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A Literature Review of Cross-Border Patient Mobility in the European Union

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¹ People going abroad for health care for reasons of (bio)ethical legislation.

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A LITERATURE REVIEW OF CROSS-BORDER PATIENT MOBILITY IN THE EUROPEAN UNION

Executive Summary

With the present literature review we set out to examine patient flows across Europe; to identify the types of patients, actors and factors which contribute to patient mobility; and to highlight the similarities and differences between cross-border initiatives as well as the broader implications they might have, bearing in mind that any literature review is limited by the availability of material. The scope of the study was defined as covering “concrete examples (...) where at least one patient moves across a border to be treated by a health care provider” (ch.1); with this focus in mind we carried out a literature search and the subsequent analysis. Yet it should be mentioned that it was not always an easy task to find and get hold of existing material, that documents do not all live up to the same quality standards and that by definition we could only include practical experiences which we found written material on. We are aware that there might be a certain bias in the review in terms of representativeness as some larger and better funded projects tend to be more documented and as we might not know about material in languages we do not cover (mainly from the ‘new’ Member States). As a consequence, some regions and countries have been described and analysed more extensively than others – without necessarily meaning that nothing happens in other parts of the EU, just that we have not found documentation in it.

To understand patient mobility we have looked at “what goes on where and why”. This approach combines the geographical element of mobility to see where patients are moving from and to, the operative element to see who (patients and other players) is involved in which arrangements to make patient mobility function and the analytical element to understand the reasons behind mobility.

In a sense, the literature review has been a mapping exercise of what goes on in Europe. One of the lessons of the study appears to be that it is very difficult to draw general, sweeping conclusions about patient mobility, its direction and purposes. Patient flows do not e.g. just go from the South to the North nor do they emerge just as a result of waiting lists. To make sense of this wilderness, we have tried to systematise the information gathered by creating a *typology* – hopefully nuanced enough to allow for the differences in the experiences ranging from Malta to Norway and from Portugal to Hungary, yet simple enough to make a multi-faceted phenomenon like patient mobility more comprehensible. As we from the outset defined the focus of the literature review to be on examples “where at least one patient moves across a border (...)” (ch.1), it was natural to start our typology with patients, then to look at the types of borders which patients cross and finally to examine the actors and arrangements which surround the mobile patient.

PATIENTS

At an early stage of our research we identified two broad types of patients: patients receiving foreign care because they happen to be abroad when they fall ill (tourists and long-term residents) and people going abroad to seek health care, either because they live in border-regions or because of some relative disadvantage in the national health care system. However, the focus has been on the latter of the two as the motivations of the patients who seek foreign health care and the arrangements which surround these patient flows, are more extensively described in the literature.

We made one assumption common to all patients – they want to be treated as close to home as possible in a system they feel familiar with, but *under some circumstances they might be willing or even prefer to be treated abroad*. The willingness or preference to go cross-border can be explained and analysed through what could be termed the five key drivers/ determinants of patient mobility:

- Familiarity/ proximity: This driver is naturally more present in border-regions where the same local community lives on each side of the frontier. Where there is a shared feeling of closeness people will prefer to cross the border to receive health care not just because it is geographically closer but also because they feel more familiar with the setting. The alternative is often travelling longer distances within the country of residence to providers and facilities which they perceive as more foreign e.g. due to cultural and linguistic differences. In this sense, distance and proximity should not merely be measured in kilometres; they also depend on people's perceptions and the value attached to them.
It should however be said that it can be difficult to define where a border-region begins and where it ends. Do Dutch patients living 30km away from the border count as border-region population? According to our definition, what distinguishes the border communities is that the border separating them is rather superficial and not perceived as a separation as such – the border is fluid and is a local setting for intense exchanges whether for work, leisure, social activities, or indeed health care.
- Availability: Two different dimensions are present when we consider availability of health care as a motor for patient mobility – availability in terms of the *quantity* of services and availability in terms of the *kind* of services.
Insufficient capacity leading to waiting times and waiting lists in the national system can make people go abroad. In such cases, the treatment required *does exist* at home but is not available within certain time limits. Where health care purchasers have recognised that there is an acute problem of under-capacity in the national system, they have sometimes turned to the solution of allowing patients access to foreign health care services, as e.g. in England, The Netherlands, Denmark and Norway.
On the other hand, when some kinds of services *do not exist* in the national system patients might also be willing and allowed to go abroad. Not all highly specialised treatments requiring hi-tech equipment are available in all countries, e.g. when limited national or regional population sizes do not justify the presence of expensive facilities. In these cases, patient mobility is an alternative to costly, uneconomical investments for public authorities
- Financial costs: Prices and co-payments, or rather differences in prices and co-payments, can be a driver for patient mobility when going abroad for treatment presents important savings for the patient. There are two characteristic aspects of the financially motivated mobility: the type of care and the destination of patient flows. Regarding the care patients go abroad for, it is treatments excluded from the national health care benefit basket or for which there are important co-payments. Because patients have to pay out-of-pocket in the home system they have a strong incentive to look for cheaper alternatives. This means that the destination of patient flows is directed towards countries where costs are comparatively lower. Although the examples in the literature only provide anecdotic evidence, the trends invariably show that these patient flows go towards the 'new' Member States (Poland, Hungary, Slovenia) and that they originate from countries with higher price levels (England, Ireland, Denmark, Germany, Switzerland...).
- Perceived quality: Dissatisfaction with the health care provided in the national system can also lead people to go for treatment abroad as the patients perceive foreign health care services as being of higher quality (in many countries this demand for 'better' health care will be absorbed by the private sector).

- Bioethical legislation: Although the least-documented type of patient flows and existing material is only anecdotal, it is perhaps the most controversial form of patient mobility when people go abroad to seek medical assistance because legislation in their home country does not allow the specific treatment. Cases include 'abortion tourism', 'fertility tourism' and even euthanasia.

Whatever the driver, it is the *difference and comparison* between the option to stay at home and the alternative to go abroad which influence the patient's choice. Drivers influence both border-region patients travelling abroad for familiarity and patients travelling abroad due to relative disadvantages in the national system (one of the other four drivers); the difference between the two groups is one of degree – it will probably require stronger push and pull factors to make the second group go abroad for health care as populations in border-regions often do not consider crossing the border as going abroad.

BORDERS

Frontiers are decisive because they constitute the geographical and spatial setting in which patient mobility takes place. The focus here has been on movements across international borders, i.e. between two countries which either share a common border or which are geographically further apart. When international borders separate two neighbouring countries they sometimes also constitute a regional border, i.e. they run through a region and a community which despite being separated by a border sees itself and lives as one entity.

In addition, frontiers present a separation between two distinct health care systems when a patient crosses from one system into the other; in this sense, access procedures to obtain health care in another Member State can be seen as an administrative bridge between two systems. A third aspect of borders is the value they have in people's minds; they can be perceived as more or less present, as a real dividing line or as an artificial demarcation. Based on these three dimensions (geographical, administrative and subjective) we have distinguished two types of borders, namely fluid borders and rigid borders, where the characteristics of "fluid" and "rigid" have to be considered with all three dimensions in mind. A fluid border can be described as a border which is physically and geographically easy to cross, which does not present an administrative barrier and which is not perceived as a separation as such. People do not see "the other side of the border" as foreign territory and the cross-border movements of patients are thus facilitated. In contrast, rigid borders are characterised by geographical and natural elements which create a physical separation, such as mountains or water, by heavy administrative access procedures which hinder most patient flows and by the unfamiliarity and foreignness felt by the populations living on each side of the border vis-à-vis each other (e.g. due to speaking different languages). Clearly, fluid borders are most prevalent in border-regions where cross-border movements and exchanges are part of everyday life and where the domino-effect (as described above) is present when one form of cross-border mobility, e.g. for working or leisure reasons, is likely to generate other forms of mobility, e.g. to seek cross-border health care.

ACTORS AND ARRANGEMENTS

If borders represent the setting in which patient mobility takes place, then actors and arrangements constitute the functional context for patient movements. Actors can broadly be regrouped into patients, providers, purchasers, public authorities and middlemen, and they can operate at the local, regional, national or European level.

