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Crossborder Healthcare In Europe: Towards a European Healthcare System

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The European integration project is built on free movement of people, goods, services and capital. However, trust in regionally available healthcare provisions, free or low-cost access at the point of use, and a high level of identification with national healthcare schemes has limited the interest in alternative provisions across borders. In recent years, however, cross border healthcare has gained in importance, on a practical level and in EU policy perspectives.

From a patient perspective, different types of crossborder treatments have to be distinguished. When EU citizens are visiting another member country, treatments not planned in advance are covered when the respective treatment becomes medically necessary during the visit. The underlying idea is that free mobility of people in the European Union should not be hindered by a risk of losing social protection when staying in another country. Over the past decades, provisions have been extended in terms of personal and material coverage and have recently been facilitated with the introduction of the Health Insurance Card.

Planned Health Treatment Abroad

Citizens may also want to travel for reasons of medical care. In this case, specific characteristics determine whether related costs are covered. Remuneration will be provided in the case of pre-authorisation by the social security system of the home country (a procedure covered by the aforementioned regulation) or in the context of bilateral agreements. In relation to overall health budgets the extent of these cases is rather limited, but they are playing a more significant role for interregional cooperation in some border regions and for specific agreementsbetween health insurance funds and/or providers. Examples are known across Europe, including the Baltic States, cooperation in the Euregio Meuse-Rhine among Belgian, Dutch and German health insurance funds and hospitals, the UK National Health Service initiative to address long waiting lists by contracting hospitals in other countries, or novel developments in the border regions between old EU members and the 2004 accession countries.

Alternatively, individuals can also travel to another country without acting in any pre-arranged context. In these individually driven cases, there is, so far, no general rule for reimbursement. But, there are European Court of Justice decisions providing important general principles. Accordingly, costs for non-hospital treatment abroad have to be reimbursed according to the terms of the health insurance institution in the home country of the patient. In the case of hospital treatment abroad, as a general rule, there is no coverage without authorisation. The underlying objective is to maintain treatment capacity and competence at national level and to safeguard the financial balance of national social security systems. However, there are reasons when authorisation has to be given, in particular when waiting time is judged as unacceptable for medical reasons (see, e.g., Judgement Watts, 16 May 2006, case C- 372/04).

Drivers of Crossborder Healthcare

Even if its financial scope is still limited in a macro-perspective, determinants of planned treatments abroad are demand and supply-sided. From the patient or consumer perspective, prices, quality and transaction costs are of key importance. Given the importance of good health, quality of care will generally be the major determinant. Differences in (expected) quality can, and are, inducing mobility across borders. In the 1990s, studies for Italy and Greece have shown that movements abroad have been mainly determined by the perception of inadequate infrastructure in the home country.

Similar quality concerns are relevant, when patients from Eastern or South-Eastern European countries are searching for treatment in Western European countries. In these latter cases, treatments are mostly paid out-of-pocket.

Costs become directly relevant for patients where the financial burden for treatments abroad has to be fully or partially covered by the patient. This is the case for health treatments outside what is generally covered under social security schemes (e.g. aesthetic surgery), or health treatments that are only partially covered by such schemes (e.g. dental care). In the case of dental care, Hungary has developed into a major

treatment centre in Central Europe, with some patients receiving partial reimbursement in their home countries, but many more patients paying out-of-pocket. It is estimated that about 160,000 Austrians are seeking dental treatment in Hungary every year. But, combining dental care treatments with spa treatments or other vacation arrangements has extended dental care tourism far beyond a regional phenomenon. Similar trends can be observed for treatments that are not covered by national health systems, such as aesthetic surgery, as well as treatments that allow some in advance planning, such as, e.g., orthopaedic surgeries, or eye and ear surgeries. Here, ability-to-pay and willingness-to-pay become major co-determinants of movements abroad for the prime purpose of healthcare consumption. Hence, providers in receiving countries with relatively lower labour and infrastructure costs can benefit by attracting patients that could not afford similar treatments in their home country. Apart from medical quality and direct costs, any decision for treatment abroad will be strongly co-determined by the broader service quality including waiting times, language barriers or administrative hurdles. And it is these arguments that are often put forward by healthcare providers attempting to attract patients from other countries.

For a provider working in the private healthcare market, traditional market principles are decisive. In these sectors, the internationalisation of healthcare provision is not limited to the EU, but an increasingly global phenomenon. Hospital treatment centres in Asian countries, in particular Thailand or India, serving an international patient clientele, are an example for this trend. For providers working in the context of national social security systems, the respective European and national regulatory framework, the capacity that is or can be made available for patients travelling in from other countries and the principles of remuneration for these patients are major determinants for whether or not such providers can attract patients from other countries. Following recent trends, provision to patients from other countries and/or outsourcing of treatments to treatmentcentres in other countries, will become an increasingly important option to hospital management, in particular in border regions where infrastructure planning so far has been constricted to national borders. Similarly, national funding institutions might find it financially attractive to contract with providers across borders. At the same time, however, they have the objective to ensure capacity and competence at national level. The aforementioned Euregio Meuse Rhine cooperation is a long-standing example of success, but hurdles also have to be taken into account.

Towards a European Healthcare System

The future development of crossborder healthcare will be driven bottom-up and top-down. Beyond interregional cooperation, there is substantial growth potential for treatments that allow some in advance planning, and even more so when patients are directly involved as payers of services. In a bottom-up process, individuals searching for cheaper and/or higher quality healthcare provisions across borders will induce reactions by potential providers. Top-down developments are reactions to these developments (e.g. by establishing bilateral agreements or through European Court of Justice decisions), but may also be proactive, such as current attempts of the European Commission towards facilitating crossborder healthcare. While respective developments improve choices for patients and are opening up new opportunities for organising healthcare, related problems are far from negligible. The enlarged European Union is characterised by substantial economic differences, at individual and on societal level. While national systems attempt to ensure equal access to a broad healthcare package to the entire population, economic differences across Europe would create inequalities in the opportunities to benefit from extended choices, at an individual and systemic level. If the common objective of high quality, accessible and sustainable healthcare is taken seriously, access and quality in crossborder healthcare have to be ensured for all EU citizens by an adequate institutional framework.

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