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

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EXECUTIVE SUMMARY OF THE RESEARCH REPORT[1]

Background

This mail survey is part of a broader study of cross-border care in Belgian hospitals through contractual arrangements[2]. It was set up to describe the patient perspective on cross-border care in Belgian hospitals contracted by two Dutch health insurers, OZ and CZ.

Our main research questions were:

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

Methods

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

Results

At the end of May 2005 we included completed questionnaires of 802 respondents. The adjusted response rate was 71.6% for the total population. Response was independent of insurer, sex, hospital and time lapse between invoice and the survey. Compared to non-responders, responders were

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1 Boffin, N. en Baeten, R. (2005), "Dutch patients evaluate contracted care in Belgian hospitals: results of a mail survey", Report for the project "Europe for patients", Observatoire social européen, Brussels, November 2005 (http://www.ose.be/files/health/RepDutchPatients.pdf).

2 See also 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).

somewhat older. Persons who did not receive actual treatment (but went to the hospital for a scan) or did not stay overnight in the hospital, were less inclined to answer the questionnaire. Of the CZ-patients 16.3% had private insurance (all OZ-patients had sickness fund insurance).

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

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

The other side of our main finding is that CZ-patients would have preferred a Dutch hospital if they could have received care with the same promptness. In their cases we see that waiting lists do play a major role. Three quarters of the CZ-patients state that there was a waiting list in the Netherlands for the care they demanded. The absence of a waiting time is definitely the most important argument in the decision to go to a Belgian hospital. We do have basic treatment data on the CZ-patient population. We found that the longest waiting lists are declared by those patients who consulted medical specialists in bariatric and abdominal surgery, plastic surgery and other surgery, and this group makes up nearly a quarter of the CZ-patients. They live further from the Belgian hospital, they are less oriented towards Belgium and they are less familiar and experienced with Belgian health services. Shorter travelling

distance to the hospital is no argument for cross-border care for the CZ-patients. Fewer CZ-patients were acquainted with the possibility of cross-border care and most of them were told about it by non-professional caregivers, i.e. family or friends. In contrast to the OZ-population, CZ-patients use informal support for obtaining information and deciding to go for Belgian hospital care. Their insurer proposes the hospital and equally helps in their decision process. Medical specialists play a minor role in giving preliminary information, proposing the hospital and helping CZ-patients to decide.
Once they have access to the Belgian hospital care, there are no significant differences between OZ-patients and CZ-patients with respect to their post-hospital path and their evaluation of the quality of care.

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

Conclusions

This survey was set up to study three research questions:

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

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

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

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

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

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

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

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