Based on the examples in the literature, one is able to discern some trends across Europe. It appears that the locally organised patient mobility is more likely to develop across fluid borders and/ or within a broader context of regional cooperation. This is not surprising since local actors understand the specificity of their region, are aware of patients' needs and therefore see the necessity in having administrative and funding mechanisms which allow mobility. This can be done through free access

zones as in Thiérache region between France and Belgium, or through simplification of authorisation procedures. Yet while many of these arrangements have been initiated from the local level, the public authority responsible for funding cross-border health care must be involved which in many cases are State-level authorities. The wider context can also play an important role as locally organised patient mobility can be one of many elements in the broader cross-border cooperation between two regions or indeed between two hospitals which aim at promoting exchanges and learning from each other. On the other hand, a very different situation arises where there are waiting lists or lack of highly specialised medical care. The reviewed literature showed that state-level authorities are often involved in the mobility arrangements when there is a problem of appropriate care in the national system, although this could be due to a bias in the available literature. In some cases, patient mobility is the direct consequence of the decision taken by national health authorities to institutionalise the use of foreign health care capacity in the national system. This decision can be based on small population numbers at national level (the Maltese experience looked at here, but Luxembourg could be another example) or at regional level (e.g. the Dutch region of Zeeuws-Vlaanderen) in which cases it is not economically viable or cost-effective to set up certain (expensive) health care facilities. Cross-border contracts between purchasers in one Member State and providers in another Member State is a way to 'internalise' foreign health care capacity into the national system as e.g. happens when Dutch insurers contract with Belgian hospitals to let their affiliated members have access there. Experimental care is another area where national health authorities might be under pressure to let patients to go abroad when treatments are not available in the country (as illustrated by the Danish case).

From the experiences it becomes clear that the actors involved, the level at which they function and whether an initiative happens bottom-up or top-down is structurally determined as it depends on the organisation of the entire health care system, the power relations between actors, the levels at which decision-making and implementation take place – aspects which 'spill over' into the cross-border setting and influence patient mobility. If e.g. purchasing of health services and financial responsibility lie at the local level, then it is local authorities, and not national health authorities, which will be involved in cross-border cooperation, contracting etc. This is demonstrated in the Scandinavian examples where health care is devolved and in the Pyreneans where French State-level health authorities cooperate with Catalan regional-level health authorities. Furthermore, it is interesting to notice how local actors and arrangements can push State-level authorities to accept the relaxation of access procedures to cross-border health care and motivate central authorities to seek bilateral agreements with governments of neighbouring countries as a way to remain involved in the cross-border developments and frame the processes so as to not lose influence over what is happening on the periphery of national territory.

When there are personal (financial) incentives in going abroad due to important price differences, it is patients themselves and possibly commercial agents which initiate cross-border mobility. If the cheaper provider is just across the border, patients can relatively easily organise the care and travel themselves, as in the case of Austrians going for dental care in neighbouring Hungary; if the provider is further away, a commercial middleman is likely to help the patient in organising the care and transport in 'package deals'. Similar patterns of personal incentives appear to exist when patients go abroad to obtain care which is not available for bio-ethical and/ or legal reasons in their home country, as for example with abortions or fertility treatments. Last but not least, where dissatisfaction with the quality in the national system 'pushes' patients abroad, it can be the permissive administrative structures which allow dissatisfaction to 'escape' to foreign health care providers who are perceived as being better.

If countless combinations thus seem to emerge from the literature, which can appear to have little in common, it is possible to distinguish three broad categories of practical/ financial arrangements.

→ Arrangements based on EU Regulation 1408/71

Arrangements for non-emergency cross-border care can be according to the 'classical' E112 procedure with prior authorisation to access health care services in another Member State, or arrangements can be based on a softened version of the E112 form when prior approval is made automatic. The softening of the procedure usually takes place in a border-region setting where purchasers and providers agree to cooperate and ease cross-border access to care as is seen in many border-regions of 'mainland' Europe (France, Germany, The Netherlands and Belgium). In contrast, the original E112 procedure does not involve any extra cooperation efforts. For patients it can be more or less difficult to obtain prior authorisation depending on the country where they live – the literature show it was particularly easy for some Italians and Greeks who wished to go abroad for what they perceived as better care.

→ Institutionally arranged care

These arrangements are based on some sort of agreement between cross-border partners. The purchasing party can be a public purchaser when e.g. the NHS sets up national programmes for patients to go abroad as in England, Malta and Norway, it can be a regional health authority as in Southern Jutland in Denmark or it can be a health care insurer as in The Netherlands. The other side of the agreement is the providers of care, usually hospitals or clinics and can be either public or private institutions. The actual agreements can range from formal contractual arrangements to gentleman's agreements, and can be embedded in bilateral framework agreements between Member States. It should also be mentioned that the purpose of the agreements is not necessarily to purchase health care, as in some (rarer) cases signing parties agree on co-financing medical equipment and sharing of facilities so that patients from both sides of the border can access the facilities in question (as on the French-Spanish border or the German-Danish border).

→ Self-managed care

In these arrangements it is the patients and possibly commercial middlemen which take the lead generally for treatments not included in the national health care basket or for which there are long waiting lists at home. When the care obtained abroad is part of the benefit package patients can in some cases claim reimbursement from the public funding authority back home (also called the Kohll and Decker procedure after the famous ECJ ruling).

Self-managed care implies that that the collection of information on cross-border care options, the organisation of the care appointments, the travelling and crucially the payment of the treatments is done by patients themselves (with possible restitution), by a private insurer or a commercial broker acting as a middleman.

Factors influencing patient mobility

The volume and direction of patient flows can vary enormously, from a few patients crossing the border to thousands of patients travelling considerable distances. It is not easy to pinpoint what makes the volumes of patients swell or fall but some features appear decisive:

- Distance and/ or ease of travel: patient numbers are more important when travelling across the border for health care is comfortable. This partly explains why patient mobility is so developed in many border-regions, but it also holds true between neighbouring countries when access routes and transportation means are easy e.g. for the thousands of Austrians going to Hungary for dental care. Yet patients' assumed aversion to travelling long distances can also be overcome if transportation is well-organised – either via publicly funded programmes for sending patients abroad, or through privately arranged consumer-friendly 'package deals' which include care, accommodation, transportation and even tourist activities for the mobile patient. Here it should also be mentioned that the emergence of low-cost airlines has also contributed to

the increasing numbers of people travelling for health care, not only because fares are cheaper but also because more destinations have become available.

- Permissive structures for accessing health care abroad: the more open borders and the easier access procedures are, the more patients will be able to travel. This can be seen in border-regions where special arrangements allow patients to move more freely; in countries where there is a liberal approach to granting prior authorisation for cross-border care through the E112 procedure; and in settings where an NHS purchaser or a health insurer contracts with health care providers in another country to give affiliates access. Yet, some purchasers and some contracts allow more patients to move than others. In the case of the English NHS overseas scheme for waiting list patients, only patients requiring a hip- and knee-replacement (and very few cardiac patients) were selected to be treated in Belgian hospitals and during the 16 months of the project only some 600 patients went to Belgium. In comparison, the Norwegian patient bridge allowed patients to go abroad for many different types of care and within the first two years of the project 10.000 treatments had been given to Norwegian patients abroad.
- Availability of care in the domestic private sector: we have seen how demand for health care not satisfied at home can “transform” into patient mobility, e.g. in the event of waiting lists in the public system. Yet, if this demand can be absorbed by private health care providers in the country where the patient lives, mobility is likely to flow to the domestic private sector rather than across the border. This has been the case both in the Danish and Irish national programmes for shortening waiting times by contracting with private clinics at home and with providers abroad (private and/ or public). Numbers from Denmark showed that over an 18-month period approx 26,000 patients benefited from the measure and were treated outside the public system, yet only 1.3% of these went to foreign contracted providers (in Sweden or in Germany). Similar trends are observed in the Republic of Ireland where more than 30,000 waiting list patients have been treated in private clinics in the country, while some 1,000 patients have travelled to Northern Ireland for treatment and around 600 patients to England.
- Learning by doing or chain reaction: patient mobility can generate patient mobility. The positive experiences and positive feedback from patients who have returned back home after successful treatment abroad is likely to encourage more patients to venture outside the national borders. Furthermore, a first successful initiative might also encourage purchasers and providers to extend their cross-border cooperation and thus to allow more patient flows to take place. This chain reaction can be observed in several border-regions across the EU, but also among waiting list patients and people obtaining cross-border care on their own initiative. As the practice of going abroad for health care becomes more widespread, the concept of travelling for medical care becomes more familiar, initial reluctance is overcome and more patients take the step to actually go across the border.

These dimensions are thus likely to influence the volumes of patient flows. It should be noted, however, that one of the main difficulties when studying patient mobility is to find exact figures on how many patients move. It has been almost impossible to obtain reliable data which are comparable in a systematic way but where present in the literature the size of patient flows has been included in the report.

In addition to the four factors affecting the volumes of patient flows, more circumstances can be distinguished in the literature as having a positive or a negative effect on mobility.

As plain as it may seem, actors' willingness to make patient mobility function is perhaps the most decisive condition for success. Yet willingness is closely linked to information and knowledge – the better informed actors are, the more likely it is that they will take part in new arrangements.

Together the importance of information and of stakeholder involvement appear to be the two issues most often highlighted in the reviewed material as prerequisites for well-functioning patient mobility – that all involved stakeholders understand how the system across the border works and realise what benefits cross-border care can entail. For health care purchasers one benefit can be that cross-border contracting expands the pool of providers with whom to contract and gives them more leeway to make good deals. For public authorities of the sending country, a beneficial aspect of cross-border care is that it presents a solution to under-capacity or lack of highly specialised care in the home system. For medical providers, foreign patients can increase income, experience and expertise; for providers in the country of residence patient mobility might be a way to tackle the highly unpopular problem of waiting lists.

