How much does patient mobility cost?

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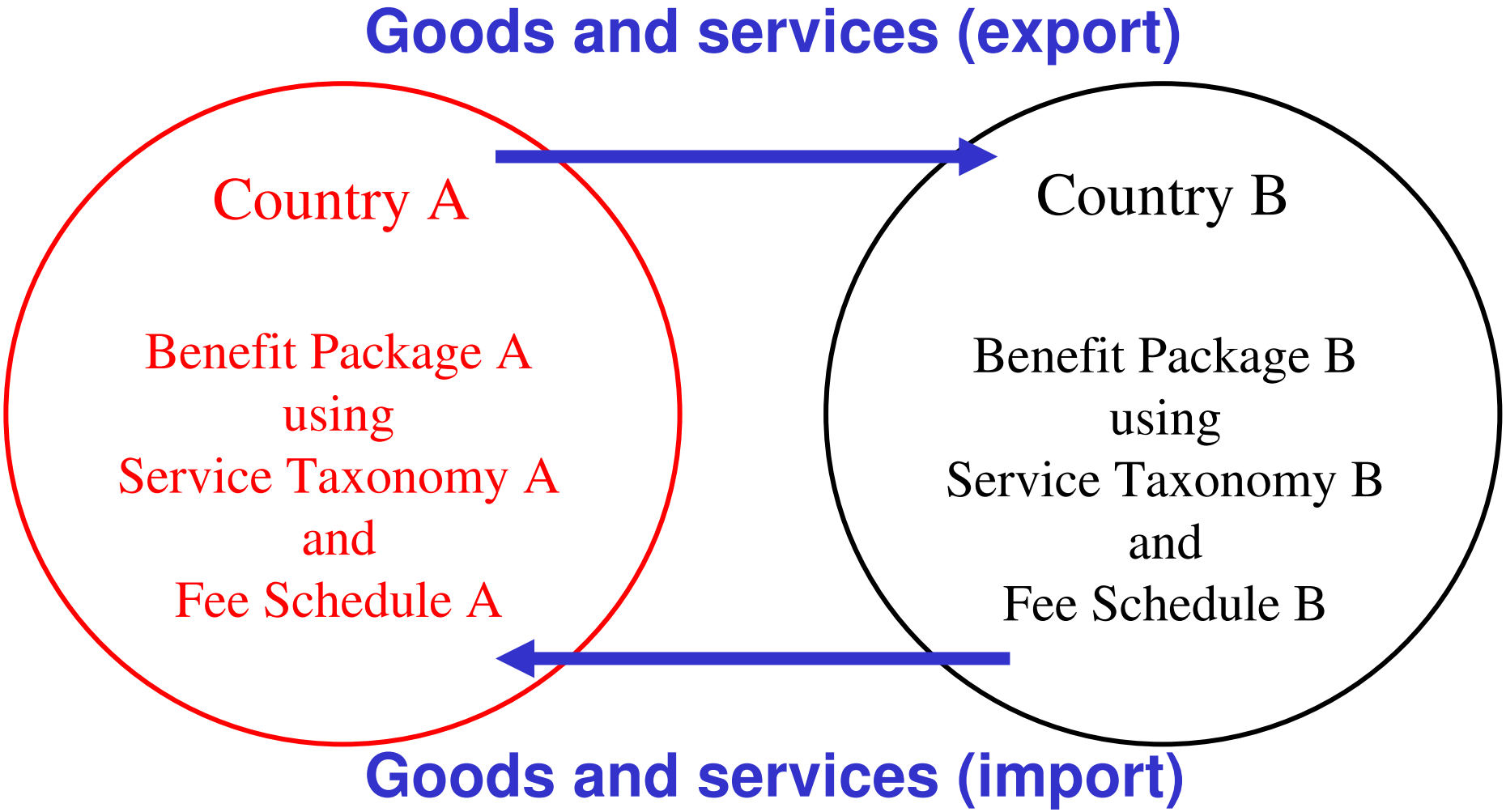
Quantifying in- and exports of health goods and services in EU-member states



What do we know?

