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The International Market for Medical Services: The UK–Germany Experience

Ian Birch and Marion v. Boxberg

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February 2004



LUTHERHAUS – DER ENGLISCHE PATIENT

**Anglo-German Foundation
for the Study of Industrial Society**

THE INTERNATIONAL MARKET FOR MEDICAL SERVICES

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Foreword

The authors of this report are Ian Birch, a British freelance consulting economist, and Marion von Boxberg, a German medical journalist. The initial motivation to investigate the potential for an international market in medical services in Europe, and in particular between the UK and Germany arose from two general observations: first, a perception that there ought to be great potential for social benefits from such trade given the current situation in the respective countries' health sectors – a well publicised shortage of capacity in the UK and a degree of over-capacity in Germany; and secondly, that for some reason(s) such a market was not developing to any great degree. We wished to investigate the reasons for this and therefore approached the Anglo German Foundation, who kindly lent their support. We hope that the report will be of interest and use in providing an independent perspective on recent developments in the UK and Germany as well as an insight into the possibilities for further international collaboration and trade in the future.

Executive summary

The rationale for undertaking this project was to investigate the opportunities for 'gains from trade' in the treatment of medical patients outside their own country, and specifically for the treatment of UK patients in Germany. This arose, firstly, from the authors' perception that there ought to be great potential for such gains given the current situation in the respective countries' health sectors – a well publicised shortage of capacity in the UK and a degree of over-capacity in Germany; and secondly, that for some reason(s) such a market was not developing to any great degree. We were keen to bring a specifically economic rather than a medical approach to the issues and it is hoped that readers from a medical background will appreciate the validity of doing this.

The aims of the project were as follows:

- To review recent experience of contracts between UK health service providers and German clinics and hospitals and to assess the potential for a market for German hospital services to develop in the UK;
- To identify barriers to the development of a competitive UK market for German hospital services in the UK. These fall into the following three categories:
 - Technical
 - Administrative/legal
 - Attitudinal

Our research involved a combination of reviewing existing studies, interviewing a number of health care professionals in Germany and conducting a survey of UK patients who have been treated in Germany. We also attempted to conduct a survey of UK general practitioners, but we experienced difficulty in achieving a significant response from our sample.

The main conclusions of the project were as follows:

- patients' attitudes amongst those UK patients already treated in Germany is overwhelmingly positive;
- while there is a shortage of capacity in the UK and some spare capacity in Germany and other countries, it would seem to make sense to allow UK patients to travel;
- there are some legal and bureaucratic issues to resolve before a market can develop;
- the key area to work on is health professionals' attitudes;
- if personal communication and trust could be built up between UK and overseas practitioners, many of the current barriers would be easier to resolve;
- German health care professionals involved in the NHS pilot project had a perception that political considerations seemed to receive a high priority on the UK side of the project, sometimes at the expense of patients;
- In order to achieve the necessary widespread consensus about the usefulness of overseas facilities as an extra NHS resource the following would be required:

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- UK doctors would need more information in order to refer patients to German hospitals with confidence. This might include information about ease of travel, English speaking capabilities and accommodation as well as clinical quality assurances;
- procedures for agreeing prices and making payments have to be agreed;
- adequate legal protection for patients.

If these issues can be resolved, there is likely to be the potential for a large, diverse market in medical services between the UK and Germany and other countries. If a European healthcare market develops, there may be further opportunities in the longer term and a new, mutually beneficial form of international 'trade' may be created.

We estimate that at least 15,000 orthopaedic operations could be carried out for the NHS in Germany under current supply and demand conditions. This is based on discussions with German health care professionals together with some rudimentary assumptions about likely demand and acceptance in the UK. There is also likely to be potential for the development of international trade and cooperation in other specialisms such as eye surgery, abdominal surgery and general surgery.

1 Introduction

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The NHS initiated a pilot project in 2001 in which 81 UK patients who had been waiting for extended periods of time were sent to hospitals in western Germany.¹ A review of this project was undertaken by the University of York for the Department of Health. We have reviewed this work and have integrated some of its key findings with our own results, which included research into the experiences of the German health providers involved in this project, as well as a substantial exercise researching patients' attitudes and experiences.

Our main sources of information and assistance were:

UK Department of Health, 'Evaluation of Treating Patients Overseas', by York Health Economics Consortium;

DoH website, selected published statistics and 2001 Population Census;

Times Legal Report, 3/10/03,

Interviews and questionnaires to UK patients treated by Germedic (24);

Questionnaires to UK general practitioners (3);

Interviews and discussions with:

Axel Hollander, Director, Germedic;

Achim Budnick, Verwaltungsdirektor, (Administration Director) Lutherhaus Krankenhaus, Essen;

Juergen Winter, Geschaeftsfuehrer (Business Leader), Lutherhaus Krankenhaus, Essen;

¹ A further 109 patients were treated in French hospitals.

Karl-Heinz Fredrich, Pflegedienstleiter (Service Leader), Lutherhaus Krankenhaus, Essen;

Anette Ehrke-Shoen, Presseabteilung (Press Department), Lutherhaus Krankenhaus, Essen;

Detlef Koessendrop, Geschaeftsfuehrer (Business Leader), Eduardus Krankenhaus, Cologne;

Olaf Schlueter, Verwaltungsabteilung, (Administration Department) Universitaetsklinik Koeln;

Dr Martin Schoelkopf, Bereich Politik (Health Policy Department), Deutsche Krankenhaus Gesellschaft

Jutta Wilkinson, Internationaler Markt (International Marketing), Gilead Krankenanstalten, Bielefeld;

Dr Francine Verhoeff, Liverpool University and Wigan General District Hospital – helpful comments from the UK consultant perspective.

We thank the above for their help with this project.

1.1 Report structure

The structure of the report is as follows:

Section 2 provides background information about the systems of healthcare in the UK and Germany and the current issues of a shortage of capacity and an excess respectively; a review of experience to date in health care contracts between the UK and Germany is made.