Conversely, unwillingness from actors and negative perceptions are likely to have adverse effects. If local doctors see patient mobility as a threat to the care they provide and the responsibility they have towards their patients or if smaller hospitals feel their livelihoods threatened in a limited catchment area, they are most likely to hinder patient flows. Important out-flows of patients can lead to cross-border rivalry as domestic providers might feel their position is at risk. Furthermore, a recurrent issue in the literature is how ignorance and uncertainty about the health care system 'on the other side', the quality of care, which treatment methods are used, the professionalism of foreign providers etc. in many cases result in local providers' unwillingness – a reluctance which they sometimes pass on to their patients. Yet problems can also be of technical nature for those already involved in patient mobility as the practical arrangements can be time consuming and labour-intensive. The setting up of contracts, coordinating funding mechanisms, exchanging medical and administrative information, managing patient pathways, adapting to system differences etc. often require considerable efforts, the benefits of which might take time to ripen, or might never materialise, which discourages participation. On the other hand, several experiences show that if obstacles are overcome then a "learning by doing" process sets in, mutual trust is built up between stakeholders and a first successful initiative can lead to further cooperation. It is also noteworthy how cross-border cooperation in a more general context between neighbouring regions or in a more specific context between border-region hospitals, can enhance efforts devoted to patient mobility.

While sweeping generalisations are risky it seems fair to say that patient mobility happens for a reason; it must be worthwhile for all stakeholders if it is to work. For patients, there is always something better, faster, cheaper across the border, otherwise they would stay in their own country. For providers, purchasers, insurers, commercial middlemen and public authorities, there is always something to gain from cross-border cooperation, otherwise they would not participate in the arrangements surrounding patient mobility.

Implications

Patient mobility makes demand for medical care in one country meet supply of medical services in another. Yet as patients cross borders between countries they simultaneously cross from one health care system into another which can have important impact for the systems involved.

In situations where patients are sent abroad due to insufficient capacity or absence of some treatments at home, patient mobility avoids public authorities to have to make costly investments which would take time to bear fruit due to the long-term nature of efforts to improve capacity in the health care system. Also, in some areas with small population numbers it might not make sense from an economic point of

view to set up expensive facilities, to have on-call services functioning just kilometres apart or provide treatments for rare diseases which require costly equipment. Sharing facilities in border-regions can also be taken one step further when local stakeholders decide to co-fund and co-organise health care infrastructure or when neighbouring hospitals decide to merge activities to complement each other. Patient mobility can thus lead to economies-of-scale as more people make use of services and equipment e.g. scanners or dialyses apparatus in a hospital; by treating foreign patients the hospital in effect expands its catchment area beyond the national borders. This can happen both at the regional level when local patients use hospitals in the border-region and at the state level when e.g. Maltese patients go to England for highly specialised treatments. In this sense, patient mobility alleviates the health care system which sends patients out while potentially contributing to hospitals in the receiving system achieving their optimal case-mix of patients and the turnover point for expensive medical machinery.

Yet a foreign patient arriving in a hospital will have a different effect on the receiving system depending on whether treatment is organised via the E112 route, the institutionally arranged care route or via the self-managed care route. In the former case, patients are integrated into the receiving system as if they were affiliated there; in the latter case, patients and especially the entire institutional set-up which surrounds the mobile patients introduce new elements into the receiving system as tariffs, quality standards, medical procedures etc. which are agreed upon in the contractual arrangements often follow the requirements and practices of the sending country, and not of the country where care is actually delivered. The risk is thus that a new system with its own tariff setting and medical protocols develops in parallel to the global system of the receiving country thereby creating new pressures and challenging established power balances between health care actors. Such developments should be monitored as e.g. higher fees charged in the parallel system could push prices up in the public system and/ or lead domestic providers to favour the more lucrative business of treating foreign patients. Interestingly, the impact of cross-border care might well be the opposite in the sending country where turning to foreign providers puts pressure on domestic providers, especially in the private sector, to remain price competitive. For domestic providers in the public sector, the possibility of seeing large patient flows leaving the country can have the effect of improving services and friendliness towards patients. Yet large outflows of patients can also present a challenge to the public system (and the budget) if patients can bypass the national gate-keeper procedure by going abroad. Also, patient mobility might solve only one part of the capacity problems at home: when people come back home after surgery which could not have been delivered within due time in the national system, they often will require after-care and rehabilitation treatments for which there might also be waiting lists. Patients in effect just move a step up in the health care chain but are likely to encounter the same problems of delays.

Patient mobility is often depicted as a marginal phenomenon in Europe as the overall numbers of patients which receive cross-border care remain minor compared with total populations. The present literature review has tried to redress this picture by providing as much evidence as possible – or as available. Material has been challenging to get hold of; material has been of very different quality and has often been incomparable; last but not least, a bias sneaks into any literature review as by definition only experiences and practices for which material has been found, can be described and analysed. Being mindful of these limitations, the literature review hopefully provides new insight into “what goes on where in Europe” and thereby reveals the impressive amount of effort, time, innovative thinking and resources which go into making patient mobility work. That numerous stakeholders in virtually all European countries go to great lengths to initiate, promote, develop or improve patient mobility indicates its vast potential in a border-free Europe and suggests that patient mobility together with its possible far-reaching consequences ought not to be ignored.

A LITERATURE REVIEW OF CROSS-BORDER PATIENT MOBILITY IN THE EUROPEAN UNION

Introduction

Purpose of the literature review

The aim of the review has been to **explore the existing practices of patient mobility**. Practical experiences found in the literature have been examined to see what could be learned about why and how patient mobility takes place. We have tried to identify the *drivers* and *structures* behind patient mobility, that is, the push and pull factors which make people go abroad for health care, as well as the practical arrangements through which patient mobility takes place. Reviewing the experiences has given insight into the phenomenon of patient mobility as the cases reviewed are characterised by different combinations of elements.

Outline of the review

Before examining the practical examples of patient mobility, the relevant concepts and objectives will be defined. Chapter one will explain the scope and methodology of the study, the research questions which guided the literature review and the technical limitations encountered. Chapter two will briefly present the technical characteristics of the material which has been examined. The conceptual framework with definitions and a typology of patient mobility will be developed in chapter three. Chapter four will present the two main categories of patient mobility and based on these describe and analyse the concrete examples of patient flows illustrated in the literature. In the final chapter, horizontal issues will be highlighted and the conclusions of the research will be presented.

Annex I contains the questions used to analyse the literature, Annex II lists the technical characteristics of each reference used in the review, while Annex III contains the complete list of references.

1. Scope and methodology

1.1 Descriptive, exploratory and explanatory research questions

A series of research questions was drawn up in the initial phases of the work to assess, analyse and synthesise the literature on the practices of patient mobility. The key themes of the research have been:

- What happens across Europe? What patient flows can be observed? What is the extent of the phenomenon?
- Which types of patient mobility can be identified? What typologies can be drawn to highlight differences and similarities between cross-border initiatives?
- Which actors take part in patient mobility, indirectly as well as directly? Does their involvement influence patient mobility in any particular way? What are their motives?
- Which factors might influence patient mobility and in what ways? Are there circumstances which might facilitate or hinder mobility? Are there any criteria or conditions for the success of patient mobility initiatives?
- What might be the implications of patient mobility for stakeholders and health care systems?
- Which policy conclusions can be drawn from the literature and existing experiences?

1.2 What the review intends to cover and what it does not intend to cover

The present literature review examines *cross-border patient mobility*. This means that the focus is on one, particular aspect of cross-border health care, i.e. patient mobility, and not on other topics of cross-border care such as professional mobility or cross-border cooperation involving research, training, laboratory tests etc. if these practices do not result in patients moving across a border. General information and theoretical work on what patient mobility could mean as well as legal analysis of the phenomenon is beyond the scope of this review. What we have been interested in are the **concrete examples** of patient mobility in the literature **where at least one patient moves across a border to be treated by a health care provider**. In the majority of cases, these movements have taken place between EU Member States and occasionally between a country of the European Economic Area (EEA) and an EU country. Occasionally and where relevant patient mobility between regions within a country has also been examined. An additional key characteristic of the reviewed experiences is that the focus has been on **patients who go abroad because they need health care**, as opposed to people who are treated abroad because they happen to be in another Member State at the moment they require medical assistance (such as long-term residents, students, travelling professionals and tourists).

