



Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives

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"Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives" is one of six national case-studies carried out in the "Europe for Patients" project. By its full name, "The Future for Patients in Europe" is a European Research Project, part of the Scientific Support to Policies (SSP) component of the European Union's 6th Framework Programme. It is a 3-year project financed by DG Research and runs from February 2004 to January 2007.

Executive summary

Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives

The present report is the result of a case-study carried out in 2004 and 2005 to understand the practices of and the motivations behind cross-border contracting between Belgian hospitals, on the one side, and Dutch and English health care purchasers, on the other.

Key research objectives have been to determine what the context for purchasing foreign care is in the Netherlands and in England; what the extent and nature of purchasing Belgian hospital treatment is; what the drivers are for the stakeholders; and what the potential impact might be for health care systems and the relevant players.

An important first step was to shed light on the extent of the phenomenon. We found that although patient mobility to Belgium is relatively limited, it is increasing. Looking at statistical data from 2002 on hospital admissions of non-Belgian patients living in another EU Member State, we realised that these admissions constitute a marginal 0.5% of total Belgian hospital admissions, while the largest in-flow came from the Netherlands, representing around 60% of non-Belgian patients. The data also showed that some 63% of foreign admissions took place in hospitals in the Flemish region. Figures on patient flows under the E112 scheme allowed comparisons between 1998 and 2003 and illustrated that the total numbers of E112 patients had more than doubled (from 10,773 to 22,333), while numbers of Dutch E112 patients had tripled (from 3,970 to 12,503). Data from the two Dutch sickness funds with the longest experience in contracting with Belgian hospitals (the OZ and CZ) showed that while around 3000 of their affiliates were treated in Belgian contracted hospitals in 2001, this number went up to almost 7,300 in 2004. These data from different sources confirm the sharply increasing, but still relatively marginal, volumes of foreign patients treated in Belgium. Yet figures from specific hospitals suggest that what appears to be a limited phenomenon across the country might be concentrated in specific hospital departments as e.g. foreign patients represented 9.3% of one Belgian academic hospital's population in its surgical department.

As the direct cross-border contracts constitute rather new and unknown practices, it was important to explain how they work. Exploring the initial phases, we found that for Dutch contracting, pre-existing cooperation links in the cross-border regions between Belgium and the Netherlands were important for the creation of the new contracts. The NHS contracts in Belgium had been facilitated by an earlier pilot project, by the signing of a bilateral framework agreement between Belgium and England and by the creation of the London Patient Choice Project, which aimed at shortening waiting times and increasing choice for patients. Zooming in on the actual contractual arrangements, we identified four types of players:

- Foreign purchasers: four Dutch insurers and the NHS Lead Commissioner (i.e. the GST which contracts on behalf of four NHS Hospital Trusts) purchasing care in Belgium
- Belgian providers: hospitals and hospital doctors
- Public authorities of the two "sending" countries (the Netherlands and England) and of Belgium
- A middleman: a Belgian sickness fund, the CM, mediating between Dutch insurers and Belgian hospitals

The first Dutch contracts with Belgian hospitals started in the late 1990s. The contracts are based on an official "model contract" which is commonly used between purchasers and providers in the Netherlands. Dutch insurers have defined various evaluation procedures for selecting Belgian hospitals. While the cross-border contracts must respect the limits of the Dutch health care package, they vary as some are comprehensive, including all treatments offered by the Belgian hospitals, while others are restricted, by limiting which treatments can be provided in Belgium. Patients can choose freely whether to be treated in Dutch or Belgian contracted hospitals and there is no difference in the referral system if a patient chooses to go to Belgium. On the medical side, Belgian standards apply and Belgian providers are not required to comply with Dutch norms. For Dutch insurers, prices and medical fees for treating Dutch patients are in accordance with Belgian tariffs. The Belgian sickness fund cooperates with two out of four Dutch insurers and ensures that the right tariffs are applied by Belgian

hospitals when invoicing them. It should be mentioned that one Dutch insurer, OZ, employs a special hybrid system of contracting which combines the E112 procedure with direct contracts.

Contracts between the NHS and five Belgian hospitals were concluded in 2003, and covered hip and knee surgery. The selection and qualification processes of Belgian hospitals, as well as the contract negotiations, were particularly long and meticulous. The 21 annexes of the contracts defined all details of the treatments, the patient pathways and the cooperation between hospitals. A "buddy system" was set up to facilitate collaboration between English and Belgian doctors but did not always work as hoped. Furthermore, non-medical liaison officers, Euro-PALs, were employed to assist patients. The contracts defined "package prices" which covered all cost components of the hip or knee surgery and were based on official Belgian tariffs.

To understand which drivers motivate stakeholders into taking part in patient mobility, we looked first at Dutch insurers. Waiting lists and increasingly competitive behaviour between insurers were key reasons for contracting abroad. Belgian hospitals appear as obvious contracting partners because of geographical and linguistic proximity, because millions of affiliates of the Dutch insurers live in the border regions close to Belgium and because Belgian hospital prices tend to be 10% cheaper than in the Netherlands. As Dutch insurers export the contracting system they use "at home", cooperating with Belgian hospitals is easy. For the NHS and the Hospital Trusts sending patients abroad, the concern to shorten waiting lists and meet government targets on waiting times were key drivers. Direct contracts were seen as the best way to ensure the quality and safety of care English patients would receive abroad. Belgian hospitals were chosen among other European providers mostly due to good travelling facilities from London. For both Dutch insurers and the NHS, cross-border contracts can also be seen as a way of putting pressure on domestic providers (public and/or private) because contracting abroad can discourage monopolistic behaviour by enlarging the pool of providers.

On their side, Belgian hospitals are eager to admit foreign patients and to conclude contracts because hospital financing is activity-based, there are financial incentives in reaching optimal capacity and the extra income generated can contribute towards covering the costs of expensive investments. Due to the abundance of supply and competition between hospitals, admitting foreign patients can be crucial for some smaller hospitals. Due to the fee-for-service system, Belgian doctors also have clear financial incentives in treating more patients, and cross-border cooperation can furthermore be a way to strengthen their reputation and skills as well as to establish links with colleagues abroad.

The main drivers for the public authorities of the two "sending" countries has been supply shortages and waiting lists in their systems, as the ECJ rulings have given patients the right to cross-border care when treatment cannot be provided at home "without undue delay". Contracting with foreign providers makes it possible for purchasers to better control patient flows as well as the quantity, quality and type of care provided. The Belgian authorities, on the other hand, have been concerned with protecting the Belgian system so that cross-border contracting does not result in increasing prices or in waiting times for national patients.

For the middleman CM, participating as a third contracting party is a way of keeping an eye on the situation and ensuring that Belgian tariffs and the general aspects of the Belgian system are respected. The CM has an interest in avoiding waiting lists emerging for its members and for foreign contracts to put upward pressure on Belgian prices. Furthermore, in the context of increasing competitive behaviour among Belgian sickness funds, engaging in contracting practices can be a way for the CM to strengthen its position both at the national and international level by establishing preferential relationships with Belgian providers and creating cross-border cooperation links.

A series of additional factors also influence patient mobility, either by enhancing or by hindering it. Organising pre- and post-treatment care can be a challenge in cross-border settings. Heavy bureaucratic procedures and lengthy negotiations with the NHS were seen by Belgian hospitals as unnecessarily complicating patient mobility. On the other hand, the Euro-PALs who assisted NHS patients during their stays in Belgium were seen as very helpful. The unforeseeable nature of contracting and the unpredictability of the volumes of patient flows contributed to an increase in uncertainty around mobility, while the lack of cooperation from Dutch and English providers was in some cases directly obstructing patients from going abroad. Due to the Belgian way of calculating daily patient rates, which does not reflect real costs, Belgian hospitals might choose to treat those foreign patients who do not represent a loss for them. From a mental perspective, cross-border health care can represent a trade-off for patients between waiting "at home" to be treated in familiar surroundings or travelling abroad to gain fast access to care in a system they feel much less confident about. This feeling of uncertainty or insecurity can hinder mobility. From a more functional perspective, patient mobility can be facilitated by the involvement of local players in the cross-border arrangements and by the bottom-up, rather than top-down,

approach to the novel practices. Last but not least, we noticed the difference between the Belgian-Dutch border compared to the Belgian-English border, as the former appears more “fluid”, due to geographical, linguistic and socio-cultural factors, which can make health care on the other side of the border appear more accessible.

Finally, looking at what impact patient mobility might have and what opportunities and risks it might entail for the “exporting” systems, cross-border contracting can offer extra possibilities to patients as they gain access faster or closer to home. Contracting abroad can also make national providers improve performance and/or cut prices as they realize that there is a risk they might lose contracts and patients to foreign providers. Yet cross-border rivalry might also distort competition when prices for health care do not cover the same cost elements in two countries. Opening the borders to patient mobility also implies expanding overall health care consumption, as access to foreign care counteracts national cost containment mechanisms, which can potentially have consequences for total health care expenses. Turning to the “importing” system, admitting foreign patients is a way of using up spare capacity and attracting extra income. Yet if foreign purchasers are able to offer higher prices than the official Belgian tariffs, there is a risk that cross-border contracting might put upward pressure on prices. Indeed, this risk has become concrete on several occasions. Another issue is the emergence of waiting times for national patients; although we have not found any indications, it would also be very difficult to determine as there is no official registration in Belgium. Furthermore, there is legal uncertainty linked to the budget calculations of Belgian hospitals and Belgian public authorities lack information about practices happening on its own territory. Reforms in the Dutch health care system might also have important repercussions in Belgium, as the impact of reforms does not stop at the border. With foreign patients entering Belgium, it is also foreign and new procedures entering the country’s health care system.

Our research suggests that, up until now, mobile patients, foreign purchasers and Belgian providers are benefiting from the increasing opportunities for cross-border care. Nevertheless, prudence is called for. Patient flows still seem to be increasing. There is a risk of upward pressure on prices when Belgian tariffs are not incorporated into the contracts. As foreign patients seem to be concentrated in specific hospitals and in specific hospital departments, close monitoring of trends is advisable to guarantee access for domestic patients.

An EU level framework for cross-border contracts between providers and purchasers, guaranteeing the involvement of the public authorities of both the sending and the receiving countries, could be an adequate instrument to increase legal certainty for all players and to guarantee that in the long run all patients, those in search of care across the border and those being treated in their national system, continue to take advantage of increased patient mobility.

Through our case-study we have gained a much clearer picture of what is happening, of how cross-border contracting works in practice and of which stakeholders are involved. Understanding the practical aspects also allows insight into the reasons behind cross-border contracting, which explains why stakeholders are motivated (or not) to engage in such innovative practices. Yet while the functioning and the drivers of the cross-border arrangements have now become clearer, other more controversial questions have emerged. At a general level, it appears legitimate to question whether patient mobility is based on free patient choice or is forced by circumstances, and at a more abstract level whether cross-border flows of patients ultimately should be seen as a success or as a failure.

Patient mobility could be seen as an artificial solution to the problem of waiting lists: instead of solving the problem within the national system, purchasers simply go abroad to look for solutions – which effectively results in exporting their country’s problem(s). Furthermore, systematically resorting to foreign health care capacity could be a way for countries to limit costly national investments in medical infrastructure. Such strategies appear relevant for regions with very specific characteristics, such as geographical isolation or low population density.

From a patient perspective, it is essential that care is delivered close to home and it therefore becomes the responsibility of those in charge of delivering health care to organize it in ways which satisfy this requirement. The importance of geographical and cultural proximity is illustrated through the volumes of Dutch patient flows: while the sickness fund members who live in the Belgian-Dutch border region go to Belgium in their thousands, insurers with affiliates from all over the Netherlands are disappointed about the low numbers of patients choosing to go to Belgium. In this respect, a distinction should also be made between:

- The population living in border-regions with Belgium, where cross-border contracting presents itself as a practical, logical and easy arrangement for the population living closer to Belgian health care facilities than to

Dutch ones. In this context, “abroad might be nearer to home” and patients might actually prefer cross-border care.

- People living further away from the border, whether in the Netherlands or in England, for whom mobility is an alternative to waiting for extended periods at home. They will generally be more reluctant to agree to go abroad as they prefer to stay as close to home as possible when in need of medical care.

This distinction begs the question of whether patient mobility is about patients’ preferences and increasing their choices, or whether it is about serving other players’ interests, in which case patients are the “tools” through which cross-border care takes place rather than the reasons behind it. One driver which appears most certainly to be behind cross-border arrangements are health care purchasers’ interests in circumventing supply shortages at home by resorting to foreign providers and warning national providers that they might lose out if they do not improve performance. Examples from both the Dutch and the English systems suggest that local providers were more prepared to work harder when the “threat” of patient mobility became very real, and there were indications that performance rates improved and waiting times shortened. Another obvious factor explaining patient mobility is the interest of the providers receiving foreign patients. Structural oversupply of hospital care, providers’ direct financial incentives and the competitive Belgian hospital environment all contribute to Belgian hospitals’ and Belgian hospital doctors’ eagerness to treat more patients. Considering these strong interests of both purchasers and providers, patient mobility appears to be a side-effect and not the goal in itself.

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INTRODUCTION

The aim of this report is to examine cross-border health care in Belgium generally and in particular to focus on foreign patients (Dutch and English) going to Belgian hospitals through contractual arrangements.

The choice of zooming in on cross-border contracting in the Belgian case-study was based on a combination of factors: it is a new and growing phenomenon with potentially significant implications for the players and health care systems involved. Furthermore, it is an undocumented area, meaning that no overview of the new arrangements and different patient flows to Belgium exists. Direct contracting across frontiers is an illustrative example of new developments emerging on the European-wide health care scene (partly triggered by the ECJ Court rulings introducing the so-called “Kohl and Decker” procedures) which have resulted in innovative practices where abundant supply in one country responds to unmet demands for health care in a neighbouring country.

The first two chapters of this report provide the general background relevant to cross-border contracting. Chapter 1 examines the different aspects and contrasts of the health care systems of the three countries which the Belgian case-study involves, i.e. the Belgian, Dutch and English health care systems. Chapter 2 gives an overview of the context in which cross-border health care takes place in Belgium and outlines some of the key factors which have contributed to patient mobility. Chapter 3 illustrates the extent of patient mobility to Belgium through statistical data.

Having set the background, chapter 4 zooms in on the contracting between Belgian hospitals and Dutch and English purchasers and is based on interviews carried out for the case-study. The first part explains the scope and objectives of the research, while the second examines how the cross-border contracting functions in practice. Chapter 5 looks at the reasons behind cross-border cooperation in the form of contractual arrangements by looking at the different stakeholders and their “drivers”. Chapter 6 presents a series of factors which we have found to facilitate or hinder patient mobility. Chapter 7 goes through the implications that cross-border contracting might have for the health care systems and stakeholders involved. The last chapter draws some tentative conclusions.

Due to the undocumented nature of the topic, other sources of information such as stakeholder interviews and statistical databases have formed the basis of the research.

The present report was researched and written by Irene A. Glinos who also prepared, carried out and analysed the interviews with key stakeholders from all three countries. The statistical data in the annexes have been analysed by Nicole Boffin, who also organised a patient survey, the results of which will be presented in a separate deliverable in the second phase of the E4P project. Rita Baeten carried out the overall supervision, coordination and management of the case-study and contributed to the project design, analysis and reporting. Most hospital interviews were done together with Barbara de Schuyter of the University of Ghent. Yves Jorens of Ghent University reviewed the report.

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CHAPTER 1: THE HEALTH CARE SYSTEMS

In recent years, both the Dutch and English health care systems have been experiencing severe shortages of medical supply for some treatments. Addressing waiting lists has been a political priority in both countries and the use of health care providers across the border has been identified as a possible solution. In the search for extra capacity, Belgian health care supply appeared as an obvious choice. In contrast with its two neighbours, Belgium has an abundant supply of health care facilities and the financing system means that providers are eager to deliver more care – including to foreign patients. Dutch and English health care purchasers have therefore started to conclude direct contracts with Belgian hospitals.

The characteristics of each health care system greatly influence the functioning of cross-border cooperation and the participating players. Key aspects of the Belgian, Dutch and English health care systems will therefore be described before zooming in on the innovative practices of direct contracting between Belgian hospitals and foreign purchasers in Chapter 4.

1. The Belgian system

The Belgian health care system is based on compulsory health insurance funded by flat rate contributions of employers and employees, independent of risk. Health insurance coverage is provided by five groups of sickness funds, historically based on a religious or political ideology, and one public fund. Contributions are identical for all funds and the system is subsidized by the State (35% of the budget).

Membership of a sickness fund is compulsory for virtually the entire population. The package of benefits is legally specified and applies uniformly to all the sickness funds. The services provided by health care providers, which respond to the norms, are reimbursed. There is no opportunity for sickness funds to selectively contract with preferred providers.

Independent medical practice and free choice¹

Delivery of health care is mainly private. Medical practitioners are self-employed. Hospitals and other inpatient health care services are provided by both public and private non-profit hospitals.

Patients have a free choice of insurer and health care provider (both individual and institutional providers). There is no referral or gate-keeper system: patients are not tied to a general practitioner, and have direct access to specialists and hospitals.

Medical professionals enjoy a strong position and physicians have protected their free choice of therapy and do not accept interference from government on medical decision-making procedures.

Fee-for-service payment

Health professionals are mainly paid fee-for-service through fixed reimbursement levels and out-of-pocket payments. Fee schedules classify the activities of health professionals in a very detailed way. A single cost is set for each item of service in a detailed “nomenclature”. Tariffs are fixed by negotiated agreements between providers (associations of professionals or institutions) and the sickness funds collectively, approved by the government. Reimbursement is based on these tariffs, but providers who did not subscribe to the convention are also reimbursed. Together with France, Belgium is the only country in Western Europe where it is legal for providers to charge higher prices than the levels which are reimbursed by the insurers. Doctors can also charge higher prices when treating patients who have chosen to be in one-person rooms during their hospital stay (as opposed to two or four-bed rooms).

¹ European Observatory on Health Care Systems (2000). Health Care in Transition: Belgium.

Hospitals receive an annual global budget. This prospective budget is paid by the several sickness funds in daily rates per patient (bed-days). This budget covers all the running costs, with the exception of payments to physicians. Medical staff in most of the hospitals work on an independent basis, paid by fee-for-service.

Supplier-induced demand and abundance of supply

Due to the fee-for-service system the Belgian health care sector has been experiencing problems with cost containment and supplier-induced demand, as providers have a direct financial incentive to increase the health care services delivered. There are pressures within the system towards more expensive and highly technological treatments (e.g. over-consumption of preoperative diagnostic examinations) and health care is strongly oriented towards curative rather than preventive care.

Belgium has an abundant supply, even an oversupply, of medical staff, medical technology, dentists, physicians etc. According to the OECD, Belgium has one of the highest proportions of medical doctors with 3.9 per 1000 inhabitants compared to the OECD average of 2.9 per 1000². In terms of equipment, the country is "over-equipped" as it e.g. has the highest rate of scanners in Europe, a high rate of Magnetic Resonance Imaging Equipment, and by far the highest concentration of bone density measurement apparatus.

Comparatively high cost sharing

To avoid over-consumption and the consequent high costs in the health care sector, co-payments are relatively high; e.g. reimbursements by sickness funds only cover 75% of doctors' fees, leaving patients to pay the remaining 25% of the bill³.

Budgets in individual hospitals

Until the end of the 1980s, hospitals were paid per patient for each day of hospitalization and public authorities did not have the means of controlling expenses.

Since the beginning of the 1990s hospitals have received an individual budget, based on their structural characteristics, compared with the costs of hospitals with the same characteristics (number of beds, types of services, paramedical staff etc). The hospital financing criteria are based on performance compared with other hospitals in the same group, i.e. length of stay, and on medical and nursing activity.

Gradually, hospital budgets have become based more on the seriousness of the pathologies that are treated than on structural elements.

Competition between sickness funds

Historically, the national health care institute (INAMI) reimbursed all invoices submitted to sickness funds and there was little incentive for insurers to contain costs. Since 1995, sickness funds have had more independent financial responsibility for health expenditure and they receive a partially capitated payment per affiliated member from which they must reimburse all health care bills. To compensate for differences in health risks of affiliates, capitation payments are corrected by a formula, taking into account possible risks (e.g. age, sex, unemployment, social insurance status, income, family structure, urban or rural provenance etc.) This new system is being implemented gradually. Sickness funds are now financially responsible for a proportion of the discrepancy between their budget, calculated as described above, and their actual spending. In this way competition between sickness funds is being introduced while maintaining a legally defined contribution setting and a legally defined covered package. It is hoped that these reforms will encourage sickness funds to put pressure on health care providers to control their expenditure. Sickness funds do not, however, have any possibility of negotiating individual contracts with providers.

² OECD Economic Report on Belgium (2005) p. 81.

³ Ibid, p. 93.

System aspects encouraging cross-border contracting – the Belgian side

The following elements of the Belgian health care system influence patient mobility into Belgium, as was highlighted and illustrated through the interviews with the stakeholders:

Incentives for Belgian hospitals

On the whole, there is overcapacity in the Belgian acute hospital sector. Many hospitals are structurally under-occupied because of decreases in average patient stays. This causes financial problems because hospitals continue to have major fixed costs that are not covered by their income. As financing is mainly activity-related and based on the number of patients, hospitals have a clear incentive to attract as many patients as possible, both national and foreign. Hospital supply is not hierarchically structured and there are no task divisions between hospitals. This means that hospitals compete on the type of services they offer, and due to over-capacity there is a tendency for hospitals to compete on the latest technologies and equipments. Some smaller hospitals have made investments that have attracted renowned specialists or have purchased expensive apparatus as a means of competing. Attracting foreign patients offers a means of covering these expenses. For larger hospitals, additional foreign patients can be a source of extra income, but can also be an opportunity to continue to specialize and offer top-quality clinical care, to make important investments and reach a critical activity level necessary to expand their competence and experience⁴.

Furthermore, hospital doctors pay part of their fee-for-service income to hospitals for using the institutions' infrastructure and apparatus. Thus, the more services doctors provide the more income for the hospitals.

Daily patient rates

Daily patient rates do not cover real costs; instead, the rate is the same for all patients in a given hospital, irrespective of the seriousness of patients' conditions and pathologies. Indeed, the daily patient rate is an artificial way to split up the global hospital budget among all the patients and between the different sickness funds. Furthermore, investment costs are only partially included in the daily patient rates, as they are partially financed by the authorities of the Flemish, French-speaking and German-speaking communities. As hospitals are bound to charge the same daily patient rates to foreign health care purchasers, it can be cheaper for foreign purchasers to buy care in Belgian hospitals.

Interests of Belgian hospital doctors

As Belgian doctors (including hospital doctors) are paid on a fee-for-service basis, they have a direct financial incentive to treat more patients, as it increases their income. Only doctors working in academic hospitals are paid by salary. For all doctors, additional patients also mean increased experience, competence and prospects for career development.

2. The Dutch system

The health care system in the Netherlands is based on health insurance, either through the public insurance scheme or through private insurance^{5 6}. People with earnings below a statutory ceiling (fixed at 32.600 EUR in 2004), as well as people receiving social security benefits, are covered by the so-called Sickness Fund Act; this concerns approximately two thirds of the population⁷, i.e. 10 million people out of a total population of 16 million⁸.

⁴ See also Jorens Y, Salamon C and De Schuyter B. Rapport "Naar een rationalisatie van de EG-Coördinatieverordeningen inzake sociale zekerheid?", Federaal Wetenschapsbeleid, Project Programma Sociale Cohesie. Universiteit Gent, maart 2005, page 136.

⁵ AIM Report, 2002.

⁶ It should also be mentioned that there is a national health insurance for exceptional medical expenses compulsory for the entire population; see den Exter, A. et al (2004). *Health Care Systems in Transition: The Netherlands*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies

⁷ Ibid, p. 33-34

⁸ Zorgverzekeraars Nederland (2004), *Bundelen, Haarbericht 2004*

Compulsory health insurance is administered either by sickness funds (non-profit organizations) or by care insurers (either for-profit or not-for-profit)⁹. Common to all insurers providing statutory cover is their legal duty to deliver care to their affiliated members.

To fulfil this obligation, care insurers conclude contracts with health care providers, as the public system is characterized by benefit-in-kind provision of health care. Indeed, contracting is a key feature of Dutch compulsory insurance and is seen as a means of controlling quality, volume and costs of health care¹⁰. Sickness fund members are free to choose which hospital they want to be treated in, as long as the hospital has a contract with their insurer.

For many years, there were severe supply restrictions in the Dutch health care sector which resulted in long waiting lists, especially for elective surgery.

In the late 1980s and early 1990s, reforms have introduced competition among health insurers and the means allocated to sickness funds are now set by budgets. This **budgeting system** is an incentive for funds to buy and organize care in the most cost-effective way, and they have to negotiate with care providers on the content and prices of services. Also, the budgeting system is adjusted every year which is a further incentive for insurers to actively look for the "best deal"¹¹.

Sickness funds are free to select which individual providers (i.e. GPs and specialists) they conclude contracts with¹² while recent reforms are gradually abolishing the obligation to contract with all accredited institutional providers.

Reforms of the Dutch health care system¹³

Two key aspects of the health care reform are particularly relevant here. Firstly, a new private basic health insurance system¹⁴ is intended to be set up from January 2006, dependent on parliamentary approval of the new Health Insurance Act. If approved, the new system will make the division between public and private insurance disappear, while there will be an obligation for the entire population to take out health insurance with an insurance company for the statutory health care package for curative care. Insurance cover will be provided by private for-profit health insurance companies operating nation-wide. Measures to avoid risk selection and cream skinning have been foreseen, as companies will be required to accept people living in their area of activity and a new system of risk equalization will be introduced. Furthermore, insurers' obligation to provide care, either in-kind from contracted providers or through reimbursement of costs, is maintained. Insurance contributions will be organized so that affiliated members pay nominal premiums, allowing insurers to compete with each other on premium levels but prohibiting that they charge their affiliates different premiums for the same policy.

Secondly, Diagnosis and Treatment Combinations (DTCs)¹⁵ are being introduced step-by-step from early 2005 for hospital financing. DTCs are seen as an instrument in the gradual introduction and implementation of regulated competition, as they allow providers and insurers to negotiate on the prices, volume and quality of care contracted for. These "combinations" are similar to Diagnose Related Groups but additionally include clinical aspects and day-care. The contracting obligation between insurers and institutional providers is being partially abolished and selective contracting is being progressively introduced; to start with, negotiations are limited to 10% of hospitals' budgets. An experimental phase already started in May 2003, as insurance companies could negotiate with providers for 17 groups of DTCs for which there were very long waiting lists.

Insurers' continuing obligation to deliver care to their members, increased competition between hospitals and between insurers, as well as the new opportunities for selectively contracting and negotiating on prices, quantity

⁹ Website of Dutch association of health insurers (ZN, Zorgverzekeraars Nederland) (<http://www.zn.nl>).

¹⁰ AIM Report, 2002.

¹¹ AIM Report, 2002.

¹² den Exter, A. et al (2004). p. 27

¹³ See also Hermans, H.E.G.M. (2005), *A New Contracting System for Health Care Providers and Institutions in The Netherlands*, presentation held at the 2005 EHMA Annual Conference 'Managing Innovation in the Health Sector'

¹⁴ Ministry of Health, Welfare and Sport (2004), *The new health insurance system in brief*, www.minvws.nl

¹⁵

http://www.healthpolicymonitor.org/en/Policy_Survey/Search_for_Policy_Reforms/Survey_Details/Diagnose_and_Treatment_Combination_s.html?issue=83&content_id=251&whichSearch=searchHomepage&search.x=45&language=en&search.y=3&single_country:254=254

and quality may open up new opportunities for cross-border contracting. With more competition and new instruments at their disposal, insurers can be expected to have stronger incentives and a broader scope to compare what is on offer and look for the “best deals” – including across the Dutch borders.

System aspects encouraging cross-border contracting – the Dutch side

The effects of competition

In a situation of limited supply of care, competing insurers might try to enlarge the pool of providers by contracting abroad when there are not enough national providers. Lack of supply *within* the health care system is effectively circumvented by resorting to supply from *outside*.

In the Dutch context, the combination of restricted supply (resulting in waiting lists) and insurers’ duty to deliver care, mean that sickness funds are forced to look abroad for a solution to limited access at home.

The problem of undersupply in the health care sector is partly due to the way Dutch hospitals are financed, as they are bound to their yearly fixed, closed budgets and cannot sell extra capacity. Hospitals have no incentive for providing more and even have a disincentive as it would force doctors, specialists etc. to work more for the same amount of money.

Another effect of increased competition is the emergence of increasingly commercial behaviour among Dutch insurers as they strive to decrease their costs and please their affiliates. Contracting with Belgian hospitals can be one strategy for ensuring faster and cheaper care as well as care perceived to be of better quality for their members. Belgian health care is generally perceived by the Dutch as being technologically advanced and of a high quality. Furthermore, prices in Belgium appear to be somewhat cheaper than in the Netherlands. Prices paid by foreign purchasers to Belgian hospitals do not, however, cover the full capital costs of facilities, as these are mainly funded through subsidies from the public authorities, unlike the situation in the Netherlands.¹⁶

3. The English system

The National Health Service (NHS) in England is a tax-funded health care system based on the benefits-in-kind provision of services, free at the point of use.

The Department of Health (DoH) is responsible for defining overall health policies and for providing health services to the population through the NHS¹⁷. At the local level, Primary Care Trusts (PCTs) are statutory bodies responsible for delivering health care to the local population. They are in charge of managing health services and ensuring that the needs of residents in their catchment are met¹⁸. To this end, PCTs provide primary care services but also have their own budgets and can commission hospital services from NHS Trusts, which deliver secondary care¹⁹. NHS Trusts are consortia of hospitals responsible for providing hospital care to the local population.

One of the priorities of the New Labour government which came into power in 1997 was to transform and modernize the health care system. An important objective has been to develop capacity to address the effects of decades of underinvestment. The so-called “NHS Plan” was drawn up as “the Government’s ten year programme of investment and reform”²⁰ and since 2000 the NHS has been undergoing major changes.

Reforms have been concentrating on the supply side both by increasing the budget spent on health and by reforming the functioning and structures of the system. While expanding capacity has been a key objective,

¹⁶ See also CVZ 2002: 13 and Visser L, Grensoverschrijdende zorg - een lust of een last?. *Management Gezondheidszorg*, Erasmus Universiteit Rotterdam, 2001, page 59.

¹⁷ Website of NHS Gateway: <http://www.nhs.uk/England/AboutTheNhs/History/Default.cmsx>

¹⁸ Ibid.

¹⁹ See also: <http://www.dh.gov.uk/assetRoot/04/05/72/10/04057210.pdf>

²⁰ “Delivering the NHS Plan: next steps on investment, next steps on reform” presented to Parliament by the Secretary of State for Health, April 2002

another priority has been to place patients at the centre and make consumer choice prominent in the new system²¹.

System aspects encouraging cross-border contracting – the English side

A series of interconnected policies²² have been introduced to transform the NHS; some of the most relevant for this report will be mentioned here. *Improving health services* by reducing waiting times and achieving better health outcomes is one part of the Plan. By 2005 the aim is to cut waiting times for outpatient appointments to a maximum of three months while maximum waiting for hospital operations would be six months, decreasing to three months by 2008. *Expanding capacity* is another key objective as short- and long-term investments are made to increase the numbers of medical professionals and of general and acute beds in hospitals; new Diagnostic and Treatment Centres are being created to perform fast-track surgery. Funding methods are also being changed. By introducing *payment by results* the idea is to reward better performance as hospitals will be paid based on undertaken activity rather than through block contracts to encourage them to reduce waiting times. *More patient choice* means that progressively patients should be able to choose where, when and how to be treated, while a new system where the money follows the patient is meant to give hospitals an incentive for improving services, cutting waiting times and increasing activity. *Plurality and diversity* is another corner-stone of the Plan as health care providers from outside the NHS are made use of to expand capacity. This includes providers from the private and voluntary sectors (e.g. through public-private partnerships) as well as overseas providers delivering services for the NHS. It is within this larger context that the NHS turned to Belgian hospitals to conclude cross-border contracts.

In 2000-2001, the Department of Health started looking at overseas treatment as an option for creating extra health care capacity in the face of long waiting lists. As part of the political reforms, there was a general government push to make more capacity available and to organize overseas treatment. In this effort, a local agency, London Patient Choice, was created and assigned the task of testing out the various overseas pathways by using the **Guy's and St Thomas' NHS Foundation Trust** (the GST) as commissioner to set up contracts as part of the choice programme. It was the GST which in 2003 started to contract with Belgian hospitals.

