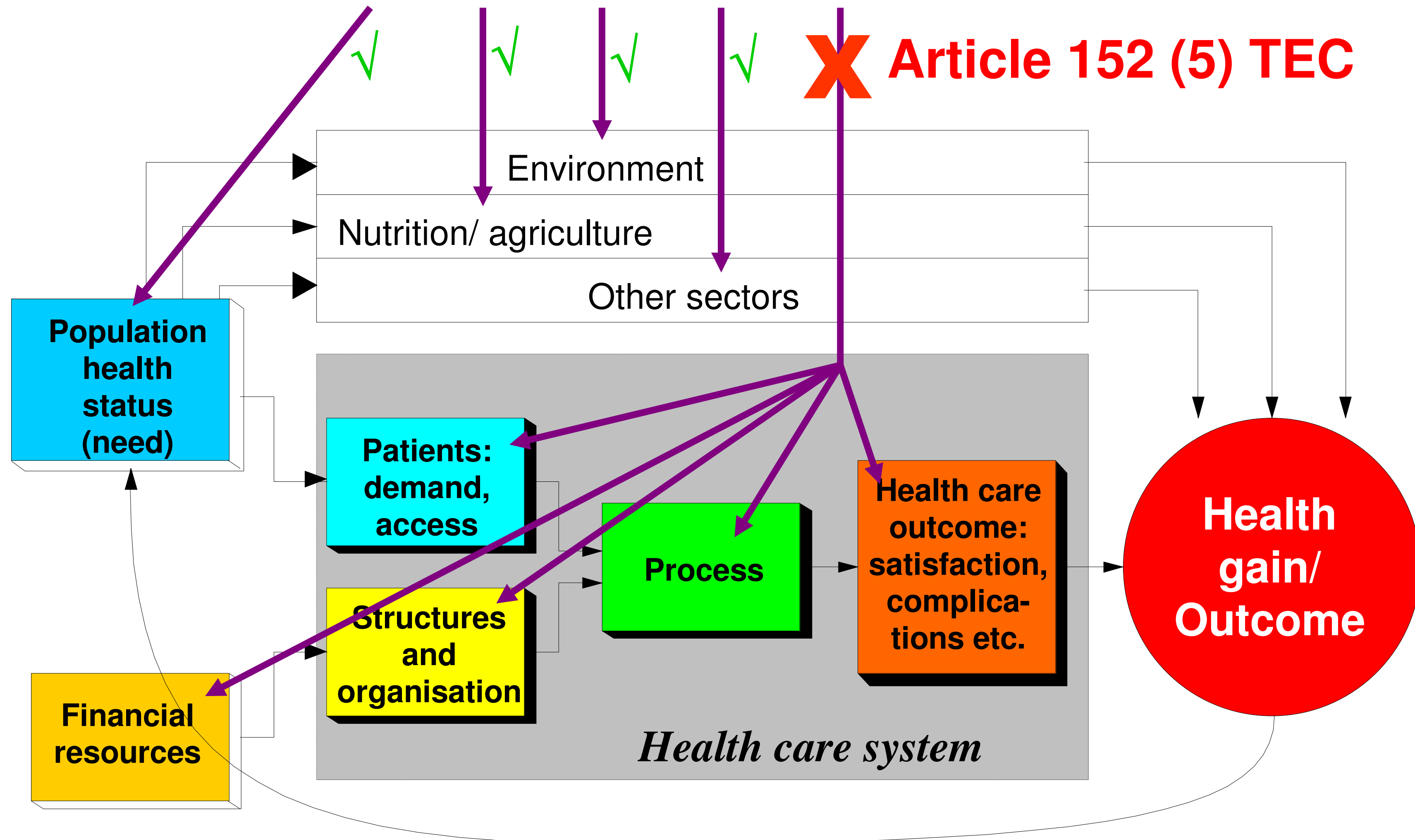
4%
56%
5%
41%
12%
11%
40%
38%
18%
39%
15%