1.3 Methodology

The completion of the present study has been a long process. The first step was to go through existing studies which give an overview cross-border health care in Europe; some of the most important were the HOPE study² of cross-border hospital cooperation, the Hermans and Brouwer study³ on quality

² HOPE (2003). *Hospital Co-operation in Border Regions in Europe*. Leuven, Standing Committee of the Hospitals of the European Union: 88 pages.

issues in cross-border care and the Bassi et al. report⁴ on cross-border cooperation in France. Based on information and references from these reviews as well as on internet research and other sources, a literature search was carried out to collect evaluation reports from projects, press coverage, official documentation, academic publications etc. Several organisations, public authorities, local stakeholders and other relevant persons were contacted to assist in the collection of material. To date, a list of some 160 references has been drawn up of which more than 100 references are reviewed in this report while the rest have served as background information and sources of more general knowledge. The list of reviewed references can be found in Annex II and the complete reference list in Annex III.

The following step was to process the acquired documentation. Based on the research questions, a synthesis structure was drawn up to guide the reading and the analysis of the literature. The reading guidelines can be found in Annex I. The material was then organised according to the cross-border experience described so that the reading, reporting and analysis concentrated on one geographical area or one case at a time.

1.4 The phases of the study

This is the final report of a literature review which was initially divided into two phases. The scope of phase 1 was defined so as to complement the material of the “Europe for Patients” case studies and provide additional information on other regions which the research project could draw on. The regions examined in the e4p case studies were looked at and incorporated in phase 2 of the review so as to include material which became available later in the project through the case-study reports.

Literature collected on patient mobility in the Euregios experiences was also analysed in the second phase. This was decided in order to be able to draw on ongoing work, co-ordinate and avoid duplication of work with another project, “EUREGIO – Evaluation of the border regions in the European Union”, within the European Commission’s Public Health Programme⁵ (DG Sanco). As the EUREGIO project has been carrying out a literature review on the Euregios, there has been exchange of information and of documentation between their research team and ours.

It should also be noted that the review focuses on themes not included in Work Package 5 of the e4p Project which looks at quality of care and patient perspectives.

1.5 Technical limitations of the review

The scope of this study has been limited by the existence, availability and accessibility of written material. Some countries and regions are extensively covered in official reports, the press etc. while documentation barely exists on other parts of Europe. It has been particularly difficult to get hold of literature on some of the Southern European countries as well as the new Member States, partly also due to language problems. Scarcity of documentation might either be a sign that no patient mobility is taking place in these areas; that nothing has been written on the matter in the case patient flows do exist; or that it has been impossible to get hold of the written material.

Depending on the actors involved in the practices surrounding patient mobility, there are also differences in the type of material and the availability as e.g. Euregio projects and arrangements where public authorities are involved or which receive EU funding tend to be better covered than informal, commercial initiatives or private initiatives from patients themselves. The quality of the material is also diverse as grey literature and newspaper articles do not live up to the same standards of other material such as official assessment reports or academic studies. Furthermore, all texts are written with a

³ Hermans, B. and W. Brouwer (2003), *Quality Issues on Cross-border Care: A Literature Search*. Rotterdam/Utrecht: 104 pages.

⁴ Bassi, D., O. Denert, *et al.* (2001). *Etat des lieux de la coopération transfrontalière sanitaire*. Rennes, Mission opérationnelle transfrontalière, Editions de l'école nationale de la santé publique: 64 pages.

⁵ http://europa.eu.int/comm/health/ph_projects/2003/action1/action1_2003_23_en.htm.

precise objective in mind; the style and focus of a paper can differ significantly depending on the audience it addresses itself to, on whose viewpoints it is representing and on whether it has been written to convince, to criticise, to analyse, to inform, to obtain funding etc. There is also a significant difference in whether a paper describes theory or practice, i.e. how a project should function and how it does (or did) function. In addition, due to the fast-changing nature of cross-border cooperation, literature may become out-dated although material on a terminated experience might still have an important illustrative value. It should also be borne in mind that as the quantity and quality of available information varied for each of the reviewed experiences, some cross-border initiatives have been examined in more detail than others. As a last point, this report by definition focuses on documented practices, which means that oral information or general knowledge on existing projects is not included. We are aware that some practices have not been described and analysed in the review as no material was found on them.

2. Technical characteristics of the literature

A wide and varied range of material has been examined and the reference list which can be found in Annex II gives an overview of the key technical characteristics of each of the reviewed documents and sources. The main types of material, of authors and of objectives have been:

TYPES OF MATERIAL

Assessment reports
Research reports
Official documentation
Academic publications
Bilateral framework agreements and contracts
Newspaper articles
Personal communications (mainly electronic mails)
Information from Internet sites

TYPES OF AUTHORS

The actors directly involved in the cross-border cooperation (doctors, hospital directors, insurance funds, middlemen etc.)
Organisations and associations of various types
Public authorities at EU, Member State, regional or local level
External experts (e.g. from think-tanks, research centres etc.)
Journalists
Academics

OBJECTIVES OF THE WRITTEN MATERIAL

To objectively analyse
To present (some) actors' views and experiences
To evaluate and draw conclusions for future initiatives
To inform a limited audience e.g. at political level
To inform a wider audience (e.g. local newspapers)
To convince the reader in order to receive support
To advertise

3. Conceptual framework: definition and typology of patient mobility

3.1 Definitions of patient movements

The following classification helps to understand the phenomenon of patient mobility as the physical movement of patients within a geographical space⁶:

- Patient mobility: general term to describe any kind of movement which involves patients moving beyond their catchment area or area of residence to access health care. This mobility can take place within the same country or between countries.
- Cross-border patient mobility: movement which involves patients going from one country to another
- Regional cross-border patient mobility: patients moving between two neighbouring regions separated by an international frontier
- Inter-regional patient mobility: movement of patients between regions within a country

3.2 Typology of patient mobility

It is possible to establish various typologies⁷ depending on which aspects of cross-border patient mobility are considered. Here, three dimensions have been chosen: patients, borders and the structures surrounding mobility. Reviewing which patients move, across which borders (the setting) and through which structures (the context), will at the same time examine key elements such as the type of care which patients go abroad for, the range of actors involved and how mobility is organised, to draw a more complete picture of the phenomenon.

3.2.1 Types of patients

Two main types of patients have been identified:

- Patients consuming cross-border care because they are abroad at the time when the need for health care arises (e.g. long-term residents, students, travelling professionals and tourists)
- Patients going abroad to seek health care either because they live in a border-region where cross-border care is more convenient, or because they perceive a relative weakness in their national health care system which pushes them to go abroad (such as waiting lists, lack of suitable treatment, or prohibitive prices)

There are five fundamental aspects of health care which influence patients in their decision to go abroad: **availability**, **familiarity/ proximity**, **quality**, **financial costs** and **(bio)ethical legislation**. It is the comparison between the domestic health care system and the foreign health care system on one or more of these dimensions which is crucial when a patient chooses whether to stay at home or go abroad. The five dimensions thus translate into drivers for patients who travel for health care. Although it is a general assumption that people want to be treated as close to home as possible, there are some **circumstances under which patients are willing, or even prefer to be treated abroad if health care abroad is...**

- ... delivered more rapidly (e.g. due to delays or waiting lists at home)

⁶ It should be noted that movements are not always 'geographical' as a patient can move from the public to the private health care sector. See e.g. the Irish and Danish cases.

⁷ Bassi, D., O. Denert, *et al.* (2001). *Etat des lieux de la coopération transfrontalière sanitaire*. Rennes, Mission opérationnelle transfrontalière, Editions de l'école nationale de la santé publique: 64 pages.

- ... more appropriate from a medical point of view (some countries do not have all the facilities and costly equipment to treat some rare diseases)
- ... closer to home than care provided within the country of residence
- ... delivered in a setting which the patient feels more familiar with
- ... perceived to be of better quality compared with the health care services available at home
- ... available at more affordable prices or with fewer co-payments
- ... delivered in a permissive legal context when specific services are unavailable at home due to (bio)ethical legislation⁸

These drivers found in the literature can be considered as **push and pull factors** which influence patient mobility either by pushing or by pulling (attracting) patients to seek cross-border health care.

For the literature review, the most important distinction will be between patients living in border-regions (often more familiar with and willing to use foreign health care facilities) and patients going abroad because of lack of timely, accessible and/ or appropriate care in the national system. A fundamental difference between these two types of patients, on the one hand, and long-term residents and tourists, on the other, is that the latter use foreign health care facilities because they find themselves abroad at the moment they need health care; the former go abroad *because* they need health care⁹. The element of choice is thus more present among these patients. In this context, it should be noted that a 'sub-group' of patients can be identified, namely migrants who have settled in another EU Member State but who prefer to return to their country of origin when in need of health care e.g. because they are more familiar with the system there. This type of patients is likely to be particularly present in border-regions where people move to the other side of the border but may continue to have easy access to the health care services 'at home'. Yet, due to lack of material on these patients, the literature review will not cover this type of mobility.

Documentation tends to concentrate on patients who go abroad for health care as most cross-border initiatives either concern projects taking place in a context of regional cooperation or concern arrangements which have been set up in response to a limitation at home. In contrast, less has been written on patient mobility linked to people who are abroad at the moment they need medical care. Yet as the Spanish and Italian case-studies of the e4p project are devoted to long-term residents and tourists, the issues surrounding these types of patient mobility and their impact on health care systems and stakeholders are extensively covered in the relevant case-study reports.