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

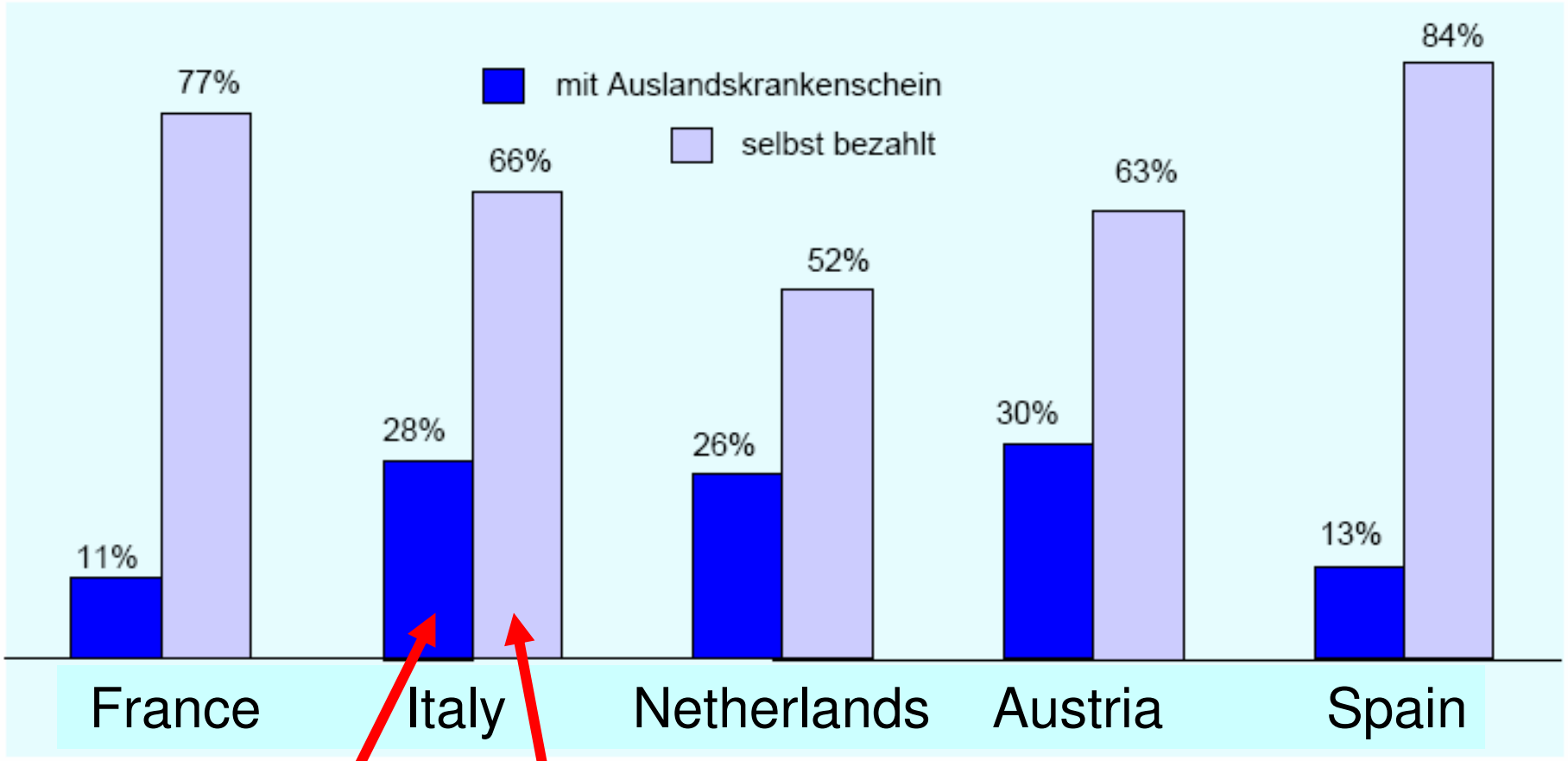
…

- Psychiatric diseases 0.4
- Pregnancy/ birth 0.4
- Cancer 0.35

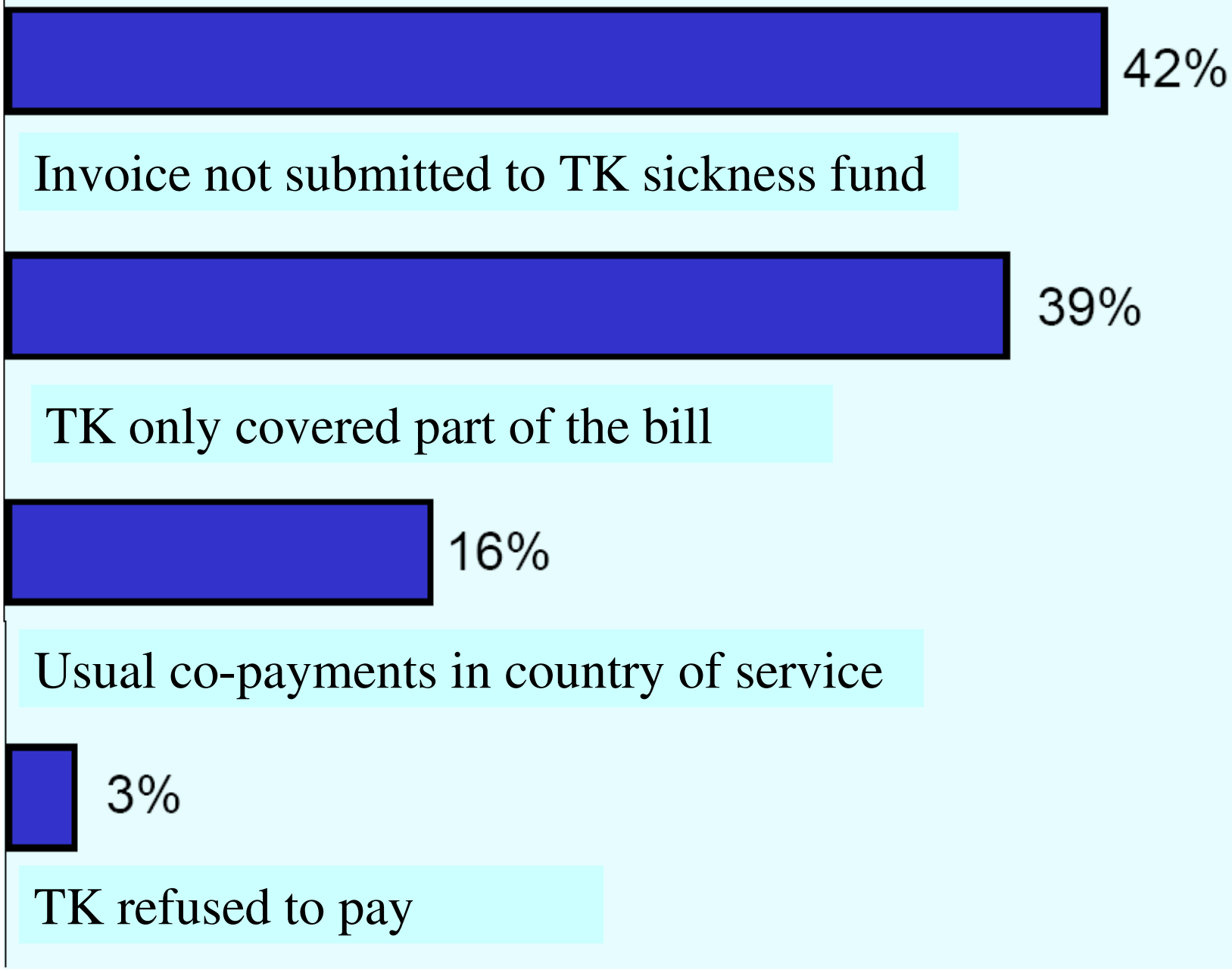
3x as often as within country

1/3x as often as within country

Is this the whole truth? Most likely not …



Reasons for not being (fully) reimbursed

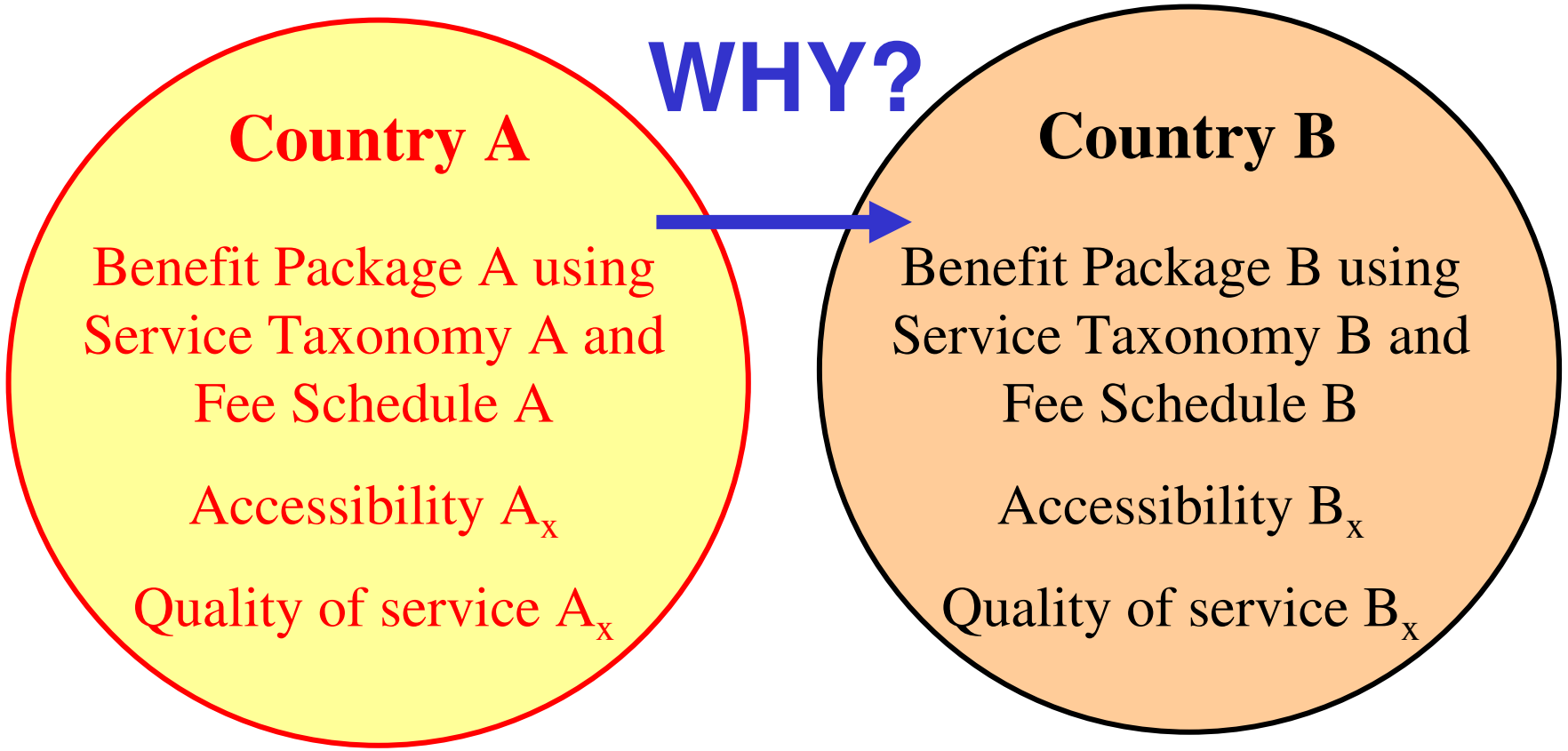


- Why do patients move? More push than pull *(difference to professionals!)* … and a lot of need arising when abroad.
- Has this led to unsustainable expenditure in the past? No, but there is probably a lot of expenditure not accounted for. Might this change? Not imminently …
- *Speculation:* The major reason for low volumes is that actors, policy makers and patients lack accurate information on …

Patient mobility

HOW MANY?

WHY?



WHICH SERVICES?

WHAT COSTS?
(SERVICES x REIMBURSEMENT)

HealthBASKET

Health Benefits and Service Costs in Europe

A European Research Project
April 2004 – March 2007

PROJECT PARTNERS ARE...

European Health Management Asssociation

Centre for Health Economics,
University of York, United Kingdom

Department of Health Care Management,
Berlin University of Technology, Germany

Health Services Management Training Centre,
Semmelweis University, Hungary

École Nationale de la Santé Publique,
France

Institute for Health Policy and Management,
Erasmus University Rotterdam, The Netherlands

