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DUTCH PATIENTS EVALUATE CONTRACTED CARE IN BELGIAN HOSPITALS: RESULTS OF A MAIL SURVEY

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Nicole Boffin will act as guarantor for the report.

SUMMARY

1. Background

This mail survey is part of a broader study on cross-border contracting of care in Belgian hospitals (1). It was set up to describe the patient perspective on cross-border care in Belgian hospitals contracted by two Dutch health insurers, OZ and CZ.

Our main research questions were:

- 1) What is the ease of access to cross-border care? What information sources are used and how effective were these? In other words, was there a fit between needed and supplied information?
- 2) What arguments were pushing and pulling patients to cross the border for health care?
- 3) How do patients evaluate the care they received in the Belgian hospital? Aspects of quality of hospital care concern care and treatment as such, hospital service aspects and aftercare information.

2. Methods

A random sample of 1195 persons was drawn from adult affiliated members of CZ and OZ, registered for contracted care in the second part of 2004 in the CareNet Scheldemond information system for contracted care. The questionnaires were sent out in February 2005 to 1120 eligible persons.

3. Results

At the end of May 2005 we included completed questionnaires of 802 respondents. The adjusted response rate was 71.6% for the total population. Response was independent of insurer, sex, hospital and time lapse between invoice and the survey. Compared to non-responders, responders were somewhat older. Persons who did not receive actual treatment (but went to the hospital for a scan) or did not stay overnight in the hospital, were less inclined to answer the questionnaire.

Of the CZ-patients 16.3% had private insurance (all OZ-patients had sickness fund insurance).

The main findings are presented in Table 39.

Our analysis shows that OZ-patients and CZ-patients are two different populations. OZ-patients are older and have a lower socio-economic status, as measured by their educational degree and main source of income. Although their current health status evaluation is comparable to CZ-patients, more OZ-patients have been hospitalized in the Netherlands in the past five years so their health condition might be poorer.

The main finding is that OZ-patients would not have gone to a Dutch hospital if they would have received care as prompt as in their homeland. Several survey findings are related to this preference. OZ-patients live closer to the

1 See also Glinos IA, Boffin N, Baeten R. Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives. Brussels: Observatoire Social Européen [Europe for patients project]; 2005.

Belgian hospital they visited and they are also more oriented towards Belgium for shopping, seeing friends or relatives and going out. They are also more familiar with Belgian health care and services as almost half of the OZ-population has been in Belgium before for medical reasons, especially for one or more visits to a medical specialist. More OZ-patients already knew they could go to a Belgian hospital for medical care before they actually needed care most recently. We did not have data on the type of medical specialist OZ-patients consulted but the survey data suggest different problems and subsequent medical interventions. Less than a quarter of the OZ-patients required a medical intervention for which there was a waiting list in the Netherlands. More OZ-patients were inpatients, i.e. they spent at least one night in the hospital. They also spent more nights in the hospital and they had to pay several visits to the hospital, suggesting more severe health problems than those suffered by CZ-patients. The OZ-patients who only found out about cross-border care when they needed it, were told about it by a medical specialist. It was also a medical specialist who proposed the specific Belgian hospital according to the majority of OZ-patients and who was most helpful in the decision to go to a Belgian hospital. There are several explanations for the major role of medical specialists in the pre-hospital path of OZ-patients. Firstly, it may be an indication of the severity of their health problems. This was confirmed by our OZ-informants, stating that many cross-border patients are chronic patients, for instance kidney patients and diabetics. But we also know from our informants and the literature that OZ has a more restrictive policy on patient mobility towards Belgium as they fear underutilization of the regional hospital in Zeeuws-Vlaanderen, which has developed a bad reputation in recent years. The high levels of satisfaction of OZ-patients with the information they had on hospital reputations may be seen as an indication of the sensitivity of OZ-patients to this issue. Even more convincing is that a better reputation of both physicians and hospitals is decisive in the decision to go to Belgium. The self-declared policy of OZ to limit cross-border care is confirmed by the survey results. OZ-patients indeed rate both the helpfulness of their insurer and the ease of obtaining authorization somewhat lower. Finally, OZ-informants equally explain the major involvement of medical specialists in the pre-hospital path of OZ-patients by cross-border professional activities. Several medical specialists work(ed) both in a Belgian hospital and a Dutch hospital and, consequently, OZ-patient flows are co-directed by cross-border networks of medical specialists.

The other side of our main finding is that CZ-patients would have preferred a Dutch hospital if they could have received care with the same promptness. In their cases we see that waiting lists do play a major role. Three quarters of the CZ-patients state that there was a waiting list in the Netherlands for the care they demanded. The absence of a waiting time is definitely the most important argument in the decision to go to a Belgian hospital. We do have basic treatment data on the CZ-patient population. We found that the longest waiting lists are declared by those patients who consulted medical specialists in bariatric and abdominal surgery, plastic surgery and other surgery, and this group makes up nearly a quarter of the CZ-patients. They live further from the Belgian hospital, they are less oriented towards Belgium and they are less familiar and experienced with Belgian health services. Shorter travelling distance to the hospital is no argument for cross-border care for the CZ-patients. Fewer CZ-patients were acquainted with the possibility of cross-border care and most of them were told about it by non-professional caregivers, i.e. family or friends. In contrast to the OZ-population, CZ-patients use informal support for obtaining information and deciding to go for Belgian hospital care. Their insurer proposes the hospital and equally helps in their decision process. Medical specialists play a minor role in giving preliminary information, proposing the hospital and helping CZ-patients to decide.

Once they have access to the Belgian hospital care, there are no significant differences between OZ-patients and CZ-patients with respect to their post-hospital path and their evaluation of the quality of care.

The overall evaluation of Belgian hospital care and the evaluation of treatment and care in the hospital are equally high in both groups. Quality of service aspects in the hospital and aftercare information are rated somewhat lower. Nearly all evaluation aspects are independent of the visited hospital.

One of the concerns of cross-border care is continuity of care. Our findings show that problems occur but in relatively small groups of patients. We found that nearly half of the population left the hospital with a drug prescription and the availability of the medication at home was rated less positive than other aspects of care. The availability of aids devices was rated negatively by the minority (14%) of patients who were in need of these. Very few patients (3%) were admitted to a nursing home or a revalidation centre after leaving the hospital. They were equally less positive about aftercare information given by the Belgian hospital. One in ten patients received home care afterwards, and they were equally mixed about the quality of the information their home care organization received from the Belgian hospital.

4. Conclusions

This survey was set up to study three research questions:

1. What is the ease of access to cross-border care? What information sources are used and how effective were these? In other words, was there a fit between needed and supplied information?
2. What arguments were pushing and pulling patients to cross the border for health care?
3. How do patients evaluate the care they received in the Belgian hospital? Aspects of quality of hospital care concern care and treatment as such, hospital service aspects and aftercare information.

We found out that most answers to the first and the second question are different for the CZ-population and the OZ-population. The answers to the third question are shared by the two subpopulations.

- **How do patients evaluate the care they received in the Belgian hospital?**

CZ-patients and OZ-patients share the same positive experiences about the care they received in the Belgian hospitals. Hospital care and treatment as such receive the most positive evaluation scores, together with overall evaluation of the most recent Belgian hospital care experience. Hospital service aspects and general aftercare, or more specific, recovery information, received lower evaluation scores but still all positive. The availability at home of the drugs and especially the aids devices that were prescribed in the hospital is suboptimal. As expected, few patients received professional aftercare after leaving the hospital. But these patients were not positive about the information that was given to their home care organization or their revalidation centre or nursing home.

- **What arguments were pushing and pulling them to cross the border for health care?**

OZ-patients and CZ-patients are pushed and pulled to Belgian hospital care by different arguments. CZ-patients are pushed towards Belgian hospitals by the long waiting lists in their homeland. Without these they would have preferred to stay in the Netherlands. OZ-patients are pulled by their closeness to Belgium in every sense of the word. They would prefer a Belgian hospital even without waiting lists. Several data suggest that the mobility of OZ-patients towards Belgium is independent of waiting lists and is related to their more severe health problems, the policy of OZ and cross-border professional activities of medical specialists. OZ patients are also more pulled towards Belgian hospitals by their good reputation.

- **What is the ease of access to cross-border care?**

More OZ-patients were acquainted with the possibilities of cross-border care before they actually needed care most recently. Medical specialists had a more pronounced role in the access of OZ-patients to Belgian hospital care. CZ-patients used more informal, i.e. non-professional, information sources and support in the decision process to go to a Belgian hospital. The fit of information on cross-border care on the whole is positive. The ease of choice and access are evaluated as even more positive.

CHAPTER 1: INTRODUCTION

This study is part of a larger research project on contracted care in Belgian hospitals (2). It was set up to describe the patient perspective on cross-border care in Belgian hospitals contracted by two Dutch health insurers, OZ and CZ.

CZ or "CZ Actief in Gezondheid" (CZ standing for "Centraal Ziekenfonds") is the second largest Dutch sickness fund with approximately 2.1 million affiliates, of which 2/3 (1.3 million) are sickness fund members and 1/3 are privately insured. The CZ covers the whole of the Netherlands but has higher concentrations in the three southern provinces of Limburg, Brabant and Zeeland, where around 85% of its affiliated members live. The CZ started contracting in Belgium in the second half of 2001 and now has contractual agreements with seven Belgian hospitals.

OZ, by its full name OZ zorgverzekeringen, is a sickness fund of 615,000 affiliates, of which the vast majority are publicly insured and 30,000 are private patients. Its geographical concentration lies in the provinces and coastal areas to the south-west of the country, i.e. Zeeuws-Vlaanderen. The OZ was the first Dutch insurer to start contracting in Belgium, from 1998-1999, and today has contracts with four Belgian hospitals.

Until now, few empirical studies have been conducted on this subject (3). Hermans *et al.* mentioned the following, "*rather hypothetical, stimulating and limiting factors for cross-border care*":

- Relatively long waiting for domestic care
- Relatively poor quality of domestic care
- Relatively long distance to domestic care
- Relatively good availability of certain types of care abroad
- Relatively high price for domestic care
- Relatively familiar with foreign care
- Certainty about insurance coverage and administrative burden
- Certainty about medical arrangement
- Advice of referrers to travel abroad
- Relatively small differences in language and (medical) culture
- Disease characteristics
- Patient characteristics (Hermans and Brouwer, 2003).

A major empirical study concerned patients' experiences in a national pilot scheme operating in 28 acute NHS trusts in England (Le Maistre *et al.*, 2003). Patients who had been on a waiting list for their heart operation for six months were offered treatment in another NHS hospital or a hospital in the private sector, or they could opt to

2 See Glinos, I. A., Boffin N. and Baeten, R. (2005), "Contracting cross border care in Belgian hospitals: an analysis of Belgian, Dutch and English Stakeholder perspectives", Report for the project "Europe for patients", Observatoire social européen, Brussels, August 2005 (http://www.ose.be/files/health/BelgianCaseStudy_ForPrint.pdf).

3 See for example InterregII-project. Vrije toegang tot de gezondheidszorg-voorzieningen in de Euregio Maas-Rijn. Modelproject "IZOM" Integratie Zorg Op Maat. Verslag 2002; 2002 and Agassi, 2002; Agasi *et al.*, 2003; Engels, 2003a and 2003b; Hermans and Brouwer, 2003; Le Maistre *et al.*, 2003; Lowson *et al.*, 2002; Miltenburg and Parmentier, 2003; Van der Schee *et al.*, 2005.

remain on the waiting list at their home hospital. The study revealed that the reputation of the hospital was the most influencing factor when patients were making a decision, but speed of treatment was also important.

A study of the "transnational" continuity of care concerning Dutch patients who were treated in Belgium identified several bottlenecks in the communication between caregivers on both sides of the border. Discontinuity of the care process was attributed to differences in professional culture and lack of knowledge of the cross-border health care system, resulting in reluctance on the part of Dutch physicians towards cross-border care (Engels, 2003a and 2003b).

The objective of our survey was to describe the expectations and experiences of cross-border patients, the push and pull in deciding to cross the national border and the barriers and facilitators in doing so. Our hypothetical framework is that patients' experiences and evaluations are dependent on characteristics of the care they received and the access to it, but also dependent on patient characteristics (their pre-condition, age, socio-economic status, closeness to Belgium, ...), prior health (care) experiences and expectations. As a result, our main research questions were:

- What is the ease of access to cross-border care? What information sources are used and how effective were these? In other words, was there a fit between needed and supplied information?
- What arguments were pushing and pulling patients to cross the border for health care?
- How do patients evaluate the care they received in the Belgian hospital? Aspects of quality of hospital care concern care and treatment as such, hospital service aspects and aftercare information.