²¹ Ibid.

²² <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/SystemReform/fs/en>

CHAPTER 2: THE CONTEXT

There have been several determining factors in the evolution of patient mobility to and from Belgium as well as in the health care related cross-border cooperation. Different contextual elements include historical and regional factors as well as the impact of European jurisprudence and of waiting lists for medical treatments.

1. History of regional cross-border movements in Belgium

Belgium is at the crossroads of Europe. Sharing international borders with five countries, it constitutes a setting for intense cross-border movements of persons, goods, capital and services. Historically, the country has acquired a certain experience in the flows and exchanges across its borders – not least in the field of health care. Geographical factors as well as linguistic proximity (the northern half of Belgium speaks Dutch, the southern half is French-speaking while a small part bordering with Germany speaks German) have facilitated cross-border cooperation and well-established projects along the Dutch, French and German borders have existed for many years, in some cases for decades. Furthermore, the nature of the Belgian health care system, where the different players have notable freedom to manoeuvre, also makes it possible for providers as well as insurers to take part in cross-border initiatives.

Conventions and bilateral agreements between Belgium and its neighbouring countries²³ have existed for over a century. As early as 1868 Belgium and the Netherlands entered into a Convention establishing the reciprocal authorization for doctors and midwives to provide care in the border regions. This was modified by a subsequent Convention on the practice of medicine in 1947. In that same year, the two countries also agreed “on the application of their reciprocal social security coverage legislation”²⁴ and successive modifications followed, but were replaced by an agreement signed in 1980 concerning the insurance cover for medical care, based on Regulation 1408/71.²⁵

Bilateral agreements were also established along Belgium’s southern and western frontiers. In 1881 Belgium and France signed a Convention (revised in 1910) which allowed Belgian and French doctors in the neighbouring regions to treat patients on the other side on the border when no “native” doctor was residing there. This agreement was brought to an end only in 1998. A similar type of accord on mutual recognition was established between Belgium and Germany in 1925²⁶. Even today there exists a name-list of more than 400 German doctors who are authorized to provide their services in Belgium, the costs of which are reimbursed by the Belgian sickness funds²⁷. Accords have also been made between Belgium and Luxembourg, in 1959 and 1994, on the reimbursement of care²⁸.

Most recently, a bilateral framework agreement was signed between the Belgian and English health authorities in February 2003 on “the referral of NHS patients to Belgium” and to “encourage closer cooperation... for optimizing the efficient use of resources and skills”²⁹.

All these bilateral agreements are not suspended by the European coordination Regulations 1408/71 and 574/72; on the contrary the inter-state conventions considerably facilitate cross-border patient mobility beyond what is foreseen by the Regulations.

²³ See also Jorens Y, Salamon C and De Schuyter B. Rapport “Naar een rationalisatie van de EG-Coördinatieverordeningen inzake sociale zekerheid?”, Federaal Wetenschapsbeleid, Project Programma Sociale Cohesie. Universiteit Gent, maart 2005, page 211

²⁴ Coheur, A. (2001). Cross border care - New prospects for convergence. European Integration and Health Care Systems: A Challenge for Social Policy, Ghent, Belgium.

²⁵ Coheur, A., P. Carnotensis, et al. Interreg II - Grensoverschrijdend project in de Euregio Maas - Rijn, Espace social européen et santé: 56 pages.

²⁶ Coheur, A. (2001), op. cit.

²⁷ Derieuw, S. and L. Moorthamer (2002). “Grensoverschrijdende gezondheidszorg in Europa - Welke toekomst voor de solidariteit?” CM-Informatie Vol.204: pp.3-14.

²⁸ Ibid.

²⁹ “A Framework for Cross-Border Patient Mobility and Exchange of Experience in the Field of Healthcare between Belgium and England”

2. Belgium: a laboratory for relaxing access to cross-border health care

As a result of favourable geographical and cultural factors, several initiatives have been taken in the last decades to relax cross-border access to health care between Belgium and its neighbours. Projects have often been initiated by local health care providers and sickness funds, while the involvement of public authorities has differed greatly between initiatives and often authorities became involved at later stages. Several projects have received support from EU Interreg funding and have become Euregios.

Many forms of cross-border cooperation in the health care sector have been set up; projects and initiatives involving patient mobility include the following:

Meuse-Rhine Euregio (B – NL – D)

Within the framework of "INTERREG", the so-called IZOM³⁰ project was launched in the Meuse-Rhine Euregio³¹ in 2000, covering 3.7 million people living in five regions³² in three countries (Belgium, the Netherlands and Germany). The project aims at facilitating access to health care for the populations of the Euregio and is based on a cooperation agreement signed by the regional health care insurers³³ and a protocol signed by the public authorities involved. The funding of the care is based on EEC Regulations 1408/71 and 574/72, and allows patients to access cross-border care through a special IZOM EMR E112+ form. The type of care covered by the experiment is characterized as "general care provided by specialist doctors, on both the diagnostic and the therapeutic levels, the prescribing of medicines with this framework of the treatment and the relevant hospital care"³⁴.

Special Regulation in Zeeuws-Vlaanderen (B – NL)

The region of Zeeuws-Vlaanderen is part of the Province of Zeeland (the Netherlands) which borders directly with Belgium³⁵. Cross-border cooperation between Belgian hospitals and Zeeuws-Vlaanderen has been a direct result of the gradual closure of local health care facilities in the late 1970s. Since 1976, an agreement named "Special Regulation on Medical Assistance in Belgium", better known as the "Zeeuws-Vlaanderen Regulation", has existed, initially based on a verbal arrangement allowing Dutch people insured under the OZ health insurer (the largest in the region) to receive top-clinical care in two Belgian hospitals.³⁶ OZ patients living in Zeeuws-Vlaanderen had access to Belgian health care with a referral from their Dutch GP and an E112 form from their sickness fund.

The Transcards project (B – FR)

The *Transcard* project is set up between the French region of Thiérache (comprising nine cantons) and the Belgian Thiérache (seven communes)³⁷. The experimental project was launched in May 2000 to facilitate the administrative procedures when treating local patients on either side of the border. As the experiment proved successful, it was decided to establish a permanent simplification of procedures by agreeing on the so-called "TRANSCARDS Convention", which was signed in November 2002 by the French and Belgian social security authorities and which took effect from January 2003^{38, 39}. Founded on the principle of a cross-border zone of

³⁰ "Integration Zorg op Maat" i.e. 'Integration of tailor-made care'

³¹ (2002). *Projet Interreg II - Soins de santé sans frontières dans l'Eurégio Meuse-Rhin, Projet expérimental IZOM*. Bruxelles: 44 pages.

³² Provinces of Liege (B) and of Limburg (B), the region of Aachen (D), and the provinces of North Brabant (NL) and of Dutch Limburg (NL).

[i] The Interreg projects aim to promote regional and cross border cohesion in different domains , such as through cross border co-operation.

³³ Eight Belgian insurance bodies, four German insurers and two Dutch insurers (the CZ and the VGZ)

³⁴ Coheur, A. (2001), op. cit.

³⁵ Derieuw, S. and L. Moorthamer (2002). Op cit.

³⁶ VanTits and Gemmel (1995). *Samenwerkingsnetwerk - Ziekenhuizen in de Euregio Scheldemond (Haalbaarheidsonderzoek)*. Tilburg/ Gent.

³⁷ Ibid.

³⁸ CPAM de Maubeuge and CPAM de St Quentin (2004). *Evaluation annuelle TRANSCARDS 2003*, CPAM de Maubeuge/ St Quentin.

unconstrained access to health care, the project extends the social security cover in a border region of 140,000 inhabitants⁴⁰, allowing people to be treated on either side of the border simply by presenting their identity and social insurance cards⁴¹. The project is coordinated by two main health insurers on each side of the border (GIE Sesam Vitale in France; the National Alliance of Christian Mutualities in Belgium) and brings together the ministries in charge of health, the health insurance bodies and representatives from six health care institutions.

Inter-hospital cooperation between Tourcoing (FR) and Mouscron (B)

A convention was set up in June 1994 between the hospitals of Tourcoing and Mouscron^{42, 43}. The French hospital has had difficulties in responding to the demands for dialysis but is specialized in the treatment of infectious diseases such as AIDS, whereas the Belgian hospital is able to absorb the exceeding demand for dialysis and sends some of its patients to the department of infectious diseases in Tourcoing⁴⁴.

The complementarity between the two institutions and the very short distance between the two hospitals thus drive the cooperation. In 2003 another cooperation initiative on medical imagery was signed between the hospitals⁴⁵.

Other initiatives

A series of other formal as well as informal local agreements exist, establishing cross-border cooperation between hospitals for specific treatments:

- Franco-Belgian border-region of Wallonia (B) – Champagne Ardennes (FR)⁴⁶: Medical care for French third degree burns victims in Belgian hospital and Belgian patients receiving rehabilitation in a medical centre in France
- On the border between Belgium, Luxembourg and France: among other things, French patients can receive medical imagery and neurosurgical treatment in a Belgian hospital⁴⁷
- On the Franco-Belgian border: Belgian patients with a malign tumour can receive radiotherapy treatment in the region of North-Picardie (FR)⁴⁸
- Relaxed access to cross-border treatment between Belgian and French institutions in the region of Lille (FR) and East Flanders (B) for patients with mental disorders⁴⁹

3. The ECJ judgements

By removing obstacles to the free movement of patients, goods and medical services, the ECJ has constituted an essential factor for the development of cross-border patient mobility. In a series of ground-breaking judgements the Court has applied the principles of freedom of movement to the health care sector which had previously been seen as exempt from the European rules on free movement⁵⁰. In two judgements in 1998 (the Kohll and Decker

³⁹ Baeten, R. (2003). *Patientenmobiliteit en grensoverschrijdende zorg*. Handboek gezondheidseconomie. Kluwer.

⁴⁰ Denert, O. (2004). *Op. cit.* p. 15

⁴¹ Coheur, A. (2001). Cross border care - New prospects for convergence. European Integration and Health Care Systems: A Challenge for Social Policy, Ghent, Belgium.

⁴² Bassi, D., O. Denert, et al. (2001). *Op. cit.*

⁴³ Baeten, R. (2003). *Op. cit.*

⁴⁴ De Backer, B. D. (2004). "Une facette injustement méconnue de l'Europe de la santé. Le dynamisme "sur mesure" de nos zones frontalières." Renouer 63: 3-5.

⁴⁵ Jorens, Salamon and De schuyter 2005

⁴⁶ Offre de soins et mobilité à l'intérieur de l'espace transfrontalier Lorraine – Grand-Duché de Luxembourg – Province de Luxembourg, June 2004, GEIE Luxlorsan « LLS »

⁴⁷ Offre de soins et mobilité à l'intérieur de l'espace transfrontalier Lorraine – Grand-Duché de Luxembourg – Province de Luxembourg, June 2004, GEIE Luxlorsan « LLS »

⁴⁸ Jorens, Salamon ...

⁴⁹ Jorens, Salamon, ...

⁵⁰ See also R. Baeten (2002). *Mobilite des Patients et Reponses Politiques de l'UE*. Revue Belge de Securite Sociale. 4th trimestre, p. 871-888

rulings) the Court spelled out that the freedom to provide services also concerned health care services, implying that people could receive medical treatment in other EU Member States with no prior authorization and be reimbursed at the tariff foreseen in the country of residence. In 2001, two new judgements took the implications for patient mobility even further as the Court made clear that the freedom to provide services applies to ambulatory as well as hospital care and equally in health care systems based on reimbursement schemes as in benefit-in-kind systems. Yet it acknowledged the specificity of the hospital sector where prior authorization might be justified to ensure the financial viability of the system or the maintaining of appropriate and accessible hospital facilities⁵¹. The judges conceded that prior authorization to be treated abroad for hospital care might be justified if based on objective and non-discriminatory criteria. However, it was also stressed that *national* non-contracted providers must not be favoured over *foreign* non-contracted providers as there may be no discrimination on the grounds of nationality or territorial location⁵². For a system based on contractual arrangements as in the Dutch health care system, the rulings imply that prior authorization to go abroad may only be refused if a patient can receive appropriate treatment *without undue delay* from a *contracted* health care provider⁵³. If care is not available without undue delay in the Netherlands, non-contracted providers in the home state and abroad have to be considered on an equal footing.

According to the Dutch interpretation of the Court of Justice rulings, the Dutch system of contracting is in conformity with EU law. Health insurers can conclude contracts with foreign providers if there is a need for it, while they may not refuse to contract with a provider solely on the grounds that the provider is located in another Member State.⁵⁴ The Dutch reading of the Court rulings implies an “exportation” of contracting practices which are central to the Dutch national health care system. Sickness funds are advised to conclude contracts with the foreign provider if they plan to systematically offer their members access to cross-border health care.⁵⁵ In addition, no distinction can be made between domestic non-contracted providers and foreign providers in cases where patients have the right to go to non-contracted providers with prior authorization from their insurer.⁵⁶ With regard to reimbursement, sickness funds are obliged to reimburse the total costs of care received abroad as long as the reimbursement levels for care received in another Member State are not defined by law⁵⁷. Treatment abroad may not be refused if the patient cannot be treated in a contracted hospital within the waiting times defined in the “Treek” norms (Dutch norms defining acceptable waiting times) for the treatment in question⁵⁸. As long as there is no law defining the levels of reimbursement for care received in another Member State, sickness funds are obliged to reimburse the total costs of this care.⁵⁹

Based on these official instructions, four Dutch health insurers have so far concluded direct contracts with Belgian hospitals: the CZ, Achmea, the VGZ and the OZ. These insurers will be returned to in greater detail in chapter 4. Since the Court rulings of July 2001⁶⁰ stakeholders in the English NHS have also had the opportunity to contract services from health care providers in the EU⁶¹.

⁵¹ See also I.A. Glinos (2002). Cross-border Health Care in the European Union: Challenges, Risks and Opportunities for Member states, public health care systems and health care users. MSc Dissertation, London School of Economics and Political Science

⁵² ECJ, case C-157/99, *Smits-Peerbooms*, 2001, I-05473, paragraph 107

⁵³ See also R. Baeten (2002)

⁵⁴ Ziekenfondsraad, Grensoverschrijdende zorg: arresten Decker en Kohll, Aan de uitvoeringsorganen ZFW en AWBZ, Circulairenummer ZFW/38/98, AWBZ/31/98, van 15 juli 1998

⁵⁵ CVZ, Circulaire 02/021 met betrekking tot grensoverschrijdende zorg, 2 mei 2002

⁵⁶ Ziekenfondsraad, Grensoverschrijdende zorg: arresten Decker en Kohll, Aan de uitvoeringsorganen ZFW en AWBZ, Circulairenummer ZFW/38/98, AWBZ/31/98, van 15 juli 1998

⁵⁷ CVZ, Tweede aanvullende circulaire inzake arrest Müller-Fauré en Van riet n.a.v. uitspraken Centrale Raad van Beroep d/d. 18 juni 2004, 1 september 2004, Circulaire 04/45

⁵⁸ CVZ, Tweede aanvullende circulaire inzake arrest Müller-Fauré en Van riet n.a.v. uitspraken Centrale Raad van Beroep d.d. 18 juni 2004, Circulaire 04/45, College voor zorgverzekeringen, Diemen, 1 september 2004 (http://www.cvz.nl/resources/circ0445_tcm13-9078.pdf).

⁵⁹ Ibid.

⁶⁰ York Health Economics Consortium, Department of Health, *Evaluation of Treating Patients Overseas*, Final Report, July 2002

⁶¹

http://www.dh.gov.uk/PolicyAndGuidance/International/OverseasTreatmentGuidanceForNHS/GuidanceForNHSArticle1/fs/en?CONTENT_ID=4000166&chk=DZ5w/I

4. Waiting lists

It is noteworthy to what extent waiting lists encourage patient mobility: they motivate health authorities and purchasers to look for solutions abroad and encourage patients to agree to travel long distances in exchange for faster access to treatment⁶². As waiting lists are perceived as a failure of the national system to deliver health care to the population and, as public dissatisfaction grows, purchasers are forced to look for alternatives. Expanding capacity within the national system requires long-term planning, investments and time, while resorting to care abroad can have immediate results.

In approximately half of all OECD countries "waiting times for publicly-funded elective surgery are a major health policy concern"⁶³. Waiting lists generally tend to emerge in systems with low patient co-payments and restrictions on capacity⁶⁴ and appear to be more frequent in benefits-in-kind systems – characteristics which are present both in the Netherlands and in England. Waiting lists are determined by the demand for care (by the population) and by the supply of health care services which depends on the capacity available within the public and the private health care sectors, and "the productivity with which capacity is used. Productivity depends, among other things, on the way in which surgeons and hospitals are paid"⁶⁵ as activity-related financing tends to give providers an incentive for increasing productivity.

Waiting lists also have a role to play in the context of cross-border care. Following the ECJ rulings, Member States are obliged to reimburse hospital care received abroad when treatment is not available without undue delay in the national system. The judgements entitle patients to receive care abroad and oblige Member States to open up the national systems to foreign providers. Concerned with the implications the jurisprudence might have, health authorities in many countries have sought to establish a managed approach to cross-border health care by creating a structured framework for patient mobility instead of potentially being confronted with large volumes of patients requesting reimbursement for treatments received abroad on their own initiative. One way to manage mobility is by contracting with foreign providers, as contractual arrangements allow health care purchasers to better control the costs, quantity and quality of care received abroad⁶⁶. This option has been favoured by public authorities in the Netherlands and in England where long waiting lists are seen as a real concern and addressing them constitutes a political priority in the face of mounting public dissatisfaction.

In contrast to the two neighbouring health care systems, Belgium with its reimbursement system, activity-based financing of providers and consequent supply abundance, is able to absorb the unmet demand for health care of other countries, and Belgian providers present themselves as obvious cross-border contracting partners.

The use of foreign health care expands the accessible volume of care. Furthermore, it frees capacity within the national system. If patients on waiting lists receive treatment abroad which requires extended hospital stays, more patients in need of shorter treatments can be treated at home. Patient mobility thus has a double effect on waiting lists and capacity as more patients gain faster access to care within and outside the system. The issue of waiting lists will also be looked at in the following chapter.

⁶² See also CVZ, 2002: 13

⁶³ L. Siciliani and J. Hurst (2004). Tackling excessive waiting times for elective surgery: a comparative analysis of policies in 12 OECD countries, *Health Policy*, p. 1

⁶⁴ Ibid

⁶⁵ Ibid, p. 2

⁶⁶ See also R. Baeten (2002), op cit.

CHAPTER 3: EXTENT OF PATIENT MOBILITY TO BELGIUM

A haemorrhage of foreign patients to Belgium

It is extremely difficult to obtain numbers on cross-border patient mobility that are reliable, comparable, complete and easy to interpret. Purchasers have their own numbers, most hospitals have some figures, while public authorities also have some data. Statistical data can include ambulatory and/or intramural care; day nursery and/or clinical nursery; care provided in contracted and non-contracted hospitals; care provided to people according to nationality or according to the place of residence; care provided to sickness fund patients and/or privately insured patients; care provided through regulation 1408/71 or not; emergency care can be included or excluded. Sometimes these distinctions are made explicit, but very often they are not.

There are several administrative routes and financing mechanisms through which foreign patients can be treated in Belgium. Programmed care can be provided and paid for through direct contracts between providers and purchasers, through out-of-pocket payments by the patient with reimbursement by the purchaser or through the procedure foreseen in Regulation 1408/71 on the co-ordination of social security schemes in the European Union. These patients are treated under the so-called E112 form. In this section we will focus on:

- numbers of patients not living in Belgium but having received hospital care in Belgium independently of financing methods
- numbers of E112 patients having received ambulatory or hospital care in Belgium
- numbers of Dutch and English patients treated in Belgium via contracting

1. Patients living abroad treated in Belgian hospitals

Official statistics from the Belgian Federal Public Service of Health show that in 2002 there were 16,383 hospital admissions of patients living in another EU Member State and whose nationality was not Belgian (EU-nationals as well as non-EU nationals). These hospital admissions concerned both patients coming to Belgium for planned care as well as patients falling ill and needing hospital care during a temporary stay in Belgium. The total number of hospital admissions in Belgium in 2002 (including all nationalities and all countries of residence) amounted to 2.8 million, which means that European admissions made up a marginal 0.5% of the total. Admissions include day-stays and classical hospitalizations. For an in-depth analysis of the data please see Annex I, which the table numbers in the brackets below refer to.

Where do the foreign patients come from? (Table 4)

Of the 16,383 admissions, an absolute majority (58.6% or 9601 cases) came from the Netherlands, while 16.3% came from France, 8.6% from Luxembourg and 6.5% from Italy. Between 1 and 4 percent of admissions concerned people residing in Germany, the UK or Spain.

Which types of hospital stay do patients come for? (Table 3)

Taking Belgium as a whole, six out of ten foreign patients were admitted for a normal hospital stay and four in ten for day hospitalization. There were some regional discrepancies as day hospitalizations amounted to 43.3% in the Flemish region but only 30.5% in the Walloon region.

Do patients come for planned or emergency care? (Table 5)

85.3% of people residing in the Netherlands received planned treatments in Belgian hospitals. The proportion was equally high for patients living in Luxembourg (84.9%). For most other countries it was below 60%. Conversely, emergency care only concerned one in ten patients from the Netherlands or Luxembourg, while for Germany, the UK and Spain it applied to around 30% of patients, which suggests that residents from these countries fell ill while on a temporary stay in Belgium.

Where in Belgium are the foreign patients hospitalized and for which types of hospital stay? (Tables 7 and 8)

There are important regional differences when looking at whether patients were treated in the Flemish region, in Brussels or in the Walloon region. The majority of foreign patients (62.8%) were treated in Flemish hospitals, one fifth in Brussels and 15.4% of hospitalizations took place in Walloon hospitals.

Virtually all Dutch patients (93.2%) were treated in Flanders; this is not surprising since the Flemish part of Belgium is Dutch-speaking and Flemish hospitals often are geographically very close to the Netherlands, making them easy to reach for Dutch patients. On the contrary, around 70% of patients from Italy and Luxembourg went to hospitals in Brussels, while over half of French patients were treated in French-speaking Walloon hospitals.

There were also regional differences in the type of care foreign patients received: 83.6% of admissions of EU-nationals in Flemish hospitals were for planned care compared to 49.7% in Walloon hospitals. Again, this suggests the importance of the linguistic dimension (for non-emergency care) as people prefer to be treated in hospitals where they speak the language.

Which treatments do Dutch and UK patients receive in Belgian hospitals? (Table 15)

The three treatments for which Dutch patients come most often to Belgian hospitals are coronary atherosclerosis (8.4%), chemotherapy (7.6%) and procreative management (5.7%). For UK patients the "top-three" were procreative management (6.1%), osteoarthritis (hip) and allied disorders (2.3%), while infertility (female), plastic surgery for unacceptable cosmetic appearance and trans-sexualism all came at 1.7%.

2. Patients treated under the E112 scheme in Belgium

Programmed care abroad can be provided and paid for through direct contracts between providers and purchasers, through out-of-pocket payments by the patient with possible reimbursement by an insurer or through the procedure foreseen in Regulation 1408/71 on the co-ordination of social security schemes in the European Union. These patients are treated under the so-called E112 form.

According to the European Commission, Belgium was the EU Member State with the highest number of patients treated under E112 (even in absolute numbers) in 2000 with a total of 14,061 persons.⁶⁷ Table 2 shows the development over time of these patient flows.

Table 1: Foreign patients treated in Belgium under E112 between 1998 and 2003

	Dutch patients	Total numbers
1998	3,970	10,773
1999	4,915	11,262
2000	6,262	14,061
2001	7,539	16,019
2002	9,254	17,085
2003	12,503	22,333

Source: INAMI-RIZIV.

The data from the National Institute for Sickness and Invalidity Insurance (the INAMI, the public body responsible for administering the E112 procedures in Belgium) show that there was a marked increase in the number of EU patients who came to Belgium for planned care via the E112 procedure over the six-year period from 1998 to 2003. While nearly 11,000 E112 forms were filed in 1998, the number doubled to over 22,000 in 2003, an increase which was also reflected in financial terms as expenditures from E112 patients swelled from 21 million EUR to 44 million between 1998 and 2002.

While the number of E112 applications per country remains relatively stable for 13 out of the 14 Member States, there is a notable increase in the volume of Dutch E112 patients, more than doubling from 4,000 in 1998 to

⁶⁷ SEC(2003) 900 Commission Staff working paper

12,500 in 2003, accounting for over half of all E112 users (the second and third largest volumes in 2003 were from Luxembourg and Italy with respectively almost 4,800 and 3,100 applications). In terms of costs, the increase of Dutch patients was even more significant, going from 8 million EUR in 1998 to almost 25 million EUR in 2003, representing 60% of all E112 expenses incurred in Belgium.

The figures in Table 2 cover ambulatory as well as inpatient care but do not include patients receiving care in Belgium under the projects which relax access to cross-border care (mainly the Interreg-Euregio projects); these patients are treated through a "soft" version of E112.

3. Dutch and English patients treated in Belgium via contracting

Patients from the Dutch insurers OZ and CZ

Data from two of the main Dutch insurers (the CZ and the OZ), which have contracts with Belgian hospitals indicate the importance of patient flows to Belgium via direct contracting. The information system "Caret Scheldemond" used by two insurers contracting with Belgian hospitals provides the following numbers:

Table 2: Accepted periods of contracted care in Belgian hospitals by year and by insurer (N=25,884).

Year	Health insurer		Total	Index
	CZ	OZ		
1999		1553	1553	100
2000		2203	2203	142
2001	452	2482	2934	189
2002	2979	2769	5748	370
2003	4617	1562	6179	398
2004	5775	1492	7267	468
Total	13823	12061	25884	

Source: Carenet Scheldemond.

The table shows the numbers of Dutch patients treated in Belgian hospitals contracted by the two Dutch health insurers, CZ and OZ, which cover the majority of the border-region population and which have concluded most contracts with Belgian hospitals. As will be explained later, the OZ patients are treated in Belgium through the procedures based on Regulation 1408/71 whereas treatment of CZ patients is directly paid by the insurer to the hospital. In 2001 almost 3000 Dutch patients affiliated with one of the two insurers were treated by Belgian contracted providers. In 2004, this number went up to almost 7300 patients. The treatments in question include ambulatory care and inpatient care in the contracted hospitals.

Affiliated members of the two insurers can, with prior authorization, also go to other Belgian hospitals or to the contracted hospitals for treatments not included in the contracts. However, these patient flows do not appear in Table 2. Furthermore, the numbers do not include patients from other Dutch insurers treated in Belgium. Yet, the figures do give an indication of ongoing developments. The table shows a steady increase of periods of care involving CZ patients while those involving OZ patients decreased after 2002. The difference between the volumes of CZ patients and OZ patients also reflects the very different policies of the two insurers, as the OZ together with local doctors encourage patients to be treated in a local Dutch hospital which otherwise could face closure, risking damage to local health services. For the complete analysis of the Carenet Scheldemond statistics, please see Annex III.

The CZ also provided us with figures on the volumes of affiliates who applied for health care in Belgium between May and December 2004 (Annex II). These statistics distinguish whether CZ patients received non-contracted care, contracted care or treatment via the E112 scheme. The data show that 6,706 CZ members had been to Belgium in the 8-month period for a total of 12,797 treatments (tables 18 and 16). Virtually all of these treatments (94.3%) were covered by contracts with Belgian hospitals (table 17) while the type of medical treatment received in Belgium was overwhelmingly ambulatory care (72.2%). Only around one in five CZ patients were actually hospitalised in Belgium (table 16). For the complete analysis of the CZ statistics, please see Annex II.

Data per hospital

Analysis of data by hospital reveals concentration of CZ and OZ patients in a limited number of Belgian hospitals. 2,608 of the CZ patients (44.3%) treated in Belgium in 2004 through contracted care were treated in one particular hospital that has a local function and has 822 beds. The data also suggest that, in the initial phase, after signing a contract, there is a considerable increase of patients going to the hospital in question, but that after some time there seems to be a degree of stabilization. The increase in CZ patients is thus largely due to contracting with additional hospitals. Yet, as the developments are very recent, prudence is called for when interpreting the numbers.

Turning to the OZ health insurer, 766 of OZ patients (47.4%) treated in Belgium in 2004 through contracted care were treated in an academic hospital with a capacity of 1061 beds.

The academic hospital also provided some data on patients treated through contracted care and patients who came on their own initiative, paid for through other arrangements. This shows that Dutch patients represent 4.7% of patient days and foreign patients in total make up 6.2% of patient days. In the surgical department, Dutch patients account for 6% of patient days and foreign patients for 9.3%. The highest numbers of foreign patients seem to be in the hospital departments that have the lowest occupation rates. These data show that foreign patients can constitute an important part of a hospital's population or of specific hospital departments. The numbers do however suggest that, at least in this academic hospital, foreign patients occupy what would otherwise be empty beds and that the impact on Belgian patients is likely to be negligible.

Another Belgian hospital which holds contracts with Dutch insurers had a total of 36,391 admissions in 2003 of which 1,479 were foreign patients (4.06%, up from 3.69% in 2001). An overwhelming majority of foreign patients came from the Netherlands: 1,280 Dutch patients were treated in the hospital in 2003, an increase from 1,049 patients in 2001. Of the 1,280 Dutch patients, 920 were admitted in classical hospitalization ("verblijf") while 354 were admitted in day hospitalization ("dagopname of -behandeling"). 58% of the 1,280 Dutch patients came through either E111 or E112, while 42% came through other arrangements.

Patients from the Dutch insurers VGZ and Achmea

According to the two insurers, the vast majority of affiliated members of the Dutch health insurers VGZ and Achmea continue to go on their own initiative rather than through contracting, either with an E112 form (publicly insured patients) or privately insured patients contact foreign providers themselves, ask for a cost-estimation which is sent to Achmea which then grants approval for reimbursement. In the whole of 2004, an estimated 3000 affiliates will have gone to Belgium on their own initiative, while another 600 will have gone through contracting.

According to VGZ, over the last year (2004), 629 affiliated members of the VGZ went to AZ Vesalius (Tongeren) and about 100 cardiac patients went to the university hospital in Antwerp. Approx 5000 VGZ members went to Belgium via E112⁶⁸.

NHS patients⁶⁹

In total, 440 NHS patients were treated in five contracted Belgian hospitals for hip and knee surgery between 2003 and 2005. Patients came from four different London NHS Hospital Trusts⁷⁰ and there were important differences between the Trusts: roughly half of NHS patients came from one Trust (208 from Barking (BHR)) and a quarter from another Trust (100 patients from University Hospital Lewisham). There were also differences over time: three quarters of all patients (319 out of 440) were treated in Belgium in 2003/2004 and one quarter (121 patients) in 2004/2005. These tendencies are also visible when looking at each Hospital Trust, e.g. 67 patients from Bromley NHS Trust went to Belgium in 2003/4 while only one went in 2004/5.

⁶⁸ Interview with VGZ, 29 November 2004

⁶⁹ Official data from Corporate Development GST, May 2005

⁷⁰ University Hospital Lewisham (South-East London); Bromley Hospitals NHS Trust (South-East London); Barnet and Chase Farm Hospitals NHS Trust; Barking, Havering and Redbridge Hospitals Trust (BHR)

The NHS patients were sent to five different Belgian hospitals⁷¹ for hip and knee surgery. There were large differences in the numbers of NHS patients which the hospitals treated as two hospitals, Aalst and Roeselare, each received over a quarter of the 440 patients. Two other hospitals, Waasland and University Hospital Ghent, each received 64 patients while VUB treated 44 patients over the two year period.

It should be noted that the flow of NHS patients to Belgium has stopped and that no new NHS patients underwent surgery in Belgian hospitals after September 2004. Yet the above data cover months of the first half of 2005 as NHS patients received follow-up care by the Belgian surgeons several months after the actual operation.

⁷¹ ASZ Aalst; AZ Waasland; SZ Roeselare; University Hospital Ghent; University Hospital VUB (Brussels)

CHAPTER 4: ZOOMING IN: DUTCH AND ENGLISH PURCHASERS CONTRACTING BELGIAN HOSPITAL CARE

1. Objectives

1.1 Research objectives

In recent years, patient flows into Belgium have been increasing. Although statistics relating to these developments remain very scarce, the available data suggest that there has been a particularly large increase in the numbers of Dutch patients treated in hospitals in Flanders, the northern part of Belgium. It seems it is not only that patients are coming to Belgium on their own initiative, but that foreign health purchasers are concluding contracts with Belgian hospitals to treat their affiliated members. This care is not necessarily funded through EC regulation 1408/71.