Section 3 reviews the possible barriers to the development of an international market in medical services using the range of information sources available to us including our own research. There are three sub sections:

- Technical – what types of patients could travel to Germany? Travel and follow up care requirements will limit the types of condition which can be treated in this way – there are many patients who are not suitable for treatment in another country because of the nature of their health problem or because of secondary aspects of their health; furthermore, it will not be viable to treat some types of condition overseas.
- Administrative and legal – health care systems are not operated according to market principles. In particular, the UK's NHS, which is a centrally planned bureaucracy, is not well suited to responding to commercial developments which offer alternative ways of delivering treatment and improving patient choice, such as this; An important UK legal ruling is described.

- Attitudinal – the willingness of both patients and medical practitioners to participate in overseas treatment arrangements will ultimately determine whether an international market can develop.

Section 4 provides a view from German health providers, by drawing on our consultations with the senior personnel involved in the NHS pilot project.

Section 5 gives the results of some calculations we made using rudimentary assumptions to show possible numbers of orthopaedic patients who might be treated in Germany under various scenarios.

The conclusions are reported in Section 6, in which our view of the prospects for the future development of a market in the light of the project's findings is provided.

2 Recent experience

2.1 Background

NHS patients are entitled to free health care at the point of use, in principle determined according to their need. However, over recent years a gap has developed between the services demanded and the ability of the system to deliver them. We have identified a number of issues which might make UK patients wish to travel to Germany:

- they often have to wait several months in non urgent cases;
- some procedures are not available on the NHS;
- private medical care in the UK is very expensive.

The quality of facilities and the services offered varies by region. Generally, patients in rural areas have shorter waits and more comfortable facilities than people in cities. London has a number of leading research and teaching hospitals, and is home to the internationally renowned Harley Street. However, it is generally recognised that the NHS in London faces bigger problems than elsewhere. It has older hospitals and more pressures than other areas, and it is harder to attract doctors and nurses to work in London because the cost of living is so much higher than in other areas. At the same time, London has the highest concentration of high income people in the UK.

For many years the UK has spent a lower proportion of its national income on healthcare than comparable European nations, although it is UK Government policy to reach average EU expenditure levels.² This is not because the state spends significantly less on health care than in other countries, but rather that there is a smaller private sector. In the UK it represents only approximately 10% of the total. The private sector provides small, comfortable hospitals in and around the main population centres in the UK. The doctors are mostly part time and usually work also in the NHS. They have contracts which specify a minimum number of hours per week which they must offer to the NHS. In comparison to some other European countries, such as Germany, there has also been less investment in private sector medical facilities, so capacity is more constrained. As a result, private healthcare is generally more expensive than elsewhere in Europe. Users of private healthcare in the UK are typically either wealthy individuals or relatively well paid employees with private healthcare insurance provided by their employers, although there are some patients who simply pay for private health care in order to avoid particular problems they experience with the NHS, such as a long wait for consultation or treatment.

The future of the NHS remains a leading political issue. It is currently undergoing reform and is benefiting from a large increase in cash resources from government. The latest evidence suggests waiting lists are declining quite rapidly. A recent newspaper article³

² In terms of the proportion of GDP per capita spent on the health care system.

³ The Times, 3 December 2003.

reported that the number of people waiting more than six months for admission to hospital declined by 28.5% over the previous year to 177,867; the number of people waiting for hospital admission fell by 7.1% to 974,000, while the number of people waiting more than thirteen weeks for outpatient consultation fell by 38% to 162,635. Despite this, some commentators believe that structural problems are not being addressed and doubt that the NHS in its current form can ever provide all that is expected of it. Nevertheless, one of the consequences of the reforms will be that all patients will eventually have much greater choice about where they are treated. This may help develop an international market in treatment provision. In any case, it will take a number of years before the current problems of the NHS are removed and this suggests patients' demand for overseas treatment is likely to remain for some time. To date the NHS has made only very limited use of overseas hospital facilities.

A potentially important recent development was a legal ruling in October 2003 which could force the NHS to pay for the treatment of its patients in overseas facilities if waiting lists remain unacceptable long, however this is defined. The effect of this is considered in Section 3.

This project has concentrated on the future development of NHS contracts with Germany rather than on the private health care market, because this is likely to be where the greatest potential lies for larger scale market development and because the barriers in this sector are greater.

In Germany, recent developments have encouraged a climate in which doctors and clinics seek to attract patients from overseas. It became clear that there was spare capacity in terms of both doctors and clinics in the late 1990s. As a response, an association (*Kuratorium zu Foerderung Deutscher Medizin im Ausland*) was founded to market German medical expertise overseas in order to utilise this. The basic question was expressed to us as "Can we offer our spare capacity to others in order to avoid losing it?"

The association's aims began to be realised when it started co-operating with a commercial partner (Germedic) which had organisational expertise. Germedic led the negotiations with state medical care providers in a number of countries, which had a shortage of capacity, including Norway, Denmark and the UK. In 2001 Germedic made contact with one of three pilot teams working in the UK, who were keen themselves to work with the association. The project is described in greater detail below.

2.2 Recent experience of UK–Germany projects

Three pilot sites in the South East of England were established in response to European Court of Justice rulings in July 2001, whereby patients in the UK are entitled to receive hospital treatment in the EEA.⁴

⁴ European Economic Area: EU, Iceland, Norway and Liechtenstein.

The three pilot sites were:

- East Kent Health Authority (EKHA);
- Portsmouth, Isle of Wight & East Hants Health Authority (P&IoW);
- West Sussex and East Surrey Health Authorities (WS&ES)

A small project team in each of these sites was responsible for commissioning healthcare overseas, establishing and managing the arrangements with the selected French and German hospitals, managing the process of sending the patients and managing the interface with the local health economy.

Three intermediaries were used:

- Germedic;
- German Medicine Net;
- Guy's & St Thomas' Corporate Development Team (G&ST CDT).

Their role was to identify and liaise directly with hospitals, to organise contracts between themselves and the hospitals and manage relationships between themselves and the pilot teams; and to monitor treatment and deal with practical problems.