3.2.2 The setting of patient mobility – types of borders

By definition, patient mobility involves the movement across a border, be it a local, regional or international border. Borders constitute the setting in which patient mobility takes place, yet they have

⁸ We would like to draw attention to the fact that we have included patient mobility due to (bio)ethical legislation in the typology for reasons of completeness. This type of mobility has not been systematically reviewed in the present study as (bio)ethical legislation was identified as a driver for mobility at a later stage in the research. Yet, some examples of this type of patient flows include *fertility tourism* due to laws on the anonymity of sperm and egg donors, see <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/04/28/wfert28.xml> and <http://www.elmundo.es/elmundosalud/2006/05/12/mujer/1147452061.html>; *abortion tourism* when abortion is prohibited, see <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9F02E3D7153BF937A15755C0A9659C8B63>, <http://news.bbc.co.uk/2/hi/europe/3017164.stm>, <http://bmj.bmjournals.com/cgi/eletters/325/7364/565/a>, <http://www.ifpa.ie/download/ifpa-CEDAW-submission.doc> and <http://flag.blackened.net/revolt/ireland/choice/index.html>; and *euthanasia* which is illegal in most countries, see <http://www.behindthemedicalheadlines.com/articles/euthanasia.shtml> and <http://news.bbc.co.uk/2/hi/europe/2676837.stm>

⁹ It should be mentioned that this distinction is not clear-cut as there is evidence of patients going abroad as tourists precisely because they need health care; see Galan, L. (2004). Turismo de sol, playa y hospital. *El Pais*.

different characteristics and different meanings which can influence mobility. The focus in this review has been on patients who cross **international borders** to get access to care, but where relevant, domestic inter-regional mobility (i.e. between regions within the same country) and mobility from the public to the private sector have also been taken into account.

Yet, international borders are not just separating two countries; they can also constitute a separating line between the regions and local communities on each side of the frontier. Some of these **border-regions** are poles of intense cross-border flows and activities in a variety of areas, including health care. One can speak about multi-dimensional proximity in these regions as culture, language, traditions, history and habits often contribute to a feeling of closeness between the local communities despite the existence of an international border. As Vandermeir describes¹⁰: “people living close to frontiers cross from one side to another sometimes without even realising, as they have erased this concept from their habits in all areas of life (leisure, work, shopping, health care etc)”. In other cases, there is no such proximity and the borders constitute a more physical separation between the countries. These characteristics suggest the distinction¹¹ between what could be termed as **fluid borders** and **rigid borders**.

The distinction is important as the types of borders, the value it has in people’s minds and everyday lives, affect the extent to which people cross the borders including to access health care. Fluid borders combine a permissive administrative framework and a mindset; they constitute a setting for intense exchanges (goods, services, people etc.) which facilitate the cross-border flow of patients, not just because procedures and structures are likely to be more flexible, but also because people are less reluctant to use the ‘foreign’ health care services. As a Danish case study puts it “the foreign is perhaps less foreign”¹² in the border-region (in this case between Denmark and Germany).

3.2.3 The context of patient mobility – types of actors and types of arrangements

Patient mobility takes place within different contexts, different arrangements and different procedures depending on where it takes place and which actors are involved. At a minimum, **patient mobility must involve a patient and a health care provider separated by a border**, but some cross-border experiences involve a large variety partners. **Actors** can broadly be categorised as patients, providers, purchasers¹³, health authorities and middlemen, and they can be situated at the local, regional, national or European levels. The different roles of the actors can be described as follows:

- Stakeholders can be actively engaged with the medical aspects of patient mobility, that is, invariably those receiving care (patients) and those providing it (hospitals or doctors).
- Actors can be involved in setting up the cross-border structures for patient mobility (e.g. contracts, agreements, procedures etc.); these administrative and organisational functions can be undertaken by the providers, insurers, public authorities and middlemen.
- Actors can be active behind the scenes where decision-making, priority-setting, allocation of budgets, signing of bilateral international agreements and legislation concerning patient mobility is taking shape; these functions can be carried out at the management level of hospitals, in national parliaments, local, regional or national governments, EU institutions etc.

¹⁰ Vandermeir, M. (1999). “Quelle complémentarité franco-belge?” *Intra-Muros*: pp-33-34.

¹¹ See also Bassi, D., O. Denert, *et al.* (2001). Op. cit. p. 30-31 and Denert, O. (2004). La coopération transfrontalière sanitaire, Mission Opérationnelle transfrontalière, p. 5.

¹² Frost, R. G. (2000). Efterbehandling af brystkræftpatienter i Flensborg af borgere fra Sønderjyllands Amt (Follow-up treatment of breast cancer patients in Flensburg of citizens from Southern Jutland County), Sønderjyllands Amt: 13. p.12

¹³ The term “purchaser” should be taken broadly. By purchaser we understand an actor which finances health care services, not necessarily by purchasing as such but also by reimbursing services which have been consumed e.g. when a health insurer pays providers based on fee-for-service.

Overlap between these activities is possible as e.g. a hospital might both be providing cross-border health care and be involved in organising the structures for patient mobility.

Depending on the actors, their roles and levels, patient mobility can be initiated through a bottom-up or top-down approach¹⁴, and cooperation between partners can be extensive and long-lasting, or ad-hoc and temporary initiatives. In some cases, it also becomes important to distinguish between public actors and private, commercial stakeholders.

As the practical experiences will illustrate, there exists great diversity in **arrangements**. An array of access procedures, patient pathways, payment methods, cooperation agreements etc. all contribute to the functioning of patient mobility in practice. In some cases, patients go abroad through organised, official structures, while in other cases people travel to another country on their own initiative. Occasionally, initially informal arrangements have later led to the set-up of formal cooperation between health care actors to facilitate and institutionalise patient mobility.

An element worth mentioning is the possible involvement of a middleman, i.e. an agency or organisation acting as an intermediary between patients in one country and providers in another. This mediation role can be performed by very different actors. One can broadly distinguish between commercial middlemen of the broker-type, which actively attract patients by promoting the foreign health care facilities and often have a pecuniary interest¹⁵, and non-profit middlemen which provide assistance to the partners of the cross-border arrangements, sometimes constitute a signing party in cross-border contracts but do not necessarily have contact with patients¹⁶.

In terms of the content of cross-border care, arrangements may cover only very specific types of care or provide for a range of services depending on the needs of patients and on the shortcomings in the health care systems at home. In terms of the direction of patient flows, they might run only one way or both ways across the border depending on health care supply and demand in the involved countries. Last but not least, a range of different funding mechanisms exists to cover the costs of cross-border care consumed by mobile patients. Here too different actors can be involved and accordingly financial responsibility can lie e.g. with patients themselves or private insurers if care is obtained via private channels, with State-level authorities if treatment is delivered via the E112 procedure, or with regional health authorities or insurers who have contractual agreements with foreign providers.

Note on the typology

It is important to notice that the types within the typology are not exclusive or exhaustive. Any typology is arbitrary and one could argue that the above distinctions are artificial categorisations. Patient mobility is a multifaceted phenomenon where all elements interact making it difficult to isolate one or the other aspect.

¹⁴ On cross-border hospital cooperation, see also Harant, P. (2003). *Hospital Cooperation in Border Regions in Europe*. HOPE Conference and Workshop: Free movement and cross-border cooperation in Europe : the role of hospitals & practical experiences in hospitals, Luxembourg, HOPE and EHL.

¹⁵ Examples include the German middlemen PatientLink and GerMedic, and the Danish 'AvMinTand'.

¹⁶ Such as the NHS Lead Commissioner Guy's and St Thomas' Foundation Trust or the Belgian sickness fund 'CM' which will be looked at in part 2 of the literature review.

4. Experiences of patient mobility across Europe

Combining the types of patients with the types of borders as defined in the previous chapter, it becomes possible to distil two broad categories of patient mobility in the literature:

Firstly, **patient mobility in border-regions**, most often through regional or local projects set-up because the best availability of appropriate health care happens to be on the other side of the border. In these cases, patient mobility is often spontaneous due to the fluid nature of the borders; cross-border distances tend to be negligible (and are often shorter than if the patient had to go elsewhere within the country of residence); people are likely to be familiar with health care facilities 'on the other side'; and going cross-border is not necessarily felt like going abroad. It is thus familiarity and proximity with cross-border health care services which constitute a pull factor. Significantly, language is not a barrier in these experiences as cross-border communities generally understand each other or even share the same dialect (even when the official languages are different). Patients are also likely to feel culturally closer to the next-door border-region than to nearby regions in their own country which could alternatively offer appropriate care. The broader context is also important as collaboration in health care often takes place within a wider effort of regional integration and many projects have benefited from EU funding at some stage. On several occasions a first successful initiative has led to further cooperation.