The Belgian authorities were – at least initially – not involved in these contracts and were worried about the potential impact these developments might have. They were concerned that they might cause an upward pressure on Belgian tariffs if foreign purchasers offered higher prices to Belgian providers. Belgian providers could be tempted to prioritize foreign patients if this proved more lucrative, potentially leading to Belgian patients facing waiting lists for specific treatments.

To explore these issues we carried out this case-study. We have focused on Dutch and English patients treated in Belgian hospitals through contractual arrangements.

Due to the unexplored nature of the phenomenon, the research objectives have been twofold: firstly, to describe what is happening (chapter 4) and secondly, to analyze why these activities take place (chapters 5 and 6) and what implications they might have (chapter 7). From a descriptive point of view, the aims have been to explain how cross-border contracting works in practice, since when and where, to identify which stakeholders are involved, and the factors which influence this type of patient mobility as well as the nature and extent of the phenomenon. From an analytical perspective, the objectives have been to look at the reasons and incentives, revealed as well as unrevealed, behind the cross-border activities, and to assess what consequences this form of direct contracting might have at the micro- and macro-levels. Clearly, the descriptive and analytical parts of the case-study are very much interlinked, and the distinction above only serves to present the research questions in a lucid way.

The research has focused on Dutch and English patients coming to Belgium through contractual arrangements, as foreign purchasers concluding contracts with Belgian hospitals predominantly concern health insurers based in the Netherlands or the NHS Lead Commissioner contracting on behalf of London hospitals.

A series of research questions have been drawn up to guide the case-study; the following issues have constituted the core of our research:

- What is the political and legal context for purchasing foreign care in each of the countries;
- What is the nature and size of the phenomenon of foreign purchasers (from The Netherlands and England) purchasing Belgian hospital treatment;
- What are the incentives for the purchasers, the providers, the patients;
- What are the experiences (positive and negative) of patients, purchasers, providers;
- What is the potential impact on the relationship between the players in the health care system of each of the involved countries;
- What is the potential (positive and negative) impact of the phenomenon on the quality, accessibility and financial viability of the health care system in each of the countries: waiting lists, prices, medicalization, planning policies, task division between health care providers, instruments to control quality, etc.?

1.2 Methodology

Interviews

As written documentation is virtually nonexistent on the topic, a series of structured, in-depth interviews was carried out between May 2004 and January 2005 with the stakeholders central to Belgian cross-border contracting (for the list of people interviewed, please see Annex IV):

- **Belgium**

On the Belgian side, managers and/or head doctors of ten hospitals were interviewed, of which all except one have contracts with one or more Dutch sickness funds and/or with the NHS. Of these nine hospitals, six were contacted as they contract with Dutch insurers, two because they have contracts with the NHS, and one which has both types of cross-border contracts. In total, 20 Belgian hospitals were asked whether they would take part in the research; eight declined, some of which did not have any cross-border contracts, but at least three did. Furthermore, interviews were carried out with the largest Belgian sickness fund (the CM) as well as with four officials working either in the Federal Public Service of Health or in the National Insurance and Invalidity Institute (INAMI).

It should be noted that eight out of the ten hospital interviews as well as two of the interviews with the insurers were carried out in close collaboration with the Ghent University research team, who was carrying out a study on cross-border flows of patients and workers between Belgium and the Netherlands. As the Belgian case-study in e4p and the Ghent University study were covering some of the same topics on the Belgian side, it was decided to carry out joint interviews where possible.

- **The Netherlands**

On the Dutch side, four insurers were interviewed, who each have between two and seven contracts with Belgian hospitals. The choice of which sickness funds to contact was based on the information obtained from the Belgian hospitals, as cross-border contracts have only been concluded with these four Dutch insurers. Furthermore, a representative organization of Dutch sickness funds, the ZN (Zorgverzekeraars Nederland) was interviewed, as well as one public authority, the Health Care Insurance Board ("College voor zorgverzekeringen", the CvZ).

- **England**

On the English side, two interviews were carried out with the Department of Health and one with the Guy's and St Thomas' NHS Foundation Trust (the GST), which acts as Lead Commissioner for the NHS contracting health care services in Belgium. As contracting is centralized at the GST, it was not deemed necessary to interview the individual hospitals taking part in the cross-border programme.

In addition to the stakeholder interviews, experts not directly involved in the cross-border contracting were also interviewed: the European affairs director of a Belgian sickness fund (Mutualité Socialiste) was interviewed as well as two academics at the Erasmus University Rotterdam specialized in the Dutch health care system and European legislation.

A feedback meeting was organized with the contributors to the interviews and the institutions that provided statistical data, on June 28th 2005, to present and discuss our main findings.

Statistical data and patient survey

Another important source of information has been the statistical data provided both by the Belgian health authorities and the Dutch sickness funds. Furthermore, a survey of Dutch patients treated in Belgian hospitals is being carried out, the results of which will be available in the second half of 2005. The purpose of the survey is to gain insight into the experiences of Dutch patients treated in Belgian hospitals and their reasons for coming to Belgium for health care.

1.3 Scope of the research

The research has focused on one specific type of patient flow coming to Belgium from two other EU Member States (the Netherlands and the UK) via a specific kind of procedural arrangement (cross-border contracting). This focus was chosen because these patient flows are a novel occurrence, appear to be increasing and can potentially have important consequences for both stakeholders and health care systems.

This means that several aspects are beyond the scope of this study:

- Dutch and British privately insured patients who are treated in Belgium through non-contractual arrangements but who can access Belgian hospitals under their insurance policies;
- patients treated in Belgium with prior authorization in non-contracted hospitals or for non-contracted pathologies, under the E112 procedure;
- patients treated under arrangements for the relaxing of access to cross-border care under the Euregio projects;
- patients coming on their own initiative and paying out-of-pocket, maybe claiming reimbursement once back home, under the “pure” Kohll and Decker procedure;⁷²
- contracts by Dutch insurers with Belgian GPs and long-term care institutions
- cross-border contracts by other purchasers, such as German sickness funds⁷³.

2. Explaining the workings of cross-border contracting between foreign purchaser and Belgian hospitals

To examine and explain the workings of cross-border contracting in Belgium we will start by looking at how it all started and describe the background for the cross-border cooperation. We will then introduce the involved parties as it is these stakeholders who set up the structures and procedures which make cross-border care possible. Having identified *who* is contracting, the focus will turn to *how* contracting works in practice, while in the following chapter, we will look at *why* contracting takes place, or in other words, the reasons behind stakeholders setting up arrangements for patient mobility.

2.1 The initial stages

The Dutch background of cross-border contracting: the Euregios and past cooperation

Initiatives have been taken on the Dutch-Belgian border for decades to ease access to cross-border care. As described in Chapter 2, one such initiative is in the Dutch region Zeeuws-Vlaanderen where, since 1978, inhabitants have had the opportunity to receive some, mainly highly specialized treatments in specified Belgian hospitals⁷⁴. Zeeuws-Vlaanderen is a region with low population density. 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.

Another initiative is the Euregio Meuse-Rhine, covering parts of the Netherlands, Belgium and Germany, where since 2000 patients from the three countries have been able to receive predefined treatments across borders⁷⁵. This process was initiated by health insurers and health providers from the three countries and in a second stage

⁷² Dutch patients coming for extra-mural care on their own initiative to Belgium is a point of particular concern for sickness funds who are seeking advice from the public body CVZ on whether or not to reimburse their members when they present bills for extra-mural care received in Belgium.

⁷³ See German chapter in forthcoming book *Patient Mobility in the European Union – Case-studies*

⁷⁴ van Tits M and Gemmel P. *Samenwerkingsnetwerk - Ziekenhuizen in de Euregio Scheldemond (Haalbaarheidsonderzoek)*. Tilburg, Universiteit van Tilburg/IVA, 1995.

⁷⁵ Carnotensis P and Coheur A. *Projet Interreg II - Soins de santé sans frontières dans l'Eurégio Meuse-Rhin, Projet expérimental IZOM*. Bruxelles, 2002, 44 pages.

Coheur A Carnotensis P and Assent J. *Interreg III - Soins de santé sans frontières dans l'Eurégio Meuse-Rhin, Projet IZOM, rapport d'évaluation*. Bruxelles, 2004.

received support from public authorities of the involved countries. Both initiatives envisage that treatments are paid according to Regulation 1408/71.

Both these initiatives have meant that good cooperation relationships as well as personal contacts have been established across the borders. Positive experiences and confidence-building have thus facilitated the creation of contractual arrangements and even closer collaboration. Two Dutch insurers, CZ and OZ, as well as several of the Belgian hospitals with which they have concluded contracts were involved as partners in the initial projects for the relaxing of cross-border care access in Zeeuws-Vlaanderen and Euregio Meuse-Rhine, so good contacts between these stakeholders existed prior to actual contracting.

The English background of cross-border contracting: the procurement process, London Patient Choice and the Bilateral Framework Agreement

▪ First phase: the pilot project “Treating Patients Overseas”

In 2000-2001, the Department of Health started looking at overseas treatment as an option for creating extra health care capacity in the face of long waiting lists, and in the context of the general government push to create overseas treatment and extra capacity as part of political reforms.

A pilot project, “Treating Patients Overseas”⁷⁶, was launched in 2002, testing cross-border health care in a number of hospitals in France and Germany for three months (February – April 2002), which in total involved approx. 200 patients. The Guy's and St Thomas' NHS Foundation Trust had a key role in the project as it set up patient pathways and contracted with hospitals.

After the pilot project, the Department of Health wanted to expand the options of overseas treatment across the country generally, and launched a Europe-wide procurement exercise in 2002 to identify high quality and value-for-money providers overseas. The appointed Lead Commissioners received expressions of interest in August 2002 (invitation to pre-qualify in July 2002) and a short-list was then drawn up. The business and logistical aspects of the applications were assessed and a team of clinical representatives (“clinical reference group”) reviewed the clinical quality of the hospitals, and afterwards a clinical visiting group and Lead Commissioners visited the short-listed hospitals.

▪ Second phase: the London Patient Choice Project

Simultaneously with the procurement process, the London Patient Choice Project was set up in October 2002, with funding from the Department of Health⁷⁷. It was assigned the task of testing out the various overseas pathways by using the GST as Commissioner to set up contracts as part of the choice programme. The Project's aims were defined as:⁷⁸

- Improving waiting times and satisfaction for patients in London
- Developing the necessary capacity in order to treat the number of patients expected to exercise Choice
- Developing a working patient Choice system
- Learning how to improve the design of the system and feeding lessons into future London and national programmes.

The GST was invited in as Lead Commissioner to set up patient pathways with a number of hospitals because of its experience from the pilot project. London Patient Choice contacted the GST as it was interested in sending London patients overseas as part of the wider choice system being put in place (including not only overseas options but also the use of additional capacity in other London hospitals). The GST proposed the option of Belgian or German hospitals. London Patient Choice chose Belgium because of the high quality of hospitals,

⁷⁶ York Health Economics Consortium, op. cit.

⁷⁷ <http://www.londonchoice.nhs.uk/about-programmeoverview.php>

⁷⁸ Source: <http://www.londonchoice.nhs.uk/about-programmeoverview.php>

easy travelling from London and the option of direct contracting with the support of the government as a bilateral framework agreement was being discussed between the English Department of Health and the Belgian Health Minister. The agreement, which guarantees the integrity of the Belgian system, was signed in February 2003.⁷⁹

Cross-border contracting with the NHS thus has to be seen in the broader context of reform efforts to increase capacity and offer more choice to patients in the "new NHS". The cross-border option is part of extended patient choice, giving patients the possibility to opt for contracted providers outside the NHS.

2.2 The players involved

Four different types of players can be identified as taking part in the cross-border contracting arrangements:

- **Foreign purchasers:** Dutch sickness funds and the NHS Lead Commissioner purchasing care in Belgium
- **Belgian providers:** Belgian **hospitals** having signed contracts to treat Dutch and English patients and Belgian **doctors** working in these hospitals
- **Public authorities:** ministries, public bodies etc. in charge of health care and involved with cross-border contracting in the "sending" countries (the Netherlands and England) and Belgium
- **A middleman:** one Belgian sickness fund acting as middleman between Dutch insurers and Belgian hospitals

These players are not the only ones involved with patients going to Belgium, as national providers in the countries where the mobile patients come from and obviously patients themselves are also directly concerned. National providers in the Netherlands and England (in particular GPs and local hospitals) and patients play key roles, but as they do not participate in the actual agreements but rather in the practical functioning of patient mobility, their position and interests will be looked at in the following chapters on the reasons and implications of cross-border contracting.

For now, we will look at the players in the order presented above, and then turn to how the contracts work in practice.

■ PURCHASERS

Two entirely distinct types of purchaser have entered into direct agreements with Belgian hospitals: Dutch health insurers contracting care for their affiliated members and the GST commissioning care for NHS patients on behalf of London Hospital Trusts.

a) Dutch care insurers

From the interviews carried out with the Belgian hospitals and with the Belgian sickness fund acting as middleman, it emerges that four Dutch insurers have direct contracts with Belgian hospitals:

- CZ, or "CZ Actief in Gezondheid" (CZ standing for "Centraal Ziekenfonds") is the second largest Dutch sickness fund⁸⁰ with approx 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 (see map in chapter 5). 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

⁷⁹ "A Framework for Cross-Border Patient Mobility and Exchange of Experience in the Field of Healthcare between Belgium and England", Common framework between the Department of Health (England) represented by John Hutton (Minister of State for Health) and Belgium, represented by Josef Tavernier (Minister for Public Health) and Frank Vandenbroucke (Minister for Social Affairs and Pensions), Brussels, 3 February 2003.

⁸⁰ <http://www.zn.nl/international/english/about-zn/dutchhealthcare/factsandfigures.asp>

coastal areas to the south-west of the country. The OZ was the first Dutch insurer to start contracting in Belgium since 1998-1999 and today has contracts with four Belgian hospitals.

- Achmea is a holding company created in the 1990s when several health insurers merged. Of these the most important are the Zilveren Kruis, Groene Land, PWZ, Avero and FBTO. Achmea also provides insurance cover for the personnel of several large Dutch companies. A total of 2.7 million members are affiliated with Achmea, making it the largest Dutch care insurer, of which 2/3 are sickness fund members and 1/3 are private patients. Due to its composite character, Achmea does not have one geographical stronghold, but has members across the Netherlands. Achmea started contracting with Belgian hospitals in spring 2003 and now has contracts with six hospitals in Belgium.
- VGZ is the third largest insurer with 1.8 million members, of which 1.2 are sickness fund patients and the rest private patients. Most of its affiliates live in the south of country. The VGZ has, since 2002, been cooperating with two Belgian hospitals and entered into formal agreement with these in 2003-2004.

Together, the three largest care insurers account for 6.5 million affiliates out of a total Dutch population of 16 million, of which more than 10 million are insured under the public scheme⁸¹.

b) The NHS

As opposed to the contractual agreements organized by the Dutch purchasers, direct contracting allowing NHS patients access to Belgian hospitals is centralized with the GST⁸²:

- The GST became Lead Commissioner because of its previous experience with the 3-month pilot project carried out in 2002. Several methods for sending patients abroad were tried and tested, and as the pathway the GST was responsible for was chosen by the Department of Health as the best and most patient-friendly method, the GST was given complete responsibility for commissioning overseas.
- Due to its function as Lead Commissioner, the GST contracts on behalf of four London Hospital Trusts⁸³ taking part in the overseas programme; these are:
 - * University Hospital Lewisham (South-East London)
 - * Bromley Hospitals NHS Trust (South-East London)
 - * Barnet and Chase Farm Hospitals NHS Trust
 - * Barking, Havering and Redbridge Hospitals Trust
- As Lead Commissioner, it is only the GST (and not the Hospital Trusts) which signs the contracts with the Belgian hospitals. The GST has a separate contract (a Service Level Agreement) with London Patient Choice, setting out what they require of the GST, and London Patient Choice has agreements with the four referring London hospitals which take part in the programme. While contracting with the Belgian hospitals is centralized with the GST, it is based on the needs and requirements of London Patient Choice for extra capacity.

■ PROVIDERS: BELGIAN HOSPITALS

The medical services delivered in the Belgian hospitals we investigated include inpatient and outpatient care. The hospitals can be regrouped into two types according to size and expertise:

- Large university hospitals offering top-clinical care
- Smaller, provincial hospitals

⁸¹ Op. cit.

⁸² Guy's and St Thomas' NHS Foundation Trust

⁸³ NHS Trusts are consortia of hospitals providing hospital care to the local population.

Hospitals closer to the border are more likely to be seen as a potential contracting partner by Dutch sickness funds. Also, hospitals offering particular *specializations* (e.g. orthopaedic surgery) are more likely to be selected for both the Dutch insurers and for the NHS.

■ PUBLIC AUTHORITIES

The roles and functions of public authorities vary significantly. In the initial phases, the public authorities of the two “sending” countries played prominent roles by encouraging (experimental) contracting following the Kohll and Decker rulings.

From a more practical perspective, Belgian authorities are not involved at any stage of the cross-border arrangements in the **Belgian-Dutch** contracts. Several attempts have been made to establish a bilateral agreement between the two countries, yet these have not so far succeeded. On the other hand, the relevant Dutch public authority (CvZ) has the mandate to check the cross-border contracts, but only those covering sickness fund patients. In the **Belgian-English** contracting, public authorities on both sides were directly involved from the beginning with the creation of the bilateral framework agreement between the two countries, but also during the cross-border cooperation, as public authorities have been going through the contracts and checking Belgian hospitals’ invoices for NHS patients.

■ THE MIDDLEMAN: A BELGIAN SICKNESS FUND

The CM (Christelijke Mutualiteit, i.e. “Christian sickness fund”) is the largest sickness fund in Belgium, with 44% of insured persons⁸⁴; its position is stronger in the Dutch-speaking part (Flanders) than in the French-speaking part of Belgium.

The CM has been collaborating closely with some of the Dutch sickness funds and has, since 1998-99, been participating as a third signing party in the OZ contracts with Belgian hospitals, and since 2001 in the CZ agreements, effectively making them trilateral contracts. The CM provides administrative assistance to the Dutch insurers by controlling the accuracy of the invoices, which the Belgian hospitals charge the Dutch insurers, and whether they are in accordance with official Belgian tariffs.

2.3 Cross-border contracts in practice

To explain what the actual contractual agreements between Belgian hospitals and the two types of foreign purchasers look like and how they work, a series of aspects will be examined, first for the Dutch contracts and then for NHS contracts. These aspects cover the following:

- Design and negotiation of contracts
- What care is contracted
- Selection of Belgian hospitals
- Patient pathways and referral system
- Prices and tariffs
- Payment methods
- Medical aspects
- Other...

■ DUTCH CONTRACTS

The context

Cross-border contracting between Belgium and the Netherlands started in the late 1990s when the OZ as the first sickness fund initiated formal agreements with five Belgian hospitals (today it has four contracts as two of the hospitals have merged). Since then, the CZ started concluding contracts in 2001, while Achmea and the VGZ

⁸⁴ AIM Report, *Health Protection Systems Today – structures and trends in 14 countries, 2002*

followed in 2003-2004. At the end of 2004, the four sickness funds have contractual arrangements with the following Belgian hospitals:

- **The OZ:**
 - University Hospital Ghent
 - AZ Sint-Jan, Bruges
 - AZ Maria Middelaes/ Sint-Jozef, Ghent
 - Gezondheidszorg Oostkust, Knokke (maternity care)
- **The CZ:**
 - Ziekenhuis Oost Limburg, Genk
 - Ziekenhuis Maas en Kempen, Maaseik
 - CAZ Ziekenhuizen Salvator/ St.-Ursula, Hasselt
 - Gezondheidszorg Oostkust, Knokke
 - Maria Ziekenhuis Noord-Limburg, Lommel
 - AZ Sint-Jozef, Malle
 - AZ Vesalius, Tongeren
- **Achmea:**
 - University Hospital Antwerp
 - AZ Middelheim, Antwerp
 - AZ Sint-Jan, Bruges
 - Gezondheidszorg Oostkust, Knokke / Blankenberge
 - AZ Maria Middelaes, St. Niklaas
 - Auroraziekenhuis, Oudenaarde
- **VGZ:**
 - AZ Vesalius, Tongeren
 - Univeristy Hospital Antwerp

Design of contracts

The contracts with the Belgian hospitals for three out of the four Dutch insurers are based on the official Dutch "model contract", which is a standard agreement most commonly used in the Netherlands and which is drawn up in a consultation process between representative organizations of Dutch insurers and of Dutch providers. The OZ adopts a different approach, which will be described later. The contracts may vary depending on which medical specialisms are included in the agreements. Contracts include doctors' payments according to the official Belgian convention tariffs and no separate agreements are made with hospital doctors. By law, Dutch health insurers are obliged to have separate contracts for their members insured under the Sickness Fund Act (the public scheme) and their privately insured members. This also applies to cross-border contracting, which means that Belgian hospitals sometimes hold two contracts with the same Dutch insurer, one for sickness fund members and one for the privately insured. All contracts covering the publicly insured are checked by the Dutch public authority, the CvZ, which is responsible for supervising the sickness funds.

Selection of Belgian hospitals and negotiations

The selection of Belgian hospitals by Dutch insurers is based on a variety of factors, such as geographical location, medical needs of affiliated members, waiting lists as well as specialties offered in the hospitals; these will be examined closely in the chapter on the reasons behind cross-border contracting.

- **Achmea** has defined a "Contract Strategy" and formulated a series of hard and soft criteria used to select foreign providers:
 - * Medical staff must speak Dutch
 - * The hospital should cooperate with nearby hostels (soft)
 - * Distance from the Dutch border should be max. 200km

- * Tariffs must be below the Dutch maximum tariffs (hard)
- * Good previous experiences (of affiliates going on their own initiative) (hard)
- * Expertise of doctors

Before concluding a contract with a Belgian hospital and as part of a “pre-contracting procedure”, a team from Achmea, composed of the contracting officer, one or two doctors, a legal advisor, an officer from “claims handling” (when drawing up the actual contract on aspects such as payments, procedures, approvals) and/or from the waiting list mediation department, will visit the hospital. A series of elements are examined:

- * Medical criteria for when a treatment is appropriate
 - * MRSA: whether the hospital has an isolation policy and an MRSA-protocol, what prescribing practices it follows
 - * Whether the hospital has a hygiene-protocol
 - * The clinical path of the patient, a written procedure which shows step-by-step what will happen to the patient, so that patients are informed and know what to expect
 - * Quality of care: the standards of intensive care, of surgical theatres, how logistics are organized
 - * Prescribing of pharmaceutical products, whether the patient is given medicine when discharged
 - * Availability of devices such as wheelchairs and braces
 - * The standard of buildings and rooms (generally more old-fashioned than in the Netherlands), sanitation etc.
- **The CZ and VGZ** also carry out such evaluation visits before contracting and have similar check-lists covering medical, organizational and logistical aspects of the hospitals. The CZ even suggested that as a result of these thorough checks it knows more about the Belgian hospitals it contracts with than about Dutch hospitals.

What care is contracted for: comprehensive vs. exclusive contracts

Common to the cross-border contracts of all the insurers is that they respect the limits of the Dutch national health care package. Yet, within the limits of the benefit package, there are differences as to what care the insurers have chosen to offer their members in Belgian hospitals.

CZ and VGZ have chosen to cover virtually all treatments offered by the Belgian hospitals in their contracts, with the exception of some top-clinical treatments (e.g. cardiac surgery, neonatal care in IC, IVF and neuro-surgery) and experimental medicine for which the hospital must ask prior authorization from the insurer.

OZ and Achmea have a more restrictive approach as through the contracts they consciously limit and control the range of treatments their members can go to Belgium for. The selection of treatments, which their affiliates may obtain in Belgian contracted hospitals, is in these cases based on the existence of long waiting lists in Dutch hospitals as well as on local shortages of care. These exclusive contracts mostly cover elective care such as orthopaedic and cardiac surgery.

Private vs. sickness fund patients

As mentioned, Dutch insurers must hold separate contracts for their sickness fund members and their privately insured members. Yet for three out of the four Dutch insurers with Belgian contracts, there are no differences in the health care the two 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. Only one insurer, OZ, has no contracts which cover privately insured patients, but as the OZ has unique contractual arrangements with Belgian hospitals, these will be returned to in greater detail later.

Patient pathways, the referral system and freedom of choice

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). Yet, this tendency could diminish with the planned reforms of 2005/2006 and the gradual abolition of the contracting obligation, as treatments such as knee and hip operations will be covered under the new system of Diagnosis and Treatment Combinations. The reforms are meant to give insurers incentives for "shopping around" for the best contracts, which as a side-effect could increase cross-border competition.

There seem to be some differences in how the sickness funds approach the provision of care abroad, as Achmea's waiting list mediation department first looks at possibilities for treatment in the Netherlands, then at options in Belgium, while for the VGZ, Dutch and Belgian contracted hospitals are equal.

Patients' choices, however, also depend on the information their insurer gives them on options abroad as well as on the attitude of their referring doctor. An important source of information for patients is the "waiting lists mediation department" of their sickness fund, which they can call to be updated on which contracted hospitals they can choose to be treated in and what the waiting times are in the different institutions.

None of the sickness funds fixes the numbers of patients which can be treated in Belgian hospitals when contracting (i.e. there is no "block purchasing").

Patients are not "sent" to Belgium but go by themselves, often after having contacted their insurer's waiting list mediation service which informs them on the different options they can choose between.

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

- Referral letter from Dutch GP or doctor
- Passport or identity card
- Their health insurance membership card

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 specialism 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", as patients call to obtain information on where they can be treated and how long they have to wait.

Affiliates can choose freely whether they go to a Dutch or a Belgian contracted hospital. According to the CZ, if a patient chooses to go to a Belgian hospital, the hospital then contacts the CZ to see whether the patient is a CZ-member, after which the patient is registered and receives the treatment, while the bill is sent to the CM for verification and then on to the CZ, who pays.

Several sickness funds have produced information brochures on what people can expect when they go abroad and what the differences are between Dutch and Belgian hospitals. For instance, leaflets explain that some personal cost items, such as extra drinks, are charged for. Dutch patients are not accustomed to paying for anything when hospitalized.

Medical aspects

Belgian standards apply when Dutch patients are treated in Belgian hospitals. None of the cross-border contracts stipulates that Belgian hospitals and doctors should change their medical procedures and prescribing practices to comply with Dutch standards when treating Dutch patients.

Several hospitals signalled that Achmea wanted to have a say in the appointment of the Belgian hospital doctors, but that the hospitals refused such an intervention from a (foreign) insurer.

One Belgian hospital, having cross-border contracts in the framework of a close cooperation with a Dutch university hospital, signals that it has taken several measures to adapt to Dutch quality standards. It recruited, for

instance, a patient information person, as is the practice in the Netherlands. It applies MRSA tests to the patients according to Dutch standards and it sends home patients with MRSA as soon as possible, as is the case in the Netherlands, whereas other hospitals signal on the contrary that Dutch patients with MRSA are kept in hospital for longer. This hospital also agreed on detailed care pads and care protocols with the Dutch university hospital.

Prices and tariffs

According to all four sickness funds, their contracts state that the prices which Belgian hospitals and hospital doctors charge for treating Dutch patients comply with the official Belgian convention tariffs according to the nomenclature (it has been possible to verify this in the contracts of two insurers). The relatively high Belgian out-of-pocket payments (by international standards) are also covered by all four Dutch insurers. Invoices for these co-payments are not sent to the Dutch patients (as is the case for Belgian patients) but directly to the insurers, except for costs called "private wishes", i.e. patients choosing to stay in one- or two-person rooms (in which case the doctors can also charge higher fees). Dutch patients thus face fewer out-of-pocket payments than Belgian patients.

According to the information from the four insurers and from the copies of actual contracts we obtained, it can generally be said that:

- Hospital doctors must respect the tariffs of Belgian conventions when treating Dutch patients. Only when a patient chooses to stay in a one-person room can specialists charge fees above the convention tariffs, in which case the patient must cover the fee supplement by out-of-pocket payment.
- Pharmaceutical products are priced according to the Belgian official tariffs and are included in the invoices sent to the Dutch insurers
- The costs of the hospitalization itself has to be according to the Belgian legislative stipulations
- No package pricing is used; payments are made per act as is the norm in the Belgian system

Belgian hospitals signal, however, that before concluding a contract, Dutch insurers ask for a cost calculation per treatment in order to compare prices between hospitals. Belgian hospitals state they only can give cost estimations, as the real cost depends on the actual acts delivered by medical staff. According to the hospitals, insurers seem to select hospitals based on these price calculations.

Hospitals also mentioned special agreements on specific treatments such as plastic surgery, bariatric surgery, for which specific tariffs are agreed.

According to Belgian hospitals, there have also been attempts by Dutch insurers to offer different prices and proposals to pay "package prices" which would include hospital stay and medical treatment in a single price (this is contrary to the Belgian system where doctors are paid on a fee-for-service basis). No hospital declared to have accepted these conditions, but several suggested that "other hospitals" did accept different tariffs. One hospital signalled that it did not accept the "package price" because this did not fit with their agreement with hospital doctors. If doctors are bound to a pre-defined price they are not free to decide on the services they provide and charge for.

The contract of one insurer includes average prices for a series of treatments and states that in 90% of cases, the cost of these treatments should not exceed the average calculated price, while for the 10% which may go above, this should only be an excess of 10% of the average cost, otherwise the hospital must ask for specific agreement from the insurer. This can be a way for the insurer to avoid that unnecessary medical procedures are carried out because of supplier-induced demand by Belgian providers.

Administration, payment flows and the role of the CM

For the two sickness funds which do not have agreements involving the CM, Belgian hospitals send their invoices directly to the Dutch insurer, who pays the bill.

For the VGZ, one bill is sent for all VGZ-members treated in the Belgian hospital in one month.

For OZ and CZ, which cooperate with the Belgian sickness fund CM (although in different ways), administrative and payment flows are different, as they happen through the CM.

▪ The CZ

The trilateral contract between the CZ, the CM and the Belgian hospital in question, defines the CZ's role as the purchaser of hospital and medical care, the CM's role as supporting the purchase of care administratively, technically and logistically, and the hospital's function as delivering the care.

The cross-border "routes" for CZ patients and payments can be described as follows:

- Members can make an appointment at the Belgian hospital themselves
- When going to the hospital, members take their CZ membership-card and their referral letter with them
- Members present themselves at the hospital reception and are registered; this is usual in Belgian hospitals and must be done every time a patient goes for a consultation, tests or other
- The hospital sends a report to the CZ via the Internet through a programme which has been developed by the CM and the CZ (called Carenet Scheldemond). The report contains information on the patient (name, address etc) and on the referring doctor and the specialist which the patient has seen
- The CZ can then approve or reject the request
- If approved, the request goes on to the CM who adds several patient codes (e.g. for entitlement) which are necessary for the hospital to invoice the CZ for the treatment
- The invoicing happens through the CM as it checks the bills on behalf of the CZ

▪ The OZ

The OZ's contractual arrangements with Belgian hospitals are entirely different from those of the other three insurers. The OZ contracts can be described as working in a hybrid system: the framework is direct contracting between the insurer and the hospitals, but the procedure followed in practice when an OZ patient goes to a Belgian hospital is the E112 procedure.

The contracts avoid OZ giving prior authorization every time someone goes to Belgium through E112, as granting permission is made easier and systematic through Carenet Scheldemond. The contracts also limit the specialisms for which people can go to Belgium. Patients are registered in the Carenet Scheldemond system and patients who live in Zeeuws-Vlaanderen have an OZ "pass" so that when they go for treatment in a contracted hospital, the hospital can ask permission through Carenet Scheldemond. This means that patients do not need to have the paper-version of E112 with them and according to OZ, the system institutionalizes cross-border care and makes it easier for all. The E112 procedure is made more sophisticated through Carenet Scheldemond, while the contracts indicate to hospitals which treatments they can provide without asking permission from OZ (i.e. those treatments covered by the contracts).

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 means that the *specialisms* and *functions* which are contracted for in Belgium are clearly defined in the contracts and are based on which 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 and Terneuzen hospital. The selection of patients going abroad is always based on the type of 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.