CHAPTER 2: METHODS

1. Questionnaire development

The six-page questionnaire was formulated on the basis of previous study reports on the same subject and progressively developed by discussion with the involved researchers, the main Dutch insurers, the CM middleman and Belgian hospital managers (4). At the start of the research project two hospitals were visited by NB (Universitair Ziekenhuis, Antwerpen and ZOL, Genk) to interview staff members closely involved in hospital care to Dutch patients. In each hospital a staff member involved in monitoring patient satisfaction was interviewed as well as a hospital manager. The questionnaire was completed after a final revision in two separate group meetings of the involved staff of CZ and OZ. The list of interviewees and informants is included in annex 2.

The questionnaire includes 64 items followed by five Likert-type response options from very unsatisfying, unimportant, untrue, difficult (1) to very satisfying, important, true, easy (5). Some questions include a sixth response option, "non applicable".

No pilot of the questionnaire was conducted because of the short time period (10 months) in which the survey had to be set up and reported.

The questionnaire was structured according to the chronological process. After starting with some factual questions on hospital identification, length of hospital stay and waiting time in the Netherlands, a range of questions followed on the "preceding process" of the Belgian hospital treatment, dealing with the information process and decision-making. The next heading on "treatment and aftercare" groups mainly evaluation questions on treatment and care in the hospital and aftercare arrangements. The final section starts with evaluating the current health status, previous health services used in Belgium and the Netherlands, to end with socio-cultural orientation towards Belgium and some personal characteristics.

On the front page, we stressed that the questionnaire was about the most recent treatment received in a Belgian hospital, i.e. in the second part of 2004. We also asked persons helping the addressed person to fill in the questionnaire to reflect his or her answers.

At the end of the questionnaire patients were invited to write their comments on the questionnaire and to describe their experiences on the back page.

The main challenge of the questionnaire was to fit the broad range of hospital interventions, ranging from patients who received overnight hospital treatment with subsequent returns to patients who only went once to the hospital

4 See for example InterregII-project. Vrije toegang tot de gezondheidszorg-voorzieningen in de Euregio Maas-Rijn. Modelproject "IZOM" Integratie Zorg Op Maat. Verslag 2002; 2002 and Agassi, 2002; Agasi *et al.*, 2003; Engels, 2003a and 2003b; Hermans and Brouwer, 2003; Le Maistre *et al.*, 2003; Lowson *et al.*, 2002; Miltenburg and Parmentier, 2003; Van der Schee *et al.*, 2005 and Winters-van der Meer *et al.*, 2004.

for a diagnostic assessment. We had to accept that not all of the questions would be relevant to all the population.

2. Study population: Sample and participants

The survey population random sample was based on the CareNet Scheldemond, the information system that is used by the hospitals, the Dutch insurers OZ and CZ and the Belgian CM middleman for the management of the delivery of contracted care (5).

We first selected the patients aged 18 years and older who had been invoiced by Belgian hospitals in the second half of 2004 and had received authorization for contracted care. From this population we drew a random sample of 350 patients insured by OZ and 845 CZ-patients. A confidentiality procedure was set up according to which addressed persons received a numerical code which was printed on the questionnaire to track the response. In the confidentiality procedure the CM middleman acted as trusted third party.

The questionnaires were sent out by the insurers in February 2005. The introduction letter was designed by the researchers, written by the health insurers and signed by both parties. The mailing included a free post envelope addressed to OSE. One week after the mailing a reminder letter was sent by the health insurers to all sample units. Four weeks after the first mailing a second mailing, including a new questionnaire copy, was sent out to non-responders.

OZ excluded 28 patients from the survey mailing because of decease, termination of membership and Belgian residence. CZ excluded 47 patients from the survey mailing because of decease or termination of membership.

3. Other data sources

As mentioned before, the survey protocol and the questionnaire were developed after reading relevant study reports and explorative interviews in the field. Most meetings and interviews were summarized using audio-registration. The list of interviewees and informants is included in annex 2.

The survey findings were discussed in a meeting that was attended by the informants and interviewees (see discussion).

Besides the CareNet Scheldemond datafile of invoices, we also used treatment data of CZ about the sample population. These data concern the type of hospital stay (inpatient or outpatient hospital care or ambulatory care) and the consulted medical specialist.

We grouped the consulted medical specialists into four commonly used subgroups:

5 See annex III in: Glinos IA, Boffin N, Baeten R. Contracting cross border care in Belgian hospitals: an analysis of Belgian, Dutch and English Stakeholder perspectives. Brussels: Observatoire Social Européen [Europe for patients project]; 2005.

1. Supporting medical specialists such as radiologists, pathologists, medical specialists in nuclear medicine and clinical chemistry
2. Contemplating medical specialists such as internists, neurologists, paediatricians, ...
3. Surgeons
4. A group of medical specialists (excluding supporters) who perform both surgical and non-surgical acts, such as gastroenterologists, cardiologists,...

We assigned only one code for the consulted medical specialists. When patients saw more than one medical specialist, we first considered surgical specialists, secondly contemplating specialists and finally supporting specialists.

4. Analysis

Quantitative analysis of the survey data was performed with the SPSS package version 12.0. Chi square statistics were used to test for differences between groups for categorical variables. Kendall's tau was used as a measure of ordinal association. Analysis of Variance (ANOVA) was used to compare the means of several groups of observations.

Factor analysis (principal component analysis) was used to construct scales and thus to reduce the number of items (see annex 3). The reliability of the scales was measured by Cronbach's alpha.

Of all Likert type evaluation questions means were reported with a minimum value of 1 and a maximum value of 5. All Likert scales go in the same direction: starting from very negative (lowest value) to very positive (highest value).

CHAPTER 3: RESULTS

1. Response

The survey response rate was 71.6% for the total sample size, after adjustment for 75 patients who were excluded by the insurers since they were no longer in their client base. We also excluded Belgian residents who returned the questionnaire, all of them CZ-patients (N=22), from the analysis. As far as we know, no patients with Belgian nationality and living in the Netherlands are included in the survey. We did not ask for nationality in the questionnaire, but as patients who lived in Belgium drew attention to this fact, we expected Belgian respondents living in the Netherlands to do likewise.

Table 1: Sample size and response

	CZ	OZ	Total
Initial sample size (N)	845	350	1195
Addressed sample population (N)	798	322	1120
Timely, minimal response (N)	597	227	824
Questionnaires included in analysis (N)	575	227	802
Adjusted response rate (%)	72	70.5	71.6

Compared to non-responders, responders were somewhat older (47 versus 51 years, ANOVA: $df=1$, $P=0.000$). Response was independent of sex, hospital and time lapse between invoice and the survey.

Analysis of the treatment data of the CZ sample population (N=705) showed a higher response rate from inpatients (84%) compared to outpatients and ambulatory patients (72.5%) ($df=1$, $P=0.003$). Response rates were lowest in outpatients having seen a supporting specialist (69.3%), higher in outpatients having seen another medical specialist (73.7%) and highest in inpatients (82.5%) having seen another medical specialist. In other words, patients who did not receive actual treatment or did not stay overnight in the hospital were less inclined to answer the questionnaire ($df=2$, $p=.02$).

2. Population characteristics

Mean age of our population is 51 years, the youngest patient is 19 and the oldest 91.

Table 2. Population characteristics (sex, age, education, income, health status)

		N	%
Sex	Male	337	42.4%
	Female	457	57.6%
Total		794	100.0%
Age	Under 20	6	.8%
	20-39 years	205	26.3%
	40-54 years	237	30.4%
	55-59 years	96	12.3%
	60 and older	235	30.2%
Total		779	100.0%
Educational level	Primary school	161	21.4%
	Lower secondary school	259	34.4%
	Higher secondary school	219	29.0%
	Higher non-university education	103	13.7%
	University degree	12	1.6%
Total		754	100.0%
Source of income	Salary	377	49.0%
	Own enterprise	55	7.2%
	Social security	293	38.1%
	Other source	44	5.7%
Total		769	100.0%
Health status	Very bad	4	.5%
	Bad	38	4.9%
	Not bad, not good	256	32.7%
	Good	327	41.8%
	Very good	157	20.1%
Total		782	100.0%

Comparison of our inpatient population with the inpatient population of the Dutch University Medical Centres (UMC) in 2002, after exclusion of patients less than 20 years of age, shows that our population is younger (see Table 2) (Winters-van der Meer *et al.*, 2004).

Table 3: Comparison inpatients characteristics with UMC inpatients 2002

	Our inpatient population	UMC inpatient population 2002
% 20-39 years	33	24
% 60 and older	30	40

Compared to the fifty-fifty distribution of male and female UMC inpatients, our population has 10% more female inpatients (without correction for age).

The current health status evaluation of the two inpatient populations is just about the same (without correction for age). Comparing the two inpatient populations for education is trickier, but considering the percentage of UMC inpatients with "higher education" (24%), our inpatient population with a higher degree (15.5%) is lower.

2.1 General characteristics of CZ-patients and OZ-patients

All OZ-patients had sickness fund insurance while 16.3% of the CZ population had private insurance. A rough comparison with the national percentage of about 35% privately insured shows this is a rather low percentage.

OZ-patients were older than CZ-patients (53 versus 50 years, ANOVA: $df=1$, $P=0.01$). As age is related to income and education, we see that fewer OZ-patients had a higher degree ($df=4$, $p=.005$) and more OZ-patients mainly lived on an income supplied by a social security fund ($df=2$, $p=.007$).

There was no difference in current health status between OZ-patients and CZ-patients. But 50% of the OZ-patients had been hospitalized in the Netherlands in the past five years while this was only the case in 30.5% of the CZ-patients ($N=790$, $df=1$, $p = .000$). Patients who were hospitalized in the past five years ($N=284$) lived (at that time) on average 18.1 kilometres from the Dutch hospital ($N=270$, median= 10, std dev= 26.38), without any statistically significant difference between OZ-patients and CZ-patients. Health status evaluation was better in patients who had not been hospitalized in the Netherlands in the past five years (3.85) compared to hospitalized patients (3.61) (ANOVA: $N=777$, $df=1$, $p=.000$).

Table 4: General population characteristics (age, income and education) by insurer

		Health insurer		Total
		CZ	OZ	
		%	%	N
Age	Under 20	.9	.5	6
	20-39 years	25.6	28.2	205
	40-54 years	34.0	21.4	237
	55-59 years	13.2	10.0	96
	60 and older	26.3	40.0	235
Total				779
Source of income	Salary	53.6	47.8	377
	Own enterprise	9.0	4.0	55
	Social security	37.4	48.3	293
	Total			725
Educational level	Primary school	19.4	26.3	161
	Lower secondary school	32.5	39.2	259
	Higher secondary school	30.3	25.8	219
	Higher non-university education	16.0	7.7	103
	University degree	1.8	1.0	12
	Total			754

2.2 Socio-cultural orientation towards Belgium

All patients were asked how frequently they visited Belgium in the last year for shopping, visits to family or friends, for an evening out, for work or studies.

Table 5: Frequency of visits to Belgium in last year

	Never	Once a year	Once a month	Once a week	Once a day	Total
	%	%	%	%	%	N
Shopping	28.2%	43.1%	20.7%	6.9%	1.1%	735
Visits to friends, family	53.6%	26.2%	12.3%	7.2%	.7%	683
Going out	54.9%	32.4%	9.9%	2.4%	.3%	657
Working	88.3%	6.7%	2.3%	1.7%	.9%	640
Studies	95.9%	1.7%	.3%	1.9%	.2%	632

A scale "*socio-cultural orientation towards Belgium*" was constructed by factor analysis (minimum value: 1, maximum value: 5).

Table 6 shows that the mean value on socio-cultural orientation towards Belgium is higher in the OZ population than in the CZ population (2.1 versus 1.8, ANOVA: df=1, P=0.000). In other words, on average OZ-patients are more oriented towards Belgium for shopping, visiting family or friends and going out. This is equally so for CZ-patients with private insurance (ANOVA: df=1, p=.023).

Table 6: Socio-cultural orientation towards Belgium by insurer and type of insurance in CZ-patients

Health insurer	Mean	N	Std. Dev.
CZ	1.7711	544	.76109
OZ	2.1463	213	.78080
Total	1.8767	757	.78454
Type of CZ insurance			
Private insurance	1.9394	88	.84538
Sickness funds	1.7387	456	.74034
Total	1.7711	544	.76109

3. Characteristics of hospital use

The distribution of hospitals in the survey is similar to the hospital distribution in the CareNet Scheldemond authorized invoices datafile of 2004 (see Table 7). More than one in three patients (35.4%) has visited the hospital ZOL, Genk.