Danish Institute for Health Services Research,
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Jagiellonian University Medical College,
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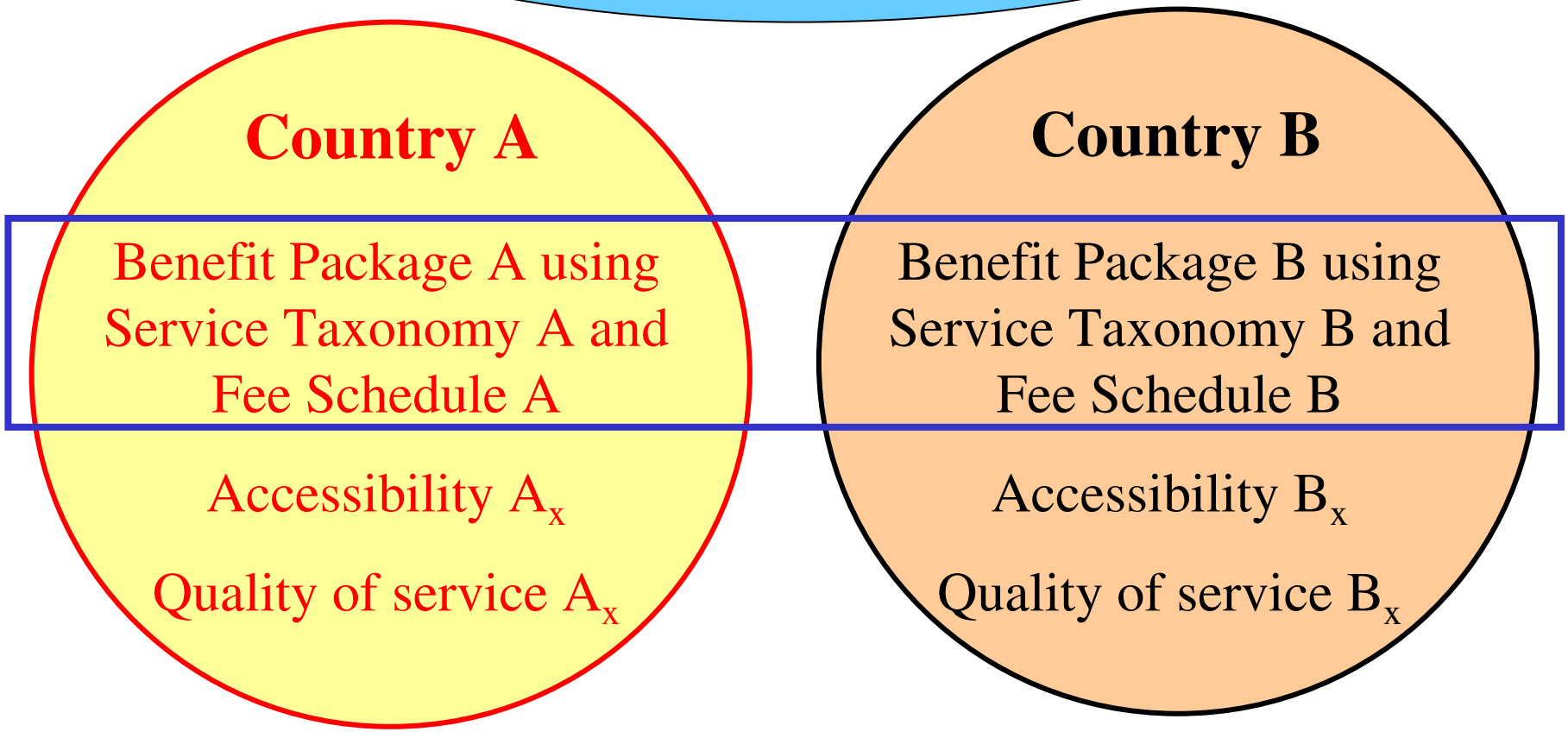
HealthBasket Project
(funded under the 6th Framework)
Phases I, II & III



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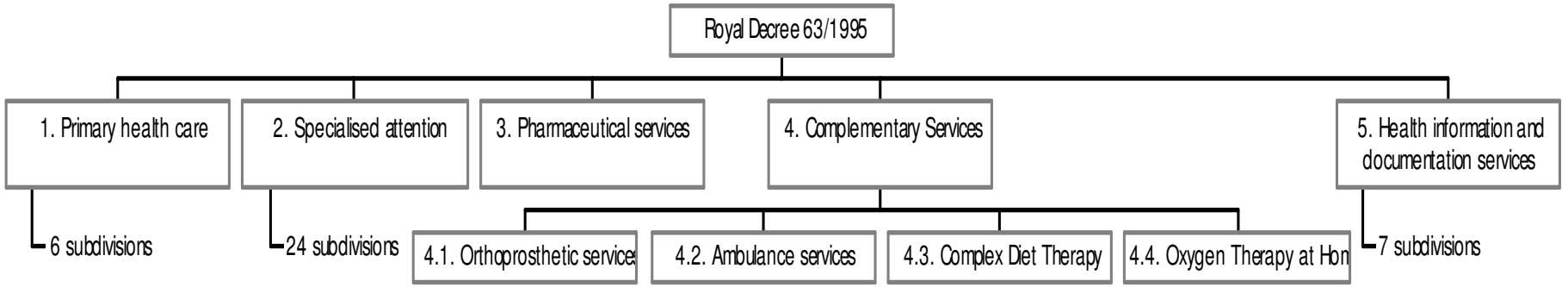
Taxonomy

theoretical study of classification,
including its basic principles,
procedures, and rules –
"the science of classification"

