Health Policy 97 (2010) 225–231

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

A patient mobility framework that travels: European and United States–Mexican comparisons

Miriam J. Laugesen[a,*], Arturo Vargas-Bustamante[b,1]

[a] Department of Health Policy & Management, Columbia University, Mailman School of Public Health, 722 W. 168th Street, New York, NY 10032, USA
[b] University of California, Los Angeles, Department of Health Services, Box 951772 31-299 CHS, Los Angeles, CA 90095-1772 USA

ARTICLE INFO

Keywords:
Cross-border healthcare
Mexico
Patient mobility
European Union
United States

ABSTRACT

Objectives: To develop a framework that parsimoniously explains divergent patient mobility in the United States and Europe.
Method: Review of studies of patient mobility; data from the 2007 Flash Eurobarometer and the 2001 California Health Interview Survey was analyzed; and we reviewed government policies and documents in the United States and Europe.
Results: Four types of patient mobility are defined: primary, complementary, duplicative, and institutionalized. *Primary* exit occurs when people without comprehensive insurance travel because they cannot afford to pay for health insurance or directly finance care, as in the United States and Mexico. Second, people will exit to buy *complementary* services not covered, or partially covered by domestic health insurance, in both the United States and Europe. Third, in Europe, patient mobility for duplicative services provides faster or better quality treatment. Finally, governments and insurers can encourage institutionalized exit through expanded delivery options and financing. Institutionalized exit is developing in Europe, but uncoordinated and geographically limited in the United States.
Conclusions: This parsimonious framework explains patient mobility by considering domestic health system characteristics relating to cost and quality.

1. Introduction

Most analyses of cross-border care or patient mobility fall into two categories, those based on European analyses [1–6] and others that draw on the experience of the United States (US), especially along the United States–Mexican border [7–13]. In Europe new government policies on patient mobility were introduced after European Court of Justice (ECJ) cases expanded the rights of Europeans to receive health care in other European Union (EU) countries. Europeans are entitled to reimbursement for the cost of emergency and planned treatment in the EU (although individuals need pre-authorisation for hospital treatment). Thus, Europeans are usually covered by national insurance funds and patient mobility gives patients access to higher quality, cheaper 'add-on' benefits [5]. Four percent of Europeans said they received health care abroad in 2007, including tourists. Fifty-three percent of Europeans said they would be willing to travel abroad for medical treatment [14].

In contrast, in the United States (US) some people travel abroad because they lack *access* to the services Europeans (and insured Americans) take for granted. Patient mobility allows the most vulnerable individuals, rather than more affluent individuals seeking the highest quality of care. People travelling abroad from the United States for medical care do so not because it is a luxury or choice: rather, they travel because it provides a level of health care cov-

* Corresponding author. Tel.: +1 212 304 5264; fax: +1 212 305 3405.
E-mail addresses: Ml3111@columbia.edu (M.J. Laugesen), avb@ucla.edu (A. Vargas-Bustamante).
[1] Tel.: +1 310 206 4744; fax: +1 310 825 3317.

0168-8510/$ – see front matter © 2010 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2010.05.006

erage that some people would be otherwise be unable to afford.

We propose a framework that uses these two cases to establish a broader understanding of patient mobility. This framework 'travels' across different national contexts, health system characteristics, levels of development, and economic integration. We contrast, but also reconcile, the European and North American approaches to patient mobility by analyzing patient mobility as influenced by the domestic nature of insurance coverage. We delineate individuals into three categories: those who exit for basic or primary insurance coverage, people with insurance coverage who travel to receive services that fall outside their primary coverage (complementary coverage), and people who have full coverage but seek faster or higher quality services (duplicative exit). Government and payers institutionalize patient mobility by providing primary, complementary, and/or duplicative services abroad. We refer to this as institutionalized exit. Europe is developing a new model of institutionalization of duplicative coverage in financing and delivery, which uses patient mobility as a conduit for quality standardization and even, possibly, regionalization, whereas the United States and Mexico are significantly less developed and institutionalized.