Table 7: Hospital use by health insurer in the survey population and CareNet Scheldemond 2004

	CZ		OZ		Total		% CareNet Scheldemond 2004
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	%
AZ St-Jan, Brugge			51	25.1%	51	6.9%	5.8%
Maria Middelaes, Gent			30	14.8%	30	4.0%	4.5%
UZ Gent	1	.2%	94	46.3%	95	12.8%	10.6%
OLV Ter Linden, Knokke	38	7.1%	28	13.8%	66	8.9%	7.2%
ZOL, Genk	263	48.8%			263	35.4%	34.8%
Maria Ziekenhuis Noord-Limburg, Lommel	96	17.8%			96	12.9%	12.6%
Maas en Kempen, Maaseik	75	13.9%			75	10.1%	10.8%
St-Jozef, Malle	32	5.9%			32	4.3%	6.2%
ZH Salvator, Hasselt	29	5.4%			29	3.9%	7%
AZ Vesalius, Tongeren	5	.9%			5	.7%	0.4%
Total	539	100.0%	203	100.0%	742		100.0%

OZ-patients live closer to the Belgian hospital they visited than CZ-patients (see Table 8).

The mean distance between the patients' residence in the Netherlands and the Belgian hospital is 48 km (Median 40, N=723, Std. Dev. 36.8). A possible benchmark is the mean distance of 18 km between the Dutch residence and the Dutch hospital of those patients who have been hospitalized in the past five years (Median 10, N=269, Std. Dev. 26.42).

On average OZ-patients live closer to the Belgian hospital they were treated in than CZ-patients (41.1 km versus 50.8 km, ANOVA: df=1, P=0.001).

Table 8. Distance between residence in the Netherlands and Belgian hospital by health insurer

		Health insurer				Total	
		CZ		OZ		<i>N</i>	<i>Col %</i>
		<i>N</i>	<i>Col %</i>	<i>N</i>	<i>Col %</i>		
Distance residency-hospital in km	1 - 24	120	23.2%	32	15.5%	152	21.0%
	25 - 40	169	32.7%	89	43.2%	258	35.7%
	41 - 99	161	31.1%	83	40.3%	244	33.7%
	>= 100	67	13.0%	2	1.0%	69	9.5%
Total		517	100.0%	206	100.0%	723	100.0%

Most patients (60.8%) did not stay overnight in the hospital. We already mentioned the over-representation of inpatients in the survey. We did not ask if patients received outpatient hospital care (also called "day care") or ambulatory care (also called "a consultation"). Analysis of the authorization data of the CZ sample population (752 cases) showed that 23% received inpatient hospital care, 5% received outpatient hospital care and 72% received ambulatory care.

The type of hospital stay is strongly related to the hospital (see Table 9), with most overnight stays in OLV Ter Linde Knokke (64.6%), contracted by OZ for obstetric care, and 25.5% overnight stays in ZOL, Genk. The low percentage of overnight stays in AZ Vesalius, Tongeren concerns only five patients.

Table 9: Overnight stays by hospital

		Overnight stays		Total population
		<i>N</i>	%	<i>N</i>
Hospital	AZ St-Jan, Brugge	29	56.9%	51
	UZ Gent	40	42.1%	95
	OLV Ter Linden, Knokke	42	64.6%	65
	Maria Middelaes, Gent	8	26.7%	30
	ZOL, Genk	67	25.5%	263
	Maria Ziekenhuis Noord-Limburg, Lommel	42	43.8%	96
	Maas en Kempen, Maaseik	32	43.2%	74
	St-Jozef, Malle	18	56.3%	32
	ZH Salvator, Hasselt	15	51.7%	29
	AZ vesalius, Tongeren	1	20.0%	5
Total		294	39.7%	740

We obtained data of the (main) consulted specialist for 492 (85%) CZ-patients from their insurer (see Table 10). Most of them were treated by an orthopaedic specialist. Plastic surgery covers a wide variety of interventions, so much is revealed by comments in the questionnaires. The high mean age (60) of involved patients confirms that cataract is the main reason for seeing an ophthalmologist, as declared by CZ. Nuclear medicine, in third place, is explained by the “scans” as mentioned in the questionnaires. Several patients visited a neurologist for a second opinion. Patients who received gastric banding (a surgical technique that has been developed for the treatment of obesity), according to the survey, have been treated by both abdominal surgeons and bariatric surgeons.

Table 10: Specialties seen by CZ-patients

	N	%
Orthopaedics	137	27.8%
Plastic surgery	51	10.4%
Nuclear medicine	47	9.6%
Neurology	30	6.1%
Ophthalmology	28	5.7%
Abdominal surgery	26	5.3%
Neurosurgery	25	5.1%
Gastroenterology	16	3.3%
Radiology	15	3.0%
Obstetrics and gynaecology	14	2.8%
Bariatric surgery	13	2.6%
Other surgery	39	7.9%
Other contemplaters	30	6.1%
Other surgery or contemplaters	21	4.3%
Total	492	100.0%

Considering the five largest hospitals receiving CZ-patients (see Table 11), we see that the hospitals attract specific patient demands, at least when it concerns contracted care. It looks as though Maria Ziekenhuis Noord-Limburg is specialized in ophthalmology, orthopaedic treatment and preceding radiology for diagnosis. Maas en Kempen is specialized in bariatric surgery. St-Jozef Malle is also specialized in orthopaedics. ZH Salvator Hasselt leads in surgery, plastic surgery, neurosurgery as well as "other" surgery. ZOL has the broadest range of treating medical specialists.

Table 11: CZ hospitals by speciality (N=448)

	Hospital				
	ZOL, Genk	Maria ZH Noord-Limburg, Lommel	Maas en Kempen, Maaseik	St-Jozef, Malle	ZH Salvator, Hasselt
	%	%	%	%	%
Orthopaedics	17.5%	57.3%	20.9%	69.2%	11.1%
Plastic surgery	15.4%	2.4%	4.5%		18.5%
Nuclear medicine	14.2%	2.4%	7.5%	3.8%	
Other surgery	9.3%	1.2%	4.5%	11.5%	14.8%
Neurology	8.9%		3.0%	3.8%	11.1%
Other contemplaters	7.7%	1.2%	4.5%		7.4%
Ophthalmology	5.3%	12.2%	4.5%		
Abdominal surgery	2.8%	2.4%	23.9%		
Neurosurgery	5.3%				33.3%
Other surgery or contemplaters	5.3%	4.9%	1.5%		
Gastroenterology	4.5%		4.5%	3.8%	3.7%
Radiology		14.6%		7.7%	
Bariatric surgery			19.4%		
Obstetrics and gynaecology	3.7%	1.2%	1.5%		
Total	246	82	67	26	27

On average inpatients stayed 6 nights (mean 6.2, median 3, std dev 8.83, N=307) in the hospital, ranging from 1 night (28.3%) to a maximum of 77 nights. Ten percent of the inpatient population stayed 15 nights or longer in the hospital.

Almost half of the OZ-patients were inpatients (48.7%), significantly more than 35.5% of the CZ-patients (df=1, P=0.000). On average OZ inpatients also spent more nights in the hospital than CZ inpatients (9 versus 4.7, ANOVA: df=1, P=0.000).

There is a significant relation between hospital and mean value of hospital nights in the OZ-patients (see Table 12). This relation is absent in CZ-patients. After excluding one OZ patient who stayed extremely long (77 nights) in the hospital, the mean of hospital nights in Maria Middelaes Gent diminishes from 17.4 to 7.5 (ANOVA: df=3, P=0.02).

Table 12: Length of hospital stay in nights in OZ and CZ inpatients by hospital

Hospitals OZ	Mean	N	Std. Dev.
AZ St-Jan, Brugge	11.86	29	13.495
UZ Gent	8.61	38	7.328
OLV Ter Linden, Knokke	3.80	23	4.428
Maria Middelaes, Gent	7.50	6	3.391
Total	8.37	96	9.412
Hospitals CZ			
OLV Ter Linden, Knokke	4.56	18	5.533
ZOL, Genk	3.91	67	5.723
Maria Ziekenhuis Noord-Limburg, Lommel	5.88	41	7.633
Maas en Kempen, Maaseik	5.25	32	8.666
St-Jozef, Malle	3.17	18	4.018
ZH Salvator, Hasselt	3.33	15	2.870
AZ vesalius, Tongeren	8.00	1	.
Total	4.52	192	6.437

Most of the population (59.8 %) went more than once to the hospital for their complaints (see Table 13). These figures should be read with care since we cannot exclude that patients considered their complaints over a longer, to us unknown, time period. On average the total population went more than three times to the hospital and half of the population went twice to the hospital (Mean 3.56, Median 2, N=762, Std. Dev. 5.259). On average OZ-patients went 4.3 times to the hospital and CZ-patients 3.3 (ANOVA: df=1, p=.022).

There is no significant relation between frequency of hospital visits and distance to the hospital.

Table 13: Subsequent hospital visits for complaints

	N	%
Only once	306	40.2%
Twice	105	13.8%
Three times	115	15.1%
Four times	58	7.6%
Five times and more	177	23.3%
Total	761	100.0%

The mean frequency of hospital visits is 4.4 in inpatients and 3 in outpatients (ANOVA: df=1, P=0.000). Our hypothesis that inpatients who went several times to the hospital are more likely to have a chronic disease is confirmed by their current health status. Patients who evaluated their current health status as (very) negative went on average 7.2 times to the hospital compared to an average of 3.2 times in patients who feel (very) good and 3.9 times in patients who are mixed about their health status (ANOVA: df=1, P=0.000). However, patients who were hospitalized in the Netherlands in the last five years on average did not go more frequently to the Belgian hospital for their current complaints.

4. Waiting time in the Netherlands

While in the total population 60% state that there were waiting lists for the management of their problem(s), this percentage is much higher in CZ-patients (74.1%) than in OZ-patients (23.7%) (see Table 14). OZ-patients either do not know if there was a waiting problem or know that there wasn't one (together 76.3%) (df=2, p=.000).

Table 14: Waiting lists in the Netherlands by health insurer

	Health insurer		Total	
	CZ	OZ	N	%
	%	%		
No	9.9%	25.1%	110	14.1%
Yes	74.1%	23.7%	471	60.2%
Don't know	16.0%	51.2%	201	25.7%
Total	100.0%	100.0%	802	100.0%

An average of 21.8 waiting weeks is reported (N=435, Std. Dev. 31.647) and the average length of waiting times reported by OZ-patients is not significantly shorter.

The average waiting time in weeks as reported by the CZ-patients shows a strong relation with the speciality they needed (ANOVA, df=13, P=0.000) with the longest waiting times for surgery and especially bariatric surgery (see Table 15).

Table 15: Waiting time in weeks by speciality in CZ-patients (N=333)

Specialty	Mean	N	Std. Dev.
Bariatric surgery	72.92	13	49.299
Abdominal surgery	71.89	18	88.244
Other surgeons	44.65	23	37.916
Plastic surgery	38.27	41	29.671
Orthopaedics	15.59	93	11.928
Ophthalmology	14.81	21	7.776
Other contemplaters	13.00	13	12.035
Nuclear medicine	12.49	37	25.197
Neurosurgery	12.00	18	7.941
Radiology	11.58	12	6.735
Gastroenterology	10.90	10	3.281
Other surgeons or contemplaters	8.90	10	3.247
Neurology	8.59	17	3.483
Obstetrics and gynaecology	7.57	7	1.397
Total	23.97	333	34.230

5. Preference for staying in the Netherlands

One has to consider the relative absence of waiting lists for the problems OZ-patients encounter, which makes the conditional question ("Would you have gone to a Dutch hospital if care could have been delivered with the same promptness?") somewhat irrelevant.

In general most patients (60%) would have gone (probably or definitely) to a Dutch hospital if care could have been delivered as promptly as in Belgium (see Table 16). But this preference is only present in CZ-patients (71.3%). Almost half of the OZ-patients (47.2%) would have gone (probably or definitely) to a Belgian hospital and a considerable proportion (22.4%) did not know ($df=4$, $p=.000$).

Table 16: Preference for Dutch hospital by insurer

		Health insurer				Total	
		CZ		OZ		N	Col %
		N	Col %	N	Col %		
Preference Dutch hospital	Definitely not	52	9.3%	59	27.6%	111	14.3%
	Probably not	60	10.7%	42	19.6%	102	13.2%
	Don't know	49	8.8%	48	22.4%	97	12.5%
	Probably yes	203	36.3%	43	20.1%	246	31.8%
	Definitely yes	196	35.0%	22	10.3%	218	28.2%
Total		560	100.0%	214	100.0%	774	100.0%

Table 17 shows that the non-preference of OZ-patients for a Dutch hospital might be related to the smaller distance between their residence and the Belgian hospital they went to. Distance in kilometres and socio-cultural orientation towards Belgium are on average higher in patients not preferring a Dutch hospital. But patients who prefer a Belgian hospital have also spent on average more nights in the hospital and went more frequently for visits to the Belgian hospital.