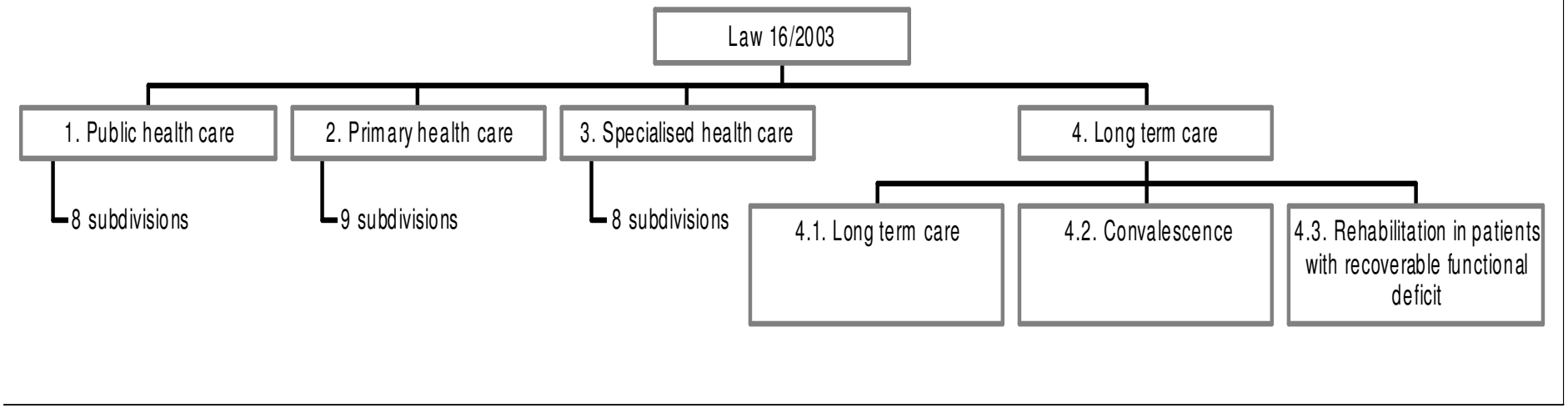
Diseases: ICD;
Functional impairments: ICF;
Health care providers: System of Health Accounts;
Health services and goods: ???

Figure 1: Taxonomy of the Royal Decree. 63/1995



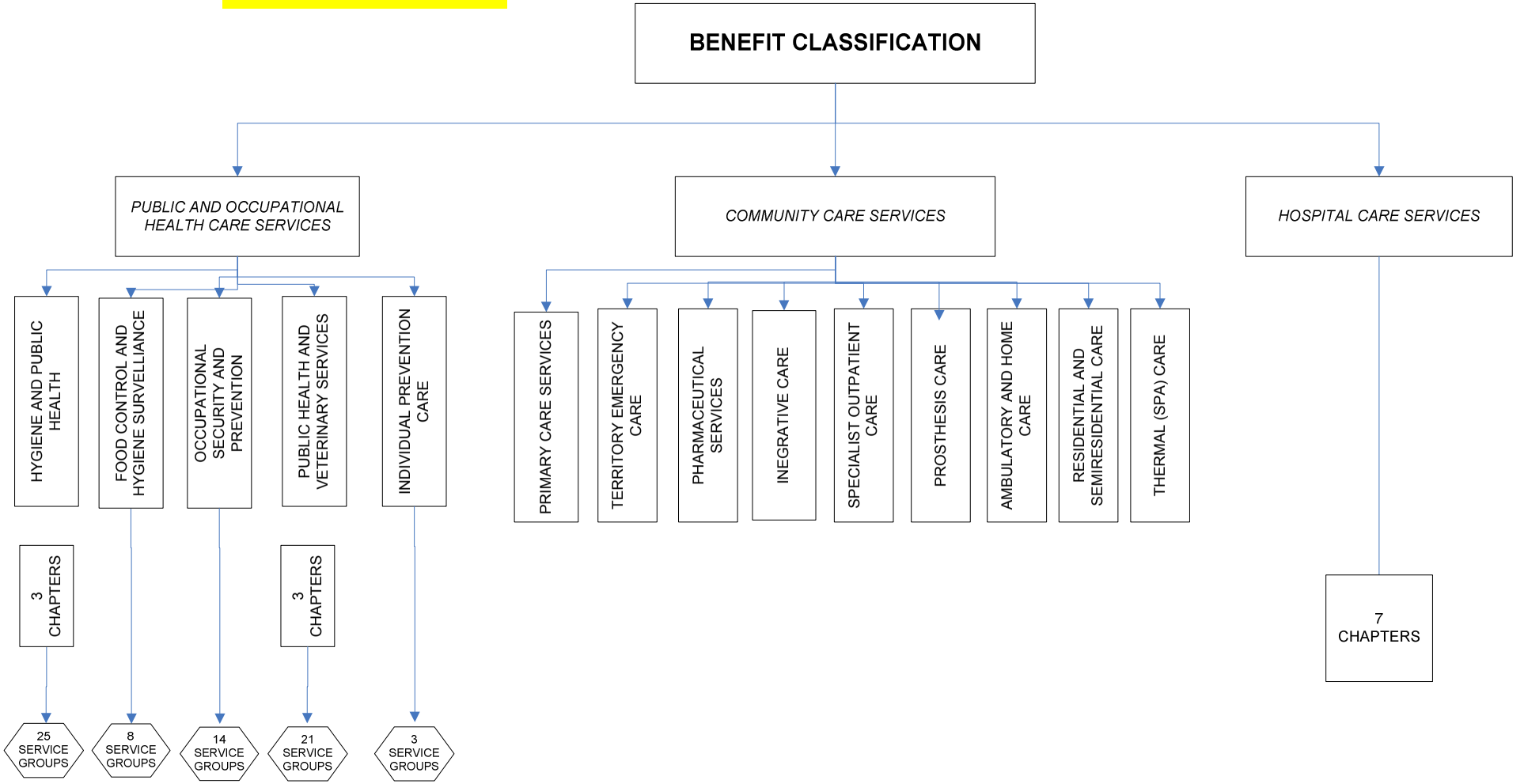
Source: Own elaboration.