As the E112 procedure is applied, hospitals send their invoices relating to the financial intervention of the Belgian health care system to the CM, who sends the bills on to the INAMI. Bills for the Belgian out-of-pocket payments are sent to the OZ and extra invoices, such as supplements for single rooms or extra drinks, are sent directly to the patient.

The hybrid system thus has the advantage of effectively protecting the regional hospital in Terneuzen and allowing OZ to carefully control the numbers of affiliates going to Belgium. The hybrid contracting also protects against the risk of seeing a very large out-flow of Dutch patients (if they prefer to be treated in Belgium), which is

not the case with standard contracts, which make Belgian hospitals equal to Dutch hospitals. This risk is limited with the hybrid contracts as they include *geographical limitations* by stating that they only cover OZ members living in Zeeuws-Vlaanderen. The public authority CVZ is opposed to this distinction made between affiliates as it is not allowed by the Sickness Fund Act to make exclusive arrangements.

Liability

Contracts state that legal liability is according to Belgian legislation.

■ ENGLISH CONTRACTS

The context

The GST had contracts with five Belgian hospitals for hip and knee surgery:

- Algemeen Stedelijk Ziekenhuis Aalst (ASZ Aalst)
- Stedelijk Ziekenhuis Roeselare (SZ Roeselare)
- Universitair Ziekenhuis Gent (UZ Gent)
- Academisch Ziekenhuis van de Vrije Universiteit Brussel (AZ VUB)
- Algemeen Ziekenhuis Waasland

The contracts were concluded between May and November 2003 and were all extended to cover the period until 31st March 2007⁸⁵. Despite this, the patient flows completely stopped after September 2004 and the Belgian authorities were informed in June 2005 about the formal end of the cross-border cooperation scheme.

While the contracts were running, each NHS Hospital Trust had a Belgian “buddy” hospital. Belgian hospitals would receive NHS patients from one, sometimes two, London Hospital Trust(s) they were collaborating closely with. The buddy links were supposed to ease communication and build firmer working relationships between the medical teams of the London and Belgian hospitals (surgeons with surgeons, nurses with nurses etc). Facilitating cooperation between the receiving Belgian hospitals and the sending London Hospital Trusts was seen as part of making secure patient pathways with no “gaps”.

Furthermore, to assist NHS patients during the entire process of overseas treatment, the GST had employed the so-called Euro-PALs who acted as bi-lingual liaison officers between patients, their families, the London Hospital Trusts and the Belgian hospitals and doctors. The Euro-PALs’ key functions were to accompany the patients at all times, explain what would happen to them and make them feel comfortable, as well as to smooth out any cultural differences and misunderstandings which might arise between the hospital staff and the patients.

Different stages in the selection and contracting of Belgian hospitals

Following the pilot project, the Department of Health wanted to expand the options of overseas treatment and launched the Europe-wide procurement exercise in 2002, to identify appropriate providers overseas. The appointed Lead Commissioners received expressions of interest in August 2002 (invitation to pre-qualify in July 2002) and a short-list was drawn up. The business and logistical aspects of the applications were assessed and a team of clinical representatives (“clinical reference group”) reviewed the clinical quality of the hospitals. Afterwards a clinical visiting group and Lead Commissioners would visit the short-listed hospitals.

Based on these pre-qualification bids and assessments, hospitals from several European countries fulfilled the criteria and were short-listed, yet London Patients Choice chose to send patients to Belgian hospitals due to ease of travel and option of direct contracting with support from the government. Hospitals in southern Europe also reached the pre-qualification stage but no contracts were set up.

⁸⁵ It should be mentioned that two additional Belgian hospitals entered contractual arrangements with the NHS in 2003 for cardiac surgery; yet these two contracts were terminated as early as March 2004.

The GST drafted a “statement of requirements”, making clear what was expected of the Belgian hospitals. The statement was agreed with the Department of Health and the “clinical visiting group” to ensure that the NHS was covering the “duty of care” aspect, building in quality of care. The actual contracts are based on these requirements.

The selection of Belgian hospitals was based on the pre-qualification bids and assessments carried out in the original procurement process in 2002.

In the “Invitation to Pre-Qualify to Bid to Provide Elective Surgery to English Patients in other EEA Countries and/or to Provide Clinical Teams to Treat Patients in England”, a series of requirements were defined:

- Business details
- Financial issues
- Company conduct
- Track record (clinical record for different treatments)
- Contracts
- Overall quality standards
- Facilities
- Consultant surgeons
- Other staff

The hospitals which pre-qualified were given a statement of requirements to see to what extent they could fulfil it, and negotiations were then started with the hospitals interested in contracting.

Based on the hospital interviews, it seems that several Belgian hospitals applied for treating English patients, but very often negotiations stopped for various reasons. Several Belgian hospitals appear to be disappointed due to the lengthy contracting negotiations and procedures with the GST and have become reluctant following the negative experience to conclude other cross-border contracts with foreign purchasers.

First stages:

- A series of negotiation meetings were held with the Belgian hospitals to agree on the statement of requirements and make sure they could work towards it
- The GST then introduced the terms and conditions of the contract, i.e. the legal terminology (indemnities, warranties)
- Finally, contracts with the hospitals were concluded and the operational arrangements were set up

Later operational stages:

- The London hospitals were given the choice of which Belgian hospitals they would like to buddy with
- The Euro-PALs service was set up and introduced into the overseas patient pathway

Steps in selection process

- Paper-sift and pre-qualification of hospitals to see whether they meet various logistical and business criteria
- Clinical paper-sift looking at infection rates, readmission rates, operation rates, how operations are carried out, surgical reputations, proving medical quality with statistics
- Clinical visit assessment taking approx half a day to check “everything” on site: theatres, seeing patients, seeing physiotherapy in action...
- Overall assessments were provided to the Department of Health and then on to the Lead Commissioner on whichever of the visited hospitals were deemed as pre-qualified to be included in the overseas treatment programme
- The pre-qualified hospitals in Belgium were then given a statement of requirements
- Negotiations and meetings around the requirements
- Defining and concluding the contract terms

Design and negotiation of contracts

As Lead Commissioner and with its past experience, GST was responsible for designing the actual contracts. It seems fair to say that “everything” was covered in the contracts with the Belgian hospitals. All the contracts were based on one model (derived from the contracts used with the German hospitals in the first pilot project) and varied slightly e.g. on the length of stay depending on each hospital's clinical protocol. A total of 21 annexes spelled out virtually all aspects of the treatment and cooperation:

- Prices
- General legal terms
- Patient consent form
- Treatment route and application of contract
- Patient referral letter
- Clinical and non-clinical criteria for selecting patients
- Detailed patient pathways
- Fitness to travel statement
- Discharge Outcome Protocol with criteria for discharging patients
- Standardized discharge letter
- Complaints procedure
- Specification of the Euro-PAL service
- Description of clinical procedures and performance standards
- Control of hospital infections
- Dispute resolution procedure

As a result of the meticulous preparation and the detailed nature of the contracts, the negotiations between the GST and each of the Belgian hospitals lasted for almost one year. According to one hospital, its contracting team travelled to Brussels once a week for nine months to meet the Lead Commissioners from the GST (either present or via video-conferencing) in the offices of a renowned law firm.

What care is contracted for?

Seven contracts were concluded between the NHS and Belgian hospitals in 2003; of these, five were for knee and hip replacements, while two contracts covered cardiac surgery but were terminated within a year. No other treatments were commissioned in Belgium by the GST.

The reasons for selecting knee and hip surgery will be looked at in detail in the following chapter, but two important factors were that it was medically possible and financially viable to send knee and hip patients overseas.

Several Belgian hospitals mentioned that the GST had shown some interest in extending the scope of the agreements to cover treatments such as spinal surgery and shoulder replacements.

Patient pathways and referral system

The “route” leading patients from their GP to the Belgian hospital was characterized by the role of the specialists at the local Hospital Trusts which acted as referring doctors, and the role of the Euro-PALs as mediators.

First access points: the GP and the local specialist

- Patient with knee or hip problem went to see his/her GP who made a referral to see a specialist at the local Hospital Trust
- The specialist assessed the patient and if operation was deemed necessary, patient was put on a waiting list until the specialist could operate on him/her (e.g. six months later)

Pre-selection by the local Trust

- Once on the waiting list, the patient might be contacted by London Patient Choice if the local hospital thought (s)he was fit to travel abroad (a patient with high co-morbidity would not be contacted by London Choice)

- If interested in the offer to go abroad, the patient would attend a pre-assessment clinic at the local Trust where diagnostics were carried out. Patients might be deemed unfit to go overseas by the local specialists, yet the selection was made based on acceptance criteria issued by London Patient Choice to make sure that all local hospitals were screening patients according to the same clinical criteria

Overseas Assessment Clinics (OACs)

- Patients meeting the acceptance criteria were sent to the overseas assessment clinic in their local hospital to meet the Belgian doctors (from the "buddy hospital" where the patients would undergo treatment) who decided whether to accept the patients. Small percentages of patients were either rejected by the Belgian specialists or changed their mind if they felt uncomfortable about going overseas for treatment
- Prior to going to London, Belgian doctors specified what diagnostics they required (blood tests, X-rays etc), so these were undertaken at the local hospitals prior to the outpatient clinic attended by the Belgian doctors
- The OACs were attended by the Euro-pals who explained to patients exactly what would happen to them on the social and environmental side, while the Belgian doctors explained what would happen on the medical side
- If the patient agreed to go to Belgium, (s)he had to sign various papers, such as a consent form

Travelling and hospitalization

- Patients met again with their Euro-PALs on the day they travelled to Belgium (usually one to three weeks later) and were accompanied to the Belgian hospital they were assigned to
- Patients were seen daily by the Euro-PALs, the doctors and the nurses during the entire hospital stay
- The Euro-PALs accompanied the patients back to the UK

After-care

- Patients were seen by the Belgian surgeons at exit follow-up clinics at their local Hospital Trust
- Exit overseas assessment clinics were held six to eight weeks after discharge and then again at six and at 12 months post operation as required
- There had only been very few cases of patients going back to Belgium for further treatment

A strict selection of candidate patients by their local hospital and by the Belgian doctors was carried out to ensure as few complications as possible (related to overall medical condition) and to avoid refusing patients and sending them back once they have already travelled to Belgium.

Medical aspects

The most important medical aspects of the contracts were spelled out in two annexes.

Description of the treatments

The content and course of the hip and knee operations were described in the annex 17 on "Procedure Specific Clinical Service Descriptions, Protocols and Performance Standards (...), including OAC timetable". The "Procedure Specific Clinical Service Description" included:

- The type of prosthetics which will be used
- Approach of the operation
- Type of anaesthesia
- Medication: names of drugs for antibiotic regime, anticoagulant regime and pain control
- Length of physiotherapy regime
- Medication on discharge
- Anticipated length of stay

The Protocols and Performance Standards included:

- The number of admissions per week, e.g. for one Belgian hospital it was foreseen that in the "initial period" it should have capacity to receive four patients weekly, while in the "full service period" it should be able to admit eight patients per week

- Which days of the week admission and surgery would take place
- Number of days patients would stay in the hospital
- Frequency of overseas assessment clinics

Comparing the content of annex 17 of all five hospitals, the overall procedures were very similar, even though some variations existed in the length of stays, the number of physiotherapy sessions or the type of prosthesis and medication used.

Discharge criteria

A Discharge Outcome Protocol had been drawn up to define which results must have been achieved before a patient could be discharged from the Belgian hospital, so as to minimize the use of NHS physiotherapy resources by patients operated on in Belgium. The criteria defined how mobile the patient must be (when walking or climbing stairs) and that (s)he must have received advice on how to exercise at home.

Prices and tariffs

The contracts defined what can be characterized as “package prices” – one price for the entire treatment (either knee or hip replacement) which included all the different aspects of the treatment. Approximately six cost components made up the package price which typically looked like this:

- 1) Medical Procedure
 - Honoraria for the surgeon, assistant, anaesthetist and medical on-duty service
 - Laboratory work
 - Pathology
 - Cardiology
 - Radiology
 - Medical follow-up and on-duty call
 - Unforeseeable medical risk and out-of-pocket payment
- 2) Revalidation
 - Treatment (unit price multiplied by number of sessions)
 - Weekend supplement
 - Additional treatment during short stay
- 3) Pharmaceutical products and blood products
 - Calculated based on a sample of the patient
 - Tariff
 - N tariff
- 4) Prosthesis
 - Current price of most frequently used prosthesis
- 5) Acute hospitalization
 - Charged daily patient rate multiplied by the number of days in hospital
- 6) Social, environmental and management elements
 - Costs of “extras” for the English patients such as tea, access to British TV and newspapers etc. and for administration

The costs of the Euro-PALs service, of travelling and the overseas assessment clinics were all borne by the GST but were not included in the package price. Belgian doctors were paid a day-rate for the outpatient clinics.

Comparing the package prices of the five Belgian hospitals, they range from 10,314 EUR to 10,800 EUR for hip replacements and from 10,738 EUR to 11,600 EUR for knee replacements⁸⁶. Around one third of the package price covers the costs of the prosthesis and another one third the stay in hospital. The “package” also contains a risk calculation component, which e.g. can cover an extra two to three nights in hospital or blood-transfusions, which adds ca. 5-10% on top of the cost of the various components.

The calculation of the package price was based on Belgian official tariffs while the tariffs applied for the medical elements of the package price were submitted to the approval of a Belgian public authority (the INAMI/ RIZIV). The bilateral framework agreement states that prices have to be according to Belgian tariffs. The prices of the medical elements of the “package price” had to be approved by the RIZIV. The price for the hospital stay, including the cost of nursing staff, was based on the official daily patient rate of the individual hospital. It was accepted in the package price that the daily patient rate was higher than the normal due to the complicated nature of the pathologies of NHS patients. Furthermore, according to Belgian hospital doctors, the 6th cost component covering the “extras” was rather generously defined and amounted to approx 10-15% of the total package price.

Payment flows

On the English side

London Patient Choice carried the extra costs of overseas treatments, and were effectively subsidizing the programme. In the overseas scheme, the London hospital that the patient came from paid what it would cost to carry out the treatment in the hospital, and London Choice subsidized the rest, as well as the travel costs. The Primary Care Trust where the patient was registered would pay the cost of a treatment done locally to the Hospital Trust, which then forwarded the money to the GST, while the remaining additional costs (above the normal cost of being treated in the NHS) was split between London Patient Choice and the Hospital Trust.

On the Belgian side

The payment flows were centralized as the GST sent the payment (based on the package price) for each treated patient to the management of the Belgian hospital, which then allocated the different parts to the relevant medical staff, services and departments within the hospital.

It was stated in the contracts that before the hospital could send the invoice for a treated patient, the Belgian surgeons had to see the patient at the exit OAC between the 6th and the 8th week following operation. Yet, as will be returned to later, the organization of OACs was not always easy in practice.

Once everything had been checked and the patients were assessed to be okay at the first exit OACs after surgery, the hospital could send the invoice. Payments were made by the GST within approx. three months.

Functions of Belgian and English authorities

Independently of the actual payments to the Belgian hospitals (after operation and after the first OAC), the GST sent copies of the hospitals’ invoices to the relevant Belgian public authorities every three months.

Furthermore, before signing, the GST gave the entire contracts as they had been agreed with hospitals to the public authorities. The Federal Public Service of Health and the INAMI gave their agreement to the UK Department of Health that the contract could go ahead and that they agreed with negotiations and the prices included.

⁸⁶ Data obtained from the Belgian public authorities

CHAPTER 5: DRIVERS FOR CROSS-BORDER CONTRACTING

Patient mobility must be worthwhile for all stakeholders if it is to work. For patients who move, there must be something better, faster and cheaper across the border, otherwise they would stay in their own country; for providers, purchasers, insurers and public authorities, there must be something to gain from cross-border cooperation, otherwise they would not participate in the arrangements surrounding patient mobility.

Understanding cross-border contracting implies looking at what factors and incentives motivate patients, purchasers, providers and public authorities to either look for health care abroad, to participate in the arrangements or to deliver health care to foreign patients. Identifying the factors and priorities which influence stakeholders is to understand the reasons behind patient mobility – or the reasons behind no patient mobility, as the case may be.

The same structure as in chapter 4 will be used to explain why the different stakeholders engage (or not) in cross-border health care. As this part of the study goes beyond the technical practicalities of cross-border contracting, the patient perspective will also be taken into account to see what reasons foreign patients might have for being treated in Belgium:

- **Foreign purchasers:** Dutch sickness funds and the NHS Lead Commissioner commissioning care in Belgium
- **Belgian providers:** **Belgian hospitals** having signed contracts to receive Dutch and English patients, and **Belgian hospital doctors** who treat the foreign patients
- **Public authorities**
- **A middleman:** one Belgian sickness fund acting as middleman between Dutch insurers and Belgian hospitals
- **Foreign patients:** Dutch and English patients receiving health care in Belgium

We will first look at the Dutch and the English purchasers because it is they who have initiated cross-border contracting; patients have crossed the borders prior to any formal agreements, but actual contracting was started by the purchasers and it is interesting to see why they have gone to such great lengths to establish the contractual arrangements. Furthermore, the purchaser perspective explains well the structural factors that encourage cross-border health care.

Secondly, the focus will turn to the Belgian providers' position, to explain contracting from their perspective and their reasons for meeting the demand for health care from foreign purchasers and patients.

In third place, public authorities and their *very* different roles in the two types of contracting will be looked at: how the Dutch are not at all involved in the practical but did encourage the initiation of cross-border contracting, how the English public authorities have a prominent steering role, and how the Belgians know very little about Dutch contracting but are more involved with the NHS contracting.

Fourthly, the CM will be looked into to see what motivates it as a middleman to perform the function of intermediary between Belgian providers and Dutch insurers.

Last but not least, the patients' reasons for going abroad for health care will be examined as the types of patients and their motives are closely related to some of the decisive factors mentioned in the previous part on purchasers.

1. The purchasers

Although the contractual arrangements and the actual organization of cross-border care are very different depending on the foreign purchaser, the **reasons behind cross-border contracting from the purchaser point-of-view** are on the whole not that different. Four questions thus illustrate the motives of the purchasers, independently of whether they are individual Dutch insurers or the centrally-placed NHS Lead Commissioner; looking first at the general level and then going more into detail, these questions are:

- 1) Why do the foreign purchasers buy health care *abroad*?
- 2) Why is *Belgian health care* favoured by the foreign contractors?

- 3) Why is cross-border *contracting* the favoured mode of purchasing care in Belgium?
- 4) Why were the particular *hospitals* chosen for contracting?

Broadly, the following reasons illustrate well what the main motivations for the purchasers are:

- 1) There is not enough health care at home; waiting lists are problematic
- 2) Belgium is a neighbouring country, has easy access, cooperative providers and language advantages
- 3) Easier for Dutch sickness funds to export the contracting arrangements they use at home; important for the NHS to have a structured approach to cross-border care
- 4) The hospitals were chosen by purchasers and by patients based on direct/explicit and indirect/implicit selection criteria

1.1 Dutch sickness funds⁸⁷

1.1.1 *Why do Dutch sickness funds buy health care abroad?*

According to insurers and their representative body, ZN, the following aspects explain why Dutch purchasers turn to foreign health care providers:

- Supply restrictions in the health care system and resulting long waiting lists “force” Dutch sickness fund to look abroad to purchase health care as they have a legal duty to deliver health care to their members.
- Increasingly commercial behaviour of Dutch sickness funds when purchasing health care to create better opportunities and services for patients and to expand capacity in a context of domestic shortage of supply. Contracting with Belgian hospitals ensures faster access to health care services, and as members’ satisfaction with their sickness fund partly depends on the ease of access to treatment it can provide, it is within every sickness fund’s interest to ensure that its affiliates are treated as fast as possible. Furthermore, as Belgian health care is generally perceived by the Dutch as being technologically advanced and of a very high quality, Dutch insurers as well as patients are keen to have access to it.
- The competitive factor is developing more and more, as cross-border contracting is a way of putting pressure on Dutch providers to make them increase their productivity and their efficiency as well as develop a more patient-oriented approach. Cross-border contracting acts as threat strategy in this sense. According to the ZN, cross-border contracting sends an important signal to Dutch providers that they cannot behave like monopolists. The Dutch health care system is characterized by shortage of providers, which during contracting and negotiations translates into the providers being in the strongest position vis-à-vis the purchasers. The option of contracting abroad not only means that demand for health care is better satisfied as supply is increased, it also serves as a “threat strategy” to warn Dutch providers who now know that they could lose out on contracts as sickness funds turn to providers not only in neighbouring countries such Belgium and Germany, but also in Italy, Spain, Poland and elsewhere⁸⁸.
- Regional undersupply of health care which may concern basic hospital care for routine treatments and services, and/or highly specialized care for complicated cases and severe illnesses. Depending on what “gaps” exist in local or regional provision, insurers look to Belgian providers to cover the needs of their affiliated members.
- Turning to health care abroad also introduces an extra competitive element to the Dutch health care scene. Restricted supply and waiting lists, combined with insurers’ duty to deliver care, force sickness funds to look abroad for a solution to unmet demand. As Gabrielle Demange and Pierre-Yves Geoffard explain, a central condition for competition among insurers to work (and to result in increased efficiency) is that they have ways

⁸⁷ The arguments contained here are based on the interviews carried out with the four Dutch insurers and the representative organization of health insurers, ZN

⁸⁸ See also CVZ, Grensoverschrijdende zorg, Circulaire 02/21, College voor zorgverzekeringen, Diemen, 2 mei 2002 (http://www.cvz.nl/resources/circ0221_tcm13-3424.pdf).

of influencing the supply of care, in particular through the selective contracting of providers, which is very difficult in the Netherlands due to the limited supply of care⁸⁹. Cross-border contracts can constitute a tactic employed by purchasers as they have the effect of making national providers aware that they could lose contracts, patients and income, giving them an important incentive for improvement.

1.1.2 *Why is Belgian health care favoured by the Dutch contractors?*

A series of explanatory factors were mentioned by the insurers and their representative organization during the interviews:

- An obvious reason for contracting with Belgian hospitals is the (above-mentioned) **geographical and cultural proximity** between Belgium and the Netherlands, who not only share a long border but also a language, as the northern part of Belgium is Dutch-speaking.
- At the regional level, **geographical location** also becomes an important explanatory factor, e.g. for a sickness fund like the CZ, as 85% of its members are concentrated in the southern Dutch provinces of Zeeland, Brabant and Limburg, which all share a frontier with Belgium to the south. Furthermore, both Zeeland and Limburg are relatively isolated from the rest of the Netherlands: Zeeuws-Vlaanderen is separated from the mainland by the waterfront, while the long and narrow province of Limburg could be described as a “super border-region”, as it is surrounded by international borders to the south, east and west (see Figure 1).
- **Infrastructure** and relative geographical isolation are also important factors, as is the case for the OZ sickness fund with its stronghold in the Zeeuws-Vlaanderen region (part of the Zeeland province), which borders with Belgium to the south while being cut off from the “mainland” by two channels (Oosterschelde and Westerschelde) to the north. 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. Furthermore, Zeeland is not a densely populated area so health care infrastructure is relatively scarce, especially since a hospital was closed down in the 1970s, while it borders with highly populated Belgian provinces with very good health care facilities.
- **Quality of care and medical technology:** Belgian health care is often perceived by the Dutch as being more advanced in terms of using high-tech medical facilities and delivering very high quality care. This is an important aspect for sickness funds eager to satisfy their members.
- Several Dutch insurers mentioned that Belgian **prices** for health care on average tend to be 10% lower compared to the Netherlands and that it constitutes a motivation to contract with Belgian hospitals.

⁸⁹ Ibid.

Figure 1: Map of the Benelux countries



Figure 1 shows the location of Belgian hospitals which have contracts with Dutch insurers and/or the NHS. Four Dutch hospitals have also been included, as these are mentioned in the report. Furthermore, the names of three Dutch provinces (Zeeland, Noord-Brabant and Limburg) and of one region (Zeeuws-Vlaanderen) are indicated, as these are neighbouring areas with Belgium and experience intense cross-border mobility.

1.1.3 Why is cross-border contracting the favoured mode of purchasing care in Belgium?

For Dutch sickness funds, the simplest way to purchase Belgian health care is via the cross-border contracts, as they are in effect an “extension” of the contractual arrangements used within the Netherlands to the Belgian setting. Prior to the direct contracts, Dutch patients were going to Belgium via the E112 procedure, the Euregio arrangements (E112 “soft”) or with prior cost-estimations and approval letters (for private patients). The contractual arrangements make it easier for insurers to control and guide the cross-border flow of patients and the resulting costs.

Dutch sickness funds are very conscious about the type of care they contract for in Belgium, which depends on what is available in the regions where their members live. Contracts allow them to control what treatments their members are going to Belgium for, as they can choose to contract basic and/or specialized care (depending on the facilities in the Belgian hospitals). In this way contracts allow for a more structured flux of patients compared to the ad-hoc nature of the E112 forms.

As contracting is based on a careful selection of hospitals, it guarantees Dutch patients that the quality of health care has been approved by their insurers. Furthermore, contracting eases the internal administration for the sickness funds and simplifies administrative procedures for affiliates as they do not need permissions nor to worry about Belgian co-payments.

One unique case

It should be noted, however, that the situation is quite different for the sickness fund OZ and that the above reasons and factors only partially explain its position. Not only are the contractual arrangements between the OZ and Belgian hospitals very different from the formal agreements which the other three insurers have, as it is a unique, hybrid system between the E112 procedure and direct contracting⁹⁰, but the reasons for cross-border contracting are also quite different in the OZ's case. Although waiting lists and regional undersupply of health care play an important role, so do more subjective factors such as historical links, habits and traditions. Due to severe regional under-capacity in the OZ stronghold, the Zeeuws-Vlaanderen Regulation⁹¹ was set up to ease access to Belgian hospitals and OZ affiliated members have, since the mid 1970s, been used to going to Belgium for hospital care and therefore take access to Belgian health facilities for granted (even) today. Indeed, a large proportion of OZ members live in the region of Zeeuws-Vlaanderen (see Figure 1) and are culturally and linguistically very strongly attached to the Belgian neighbouring regions. Going to the Flemish provinces of East- and West-Vlaanderen in Belgium for shopping, leisure, social events etc., as well as health care, is an entirely integrated part of their lifestyle.

Reasons for having a hybrid system of contracting and E112 forms

According to the OZ, cross-border care in Zeeuws-Vlaanderen is an alternative to travelling long distances in The Netherlands and is therefore not intended to be an option when care can be provided in the region. It is in everyone's interest that the local hospital of Terneuzen remains operational, as its closure would make the problem of waiting lists even more acute in the region. As a result, there is a conscious effort both by primary care providers and OZ to direct as many patients as possible to Terneuzen.

The contracts avoid OZ having to give prior authorization every time someone goes to Belgium through E112, as granting permission is made easier and systematic through Carenet Scheldemond. The contracts also restrict the range of treatments people can receive in Belgium, which consequently limits costs and ensures the Dutch hospital's survival.

The hybrid contracting also protects against the risk of seeing large volumes of Dutch patients crossing the border if they prefer to be treated in Belgium, which is not the case with standard contracts which make Belgian hospitals equal to Dutch hospitals. This risk is reduced with the hybrid contracts as they include *geographical limitations* by only covering OZ members living in Zeeuws-Vlaanderen. CVZ, the public authority supervising sickness funds, is opposed to this distinction made between affiliates as it is not allowed by the Sickness Fund Act to make exclusive arrangements and puts pressure on the OZ to change their system. On the other hand, the CM, but also Belgian hospitals, express their preference to continue working under the actual formula.

On the other hand, without the E112, OZ would have to do the administration itself, check the bills itself (or ask someone else to do it, e.g. the Belgian sickness funds CM), reconsider who to contract and for what care, as it would have to follow the procedures of the Dutch system, whereas with E112, OZ just follows the Belgian system and has no extra work with checking Belgian bills according to Dutch law.

⁹⁰ See section 3.2.2.

⁹¹ See chapter 2, section 1.2 of this report

Yet, OZ also mentioned that when it started with the combination of E112 and contracting it was very convenient, but that with ICT and Internet it has become easier to receive bills directly from Belgian hospitals and to convert Belgian tariffs into Dutch tariffs which OZ has to report to the CVZ.

1.1.4 Why were those particular hospitals chosen for contracting?

Above we looked at the reasons why Dutch sickness funds are contracting with Belgian hospitals, while here the focus will be on the reasons why they contracted with those specific Belgian hospitals – what are the factors and criteria behind the sickness funds' choices?

According to the four insurers, a series of elements are taken into consideration in their choice of which Belgian hospitals to contract with:

- Expertise and reputation of doctors/hospitals in particular specialties, especially in areas with long waiting lists in the Netherlands, such as orthopaedic and cardiac surgery.
Example: the VGZ has contracted with UZ Antwerp, as the two Dutch academic hospitals of Nijmegen and Rotterdam are too far away for VGZ members and have long waiting lists, so the sickness fund looked for a Belgian provider close to the Dutch southern border which could deliver highly specialized care for rare and difficult cases. As a result, UZA is not used for the minor waiting lists pathologies.
- Geographical location: it is important for sickness funds to offer access to care close to their members and achieve a good regional spread of contracted hospitals
Example: looking at a map of the Netherlands one notices how roads in Zeeuws-Vlaanderen go in the direction of Ghent and Bruges (while Antwerp is more difficult to reach) so the choice for the OZ to contract with UZ Ghent and St Jan in Bruges was obvious. As the OZ explained, its members in Zeeuws-Vlaanderen must either "cross the water or cross the Belgian border" (see Figure 1) to access top-clinical care and most prefer the latter of the two.
- Past experiences: Dutch sickness funds know where their members go for health care abroad (e.g. for extra-mural) and can "follow" their members' preferences by choosing these hospitals when contracting, especially when affiliates give positive feedback.
Example: past experiences existed with surgeons of the hospital Gezondheidszorg Oostkust, Knokke/Blankenberge (B) as Achmea members had been treated in the hospital and had given very positive feedback to Achmea's mediation department.
- Past cooperation: several insurers had pre-contractual arrangements and cooperation links existed between local providers and Belgian specialists before the formal contracts were established.
Examples: since October 2002 there has been an agreement between the Belgian hospital in Tongeren and the Dutch university hospital of Maastricht (see Figure 1) according to which the academic institution could send patients to Tongeren together with its medical students so they could experience working in a small hospital where they could use the facilities, partly because Maastricht is one of the worst performing hospitals in terms of waiting times. VGZ was involved in this agreement between the two hospitals. An actual contract was signed in October 2003, as the very long waiting times in Maastricht hospital meant that the VGZ wanted to offer its affiliates in the Maastricht region an alternative close by.
The OZ contracted with Maria Middelaes in Ghent (B) because its cardiology department had previous links with a cardiologist working in Terneuzen hospital, who used to operate on his patients in the Belgian hospital using its facilities; now there are also Belgian cardiologists who carry out the same operations on patients from Terneuzen.
- Contacts with the CM: for the CZ, the selection of Belgian hospitals was carried out in cooperating with the CM, and concentrated on hospitals interested in making contracting agreements.
- Type of care: the match between the type of *care needed* by affiliated members (often due to waiting lists) and the type of *care offered* by the Belgian hospitals is important for all the sickness funds; in some cases

insurers look for top-clinical care in Belgium as Dutch university hospitals might be far away or have long waiting lists.

1.2 The NHS⁹²

The reasons behind cross-border contracting between Belgian hospitals and the NHS are not to be found within the GST, which has a purely technical role as Lead Commissioner. The reasons lie instead with London Patient Choice and the London hospitals Trusts, on behalf of which the GST is commissioning Belgian care. As a reminder, the questions looked at are:

1. Why does the GST buy health care *abroad*? Why do NHS Trusts refer patients abroad?
2. Why is *Belgian health care* favoured by the GST and London Patient Choice?
3. Why is cross-border *contracting* the favoured mode of purchasing care in Belgium?
4. Why send patients overseas for hip and knee replacements?

1.2.1 *Why buy health care abroad?*

The overseas treatment option for English patients should be considered in the broader context of giving London patients more choice in health care and at the same time creating more capacity for tackling waiting lists. Prior to "choice" becoming a political priority, patients would be referred to a hospital by their local GP and wait on the waiting list until they were treated, and did not have any choice.

Simultaneously with the nation-wide procurement and assessment processes for the Department of Health, the GST was approached by London Patient Choice to look at setting up an **overseas treatment** scheme as part of the choice system which London Choice was putting into place, which included not only overseas care but also the use of capacity in other London hospitals. The GST was invited in as Lead Commissioner to set up patient pathways with a number of hospitals because of its experience from the earlier pilot project.