Table 17: Analysis of variance between subgroups of Dutch hospital preference

		Distance	Socio-cultural	Length of stay	Frequency of
Definitely not	Mean	41.80	2.0440	3.89	4.77
	N	103	106	109	100
	Std. Dev.	24.098	.82818	8.822	5.386
Probably not	Mean	39.64	2.0707	2.28	4.26
	N	92	99	100	95
	Std. Dev.	23.232	.79329	5.366	5.235
Don't know	Mean	43.20	1.9508	2.54	2.86
	N	91	88	97	95
	Std. Dev.	29.411	.84386	6.421	3.631
Probably yes	Mean	49.06	1.8507	2.29	3.66
	N	215	230	243	237
	Std. Dev.	42.872	.75838	5.449	7.114
Definitely yes	Mean	56.23	1.6706	1.30	2.89
	N	200	210	217	210
	Std. Dev.	42.637	.71150	2.832	2.816
Total	Mean	48.04	1.8688	2.27	3.57
	N	701	733	766	737
	Std. Dev.	37.178	.78350	5.674	5.293
ANOVA (df=4)	P	.001	.000	.004	.02

In the CZ population there is no significant relation between specialty of treatment and hospital location preference. In the population who had been hospitalized in the Netherlands in the past five years, there is no significant relation either between mean distance to the Dutch hospital they were in and hospital location preference.

6. Information sources and decision process

6.1 *Preceding knowledge of possibilities and experiences with health care in Belgium*

The possibility of receiving hospital care in Belgium was already known to 61.6% of the population when their actual problems emerged. More OZ-patients (73.8%) than CZ-patients (56.8%) were acquainted with this possibility (df=1, N=802, p=.000).

Of the total population, 23.3% (N=187) had been in Belgium before for medical reasons. The majority of patients with earlier experiences of Belgian care had been on a visit to a medical specialist (51.9%) and 32% had been in a Belgian hospital before. Far more OZ-patients (45.8%) than CZ-patients (13.2%) had previous care experiences in Belgium (df=1, p=.000). However, there is no significant relation between the type of Belgian care provider and health insurer.

Table 18: Previous visited health care providers in Belgium (N=187)

	N	Col %
Previous visit to a Belgian medical specialist	97	51.9%
Previous visit to a Belgian hospital	59	31.6%
Previous visit to other care in Belgium	58	31.0%
Previous visit to a Belgian GP	33	17.6%
Previous visit to a Belgian dentist	33	17.6%

Of those with previous experiences of Belgian caregivers, 23.5% (N=42) stated they knew for a longer time that they could go to a Belgian hospital. Analysis of this subgroup (those who knew they could go to a Belgian hospital) showed that only 7 of the 42 had previous hospital experiences in Belgium.

6.2 *Information sources on Belgian hospital care possibilities*

Patients who only found out about Belgian hospital care possibilities when they needed it (N=308) were asked who told them about it (see Table 19). Most patients learned that they could go to a Belgian hospital from friends or family members. Several patients marked the option of "other source" and stated their work company doctor suggested it.

Sources of information on the possibility of going to a Belgian hospital for medical care are significantly related to the health insurer of the population (df= 6, p=.000). More OZ-patients (57.9%) than CZ-patients (7.7%) were informed by a medical specialist on the possibility of Belgian hospital care. This finding is coherent with the

results of the analysis of invoices in CareNet Scheldemond, showing that only 48.2% of the requests for treatment of OZ-patients were made by a GP, compared to 96.9% of the requests for treatment of CZ-patients. In terms of information accessibility to Belgian hospital care, thresholds were higher for OZ-patients than CZ-patients. CZ-patients received information from caregivers on the zero line (family and friends), then the first line (GPs) and a minority received information from caregivers on the second or third line, while the opposite order is present in OZ-patients.

This corresponds to a declared OZ policy to prevent an exodus from the Dutch border hospital. This regional hospital has a bad reputation, which was also discussed in a Dutch research report (Van der Schee *et al.*, 2005).

Table 19: Sources on possibility of Belgian hospital care by health insurer

	Health insurer				Total	
	CZ		OZ		N	Col %
	N	Col %	N	Col %		
Family, friends	81	32.8%	5	8.8%	86	28.3%
GP	55	22.3%	6	10.5%	61	20.1%
Medical specialist	19	7.7%	33	57.9%	52	17.1%
Insurer	43	17.4%	2	3.5%	45	14.8%
Other source	25	10.1%	5	8.8%	30	9.9%
Several sources	22	8.9%	6	10.5%	28	9.2%
External care broker	2	.8%			2	.7%
Total	247	100.0%	57	100.0%	304	100.0%

Table 20 shows that when it comes to selecting the specific hospital, CZ-patients and OZ-patients mentioned different parties (df = 6, p=.000). This was proposed by the consulted specialist doctor according to most of the OZ-patients (55.6%). These findings show that CZ-patients feel, or are more, free to choose themselves (17.5%) or follow the advice of family and friends (21%) but 29.5% state that the insurer proposed the hospital.

Table 20: Party proposing specific Belgian hospital

	Health insurer		Total	
	CZ	OZ	N	%
	%	%		
GP	18.5%	18.2%	146	18.4%
Medical specialist	7.1%	55.6%	165	20.8%
Insurer	29.5%	1.8%	171	21.6%
External care broker	2.5%	1.3%	17	2.1%
Family, friends	21.0%	6.2%	133	16.8%
You	17.5%	9.3%	120	15.2%
Several sources	4.1%	7.6%	40	5.1%
Total	100.0%	100.0%	802	100.0%

6.3 Fit of information with needs

All patients were asked to evaluate the fit of information they had to what they should have known, on eight aspects. Besides five evaluation options, from very negative (1) to very positive (5), there was also a “not applicable, no information need” option.

Table 21 shows the percentages of patients evaluating the fit of information as (very) positive and the percentages of patients evaluating the fit of information as (very) positive or in no need of information. The results show that more patients did not know about complaint procedures in Belgian hospitals and possible extra costs to consider, but apparently did not need information on these aspects.

A closer look at the data showed that half of the population stated they did not need any information on complaint procedures and 28.4% did not need any information on possible extra costs that they should consider. Fewer OZ-patients (21.3%) stated they were not in need of this kind of information compared to CZ-patients (31%) (df= 1, p=.009).

Table 21: Fit of information

	(Very) positive (%)	(Very) positive and no information need (%)	N
Insurance papers to take to the hospital	79	89	745
Reputation of hospital	79	88	747
Reputation of physician	74	88	748
Medical documents to take to the hospital	68	86	738
Conditions of reimbursement	78	84	765
Course of events in Belgian hospitals	75	82	754
Complaint procedures in Belgian hospitals	29	79	721
Possible extra costs	44	72	737

With “not applicable” recoded to “good fit”, OZ-patients were on average more positive about the information on the Belgian hospital’s reputation and the Belgian physician’s reputation (see Table 22). Possibly this is a sensitive issue for the OZ-patients with “bad” hospital experiences in their region. The order and significance of mean fit of information scores stay the same if we consider “not applicable” as a missing value.

Table 22: Fit of information by health insurer

	CZ			OZ			Total			ANOVA
	Mean	N	Std. Dev.	Mean	N	Std. Dev.	Mean	N	Std. Dev.	P
Conditions of reimbursement	4.00	550	.893	3.86	215	1.006	3.96	765	.928	.053
Possible extra costs	3.59	535	.947	3.55	202	.936	3.58	737	.944	.581
Medical documents to take to the hospital	3.91	532	.802	3.90	206	.797	3.91	738	.800	.962
Insurance papers to take to the hospital	4.02	540	.715	3.91	205	.787	3.99	745	.737	.069
Reputation of hospital	4.01	538	.812	4.29	209	.662	4.09	747	.782	.000
Reputation of physician	4.17	538	.876	4.31	210	.798	4.21	748	.857	.033
Course of events in Belgian hospitals	4.04	544	.960	4.10	210	.823	4.06	754	.924	.420
Complaint procedures in Belgian hospitals	3.70	522	.892	3.68	199	.838	3.69	721	.877	.870

We constructed a “fit of information scale” composed of the means on the eight items. Oz-patients and CZ-patients had the same mean score of 4.0.

7. Decisional aspects in opting for a Belgian hospital

7.1 Presence of positive arguments in deciding on a Belgian hospital

On a Likert-scale from 1 (completely untrue) to 5 (completely true), the shorter waiting time was the most prominent (“true”) argument in opting for a Belgian hospital, while a shorter travelling distance was not a true argument in the total population.

But again, CZ-patients and OZ-patients do differ in their perception of present or true positive arguments in opting for a Belgian hospital (except for hospital service and costs of care). CZ-patients were most positive about the (presence of a) shorter waiting period and least positive about the shorter distance. OZ-patients were more positive (in decreasing order) about the reputation of the physician and hospital, possibility to see family or friends and travelling distance.

Table 23: Presence of positive arguments in the choice for a Belgian hospital

	CZ			OZ			Total			Anova (df=1)
	Mean	N	Std. Dev.	Mean	N	Std. Dev.	Mean	N	Std. Dev.	
Waiting time was shorter	4.61	557	.624	3.69	195	1.010	4.37	752	.846	.000
Travelling distance was shorter	2.40	544	1.089	3.04	194	1.373	2.57	738	1.203	.000
Reputation of hospital was better	3.46	533	.912	3.77	201	.959	3.54	734	.935	.000
Reputation of physician was better	3.62	524	.950	3.85	202	.981	3.68	726	.964	.003
Possibility to see family/friends was better	2.93	494	.961	3.36	188	1.103	3.05	682	1.020	.000
Service of hospital was better	3.63	526	.951	3.51	196	1.015	3.59	722	.970	.138
Costs of care were lower	3.15	467	.808	3.04	182	.891	3.12	649	.833	.138
Less paperwork	3.25	495	.882	3.05	190	.895	3.19	685	.889	.010

7.2 Importance of arguments in deciding on a Belgian hospital

We also asked all patients to rate the importance of the same arguments on a Likert-scale from 1 (completely unimportant) to 5 (very important). We then computed the differences between importance of arguments and the presence of the positive value of the arguments. We see in Table 24 that waiting time is the most important decision argument, and, on average, the positive value of this argument is even more present. For all the other arguments mean importance is higher than mean presence, with the largest gap for (lower) costs of care.

Table 24: Importance of arguments in decision to go to a Belgian hospital

	Importance	Presence	Importance - presence
(Shorter) waiting time	4.28	4.37	-.09

(Better) physician reputation	3.98	3.68	.31
(Better) hospital service	3.87	3.59	.31
(Better) hospital reputation	3.83	3.54	.30
(Lower) costs of care	3.54	3.12	.44
(Less) paperwork	3.36	3.19	.21
(Better) possibility to see family/friends	3.20	3.05	.17
(Shorter) travelling distance	2.93	2.57	.36

CZ-patients and OZ-patients do also differ in their attribution of importance to decision arguments for a Belgian hospital (see Table 25).

The most important argument for CZ-patients is the waiting period, for the OZ-patients it is the reputation of the physician (and the hospital in second place).

Analysis of variance shows that to CZ-patients the waiting period was more important while OZ-patients attach more importance to the reputation of the hospital, travelling distance and the possibilities to see family or friends.

Table 25: Importance of arguments in decision to go to a Belgian hospital by health insurer

	CZ			OZ			Total			Anova (df=1)
	Mean	N	Std. Dev.	Mean	N	Std. Dev.	Mean	N	Std. Dev.	
Waiting time	4.53	555	.863	3.56	191	1.328	4.28	746	1.087	.000
Travelling distance	2.75	532	1.088	3.39	197	1.315	2.93	729	1.187	.000
Reputation of hospital	3.79	531	.905	3.95	199	1.046	3.83	730	.948	.035
Reputation of physician	3.96	531	.973	4.06	197	1.036	3.98	728	.991	.231
Possibility to see family/friends	3.09	508	1.135	3.49	184	1.254	3.20	692	1.180	.000
Service of hospital	3.86	531	.930	3.87	198	.992	3.87	729	.946	.906
Costs of care	3.57	516	1.085	3.46	195	1.211	3.54	711	1.121	.243
Paperwork	3.35	520	1.077	3.39	196	1.174	3.36	716	1.104	.629

7.3 Helpfulness of involved parties in decision process

In the CZ patient population medical specialists were not involved in helping patients in their decision to go to a Belgian hospital (see Table 26). Only 11% of the CZ-patients found a medical specialist (very) helpful while this was the case in almost half (47.8%) of the OZ population. A lot of the CZ-patients (42%) did not ask their medical specialist to help them.

