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CONTRACTING CROSS-BORDER CARE IN BELGIAN HOSPITALS: AN ANALYSIS OF BELGIAN, DUTCH AND ENGLISH STAKEHOLDER PERSPECTIVES

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EXECUTIVE SUMMARY OF THE RESEARCH REPORT[1]

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 for intra- and extra-mural care 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

[1] Glinos, I. A., Boffin, N. en Baeten, R. (2005), "Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives", Report for the project "Europe for patients", Observatoire social européen, Brussels, August 2005 (http://www.ose.be/files/health/BelgianCaseStudy_ForPrint.pdf).

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, by 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, which cooperates with two out of four Dutch insurers, controls that the correct tariffs are applied and are in accordance with Belgian law when Belgian hospitals invoice Dutch sickness funds. 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 mainly 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 for providers to use up spare

capacity and attract 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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