The whole overseas treatment system was based on the *local NHS Trusts offering choice to their patients*. It was the task of the GST to explain to Trusts what London Choice was about and how the scheme worked, while the NHS hospitals were free to decide whether they wanted to participate in the programme or not. Four Trusts opted in and started assessing and referring patients abroad. According to the GST, a strong incentive for the NHS hospitals to participate was to reach the government targets on waiting times. A main target was 31 March 2004 by which time all Trusts had to reduce waiting times down to nine months. This implied a big rush in 2003 and early 2004 while the target-pressure eased after April 2004. Looking at the numbers of NHS patients sent to Belgian contracted hospitals, they reflect this effort to cut waiting lists, as 331 patients were treated in Belgium in 2003/4 compared to 109 in 2004/5⁹³.

Contracting abroad also has to be seen in the context of the NHS reforms in which the NHS is negotiating with providers from the private sector to treat NHS patients. Contracting abroad can in this context be seen as a strategy employed by the NHS to put pressure on the private health care sector in England. As in the Dutch case, resorting to Belgian providers expands the pool of suppliers available for contracting with the effect of discouraging monopolistic behaviour by national (private) providers. The option of commissioning care in Belgium puts pressure on private English clinics to remain competitive on prices.

1.2.2 *Why Belgian health care?*

The GST proposed the options of Belgian and German hospitals. **Belgium** was chosen by the London Patient Choice because of the easy access and travelling from London with the Eurostar and because of the nature of the Belgian system with the option of direct contracting with the support of the government (and positive feedback from the Department of Health in setting up the bilateral framework agreement). The selection of Belgium (and

⁹² Information contained here is based on the interview carried out with the Lead Commissioner

⁹³ Official statistics obtained from the GST/ the INAMI

not Germany) by London Patient Choice was based on travel, social and environmental criteria, and had nothing to do with the health care systems as such.

1.2.3 Why cross-border contracting?

Setting up cross-border contracts between the NHS and foreign providers was seen as the best way to achieve a managed approach to patient mobility by controlling patient flows *and* guaranteeing the quality and safety of care through the strict assessment of foreign providers and the carefully defined patient pathways.

1.2.4 Why knee and hip replacements?

Very different considerations came into play when choosing which patients could be sent abroad for treatment:

- It is possible to establish easy and well-definable patient pathways for both operations
- It is medically feasible to send patients abroad (which is not the case for all pathologies)
- These treatments were key priorities for the government as hip and knee operations had some of the longest waiting lists in the country
- It is financially viable to treat these pathologies abroad (e.g. not worth sending day-cases overseas)
- Treating knee and hip patients abroad would have the biggest impact on the whole system, as a patient stays approx. two weeks in hospital and therefore takes up capacity in the local system. When this capacity is freed by sending patients overseas the hospital is able to do considerably more day-cases

2. The providers: Belgian hospitals and doctors⁹⁴

As there is overcapacity in the Belgian acute hospital sector, and because of decreases in average patient stays, many hospitals are structurally under-occupied. This causes financial problems because hospitals continue to have major fixed costs that are not covered by their income. As financing is mainly activity-related and based on the number of patients, hospitals have a clear incentive to attract as many patients as possible, both national and foreign, at least up until their optimal “justified” activity level. Reaching optimal capacity brings financial gain for hospitals and it is attractive for hospitals to “fill up” available facilities, use resources and get paid for the services provided, instead of having capacity which is unused.

Hospital supply in Belgium is not hierarchically structured and there are no task divisions between hospitals. This means that hospitals compete on the type of services they offer. Hospitals therefore attract renowned – expensive – specialists and purchase expensive apparatus as a means of competing. Attracting foreign patients offers a means to cover these expenses.

Hospitals are paid based on a global budget for investment costs, general costs and nursing staff. As this global budget is artificially subdivided into daily patient rates, the daily patient rates are average prices, and do not reflect real costs. This seems to be an incentive for some hospitals to only accept treatment of Dutch patients for which the costs are below the daily patient rate they can charge, but to refuse heavy surgical interventions, for which intensive nursing care is necessary, and where costs exceed the price they can charge.

Hospitals also show a clear interest in the medical activity (ambulatory and inpatient) for foreign patients. As doctors have agreements with the hospital management to pay part of their fees to the hospitals for using infrastructure, diagnostics on foreign patients mean also an extra income for the hospital, allowing debit of their investment costs. This, and the interest of hospital doctors, explains why the major part of the activity related to foreign patients is ambulatory care in the hospital.

For larger hospitals, additional foreign patients can be a source of extra income, but can also be an opportunity to continue to specialize and offer top-quality clinical care, to make important investments and reach a critical activity level necessary to expand their competence and experience.

⁹⁴ See also Jorens Y, Salamon C and De Schuyter B. Rapport “Naar een rationalisatie van de EG-Coördinatieverordeningen inzake sociale zekerheid”, Federaal Wetenschapsbeleid, Project Programma Sociale Cohesie. Universiteit Gent, maart 2005, page 136.

As an indication of Belgian providers' eagerness to conclude cross-border contracts, several Dutch insurers mentioned during interviews how they were approached (sometimes to an increasing extent) by Belgian hospitals and hospital doctors who wish to engage in contracting.

According to the hospitals themselves, cross-border contracting – as a way of admitting foreign patients – brings further advantages. Contracts guarantee hospitals a flow of foreign patients. Although it can be difficult (and risky) to try and estimate numbers of contracted patients who will come to the hospital, a contract with a foreign purchaser virtually ensures that extra patients and therefore extra funding will be directed to the hospital. In this sense, contracting provides a guarantee which the E112 procedure by definition cannot. Having formal agreements with purchasers also simplifies and systematizes administrative procedures as well as ensures that hospitals will be correctly and promptly paid for the care they deliver, something which is not always the case when admitting patients paying out-of-pocket. As several Belgian hospitals explained, if a privately insured Dutch patient from a non-contracted insurer seeks treatment in the hospital, it must make a pre-calculation of costs and send it to the insurer, who must grant authorization. If the insurer agrees to pay the treatment, the patient comes to the hospital with a proof that they are insured. The administrative procedure takes time and means extra work for the hospital's financial department. Yet if foreign patients decide to come and pay for themselves, the hospital sends the bill directly to the patients but must very often chase the money, which also represents extra workload.

As one hospital doctor said, speaking about the hospital's involvement in the NHS overseas scheme, it was clearly for the financial gain that both the hospital and the doctors were interested in treating English patients – without it they would not have taken part in the programme, as it did constitute extra work and effort for all. The payments from the GST constituted not just a source of additional income but also an immediate source of extra funding.

These advantages related to contracting may give more security and make planning easier for hospitals. Yet, hospitals are also aware of the possibility that patient flows might decrease when waiting lists in the Netherlands go down. Contracts are usually limited in time. Due to this, and to the fact that foreign patients do not contribute to investment costs, hospitals are willing to treat foreign patients as long as they fit into the available capacity. Hospitals are not willing to make investments specifically to treat Dutch patients, as this is too risky and most hospitals indicate the intention to limit the treatment of Dutch patients to the point where they reach full capacity. Counting on a stable in-flow of contracted patients also has its risks as will be explained in the next chapter.

Yet, incentives and interests also depend on the size, location, profile etc. of hospitals. As mentioned in chapter 4, Belgian hospitals can be regrouped according to their characteristics which also play a role in their motives for admitting foreign, contracted patients. Still, some incentives remain common to all the institutional providers.

Based on the interviews with hospital managers, three broad (and to some extent overlapping) categories of hospitals can be distinguished, each with a set of motivations:

- Large university hospitals are eager to offer highly specialized care. The Belgian system, with no hierarchical structure of hospital supply, allows all patients to have direct access to academic hospitals even for common pathologies. Furthermore, non-academic hospitals compete to treat highly specialized cases. In a context of oversupply of even university hospital beds, this implies that an important share of treatments in academic hospitals concern common pathologies (including non-complicated deliveries, for instance). These hospitals want to tighten up their academic profile by attracting academic pathologies across the borders. They are looking to use their high-level expertise and facilities to full potential by achieving optimal patient-mix of complicated cases and rare diseases. Extra patients who undergo specialized treatment contribute directly to the high fixed costs of technologically advanced equipment which the hospitals have invested in. Another important incentive for these hospitals and their doctors is reputation and prestige. Establishing themselves as centres of reference with European-wide recognition (in one or more fields) is an aim per se but also helps to attract patients from further away. Linked to this aspect is also the interest in participating in international networks with other leading hospitals. Academic hospitals also signal that patient mobility is strongly embedded in cross-border cooperation between medical doctors.

One academic hospital mentioned that the highly structured nature of the Dutch health care system was of particular importance to them, as it guarantees that only heavy pathologies are referred to their university centre – in contrast to the Belgian system.

- Smaller, provincial hospitals competing with each other to attract patients, either national patients who contribute to their yearly budget allocated by the health authorities, or foreign patients who provide a direct extra income. For these hospitals increasing turnover and improving occupation rates seem to be the most important drivers. Due to the abundance of hospital capacity in Belgium as well as the unique territorial and linguistic division of the country (a French-speaking Belgian patient will prefer to travel a long distance to go to a French-speaking hospital rather than crossing the linguistic border to go to a Dutch-speaking hospital a few kilometres away), some hospitals “on the periphery” are forced to look for patients beyond their natural catchment area, and this is where foreign patients become an attractive option.
- Border-region hospitals with long-established links with Dutch patients and insurers. Due to the geographical as well as cultural proximity between the Dutch region of Zeeuws-Vlaanderen and the Belgian regions of Oost-Vlaanderen and West-Vlaanderen, there is a tradition for Belgian hospitals in these regions to treat Zeeuws-Vlaanderen patients, who are not viewed as “foreign patients”. The cross-border flow of patients is seen as a natural occurrence. As one hospital expressed during an interview: “we don’t care which side of the border patients come from”.

BELGIAN DOCTORS

As mentioned in chapter 1, the Belgian system of remunerating doctors by fee-for-service means that doctors have a direct financial incentive to treat more patients and therefore also to attract foreign patients. This payment method clearly explains why several hospitals mention that the first contacts for attracting foreign patients were made by doctors rather than by the hospital managers.

In university hospitals, the incentive to admit foreign patients is more important for the hospitals, as they collect doctors’ fees and pay doctors a fixed, monthly salary.

Yet it is important to underline that the financial interests in treating foreign patients are not always the same for hospitals and for hospital doctors. While doctors in Belgium receive a fee-for-service for every medical act delivered to the patient they treat, hospitals are paid based on a global budget for investment costs, general costs and nursing staff. As this global budget is artificially subdivided into daily patient rates, the daily patient rates are average prices, and do not represent the actual cost. The different payment mechanisms for individual providers and institutional providers mean that the tariffs according to which hospitals are paid do not always cover the real costs for some complicated treatments. Interestingly, at least one Dutch insurer mentioned that there had been cases where Belgian hospital doctors contacted the insurer because they wished to set up cross-border contracts, but when the insurer then made contact with the relevant hospital board, the management did not want to contract. Another insurer mentioned how it had to withdraw a specific treatment from its contract with a Belgian hospital because the hospital surgeons would not agree to adhere to the official Belgian nomenclature, as the contract explicitly stated.

The fact that most Dutch patients are treated in Belgian hospitals for ambulatory care is also a sign that the financial incentives for the doctors are more important than the pecuniary incentives for the hospitals.

Doctors also have an incentive to increase the numbers of patients treated as a way to improve and maintain skills and expertise which are important for their career development. Furthermore, international recognition and cooperation links with colleagues abroad can be important motivations.

Strengthening expertise, experience and reputation is motivating for all hospitals and hospital doctors. All providers welcome the opportunity to expand know-how, whether in smaller hospitals which treat uncomplicated cases or in large, academic hospitals which are eager to take on rare diseases. This was in particular a reason mentioned in relation with the NHS patients, as operating on more patients means acquiring more experience for orthopaedists, which is important for their future career, as the number of patients operated on is stated on their CV. Studies have shown that outcomes of knee and hip replacements improve as the volume of operations a

surgeon has carried out increases. And, clearly, hospitals as institutions also gain reputation by having skilled and renowned doctors.

Hospital financing and incentives of Belgian hospitals⁹⁵

Hospital financing in Belgium is based on a global, closed budget for the whole country. Public and private not-for-profit hospitals are all managed according to the same principles, and an increase in one hospital's budget will be compensated in the global budget by a decrease in the resources allocated to the other hospitals.

Each hospital's budget allowance is fixed by the Federal Public Service of Health. Financing is dynamic based on hospital activity.

For each hospital budget there is a fixed and a variable part. The total budget is calculated on the basis of the number of "ZIV" patients (i.e. patients covered by the Belgian health insurance system, ca. 97% in which E 112 patients are included) and non-ZIV patients (patients external to the national system, ca. 3% in which foreign contracted or private patients are included). This global budget for the hospital is then artificially divided into daily patient rates, which are an average of the costs of that hospital, but do not reflect real costs.

Hospitals are allowed to treat foreign patients but are not allowed to exceed their fixed part of the budget. Any excess income will have to be paid back to the authorities. Hospitals may fill any surplus capacity and reach 100% of the fixed costs, but once they go above the limit it signals that they use non justified capacity.

According to an official in the Ministry of Health, foreign patients treated in Belgium can virtually be considered as commercial patients and are very much encouraging commercial behaviour in public and not-for-profit private hospitals ("hospitals are not motivated by altruism but by financial gains").

Reforms

Since 2002, financing reforms have gradually been introducing activity-related budgets to the hospital sector.

Furthermore, there are plans to change the financing system so that patients whose care is not funded through the compulsory health insurance system (including through 1408/71) will not be counted anymore in the hospital budget and will not be taken into account in the calculation of the justified activity of each hospital. Hospitals will thus have to pay the nursing staff who treat foreign patients from the extra income these patients generate. Yet this means that once a hospital has started treating foreign patients and is counting on them as a source of revenue to pay part of its fixed costs (e.g. nursing staff), it cannot suddenly stop. Providers can enjoy a quick win situation when they set out to admit foreigners but will on the other hand *have* to continue once they start or at least stop very gradually. The authorities are aware of the risk that hospitals might specialize in foreign patients. Also, several hospitals pointed out in the interviews that such a reform might be an incentive for the hospitals to treat foreign patients by priority.

3. Public authorities

There is a distinction to be made between launching the idea of direct contracting and promoting it on the one hand, and putting the contracts into practice on the other.

Public authorities in the "sending" countries have pushed forward the idea of cross-border arrangements by encouraging the players in the field, especially the purchasers, to set up the actual agreements (sometimes by way of experiment). The main drivers for pushing cross-border contracting were on the one hand linked to domestic supply shortages leading to waiting lists, and on the other hand linked to the ECJ rulings.

⁹⁵ Based on interview with Koen Schoonjans, Federal Public Service of Health

Waiting lists motivate health authorities to look for solutions abroad⁹⁶. Waiting lists are perceived as a failure of the national system to deliver health care to the population. Expanding capacity within the national system requires long-term planning, investments and time, while resorting to care abroad can have immediate results. The use of foreign health care expands the accessible volume of care.

Furthermore, according to the rulings of the European Court of Justice, health care systems that are unable to provide the necessary care to their populations “without undue delay” have to offer patients the possibility of being treated abroad. Contracting with foreign providers makes it possible for purchasers to control patient flows as well as the quantity, quality and type of care provided in other Members States. Both the English and Dutch cross-border contractual arrangements have been put in place as a result of the ECJ rulings.

The fact that the OZ was encouraged by the Dutch public authorities to experiment with direct contracting with Belgian hospitals following the Kohll and Decker rulings illustrates the role of the authorities. The NHS overseas programme also had clear political backing.

The Dutch public authorities responsible for supervising sickness funds affirm to have a positive attitude towards cross-border contracting as it sees it as a practical solution and a logical arrangement, especially in border regions. Also, it is preferable from a financial point of view as cross-border contracted care does not lead to an increase in sickness funds' expenses and can lead to increased competition between hospitals as there are more providers on the market. The CVZ is of the general opinion that cross-border contracting should be encouraged, but is also aware that the reasons behind it (mainly waiting lists) are due to problems in the national system, and that instead of solving these, players just go abroad in looking for solutions, which amounts to exporting the country's problems⁹⁷.

Discussions between the UK Department of Health and the Belgian Health Minister over the framework agreement were initiated partly by the Belgian authorities when they became aware of the London Patient Choice's interest in contracting with Belgian hospitals. The Belgian Health Minister was eager to ensure that the cross-border contracts would not be to the detriment of Belgian patients by resulting in waiting times for the local population (“Belgium is prepared to receive NHS patients... within the limits of available spare capacity” and “contracts should explicitly require that NHS patients do not receive priority over people insured under Belgian legislation”⁹⁸) or by hospitals charging higher prices when treating English patients (“The NHS Lead Commissioners... will pay for the cost of treating NHS patients in accordance with the relevant Belgium tariff prices”⁹⁹). The English authorities also had an interest in ensuring that Belgian providers would not charge higher prices to English patients. The common framework agreement was signed on 3rd February 2003.

4. The middleman: The CM

The Belgian sickness fund CM plays a key role in the cross-border contracts between two Dutch sickness funds (OZ and CZ) and Belgian hospitals. By taking part in the agreements as a third signing party, it provides administrative assistance to its Dutch partners and, crucially, it checks the invoices of the Belgian hospitals before forwarding the bills to the insurers, who pay the hospitals directly.

According to the CM, there is much better information on and better control of the situation when cross-border health care happens through contracts, as these also cover privately insured Dutch patients (not covered by the E112 scheme) which would otherwise cross the border unnoticed. Furthermore, official Belgian tariffs are always respected in contracts where the CM participates. Dutch private insurers attempt to apply “package pricing” when contracting with Belgian hospitals and there is a risk of such practices becoming more widespread if the CM is not involved as a third party. Also, according to the CM, Dutch private insurers are more inclined to practise “block purchasing” in terms of fixing numbers of how many patients will be treated in Belgian hospitals. The contracts the CM takes part in do not fix the number of patients but rather define the duration of the cooperation. As such,

⁹⁶ See also CVZ, 2002: 13

⁹⁷ Interview with the CVZ, Amsterdam, 9 November 2004.

⁹⁸ A Framework for Cross-border Patient Mobility and Exchange of Experience in the Field of health care between Belgium and England

⁹⁹ Op. cit.

the CM considers that it guards the social aspect of the Belgian system, while at the same time encouraging mobility.

Furthermore, some elements of competition between Belgian sickness funds were introduced in the 1990s and funds must bear a part of their expenditures. Yet, sickness funds do not currently have many instruments to control costs, as they have to reimburse all care provided to their affiliates at tariffs set at national level and provided by all registered providers. Some sickness funds hope to be given tools in the future to control their costs, such as the possibility of concluding contracts with selected providers. We assume that the CM, by being involved in cross-border contracting, tries to anticipate potential reforms and establish preferential relationships with Belgian providers. The fact that the CM played a key role in the selection of Belgian hospitals by the Dutch insurers and made the first contacts with the hospitals to check their willingness to cooperate, confirms this assumption.

Being in a position to keep an eye on in-flows of foreign patients can be advantageous to avoid the emergence of waiting lists for its own affiliates and to prevent upward pressures on Belgian prices.

On the international scene, cross-border cooperation between sickness funds also creates preferred relationships. This can mean comparative advantages for the sickness funds involved when they want to offer services to their members for care abroad. It could also lead to the creation of international chains of sickness funds and cooperation to offer supplementary health insurance to their members. In this context, cross-border contracting can be a strategy for national and international positioning in the changing landscape of health insurers involved in public schemes.

5. The patients

5.1 Dutch patients

Reasons why Dutch patients go to Belgium – Need vs. Preferences

As mentioned earlier, several types of mobile patients can be identified:

- People living in the border-region who go to Belgium because it is close (even sometimes closer than Dutch hospitals) and because they are familiar with the neighbouring country
- People living in three southern provinces of the Netherlands – Zeeland, Brabant and Limburg – who feel closer to the Belgian Dutch-speaking regions than do the people of the Dutch provinces north of the “Moerdijk”, which culturally separates the Netherlands into a northern and a southern part
- People in Zeeuws-Vlaanderen who go to Belgium because of local lack of hospitals for specific care
- People who have had previous positive experiences with Belgian health care
- People who go to Belgium because of waiting lists, also living in the “rest of the country”. These patients seem to come mainly for elective surgical treatment such as orthopaedic or ophthalmologic surgery

Some of these “types” are clearly overlapping as patients are likely to go to Belgium for several reasons and not just one. Furthermore, one sickness fund noted that while patients in the beginning went to Belgium because of long waiting lists, they then continued to prefer Belgian providers because of very positive experiences – even after waiting times decreased “at home”. This example illustrates how in some cases, medical *need* coupled with waiting lists “force” patients to go abroad, while in other circumstances, patients follow their preferences and cross the border “voluntarily” because they have become used to the foreign provider and choose to be treated there. As for the OZ, it should be noted that the many OZ members going to Belgium are older patients often with co-morbidities and severe illnesses, due to the sickness fund’s strategy of keeping uncomplicated cases “at home” to protect the local hospital.

Satisfaction rates

- Achmea carried out a satisfaction survey covering a one-year period between 2003 and 2004; approx. 150 Dutch patients treated either in AZ Sint-Jan (Bruges) or Gezondheidszorg Oostkust (Knokke-Heist) were asked whether they were satisfied with their treatment. Patients had either undergone coronary bypass operations, or had received hip, knee or back surgery. According to Achmea, of the approx. 60% of patients who answered the questionnaire, 80% reported to be "very satisfied" with the care they received. People are particularly satisfied with the patient-oriented attitudes of doctors and nurses in Belgium, whereas in the Netherlands they feel like a number. On the other hand, the "weak" point is Belgian hospital rooms, which Dutch patients think are small and old-fashioned.
- Other Dutch sickness funds state that they implicitly know that their members are very satisfied with Belgian care simply because they go back to Belgium and even expect to have free access to Belgian hospitals, despite them being on the other side of the border.

It should be mentioned that the above information on Dutch patients is based on the interviews carried out with the Dutch insurers and not with patients themselves. The views of Dutch patients will become clearer with the results of the patient survey carried out in early 2005.

5.2 English patients

As the cross-border flow of English patients was taking place within clearly defined structures and *only* patients on waiting lists were offered the overseas option, the number one reason for NHS patients going to Belgium was to reduce the time they had to wait until they could be operated on.

Before, most patients would be referred to a hospital by their local GP and wait on the waiting list until they were treated, as they had little choice. London Patient Choice gave more options to waiting list patients by offering the choice of going to another hospital in London, to a private hospital in London or to a foreign provider.

Satisfaction surveys

According to the GST, there have been very positive results from English patients treated in Belgian hospitals:

- 99% of English patients declared that the whole overseas experience was either "good" or "excellent" and the item they were least satisfied with were the meals which "only" scored 72% of satisfaction (NHS survey). The GST routinely carries out surveys.
- Sample of quotes from the GST surveys suggest that patients were particularly happy and relieved to be treated.

Several Belgian hospitals also mentioned that NHS patients had an attitude of gratefulness when being treated and that some former patients even visited the hospitals and doctors afterwards, while others sent cards, sweets etc to express their appreciation to the medical teams.

CHAPTER 6: ENHANCING AND HINDERING FACTORS FOR PATIENT MOBILITY

In this chapter we look at some factors which are likely to have an impact on patient mobility. The attitudes of domestic providers, of patients, the level at which cross-border arrangements are initiated and the characteristics of the borders, all directly influence patient mobility.

1. Managing pre- and post treatment

On the whole, hospitals do not have specific provisions concerning pre- and post treatment care 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 centre. The situation seems somewhat different for hospitals working with OZ, which sends more complicated pathologies needing more advanced follow-up care to Belgium. In this case, arrangements are made with the Dutch social service at an early stage.

Some hospitals do mention that patients can encounter problems obtaining the prescribed pharmaceutical products in the domestic pharmacies, as they are not available under the same name and the same form.

2. Accompanying patients abroad

Treating English patients was greatly facilitated by the Euro-PALS liaison officers, who hospitals agree did a very good job in:

- picking up the patients in London and accompanying them to the Belgian hospital
- ensuring the patients felt comfortable and translating everything as necessary
- always being available in case of problems, e.g. with the family

3. Bureaucratic procedures

According to Belgian hospitals participating in the NHS scheme, there were only a few difficulties in the actual treatment of English patients, yet the administrative phase of setting up the contracts was a very drawn-out and demanding process.

Negotiations and contracting

Hospitals agreed that negotiations were very long, formal and technical, and the outcome was extremely detailed. There were also cultural differences, as the Belgians found the British approach very rigid. According to one hospital manager, Belgians have an attitude of not finding it necessary to wait for the administrative details if the practical elements are in place to start cooperation, and consider a verbal agreement to be enough to launch projects which have clear advantages for all. It required both time and effort from the hospital, and it was difficult to keep surgeons and management interested in a project that took more than a year to draw up and even longer before seeing any clear outcomes.

Another hospital doctor directly involved with the overseas scheme mentioned the following difficulties and disappointments:

- difficult to organize and coordinate the work in practice as a routine could not be established, partly because so few patients came, contrary to expectations, partly because of recurrent changes made to pre-arranged dates and meetings
- English GPs reluctant to cooperate
- time-consuming cooperation requiring important coordination efforts

- after one year of negotiations and heavy administration in starting up the programme, the extra effort was not rewarded
- yet, the doctor estimates that the hospital negotiated the package price well and therefore did not lose any money due to investments and few English patients

The disappointing experiences in lengthy and costly negotiations with the NHS, not leading to an actual contract, made some hospitals less willing to participate in new cross-border arrangements, according to a sickness fund spokesperson.

Unsuccessful stories like these might make hospitals consider cross-border contracting too risky and not worth the effort.

4. Cross-border contracting – an unforeseeable business?

Several Dutch insurers have said that they expect to review their Belgian contracts following the introduction of the DTCs, in particular to see whether Belgian tariffs become higher compared to the Dutch package prices. This implies that changes to the Dutch health care system can influence the volumes of patient flows going to Belgium. This in turn has repercussions for the Belgian hospitals as it becomes questionable to what extent they can count on stable influx of foreign patients coming via contracting and it means that planning becomes more uncertain and therefore more risky.

Belgian hospitals voiced clear awareness that patient flows from the Netherlands might decrease considerably once waiting lists were resolved. Therefore, they clearly did not want to become dependent on the treatment of Dutch patients and wanted to limit the share of Dutch patients in their clientele.

One hospital manager, having contracted with the NHS, said the hospital would probably not have participated in the project had it known that it would only be for one to two years and that it would only involve 160 patients, as such a big effort was put into a complicated contract. When the GST explained the programme to the hospital, they presented figures showing that there were around 20,000 people on waiting lists for knee and hip operations, giving the impression that the flow of English patients to the hospital would involve very significant numbers and would carry on for years. Yet, the GST themselves seem to be disappointed by the small numbers as they too expected more and have set up a big organization, employed Euro-PALs etc.

The last English patients were operated on in September 2004, which means that the programme remained “active” for just 16 months.

In January 2005, the GST said that the programme had stopped “temporarily” because of financing problems (as the budget had ended). Yet, according to one Belgian hospital, there were clear signs that the scheme was completely over as the GST terminated all the contracts with the Euro-PALs from December 2004/January 2005 and the last NHS patients came to the hospital in question in July 2004, even though the contract carried on until 2007. Indeed since then, in June 2005, the overseas programme was formally ended.

Another hospital having treated English patients mentioned disappointment in the fact that after one year of negotiations and all the work put into setting up the programme (making introduction videos for the patients, translations...) the extra effort was not rewarded. Despite the very convincing arguments from the GST that the hospital could count on having English patients for “at least six to seven years” and could expect to have hundreds and hundreds of NHS patients, only few patients came. From the beginning the hospital said that it could treat a maximum of four English patients per week or per 10 days. GST argued this was too few, but in the end there has been an average of only 2.5 patients per week. The hospital was considering expanding the infrastructure of the hospital considerably, but luckily did not do so.

5. Lack of cooperation from domestic providers

It should be pointed out that the following analysis is based on interviews with Dutch insurers, the GST, Belgian hospitals and experts and *not* with the domestic providers themselves.

While cross-border competition may lead to a conscious effort by national providers to improve their services, it might also make them want to keep patients "at home". There have been accounts of domestic providers' unwillingness to cooperate, which could signal that they feel threatened by cross-border competition.

In the Dutch and English systems, there are no financial disincentives for doctors or hospitals to send patients abroad. Yet when contracting abroad, purchasers' money goes to foreign hospitals instead of remaining in the national system – something that domestic providers see in a bad light. At the same time, however, when a patient is sent abroad, it "liberates" the system and the domestic hospital can take in other patients faster. In this sense, cross-border health care has the effect of expanding the total volume of care consumed by Dutch and English patients. This might be less of a problem so long as waiting lists exist, but could have adverse consequences for domestic providers if waiting lists go down and they have capacity which is not fully used if people continue to go abroad.

Refusing referrals or after-care

In its report "*Contracting abroad*", the Dutch association of health insurers points out that one of the reasons why the demand for foreign treatment is lagging behind the supply of foreign care are the hindrances caused partly by the national providers who would rather see insurers' money being invested within the Dutch system than streaming out of the country, and consequently view their "colleagues" abroad as competitors. In some cases, this attitude of rivalry even amounts to direct obstruction by refusing to hand over patient files to the foreign providers¹⁰⁰. This obstacle to patient mobility has also been underlined by some of the interviewed Belgian hospitals, who complain about the reluctance of Dutch GPs to send patients abroad, but less so in the border-regions. The Dutch sickness funds also mention how some doctors are reluctant to refer patients abroad and to give after-care to patients coming back after being treated in Belgium, in particular specialists working in hospitals or GPs with close links and "referral relations" to these specialists. On the other hand, both Belgian hospitals and Dutch insurers have pointed out that most Dutch GPs were cooperative and supportive of cross-border mobility, especially in the border-regions and in the face of long waiting lists.

Yet, one sickness fund, the VGZ, illustrated how Dutch providers' reluctance or even refusal to provide after-care could have negative, even devastating, consequences for patients and their families. According to Dutch insurers, domestic providers use the risk of hospital infection (Belgian hospitals have higher MRSA rates than Dutch institutions) as an argument for not giving follow-up care to patients treated in Belgium.

According to the VGZ¹⁰¹, this was especially a problem for seriously ill patients, such as cancer patients, who in the early stages of their illness were following radiotherapy in Brussels or in Leuven, but as they got weaker in the final phases and needed actual hospitalization (and not just check-ups) closer to home, Dutch hospitals refused to treat them because of – according to the VGZ – exaggerated fears of MRSA. The Dutch hospitals used the argument about infections as a pretext by saying they did not have enough room or staff to isolate patients as is required by the MRSA protocol. In several cases, the terminally ill patients died in the Belgian hospitals while their relatives were in the Netherlands.

Still, according to the same Dutch insurer, the problem also occurs with minor treatments when patients a couple of weeks after being treated in Belgium visit their GP or another doctor, who automatically react as if patients are infected, which has an intimidating effect on patients. With free access to cross-border extra-mural care such unhelpful attitudes could mean that Dutch patients will just avoid going to Dutch doctors and only seek medical help in Belgium if they are satisfied there.

Although doctors see sending patients abroad "as a loss of income" – which is strange in a budgetary system – there is no financial disincentive for doctors or for hospitals to send patients abroad. Yet, several other factors do contribute to Dutch providers' reluctance to send people to Belgium¹⁰²:

¹⁰⁰ M.J.G Smeets, I. Bruinsma and G. Straetmans, '*Contracting abroad*' (*Contracteren in het buitenland*), ZN Report, 25 June 2002.

¹⁰¹ Interview with two representatives of the VGZ, 29 November 2004

¹⁰² Interview with Dr Brouwer, Erasmus University Rotterdam, 4 November 2004

- Ignorance - "they have no idea about the quality of care in other countries". If doctors are better informed, they will see "it's not the jungle across the border"
- Fear - "what if they had these nasty hospital bacteria in Belgium and they brought it with them?"
- Myths - "mumbo-jumbo stories"
- Feeling of obligation to care well for their patients (professional oath) and "if we send them abroad we have no idea whether or not they will get good quality care" - "fundamental professional distrust"
- Sense of responsibility from doctors
- Distrust of Belgian hospitals because of supplier-induced demand: that hospital doctors might perform unnecessary treatments or operations just because it is lucrative

Increasing referring doctors' knowledge about the possibilities and arrangements of cross-border care would result in much more fluent flows of patients across the borders¹⁰³. Patients trust their GP/specialist more than anyone else (insurer, family, friends...) so although they are free to choose where they want to be treated (as long as the provider is contracted), more people would move if their doctors referred them to Belgian hospitals. The case in Zeeuws-Vlaanderen is an illustration of the importance of information, as referring doctors were more knowledgeable about treatment options in Belgium and patient flows became more fluent as a result¹⁰⁴.