Figure 2: Taxonomy of LAW 16/2003



Source: Own elaboration.

ITALY


BENEFIT CLASSIFICATION
PUBLIC AND OCCUPATIONAL HEALTH CARE SERVICES
COMMUNITY CARE SERVICES
HOSPITAL CARE SERVICES
HYGIENE AND PUBLIC HEALTH
FOOD CONTROL AND HYGIENE SURVELLIANCE
OCCUPATIONAL SECURITY AND PREVENTION
PUBLIC HEALTH AND VETERINARY SERVICES
INDIVIDUAL PREVENTION CARE
PRIMARY CARE SERVICES
TERRITORY EMERGENCY CARE
PHARMACEUTICAL SERVICES
INEGRATIVE CARE
SPECIALIST OUTPATIENT CARE
PROSTHESIS CARE
AMBULATORY AND HOME CARE
RESIDENTIAL AND SEMIRESIDENTIAL CARE
THERMAL (SPA) CARE
3 CHAPTERS
3 CHAPTERS
7 CHAPTERS
25 SERVICE GROUPS
8 SERVICE GROUPS
14 SERVICE GROUPS
21 SERVICE GROUPS
3 SERVICE GROUPS

*Health*BASKET Phase I – How are benefit baskets determined and which services are included?

- Taxonomy differs largely from country to country – even if most tend to sort ambulatory care by physician specialty and inpatient care by diagnosis and procedure (DRGs/HRGs/DBCs …)
- No country has one uniform catalogue; it‘s rather a mixture of differently defined lists (entitlements, payment, guidelines …)

*Health*BASKET Phase I – How are benefit baskets determined and which services are included?

- Only small variation of provided benefits between countries – most countries exclude similar benefits: cosmetic surgery, vaccination for travelling purposes) and certain non-conventional treatments (e.g. acupuncture)
- variation might be even larger within countries due to decentralisation processes e.g. in Spain and Italy

*Health*BASKET Phase I – How are benefit baskets determined and which services are included? -> The example of inpatient care

- France and Poland have defined explicit inpatient benefit catalogues, listing detailed procedures/ in other countries DRGs- and other grouping-systems (e.g. HRGs in UK) serve as implicit tool for defining maximum resource consumption
- Regional variations of explicitness in Italy and Spain; e.g. Italian region of Lombardy added three new DRGs to its system in order to specifically consider the use of drug eluting stents (DES) and to encourage its utilisation
- decision criteria for the inclusion of benefits are in most cases officially announced, but seldom applied/ in reality inclusion decisions are rather guided by lobbyism of actors

_Health_BASKET Phase I –
How are benefit baskets determined and which services are included?
-> The example of inpatient

A supplement of the European Journal of Health Economics summarising the results will be available in November.

*Health*BASKET Phases II & III

- How do countries fix/ negotiate reimbursement?
- How much do prices/ reimbursement rates really differ?
  Or are they rather explained by systematic differences (e.g. capital costs included/ not included)?
  Or by differences in service intensity (e.g. pre-operative tests)?