Eight hospitals and one-day case clinic were used in Germany. Germedic identified the Lutherhaus in Essen and the Eduardus Krankenhaus in Cologne; G&ST CDT identified the Henriettenstiftung in Hannover, Das Klinikum in Osnabrueck and the Gilead in Bielefeld; German Medicine Net identified the Endo Klinik in Hamburg, the Ostseeklinik in Damp and a clinic run by a consultant in Celle.

A total of 190 patients were treated as inpatients overseas⁵ (153 orthopaedic and 37 ophthalmic). The breakdown is shown in Table 2.1:

Table 2.1: Breakdown of numbers of patient treated overseas

Intermediary pilot site	German medicine net	Germedic	G&ST	EKHA/own arrangements	Total
P&IoW	26	26	23	1	50
WS&ES		27	5	12	44
EKHA				96	96
Total	26	27	28	109	190

The financial arrangements were administered by the intermediaries, where used (EKHA contracted directly with its French hospitals). The NHS Trusts each purchased a treatment at an agreed fixed price per patient, which was written into the contracts, irrespective of any complications which might arise. This ensured that all the financial risk was taken by

⁵ Other patients were treated as outpatients by French and German doctors in the UK.

the German providers. It was made clear to us that the NHS would not have found any other form of arrangement acceptable.⁶

The pilot sites were evaluated by the York Health Economics Consortium who reported to the Department of Health⁷ in July 2002. Their report assesses the clinical, legal and quality issues associated with commissioning overseas treatment for NHS patients. This work did not attempt to analyse the outcomes of treatment and it did not seek to evaluate the experiences of the German intermediaries, hospital administrators or clinicians in their dealings with the NHS or in treating the patients. Our work builds on this research by consulting patients after almost two years since their treatment and by consulting a number of German health professionals on their experiences of the pilot projects.

⁶ The German providers were not very happy with this arrangement as they believed that they received a particularly high proportion of patients with secondary medical conditions. In some cases this increased the treatment costs, for which the providers were not compensated.

⁷ "Evaluation of Treating Patients Overseas", July 2002.

3 Possible barriers to the development of an international market

3.1 Introduction

In this section the possible barriers to the development of successful overseas treatment projects are identified and ways of overcoming them are proposed. The possible barriers can be analysed according to the following three categories:

- Technical;
- Bureaucratic and legal;
- Attitudinal.

A useful starting point for the analysis is to note the issues which arose during the three NHS pilot projects described in Section 2. It was originally intended that these would include far more patients and a wider range of cases than orthopaedic and ophthalmic patients only. Other sectors originally planned to be included were Ear, Nose & Throat (ENT), urology and general surgery. The DoH report states that the number of patients treated in Germany was lower than that originally intended, for the following reasons:

1. Contracting with hospitals was more time consuming than envisaged;
2. There was conservative patient selection; ENT, urology and general surgery cases were not sent overseas, although this had been originally envisaged;
3. There were problems in getting UK clinicians to participate fully and this necessitated alternative strategies for identifying patients and obtaining base line information. This was particularly the case for P&loW and WS&ES (which used German hospitals);
4. There was a limited "financial envelope," which allowed for no more than 250 complex cases.

Of the above points, numbers 1 and 4 are of a bureaucratic/legal nature; number 3 is attitudinal and Number of 2 is probably a mixture of technical and attitudinal – this highlights a general problem with health policy analysis which is that much of the information needed resides within the system with doctors and other professionals who may have their own professional interests to defend.

Experience of the larger scale project to send patients overseas in Norway was reported in the DoH study. An £85m project to treat Norwegian patients overseas has been in operation since 2000. This is much broader in scope and ambition than the UK project and is therefore useful as it has accumulated more experience and it raises issues which may face larger scale projects operating over a longer period of time. The DoH study reported on this and this is drawn upon in the sections below.

3.2 Technical barriers

It has proved very difficult to identify with precision the technical criteria for the suitability of sending patients overseas for treatment. The reason is that they are to a degree subjective and responsibility for determining them lies with doctors, whose personal attitudes will influence their decisions. Ethically it would be very problematic to either force patients to travel overseas, or to disadvantage them if they refused an offer of overseas treatment. Other than patients' willingness to travel, there are two groups of technical issues which should be analysed distinctly from one another in order to facilitate ethically justifiable decisions when selecting patients for overseas treatment. These are *patient welfare* and *viability*.

Patient welfare issues are, of course, paramount. It could be argued by medical professionals that patients for whom there is any additional risk or pain associated with travel should not be sent overseas. Such patients may be suffering from a condition which is itself responsible for this. Alternatively the condition to be treated may not itself render a patient at greater risk from travelling, but certain co-morbidities, or secondary illnesses, may. However, a more *economic*⁸ view of patient welfare might factor into the decision criteria the risk and suffering associated with the consequent extended wait which the patient would have to endure. It would also place greater emphasis on the patients' own preferences, where these are supported by adequate medical and non medical information. The resultant decision criteria might therefore be broader and take greater account of individual preferences.

The viability question also requires a broader analysis. The centrally planned budgets which the pilot projects were allocated represent an inflexible financial constraint which reduced their effectiveness. Larger scale projects should aim to integrate the decision to send patients overseas with the full range of treatment options. The opportunity costs of travel, accommodation, contracting and other organisation, as well as the treatment itself need to be understood in the broader context of available resources. For example, it is unlikely that most day cases could be justified for overseas treatment. On the other hand, there are certain fixed costs associated with overseas treatment, such as legal contracts, which means there are economies of scale – ie, the average cost of overseas treatment should decline as the number of cases increases (under a given organisational umbrella).

The technical complexities highlight a need for a framework in which the technical criteria for selecting patients is clearly specified, if a market is to develop for the overseas treatment of NHS patients. A broad consensus amongst professionals within the NHS would then be required. The desirability of such a systematic approach is perhaps made greater by the possibility of individuals pursuing claims for the right to overseas treatment in court, which they may in greater numbers, following a recent ruling. This is described briefly below:

The legal judgment in October 2003 of Regina (Watts) v Bedford Primary Care Trust and Another established that "Prior authorisation for treatment by a National Health

⁸ Not to be confused with *commercial*. Here, the term *economic* refers to rational resource allocation decisions which take account of all available information.