To illustrate this kind of patient mobility, the following cross-border settings will be examined:

- Sweden – Denmark
- Denmark – Germany
- Germany – The Netherlands
- Germany – The Netherlands – Belgium
- Belgium – The Netherlands
- Belgium – Germany
- The Netherlands – Belgium/ Germany
- Germany – Austria
- Germany – Switzerland
- Belgium – France– Luxembourg
- France – Belgium
- France – Italy
- France – Spain
- Estonia – Latvia
- Northern Ireland – Republic of Ireland

Secondly, **patient mobility which takes place due to circumstances in the national health care system** which push patients to go abroad; this can either be waiting lists, unavailable services, perceived lower quality or price differences for treatments which patients contribute to through out-of-pocket payments. In this sense, there is a trade-off between what is available at home and what can be found abroad. As the comparative weaknesses at home are viewed unfavourably by patients, they act in favour of patient mobility as people whose needs and/ or expectations are not met at home will be more willing to travel abroad. This form of patient mobility can involve travelling considerable distances and the feeling of going abroad is more immediate than in border-regions.

To illustrate these patient flows, the following cases will be looked at:

PATIENT MOBILITY DUE TO AVAILABILITY SHORTCOMINGS (WAITING LISTS, LACK OF COMPETENCE OR LACK OF CAPACITY):

- Denmark – EU
- Norway – EU
- Europe – Sweden (Stockholm)
- Malta – the UK
- UK NHS patients – Germany/ France/ Belgium
- Republic of Ireland – Northern Ireland/ UK
- Spain – Portugal

PATIENT MOBILITY DUE TO DIFFERENCES IN PRICES OR CO-PAYMENTS:

- Germany/ Denmark/ the UK – Poland
- Austria (etc) – Hungary (etc)
- Austria/ Italy – Slovenia
- Finland/ Sweden – Estonia

PATIENT MOBILITY DUE TO PERCEIVED LOWER QUALITY AND DISSATISFACTION WITH THE SYSTEM:

- Italy
- Greece

Clearly, overlap can exist between these two broad categories of patient mobility as e.g. lack of accessible health care at home can lead patients living in a border-region to seek treatment across the border when facilities are better there. Important for the distinction is whether patient mobility is taking place in the immediate border-region and whether it is motivated by a feeling of proximity or the choice to avoid a weakness such as delays at home. This distinction will become clearer through the analysis of concrete examples of patient mobility on a Europe-wide scale.

To illustrate how patient mobility functions and why it takes place, we will start by examining practical examples from the border-regions and then turn to patient mobility related to disadvantages in the national health care system (in the order presented above).

The main characteristics and most noteworthy points of each experience will be emphasised in bold characters.

4.1 Patient mobility in border-regions

■ SWEDEN – DENMARK THE ORESUND REGION



Cross-border patient mobility between Sweden and Denmark is part of **wider regional integration efforts**. Importantly, the Oresund Bridge was opened in July 2000 connecting the two countries (and regions) otherwise separated by a narrow water channel.¹⁷

The Oresund Committee, which promotes local and regional cooperation across the channel, has taken several initiatives in different areas including the health care sector to facilitate the cross-border activities of Danish and Swedish citizens living and working in the Oresund region. Cross-border workers have been commuting across the channel for many years and the coordination of health care services becomes important for their fluent mobility.

Cooperation in the field of health care has been relatively intensive as the Swedish regional authority of Skaane identified around 20 cooperation arrangements based on formal contracts and roughly another 20 informal cooperation activities. All projects have had a bottom-up approach as **local stakeholders** have had a prominent role. Yet, it should be noted that this is partly explained by the fact that responsibility for health care services has been devolved to the local level in both Sweden and Denmark.

According to the Oresund Committee report, only in few cases have projects led to patient mobility as the overall aim of initiatives has not been to tackle capacity problems, but rather to improve the quality of care through exchange of experience and staff, joint education, research coordination, development of clinical methods etc. Cooperation projects which do involve patient mobility have been set up to **overcome acute problems of shortage of capacity** or of beds to allow patients faster access to treatment 'on the other side of the Sound'. Such projects can either be running agreements or on a temporary basis and areas of collaboration have included neonatology and intensive care.

Continuing inter-hospital cooperation across the channel

On-going cooperation has taken place between Copenhagen University Hospital, Malmo University Hospital and the Lund University Hospital in the field of intensive care, including neonatology. An **informal agreement** has for several years allowed the exchange of intensive care patients and in

¹⁷ Oresundskomiteen and Oresund direct (2003). Health Care without Borders in the Oresund region. Copenhagen (?), Oresundskomiteen: 19 pages, appendix 12 pages.

spring 2002 a **written agreement** was signed by the chief doctors of the three institutions to assist each other in the event of **shortage of beds for intensive care** patients and premature babies. In practice it means that acute cases requiring I.C. are taken to the nearest hospital where they are stabilised and transferred to another hospital in case of insufficient beds. According to the hospital director of the University Hospital in Lund, the cooperation has been successful and might be extended to more hospitals¹⁸.

According to the report, there were no real obstacles to cooperation, rather start-up problems relating to legal aspects of the rights of patients, health insurance coverage and liability insurance for medical staff. There have been cases where people have been **refused access** to care although legally entitled to it due to **misinterpretations** or **misinformation** from providers' side or incompatibilities between the two health care systems.

Concluded project in the Oresund initiative between Lund and Gentofte hospitals

Inter-hospital agreement between the Department of Cardiology and Chest Medicine at University Hospital Lund (Sweden) and Gentofte Hospital (Denmark) that **60 Swedish cardiac patients** would receive coronary bypass operations at Gentofte Hospital (located in the region of Copenhagen) because of **temporary under-capacity** in Lund hospital. The active cooperation started in May 2001, lasted for nine months and was a consequence of the recruitment problems which Lund experiences as it was under-staffed in nurses. According to Director of the Heart and Lung Centre at Lund, the collaboration worked out very well and was discontinued due to extended capacity in Lund¹⁹. There has not been any formal evaluation of the collaboration apart from follow-up of the surgical results, which was according to set standards. Yet, the local press has been interested in the project.

On the Danish side, a press release from the Directorate for Hospitals of the Copenhagen County describes how the 'invasion' of Swedish cardiac patients at Gentofte Hospital had been a success²⁰. The article gives an overview of how the different involved actors judge the experience:

- According to the Swedish coordinator it was never a problem finding patients willing to cross the channel to go to Denmark as the first ones treated were very satisfied.
- According to the head of the hospital committee of Copenhagen County, the experience taught all parties how easy it is to cooperate across the Oresund-bridge to use each other's facilities in case of under-capacity. Furthermore, the crossing of borders was not a problem nor for the patients nor for their relatives. For many years there had been good contacts between the two hospitals which since 2002 have been intensified through concrete agreements and projects.
- Chief cardiac surgeon at the Gentofte hospital also viewed the cooperation very positively and the arrangements had worked 'perfectly' due to the helpful attitude of Swedish coordinators and Gentofte's staff. Furthermore, it was an opportunity to learn from each other as the Danish and Swedish teams of medical doctors participated in field trips.

On the Swedish side, an article in the local newspaper described the project from a user perspective by interviewing one of the first patients to be operated at Gentofte Hospital²¹. The patient explains how he personally took the initiative to contact Lund hospital after reading about the agreement between the

¹⁸ Ibid. Appendix p. 7.

¹⁹ Claes, A. (2005). Europe for Patients project. Personal communication (email) from the Director of the Heart and Lung Centre at Lund University Hospital.

²⁰ Sygehusdirektoratet (2002). Svensk invasion paa Amtssygehuset i Gentofte en succes (Swedish invasion at the County Hospital in Gentofte - a success). Press release. Copenhagen, Sygehusdirektoratet, County of Copenhagen.

²¹ Ingels, G. (2001). Operation i Danmark kortar väntetiden. *Kristianstadsbladet*.

two hospitals starting in May 2001²². Taking the initiative to look for overseas treatment meant that his waiting time was shortened by around 6 months. Although he was placed on Lund Hospital's waiting list as a 'priority patient' early 2001, the bypass surgery would probably not have taken place at Lund before the autumn.

One of the most positive aspects of the cross-border treatment according to this patient was the information he was given about the overseas care. When it was decided he would be treated abroad and before going to the Danish hospital, he received a brochure from Gentofte Hospital on what would happen to him during the whole process. Upon arriving at the hospital, additional practical and medical aspects of the treatment were explained, including by the surgeon who was going to operate him. He also got advice on how to recover quickly. Yet, despite very detailed information, the patient was overwhelmed by the complexity of the operation, the time it took to recover and underlined how important it was to have the support of a relative.

The patient was also satisfied with the way he had been looked after by the Danish hospital staff (despite the hospital being undermanned), but was disappointed about not being placed on a ward with other Swedish patients from Kristianstad and about the lack of recreational activities to take part in at the hospital.

Asked about the regional cooperation across the Sound, the patient declared to be in favour of the health-related collaboration in cases of under-capacity.