A lot of the OZ-patients (46.8%) did not ask their insurer to help them, while this was only the case in 18.5% of the CZ population. More OZ-patients stated they did not need help from similar patients (52%) or their friends (44%).

Table 26: Helpfulness of involved parties by health insurer: crosstabs

		CZ		OZ		Total		df=2
		<i>N</i>	<i>Col %</i>	<i>N</i>	<i>Col %</i>	<i>N</i>	<i>Col %</i>	<i>P (Chi²)</i>
Help GP	No help	202	38.9%	66	36.9%	268	38.4%	
	Helpful	213	41.0%	65	36.3%	278	39.8%	
	No need	104	20.0%	48	26.8%	152	21.8%	
Total		519	100.0%	179	100.0%	698	100.0%	.157
Help medical specialist	No help	234	46.7%	57	27.3%	291	41.0%	
	Helpful	56	11.2%	100	47.8%	156	22.0%	
	No need	211	42.1%	52	24.9%	263	37.0%	
Total		501	100.0%	209	100.0%	710	100.0%	.000
Help insurer	No help	142	26.6%	59	31.7%	201	27.9%	
	Helpful	293	54.9%	40	21.5%	333	46.3%	
	No need	99	18.5%	87	46.8%	186	25.8%	
Total		534	100.0%	186	100.0%	720	100.0%	.000
Help external care broker	No help	166	33.9%	46	25.8%	212	31.8%	
	Helpful	31	6.3%	8	4.5%	39	5.8%	
	No need	292	59.7%	124	69.7%	416	62.4%	
Total		489	100.0%	178	100.0%	667	100.0%	.063
Help similar patients	No help	135	26.6%	40	22.6%	175	25.6%	
	Helpful	169	33.3%	45	25.4%	214	31.3%	
	No need	203	40.0%	92	52.0%	295	43.1%	
Total		507	100.0%	177	100.0%	684	100.0%	.020
Help family and friends	No help	116	22.2%	42	23.1%	158	22.4%	
	Helpful	271	51.9%	60	33.0%	331	47.0%	
	No need	135	25.9%	80	44.0%	215	30.5%	
Total		522	100.0%	182	100.0%	704	100.0%	.000

After recoding the answer “not applicable, I did not ask for any help” to “helpful” (4.5 on a scale from 1 to 5), we see that help from family, friends and similar patients, the so-called zero line, plays a major role in the decision process for both populations (see Table 27). OZ-patients stated that their Dutch medical specialist helped them in their choice to go to a Belgian hospital, while CZ-patients stated that their insurer helped them.

Table 27: Helpfulness of involved parties in decision process by health insurer: analysis of variance

	CZ			OZ			Total			ANOVA
	Mean	N	Std. Dev.	Mean	N	Std. Dev.	Mean	N	Std. Dev.	
Help GP	3.4277	519	1.55531	3.5810	179	1.46029	3.4670	698	1.53194	.249
Help medical specialist	2.9371	501	1.71742	3.8804	209	1.50801	3.2148	710	1.71239	.000
Help insurer	3.9373	534	1.37633	3.6210	186	1.45385	3.8556	720	1.40260	.008
Help external care broker	3.3804	489	1.60701	3.6404	178	1.50327	3.4498	667	1.58307	.060
Help similar patients	3.7426	507	1.44679	3.8192	177	1.39645	3.7624	684	1.43331	.541
Help family and friends	3.9837	522	1.28150	3.8571	182	1.32191	3.9510	704	1.29231	.255

CZ-patients with a waiting list problem (all of them surgery patients) were more helped by similar patients (4) compared to other CZ-patients (3.7) (ANOVA: $df=1$, $p=.018$). This is the only finding confirming our hypothesis that CZ-patients with a waiting list problem might have other information sources and resources in the pre-hospital phase. For example, people suffering from extreme obesity might use more informal (and less institutional) sources, such as other people with the same condition. However, these patients (CZ-patients with a waiting list problem) used the same sources on the possibility of going to a Belgian hospital and the same parties proposed the specific Belgian hospital.

7.4 Ease of choice and access

Most patients, both CZ-patients and OZ-patients, found making the choice to go to Belgium and the overall access to care in Belgium very easy (see Table 28). Both patient groups have a mean score of 4.5 on ease of choice and 4.4 on the ease of arranging access to Belgian hospital care.

There is a negative relation between the ease of choice to go to Belgium and the preference for a Dutch hospital without waiting lists (Kendall's tau-b= -0.109, $p=.001$)

Table 28: Ease of choice and access to Belgian hospital care

	Ease of choice		Overall ease of access	
	N	%	N	%
Very difficult	2	.3%	5	.7%
Difficult	10	1.3%	16	2.1%
Not difficult, not easy	54	7.1%	37	4.8%
Easy	245	32.1%	314	41.2%
Very easy	452	59.2%	391	51.2%
Total	763	100.0%	763	100.0%

Both CZ-patients and OZ-patients found it (rather) easy to obtain a referral from their GP or medical specialist (see Table 29). On a scale of 1 (very difficult) to 5 (very easy), with “no need” recoded to 4.5, the mean score (4.4) is not related to the health insurer.

CZ-patients found it easier to obtain the authorization from their insurer (see Table 29). On a scale of 1 (very difficult) to 5 (very easy), with “no need” recoded to 4.5, CZ-patients have a mean score of 4.5 and OZ-patients 4.3 (ANOVA, df=1, p=.005).

Table 29: Ease of obtaining a referral card and authorization by health insurer

		Health insurer				Total	
		CZ		OZ		N	Col %
		N	Col %	N	Col %		
Ease of obtaining referral	Very difficult	9	1.6%	3	1.4%	12	1.6%
	Difficult	17	3.1%	10	4.8%	27	3.5%
	Not difficult, not easy	27	4.9%	5	2.4%	32	4.2%
	Easy	158	28.7%	49	23.3%	207	27.2%
	Very easy	278	50.5%	120	57.1%	398	52.3%
	Not applicable	62	11.3%	23	11.0%	85	11.2%
Total		551	100.0%	210	100.0%	761	100.0%
Ease of obtaining authorization	Very difficult	12	2.2%	6	3.0%	18	2.4%
	Difficult	14	2.5%	9	4.5%	23	3.0%
	Not difficult, not easy	20	3.6%	11	5.5%	31	4.1%
	Easy	142	25.6%	50	24.9%	192	25.4%
	Very easy	306	55.2%	72	35.8%	378	50.1%
	Not applicable	60	10.8%	53	26.4%	113	15.0%
Total		554	100.0%	201	100.0%	755	100.0%

8. Evaluation of treatment and aftercare

8.1 Hospital care and treatment by caregivers

Table 30 shows that the mean scores on all six questions are very high. Two aspects of patient involvement, i.e. giving treatment information and shared decision-making, have the lowest mean scores.

There are no significant differences in evaluation of hospital care and treatment between CZ-patients and OZ-patients, either on the separate questions or on the “Hospital care and treatment”-scale.

Mean scores on “Hospital care and treatment” (range 4.61 to 5.00) are not related to the hospital visited.

Table 30: Evaluation of hospital care and treatment: separate questions and scale

	Mean	N	Std Dev
Respect and politeness of caregivers	4.8	N=789	.5
Readiness of caregivers to listen	4.7	N=775	.6
Confidence in caregivers	4.8	N=776	.5
Patient involvement in treatment decisions	4.6	N=771	.7
Hospital staff helpfulness	4.7	N=782	.7
Treatment information	4.6	N=780	.8
Hospital care and treatment scale	4.7	N=790	.55

8.2 Service aspects of hospital

Only inpatients were asked to rate five questions on service aspects (see Table 31). Four questions were included in the "Service aspects of hospital" scale, and evaluation of waiting time for room assignment was not included.

Of the five questions only one, room privacy, is significantly related to the hospital (ANOVA: $df=9$, $p=.000$). CZ-patients and OZ-patients do not differ significantly in their evaluation of hospital service. This is the case both for CZ-patients with private insurance and those with sickness funds insurance.

Table 31: Evaluation of service aspects of hospital: separate questions and scale

	Mean	N	Std Dev
Waiting time for room assignment	4.5	N=309	1.1
Quietness of room	4.4	N=304	.9
Cleanliness of room	4.5	N=307	.8
Privacy of room	4.1	N=306	1.1
Meals	4.0	N=289	1.2
Service aspects of hospital scale	4.3	N=309	.79

8.3 Evaluation of discharge and aftercare information

Most inpatients felt they were informed on time about the moment of discharge (see Table 32). There is a negative relation between the degree of preference for a Dutch hospital and their evaluation of the moment they received information on their discharge (Kendall's tau-b= -0.12 , $p=.016$). The more positive inpatients were about their preference for a Dutch hospital, the more negative they were about the information on the moment of their discharge.

Table 32: Evaluation of information on hospital discharge

	Mean	N	Std Dev
Moment of information on hospital discharge	4.3	N=303	1.0

Patients were also rather positive about the two aspects of aftercare information (see Table 33). Evaluation was independent of health insurer and hospital. CZ-patients having seen a supporting specialist were less positive (mean 3.9) about aftercare information compared to patients having seen a cutting or contemplating specialist (mean 4.4) (ANOVA: $df=1$, $N=370$, $p=.025$).

Table 33: Evaluation of aftercare information

	Mean	N	Std Dev
Information to assure recovery	4.3	N=616	1.0
Information who to contact in case of worries	4.3	N=582	1.0
Aftercare information scale	4.3	N=622	.94

Almost half of the population (48.9%) left the hospital with a prescription for drugs and a minority (14%) were given a prescription for aids devices (see Table 34). In most cases (52%) the aids devices concerned crutches. Other aids devices were corsets, bandages, arm slings, elastic stockings and neck braces. Of the CZ-patients who visited an orthopaedic specialist, 28% left the hospital with a prescription for aids devices.

Table 34: Hospital drug prescription and prescription of aids devices at discharge

	No		Yes		Total	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Drug prescription	365	51.1%	349	48.9%	714	100.0%
Aids devices	583	86.0%	95	14.0%	678	100.0%

Table 35 clearly shows that patients were in general less positive about the ease of obtaining the prescribed drugs in their home country. The information they received about the drugs was evaluated in a more positive way. Evaluation of drug information and availability were independent of the medical specialist seen by the CZ-patients, hospital and health insurer.

There is a negative evaluation between educational level and evaluation of the drug information received (Kendall's tau-b= -0.15, $p=.001$), in other words the evaluation becomes less positive as the level of education increases.

Table 35: Evaluation of drug information and availability of drugs in the Netherlands

	Mean	N	Std Dev
Evaluation of drug information	4.4	N=336	.9
Ease of availability of drugs	3.9	N=328	1.4

Table 36 shows that the availability, and certainly the ease of reimbursement of these devices by the health insurer, is evaluated negatively by the small group of involved patients. Their evaluation is independent of their health insurer, consulted medical specialist and insurance type in CZ-patients.

Table 36: Evaluation of availability of aids devices and ease of reimbursement

	Mean	N	Std Dev
Availability of aids devices	3.8	N=79	1.5
Ease of reimbursement aids devices	2.3	N=88	1.7

Only 25 persons (3.1%) went to a nursing home or a revalidation centre after hospital discharge. Their mean evaluation score of the information given to the revalidation centre or nursing home was 3.8 (N=23, std dev =1.557).

Ten percent of the population received home care after hospital discharge (see Table 37). More than twice as many OZ-patients(16.4%) as CZ-patients (7.5%) received home care (df=1, p=.000). Their mean evaluation score of the information given to their home care organization was 3.6 (N=73, std dev =1.39).

Table 37: Home care received after hospital discharge

		Health insurer			Total		
		CZ		OZ	N	Col %	
		N	Col %	N	Col %		
Home care given	No	534	92.5%	188	83.6%	722	90.0%
	Yes	43	7.5%	37	16.4%	80	10.0%
Total		577	100.0%	225	100.0%	802	100.0%

Patients who did see their GP meanwhile (N=523), were relatively positive about the information the hospital gave to their GP on their treatment and necessary aftercare (mean 4.4, N=523, std dev =1.09).

8.4 Global evaluation of Belgian hospital care

Overall, patients were positive about the care they received in the Belgian hospital and they would recommend the Belgian hospital to patients with similar problems (see Table 38). There is no significant relation between overall evaluation and health insurer, hospital or consulted medical specialist in CZ-patients.