2. Conceptualising patient mobility

2.1. Choosing to exit: defining types of mobility

Patient mobility can be conceptualized in a variety of ways. In Europe one analysis proposed five types of mobile patient: people who are temporarily abroad and who fall ill; people retiring to other countries; people living in border areas; those who are referred abroad by their governments, and individuals who choose to go abroad for care [1]. In both the United States [11] and Europe, geographic proximity to other countries, such as people living in border regions [1], encourages patient mobility [5,11].

We focus on patients who are mobile *by choice*, including patients living in border areas, and individuals who are referred abroad by their government. Individuals who are temporarily abroad, and people who retire to foreign countries are excluded, because medical treatment is presumably not the *primary reason* they travelled abroad.

2.2. Motivations and conditions for patient mobility

The choice to go abroad for treatment is one that is influenced by two major factors, the quality and cost of care. Albert Hirschman suggests consumers can choose exit, loyalty, or voice when there is an absolute or comparative deterioration in the quality of a product or service [15]. For example, people go abroad from Europe to get faster treatment and higher quality of care [6]. Loyalty to the product or service, the cost of exiting, and optimism about the future quality of the product will influence whether a citizen will exit, speak out using voice, or use a combination of the two [16].

Certain patient characteristics may encourage care-seeking abroad. For example, cultural familiarity and prior experience with seeking care abroad also encourages people to seek care. Mexicans living in the US return home to receive health care because they feel comfortable and are familiar with the health care system there [13,17]. Likewise, European patients who seek care usually share cultural or linguistic links within a region [6] are more likely to seek care abroad. Individuals who have been abroad for care before are also more likely to select care abroad due to their familiarity with this process [5]. In other cases patients will travel because they want a medical service that is banned in their home country for ethical reasons [5] or safety. Additionally a service may have access restrictions, such as drugs that do not require a prescription in one country, but not another [10].

2.3. Framework for analyzing patient mobility

Cost and quality influences exit to other countries. Cost and quality is influenced by the (1) gaps in benefit coverage policies and international price differentials, (2) access to quality care domestically, and (3) whether the patient is 'sponsored' by government policies that offer reimbursement or provide care through formalized agreements with providers or payers [5,6,18] as is increasingly happening in Europe. We adapt a typology that was originally developed to classify the purchase of private insurance [19] by researchers at the Organization for Economic Cooperation and Development. This framework allows us to classify the 'gaps' in coverage that structure the choice to seek care abroad. We categorise the flow of patients across borders into four categories: primary exit, complementary exit, duplicative exit, and institutionalized exit.

First, patients exit because they lack comprehensive *primary* health insurance coverage in their country of residence and need a cheaper source of health care. Many people seeking care abroad will be partially or substantially motivated by lower prices [13], because patients are very price sensitive to differences in out of pocket payments and benefit generosity [20]. This type of patient mobility may depend more on proximity, because patients are likely to need more frequent or ongoing care and so border area residents may be more likely to seek primary coverage. People may not have primary health insurance coverage for a number of reasons, for example, they could be ineligible for public health insurance, or people may not be able to afford comprehensive health insurance coverage.

Patient mobility of this kind is much less prevalent in Europe, because of a more uniform and universal coverage safety net. In contrast, in the US, patient mobility serves as a safety net for the uninsured, the poor, and the under-insured, who are the biggest users of care abroad. As one observer suggested, care-seeking abroad is "driven by the escalation of out-of-pocket spending for health care and insurance premiums beyond the grasp of low- and middle-income Americans—an escalation that is forcing many workers to forgo health care and insurance coverage" [21]. Analysis of data on patient mobility confirms people without insurance are more likely to travel abroad: 1.4 percent of those *with insurance* in California went abroad for medical care compared to 7.1 percent of those *without insurance* [22]. Multivariate analysis by other authors using the same data found the likelihood of using care abroad