The testimony illustrates some of the inconveniences related to the unfamiliar or **foreign surroundings**. On the other hand, it also shows how **long waiting times** for critical conditions can be an important **push-factor** to seek care abroad. According to the Oresund Committee report²³, waiting time for heart surgery at Lund was between eight and twelve months and the hospital's waiting list had **250 patients** registered at the time of signing the agreement (March 2001). Thanks to the cross-border solution, the most serious cases were treated within weeks and waiting times shortened for all patients.

Pre- and after-care was carried out in Sweden while a Swedish doctor and nurse assisted Swedish patients while hospitalised at Gentofte.

Assessing the project, waiting lists at Lund went down, patients were generally happy with their cross-border surgery and staffs from both cardiology departments saw it as a positive experience.

²² HOPE (2003). Hospital Co-operation in Border Regions in Europe. Leuven, Standing Committee of the Hospitals of the European Union: 88 pages. p. 55.

²³ Op. cit, Appendix p. 11-12.

■ DENMARK – GERMANY
SOUTHERN JUTLAND – SCHLESWIG-HOLSTEIN



There has been **long-standing cooperation** in the border-region between the Danish county of Southern Jutland and German health care providers. The experience across the Danish-German border illustrates how a first successful cross-border initiative can lead to extended cooperation for a broader range of treatments involving a range of health care providers.

Due to long **waiting lists** in the county of Southern Jutland, patients have been referred to hospitals in other Danish counties. Yet since November 1998, **cancer patients** living in Southern Jutland have been offered the option to go to the Malteser Krankenhaus in Flensburg (Northern Germany) to receive radiation treatment. Following surgery for breast cancer, which takes place in Denmark, the vast majority of operated women (80%) from Southern Jutland choose to undergo **radiation therapy at the German hospital**²⁴. According to the public authorities of Schleswig-Holstein, this cross-border arrangement allows synergy and complementarity between the oncology treatments in Southern Jutland and radiation therapy in Schleswig-Holstein²⁵.

It should also be mentioned that the border-region in question is one of multiple exchanges and proximity²⁶, particularly in historical and linguistic terms, and is characterised by a **fluid border**.

Two factors appear to be of particular importance for patient mobility in the region: **waiting time** and **travelling time**. Malteser Krankenhaus offers considerably faster access to radiation treatment (within a few weeks while the maximum accepted waiting time in Denmark is two months) *and* is closer to where patients live compared to Danish hospitals in other counties²⁷. These factors are all the more important

²⁴ (1999). Flere soenderjyske patienter til Flensburg (More patients from Southern Jutland to Flensburg), Soenderjyllands Amt Newsletter. www.sja.dk.

²⁵ Landesregierung Schleswig-Holstein (2002). Grenzüberschreitende Inanspruchnahme von Gesundheitsleistungen, Schleswig-Holsteinischer Landtag.

²⁶ See also Drespe, A. (1999). EUREGIOsocial - Euroregionale Zusammenarbeit im Gesundheitswesen. Brussels, European Social Insurance Partners. p. 21.

²⁷ (2001a). Flere soenderjyder kommer hurtigere i behandling (More people from Southern Jutland get faster treatment), Soenderjyllands Amt Newsletter. www.sja.dk.

as a complete treatment by radiation therapy generally involves between 15 and 25 hospital visits in ambulatory care^{28 29}.

The initial success of the breast cancer initiative meant that cross-border **cooperation was extended** in late 2001 to include other types of cancer treatment³⁰ and again in 2004 to cover additional types of care involving surgery in areas such as orthopaedics. Today, the county of Southern Jutland has agreements with three German hospital centres (two in Flensburg and one North Frisia), the Flensburg Fire Brigade and with the Deutches Rettungsflugwacht (emergency helicopter service)³¹. Currently, treatments available across the border for Danish patients include^{32 33}:

- Radiation treatment in ambulatory care following operations for breast-, lung-, prostate- and throat-cancer as well as for gynaecological types of cancer³⁴
- Surgery, in particular day surgery for which there are long local waiting lists, such as hernia, varicose veins, minor orthopaedic surgery etc.³⁵
- Ambulance service in cases of emergency where the Flensburg Feuerwehr can reach the patients faster than the Danish services. If necessary, patients are brought to the hospitals in Flensburg for emergency treatments
- Referrals of patients to the neuro-surgical department in Flensburg if fast access to care is required and if there are capacity problems in other Danish counties
- Access to maternity department in North Frisia for women living in a locality of Southern Jutland where maternity facilities have been closed down

Factors influencing patients

A study carried out in 2001 by the County of Southern Jutland³⁶, analysed the **relationship between distance to care, waiting times and willingness to go abroad** for women living in the county and suffering from breast cancer. Patients have the option between going to Odense University Hospital (OUH) (located in another county) which is approximately 130km away and has waiting times for radiation therapy of more than 6 weeks, or going to St. Franziskus Hospital in Flensburg which is ca. 50km away and offers radiation treatment within 2 weeks. In 1999, 63 patients chose treatment in Flensburg, while 64 chose to go to OUH, but geographical differences within these two groups were important. Patients living in the north and middle of the county (furthest away from the German border) were significantly more likely to choose to go to OUH despite having to wait three times longer and travel sometimes more than double the distance compared to St. Franziskus. Only people living in the southern parts of the county, very close to the border and with maximum distance to Flensburg of 25km (while OUH is ca. 150km away), were more inclined to prefer the German hospital. The study concludes that significantly **shorter waiting time in Flensburg is not the most decisive pull-factor, while the long distance to OUH is not as strong a push-factor** as might have been expected. Although the media and policy-makers always focus on waiting time and distance, and they do indeed

²⁸ (2001b). Straalebehandling paa kortere tid (Radiation therapy at shorter times), Soenderjyllands Amt Newsletter. www.sja.dk.

²⁹ (1999), op. cit.

³⁰ (2001a), op. cit.

³¹ (2004), Hurtigere hjælp ved ulykker (Faster assistance at accidents), Soenderjyllands Amt Newsletter. www.sja.dk

³² Toftgaard, C. (2005), Straalebehandling i Tyskland (Radiation therapy in Germany). Personal communication (email) from C. Toftgaard, Head of Health Affairs at Southern Jutland County.

³³ See also Drespe, A. (1999), EUREGIOsocial - Euroregionale Zusammenarbeit im Gesundheitswesen. Brussels, European Social Insurance Partners.

³⁴ (2001b), op. cit. www.sja.dk.

³⁵ Toftgaard, C. (2005), op. cit.

³⁶ Frost, R. G. (2000). Efterbehandling af brystkræftpatienter i Flensburg af borgere fra Soenderjyllands Amt (Follow-up treatment of breast cancer patients in Flensburg of citizens from Southern Jutland County), Soenderjyllands Amt: 13.

have some explanatory value, one should not underestimate other factors such as habit, language, expectations and familiarity with German health care system. The indication that these factors might be less influential closer to the border, suggests that reluctance towards being treated abroad diminishes as people are more familiar with travelling to Germany and with the German language so that “the foreign appears less foreign in the southern region of the county”³⁷. In other words, the border is experienced as fluid by the border population.

Yet, the number of Danish patients treated in Flensburg has been increasing steadily from 71 in 1999, 125 in 2002 and 168 in 2004³⁸.

Such increases in numbers could suggest that more and more people are willing to go to abroad (in this case to Germany) as the cross-border option becomes better known, is established over the years and people have time to familiarise themselves with it.

Factors influencing at county, regional and national levels

For the Southern Jutland Health Authority, financial incentives play a certain role as **prices** in the German hospitals are 10% lower than the Danish DRG-rates which the counties pay the local hospitals³⁹.

Yet, the purchasing of health care should also be seen in the broader context of cross-border cooperation which includes activities in other areas such as employment, the labour market, tourism, environment and the economy⁴⁰. A **partnership agreement** was signed between the County Mayor of Southern Jutland and the Minister President of the Land of Schleswig-Holstein in June 2001 to promote collaboration and development in the border-region⁴¹. In the field of health care, this agreement has meant that as from September 2001, Danish patients suffering from any type of cancer or from specific cardio-vascular diseases can go for treatment in Schleswig-Holstein. Before, this mobility was only granted to four types of cancers to shorten waiting times⁴². In December 2001, an Interreg IIIA programme was also launched to further stimulate cross-border projects in a number of fields⁴³.

It is also interesting to notice the **difference in views between the position of the Southern Jutland county authorities and the Danish authorities at State level**⁴⁴. When the cross-border care option was set up in 1998, the Danish Minister of Health was particularly negative towards the initiative as he saw it as a threat to the Danish cancer strategy which was being launched at the time to increase capacity for radiation therapy. Yet the County maintained that using capacity in Germany was a solution to waiting lists which could alleviate the national system, offer faster treatment to patients and would not influence national planning as the hospital in Flensburg had sufficient numbers of both technical and trained staff for radiation therapy⁴⁵. As a clear signal of its commitment to patient mobility, the **County signed in October 2001 a 5-year cooperation agreement with the St. Franziskus Hospital**, allowing patients to be treated in Flensburg without any limitations on the number

³⁷ Ibid, p. 12.