Difficult cooperation with NHS providers

The key role of national providers as referrers on the one hand, and their sometimes unhelpful attitudes on the other, was also pointed out by Belgian hospitals treating NHS patients. Lack of cooperation from national providers has been one of the negative points most often mentioned by Belgian hospitals participating in the overseas programme.

One Belgian hospital described how there had been a clearly unfriendly attitude, even "hostility", from orthopaedists at one of its two buddy hospitals towards the overseas project and the Belgian buddy-hospital. When the Belgian team went to the London Trust for pre-and post-surgery clinics, they never met the orthopaedic surgeons (only once did they meet the head of the orthopaedic department), and Belgian surgeons were unable to get in touch with their buddy colleagues (it should be mentioned that there is nothing stated in the contract on how often buddy doctors should meet).

According to the same hospital, the GST underestimated that the signing of referral letters – stating they were handing over responsibility of "their" patients to doctors of the Belgian hospital – by the UK specialists could be an obstacle. There had been cases in the same London hospital where the head of the orthopaedic department refused to sign these referral letters for patients to go overseas.

Paradoxically (or perhaps not), the Belgian hospital manager interviewed had the feeling that the happier the patients were with their Belgian treatment, the more sceptical the London buddy doctors were. In this sense, it is noteworthy how high satisfaction rates of patients going abroad can make local doctors even more adverse, as it becomes a matter of professional and personal pride to refer or keep patients, and foreign doctors are then seen as rivals.

In contrast, the head of the orthopaedic department from the other Hospital Trust the Belgian hospital was buddied with, always made an effort to meet with the Belgian team and was very correct. Belgian doctors could also call their peers at this hospital if they had any questions.

Furthermore, management teams and nurses were easier to cooperate and communicate with at both Trusts.

Mild sabotage?

An illustration voiced by a Belgian hospital manager of the unwelcoming attitude in one NHS hospital:

Reluctance in the resolutely uncooperative London hospital did not just amount to hindering referrals and minimizing buddy communication, it went as far as effectively obstructing the work of the Belgian medical team,

¹⁰³ Ibid.

¹⁰⁴ Ibid.

which complained that it could sometimes be difficult to schedule an appointment at the Trust. Apparently, there were no consultation rooms available for the Belgian team to carry out the overseas assessment clinics, as all rooms were fully booked.

When the Belgian Lead Commissioner and doctors came to the Trust to do the out-clinics, both pre-surgery to select patients and post-operation to check on patients' progress, the Belgian team was given one of the least equipped rooms in one of the hospital's oldest wards (which seemed to be a storage area for unused items). There was a very old bed in the room, but no desk and no chairs (for patients suffering from hip and knee problems!). They had to arrange themselves for there to be a desk for the doctors, while two old chairs were eventually found elsewhere and brought into the room. After the initial shock when the Belgian team entered the Spartan room (the hospital manager even regrets not bringing his camera with him), they understood that if they started complaining about such "details", the cooperation between them and the London hospital would never work, so they made do with what they had. Moreover, they met no-one from the hospital except for one nurse, so they were not only relegated to the oldest ward, but were also thoroughly isolated.

The same hospital manager argued that, in general, if the communication had been better between English and Belgian doctors, the whole programme would have worked better (and had more success) for the patients too, as a good understanding between doctors means that any problems after the operation are more easily remedied.

The official explanation from the GST for the patient flows to Belgian contracted hospitals stopping is that the budget of the London Patient Choice for the overseas programme ran out and that more capacity became available locally in London. According to a Belgian hospital, there could also be a national pride factor as the UK Prime Minister and the Secretary of Health saw it as shameful that the country had to send patients abroad.

6. Price calculations

The Belgian daily patient rate, which Belgian hospitals charge Dutch insurers, does not reflect the real costs for the hospital. On the one hand, prices only partially cover investment costs. This does not constitute a problem for hospitals as long as only spare capacity is used for foreign patients. It is however a clear incentive for foreign insurers to give preference to Belgian providers over domestic providers.

On the other hand, the daily patient rate is an artificial price, based on the average cost and the pathology mix of the hospital in question. This means that for some patients real cost is higher and for others it is lower. In the Belgian context these patient categories keep each other in balance. Yet in a context of cross-border contracting, this price calculation can be an incentive for hospitals to select only treatments which are profitable to them. Indeed, some hospitals refuse to provide complicated surgery in their cooperation with Dutch insurers and are in this way effectively hindering patient mobility.

7. Patients' trade-off between waiting times and familiarity

The cross-border patient flows are closely linked to the existence of waiting lists in the Netherlands. This is clearly expressed by all the stakeholders interviewed. Nonetheless, as mentioned in chapter 3, numbers of Dutch patients treated in Belgium through contracted care remain relatively marginal, although there is an important increase over time. Two of the Dutch insurance funds find that fewer patients than expected are going to Belgium via the contracts (constituting a difficulty and disappointment for the insurers), while thousands of members from the other two funds flow into Belgium every year. While the two former insurers attribute the feeble mobility to ignorance about cross-border options through contracting, the two latter sickness funds attribute their members' mobility to habit as well as cultural and geographical proximity with Belgium. Furthermore, it should be remembered how dependent patient mobility is on doctors' willingness to refer abroad, especially in a context of rigid referral system. Referrers can to a large extent control patient flows; the more familiar referring doctors are with cross-border contracts and the foreign health care systems, the more likely they are to refer patients abroad. Also in the NHS experience, fewer patients than expected accepted the offer of overseas treatment, getting local doctors involved was problematic and the entire scheme was ended prematurely.

According to a Dutch expert, it can be argued that there is a contrast between revealed and stated preferences: when asked, people say that waiting lists are the biggest problem of the Dutch system, but if they are offered the

option of going abroad instead of waiting, they are reluctant to actually agree to go and be treated in another region, let alone another country¹⁰⁵.

Yet, it is questionable whether it is not only an apparent contradiction between complaints about waiting times and reluctance to go abroad. The two are not fundamentally incompatible. Going abroad for health care can be hard to accept for people because of fears, uncertainties, ignorance etc. related to going abroad.

People are reluctant to travel within the Netherlands and even more to go abroad because of what could be called "mental barriers": jokes about Belgians, mistrust, cultural misconceptions, "myths" e.g. about German doctors from WWII films, practical concerns e.g. on after-care and what will happen after the operation. There is a trade-off between waiting and going abroad – the dilemma of should I stay or should I go?¹⁰⁶ – most people choose to stay and wait rather than travel abroad, which shows that waiting lists actually are not as problematic as stated as "all the uncertainties concerning cross-border care lead people to stay in the situation that they at least know"¹⁰⁷.

Furthermore there is a traditional factor. Dutch people are not accustomed to having an active role in health care, but are rather guided through the health care system, "the GP will guide me to a specialist and the specialist will guide me to a better health and I will just follow this pathway". Another problem is the rigid referral system of GPs as they always refer to the same specialists they know well, are reluctant to change their practices and do not want to refer to doctors they do not know. "There is a very rigid flow and if people are in that flow, they will not make active choices in order to change it"¹⁰⁸. Yet, when people do go abroad, they are very satisfied with the care they receive.

Numbers of people going abroad for health care remain limited and could be expected to stabilize or decrease as the Dutch system is changing and waiting times are expected to decrease. According to the expert, if waiting times continue to go down the "typical Dutch patient" will have less of an incentive to go abroad, assuming that waiting times are the biggest motivation for people to travel for health care. Belgian hospitals also expressed awareness that patient flows to Belgium might dry out when waiting times go down and they are consequently reluctant to undertake investment costs specifically to treat Dutch patients. The fact that most of the contracts are limited in the time is also an indication that Belgian hospitals might not count on flows of Dutch patients "forever".

8. Bottom-up vs. top-down

It is interesting to notice the differences in how the Dutch and the NHS contractual arrangements were initiated. Although political support in favour of cross-border contracting was decisive in both countries in the initial "deliberation phases", the direct involvement in the "implementation phases" of grass-root level Dutch and Belgian players – already experienced in cross-border cooperation and with a clear interest in strengthening it – gives a bottom-up quality to the Dutch contracting. The distinction is not just between bottom-up and top-down, but also between the decision-making phases and the stages in which the cross-border arrangements are being constructed and put into place.

The fact that the actual contracts were set up by Dutch and Belgian local purchasers and providers can perhaps explain why these contracts have been well-functioning and are perceived to be successful by the participants. In contrast, it could be argued that the lack of involvement of local NHS providers in constructing the contracts, instead having unfamiliar contractual arrangements being "imposed" upon them (whereas contracts are a key feature in the Dutch system), coupled with the more top-down and centralized character of the NHS, could explain the lukewarm reception of the cross-border cooperation. Furthermore, participating in the overseas treatment scheme could have a somewhat negative aspect for NHS hospitals as it was associated with meeting government targets on waiting times and thus with being officially assessed. The difficulty in getting English doctors to accept the concept of sending patients abroad for treatment and to get them "positively involved" in the

¹⁰⁵ Ibid.

¹⁰⁶ W. Brouwer et al., *'Should I stay or should I go? Waiting lists and cross-border care in The Netherlands'*, Health Policy 63 (2003)

¹⁰⁷ Interview with Dr Brouwer, Erasmus University Rotterdam, 4 November 2004

¹⁰⁸ Ibid.

overseas scheme was also acknowledged by the GST in a contract monitoring meeting with a Belgian hospital in early 2004¹⁰⁹.

9. Fluid vs. rigid borders¹¹⁰

The stark difference between the Belgian-Dutch border and the Belgian-English border should also be underlined. Several stakeholders have expressed that the flows of Dutch patients are to a large extent a “natural” or spontaneous phenomenon, not just motivated by waiting lists, because of the geographical, linguistic and to some extent socio-cultural proximity between Flanders, the Northern part of Belgium, and the southern part of the Netherlands. Because of these characteristics of closeness, the border between the two countries can be seen as “fluid”, i.e. allowing easy and unhindered exchanges and flows of people, economic activities, services, ideas, cooperation initiatives etc. This sort of proximity does not exist to the same extent across the Belgian-English border, firstly because the two countries are much more physically separated by The Channel, but also because the languages differ. This border constitutes a more real separation and could therefore be characterized as rigid.

¹⁰⁹ Minutes of Contract Monitoring Meeting between the GST and UZ Gent, 20 January 2004

¹¹⁰ For more details on fluid and rigid borders, please see the Literature Review (Work Package 3) of the Europe for Patients project

CHAPTER 7: IMPLICATIONS OF CROSS-BORDER CONTRACTING: OPPORTUNITIES VS. RISKS

What follows is an overview of the possible implications of patient mobility and cross-border contracting for the systems sending patients abroad and for the system receiving foreign patients.

Our research suggests that the implications of cross-border contracting can differ depending on which perspective one considers, i.e. that of providers, purchasers, patients, public authorities or of the health care systems in general. Yet, as the cross-border arrangements have several, simultaneous effects, these will not be regrouped by stakeholder but rather looked at by theme.

1. Implications for the “exporting” system

1.1 Opportunities for patients

Cross-border contracting can provide extra treatment opportunities for patients by allowing them to be treated close to home, on the other side of the border. It makes it possible to offer medical care which is not available or is only accessible at long distances in the home country, and/or to offer treatment in centres of excellence.

1.2 Better performance due to increased competition

Introducing competition among insurers in a situation of insufficient providers is unlikely to increase efficiency in the health care sector; instead it tends to reinforce providers in their monopolistic behaviour and their position of power when negotiating with purchasers¹¹¹. In a situation of limited supply of care, competing insurers might try to enlarge the pool of providers by contracting abroad when there are not enough national providers. Lack of supply *within* the health care system is effectively circumvented by resorting to supply from *outside*.

In the Dutch context, the combination of restricted supply (resulting in waiting lists) and insurers' duty to deliver care, means that sickness funds are forced to look abroad for a solution to limited access at home. As Gabrielle Demange and Pierre-Yves Geoffard explain, one of the key conditions for competition among insurers to work (and for the competition to lead to increased efficiency) is that they have ways to influence the supply of care, in particular through the selective contracting of providers. Yet, “in the Netherlands the selection of providers proves to be impossible to put into practice because the supply of care is limited and strongly organized”¹¹².

Resorting to health care abroad introduces a competitive element to the national health care scene. When the option of going abroad for treatment exists, national providers become aware of the risk of losing patients as well as income and therefore have an incentive for improving by cutting prices or delivering better services. Cross-border competition, coupled with significant price differences, can put pressure on providers to lower prices to remain competitive and obtain contracts with sickness funds. As one expert put it, “competition in border regions might have a chain effect further into the country”¹¹³. If a Dutch border region hospital competes for a contract with a Belgian hospital with lower prices there is a certain domino-effect in terms of prices.

Cross-border competition and the concern of “losing” patients (which can have financial implications) can also motivate domestic providers to improve by delivering faster and better services to patients. Although it is very difficult, if not impossible, to prove the causal relationship between access to foreign health care and the concerted effort to improve, this tendency has been noticed by both the NHS Lead Commissioner and by sickness funds in the Netherlands. One Dutch insurer gave the example of a hospital in Breda, very close to the Belgian border and to several important Belgian hospitals, where waiting lists for heart surgery have decreased significantly (to a few weeks) compared to a hospital in Zwolle, which is in the middle of the Netherlands and where people are waiting six months.

¹¹¹ Gabrielle Demange and Pierre-Yves Geoffard, « A quoi peut servir la concurrence en assurance santé? » (<http://www.delta.ens.fr/demange/concurrence.pdf>). (free translation)

¹¹² Ibid.

¹¹³ Interview with Dr Brouwer, Erasmus University Rotterdam, 4 November 2004

Another Dutch sickness fund had clear indications that the local hospital was performing much better in terms of waiting lists, while also striving to become more patient-oriented, and was attributing this to the risk of an important out-flow of patients to Belgium if the local hospital did not offer improved services to the local population.

Similar to the Dutch accounts of increased work effort, the NHS Lead Commissioner noticed that in some hospitals, doctors were more prepared to work harder and do extra sessions after having heard the GST present the scheme for sending patients awaiting hip and knee surgery abroad. Furthermore, the explanation given by the Lead Commissioner from the NHS, in letters justifying the termination of the contracts with two Belgian hospitals in January 2004 after just six months of running and only 21 patients, was that the NHS was "in a position to be able to meet the government's waiting list targets for cardiac surgery", implying that hospitals and doctors had striven to tackle waiting lists. Indeed, no cardiac patients were treated in Belgium after October 2003, while the government targets came into force from March 2004.

1.3 Distortion of competition

Competition between providers across borders, coupled with significant price differences, can put pressure on providers to lower prices. Yet this would imply that the pricing systems in the countries are comparable. Many prices and tariffs in health care systems are variable costs and do not cover buildings, fixed costs or capital costs.

Foreign patients treated in Belgium do not pay for the facilities, capacity, education etc – they only use them and pay the variable costs. If different pricing systems have different cost components in the prices, tariffs become incomparable.

The same argument is expressed by Mr J. Carpay, director of the management board of the Academic Hospital Maastricht (NL) who speaks of "distortion of competition" in relation to the CZ contracting with Belgian hospitals which have tariffs 10-15% cheaper than in the Netherlands, due to the different methods in calculating prices. He argues that when patients go across the border, it impoverishes the Dutch health care system and that "Dutch patients in (...) Belgium effectively are subsidized by the (...) Belgian taxpayer". The CZ takes the criticism very seriously and defends itself by saying that they want to help patients as soon as possible and offer them the choice of where to go¹¹⁴.

With the new system of Diagnosis and Treatment Combinations (DTCs), striving to stay competitive might have even greater repercussions on prices. The introduction of DTCs is meant as a tool for Dutch providers to compete on prices when they negotiate contracts with health insurers. Yet in the cross-border setting, Belgian hospitals will also be considered as interesting contracting partners if they offer attractive deals at lower prices. Also, Dutch hospitals are likely to face even harsher competition in the future due to the gradual abolition of the contracting obligation. In the long run, a cross-border "price-war" could potentially have damaging consequences for quality of care, and ultimately for patients as health care consumers.

1.4 Circumventing cost containment mechanisms

For a system with supply shortages and no demand restrictions, opening the doors across the border to unlimited supply can have important implications. The possibility of accessing foreign care effectively neutralizes domestic supply restriction policies, expands the limits of national health care consumption and can have a significant impact on costs. There is a potential threat of both supply-induced demand and of demand-induced supply. In a cross-border context, one way to prevent this risk could be through the introduction of demand controls: while supply restrictions stop at the border, demand restrictions are mobile.

There are also indications that the Dutch gatekeeper system is being breached by patients going to Belgium, as Belgian specialists do not expect a referral letter and do not have any incentive to do so. Dutch patients formalize the situation on their return by retrospectively asking for a referral letter.

One study reveals that more examinations, scans and laboratory tests are invoiced for Dutch patients from the Zeeuws-Vlaanderen region treated in Belgium than for comparable patients treated in the Netherlands and that

¹¹⁴ Jan Beentjes, *De Volkskrant*, 17.08.2001

these tests, as judged by Dutch doctors, are often unnecessary. It also appears that some procedures have been carried out twice, once in the Netherlands and once in Belgium¹¹⁵. Several hospitals also signal that Dutch patients are coming to Belgian hospitals for a second opinion, something that might be even more problematic in a country with supply restrictions and waiting lists.

Dutch insurers especially fear supplier-induced demand associated with Belgian doctors as it is difficult to control providers in Belgium. The fact that at least one insurer includes in its Belgian contracts that only 10% of treatments may exceed a calculated average price, and that if costs exceed the average by more than 10%, then the insurer must give its prior agreement for the hospital to go ahead with the treatment, could be seen as a way to limit unnecessary procedures and supplier-induced demand.

In general, it can be difficult for foreign purchasers to control what goes on in health care systems of other countries where they buy cross-border care.

Expanding the limits of national health care consumption can have consequences in terms of rising costs and consequently also for the management of health care budgets.

According to Siciliani and Hurst, by increasing supply of health care through the use of foreign capacity there is a risk that demand for health care will simultaneously increase due to “feedback effects”: there are “feedback effects from waiting times to quantities demanded and supplied of elective surgery because waiting times act rather like prices do, helping to equilibrate demand and supply”¹¹⁶.

2. Implication for the “importing” system

2.1 Use of spare capacity

For the institutional providers of the receiving country, patient mobility can offer opportunities for using up spare capacity, which generates extra income for the providers involved to cover their fixed costs, but also opportunities to acquire and keep up with medical developments.

2.2 Upward pressure on prices

Foreign patients treated in Belgium are encouraging commercial behaviour in Belgian hospitals. Yet, when hospitals’ incentives to attract extra patients (and income) meet foreign purchasers’ interest in shopping for best deals, there could be a risk that hospitals start to favour foreign over national patients. This risk is accentuated if hospitals can charge higher prices when treating foreign patients and if foreign purchasers are willing to pay because the prices proposed by the Belgian hospitals remain lower than what they would have to pay “at home” – which is a realistic scenario in the Belgian-Dutch and Belgian-English cross-border context. According to the representative from the Dutch insurers’ organization, ZN, as long as the prices in Belgian hospitals are the same or lower than in the Netherlands, sickness funds will agree to contract with Belgian hospitals¹¹⁷.

So far, several cross-border contracts stipulate that only official Belgian tariffs may be charged, and there are no signs so far that Belgian hospitals are charging higher prices to Dutch insurers. Yet the risk remains.

If the application of the Belgian tariffs is safeguarded, it is due to two arrangements: on the one hand the bilateral agreement signed between Belgian and English public authorities on conditions for cross-border contracting, and on the other the involvement of a Belgian sickness fund as a third party in contracts between two Dutch health insurers and Belgian hospitals. Furthermore, the foreign health purchasers also have an interest in keeping prices down. Nevertheless, where a “guardian of the Belgian tariffs” (i.e. a Belgian public authority or sickness fund) is not involved, concern is well-founded as Belgian providers might try to charge higher tariffs. Especially in cases of long waiting lists, mounting dissatisfaction of affiliated members or when a hospital likely to be a new contracting partner is very close to the border, Dutch insurers would be more inclined to accept a decision by Belgian providers to increase prices. We did come across such cases, yet the involvement of a Belgian sickness fund, the CM, as a third contracting party, has prevented the Dutch insurer from accepting higher prices. In this way, the CM appears to play a key role as “guardian” of the Belgian system by ensuring that the official Belgian tariffs are

¹¹⁵ Visser, 2001: 55-58.

¹¹⁶ L. Siciliani and J. Hurst (2004). Op cit. P. 2

¹¹⁷ Interview with M. Smeets, Zorgverzekeraars Nederland. 3rd June 2004.

respected. The supervision of hospitals' behaviour serves the interest of Dutch insurers as they are charged the normal Belgian fees, but also protects the integrity of the Belgian system by ensuring that Dutch patients do not become preferred customers and that cross-border contracting does not create two parallel pricing systems in Belgium.

Two cases illustrating the influence of the CM and the risk of Dutch insurers paying more

According to the Dutch insurer CZ, its close cooperation with the CM means that it respects Belgian tariffs by not offering to pay hospitals more, and illustrates this with two examples.

In 2001, the CZ had been engaged in extensive negotiations with a Belgian hospital which failed, partly because several of the hospital's doctors refused to respect Belgian nomenclature on tariffs, instead asking for special fees to treat Dutch patients. This was unacceptable to the CZ and did not fit with its strategic cooperation with the CM, as they have agreed that Dutch patients should not be favoured customers over Belgian patients (the CM is very opposed to different tariffs for Dutch and Belgian patients). Furthermore, paying higher prices was against the demands of both the CVZ and the INAMI, who were looking over the CZ's shoulders to see what they were doing.

A second case occurred in 2002-03 when the CZ almost agreed to pay above the Belgian official tariffs for cardiac surgery as there were very long waiting lists in the Netherlands. The Belgian hospital in question wanted to make a contract with the CZ but at a higher price because the official tariff did not cover real costs. The CZ was prepared to accept the price, which was still cheaper than in the Netherlands, but did *not* conclude the contract as it was against the principles of cooperation with the CM. Furthermore, this incident coincided with the parliamentary discussion on foreign patients in Belgium, so the hospital retreated as it considered it too risky.

On the other hand, the CZ admits that it would like to have more flexibility to make deals offering more attractive prices. At the same time, it realizes that it does not fit within the principles of the Belgian system and that with the new system of Diagnosis and Treatments Combinations (DTCs), conflicts between the CZ's interests, the CM and the Belgian system are even more likely to arise in the future.

Yet such problems remain theoretical, as capacity is increasing in the Netherlands partly due to the new fee-for-service payment system with the DTCs. The CM's role as guarding the Belgian system might become even more important with the DTC system, which introduces free price-setting, as it could encourage Belgian hospitals to compete with Dutch hospitals on prices.

The VGZ has also experienced similar demands from Belgian hospitals: both its contracts include all treatments offered by the Belgian hospitals, with the exception of plastic surgery, which is excluded because the hospitals proposed tariffs different to the official nomenclature. The contracts state that Belgian tariffs must be adhered to and while the hospital management accepted this, the plastic surgeons did not.

2.3 Increasing waiting times

We did not find indications of increased waiting times for Belgian patients. However, it would be extremely difficult to ascertain increasing waiting times in the Belgian context, as there is no official registration and Belgian providers are highly unlikely to admit that they give priority to foreign patients. The data on Dutch patients show that foreign patients are concentrated in specific hospitals and specific hospital services, which signals that prudence is called for. Most hospitals state that they would limit the access for foreign patients when their spare capacity is used up. One hospital mentioned it had already limited the "foreign inflow" as it reached full capacity. Another hospital stated that it would not differentiate between domestic and foreign patients and that when it reached its maximum capacity, treatments for patients would be postponed irrespective of where they lived. Jorens et al. argue that the share of available capacity used for foreign patients should be controlled, as hospitals have so far failed to define what is desirable.¹¹⁸

¹¹⁸ Jorens *et al.*, 2005: 137.

2.4 Legal uncertainty and the involvement of public authorities

A concern for players involved in cross-border contracting between Dutch insurers and Belgian hospitals is that the arrangements are taking place in a legal no-man's-land. There is a clear demand from all involved stakeholders for more clarity and legal certainty about the practices they are involved in. A bilateral agreement between the two countries leaving enough flexibility for players to continue with the existing arrangements would be a possible solution. The Dutch Health Tariff Authority does not have a mandate to check foreign tariffs. The only control mechanism which is present in cross-border contracts is that tariffs cannot go beyond the Dutch maximum tariffs, which are controlled by the CvZ and which are defined by the Insurance Law¹¹⁹.

Furthermore, there is a certain paradox as the Belgian health authorities end up being the least informed stakeholder about a new practice taking place within its territory. Dutch authorities know more about Belgian hospital practices than do the Belgian authorities, because they have a mandate to check the contracts of the Dutch insurers which cover publicly insured people. On the other hand, the Belgian insurer CM also knows more than the Belgian authorities because it is a signing party in several cross-border contracts and controls all the invoices sent from Belgian hospitals to the Dutch purchasers it collaborates with. For obvious reasons, this information gap is of concern to the Belgian authorities and they have been searching for ways to oblige Belgian health care suppliers to provide them the necessary information.

2.5 Spill-over of reforms

With the planned Diagnosis and Treatment Combination system in the Netherlands, Dutch hospitals will offer "treatment packages" to insurers, specifying the exact care product and the different steps in the treatment process (e.g. the number of days patients are hospitalized, how operations are carried out, the after-care etc). This should allow insurers to better compare the content of the care they purchase as well as to understand what it is they are paying for. Furthermore, the system implies that insurers will have a say in how care is provided and what the composition of the "care products" will be.

With the DTCs, Dutch and Belgian tariff systems will become even more different (Belgian bills are very detailed containing all acts performed on the patient, whereas DTCs are based on one, inclusive "care product"). Yet this is not the only implication. In a cross-border setting, the new system might imply that Belgian providers also are forced to define such treatment packages – something which is unfamiliar to the Belgian system. This could require extensive administrative as well as logistical resources, and perhaps most importantly, could alter the relationship not just between purchasers and providers, but also between Belgian hospitals and Belgian hospital doctors. If a Belgian hospital agrees to contract with Dutch insurers based on DTCs, it would require the hospital's doctors to comply with the predefined care packages and partly give up their free choice of therapy. The potential impact of the DTCs highlights how a reform in country A can interfere with the practices of country B. With patient mobility, reforms do not necessarily stop at the border.

The question is what might Belgian hospitals be willing to do to remain attractive contracting partners for Dutch insurers? Provincial hospitals "on the periphery" in particular are more likely to accept unusual measures to please foreign purchasers, as they in some cases struggle to survive due to their limited catchment area.

2.6 Foreign patients, foreign procedures

Cross-border contracting can involve difficulties and risks as a result of price differences, different pricing systems, negotiation procedures etc. With patient mobility to Belgium, it is foreign patients *and* foreign procedures that enter the country. The sending countries (the Netherlands and England) are not just exporting their patients (and waiting list), but also the administrative procedures and schemes which allow their patients access to Belgian hospitals – and the more eager the Belgian providers are to treat foreign patients, the more willing they will be to accept unfamiliar arrangements, cumbersome as they might be.

The contracting with the NHS illustrated this point, as Belgian doctors agreed to be paid according to a different mechanism than the usual Belgian system, and agreed to follow very precise instructions on medical procedures

¹¹⁹ Ibid.

when treating NHS patients, something rather unusual, if not revolutionary, in Belgium where providers have free choice of therapy and staunchly protect this freedom. Paradoxically, Belgian health authorities would have great difficulty in convincing the collective bodies of Belgian doctors to accept anything similar.

Some hospitals also mentioned the attempts of a Dutch insurer, Achmea, to apply package prices and to have its say in the appointment of Belgian hospital doctors, as insurers do in the Netherlands. We did not find hospitals who said they had accepted these conditions, as they would not fit either in the relationship between Belgian hospital managers and hospital doctors nor in the Belgian balances of power between sickness funds and hospital boards. Nevertheless, as the contracts with the NHS show, hospitals and hospital doctors are willing to change these balances when the drivers to attract foreign patients are important enough.

The Belgian experience with cross-border contracting highlights the importance of supervising the practices of cross-border arrangements – not to hinder them, but to ensure that they do not result in procedures or agreements which could have unintended, unexpected adverse effects. Making sure that Belgian official tariffs are adhered to, that the official pricing system is not put at risk, and that hospitals do not give priority to foreign patients, is essential to safeguard the equity and sustainability of the Belgian system. Foreign purchasers cannot be expected to have these concerns in mind when contracting abroad. In the contracts with some of the Dutch insurers, it is the Belgian sickness fund CM, who acts as a “guardian”, while in the cooperation with the NHS, Belgian public authorities have protected the national system by building safeguards into the bilateral framework agreement signed with the UK health authorities. However, Belgian authorities do not have the instruments to enforce their involvement in channelling the cross-border flows and contracts. Only an EU-level engagement between Member States, with the public authorities of the sending and receiving country involved in the cross-border contracting of statutory bodies, could allow public authorities to monitor the developments and avoid lapses.

2.7 Introduction of new hospital culture

Being involved in cross-border contracting can introduce new procedures into hospital culture. One hospital signalled that they had to contact Dutch social services in a more systematic way and at an early stage before discharging a patient. The hospital signalled that this different way of working also had an impact on their attitudes toward discharge procedures for Belgian patients. Another hospital recruited a patient information person, because this was common in Dutch hospitals. This person could also be of benefit for Belgian patients. Such changes are interesting as they indicate how cross-border contracting can be a source of innovation.

CHAPTER 8: CONCLUSIONS AND TENTATIVE RECOMMENDATIONS

1. The Belgian experience of cross-border contracting

At the beginning of our case-study, we set out to find out what the context for purchasing foreign care is in the Netherlands and in England; what the extent and nature of purchasing Belgian hospital treatment is; what the drivers are for the stakeholders and what the potential impact might be for health care systems and the players.

We tried to shed some light on the extent of the phenomenon and found that although patient mobility to Belgium is relatively limited, it is increasing. Looking at statistical data from 2002 on hospital admissions of non-Belgian patients living in another EU Member State, we found that these admissions constitute a marginal 0.5% of total Belgian hospital admissions, while the largest in-flow came from the Netherlands, representing around 60% of non-Belgian patients. The data also showed that some 63% of foreign admissions took place in hospitals in the Flemish region. Figures on patient flows under the E112 scheme allowed comparisons between 1998 and 2003 and illustrated that the total numbers of E112 patients had more than doubled (from 10,773 to 22,333), while numbers of Dutch E112 patients had tripled (from 3,970 to 12,503). Data from the two Dutch sickness funds with the longest experience in contracting with Belgian hospitals (the OZ and CZ) showed that while around 3000 of their affiliates were treated in Belgian contracted hospitals in 2001, this number went up to almost 7,300 in 2004. These data from different sources confirm the sharply increasing, but still relatively marginal, volumes of foreign patients treated in Belgium. Yet figures from specific hospitals suggest that what appears to be a limited phenomenon across the country might be concentrated in specific hospital departments as, e.g. foreign patients represented 9.3% of one Belgian academic hospital's population in its surgical department.