Table 38: Overall evaluation

	Health insurer								
	CZ			OZ			Total		
	<i>Mean</i>	<i>N</i>	<i>Std. Deviation</i>	<i>Mean</i>	<i>N</i>	<i>Std. Deviation</i>	<i>Mean</i>	<i>N</i>	<i>Std. Deviation</i>
Overall evaluation of Belgian hospital care	4.72	537	.666	4.70	213	.646	4.72	750	.660
Recommendation of Belgian hospital	4.74	541	.674	4.74	212	.699	4.74	753	.681
Overall evaluation scale	4.7297	542	.64081	4.7153	216	.64426	4.7256	758	.64140

CHAPTER 4: MAIN FINDINGS OF THE SURVEY

Table 39: Overview main survey findings

		CZ	OZ	Total	Valid N	P
Population characteristics	% men	43.6	39.5	42.4	794	NS
	% >= 51 yrs	50.5	55.2	51.8	779	.010
	% >= 2nd school	48.1	34.4	44.3	754	.005
	% on social security	37.4	48.3	40.4	769	.007
	% CZ-patients with private insurance	16.3	.	.	572	NS
	Belgian socio-cultural orientation scale	1.8	2.1	1.9	757	.000
	% hospitalized in the Netherlands < 5yrs ago	30.5	50.0	35.9	790	.000
	% with previous Belgian health services experiences	13.9	47.6	23.3	802	.000
	Current health status	3.8	3.8	3.8	782	NS
Characteristics of hospital care	Km between residence and Belgian hospital	50.8	41.1	48.0	661	.001
	% overnight hospital stay	35.5	48.2	39.0	799	.001
	Number of hospital nights	1.7	4.3	2.4	793	.000
	Number of hospital nights spent by inpatients	4.7	9.1	6.2	307	.000
	% CZ-patients orthopaedics	27.8			492	
	% CZ-patients plastic surgery	10.4			492	
	% CZ-patients nuclear medicine	9.6			492	
	% CZ-patients abdominal surgery	5.3			492	
	% CZ-patients bariatric surgery	2.6			492	
	% CZ-patients other surgery	7.9			492	
	% > 1 hospital visit	61.7	66.2	63.0	797	NS
	Number of hospital visits	3.3	4.3	3.6	762	.020
	% with waiting list problem	74.1	23.7	60.2	782	.000
	Waiting time in weeks	22.7	13.8	21.8	435	NS
	Waiting time in weeks in CZ-surgery patients	50.9			333	.000
% preferring Dutch hospital if care as prompt	71.3	30.4	59.9	774	.000	
Information sources, needs and processes	% previous knowledge on possibility Belgian hospital care	56.8	73.8	61.6	802	.000
	Information sources of patients without previous knowledge:					
	% family or friends	32.8	8.8	28.3	304	.000
	% GP	22.3	10.5	20.1	304	.000
	% medical specialist	7.7	57.9	17.1	304	.000
	% insurer	17.4	3.5	14.8	304	.000
	Hospital proposed by:					
	% GP	18.5	18.2	18.4	792	.000
	% medical specialist	7.1	55.6	20.8	792	.000
	% insurer	29.5	1.8	21.6	792	.000
	% family or friends	21.0	6.2	16.8	792	.000
	% patient self	17.5	9.3	15.2	792	.000
	Helped in decision for Belgian hospital by:					
	% GP	41.0	36.3	39.8	698	NS
	% medical specialist	11.2	47.8	22.0	710	.000
	% insurer	54.9	21.5	46.3	720	.000
	% similar patients	33.3	25.4	31.3	684	NS
	% family or friends	51.9	33.0	47.0	704	.000

	% not asked GP to help	20.0	26.8	21.8	698	NS
	% not asked medical specialist to help	42.1	24.9	37.0	710	.000
	% not asked insurer to help	18.5	46.8	25.8	720	.000
	Fit of information with needs concerning:					
	Conditions of reimbursement	4.0	3.9	4.0	765	NS
	Possible extra costs	3.6	3.5	3.6	737	NS
	Medical documents to take	3.9	3.9	3.9	738	NS
	Insurance papers to take	4.0	3.9	4.0	745	NS
	Hospital reputation	4.0	4.3	4.1	747	.000
	Physician reputation	4.2	4.3	4.2	748	.030
	Course of events in hospital	4.0	4.1	4.1	754	NS
	Belgian complaints procedures	3.7	3.7	3.7	721	NS
	Fit of information scale	4.0	4.0	4.0	784	NS
	% no information need on extra costs	31.0	21.3	28.4	737	.009
	% no information need on complaints procedures	51.3	46.2	49.9	721	NS
Decisional aspects in choice process	Presence of positive arguments					
	Shorter waiting time	4.6	3.7	4.4	752	.000
	Shorter travelling distance	2.4	3.0	2.6	738	.000
	Better hospital reputation	3.5	3.8	3.5	734	.000
	Better physician reputation	3.6	3.9	3.7	726	.003
	Better possibility to see family or friends	2.9	3.4	3.0	682	.000
	Better hospital service	3.6	3.5	3.6	722	NS
	Lower costs of care	3.2	3.0	3.1	649	NS
	Less paperwork	3.2	3.1	3.2	685	.010
	Importance of arguments					
	Waiting time	4.5	3.6	4.3	746	.000
	Travelling distance	2.8	3.4	2.9	729	.000
	Hospital reputation	3.8	4.0	3.8	730	.035
	Physician reputation	4.0	4.1	4.0	728	NS
	Possibility to see family or friends	3.1	3.5	3.2	692	.000
	Hospital service	3.9	3.9	3.9	729	NS
	Costs of care	3.6	3.5	3.5	711	NS
Paperwork	3.3	3.4	3.4	716	NS	
Ease of choice and access	Ease of choice	4.5	4.5	4.5	763	NS
	Ease of access to Belgian hospital care	4.4	4.3	4.4	763	NS
	% no need of referral card from GP	11.3	11.0	11.2	761	NS
	% no need of authorization from insurer	10.8	26.4	15.0	755	.000
	Ease of obtaining referral card < doctor	4.4	4.5	4.4	761	NS
	Ease of obtaining authorization < insurer	4.5	4.3	4.4	755	.005
Quality of treatment and aftercare	Respect and politeness of caregivers	4.8	4.8	4.8	789	NS
	Readiness of caregivers to listen	4.7	4.7	4.7	775	NS
	Confidence in caregivers	4.8	4.8	4.8	776	NS
	Patient involvement in treatment decisions	4.6	4.6	4.6	771	NS
	Hospital staff helpfulness	4.7	4.6	4.7	782	NS
	Treatment information	4.6	4.6	4.6	780	NS
	Hospital care and treatment scale	4.7	4.7	4.7	790	NS
	Waiting time for room assignment	4.4	4.5	4.5	309	NS
	Quietness of room	4.4	4.4	4.4	304	NS
	Cleanliness of room	4.5	4.5	4.5	307	NS
	Privacy of room	4.1	4.3	4.1	306	NS

Meals	4.0	4.0	4.0	289	NS
Service aspects of inpatient hospital scale	4.2	4.3	4.3	309	NS
Information to assure recovery	4.4	4.3	4.3	616	NS
Information who to contact in case of worries	4.3	4.3	4.3	582	NS
Aftercare information scale	4.3	4.3	4.3	622	NS
Overall evaluation of Belgian hospital care	4.7	4.7	4.7	750	NS
Recommendation of Belgian hospital	4.7	4.7	4.7	753	NS
Overall evaluation scale	4.7	4.7	4.7	758	NS
Timeliness of inpatient hospital discharge	4.3	4.2	4.3	303	NS
% drug prescription to take home	48.3	50.2	48.9	714	NS
Information given on drugs to take home	4.4	4.3	4.4	336	NS
Availability of prescribed drugs at home	3.9	4.0	3.9	328	NS
% prescription for aids devices	15.4	10.5	14.0	678	NS
Availability of aids devices at home	2.3	2.2	2.3	88	NS
Ease of reimbursement aids devices	3.8	3.9	3.8	79	NS
% admission in revalidation centre or nursing home	3.1	3.1	3.1	802	NS
Information to revalidation centre or nursing home	3.9	3.7	3.8	73	NS
% home care	7.5	16.4	10.0	802	NS
Information to home care organization	3.4	3.8	3.6	23	NS
GP information from hospital	4.4	4.3	4.4	523	NS

Our analysis shows that OZ-patients and CZ-patients are two different populations. OZ-patients are older and have a lower socio-economical status, as measured by their educational degree and main source of income. Although their current health status evaluation is comparable with CZ-patients, more OZ-patients have been hospitalized in the Netherlands in the past five years, so their health condition might be poorer.

The main finding is that OZ-patients would not have gone to a Dutch hospital if they would have received care as prompt as in their homeland. Several survey findings are related to this preference. OZ-patients live closer to the Belgian hospital they visited and they are also more oriented towards Belgium for shopping, seeing friends or relatives and going out. They are also more familiar with Belgian health care and services, as almost half of the OZ-population has been in Belgium before for medical reasons, especially for one or more visits to a medical specialist. More OZ-patients already knew they could go to a Belgian hospital for medical care before they actually needed care most recently. We did not have data on the type of medical specialist OZ-patients consulted but the survey data suggest different problems and subsequent medical interventions. Less than a quarter of the OZ-patients required a medical intervention for which there was a waiting list in the Netherlands. More OZ-patients were inpatients, i.e. they spent at least one night in the hospital. They also spent more nights in the hospital and they had to pay several visits to the hospital, suggesting more severe health problems than those suffered by CZ-patients. The OZ-patients who only found out about cross-border care when they needed it were told about it by a medical specialist. It was also a medical specialist who proposed the specific Belgian hospital according to the majority of OZ-patients and who was most helpful in the decision to go to a Belgian hospital. There are several explanations for the major role of medical specialists in the pre-hospital path of OZ-patients. Firstly, it may be an indication of the severity of their health problems. This was confirmed by our OZ-informants, stating that many cross-border patients are chronic patients, for instance kidney patients and diabetics. But we also know from our informants and the literature that OZ has a more restrictive policy on patient mobility towards Belgium as they fear underutilization of the regional hospital in Zeeuws-Vlaanderen, which has developed a bad reputation in recent years (Van der Schee *et al.*, 2005). The high satisfaction of OZ-patients with the information

they had on hospital reputation may be seen as an indication of the sensitivity of OZ-patients to this issue. Even more convincing is that a better reputation of both physicians and hospitals is decisive in the decision to go to Belgium. The self-declared policy of OZ to limit cross-border care is confirmed by the survey results. OZ-patients indeed rate both the helpfulness of their insurer and the ease of obtaining authorization somewhat lower. Finally, OZ- informants equally explain the major involvement of medical specialists in the pre-hospital path of OZ-patients by cross-border professional activities. Several medical specialists work(ed) both in a Belgian hospital and a Dutch hospital and consequently, OZ-patients flows are co-directed by cross-border networks of medical specialists.

The other side of our main finding is that CZ-patients would have preferred a Dutch hospital if they could have received care with the same promptness. In their cases we see that waiting lists do play a major role. Three quarters of the CZ-patients state that there was a waiting list in the Netherlands for the care they demanded. The absence of waiting time is definitely the most important argument in the decision to go to a Belgian hospital. We do have basic treatment data on the CZ-patient population. We found that the longest waiting lists are declared by those patients who consulted medical specialists in bariatric and abdominal surgery, plastic surgery and other surgery, and this group makes up nearly a quarter of the CZ-patients. They live further from the Belgian hospital, they are less oriented towards Belgium and they are less familiar and experienced with Belgian health services. Shorter travelling distance to the hospital is no argument for cross-border care for the CZ-patients. Fewer CZ-patients were acquainted with the possibility of cross-border care and most of them were told about it by non-professional caregivers, i.e. family or friends. In contrast with the OZ-population, CZ-patients use informal support in obtaining information and deciding to go for Belgian hospital care. Their insurer proposes the hospital and equally helps in their decision process. Medical specialists play a minor role in giving preliminary information, proposing the hospital and helping CZ-patients to decide.

Once they had access to the Belgian hospital care, there are no significant differences between OZ-patients and CZ-patients with respect to their post-hospital path and their evaluation of the quality of care.

The overall evaluation of Belgian hospital care and the evaluation of treatment and care in the hospital are equally high in both groups. Quality of service aspects in the hospital and aftercare information are rated somewhat lower. Nearly all evaluation aspects are independent of the visited hospital.

