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Purchasing health services abroad: Practices of cross-border contracting and patient mobility in six European countries

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ABSTRACT

Objectives: Contracting health services outside the public, statutory health system entails purchasing capacity from domestic non-public providers or from providers abroad. Over the last decade, these practices have made their way into European health systems, brought about by performance-oriented reforms and EU principles of free movement. The aim of the article is to explain the development, functioning, purposes and possible implications of cross-border contracting.
Methods: Primary and secondary sources on purchasing from providers abroad have been collected in a systematic way and analysed in a structured frame.
Results: We found practices in six European countries. The findings suggest that purchasers from benefit-in-kind systems contract capacity abroad when this responds to unmet demand; pressures domestic providers; and/or offers financial advantages, especially where statutory purchasers compete. Providers which receive patients tend to be located in countries where treatment costs are lower and/or where providers compete. The modalities of purchasing and delivering care abroad vary considerably depending on contracts being centralised or direct, the involvement of middlemen, funding and pricing mechanisms, cross-border pathways and volumes of patient flows.
Conclusions: The arrangements and concepts which cross-border contracting relies on suggest that statutory health purchasers, under pressure to deliver value for money and striving for cost-efficiency, experiment with new ways of organising health services for their populations.

1. Introduction

Cross-border care in the form of patients obtaining treatment outside their country of residence can take various forms in the EU. The focus of this paper is on a specific type of patient mobility – namely when care is planned, purchased by statutory purchasers and delivered outside the country which funds it. Such an approach differs markedly from the case-by-case authorisations foreseen by EU Regulation 1408/71 on the coordination of social security systems and from individuals travelling for care on their own initiative, possibly reimbursed afterwards according to the Treaty-based rights on the free movement of services [1]. As opposed to these frameworks, the origin and procedures of the examined patient mobility are not necessarily rooted in EU legislation but in explicit contractual agreements between purchasers and providers.

'Planned' in this sense refers to the non-emergency character of the care, and to the planning which statutory insurers or health authorities undertake when contracting treatments outside the public system. In this way, systems open up to 'external' capacity – from providers abroad,

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and often in parallel from domestic non-public, for-profit providers.

These practices, and the concepts they rely on, are in contrast to the traditionally closed health systems. Since their inception, welfare systems have been constructed on geographical and membership boundaries which demarcate the territorial reach and the contributors/beneficiaries of a system [2]. The *principle of territoriality* implies that Member States use territorial elements in defining the scope of social security schemes, and when determining the qualifying conditions and the conditions of entitlement to benefits [3]. In terms of access to health services, it implies that in theory only individuals lawfully residing in the national territory can obtain health care from providers also established there [4]. Member States can thus control quality of care, protect the financial sustainability of the national system and ensure adequate planning of health care infrastructure and capacity [4]. While cross-border care takes place outside the domestic borders, contracting allows Member States to achieve these same three objectives even as patients leave the national territory. Cross-border contracting de-territorializes health services delivery but keeps quality, costs and planning under control.

The aim of the article is threefold. Firstly, to clarify the developments which have led national health systems to open up to foreign capacity. Secondly, to systematise the findings on cross-border contractual arrangements and to explain how purchasing and delivering health services 'outside' works in practice. The third aim is to identify the incentives behind cross-border contracting as well as its potential implications for systems involved.

2. Materials and methods

The article is a qualitative study which systematises and analyses the evidence on purchasing planned health care services from foreign suppliers to which patients are sent.

The material used originates from two sources: a study on contracted care in Belgian hospitals, based on in-depth interviews with stakeholders[1] [5]; and a systematic literature review of cross-border patient mobility in the European Union[2] [6]. Findings from both sources have been systematically analysed to distil information relevant to cross-border contracting.

The Belgian study included more than 20 structured stakeholder interviews with Belgian, Dutch and English organisations[3] as well as three interviews with experts [5]. Interviewees were selected based on the advice of privileged observers and public officials as well as using 'snowballing' to identify stakeholders.

The literature review consists of material from secondary sources. Data collection was done using a 'snowballing' method by which experts, public officials and involved stakeholders were contacted to identify documentation. These sources in turn provided new research paths which lead to new information, and so forth. Systematic internet searches in 11 languages[4] revealed documentation in national languages. As relevant peer reviewed, academic literature on the topic is almost non-existent, grey literature was included.

In 2008–2009, additional literature and internet searches were conducted to update data, and relevant German, Dutch, Irish and Norwegian stakeholders and experts were contacted to confirm and complete information.

The article includes material on cross-border contracting ranging from 2000 to date. Literature on practices which are part of border-region cooperation initiatives has however not been included as different dynamics are at play in these contexts.

While recognising the incompleteness of the empirical data, we assume to have included the most important schemes for sending patients abroad via cross-border contracting in Europe on which publicly accessible reports exist in Danish, Dutch, English, French and Norwegian.

3. Results

We have found material on purchasers engaged in cross-border contracting in Denmark, England, Germany, Ireland, the Netherlands, and Norway. Before explaining how purchasing and delivering care outside the system function, the section briefly describes the policy background in which cross-border practices have taken place in the six countries. The national contexts provide clues to the rationales behind contracting.

3.1. The policy context

In recent decades, governments across the EU have undertaken reforms to improve the performance of health systems [7]. In many countries, the responsibility for purchasing health care has been split from that of service provision, opening the door to new instruments such as strategic purchasing. In Bismarckian systems, market-oriented reforms have replaced passive forms of purchasing with selective contracting and introduced competition among insurers [8,9]. By selecting which services to buy from which hospitals, so the logic goes, new incentives may encourage providers, increasingly remunerated according to activity, to become more responsive and efficient as they compete for contracts [10]. Whether these objectives have been achieved is beyond the paper's scope;

[1] Carried out at the Observatoire social européen in the framework of the 'Europe for Patients' project (2004–2007). By its full name, 'The Future for Patients in Europe' was a European Research Project part of the Scientific Support to Policies component of the EU's 6th Framework Programme, financed by DG Research.

[2] Initial material collected and analysed at the Observatoire social européen in the framework of the 'Europe for Patients' project (see ibid).

[3] In Belgium, interviews were carried out with 10 hospitals which had cross-border contracts, with the largest sickness fund, and with four officials from public authorities. In the Netherlands, interviews were carried out with the four insurers known to have contracts with Belgian hospitals, the representative organisation of sickness funds and one public authority. In England, two interviews were carried out with the Department of Health, and one with the Guy's and St Thomas' NHS Foundation Trust acting as Lead Commissioner in cross-border contracts with Belgian hospitals. More details on interviewees available upon request.

[4] These include: Danish, Dutch, English, French, German, Greek, Italian, Norwegian, Portuguese, Spanish, and Swedish.