Österreich
Niederlande
Frankreich
Italien
Spanien

besser
gleichwertig
schlechter
Differenz zu 100% = keine Angaben

Better
Same
Worse

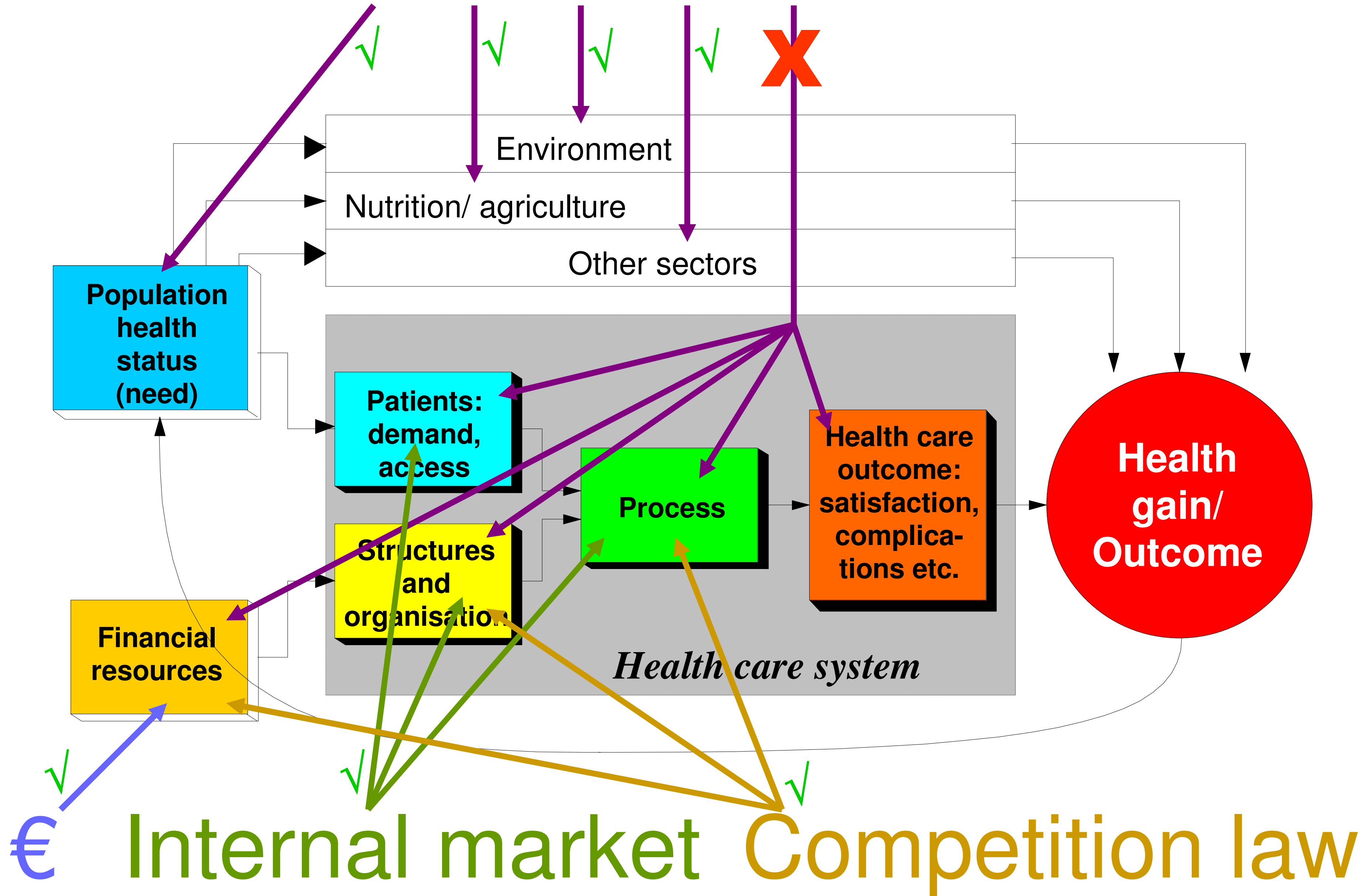
- Why do patients move? More push than pull … and a lot of need arising when abroad.
- Has this led to unsustainable expenditure in the past? No, but there is probably a lot of expenditure not accounted for. Might this change? Not imminently …
- What should we in the EU do about it?