One of the concerns of cross-border care is continuity of care. Our findings show that problems occur, but in relatively small groups of patients. We found that nearly half of the population left the hospital with a drug prescription and the availability of the medication at home was rated less positive than other aspects of care. The availability of aids devices was rated negatively by the minority (14%) of patients who were in need of these. Very few patients (3%) were admitted to a nursing home or a revalidation centre after leaving the hospital. They were equally less positive about aftercare information given by the Belgian hospital. One in ten patients received home care afterwards, and they were equally mixed about the quality of the information their home care organization received from the Belgian hospital.

CHAPTER 5: CONCLUSIONS

This survey was set up to study three research questions:

4. What is the ease of access to cross-border care? What information sources are used and how effective were these? In other words, was there a fit between needed and supplied information?
5. What arguments were pushing and pulling patients to cross the border for health care?
6. How do patients evaluate the care they received in the Belgian hospital? Aspects of quality of hospital care concern care and treatment as such, hospital service aspects and aftercare information.

We found out that most answers to the first and the second question are different for the CZ-population and the OZ-population. The answers to the third question are shared by the two subpopulations.

- **How do patients evaluate the care they received in the Belgian hospital?**

CZ-patients and OZ-patients share the same positive experiences about the care they received in the Belgian hospitals. Hospital care and treatment as such receive the most positive evaluation scores, together with overall evaluation of the most recent Belgian hospital care experience. Hospital service aspects and general aftercare, or more specific, recovery information, received lower evaluation scores but still all positive. The availability at home of the drugs and especially the aids devices that were prescribed in the hospital is suboptimal. As expected, few patients received professional aftercare after leaving the hospital. But these patients were not positive about the information that was given to their home care organization or their revalidation centre or nursing home.

- **What arguments were pushing and pulling them to cross the border for health care?**

OZ-patients and CZ-patients are pushed and pulled for Belgian hospital care by different arguments. CZ-patients are pushed towards Belgian hospitals by the long waiting lists in their homeland. Without these they would have preferred to stay in the Netherlands. OZ-patients are pulled by their closeness with Belgium in every sense of the word. They would prefer a Belgian hospital even without waiting lists. Several data suggest that the mobility of OZ-patients towards Belgium is independent of waiting lists and instead related to their more severe health problems, the policy of OZ and to cross-border professional activities of medical specialists. OZ patients are also more pulled towards Belgian hospitals by their good reputation.

- **What is the ease of access to cross-border care?**

More OZ-patients were acquainted with the possibilities of cross-border care before they actually needed care most recently. Medical specialists had a more pronounced role in the access of OZ-patients to Belgian hospital care. CZ-patients used more informal, i.e. non-professional, information sources and support in the decision process to go to a Belgian hospital. The fit of information on cross-border care on the whole is positive. The ease of choice and access are evaluated as even more positive.

CHAPTER 6: DISCUSSION

1. Confrontation of the survey results with the stakeholder analysis report

In this section we present relevant data from the related report on cross-border contracting in Belgian hospitals, which analyses the stakeholder perspectives (6), to discuss and understand the survey results.

In the stakeholder analysis report, the region of Zeeuws-Vlaanderen, where OZ is active, is described as a region with low population density, where local health care infrastructure declined in the 1970s and only one hospital remained. Geographically, historically and culturally this region is more oriented towards Belgium than towards other regions of the Netherlands. Hence cross-border cooperation between Zeeuws-Vlaanderen and Belgian hospitals has a relatively long and strong history. Noteworthy is that OZ's contractual arrangements with Belgian hospitals only cover OZ-members living in Zeeuws-Vlaanderen.

In the case of CZ, 85% of its members are concentrated in the southern Dutch provinces of Zeeland, Brabant and Limburg, which all share a border with Belgium to the south. Furthermore, both Zeeland and Limburg are relatively isolated from the rest of the Netherlands. In the case of OZ, good roads and infrastructure make crossing the border to Belgium easier than having to cross the water to the rest of the Netherlands, and consequently accessibility to Belgian hospitals is also unproblematic.

A major difference between contractual policies of both insurers is that CZ has chosen to cover virtually all treatments offered by the Belgian hospitals in their contracts, while OZ has a more restrictive approach. Through the contracts OZ consciously limits and controls the range of treatments their members can go to Belgium for. These exclusive OZ-contracts mostly cover elective care such as orthopaedic and cardiac surgery. Affiliated members of sickness funds can choose freely whether they want to go to a Dutch contracted hospital or a Belgian contracted hospital as long as the treatment they need is included in the contract between the hospital and their insurer and they have been referred by a doctor for hospital treatment. Yet as sickness funds are obliged to contract with all Dutch hospitals, insurers might have a tendency to want to use domestic capacity first before sending patients abroad (the less patients are sent to Dutch hospitals, the higher the costs for the insurers because of obligation to contract).

In case of OZ's contractual arrangements, the stakeholder analysis report states that the inclusion of a treatment in the contract is based on what medical care can be provided in the local hospital of Terneuzen. Only treatments which cannot be provided locally are included in the Belgian contracts so as to direct as many patients as possible to the local hospital, which could otherwise face closure if facilities are not sufficiently used. Contracting consequently both limits costs and ensures the survival of a Dutch local hospital. This also means that the specialisms and functions which are contracted for in Belgium are clearly defined in the contracts and are based on whatever services/ treatments are not available in Terneuzen and for which Dutch patients otherwise would have to travel long distances to access an academic Dutch hospital. The referral of patients is made either by a GP or by a hospital specialist and is based on local capacity as there is a very good cooperation between GPs

6 Glinos IA, Boffin N, Baeten R. Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives. Brussels: Observatoire Social Européen [Europe for patients project]; 2005.

and Terneuzen hospital. The selection of patients going abroad is always based on the type of care treatments; those who need the most specialized care and have difficult medical profiles are referred to Belgian hospitals, whereas easy cases are kept in the region.

In its contracts CZ did not include differences in the health care their sickness fund members and their privately insured groups of patients receive. Extra costs, e.g. higher medical and non-medical tariffs for patients choosing to stay in one-person rooms, are not covered by insurers unless the patient has an additional insurance cover for such "first class" extras. OZ has no contracts which cover privately insured patients.

Patients need to have the following with them when going to a hospital:

- Referral letter from Dutch GP or a specialist doctor (idem in the Netherlands)
- Passport or identity card (also in the Netherlands from 2005)
- Their health insurance membership card (also in the Netherlands)

This referral system works exactly in the same way, whether a patient goes to a contracted hospital in the Netherlands or in Belgium. Patients have to pass through their GP to get referred to more specialized care. A referral letter normally mentions the specialty which the patient is referred to, and can also include a name of a particular specialist or a particular hospital, but the patient is free to choose where to go. One way for insurers to "guide" their members to particular hospitals is through their "waiting list mediation department", which patients call to obtain information on where they can be treated and what the waiting times are for different institutional providers.

On the whole, hospitals do not have specific provisions concerning pre- and post treatment for foreign patients and only signal very few particular problems. Most hospitals hand a letter over to patients for the GP who is supposed to look after home care arrangements. Hospitals signal very few patients who would need further institutionalized care in their home country, such as care in a rehabilitation institution. The situation seems somewhat different for hospitals working with OZ, which sends more complicated pathologies to Belgium and which need more advanced post-care. In this case, arrangements are made with the Dutch social service at an early stage. Some hospitals do mention that patients can encounter problems in obtaining the prescribed pharmaceutical products in the domestic pharmacies, as they are not available under the same name and the same form.

2. Discussion of the survey results in feedback meeting

The survey results were presented in a discussion meeting attended by the informants JS, GB, and PC (see annex 2). In general the survey results were positively received.

It was confirmed that OZ has an intentional policy to send patients to Belgium for treatments needing hospitalization. The patients are often referred from the Terneuzen hospital for hospitalization in Belgium. This might explain the higher hospitalization rates.

It was equally confirmed that the high number of overnight stays of OZ patients could be explained by their higher age and the specific, more complex pathologies they are sent to Belgian hospitals for.

The informants also affirm that OZ patients (from Zeeuws-Vlaanderen) are socio-culturally much more oriented towards Belgium and therefore they do not consider hospitalization elsewhere in the Netherlands. When treatment in the local hospital is not an option, they prefer to be treated in Belgium. This also explains why they do not know whether there are waiting lists in the Netherlands for their treatment.

The less positive evaluation about the ease of obtaining prescribed drugs and medical devices in the Netherlands could be explained, according to the informants, by the fact that some products prescribed in Belgium are not in the Dutch benefit package. The pharmaceutical product might also not be on the Dutch market or the brand name of a drug might be different in Belgium and the Netherlands. Some medical devices can only be paid for in the Netherlands if they are included in the global price for the hospital treatment and cannot be charged for separately.

The less positive evaluation on the information transfer between the Belgian hospital and the Dutch aftercare services might, according to the informants, be explained by the fact that Belgian hospitals and referrers are not familiar, and not used to cooperating, with the Dutch health facilities.

3. Contributions and limits of this study

Although we succeeded in yielding a large survey response and consistent survey data, our study has some limitations.

We did have minimal treatment data for the CZ-patients but not for the OZ-patients.

We did not include a non-intervention group, i.e. patients with similar characteristics to the mobile patients included in the survey, with the exception of having stayed in the national health system.

We did not analyse the geographical spread of the population. We know that CZ is active in Midden-Limburg and OZ in Zeeuws-Vlaanderen, but we did not analyse the population by the postal codes of their residences in the Netherlands.

We did not perform a qualitative analysis of the comments and histories told by the respondents (7). Closely related with this limitation of our findings is the absence of qualitative data on the decision process that led to choosing to cross the border. Only a qualitative study could have captured the story behind this decision.

The limited time frame of this survey did not allow an extensive discussion of the survey results in the light of previous survey reports.

7 See annex 4 for a selection of quotes by respondents.

We did not perform a comparative analysis of early and late responders in order to clear out a response bias. Although a large number of both CZ-patients and OZ-patients responded to the survey, we are aware of the danger of a response bias. There is some evidence that patients who do not respond to mail surveys report significantly poorer outcomes than do responders (Gasquet *et al.*, 2001). By comparing non-respondents to respondents, we found indications that patients who went to a Belgian hospital for a minor intervention were less inclined to fill in and return the questionnaire.

We did perform a multiple linear regression to investigate the effect of several, independent variables on the preference for treatment in a Dutch or a Belgian hospital. The results showed a high degree of correlating independent variables and, moreover, the problem of unobserved heterogeneity between the two populations.

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ANNEXES

ANNEX 1: LIST OF INFORMANTS AND INTERVIEWEES

Informants (consulted regularly by e-mail or face-to-face and involved in several meetings)

- **CZ**

J.G. Stevens, Projectmanager strategie en innovatie

H. Kusters, manager

- **OZ**

R. Swens, manager zorginnovatie

- **Christelijke Mutualiteit Limburg**

P. Carnotensis,

G. Brouwers, adjunct directeur

- **Christelijke Mutualiteit Oost-Vlaanderen**

G. Basyn

Interviewees (interviewed once)

- **ZOL, Genk**

Luc Van Camp, program manager

Tilly Postelmans, Kwaliteitsadviseur

- **UZA, Universitair Ziekenhuis Antwerpen**

L. Avonds, hoofd directie verpleging

N. Delmotte, kwaliteitscoördinator

ANNEX 2: SCALE CONSTRUCTION

Four quality scales were constructed by principal component analysis. There was a large overlap between composed questions and scales as measured by factor analysis. The internal consistence of the scales was measured by Cronbach's alpha.