As the direct cross-border contracts constitute rather new and unknown practices, it was important to explain how they work. Exploring the initial phases, we found that for Dutch contracting, pre-existing cooperation links in the cross-border regions between Belgium and the Netherlands were important for the creation of the new contracts. The NHS contracts in Belgium had been facilitated by an earlier pilot project, by the signing of a bilateral framework agreement between Belgium and England and by the creation of the London Patient Choice Project, which aimed at shortening waiting times and increasing choice for patients. Zooming in on the actual contractual arrangements, we identified four types of players:

- Foreign purchasers: four Dutch insurers and the NHS Lead Commissioner (i.e. the GST which contracts on behalf of four NHS Hospital Trusts) purchasing care in Belgium
- Belgian providers: hospitals and hospital doctors
- Public authorities of the two "sending" countries (the Netherlands and England) and of Belgium
- A middleman: a Belgian sickness fund, the CM, mediating between Dutch insurers and Belgian hospitals

The first Dutch contracts with Belgian hospitals started in the late 1990s. The contracts are based on an official "model contract" which is commonly used between purchasers and providers in the Netherlands. Dutch insurers have defined various evaluation procedures for selecting Belgian hospitals. While the cross-border contracts must respect the limits of the Dutch health care package, they vary, as some are comprehensive, including all treatments offered by the Belgian hospitals, while others are restricted, by limiting which treatments can be provided in Belgium. Patients can choose freely whether to be treated in Dutch or Belgian contracted hospitals and there is no difference in the referral system if a patient chooses to go to Belgium. On the medical side, Belgian standards apply and Belgian providers are not required to comply with Dutch norms. For Dutch insurers, prices and medical fees for treating Dutch patients are in accordance with Belgian tariffs. The Belgian sickness fund cooperates with two out of four Dutch insurers and ensures that the right tariffs are applied by Belgian hospitals when invoicing them. It should be mentioned that one Dutch insurer, OZ, employs a special hybrid system of contracting which combines the E112 procedure with direct contracts.

Contracts between the NHS and five Belgian hospitals were concluded in 2003, and covered hip and knee surgery. The selection and qualification processes of Belgian hospitals, as well as the contract negotiations, were particularly long and meticulous. The 21 annexes of the contracts defined all details of the treatments, the patient

pathways and the cooperation between hospitals. A “buddy system” was set up to facilitate collaboration between English and Belgian doctors but did not always work as hoped. Furthermore, non-medical liaison officers, Euro-PALs, were employed to assist patients. The contracts defined “package prices” which covered all cost components of the hip or knee surgery and were based on official Belgian tariffs.

To understand which drivers motivate stakeholders into taking part in patient mobility, we looked first at Dutch insurers. Waiting lists and increasingly competitive behaviour between insurers were key reasons for contracting abroad. Belgian hospitals appear as obvious contracting partners because of geographical and linguistic proximity, because millions of affiliates of the Dutch insurers live in the border regions close to Belgium and because Belgian health care prices tend to be 10% cheaper than in the Netherlands. As Dutch insurers export the contracting system they use “at home”, cooperating with Belgian hospitals is easy. For the NHS and the Hospital Trusts sending patients abroad, the concern to shorten waiting lists and meet government targets on waiting times were key drivers. Direct contracts were seen as the best way to ensure the quality and safety of care English patients would receive abroad. Belgian hospitals were chosen among other European providers mostly due to good travelling facilities from London. For both Dutch insurers and the NHS, cross-border contracts can also be seen as a way of putting pressure on domestic providers (public and/or private) because contracting abroad can discourage monopolistic behaviour by enlarging the pool of providers.

On their side, Belgian hospitals are eager to admit foreign patients and to conclude contracts because hospital financing is activity-based, there are financial incentives in reaching optimal capacity and the extra income generated can contribute towards covering the costs of expensive investments. Due to the abundance of supply and competition between hospitals, admitting foreign patients can be crucial for some smaller hospitals. Due to the fee-for-service system, Belgian doctors also have clear financial incentives in treating more patients, and cross-border cooperation can furthermore be a way to strengthen their reputation and skills as well as to establish links with colleagues abroad.

The main drivers for the public authorities of the two “sending” countries has been supply shortages and waiting lists in their systems, as the ECJ rulings have given patients the right to cross-border care when treatment cannot be provided at home “without undue delay”. Contracting with foreign providers makes it possible for purchasers to better control patient flows as well as the quantity, quality and type of care provided. The Belgian authorities, on the other hand, have been concerned with protecting the Belgian system so that cross-border contracting does not result in increasing prices or in waiting times for national patients.

For the middleman CM, participating as a third contracting party is a way of keeping an eye on the situation and ensuring that Belgian tariffs and the general aspects of the Belgian system are respected. The CM has an interest in avoiding waiting lists emerging for its members and for foreign contracts to put upward pressure on Belgian prices.

A series of additional factors also influence patient mobility, either by enhancing or by hindering it. Organizing pre- and post-treatment care can be a challenge in cross-border settings. Heavy bureaucratic procedures and lengthy negotiations with the NHS were seen by Belgian hospitals as unnecessarily complicating patient mobility. On the other hand, the Euro-PALs who assisted NHS patients during their stays in Belgium were seen as very helpful. The unforeseeable nature of contracting and the unpredictability of the volumes of patient flows contributed to an increase in uncertainty around mobility, while the lack of cooperation from Dutch and English providers was in some cases directly obstructing patients from going abroad. Due to the Belgian way of calculating daily patient rates, which does not reflect real costs, Belgian hospitals might choose to treat those foreign patients who do not represent a loss for them. From a mental perspective, cross-border health care can represent a trade-off for patients between waiting “at home” to be treated in familiar surroundings or travelling abroad to gain fast access to care in a system they feel much less confident about. This feeling of uncertainty or insecurity can hinder mobility. From a more functional perspective, patient mobility can be facilitated by the involvement of local players in the cross-border arrangements and by the bottom-up, rather than top-down, approach to the novel practices. Last but not least, we noticed the difference between the Belgian-Dutch border compared to the Belgian-English border, as the former appears more “fluid”, due to geographical, linguistic and socio-cultural factors, which can make health care on the other side of the border appear more accessible.

Finally, looking at what impact patient mobility might have and what opportunities and risks it might entail for the “exporting” systems, cross-border contracting can offer extra possibilities to patients as they gain access faster or closer to home. Contracting abroad can also make national providers improve performance and/or cut prices as

they realize that there is a risk they might lose contracts and patients to foreign providers. Yet cross-border rivalry might also distort competition when prices for health care do not cover the same cost elements in two countries. Opening the borders to patient mobility also implies expanding overall health care consumption, as access to foreign care counteracts national cost containment mechanisms, which can potentially have consequences for total health care expenses. Turning to the “importing” system, admitting foreign patients is a way of using up spare capacity and attracting extra income. Yet if foreign purchasers are able to offer higher prices than the official Belgian tariffs, there is a risk that cross-border contracting might put upward pressure on prices. Indeed, this risk has become concrete on several occasions. Another issue is the emergence of waiting times for national patients; although we have not found any indications, it would also be very difficult to determine as there is no official registration in Belgium. Furthermore, there is legal uncertainty linked to the budget calculations of Belgian hospitals and Belgian public authorities lack information about practices happening on its own territory. Reforms in the Dutch health care system might also have important repercussions in Belgium, as the impact of reforms does not stop at the border. With foreign patients entering Belgium, it is also foreign and new procedures entering the country’s health care system.

Our research suggests that, up until now, mobile patients, foreign purchasers and Belgian providers are benefiting from the increasing opportunities for cross-border care. Nevertheless, prudence is called for. Patient flows still seem to be increasing. There is a risk of upward pressure on prices when Belgian tariffs are not incorporated into the contracts. As foreign patients seem to be concentrated in specific hospitals and in specific hospital departments, close monitoring of trends is advisable to guarantee access for domestic patients.

An EU level framework for cross-border contracts between providers and purchasers, guaranteeing the involvement of the public authorities of both the sending and the receiving countries, could be an adequate instrument to increase legal certainty for all players and to guarantee that in the long run all patients, those in search of care across the border and those being treated in their national system, continue to take advantage of increased patient mobility.

Through our case-study we have gained a much clearer picture of what is happening, of how cross-border contracting works in practice and of which stakeholders are involved. Understanding the practical aspects also allows insight into the reasons behind cross-border contracting, which explains why stakeholders are motivated (or not) to engage in such innovative practices. Yet while the functioning and the drivers of the cross-border arrangements have now become clearer, other more controversial questions have emerged. At a general level, it appears legitimate to question whether patient mobility is based on free patient choice or is forced by circumstances, and at a more abstract level whether cross-border flows of patients ultimately should be seen as a success or as a failure.

Patient mobility could be seen as an artificial solution to the problem of waiting lists: instead of solving the problem within the national system, purchasers simply go abroad to look for solutions – which effectively results in exporting their country’s problem(s). Furthermore, systematically resorting to foreign health care capacity could be a way for countries to limit costly national investments in medical infrastructure. Such strategies appear relevant for regions with very specific characteristics, such as geographical isolation or low population density.

From a patient perspective, it is essential that care is delivered close to home and it therefore becomes the responsibility of those in charge of delivering health care to organize it in ways which satisfy this requirement. The importance of geographical and cultural proximity is illustrated through the volumes of Dutch patient flows: while the sickness fund members who live in the Belgian-Dutch border region go to Belgium in their thousands, insurers with affiliates from all over the Netherlands are disappointed about the low numbers of patients choosing to go to Belgium. In this respect, a distinction should also be made between:

- The population living in border-regions with Belgium, where cross-border contracting presents itself as a practical, logical and easy arrangement for the population living closer to Belgian health care facilities than to Dutch ones. In this context, “abroad might be nearer to home” and patients might actually prefer cross-border care.
- People living further away from the border, whether in the Netherlands or in England, for whom mobility is an alternative to waiting for extended periods at home. They will generally be more reluctant to agree to go abroad as they prefer to stay as close to home as possible when in need of medical care.

This distinction begs the question of whether patient mobility is about patients’ preferences and increasing their choices, or whether it is about serving other players’ interests, in which case patients are the “tools” through which cross-border care takes place rather than the reasons behind it. One driver which appears most certainly to

be behind cross-border arrangements are health care purchasers' interests in circumventing supply shortages at home by resorting to foreign providers and warning national providers that they might lose out if they do not improve performance. Examples from both the Dutch and the English systems suggest that local providers were more prepared to work harder when the "threat" of patient mobility became very real, and there were indications that performance rates improved and waiting times shortened. Another obvious factor explaining patient mobility is the interest of the providers receiving foreign patients. Structural oversupply of hospital care, providers' direct financial incentives and the competitive Belgian hospital environment all contribute to Belgian hospitals' and Belgian hospital doctors' eagerness to treat more patients. Considering these strong interests of both purchasers and providers, patient mobility appears to be a side-effect and not the goal in itself.

2. Neighbouring health care systems: complementarity and incompatibility

Three questions appear central in the debate about patient mobility. One concerns how practical obstacles to cross-border cooperation can be removed. Another question is how mental barriers to patient mobility can be overcome, while a third challenge is how to avoid cross-border arrangements putting health care systems at risk.

Firstly, the Belgian case-study underlines the importance of having the support of all involved players, not least the national providers who act as gatekeepers. Administrative procedures, paper forms, unusual arrangements, foreign practices, synchronizing very different systems etc. – can all be made to work *if* the will is there. Yet, removing practical barriers to mobility requires the willingness of *all* stakeholders. Different players influence how cross-border arrangements function (or dysfunction) but they also influence each other (e.g. when doctors encourage or discourage patients from going abroad). Here, the difference between top-down and bottom-up cross-border initiatives is important as stakeholders are more likely to be positively motivated when cross-border arrangements are set up for and by them.

Secondly, it is important that patients feel comfortable and safe. Aspects such as good continuity of care and the presence of medical staff speaking their language are important to remove patients' uncertainties. Doctors have a key role in directly referring or even recommending people to go abroad and have faster access to care. E.g. it would greatly increase patients' confidence in the foreign system if domestic doctors were obliged to mention whether cross-border care is an option when setting a diagnosis¹²⁰.

Mental barriers such as ignorance, unwillingness and fear must be removed to make people feel comfortable about using foreign health care facilities and make referrers confident in sending patients abroad. In terms of recommendations, this translates into the following: if the use of cross-border health care is to be increased, then information, awareness and confidence must be improved. In particular, the cooperative attitude of national doctors seems a key to success in cross-border projects.

Lastly, the contrasting situations of the Belgian health care system on the one hand and Dutch and English systems on the other are noteworthy. While Belgium has supply abundance and demand controls (with relatively high co-payments), the Netherlands and England have experienced supply restrictions and few constraints on demand as these become unnecessary when provision is controlled. These differences have led to two systems with supply shortages neighbouring a system with supply abundance. In a setting of geographical proximity, it is the complementarity between undersupply and oversupply which encourages cross-border care arrangements; one could say that unlimited Belgian supply meets unlimited demand from Dutch and English patients.

On the other hand, there are also incompatibilities between the systems which become apparent in the context of cross-border cooperation: cross-border contracting between Belgian providers and foreign purchasers has introduced direct contracting into the Belgian system. While contracts are a key feature of the Dutch health care system, Belgian hospitals are not used to this form of arrangement. Furthermore, there are significant differences in the ways of calculating hospital tariffs and in prices between the countries involved. NHS contracts have also introduced practices and procedures which are unfamiliar to the Belgian health care system. Through the cross-border activities, new elements are "imported" into Belgium and are effectively creating satellite "mini-systems" within the Belgian health care system. The challenge is to ensure that the innovative practices do not result in

¹²⁰ Interview with W. Brouwer

parallel structures, procedures and payment mechanisms, which could put pressure on the subtle checks and balances between the players of the Belgian system.

As in any setting of cross-border movements it is also worth asking who is paying for investments, education, infrastructure etc. This question is not just related to health care and mobile patients, but arises in all cross-border contexts where the users of facilities and services are not always contributing to the system at large simply because they live (and pay taxes) on the other side of the border. This can have consequences for equity and fairness.

Risks also exist for the “sending” countries. While demand restrictions are mobile, supply restrictions stop at the border. Patients can cross the border with their insurance coverage and take their restrictions with them, and it therefore does not matter “where they exercise their demand”¹²¹. In contrast, supply restrictions within the national territory combined with the option of going abroad for care counteract each other as demand not satisfied at home is exported beyond the national frontiers. Supply restrictions are thus circumvented by mobility and there is a risk that total costs are not controlled.

Furthermore, safe cross-border contracting requires good knowledge of the other system and its functioning so as to avoid its “weak points”. It is therefore no coincidence that several Dutch insurers rely on the assistance of a Belgian sickness fund in their cooperation with Belgian hospitals.

The fact that neighbouring health care systems complement each other’s needs should not happen to the detriment of any of the systems – neither the system which “exports” patients, nor the system which “imports” foreign patients. A key concern must be to protect patients *as well as* health care systems. Guaranteeing that citizens have timely access to high quality, safe and appropriate medical treatment when they need it is the overriding objective for health authorities. Guaranteeing the integrity, unity and sustainability of the health care system must therefore also be a top priority.

Where patient mobility can help to improve access to quality health care, there are good reasons for encouraging it to take place.

¹²¹ Interview with W. Brouwer

ANNEXES

ANNEX I: REPORT ON HOSPITAL ADMISSIONS IN 2002 OF PATIENTS WITHOUT BELGIAN NATIONALITY LIVING OUTSIDE BELGIUM IN THE EU

Introduction

In order to describe the volume and main characteristics of Belgian hospital care delivered to non-Belgian patients in the last decade, we analyzed the Minimum Clinical data received from the Belgian Ministry of Public Health.

Material and methods

We obtained the data we describe in this short report from the Belgian Ministry of Public Health in the form of Excel files. The hospital admissions concern inpatient and outpatient hospital care, which in the Belgian terminology are called normal (or classical) hospital stays and day hospital stays. Ambulatory consultations in hospital services, including emergency consultations, are thus not included. Psychiatric admissions in general hospitals and psychiatric hospitals are not included either.

Each admission is a new entry, implicating that one patient can appear several times in the data file, i.e. in case he has been hospitalized several times.

The data concern 16,383 hospital admissions in 2002 of patients living outside Belgium but in an EU country and whose nationality is not Belgian or is unknown (see Table 1). For reasons of convenience, we will call this population "EU-residents" in this report. Of these 16,383 EU-residents, 70.9% have an EU country nationality and 17.2% a nationality of a country outside the EU. The nationality of 1,958 patients (12%) is unknown; they might also have Belgian nationality.

In this report we do not describe the hospital admissions of patients of Belgian nationality who live abroad, in or outside the EU, or patients who reside in Belgium but who do not have Belgian nationality.

We could not have access to similar data for the previous years in order to describe the evolution of hospital care for non-Belgian patients. According to our contact person in the Belgian Ministry of Public Health, the quality of these data, especially the codes used at data entry level by the hospitals, is problematic. At the last minute, we received some missing figures and tables from 2002, together with some tables on hospital admissions in 2003.

Results

1. Hospital admissions 2002

The total number of hospital admissions in Belgium in 2002 amounted to 2.8 million.

Table 1: Belgian hospital admissions in 2002 by nationality and country of residence (N= 2,806,612)

Country of residence	Nationality					
	EU	Non-EU	Unknown	Total non-Belgian nationality and unknown	Belgian	Total
Non Belgian residence, EU	11 609	2 816	1 958	16 383	11 542	27 925
1) Non Belgian residence, worldwide	11 783	4 142	2 203	18 128	12 279	30 408
2) Belgian residence	75 980	90 823	202 135		2 407 265	2 776 204
Total (1 & 2)	87 763	94 965	204 338		2 419 544	2 806 612

Table 2 shows the proportion of day stays (39.8%) in admissions of EU-residents. This proportion coincides with the proportion of day stays of all hospital admissions in 2002. The proportion of classical hospital stays is larger in patients with a nationality of a country outside the EU (77.8%).

Table 2: Type of hospital stays 2002 in Belgian hospitals by nationality in EU-residents (N=16,383)

		Nationality						Total	
		Nationality EU		Non EU nationality		Nationality unknown		N	Col %
		N	Col %	N	Col %	N	Col %		
Type of stay	Normal hospital stay	6465	55.7 %	2190	77.8 %	1203	61.4 %	9858	60.2 %
	Day hospital (incl surgical)	5144	44.3 %	626	22.2 %	755	38.6 %	6525	39.8 %
Total		11609	100%	2816	100%	1958	100 %	16383	100%

Table 3 shows more day stays (43.3%) in hospitals in the Flemish region compared to the total (39.8%). We find the same trend in the total of Belgian hospital admissions, with 39% day stays in Brussels hospitals, 42% in Flemish hospitals and 34% in Walloon hospitals.

Table 3: Type of hospital stays by region (N=16,383)

		Region						Total	
		Brussels		Flemish region		Walloon region		N	Col %
		N	Col %	N	Col %	N	Col %		
Normal hospital stay		2268	63.6%	5836	56.7%	1754	69.5%	9858	60.2%
Day hospital (incl surgical)		1297	36.4%	4459	43.3%	769	30.5%	6525	39.8%
Total		3565	100%	10295	100%	2523	100%	16383	100%

Table 4 shows that almost 59% of the EU-residents live in the Netherlands, and 16.3% live in France. The vast majority of EU-residents (83.5%) live in the Netherlands, France or Luxembourg. Most of the patients with an unknown nationality (51.5%) live in France. They might have Belgian nationality, since France borders Belgium. Of all unknown nationalities 84.8% live in the Netherlands, France or Luxembourg. Compared to other countries (17.2%), Italy houses a large percentage of non-EU patients (41%).

Table 4: Country of residence in EU by nationality (N=16.383)

		Nationality									Total	
		Nationality EU			Non EU nationality			Nationality unknown			N	Col %
		N	Row %	Col %	N	Row %	Col %	N	Row %	Col %		
Country of residence patient	Netherlands	7830	81.6%	67.4%	1381	14.4%	49.0%	390	4.1%	19.9%	9601	58.6%
	France	1313	49.3%	11.3%	341	12.8%	12.1%	1009	37.9%	51.5%	2663	16.3%
	Luxembourg	877	62.2%	7.6%	271	19.2%	9.6%	261	18.5%	13.3%	1409	8.6%
	Italy	568	53.2%	4.9%	438	41.0%	15.6%	61	5.7%	3.1%	1067	6.5%
	Germany	442	67.3%	3.8%	98	14.9%	3.5%	117	17.8%	6.0%	657	4.0%
	UK	199	58.0%	1.7%	86	25.1%	3.1%	58	16.9%	3.0%	343	2.1%
	Spain	127	63.8%	1.1%	43	21.6%	1.5%	29	14.6%	1.5%	199	1.2%
	Other	253	57.0%	2.2%	158	35.6%	5.6%	33	7.4%	1.7%	444	2.7%
Total		11609	70.9%	100%	2816	17.2%	100%	1958	12.0%	100%	16383	100%

Table 5 shows that a large percentage of patients living in the Netherlands (85.3%) and Luxembourg (84.9%) planned the care they received in a Belgian hospital, compared to France, another neighbouring country (56.9%). Patients living in the UK (23.5%), in Germany (18.6%) and France (17.6%) were admitted in larger proportions by emergency transport than the general population (7.4%). If we take all emergency care together, patients residing in the Netherlands are also the most important group for emergency care, followed by patients residing in France.

Of all admissions to Belgian hospitals in 2002, 69.45% concern planned admissions, 23.67% emergencies without transportation and 6.88% emergencies with transport.

Table 5: Planned or emergency admissions by country (N=15,861, excl. 522 omissions)

		Planned or emergency									Total	
		Planned			Emergency, non-planned			Emergency with transport			N	Col %
		N	Row %	Col %	N	Row %	Col %	N	Row %	Col %		
Country of residence patient	Netherlands	7927	85.3%	65.2%	1029	11.1%	40.9%	342	3.7%	29.0%	9298	58.6%
	France	1454	56.9%	12.0%	652	25.5%	25.9%	450	17.6%	38.1%	2556	16.1%
	Luxembourg	1144	84.9%	9.4%	154	11.4%	6.1%	50	3.7%	4.2%	1348	8.5%
	Italy	839	79.5%	6.9%	149	14.1%	5.9%	67	6.4%	5.7%	1055	6.7%
	Germany	316	49.3%	2.6%	206	32.1%	8.2%	119	18.6%	10.1%	641	4.0%
	Other	215	49.2%	1.8%	169	38.7%	6.7%	53	12.1%	4.5%	437	2.8%
	UK	154	46.4%	1.3%	100	30.1%	4.0%	78	23.5%	6.6%	332	2.1%
	Spain	115	59.3%	.9%	57	29.4%	2.3%	22	11.3%	1.9%	194	1.2%
Total		12164	76.7%	100%	2516	15.9%	100%	1181	7.4%	100%	15861	100%

Table 6 shows that Belgians living in the Netherlands represent 61.5% of the hospital admissions of Belgians living in another EU country and 81.7% of the admissions of Belgians living abroad for planned care in the Flemish region. Belgians living in the Netherlands represent 43.3% of the total number of patients living in the Netherlands being treated in Belgium.

Table 6: Hospitals admissions in 2002 of Belgians living in other EU countries

Country	Planned					Emergency					Total					
	Region					Region					Region					
	Flemish	Brussels	Wal-loon	Tot		Flemish	Brus-sels	Wal-loon	Tot		Flemish	Brus-sels	Wal-loon	Tot		
N	%				N	%				N	%			N	%	
NL	5456	81.7%	80	12	5548	1504	60.5%	8	41	1553	6960	75.9%	88	53	7101	61.5%
FR	408	6.1%	175	698	1281	320	12.9%	47	547	914	728	7.9%	222	1245	2195	19.0%
LU	228	3.4%	154	207	589	73	2.9%	23	56	152	301	3.3%	177	263	741	6.4%
IT	50	0.7%	24	35	109	16	0.6%	8	31	55	66	0.7%	32	66	164	1.4%
DE	209	3.1%	15	20	244	247	9.9%	4	46	297	456	5.0%	19	66	541	4.7%
UK	120	1.8%	15	5	140	183	7.4%	9	11	203	303	3.3%	24	16	343	3.0%
ES	137	2.1%	24	20	181	52	2.1%	10	9	71	189	2.1%	34	29	252	2.2%
Other	74	1.1%	15	4	93	89	3.6%	10	13	112	163	1.8%	25	17	205	1.8%
Total	6682	100%	502	1001	8185	2484	100%	119	754	3357	9166	100%	621	1755	11542	100%

Table 7 shows, as expected, that most Dutch patients were in a Flemish hospital (93.2%), and most French patients in a Walloon hospital (55.2%). Patients living in Luxembourg (71.6%) and Italy (72.1%) went to a Brussels hospital. Almost 87% of the EU-residents in Flemish hospitals live in the Netherlands, while 58% of the non-Belgian patients in Walloon hospitals live in France.

Table 7: Hospital region by country of residence

		Region									Total	
		Flemish Region			Brussels			Walloon Region			N	Col %
		N	Row %	Col %	N	Row %	Col %	N	Row %	Col %		
Country of residence patient	Netherlands	8949	93.2%	86.9%	331	3.4%	9.3%	321	3.3%	12.7%	9601	58.6%
	France	500	18.8%	4.9%	692	26.0%	19.4%	1471	55.2%	58.3%	2663	16.3%
	Luxembourg	63	4.5%	.6%	1009	71.6%	28.3%	337	23.9%	13.4%	1409	8.6%
	Italy	187	17.5%	1.8%	769	72.1%	21.6%	111	10.4%	4.4%	1067	6.5%
	Germany	227	34.6%	2.2%	276	42.0%	7.7%	154	23.4%	6.1%	657	4.0%
	Other	155	34.9%	1.5%	238	53.6%	6.7%	51	11.5%	2.0%	444	2.7%
	UK	155	45.2%	1.5%	135	39.4%	3.8%	53	15.5%	2.1%	343	2.1%
	Spain	59	29.6%	.6%	115	57.8%	3.2%	25	12.6%	1.0%	199	1.2%
Total		10295	62.8%	100%	3565	21.8%	100%	2523	15.4%	100%	16383	100%

Table 8 shows that 83.6% of the care delivered by Flemish hospitals to EU-residents is planned, compared to 49.7% in Walloon hospitals. The percentage of planned admissions in all Belgian admissions in 2002 is equally lower in the Walloon region (65.6%) compared to the Flemish region (71.6%) and Brussels (70.7%). Emergency admissions without transport are respectively 22.8% in Brussels, 22.3% in Flemish hospitals and 27.1% in Walloon hospitals. Emergency admissions with transport are respectively 5.6% in Brussels, 7% in Flemish hospitals and 7.3% in Walloon hospitals.

**Table 8: Planned and emergency care by region
(N=15,861, excl. 522 omissions)**

	Region									Total	
	Flemish Region			Brussels			Walloon Region			N	Col %
	N	Row %	Col %	N	Row %	Col %	N	Row %	Col %		
Planned	8302	68.3%	83.6%	2624	21.6%	76.3%	1238	10.2%	49.7%	12164	76.7%
Emergency, non-planned	1138	45.2%	11.5%	598	23.8%	17.4%	780	31.0%	31.3%	2516	15.9%
Emergency with transport	489	41.4%	4.9%	217	18.4%	6.3%	475	40.2%	19.1%	1181	7.4%
Total	9929	62.6%	100%	3439	21.7%	100%	2493	15.7%	100%	15861	100%

2. Hospital admissions 2002-2003

The figures in the following tables (9 and 10) are complete, while those we received earlier, i.e. in tables 5 and 8, concerned only data on emergency/planned care of 15,861 hospital admissions.

Table 9 shows that hospital admissions of EU-residents increased by 17% in 2003 compared to 2002. This increase is prominent in the Flemish region (25%) compared to the Brussels region. In hospitals in the Walloon region, admissions of EU-residents were down by 5%. The ratio between emergency and planned admissions stays nearly the same over the two years in the three regions.

**Table 9: Planned and emergency care by region in 2002
(N=16,383) and 2003 (19,090)**

		Region							
		Flemish region		Brussels		Walloon region		Total	
		N	%	N	%	N	%	N	%
2002	Planned	8668	84.2	2750	77.14	1268	50.26	12686	77.43
	Emergency	1627	15.8	815	22.86	1255	49.74	3697	22.57
	Total	10305	100.00	3565	100.00	2523	100.00	16383	100.00
2003	Planned	10924	84.83	3034	79.51	1193	49.77	15151	79.37
	Emergency	1953	15.17	782	20.49	1204	50.23	3939	20.63
	Total	12877	100	3816	100	2397	100	19090	100
	Growth index		125		107		95		117

Table 10 shows that the hospital admissions of EU-residents living in the Netherlands increased by 25%, with similar proportions of planned care and emergency care over the two years. The developments from 2002 to 2003 show that the increase in Dutch patients being treated in Flemish hospitals for planned care (with +2003 hospital admissions), explains the major part of the total increase in hospital admissions (+2707 admissions) of non-Belgians living in other EU countries. If we count the proportion of patients from the Netherlands being admitted for planned care in the Flemish region, they account for 91% in 2002. These figures also show that the proportion of Dutch patients admitted for planned care in the Brussels region (69% in 2002 and 2003) is somewhat less than the proportion shown in table 7 for all EU-residents (76%). Looking at the proportion of Dutch patients admitted for planned care in hospitals in the Walloon region (26.48% in 2002 and 24.62% in 2003), these are about half of the proportion shown in table 7 for all EU-residents admitted for planned care in the Walloon hospitals (49.7%).

Table 10: Planned and emergency care by region in 2002 (N=9,601) and 2003 (12,008) for hospital admissions of EU-residents living in the Netherlands

		Region							
		Flemish region		Brussels		Walloon region		Total	
		N	%	N	%	N	%	N	%
2002	Planned	7915	88.45	230	69.49	85	26.48	8230	85.72
	Emergency	1034	11.55	101	30.51	236	73.52	1371	14.28
	Total	8949	100	331	100	321	100	9601	100
2003	Planned	9998	88.42	262	69.68	80	24.62	10340	86.11
	Emergency	1309	11.58	114	30.32	245	75.38	1668	13.89
	Total	11307	100	376	100	325	100	12008	100
Growth index			126.3		113.6		101.2		125.1

3. Main diagnosis 2002

Table 11 shows the main diagnosis in ICD-9 3-digit codes for 35.2% of the population. Almost 8% of the main diagnoses fall under V58. Most patients (1212 or 7.4% of the total population) received chemotherapy (V58.1). This corresponds to the main diagnoses in the total population admitted in 2002 to Belgian hospitals: 272,941 of 2,745,397 main diagnoses (9.94%) concern V58.1 or chemotherapy. Main diagnoses with a V26 code occur much less in the total population of admissions, i.e. 0.45%.

ICD-9 V-codes can only be assigned for main diagnosis in specific cases, according to instructions of the Ministry. They describe a specific service as the reason for encounter, such as revalidation, replacement of a pacemaker, etc. Patients with this type of code usually don't have an acute disease, but have a chronic disease or were treated before for a specific disease and treated for after-care, such as the removal of orthopaedic material. The V-codes for chemotherapy (V58.1) or radiotherapy (V58.0) are exceptions: they can be used as main diagnosis for acute diseases. V67 is used when a patient is hospitalized to control any residual harm or aggravation of the disease that was treated before.

Table 11: TOP15 of ICD-9 main diagnosis (3digit codes)

	N	Col %
Encounter other & unspecified procedures	1296	7.9%
Procreative management	1011	6.2%
Other forms of chronic ischemic heart	863	5.3%
Follow-up examination	383	2.3%
Obesity and other	355	2.2%
Cataract	343	2.1%
Osteoarthritis and allied	319	1.9%
Intervertebral disc disorders	228	1.4%
Inguinal hernia	201	1.2%
Other disorders of breast	149	.9%
Infertility, female	148	.9%
Elective surgery not for remedying health	139	.8%
Varicose veins of lower extremities	130	.8%
Dislocation of knee	103	.6%
Angina pectoris	95	.6%
Other	10620	64.8%
Total	16383	100%

Table 12 shows that only 11.6% of the main diagnoses in the Walloon region are covered by the TOP15. We found that in the Walloon hospitals 104 main diagnoses (4%) concern ICD-9 code "592" or "diseases and injuries of calculus of kidney and ureter".