Service patient in another member state of the European Union at the expense of the NHS could be refused only on the ground of lack of medical necessity only if the same or equally effective treatment could be obtained without undue delay at an NHS establishment”.

Times Law Report, 3 October 3, 2003

This indicates that the NHS is liable to pay for treatment of patients who wish to go overseas if they cannot be offered treatment in the UK in a reasonable period of time. It can be expected that further court cases will define the practical meaning of this more precisely over time under various conditions.

3.3 Bureaucratic and legal barriers

The NHS, as a large state bureaucracy, must be seen to act fairly. This requirement carries with it a heavy bureaucratic burden. Patients cannot, for example, be seen to ‘jump’ waiting lists without medical justification. The pilot projects involved elaborate hospital and patient selection criteria, which would have been necessary to be seen to produce a fair and appropriate outcome. The results were very conservative, which might suggest that the criteria were very strict. As a result, the number of patients sent overseas was lower than anticipated. Nevertheless, our research in Germany suggests some cases of questionable suitability were sent. This, together with our patient research, suggests the selection criteria were more ad hoc in practice than suggested by the elaborate criteria. This, in turn, implies that the low numbers of patients sent may have non-medical reasons. The Norwegian research provides some interesting insights into this issue.

Detailed work in four County Boroughs as part of the analysis of the Norwegian project made the following conclusions:

- Hospitals with the longest waiting lists were the most active users of the scheme;
- there was some disagreement about how to assess waiting lists;
- tension between administrators and health professionals tends to produce poor conditions for carrying out the arrangements;
- the arrangements tend to work better if organised at a specialty rather than a higher level;
- the criteria for inclusion in the scheme varies across counties and boroughs;
- responses from patients are dependent on the method of contact.

The researchers recommend, inter alia, that:

- waiting lists are measured more objectively to help decide which hospitals should be participating;
- specialties should “own” the problem of patients on waiting lists, since this is more likely to motivate them to participate;
- selection criteria should not only be directed at those with the longest waits since the number of patients may be small;

- personal contact with patients improves the take up rate, although this method is resource intensive and additional support may be needed for this where departments have limited resources.

There is evidence that improved information sharing within the NHS would reduce the bureaucratic burden of such schemes and improve the chances of success at a larger scale. The sites used different mechanisms in the commissioning process and it is not clear that information was exchanged and duplication of effort avoided. The DoH report indicates that selection criteria were conservative but that EKHA had a slightly less conservative approach, in that co-morbidities which were known and well managed were not necessarily seen as a deterrent to sending patients overseas. The selection of patients was hindered in some cases by problems in accessing hospital waiting lists, and adverts in local media had to be used instead. This attracted some patients who were not on waiting lists. It was also found that the take up of offers to be treated varied greatly, and was affected by who had contacted the patient (10% with some, 40–50% with others). In one of the pilot sites there were two different procedures because there was one supportive hospital trust and one less so. (Our research indicates that the support of consultants varied and was important in determining this aspect of the pilot project.)

Our research indicates that while the logistics was mostly planned in a satisfactory way, there were major problems with patient pathways following treatment in Germany, with patients reporting a lack of co-ordination with follow up care provision in the UK. The DoH report went on to describe detailed problems with the execution of these steps and ways in which lessons may be applied in the future.

3.4 Patient attitudes

Most of the patients treated at the Lutherhaus Krankenhaus, in Essen, and the Eduardus Krankenhaus, in Cologne, agreed to assist us with our research. These clinics, as well as Germedic, the agency which mediated between them and the East Surrey/West Sussex project team, also provided feedback about their own impressions of the project. It was pointed out to us that no one from the East Surrey/West Sussex Pilot had contacted Germedic or the clinics for feedback about their experiences.

We spoke to five 5 patients directly by telephone (they had explicitly agreed to be contacted in this way); the remainder were either contacted by post or fax. The response rate was exceptionally good. From a total of 27 patients treated through Germedic we received a response from or spoke to 24 (89% of total). We also contacted a UK patient who had contacted Germedic privately and had paid for her own treatment, and another who had been referred by the NHS but opted to be treated privately in Germany. The results of this phase of the work are analysed below.

All the patients who responded have been treated overseas on only one occasion since 1995 and all traveled by air. 15 of the patients (57.7%) were treated in the Lutherhaus, Essen and 11 of the patients (42.3%) were treated at the Eduardus Krankenhaus in Cologne. The patients were asked to select reasons for travelling to Germany. A number of them of mentioned more than one reason. The overwhelming reason was the shorter wait times. Some patients had been presented with a choice of eg a 10-month wait for

treatment in the UK or a 2-week wait for treatment in Germany. 23 of the 26 patients (88.5%) mentioned shorter wait times as a reason. Eight of the patients (15.4%) mentioned the good reputation of the German health care system, although none mentioned this as their sole reason. Although there were only 2 private patients in the sample, 4 mentioned the lower cost of treatment in Germany. Two patients mentioned that the treatment was not available in the UK. We spoke to another patient who had a knee replacement in Germany who felt she had had great difficulty in obtaining a diagnosis in the UK and therefore in obtaining the appropriate treatment.

There was a relatively broad spread of answers to the question about where the patients got to know about the option of travelling to Germany. The modal answer was the local hospital, mentioned by 12 patients (46.2%); the local hospital trust was mentioned by 5 patients (19.2%) and self or family was mentioned by 15.4%. GPs were mentioned by only 3 patients (11.5%) which we consider to be a very low proportion considering the 'guardian' role which a GP is expected to play in the UK health system. Local newspaper coverage of the scheme was cited by one patient.

When asked who organised their treatment in Germany patients' perceptions seem to vary considerably. Fourteen patients (53.8%) identified their local hospital as responsible. The 5 patients (19.4% of total) to identify their local hospital trust were the same 5 patients with whom the telephone interviews were made, which suggests that the responses to this question may have been influenced by the survey method. 4 patients (15.4%) mentioned an agency, 3 patients mentioned their GP and 2 patients identified themselves or their family.