Scales	Mean	Std Dev	Factor loadings	Cronbach's alpha
Hospital care and treatment by caregivers Items included (question 16, items 1-6): <ul style="list-style-type: none"> – Respect and politeness of caregivers – Readiness of caregivers to listen – Confidence in caregivers – Patient involvement in treatment decisions – Hospital staff helpfulness – Treatment information 	4.7	0.55	0.805 to 0.856	.91
Service aspects of hospital Items included (question 17, item 2 to 5): <ul style="list-style-type: none"> – Quietness of room – Cleanliness of room – Privacy of room – Meals 	4.3	0.79	0.758 to 0.855	.81
Discharge information Items included (question 18, item 1 to 2): <ul style="list-style-type: none"> – Information to assure recovery – Information who to contact if worries 	4.3	0.94	0.929 to 0.929	.84
Overall evaluation Items included (questions 26 and 27): <ul style="list-style-type: none"> – Overall evaluation of hospital care – Recommendation of hospital 	4.7	0.64	0.953 to 0.953	.89
Socio-cultural orientation towards Belgium Items included (question 31, item 1 to 3): <ul style="list-style-type: none"> – Frequency of shopping in Belgium – Frequency of visits to friends, family – Frequency of going out in Belgium 	1.9	0.78	0.817 to 0.859	.78
Fit of information scale Items included (question 9, item 1 to 8, "Not applicable, no information need" is recoded to 4.5): <ul style="list-style-type: none"> – Conditions of reimbursement – Possible extra costs – Medical documents to take to the hospital – Insurance papers to take to the hospital – Reputation of hospital – Reputation of physician – Course of events in Belgian hospitals – Complaints procedures in Belgian hospitals 	4.0	0.67	0.664 to 0.785	.87

ANNEX 3: SELECTION OF COMMENTS BY RESPONDENTS ON LAST PAGE OF QUESTIONNAIRE

Woman of 37 (OZ)	I personally chose Belgium because acquaintances referred me. Since the age of sixteen I have had a skin problem, after a vague examination I did not receive an answer to my questions. In Gent it seems I had something completely different than the Dutch diagnosis. I was seen there as a person, not as a number? Now I take medication on advice of the professor from Gent and for <u>20</u> years now I have been free of pain!!! The choice is not because of waiting time but because of "competence"!
Woman of 48	My experience in a Belgian hospital is good, physicians take time for a patient and get to the bottom to find out what is going on
Woman of 50	My main objection against a visit or admission to a Belgian hospital is the distance, also transportwise. As a single person one has to appeal to third persons. Because transport by taxi is <u>no</u> longer reimbursed by the sickness funds. And driving oneself is usually impossible after an operation. Also visits by friends and relatives are more difficult. Moreover I think it is necessary that the physician clearly explains what treatment he will do and how.
Man of 46	My Belgian dentist advised me to go to a Dutch specialist for jaw surgery...this year the waiting time was <u>shorter</u> in the Netherlands than last year when I was in X! Friendliness and professionalism were equal in both hospitals but making an appointment was fairer and easier in Belgium. In the Dutch hospital an old-fashioned computer appeared to be the direct cause for longer waiting times! New appointments were entered at the end of the list, <u>not</u> in the empty places...Possible result of economy measures!
Woman of 28	I am not satisfied with the collaboration between the health insurer and the Belgian hospital. My son was born 9 months ago. He has been in an incubator for six weeks...I still receive registered bills for large amounts (1500 €, 1000 € and so on). Communication is very difficult! Nevertheless I would immediately go back to a Belgian hospital. Am very satisfied.
Women of 40	In Belgium one is a person in the hospital and here a number. It goes very easy there, an appointment is an appointment and no waiting for hours for your turn. If you need several doctors this is possible on one day, here you have to make a new appointment for everything. Waiting times in the Netherlands are all too long.
Woman of 64, meniscus removed in Belgian hospital	...here in the Netherlands they told me that doctor X should not have removed the whole meniscus. Now my knee will deteriorate since it is already bad. It is a pity, now I have to be operated again and it might take some weeks before I have recovered. Next time to Belgium is still a big question mark. Long travelling, and treatment not completed.
Man of 48	I have been twice in hospital x for a rupture of the Achilles tendon. Positive was the prompt examination, no waiting time. With referral card from the GP, no appointment, very easy to arrange...I was less pleased with the communication between staff and patient. They did not explain to me what they found. The diagnosis was given to me in a closed envelope for the GP. And then you wait for what the GP tells you...Openness between provider and patient has to be an accepted practice.
Woman of 49	I wanted to go to the hospital in X but this was not reimbursed by the insurance company. After my visit to hospital Y (<i>a contracted hospital</i>), where I had to wait for 4 hours before they saw me and where they did not want to treat me, I still went to a Dutch hospital for treatment. This is not a money-saver for the insurer while I could have been treated right away in hospital x!
Woman of 38	My first hospital visit was in 2004 in X (Belgium). They referred me to hospital Y (Belgium). The collaboration between the two hospitals was good. Consultation and agreements between the two specialists were arranged on the spot. Not by assistants but by themselves. For results or advice I

	<p>immediately received the telephone number of the doctor himself. These things are unknown in the Netherlands. Also, the length of a consultation was sometimes about an hour. In the Netherlands one has to convince the doctor in 10 minutes of one being ill and then you are outside and you realize you forgot some things. Follow up visits and examinations are planned within a week...If one is ill you want to get better as soon as possible and be released from insecurity and distress. For what does it cost, in economic terms, if every patient spends more months at home instead of at work. We are very impressed. We hope the Netherlands learn something.</p>
Woman of 30	<p>After three months on a waiting list, they told me it would take another two months and they told me I should see my GP to try Belgium. The GP referred me to the insurance company...after two weeks I was operated! Perfect! In the hospital they gave me a leaflet asking for several medical and insurance papers. I arranged for them but later it seems I only needed my insurance polis and a referral card. It is a pity about the unnecessary fuss, but you won't hear me complain! I am very satisfied, especially about service and speed, and I recommend it to everyone. Moreover, I did so a couple of times because there are plenty of candidates for Belgium because of these stupid waiting lists in the Netherlands...</p>
Woman of 58	<p>Referral to a Belgian hospital for my complaints was only mentioned when I had such a long waiting time here. If there was no waiting list in the Netherlands I would not have known that this is possible. I was treated very well in X, nice welcome, good support, nice feeling of medical care in Belgium.</p>
Man of 50	<p>The Netherlands can take medical care in Belgium as an example. In Belgium medical care is seen as a service, in the Netherlands as a status.</p>

ANNEX 4: ORIGINAL VARIABLES IN THE QUESTIONNAIRE

The list of variables in the questionnaire includes the number of the question in the first column. The short description of the variable is followed by no/yes, in case these were the response categories. Subquestions are marked by an "S" after the question ("Q") number. In case the response categories are Likert scales, the number of possible answers is indicated between underscores.

In several questions, response categories such as strongly disagree, disagree, disagree nor agree, agree and strongly agree are utilized, so-called Likert scales. All Likert scales go in the same direction: starting from very negative (lowest value) to very positive (highest value). Most Likert scales include 5 points from 1 to 5. **All mean values on Likert scale questions have a minimal value of 1 and a maximum value of 5.**

Question 6 is exceptional, the highest value is option 4 "definitely yes", and option 5 is "do not know".

Questions 9, 12, 14 and 25 include six options, from 1 (the most negative option) to 5 (the most positive option) and a sixth option for "not applicable".

Question	Short description of variable
Q1	Place Belgian hospital
Q1	Name Belgian hospital
Q2	Distance residency- hospital in km
Q3	Hospital stay overnight (no/yes)
Q3	Length of stay in hospital in nights
Q4	More than once to Belgian hospital (no/yes)
Q4	Frequency of visits to Belgian hospital
Q5	Waiting time in Netherlands(no/yes)
Q5	Waiting time in N in weeks
Q6	Preference Dutch hospital (Likert scale 1 to 4, 5: do not know)
Q7	Preceding knowledge on possibilities of care in Belgium (no/yes)
Q7	Information source if no preceding knowledge on possibilities of care in Belgium
Q7S1	GP
Q7S2	Specialist
Q7S3	Family, friends
Q7S4	Insurer
Q7S5	External care broker
Q7S6	Other source
Q8	Who proposed specific Belgian hospital
Q8S1	GP proposed hospital
Q8S2	Specialist proposed hospital
Q8S3	Insurer proposed hospital
Q8S4	External care broker proposed hospital
Q8S5	People, patients proposed hospital
Q8S6	No one, just you proposed hospital
Q9	Fit of information you had to what you should have known (Likert scale 1 to 5, 6: not applicable)

Q9S1_1_6	Conditions of reimbursement
Q9S2_1_6	Possible extra costs
Q9S3_1_6	Medical documents to take to the hospital
Q9S4_1_6	Insurance papers to take to the hospital
Q9S5_1_6	Reputation of hospital
Q9S6_1_6	Reputation of physician
Q9S7_1_6	Course of events in Belgian hospitals
Q9S8_1_6	Complaints procedures in Belgian hospitals
Q10	Importance of arguments in decision to go to a Belgian hospital (Likert scale 1 to 5)
Q10S1_1_5	Waiting time
Q10S2_1_5	Travelling distance
Q10S3_1_5	Reputation of hospital
Q10S4_1_5	Reputation of physician
Q10S5_1_5	Possibility to see family/friends
Q10S6_1_5	Service of hospital
Q10S7_1_5	Costs of care
Q10S8_1_5	Paperwork
Q11	Presence (prevalence) of positive arguments in decision to go to a Belgian hospital (Likert scale 1 to 5)
Q11S1_1_5	Waiting time was shorter
Q11S2_1_5	Travelling distance was shorter
Q11S3_1_5	Reputation of hospital was better
Q11S4_1_5	Reputation of physician was better
Q11S5_1_5	Possibility to see family/friends was better
Q11S6_1_5	Service of hospital was better
Q11S7_1_5	Costs of care were lower
Q11S8_1_5	Less paperwork
Q12	Helpfulness of different parties in choice to go to a Belgian hospital (Likert scale 1 to 5; 6: not applicable)
Q12S1_1_6	Help GP
Q12S2_1_6	Help specialist
Q12S3_1_6	Help insurer
Q12S4_1_6	Help external care broker
Q12S5_1_6	Help similar patients
Q12S6_1_6	Help family and friends
Q13_1_5	Ease of choice (Likert scale 1 to 5)
Q14S1_1_6	Ease of obtaining referral (Likert scale 1 to 5; 6: not applicable)
Q14S2_1_6	Ease of obtaining permission (Likert scale 1 to 5; 6: not applicable)
Q15_1_5	Overall ease of access (Likert scale 1 to 5)
Q16	Evaluation of treatment in Belgian hospital (Likert scale 1 to 5)
Q16S1_1_5	Respect and politeness of caregivers
Q16S2_1_5	Readiness of caregivers to listen
Q16S3_1_5	Confidence in caregivers
Q16S4_1_5	Patient involvement in treatment decisions
Q16S5_1_5	Hospital staff helpfulness
Q16S6_1_5	Treatment information
Q17	Only inpatients: Evaluation of reception and hospital stay (Likert scale 1 to 5)

Q17S1_1_5	Waiting time for room assignment
Q17S2_1_5	Quietness of room
Q17S3_1_5	Cleanliness of room
Q17S4_1_5	Privacy of room
Q17S5_1_5	Meals
Q18	Evaluation of information given by the hospital concerning... (Likert scale 1 to 5)
Q18S1_1_5	To assure recovery
Q18S2_1_5	Who to contact in case of worries
Q19YN	Drug prescription given by the hospital (Y/N)
Q19S1_1_5	Evaluation of drug information (Likert scale 1 to 5)
Q19S2_1_5	Evaluation of availability of drugs in the Netherlands (Likert scale 1 to 5)
Q20YN	Aids devices prescribed by the hospital (Y/N)
Q20S1_1_5	Evaluation of availability of aids devices in the Netherlands (Likert scale 1 to 5)
Q20S2_1_5	Ease of reimbursement aids devices (Likert scale 1 to 5)
Q21_1_5	Only inpatients: Timeliness of hospital discharge (Likert scale 1 to 5)
Q22YN	Admission in revalidation centre or nursing home (Y/N)
Q22S1_1_5	Evaluation of information to revalidation centre or nursing home (Likert scale 1 to 5)
Q23NY	Home care given (Y/N)
Q24_1_5	Evaluation of information given to home care organization (Likert scale 1 to 5)
Q25_1_6	Evaluation of information given to GP (Likert scale 1 to 5; 6: not applicable)
Q26_1_5	Overall evaluation of Belgian hospital care (Likert scale 1 to 5)
Q27_1_5	Recommendation of Belgian hospital (Likert scale 1 to 5)
Q28_1_5	General health status evaluation (Likert scale 1 to 5)
Q29YN	Hospitalization in Netherlands in last 5 years (Y/N)
Q29Y	Year
Q29KM	Distance away from hospital
Q30NY	Previous experiences with Belgian health care services (Y/N)
	If yes, type of care received:
Q30S1	GP
Q30S2	Dentist
Q30S3	Specialist
Q30S4	Hospital
Q30S5	Other care
Q31	Frequency of visits to Belgium in last year (from 1 "never" to 5 "almost every day")
Q31S1_1_5	Shopping
Q31S2_1_5	Visits of friends, family
Q31S3_1_5	Going out
Q31S4_1_5	Working
Q31S5_1_5	Studies
Q31S6	Other
Q32_1_2	Sex
Q33	Age
Q34_1_5	Educational level (5 options)
Q35_1_9	Source of income (9 options)
Q36_1_2	Type of insurance (2 options)