Table 12: Main diagnosis by region

	Region						Total	
	Flemish Region		Brussels		Walloon Region		N	Col %
	N	Col %	N	Col %	N	Col %		
Encounter other & unspecified procedures & after-care (V58)	772	7.5%	390	10.9%	134	5.3%	1296	7.9%
Procreative management (V26)	520	5.1%	487	13.7%	4	.2%	1011	6.2%
Other forms of chronic ischemic heart disease (414)	819	8.0%	23	.6%	21	.8%	863	5.3%
Follow-up examination (V67)	65	.6%	315	8.8%	3	.1%	383	2.3%
Obesity and other hyperalimantation (278)	327	3.2%	12	.3%	16	.6%	355	2.2%
Cataract (366)	300	2.9%	29	.8%	14	.6%	343	2.1%
Osteoarthritis and allied disorders (715)	298	2.9%	10	.3%	11	.4%	319	1.9%
Intervertebral disc disorders (722)	208	2.0%	8	.2%	12	.5%	228	1.4%
Inguinal hernia (550)	184	1.8%	6	.2%	11	.4%	201	1.2%
Other disorders of breast (611)	127	1.2%	2	.1%	20	.8%	149	.9%
Infertility, female (628)	102	1.0%	40	1.1%	6	.2%	148	.9%
Elective surgery not for remedying health states (V50)	112	1.1%	15	.4%	12	.5%	139	.8%
Varicose veins of lower extremities (454)	116	1.1%	3	.1%	11	.4%	130	.8%
Dislocation of knee (836)	96	.9%	1	0%	6	.2%	103	.6%
Angina pectoris (413)	76	.7%	8	.2%	11	.4%	95	.6%
Other	6173	60.0%	2216	62.2%	2231	88.4%	10620	64.8%
Total	10295	100%	3565	100%	2523	100%	16383	100%

Table 13: Planned or emergency care by main diagnosis

	Planned or emergency			Total N
	Planned	Emergency, non-planned	Emergency with transport	
	Row %	Row %	Row %	
Encounter other & unspecified procedures & after-care (V58)	98.1%	1.6%	.3%	1223
Procreative management (V26)	91.7%	8.3%		878
Other forms of chronic ischemic heart disease (414)	93.5%	5.4%	1.2%	858
Follow-up examination (V67)	99.0%	.8%	.3%	383
Obesity and other hyperalimantation (278)	97.1%	2.0%	.9%	342
Cataract (366)	94.1%	5.9%		337
Osteoarthritis and allied disorders (715)	98.1%	1.9%		317
Intervertebral disc disorders (722)	92.5%	6.2%	1.3%	227
Inguinal hernia (550)	94.5%	5.0%	.5%	199
Other disorders of breast (611)	97.9%	1.4%	.7%	145
Elective surgery not for remedying health states (V50)	99.3%	.7%		138
Varicose veins of lower extremities (454)	99.2%	.8%		130
Infertility, female (628)	100.0%			108
Dislocation of knee (836)	96.0%	3.0%	1.0%	100
Angina pectoris (413)	74.7%	17.6%	7.7%	91
Other	66.8%	22.1%	11.1%	10385
Total	76.7%	15.9%	7.4%	15861

Table 14, representing 34% (n=5540) of the EU-residents, shows that in 15 out of 20 diagnoses, the majority of patients come from the Netherlands. For "follow-up examination after operation" (69.2%), complications after a kidney transplant (97.5%), most of the patients come from Italy. For "infertility, female" (53.3%), removal of a kidney stone (40.3%) and trans-sexualism (86.2%), most of the patients come from France. Of all patients having received chemotherapy, 21% live in Luxembourg (compared to 8.6% of the total population).

**Table 14: Top 20 diagnoses (row percentages) by country
(N=5540 or 34% of all EU-residents)**

	Neth	UK	Italy	Germ	Lux	Spain	France	Else	Total
Chemotherapy	60.2	.2	1.4	1.3	21.0	1.5	12.7	1.6	1212
Procreative management	54.1	2.1	3.4	10.6	8.1	.3	20.0	1.5	1011
Coronary atherosclerosis	94.2	.6	1.1	.6	1.2	.1	1.6	.6	852
Follow-up examination after operation	11.0	.6	69.2	5.2	6.3	0	1.2	6.9	347
Morbid obesity	92.5	.9	0	1.7	.3	0	4.3	.3	345
Cataract	87.1	.4	1.2	.8	3.7	2.1	3.3	1.2	241
Osteoarthritis (hip) & allied disorders	90.9	4.3	1.1	0	1.1	0	2.7	0	186
Lumbar intervertebral disc without myelopathy (hernia neck)	85.0	1.4	0	2.1	1.4	2.1	3.6	4.3	140
Infertility, female	15.3	4.4	2.2	8.8	12.4	0	53.3	3.6	137
Plastic surgery for unacceptable cosmetic appearance	76.3	4.4	.7	4.4	5.9	.7	6.7	.7	135
Hypertrophy of breast	92.5	1.5	.8	.8	.8	0	3.8	0	133
Asymptomatic varicose veins	89.8	.8	.8	.8	.8	0	6.3	.8	128
Inguinal hernia	90.1	1.7	.8	.8	.8	.8	4.1	.8	121
Angina pectoris	78.0	2.2	4.4	5.5	0	1.1	5.5	3.3	91
Trans-sexualism	4.6	6.9	1.1	0	1.1	0	86.2	0	87
Meniscus of knee	90.1	0	0	0	0	1.2	6.2	2.5	81
Complications kidney transplant	2.5	0	97.5	0	0	0	0	0	79
Plastic eye surgery (blefarochalasis)	77.8	4.2	0	1.4	5.6	2.8	8.3	0	72
Kidney stone	31.9	2.8	5.6	5.6	1.4	2.8	40.3	9.7	72
Ischias	90.0	0	0	2.9	0	2.9	1.4	2.9	70

After selecting the patients residing in the Netherlands or in the UK, Table 15 shows their main diagnosis, including 38.5% of the patients from the Netherlands (N=3698) and 21.8% of the patients from the UK (N=75). Similar diagnoses allow us to present them in one table, although shifts in ranking are present. We see that most of the British were in a Belgian hospital for procreative management (6.1%) or osteoarthritis of the pelvic region (2.3%). Most of the Dutch patients are diagnosed with coronary atherosclerosis (8.4%), for receiving chemotherapy (7.6%), or for procreative management (5.7%).

**Table 15: Main diagnosis of patients from Netherlands
(N=3698 of 9601) and UK (N=75 of 343)**

	Neth	UK
	%	%
Chemotherapy	7.6	.9
Procreative management	5.7	6.1
Coronary atherosclerosis	8.4	1.5
Follow-up examination after operation	.4	.6
Morbid obesity	3.3	.9
Cataract	2.2	.3

Osteoarthritis (hip) & allied disorders	1.8	2.3
Lumbar intervertebral disc without myelopathy (hernia neck)	1.2	.6
Infertility, female	.2	1.7
Plastic surgery for unacceptable cosmetic appearance	1.1	1.7
Hypertrophy of breast	1.3	.6
Asymptomatic varicose veins	1.2	.3
Inguinal hernia	1.1	.6
Angina pectoris	.7	.6
Trans-sexualism	0	1.7
Meniscus of knee	.8	0
Complications kidney transplant	0	0
Plastic eye surgery (blefarochalasis)	.6	.9
Kidney stone	.2	.6
Ischias	.7	0

Discussion

The data we analyzed concern all hospital admissions to Belgian hospitals. They do not allow for making a distinction concerning the way the care is funded. They include patients treated in Belgium through contracted care, but equally patients who came to Belgium for planned care with prior authorization from their competent funding institution, whose care is funded with a form E112 or by their private insurer, and patients who came to Belgium for planned care paid out-of-pocket. They also include patients who were in need of urgent treatment during a temporary stay in Belgium (tourists, work, etc.) and whose care is paid through the regulation 1408/71, based on the form E111.

Unfortunately we had no data on admissions of “foreign patients” in the last decade at our disposal, due to a lack of consistent quality of data entry in the hospitals. The hospital admissions in 2002 are not complete either: 12% of the EU-residents have an unknown nationality. The nationality of some non-EU residents shows inexplicable features: for instance 41% of the non-Belgian patients residing in Italy are non-EU nationals (see table 4). In spite of these shortcomings, the data allow us to confirm other results of our study.

The data on admissions to Belgian hospitals in 2002 show that of all admissions (N=2,806,612), only 1.1% concern non-Belgian patients residing outside Belgium (N=30,408) and only 0.6% concern non-Belgian patients residing outside Belgium but in the EU (N=16,383). The overall figures of foreign patients in Belgian hospitals in 2002 are thus low and suggest a low impact on accessibility of Belgian hospitals to the local population. However, these figures do not give any information on the micro level, on the potential concentration of these foreign patients in specific hospitals or hospital services.

As expected, most of the “EU-residents” come from neighbouring countries and are treated in the region they share a language with. At the same time, this cultural closeness coincides with a geographical closeness. Be it for emergency care or planned care, French patients are closer in both senses to the Walloon region, in the same way that Dutch patients are closer to the Flemish region.

As expected, of all the EU-residents, patients living in the Netherlands are strongly present, accounting for 58.6% of the admissions of non-Belgian patients living abroad. The same applies for Belgian patients living in the Netherlands, representing 61.5% of the hospital admissions of Belgians living in another EU country. These Belgians, when they work and live in the Netherlands, are usually insured with Dutch health insurers, and thus can also rely on the opportunities for relaxed access to cross-border care into Belgium. Belgians living in the Netherlands account for 43.3% of the patients living in the Netherlands being treated in Belgium. This is an indication that increased opportunities for access to cross-border care will in the first place be used by those who have a strong (cultural-social) link with the country of treatment.

The category of patients most relevant to our case-study are those who came to Belgium for planned care. Most of the patients – although not all – residing in the Netherlands and treated in Belgian hospitals through contracted care, come for planned care. Therefore we showed the distribution of patients admitted to the hospital through the emergency service as well as those who were not. We can be fairly sure that patients who planned to come to Belgium specifically for treatment would have been admitted directly to the hospital and would not pass by the

emergency service. On the other hand, patients who need urgent treatment during a temporary stay in Belgium, certainly from the neighbouring countries, will in principle pass through the emergency service. Foreign patients living in the Netherlands are strongly present in the category "planned hospital admissions of EU-residents", since they represent 65% of all admissions in 2002 and even 91% in the Flemish region in 2002. This reflects the practices of Dutch health insurers who strongly relax access to and funding of care in Belgium. We cannot however reveal whether it concerns contracted care. Many cross-border contracts only started in 2002. We cannot indeed conclude from the data whether these patients are treated through contracted care or through other arrangements such as E112 form, the E112 "light" forms in the framework of the Euregio projects, or direct payments by the Dutch private health insurers. In short, the data do not provide any data on the method of funding for the provided care.

The in-flow of patients residing in the Netherlands coming to Belgium for planned care is still increasing, which suggests that there is not only a shift in the way Dutch insurers pay for patients, as was suggested by some stakeholders in the interviews, but that additional patient groups are coming to Belgium for treatment.

The Top 20 of main diagnoses (see table 13) is biased by the strong presence of Dutch patients: they represent 58.6% of the EU-resident patients. They also fit with the authorization data given in 2004 by CZ. These especially concern bypass surgery in case of coronary atherosclerosis, bariatric surgery in case of obesity, cataract surgery, hip replacement in case of osteoarthritis and plastic surgery. On the other hand, the top 20 of main diagnoses only covers 38.5% of the Dutch patient population. The diagnoses of the total Dutch population are dispersed over 1620 ICD9 main diagnosis codes, which tells us that there are many other "common" reasons for Dutch patients receiving Belgian hospital care. The predominant place of chemotherapy as a main "diagnosis", equally for Dutch patients (7.6% of the Dutch patients), can be explained by the registration system, considering every chemotherapy session as one unit, i.e. a re-admission.

ANNEX II: REPORT OF THE CZ AUTHORIZATIONS IN THE PERIOD MAY-DECEMBER 2004 TO ALL CZ CLIENTS WHO APPLIED FOR HEALTH CARE IN BELGIUM

The figures in this report concern the authorizations that were given by CZ in the eight month period of May-December 2004 to all CZ clients who applied for health care in Belgium. We learned from the administrator that "authorizations" is to be understood as "registrations", i.e. that the care was indeed given/received.

Table 16 and Table 17 show that 12,797 authorizations were given to 6707 patients. Patients received at least one authorization (55%) and up to 25. Table 16 shows the details of the authorizations over 23 categories, and in Table 17 these are reduced to four categories. In Table 16, hospitalization in contracted care (N=2355) includes day hospitalizations or outpatient hospital care.

Table 16: Type of authorization given to CZ patients (N=6706) for treatment in Belgium (N=12,797) from May to December 2004

		Type of authorized care	
		N	%
Non contracted care	Bariatric surgery in Belgium	2	0%
	Consultation in Belgium	11	.1%
	Assisting devices in Belgium	12	.1%
	IVF in Belgium	5	0%
	Hospitalization in Belgium	21	.2%
	Other in Belgium	54	.4%
	Paramedical care in Belgium	20	.2%
	Plastic surgery in Belgium	20	.2%
	Specialist care in Belgium	7	.1%
	Dental care in Belgium	2	0%
Contracted care	Bariatric surgery in contracted hospital	121	.9%
	Assisting devices in contracted hospital	3	0%
	Surgery of jaw in contracted hospital	48	.4%
	Registration of hospitalization in contracted hospital	2355	18.4%
	Registration of ambulatory care in contracted hospital	9237	72.2%
	Registration of plastic surgery in contracted hospital	418	3.3%
E112	E 112 consultation	8	.1%
	E 112 hospitalization	58	.5%
	E 112 other	11	.1%
	E 112 plastic surgery	8	.1%
	E 112 specialist care	374	2.9%
All other treatments		2	0%
Total		12797	100%

Table 17: Summary of type of authorization given to CZ patients (N=6706) for treatment in Belgium (N=12,797) from May to December 2004

	Type of authorized care	
	N	%
Authorization treatment non-contracted care	273	2.1%
Authorization treatment contracted care	12069	94.3%
Authorization treatment E112	453	3.5%
Other	2	0%
Total	12797	100%

In the following tables we present the results of the aggregated data by patients, by reducing several authorizations per category to one.

Table 18 and Table 19 show that 6973 authorization types were given to 6706 patients. Two patients received three authorizations of different types and 263 patients two authorizations of different types.

Table 19 shows that out of the 6973 authorisations issued for obtaining care from a Belgian provider, 93.9% of cases (N=6299) concerned contracted care. Most of the remaining authorisations were covered by an E112 form (401 or 6%), while 271 authorisations (4%) were given for non-contracted care.

Table 18: Number of authorization types given per patient (N=6706 patients)

Number of authorizations given				
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	6441	96.0	96.0
	2 >	265	4.0	100.0
Total		6706	100.0	

Table 19: Authorization types given (N=6973 authorizations)

	1 and >	
	N	%
Authorization treatment non-contracted care	271	4.0%
Authorization treatment contracted care	6299	93.9%
Authorization treatment E 112	401	6.0%
Other	2	0%

Table Table 20 shows that 67% of patients received ambulatory care in a contracted hospital and 26.6% received both ambulatory and hospital care in a contracted hospital. Six percent of the population received non-contracted care. By hospitalization, we mean inpatient and outpatient hospital care, but we cannot make the distinction between the two.

Table 20: Ambulatory or hospitalization authorizations for contracted care (N=6973)

	N	%
Hospitalization in contracted hospital	265	4.0%
Ambulatory care in contracted hospital	4499	67.1%
Ambulatory care and hospitalization in contracted hospital	1513	22.6%
Other	429	6.4%
Total	6706	100.0%

Discussion

There is a divergence between the data we extracted from Carenet Scheldemond (Annex III) and these data. In Carenet Scheldemond, 5775 periods of care are registered in the year 2004 (Table 21), concerning 5648 patients. If we extrapolate the number of patients (6707) receiving a CZ authorization for contracted care in the period May to December 2004 from 8 to 12 months, we end up with 10,060 patients, or 3353 patients more.

ANNEX III: CONTRACTED BELGIAN HOSPITAL CARE BY CZ AND OZ: PERIODS OF CARE AND PATIENTS BETWEEN 1999 AND 2004

This analysis is based on the data included in Care-net Scheldemond, the information system used by the hospitals, the Dutch insurers OZ, and CZ and the Belgian CM middleman, for management of the delivery of contracted care. As Care-net Scheldemond has not been in use since spring 1999, patients receiving contracted care before the introduction of Care-net Scheldemond database (if any) are not included.

In the period between 1999 and December 2004, 26118 accepted periods of care concerning 25125 persons were included in the Carenet Scheldemond database (Table 21). An accepted period of care is a formal acceptance of funding the treatment by the Dutch health insurer given to the Belgian hospitals when the patient enters the hospital, and is valid for three months. Requests for treatment are entered by hospitals for a three month period. As a result, data for 2005 were already available in December 2004, when we received the data.

The data include contracted care for ambulatory inpatient and outpatient treatments. They include for CZ their privately insured patients and sickness fund patients. OZ has almost no privately insured patients. Five percent of the patient population (N=1264) identified by their insurance numbers (both Dutch and Belgian), their date of birth and postal code, appear more than once in the system. Of 11.9% (N=151) of these 1264 patients, at least one request for care was declined while at least one was accepted by CZ or OZ.

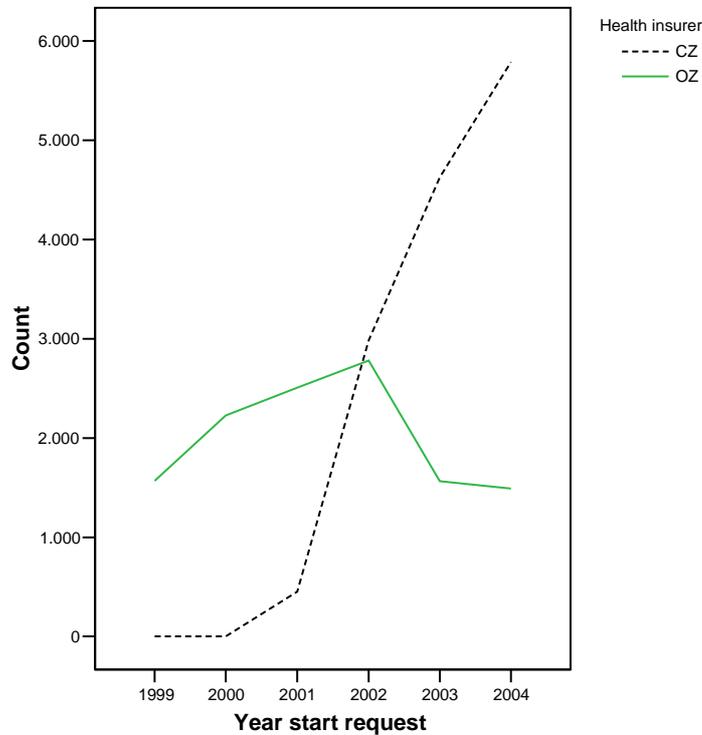
1. Periods of care

Table 21: Accepted periods of contracted care in Belgian hospitals by year and by insurer (N=26.118)

		Health insurer						Total	
		CZ			OZ				
		N	Row %	Col %	N	Row %	Col %	N	Col %
Year start request	1999				1553	100.0%	12.7%	1553	5.9%
	2000				2203	100.0%	18.1%	2203	8.4%
	2001	452	15.4%	3.2%	2482	84.6%	20.4%	2934	11.2%
	2002	2979	51.8%	21.4%	2769	48.2%	22.7%	5748	22.0%
	2003	4617	74.7%	33.1%	1562	25.3%	12.8%	6179	23.7%
	2004	5775	79.5%	41.4%	1492	20.5%	12.2%	7267	27.8%
	2005	111	47.4%	.8%	123	52.6%	1.0%	234	.9%
Total		13934	53.4%	100%	12184	46.6%	100%	26118	100%

Figure 1 shows a steady increase of CZ periods of care while the amount of OZ periods of care fell back after 2002 to the same number as in the starting year of the contract.

Figure 1: Number of CZ and OZ periods of care 1999-2004 (N=25.884)



More than 60% of all CZ care periods took place at ZOL (Genk) and more than half of the OZ care periods (52.3%) in UZ Gent (Table 22).

In 2003 the hospital "Gezondheidszorg Oostkust" at Knokke was contracted by both CZ and OZ. In that year there was a fall back in the total OZ periods of care, especially at "Gezondheidszorg Oostkust" (see Table 24).

Table 22: Periods of care by hospitals and by insurer (N=26,118)

	Health insurer						Group Total	
	CZ			OZ			N	Col %
	N	Row %	Col %	N	Row %	Col %		
Gezondheidszorg Oostkust. Knokke	682	57.4%	4.9%	506	42.6%	4.2%	1188	4.5%
UZ Gent	66	1.0%	.5%	6367	99.0%	52.3%	6433	24.6%
AZ Maria Middelaes. Gent	35	1.9%	.3%	1789	98.1%	14.7%	1824	7.0%
AZ St Jan. Brugge	8	.2%	.1%	3522	99.8%	28.9%	3530	13.5%
ZOL Oost Limburg. Genk	8436	100.0%	60.5%				8436	32.3%
ZH St- Ursula - Salvator. Hasselt	906	100.0%	6.5%				904	3.5%
Maria ZH Noord Limburg. Lommel	2439	100.0%	17.5%				2439	9.3%
AZ Vesalius. Tongeren	32	100.0%	.2%				32	.1%
ZH Maas en Kempen. Maasseik	813	100.0%	5.8%				813	3.1%
AZ ST Josef. Malle	517	100.0%	3.7%				517	2.0%
Other	2	100.0%	0%				2	0%
Total	13934	53.4%	100%	12184	46.6%	100%	26118	100%

Table 23 shows that the Care-net Scheldemond database includes 111 (0.79%) accepted requests for treatment for CZ insured patients by five hospitals that are not contracted by CZ.

Table 23: CZ periods of care by hospital by year (N=13,934)

	2002			2003			2004			Total	
	N	Row %	Col %	N	Row %	Col %	N	Row %	Col %	N	Col %
Gezondheidszorg Oostkust. Knokke	2	.3%	.1%	227	33.3%	4.9%	453	66.4%	7.7%	682	4.9%
UZ Gent	2	3.0%	.1%	34	51.5%	.7%	30	45.5%	.5%	66	.5%
AZ Maria Middelaes. Gent	2	5.7%	.1%	19	54.3%	.4%	14	40.0%	.2%	35	.3%
AZ St Jan. Brugge				5	62.5%	.1%	3	37.5%	.1%	8	.1%
ZOL Oost Limburg. Genk	3017	35.8%	87.9%	2811	33.3%	60.9%	2608	30.9%	44.3%	8436	60.5%
ZH St- Ursula – Salvator. Hasselt	4	.4%	.1%	373	41.3%	8.1%	527	58.3%	9.0%	904	6.5%
Maria ZH Noord Limburg. Lommel	396	16.2%	11.5%	1098	45.0%	23.8%	945	38.7%	16.1%	2439	17.5%
AZ Vesalius. Tongeren				2	6.3%	.0%	30	93.8%	.5%	32	.2%
ZH Maas en Kempen. Maasseik				1	.1%	.0%	812	99.9%	13.8%	813	5.8%
AZ ST Josef. Malle	7	1.4%	.2%	46	8.9%	1.0%	464	89.7%	7.9%	517	3.7%
Other	1	50.0%	0%	1	50.0%	0%				2	0%
Total	3431	24.6%	100%	4617	33.1%	100%	5889	42.2%	100%	13934	100%

Table 24: OZ periods of care by hospital by year (N=12.184)

	Hospital												Total	
	Gezondheidszorg Oostkust. Knokke			UZ Gent			AZ Maria Middelaes. Gent			AZ St Jan. Brugge			N	Col %
	N	Row %	Col %	N	Row %	Col %	N	Row %	Col %	N	Row %	Col %		
1999	47	3.0%	9.3%	989	63.7%	15.5%	186	12.0%	10.4%	331	21.3%	9.4%	1553	12.7%
2000	96	4.4%	19.0%	1246	56.6%	19.6%	295	13.4%	16.5%	566	25.7%	16.1%	2203	18.1%
2001	137	5.5%	27.1%	1615	65.1%	25.4%	295	11.9%	16.5%	435	17.5%	12.4%	2482	20.4%
2002	100	3.6%	19.8%	1010	36.5%	15.9%	336	12.1%	18.8%	1323	47.8%	37.6%	2769	22.7%
2003	36	2.3%	7.1%	741	47.4%	11.6%	350	22.4%	19.6%	435	27.8%	12.4%	1562	12.8%
2004	90	5.6%	17.8%	766	47.4%	12.0%	327	20.2%	18.3%	432	26.7%	12.3%	1615	13.3%
Total	506	4.2%	100%	6367	52.3%	100%	1789	14.7%	100%	3522	28.9%	100%	12184	100%

Table 25 shows the specialisms at the origin of the requests for treatment. These are restricted to 94% of the accepted requests (excluding mainly those for which requests were made from several specialisms).

Table 25: Specialism at origin of request for treatment (N=24,549)

	Specialism doing request for treatment	
	Count	%
Cardiology	1818	7.4%
Dermatology and venerology	377	1.5%
GP	18375	74.9%
Internal medicine	477	1.9%
Neurosurgery	932	3.8%
Orthopaedics	969	3.9%
Obstetrics and gynaecology	287	1.2%
Other specialities	1314	5.4%
Total	24549	100%

The next table (Table 26) shows that requests for treatment for CZ patients are almost exclusively coming from GPs (96.6%) compared to less than half (48.2%) of the OZ patients. According to an OZ representative, this is the logical result of their policy of preventing under-utilization of eligible Dutch near-border hospitals and of limiting the patient flow to Belgian hospitals.

Table 26: Specialism at origin of request for treatment by insurer (N=24549)

	Health insurer				Total	
	CZ		OZ		N	Col %
	N	Col %	N	Col %		
Cardiology	42	.3%	1776	16.0%	1818	7.4%
Dermatology and venerology	11	.1%	366	3.3%	377	1.5%
GP	13027	96.9%	5348	48.2%	18375	74.9%
Internal medicine	25	.2%	452	4.1%	477	1.9%
Neurosurgery	14	.1%	918	8.3%	932	3.8%
Orthopaedics	158	1.2%	811	7.3%	969	3.9%
Obstetrics and gynaecology	8	.1%	279	2.5%	287	1.2%
Other specialities	164	1.2%	1150	10.4%	1314	5.4%
Total	13449	100%	11100	100%	24549	100%

As OZ has a contract with Gezondheidszorg Oostkust Knokke for maternity care, 98.1% of the requests for treatment are done by GPs (Table 27). Obviously, the contract with the hospital AZ Middelares in Gent is restricted to cardiology, with 98.6% referred by a cardiologist. The scope of specialisms referring to UZ Gent and AZ St-Jan. Brugge is much broader.

Table 27: Specialism at origin of request for treatment for OZ patients (N=11,000)

	Hospital												Total	
	UZ Gent			AZ St Jan. Brugge			AZ Maria Middelares. Gent			Gezondheidszorg Oostkust. Knokke			N	Col %
	N	Row %	Col %	N	Row %	Col %	N	Row %	Col %	N	Row %	Col %		
GP	2758	51.6%	50.4%	2110	39.5%	62.6%	4	.1%	.2%	476	8.9%	98.1%	5348	48.2%
Cardiology	25	1.4%	.5%	7	.4%	.2%	1743	98.1%	98.6%	1	.1%	.2%	1776	16.0%
Neurosurgery	335	36.5%	6.1%	573	62.4%	17.0%	9	1.0%	.5%	1	.1%	.2%	918	8.3%
Orthopaedics	473	58.3%	8.6%	336	41.4%	10.0%	2	.2%	.1%				811	7.3%
Internal medicine	298	65.9%	5.4%	150	33.2%	4.4%	4	.9%	.2%				452	4.1%
Dermatology and venerology	366	100%	6.7%										366	3.3%
Obstetrics and gynaecology	278	99.6%	5.1%							1	.4%	.2%	279	2.5%
Paediatrics	224	97.8%	4.1%	4	1.7%	.1%				1	.4%	.2%	229	2.1%
Pulmonary diseases and TBC	209	95.9%	3.8%	9	4.1%	.3%							218	2.0%
Otolaryngology	137	89.0%	2.5%	17	11.0%	.5%							154	1.4%
Urology	30	27.5%	.5%	79	72.5%	2.3%							109	1.0%
Other specialities	343	78.0%	6.3%	86	19.5%	2.6%	6	1.4%	.3%	5	1.1%	1.0%	440	4.0%
Total	5476	49.3%	100%	3371	30.4%	100%	1768	15.9%	100%	485	4.4%	100%	11100	100%

2. Patient population

The OZ patients are older than the CZ patients (mean age of 50.6 versus 47.3, one-way ANOVA $F=179.1$. d.f.=1. $p=.000$).

Table 28 also shows that OZ equally has more children in its population.

Table 28: Age of patients by insurer (N=25,125)

	Health insurer				Total	
	CZ		OZ		N	Col %
	N	Col %	N	Col %		
Age -4	145	1.1%	215	1.9%	360	1.4%
5-9	131	1.0%	240	2.1%	371	1.5%
10-14	152	1.1%	204	1.8%	356	1.4%
15-19	313	2.3%	249	2.2%	562	2.2%
20-24	577	4.2%	359	3.1%	936	3.7%
25-29	744	5.4%	594	5.2%	1338	5.3%
30-34	1097	8.0%	955	8.3%	2052	8.2%
35-39	1331	9.7%	1017	8.9%	2348	9.3%
40-44	1465	10.7%	854	7.5%	2319	9.2%
45-49	1470	10.7%	728	6.4%	2198	8.7%
50-54	1479	10.8%	793	6.9%	2272	9.0%
55-59	1396	10.2%	925	8.1%	2321	9.2%
60-64	1053	7.7%	796	7.0%	1849	7.4%
65-69	852	6.2%	824	7.2%	1676	6.7%
70-74	675	4.9%	887	7.8%	1562	6.2%
75-79	465	3.4%	833	7.3%	1298	5.2%
80-84	228	1.7%	644	5.6%	872	3.5%
85-89	89	.7%	230	2.0%	319	1.3%
90-95	19	.1%	77	.7%	96	.4%
95-	2	0%	18	.2%	20	.1%
Total	13683	100%	11442	100%	25125	100%

Five percent of the patients had more than one period of care and most of them (4.9%) two periods of care. More OZ (8.1%) than CZ patients (2.4%) have multiple periods of care ($p=.000$). But if we select only patients with the first period of care in 2002 and later, this relation changes in the opposite direction with 2.5% of the CZ patients and 1.3% of the OZ patients with more than one period of care ($p=.000$).

ANNEX IV: LIST OF INTERVIEWED PERSONS ACCORDING TO COUNTRY AND INSTITUTION/ ORGANIZATION

BELGIUM

Hospitals

Algemeen Stedelijk Ziekenhuis Aalst – Dr Y. Gryssole (head physician). Mr Brantegem (financial and administrative manager)

Algemeen Ziekenhuis Sint-Jan AV. Bruges – Mr Vankersschaever (hospital director)

Algemeen Ziekenhuis Sint-Jozef. Malle – Mr P. De Becker (hospital director). Dr P. De Wit (head physician)

Algemeen Ziekenhuis Vesalius. Tongeren – Mr J. Iven (hospital director). Dr J. Voets (head physician)

H.-Hartziekenhuis Roeselare-Menen – Mr Waterbley (hospital director)

Maria Ziekenhuis Noord-Limburg. Lommel – Mr R. Luyten (hospital director)

Stedelijk Ziekenhuis Roeselare – Dr Missinne (orthopaedic surgeon)

Universitair Ziekenhuis Antwerpen. Antwerp – Mr Van Der Straeten (hospital director). Prof Moulijn (former head of cardiac surgery department). Mr L. Avonds (manager)

Universitair Ziekenhuis Gent. Ghent – Dr Colardyn (hospital director). Mr Guy de Rudder (administrator)

Ziekenhuis Oost Limburg (ZOL). Genk – Mr Luc Van Camp (financial and programme manager). Mr Hellings (hospital director). Ms Lydia Moors (financial manager). Ms Elke Panens (administrative officer)

Sickness funds

CM : Patrick Carnotensis

Geert Basyn

Mutualité Alain Coheur

Socialiste:

Federal Public Service of Health

Jean Legrand

Koen Schoonjans

Marleen Steenbrugghe

INAMI / RIZIV

Chris Segaert

THE NETHERLANDS

Health insurers

VGZ: Dr. Van de Berk
Angeline Koolen

OZ: Rolf Swens
Heidi Taelman

CZ: Nico Martens
John Stevens

ACHMEA: Arnoud Zanen

Association of Dutch insurers – ZN

Marcel Smeets

Public authority – CvZ

Ms. C. Smand
Mr N. Stiemer
Ms. Van Drooge
Mr G.J. Velders

Erasmus University Rotterdam

Dr Werner Brouwer
Dr Andre Den Exter

ENGLAND

Lead Commissioner – Guy's and St Thomas' Foundation Trust

Christina Firmin
Tony Reeves

Department of Health

Jonathan Mogford
Paul Whitbourn