Twenty-four of the 26 patients (92.3%) waited less than 8 weeks between deciding to go to Germany and going. 5 patients (19.2%) travelled in less than 2 weeks; 13 patients (50%) travelled in between 2 and 4 weeks, and 6 patients (23.1%) travelled in 4 to 8 weeks.

Only 2 patients (7.7%) mentioned experiencing problems of any nature in the organisation of their treatment within Germany. In fact the two problems which were mentioned were both related to travel; the patients concerned were satisfied with the overall experience of their treatment in Germany.

The answers concerning the quality of follow up care in the UK were far more mixed. 6 patients (23.1%) described this as 'excellent'; 3 patients (11.6%) described it as 'good'; 5 patients (19.2%) described it as 'satisfactory', although in some cases the information added to this suggests the patient was not treated adequately. 10 patients (38.5%) described the follow up care as 'unsatisfactory'. Two patients (7.7%) stated that they did not require follow up care in the UK. Of those patients who were unsatisfied, 4 (15.4%) received no follow up care whatsoever, and one of these now complains that their knee condition is now as bad as before the treatment. Two patients complained that their NHS surgeon refused to see them upon their return from Germany.⁹

Patients were asked for their general comments about their experience of treatment in Germany. There was lavish praise for the German hospital staff, quality of treatment and

⁹ This was the same surgeon, who is known to have been unsupportive of the project.

facilities. 16 patients (61.5%) mentioned this (unprompted). Four patients (15.4%) mentioned that they had not liked the food very much (all of these described a very positive overall experience, however). There were additional comments contrasting the high quality of German after care, mainly physiotherapy, with the inadequate treatment offered upon their return to the UK. The complete lack of adverse comments about treatment in the German hospitals is striking. Only two patients (7.7%) commented adversely about the facilities, in both cases feeling that there was a lack of privacy on the ward, in particular the absence of curtains between beds. Two (7.7%) patients commented that they had felt isolated while in Germany. One patient mentioned each of the following: a lack of organisation at Dusseldorf Airport upon their return, necessitating a painful walk; good organisation of the project in the UK; poor organisation of the project in the UK; a poor medical outcome, attributed by the patient to the lack of appropriate physiotherapy in the UK; an excellent medical outcome; problems with UK doctors prior to their treatment in Germany; a positive impression of one of the agencies which helped organise the project.

It should be noted that these results should be treated with care, since specific attitudinal issues may have affected the results. The full replies are available in a separate document.

The DoH report also includes analysis of patient questionnaires which inquired about their experiences. The results bear out our own. Almost 80% of both the French and German hospital groups were very satisfied with their experience. Of the German hospital group, no patients found their experience unsatisfactory. Areas identified for improvement included:

- Better organisation of after care in England;
- Access to English TV, newspaper and radio;
- Communal meeting places for patients;
- Availability of an interpreter;
- Better food;
- Improved travel arrangements.

Views on the overall working of the scheme were very positive, with almost all patients satisfied with the choices offered about when and where they would receive treatment. Almost 60% of patients felt they were still receiving treatment under the NHS; for those who did not, a number felt they were receiving treatment similar to that of private patients. In almost all cases, patients felt they were being offered a good service and that the option of receiving treatment overseas should be extended to more patients. Food in German hospitals receiving a somewhat lower rating than in France and there was general concern about the lack of rehabilitation arrangements provided upon patients' return to the UK. The DoH report notes that the results should be treated with caution because the fact that patients and clinicians were being studied may have altered their behaviour.¹⁰

Overall it is clear that patients' attitudes are very positive towards the option of overseas treatment, and about their experience of it. They are not likely to be a significant barrier to market development.

¹⁰ This phenomenon is known as the Hawthorne effect.

3.5 Health professionals' attitudes

Our survey of GPs was less successful – of sixteen questionnaires distributed, only two replies were received. This itself suggests a lack of interest amongst UK GPs in overseas treatment options, although the sample size was very small. The two GPs who did reply were positive: one would 'definitely consider' sending patients overseas and the other would 'maybe consider' it. Both stated that they would require good information about clinical quality, and a number of other conditions to be met.

Qualitative information was also gained from professionals involved in the DoH study. It was found that not all interviewees thought the project was necessary. It was believed that resources should have been invested locally and that the project was not cost effective. However, if the treatment of patients was the criterion, the project was judged successful by most interviewees. It was noted by the professionals that even when patients turned down the option of overseas treatment they were positive about being invited.

UK clinicians make three main points:

- The clinical governance problem – who has responsibility for complications?
- It is considered poor practice for one consultant to treat a patient and for another to follow up;
- Resources were not allocated in the pilot sites for follow up in UK hospitals.

The DoH report provides detailed information about the experiences from Norway. It was found that where doctors did not participate they cited a lack of suitable patients and insufficiently long waiting lists as principal reasons. The researchers are not convinced by these explanations and believe that general resistance to the project is a more important issue. Also there was a lack of familiarity with the arrangements amongst doctors, which indicated that more information was needed. A further requirement is that sufficient assurances of quality are made, backed up with evidence if necessary. It was also concluded that doctors and hospitals claiming their waiting lists were too short should be challenged.¹¹ It is recommended that the option is presented to doctors as an opportunity rather than a threat. A further way of promoting the scheme is to provide better information to patients so that they put pressure on doctors to offer the arrangement to them.

The DoH report's conclusions about attitudes were that clinicians in both Norway and the UK were less than happy about these schemes – the main issue being that they believed resources should be deployed locally to address their problems. Project managers reported a lack of cooperation at times from consultants, while consultants reported a lack of involvement or an opportunity to review plans for patients going overseas, which emphasises the need for local clinical involvement and commitment. While managers reported that one benefit of the pilot was to bring different thinking and exposure to different practices into an organisation, clinicians did not recognise this.

¹¹ For example, the acquisition of infections from hospitals and multi resistant bacteria was a concern although no patients had returned with these.