EU health policy
√
√
√
√
X
Article 152 (5) TEC
Environment
Nutrition/ agriculture
Other sectors
Population health status (need)
Patients: demand, access
Structures and organisation
Process
Health care outcome: satisfaction, complica-tions etc.
Health gain/ Outcome
Financial resources
Health care system

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*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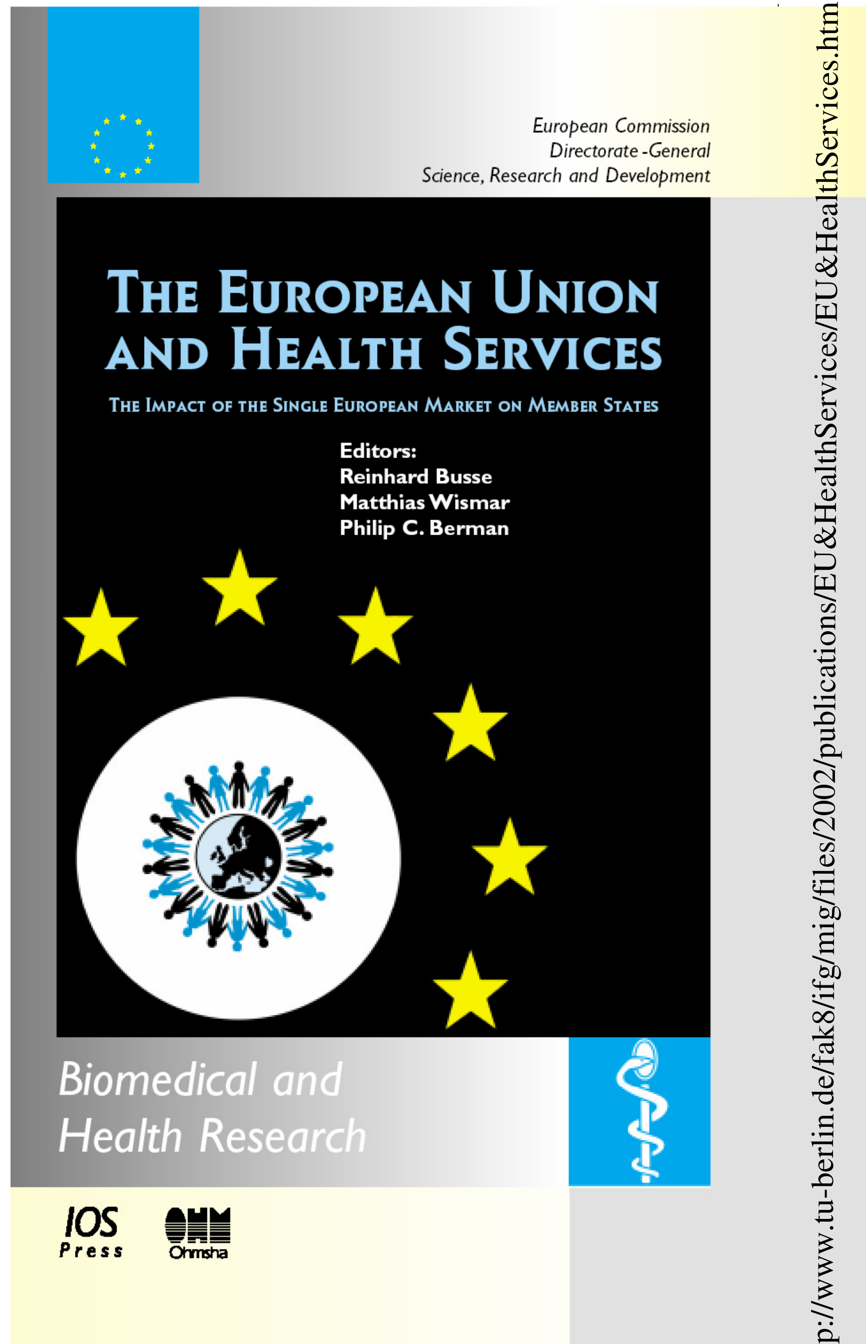
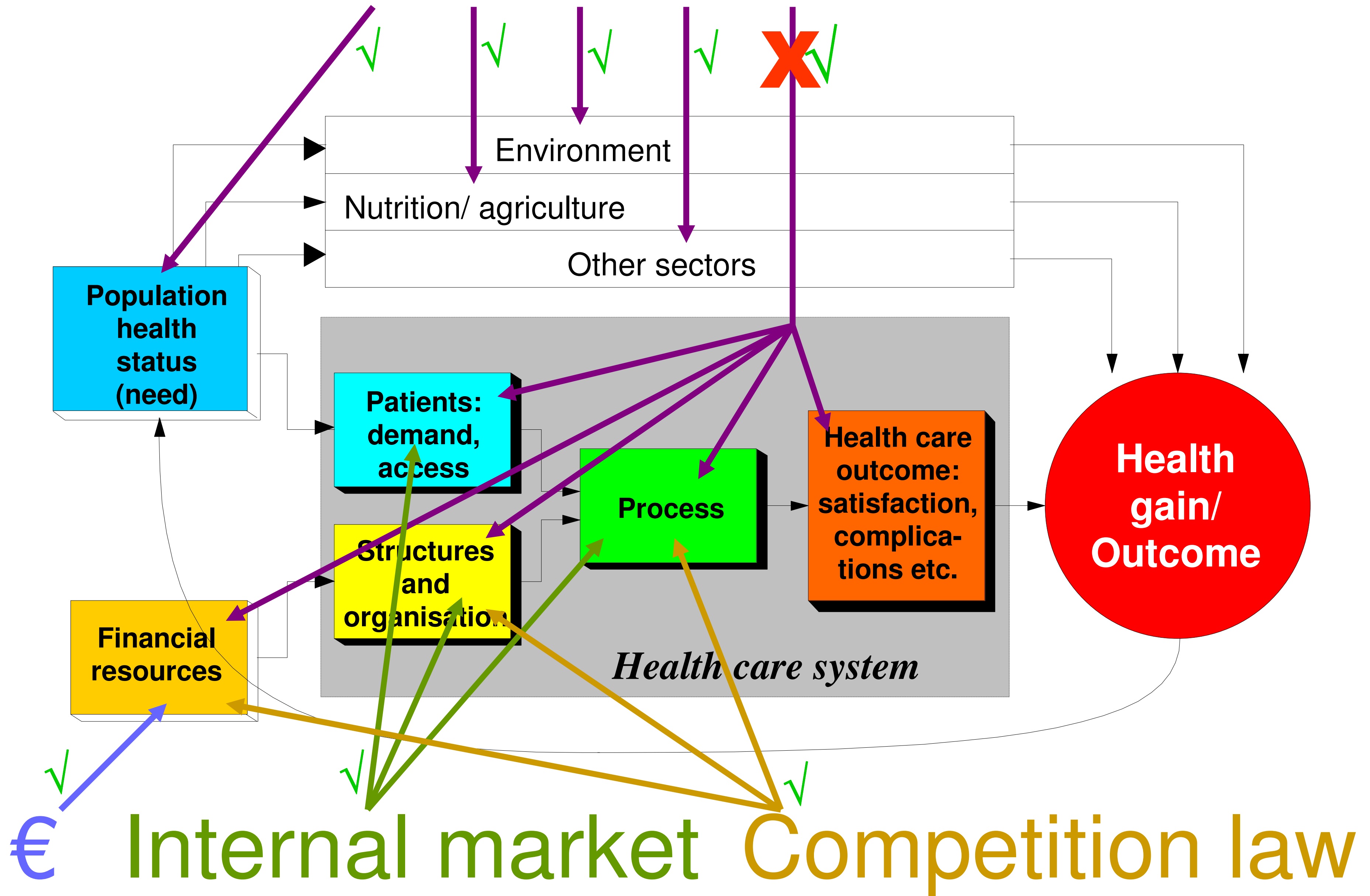
√
√
√
€
Internal market
Competition law



“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.“

EU health policy



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:

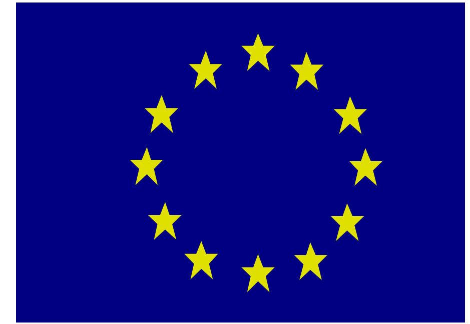
- **Accessibility of care** for all, based on fairness and solidarity, taking into account the needs and difficulties of the most disadvantaged groups and individuals, as well as those requiring costly, long-term care;
- **High-quality care** for the population, which keeps up with medical advances and 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 i
service inte

HealthBasket Project
(funded under the 6th Framework)
Phases I, II & III

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.*

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This presentation and more material can be found on my department's website

http://mig.tu-berlin.de

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