Methodology:
Case vignettes

www.***Health*BASKET**.org

*Health*hBASKET Phase II – How are services priced and how are prices determined?

- Most countries have already installed performance-based remuneration schemes for in- and outpatient services, while they are often lacking for long-term care, rehabilitation etc.
- There is a clear trend towards the use of micro-costing data (especially for inpatient services) to determine remuneration rates, reflecting the real costs of providers

  -> problem:
  insufficient quality of data delivered by providers
- Phases I+II = basis for phase III as the core of the project

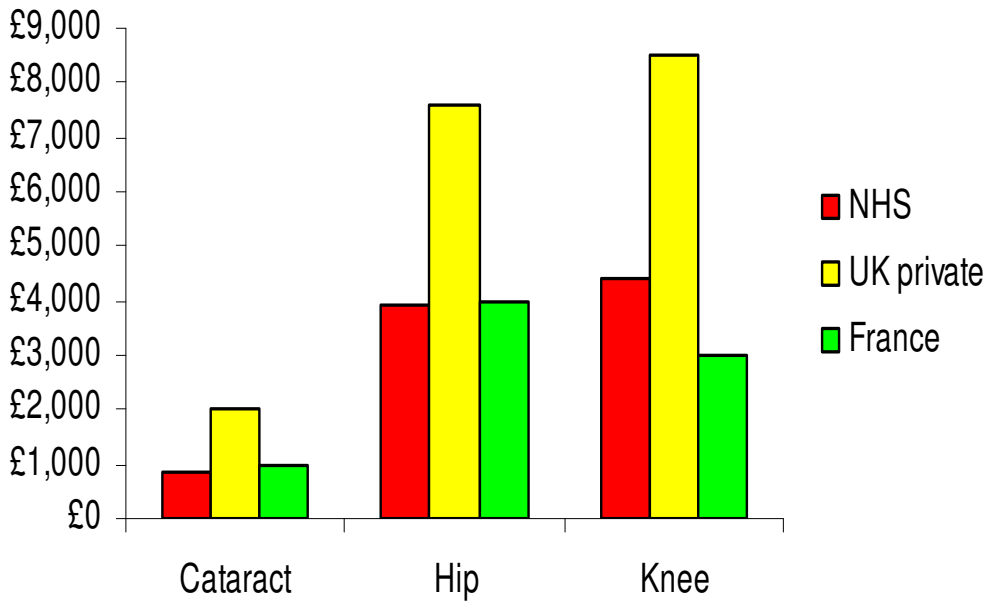
*Health*BASKET Phase III – Calculation of costs and prices for 10 case vignettes and analysis of differences

- 10 case vignettes ("service packages") are designed around episodes of care, e.g. hip replacement, cataract, coughing child
- To ensure comparability across vignettes, each is divided into detailed path components e.g. diagnostic procedures, care before operation etc.
- To ensure homogeneity within case vignettes, health status and indication of each patient is defined in detail for each vignette
- Partners in each country calculate costs and prices for case vignettes with data from at least 5 representative providers

-> Finally costs and prices are compared and differences are analysed

The *Health*BASKET project is limited in scope – but important!

The first nine patients sent to France by the English NHS (not shown: the 40 journalists who accompanied them)

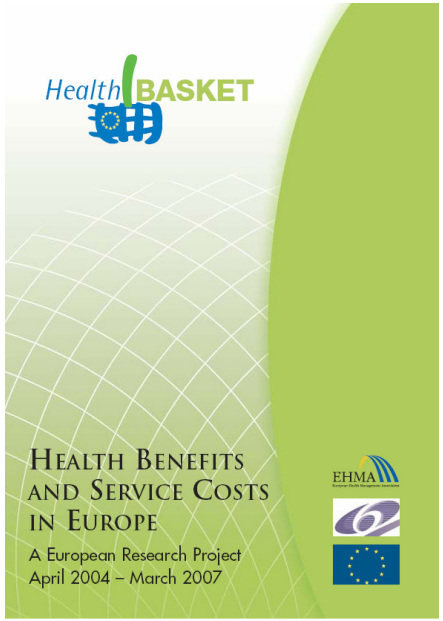


ARE THESE DATA REALISTIC?
ARE THEY REPRESENTATIVE?
HOW CAN THE DIFFERENCE BY EXPLAINED?

Technische Universität Berlin

This presentation and more material can be found on the following websites:

http://mig.tu-berlin.de



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