3.6 Summary of experience and possible lessons

Possible improvements for the benefit of patients were identified as:

- allowing more time between assessment clinics and treatment to allow for:
 - better travel planning;
 - fewer problems collating patient information,
 - patients to make better domestic arrangements;
- improvements in travel to reduce waiting times and travel times, and to use airlines which could accommodate patients' needs;
- the management of pre assessment clinics could be improved;
- improved after care in UK and improved coordination of stages of the process. In general the process could be more seamless and there could be a clearer understanding of the relative roles and responsibilities.

There were no major contractual problems identified. In summary the DoH report identifies the following key areas to improve the processes:

- Separation of commissioning from managing of patient journeys;
- rationalisation of commissioning;
- focus on clusters of overseas providers to improve local management etc;
- extension of the case mix and inclusion criteria to bring more patients into the scheme;
- develop improved local arrangements for patient selection, eg having a single patient pathway for assessment of waiting list patients;
- work more extensively on local buy-in to remove administrative and clinical barriers as part of a shared clinical and management approach to waiting list reduction.

Our research suggests the last of these is particularly important.

4 German health providers' view

In this section we report on the consultations undertaken with Germedic, one of the intermediaries used in the NHS pilot project, and key senior personnel at the Lutherhaus Krankenhaus, Essen and the Eduardus Krankenhaus, Cologne.

4.1 Germedic

Some of the key questions put during this interview are reproduced here together with our summary of each answer. These are not precise translations but are intended to reflect as clearly as possible our interpretation of the intention of the answers given.

According to which criteria were the German hospitals selected?

Here it's necessary to distinguish between Germedic's own criteria and the criteria which were used by the NHS. These were created on the basis of Germedic's advice.

NHS criteria: One component of the contract with ESWS was that before the pilot project started Germedic would provide detailed information about the hospitals. This included: the number of cases treated; qualifications of doctors who would be undertaking the treatment; the hygiene regime; rate of complications; type of implants used etc. These criteria were used by the NHS and similar questionnaires were developed by both sides to be used in the tendering process.

As well as the medical criteria, the feasibility of the treatment prices was important. Germedic had already dealt with this problem prior to the project and they only suggested hospitals which could provide value for money.

Furthermore, proximity to an airport and Köln were also important, although the last of these was only relevant to the pilot project because they wanted to be near in case there were any teething problems with the project. Germedic's experience of the selected hospitals' service quality and readiness to co-operate was also very important. Germedic's experience with a very large hospital network gives them a feeling for these "softer" criteria.

Did other German hospitals want to take part?

In principle, all of their partner hospitals (100 in total) which had the appropriate capabilities would have wanted to take part in treating these patients. A basic part of our approach was they wanted patients in groups in hospital, ie not alone. Continuity and better use of capacity was central to the concept. Continuity has the following advantages for patients: the project would be known about within the hospital; the service can continually be improved and the patients are able to communicate with other

people from UK. For the hospitals the advantage is that they can plan their business management better.

How was the first contact made between Germedic and the W Sussex NHS Trust? When and by whom was it initiated?

The former leader of the Primary Care Group/Trust in Crawley made the first contact. This trust had previously had positive experience using private hospital capacity in the UK. They wanted to expand their experience to European hospitals. However a number of internal problems occurred at the trust and the project was not pursued at this stage. The leader was replaced shortly afterwards.

As pressure on waiting lists increased, the subject was taken up again after 5 months and the West Sussex Health Authority re-established contact with Germedic. They established contract negotiations under the leadership of the Department of Health and finally the pilot project was realised.

How many responsible people were involved in pilot project in the UK?

The management of the W Sussex Health Authority worked intensively on the project, together with members of a project-group in the Department of Health. UK doctors were not involved at any time (at least they had no direct contact with Germedic). The selection of the patients, the communication with the British. Doctors and the (avant-examination) were made by employees (MITARBEITER) of the Health Authority.

In my opinion the pilot-project was over-accompanied. The basic problem was that the NHS felt as responsible for the patients who were treated in Germany as they would have done if they were being treated in the UK. This is not necessary and from the organisational point of view will not be sustainable. The NHS should only exercise its right to patient selection, and not become so involved in Germany. *Researcher's comment:* this is a symptomatic of the structure of the NHS – very paternalistic and cautious, being an organ of state.

What impression did you have of the internal organisation of the NHS?

The administration of the project was very comprehensively organised. But the focus of attention was not unconditionally to help the patients efficiently and quickly. *It was implied that they had the perception that the managers were politicised.* They want to avoid showing any weaknesses in terms of image and legality; so it was over-regulated rather than orientated towards the (patients'?) problems.

If the NHS had less angst about losing its importance, a lot of things could be better organised.

Have there been further pilot projects since this?

Some long-term announcements were made about different subjects, e.g. medical care of heart patients, Flying doctors, building up of small hospitals in UK with international teams etc. This all was connected with big conferences, huge questionnaires and huge negotiation papers (*Unterlagen*)

How many British patients could be treated in Germany in the future?

We made an offer to the Department of Health (ANGEBOT UNTERBREITEN) to treat 12,000–15,000 patients p.a. at a fixed price (without flight-costs). We referred them to the positive Danish model.

What are the barriers to reaching this objective?

Political, financial and supposedly medical reasons (*cynical!*)

Apart from orthopaedic operations are there any others?

We have had orthopaedic patients only in the pilot project. Of course there are further treatment needs. But our experience shows that patients are more willing to travel to Germany when they have to wait for a bigger operation

What other types of operation are wanted by British patients?

Even private patients are mainly orthopaedic (hip and knee-endoprosthesis) and there is also demand for general operations and abdominal surgery.

We don't have any experience with HNO (neither requests nor treatment given).

Which other countries does Germedic work with?

Germedic is working at the moment with Denmark and the Netherlands as a European project and also with Saudi-Arabia, Kuwait and Oman. Private patients from Eastern European countries and CIS States. There are also negotiations with Iran.

Why were there so many problems regarding the after care?

Firstly, these problems exist because countries with waiting lists have a lack of capacity in their medical treatment systems and it is then difficult to integrate patients who have been treated abroad into the after care system (which also faces shortages). Besides, many doctors would prefer their own system to be properly funded so that sending patients abroad became superfluous. The interests of the patients, and this is our experience throughout, are placed as a rule behind everything else.

H. Hollander also attended the meeting with the German clinics. His views expressed at his meeting are summarised as follows:

He believes the competition between hospitals in Germany pushes up quality as they have to compete for patients. He believes Germany could cope with 15,000 patients per year from the UK without trouble. He believes the UK could easily clear its waiting lists in this way, although the decision should come from the patient without pressure from the PCT etc – they are not given the choice at the moment, however.

A big problem is after care in the UK – it needs to be integrated with the NHS system.

It seems UK doctors have too little trust in Germany, which is a systemic problem, rather than the fault of individual doctors. He believes the patients are the last link in the chain in the UK system. (Efficient markets have high information requirements)

4.2 Lutherhaus Krankenhaus, Essen

A list of patients was agreed by ESWS and criteria selected. (Patient feedback suggests the procedure was *not* very formalised or consistent.) About thirty patients were selected for treatment in Essen and Cologne. This represented the first instance of formal agreement between the NHS and a German hospital. The NHS insisted on a relatively formalised approach: firstly, the NHS inspected the hospitals and met the clinicians etc. They were particularly keen to check hygiene standards. After this nurses were sent in order to familiarise themselves with the hospitals, and travel arrangements etc. The third step was that patients were sent, always in groups of three, and accompanied by one of these nurses. Patients travelled out on Fridays and operations generally took place on Mondays. The NHS would pay for everything, including the flight, organisation and the treatment.

It was reported that some patients had significant secondary medical problems, although they should have been filtered out if they were too serious to travel safely. (This seems odd since so many patients were filtered out!)

The quality of after care in the UK seems to have varied greatly: some patients were refused after care by the NHS; some were seen but didn't get appropriate physiotherapy, which suggests there was inadequate communication or other problems. Some patients had to wait too long. It was pointed out that appropriate and high quality after care is essential for a good result in these types of orthopaedic cases.

Experience shows that after 6 months it is possible to check if there are problems and whose fault they are. Well specified contracts are therefore essential. In fact personnel from Essen visited the UK six months after the patients returned to check their progress. It was found that the NHS did not provide as much feedback as had been hoped for. In fact the visit revealed that some of the patients had experienced a deterioration in their ability to walk. Other patients had paid for themselves to return to Germany in order to receive higher quality after care. One patient (in his 80s) used his military home's facilities with good results. The after care in the UK was not properly organised. It was not clear what the objective standard was – in Germany it is to walk unaided – they were not sure if a lower standard was expected in the UK.

The German view is that the coordinator role (ie Germedic) is very important for organising finance and travel etc.

Some patients came on their own initiative, following press reports they had seen. These patients either organised everything themselves, which is onerous (payment must be made in full prior to treatment) or used Germedic. It is not clear to what extent such patients can then claim their money back from the NHS. The view is that it is better if patients come through the NHS.

It is believed that the shortage of patients (despite the good results) arose for political reasons rather than through over conservative selection criteria – the fact that some patients with fairly serious secondary problems were sent seems to support this. It was noted that the pilot project occurred just before the 2001 election when the Labour Party wanted to be seen to reduce waiting lists quickly. They are aware that the NHS is popular and therefore a politically sensitive subject.

In terms of patient results – they were all satisfied and thankful. Some very good personal contacts/relationships were established, some of which are maintained. There was close cooperation between the hospitals and the patients. The patients were highly motivated. Some accompanying relatives also stayed at the hospital, although they had to pay for themselves.

It was planned that ESWS would give feedback, but they gave none. It would have been appreciated if impressions had been communicated and information about the chances of continuing the project made.

There had been an agreement that the patients would arrive with their x rays – but most did not and some came with inadequate pictures.

Other German hospitals would have liked to work with Germedic, but they didn't want the risk – of a fixed price contract with the NHS.

Derbyshire and Northumberland also wanted to work with Germedic but it is thought these projects did not take place for political reasons.

The whole project involved 2 French, 2 German and 2 Belgian hospitals. H. Fredrich didn't hear from the UK doctors again after the treatment phase.

It is more expensive to send German doctors to the UK than to send UK patients to Germany (2.5 times more expensive!). He believes there was some counter-productive behaviour during the after care by UK doctors, making the patients the victims. UK doctors were "looking for every little complication" – in fact there was some very poor after care in the UK. H. Fredrich believes there would have to be continuity in a new project, in order to build relationships and avoid such problems in the future.

4.3 Eduardus Krankenhaus, Cologne

Germedic only works with hospitals in the DMA because of established quality criteria. The NHS chose the patients but the German had no information about the criteria or methods of choosing. At the beginning they sent patients without secondary problems, but later such patients were sent. This was a problem because of the fixed price nature of the contract. The Eduardus Krankenhaus has always attracted international patients. H. Koessendrop sees great potential in this market, particularly following the important legal ruling in the UK in October 2003 (see Section 3). He thinks in the future the NHS will organise the overseas treatment, because it is in their interests to do so.

In Germany there is still no duty to publish quality performance figures, although it is understood this situation will soon change.

Although some patients gave feedback, the hospital got no feedback from the NHS. This was a problem.

The NHS provided very old information about some of the patients (in some cases 2–3 years out of date). There was no contact between the hospital and patients' GPs. He says that patients were supposed to be sent from the waiting list, but that others were sent, which indicated that length of wait was not an important selection criteria for sending patients. Incorrect x-rays were also sent, necessitating additional x-rays to be made upon arrival. The communication was not as good as expected.

5 Potential market size

We were not able to obtain complete data about the current numbers travelling from the UK to Germany for medical treatment. In particular, the number of people travelling to Germany and paying for their treatment out of their own pockets is not known, although for example, the Universitaetsklinik reported treating a handful of UK patients on this basis and we were in contact with a handful of patients who had adopted this method. The total number is likely to be modest, since UK private healthcare provision is likely to be chosen by the majority of UK residents opting out of the NHS. However, since private medical treatment is generally somewhat cheaper in Germany than in the UK, there will be some patients who find travelling to Germany worthwhile despite the costs of travel, time and inconvenience, accommodation costs and possibly agency fees. We do not make any attempt to estimate the numbers of these people.

The NHS sent 81 patients to Germany in a pilot project at three sites in the South East of England during 2002. A further 109 patients were sent to France. Of the 190 patients in total, 153 were orthopaedic cases and the remainder were ophthalmic cases. The Health Authorities covered by the scheme had approximately 5,100 elective (non day case) orthopaedic patients waiting for over 6 months at this time. Of these 1,253 had been waiting more than 12 months. It can thereby be deduced that the equivalent of 3% of all elective (non day case) orthopaedic patients waiting more than 6 months in the pilot areas were sent to France and Germany during the scheme. It should be noted that it is not clear that all the patients sent overseas had waited more than 6 months, although length of wait was an important (stated) selection criterion.

We have calculated the scale of a national scheme which achieved the same rate of take up (orthopaedic cases only), assuming that the proportions of the population waiting for orthopaedic operations longer than 6 months in the pilot area is representative of that in the rest of the country. The area covered by the pilot project represented roughly 35%–40% of all patients on waiting lists in the South East region, which has a population of approximately 8.6m (14.5% of the UK total). This implies that a national scheme with the same rate of take up and assuming similar numbers on waiting lists would be expected to involve the treatment of 2,915 patients (this assumes there are 97,177 orthopaedic patients on waiting lists for more than 6 months nationally).

In fact, there are good reasons to suppose that a significantly higher take up than 3% could be achieved through better and more consistent patient selection as well as a more widespread level of commitment to such a scheme from UK health professionals. However, it is inevitable that large numbers of patients on waiting lists will not be suitable, either through unwillingness to travel or because of certain co-morbidities which would increase the risk of travelling for treatment. Nevertheless we consider it reasonable to expect the potential number of willing and able patients to be several times greater than 3%. Table 5.1 provides an illustration of the numbers of patients associated with higher percentages of take up, based on the same assumptions about the numbers on waiting lists nationally.

Table 5.1: Potential numbers of NHS orthopaedic patients travelling overseas under various scenarios¹²

Assumed % of patients waiting 6 months or more travelling overseas for treatment	Projected number of patients
3	2,915
5	4,859
10	9,718
15	14,577

It should be noted that the figures in Table 5.1 are only illustrations. They are not forecasts. There is no information to suggest that the NHS will initiate a national scheme to treat patients overseas.

It should also be noted that these illustrations were based on 2002 figures. The current trend is towards reduced waiting lists, and in fact the numbers of patients on waiting lists are declining relatively quickly. The total number waiting (all hospital-based treatments) fell by 8% between November 2002 and November 2003. The total number of patients on NHS waiting lists in November 2003 was 958,900.¹³ The distribution of waits is also changing. Efforts have been concentrated on reducing very long waits (probably for political reasons) and in fact official waits of longer than 12 months have now been almost eradicated. There were approximately 12,900 patients waiting more than 12 months in November 2002; by November 2003 there were significantly fewer than 500.

There have, however, been some reports that patients have had to wait to get onto waiting lists. We have insufficient information to comment on the prevalence of this phenomenon. Nevertheless there is now clear evidence that waiting lists are reducing. It remains to be seen at what rate they continue to decline and at what point they stabilise in the future. This trend is a very important determinant of the future potential market for international medical services, since having to wait for treatment is the most important factor in motivating people to accept treatment overseas. If waits of over 6 months are eliminated over the next few years there are not likely to be significant numbers of NHS patients travelling to Germany for treatment. However, it remains less than certain that the current rate of improvement in wait times will be sustained over the longer term.

¹² Based on the assumption of 97,177 orthopaedic patients waiting over 6 months nationally.

¹³ Department of Health Press Release: reference 2004/0011.

6 Conclusions

6.1 Development of an international market

A few years ago the idea of travelling overseas for medical treatment would have been unthinkable for most NHS patients. However, media coverage of problems in the NHS and the successful treatment of some patients in other European countries has started to change attitudes. In particular we believe there are relatively large groups of people willing to consider overseas treatment for non urgent (but possibly painful) conditions for which patients have been placed on an NHS waiting list. Examples include hip and knee joint replacements. There may also be the potential for developing a private market for treating patients for procedures not available through the NHS, such as certain types of cosmetic surgery.

While there is a shortage of capacity in the UK and some spare capacity in Germany and other countries, it would seem to make sense to allow UK patients to travel. There are some legal and bureaucratic issues to resolve before a market can develop. The barriers have been discussed in Section 3.

We believe the key area to work on is health professionals' attitudes, and that if personal communication and trust could be built up between UK and overseas practitioners, many of the current barriers would be easier to resolve. Our consultations with German clinics highlights this need, since they perceive a lack of communication about medical information during the pilot projects as well as a lack of feedback afterwards. Their perception was also that political considerations seemed to receive a high priority during the project, sometimes at the expense of patients – in particular they felt the very limited scope of the project reflected this. A necessary condition would be a widespread consensus about the usefulness of overseas facilities as an extra resource when domestic capacity is not available.¹⁴ In order to achieve this, the following would be required:

- UK doctors would need more information in order to refer patients to German hospitals with confidence (in the UK system, the General Practitioner takes responsibility for ensuring patients receive proper treatment). This might include information about ease of travel, English speaking capabilities and accommodation as well as clinical quality assurances;
- Procedures for agreeing prices and making payments have to be agreed;
- Ensuring patients have adequate legal protection.

If these issues can be resolved, there is likely to be the potential for a large, diverse market in medical services between the UK and Germany and other countries. If a European healthcare market develops, there may be further opportunities in the longer term and a new, mutually beneficial form of international trade may be created.

¹⁴ That is, overseas providers should not be presented as a threat to domestic practitioners.