³⁸ Toftgaard C. (2005) op cit. Personal communication from Southern Jutland County and St Franziskus Hospital, Flensburg. Unfortunately it was not clear whether these numbers cover breast cancer patients only, cancer patients in general or all Danish patients treated at St Franziskus.

³⁹ (2004), Koeber plads paa tyske sygehuse (Purchasing space in German hospitals), Soenderjyllands Amt newsletter. www.sja.dk.

⁴⁰ Ibid.

⁴¹ (2001), Samarbejde hen over graensen (Cooperation across the border), Soenderjyllands Amt newsletter. www.sja.dk.

⁴² Landesregierung Schleswig-Holstein (2002). Grenzüberschreitende Inanspruchnahme von Gesundheitsleistungen, Schleswig-Holsteinischer Landtag.

⁴³ (2001), Interreg III-aftale underskrives (Interreg III agreement is signed), Soenderjyllands Amt newsletter. www.sja.dk.

⁴⁴ Frost, R. G. (2000), op. cit.

⁴⁵ Ibid.

of patients which could go cross-border and with no criteria that a medical diagnosis had to be set before going to Flensburg (as opposed to before signing the agreement)⁴⁶.

It should be highlighted that since then, cooperation has further been extended. The radiotherapy department in Flensburg is now recognised as “hospital of guarantee” for patients from four Danish regions (Southern Jutland, Vejle, Ribe and Fyn) in the areas where the hospital is authorised to treat Danish patients and **follows Danish treatment protocols and medical standards**. This new agreement, which concerns mainly breast cancer but also other forms of cancer, implies that patients are entitled to be offered the choice to go to Flensburg if waiting times for radiotherapy in the local hospitals exceed the official maxima for waiting times⁴⁷.

The decision is closely linked to the fact that **Southern Jutland co-finances a radiotherapy machine at the German hospital** and “therefore views capacity in Flensburg as a natural part of the capacity in the [region]”⁴⁸. On its part, the Land of Schleswig-Holstein engaged itself to subsidise the construction of new radiotherapy facilities with 3.9million DM⁴⁹.

In general, it seems fair to say that the public authorities of the Land of Schleswig-Holstein – together with hospitals and the hospital association – are **eager to attract foreign patients**, promote cross-border cooperation and create the necessary institutional structures⁵⁰. There appears to be awareness about the opportunities which long waiting lists in other countries (Denmark, Norway but also England) might entail for health care providers in the Land, not least due to its strategic geographical position as the northernmost part of Germany and sharing a fluid border with neighbouring Denmark. The Land presents itself as a “pool of experience”⁵¹ in the field of cross-border health care while its government actively promotes the development of health policy at the European level and even argues for taking the cross-border dimension into account in the planning of health care services in order to ensure availability and good quality health care for all patients⁵².

⁴⁶ Landesregierung Schleswig-Holstein (2002). Grenzüberschreitende Inanspruchnahme von Gesundheitsleistungen, Schleswig-Holsteinischer Landtag.

⁴⁷ Toftgaard, C. (2006). Straalebehandling i Tyskland.

⁴⁸ (2005). Straalebehandling paa St Franziskus Hospital i regional sammenhaeng. *Health Committee*.

⁴⁹ Landesregierung Schleswig-Holstein (2002), op. cit.

⁵⁰ Schnack, D. (2003). “Grenzüberschreitende Gesundheitsversorgung.” *Schleswig-Holsteinisches Arzteblatt*(1): 2.

⁵¹ Landesregierung Schleswig-Holstein (2002). Op cit. p. 18.

⁵² Ibid.

■ GERMANY – THE NETHERLANDS RHINE – WAAL



In the Euregio Rhine-Waal it has since 1996 been possible for people insured in Germany and living in the local district of Kleve (situated in the Land of North Rhine-Westphalia) to receive **highly specialised care** in the university hospital of Nijmegen in The Netherlands⁵³. As Kleve neighbours upon the Dutch province of Gelderland, where the Nijmegen hospital is located, the cross-border arrangement saves patients and their relatives from having to travel longer distances within North Rhine-Westphalia to the cities of Duisburg or Essen⁵⁴. According to the sickness fund AOK Rheinland, this **direct cross-border contract** was the first to be signed between a **German insurer** (AOK Rheinland) and a **Dutch hospital** (UMC St Radboud)⁵⁵. The treatments covered by the contract concern cardiac surgery, radiotherapy, kidney transplantation, neurosurgery and traumatology, while the cross-border scheme also ensures the transportation of the German patients to/from the academic hospital in a radius of 80-100km. In the period 1996-1999, around *400 patients yearly* benefited from the cross-border option at Nijmegen hospital. The participants in the project are on the German side the AOK Rheinland with more insurers joining at a later stage, and on the Dutch side the two insurers CZ and VGZ as well as the University Medical Centre (UMC) St Radboud, Nijmegen.^{56 57} It should be mentioned that cross-border cooperation has been intensive between AOK-Rheinland and the Dutch CZ insurer not just in Rhine-Waal region but also in Euregios Meuse-Rhine and Rhein-Maas-Nord. The aim of cooperation has been to provide timely care close to where patients live and a health care card (*GezondheidsCard international*) was launched in 2000 to simplify the access procedures to specialist treatments (including diagnostics and in-patient care if required) and to pharmaceuticals. Although the population has shown interest in the card (some 3800 cards have been issued on German side and 18 500 on Dutch side) the number of

⁵³ Drespe, A. (1999). EUREGIOsocial - Euroregionale Zusammenarbeit im Gesundheitswesen. Brussels, European Social Insurance Partners.

⁵⁴ Jacobs, W. (2005). *Praxisbericht: Verträge mit ausländischen Leistungserbringern Europaweite Gesundheitsversorgung*. AOK im Dialog: "Europa für die Versicherten gestalten", Berlin.

⁵⁵ Ibid.

⁵⁶ Drespe, A. (1999), op. cit.

⁵⁷ See also the so-called "Euregio health care portal":

http://www.euregiogezondheidsportaal.nl/euregiportal/index.php?id=z_7_0_&L=2.

treatments provided via the card has not been significant as people appear to consider it rather as a back-up solution⁵⁸.

Another recent study also looked at cross-border care in Rhine-Waal but from a different perspective⁵⁹. Researchers from the UMC tried to explain why there is a small but stable flow of German patients to St Radboud, while only few Dutch patients go in the opposite direction despite waiting lists in The Netherlands and attempts to encourage the cross-border provision of ophthalmology treatments and MRI in the hospital in Kleve. To find out, surveys were sent to German patients treated at the UMC and questionnaires were sent to Dutch doctors working close to the border.

Information gathered from the **patient surveys** revealed that **geographical location** of St Radboud was the main reason for going abroad for 60% of German patients. Around one fifth of day care patients went to the hospital because it had been recommended by a GP or specialist, while one in eight went because they expected more appropriate care in The Netherlands. Almost 40% knew about cross-border care through a specialist, one third through a relative or friend. A quarter of respondents thought that **information** about the possibilities for cross-border care was insufficient; yet, three quarters (or more) of **German patients were satisfied** with the treatment received at St Radboud and with the expertise of the Dutch doctors.

On the **provider side**, 11 Dutch GPs took part in the UMC questionnaire. The responses showed some trends: although generally positive towards the idea of facilitating cross-border care, less than half thought it was necessary to have a referral possibility to Germany. 6 out of 11 GPs had already once referred patients to see a German specialist due to waiting lists, but more than half had never had contacts with German peers and did not know to which specialist to send patients in specific cases. Noteworthy is that Dutch GPs appear to realise their own **reluctance** because when asked about why patient mobility was so limited, they answered it was due to a series of **obstacles** such the lack of initiative from Dutch GPs, insufficient information to patients, language barriers, too much paper work, unnecessary, complicated procedures, and no compensation for the extra time and effort GPs had to use.

The authors of the study conclude by underlining the satisfaction of German patients with cross-border care and particular aspects such as attention from medical staff, comfort and quality of care. On the other hand, they suggest how one of the characteristics of the Dutch health care system – the role of **GPs as gate-keepers – might be a reason for the more limited flows** of Dutch patients. Dutch GPs would rather see a domestic solution to the problem of waiting lists, which they consider as a consequence of the artificial limitation of health care supply, and are reluctant to refer abroad in order not to damage relations with specialists working in Dutch hospitals⁶⁰. This constitutes a direct obstacle to patient mobility from The Netherlands and contributes to explaining the uneven patterns of patient flows in the Euregio Rijn-Waal.

⁵⁸ Nebling, T. and H.-W. Schemken (2006), Cross-border contracting: The German experience. *Patient Mobility in the European Union: Learning from experience*. M. Rosenmoller, M. McKee and R. Baeten. Copenhagen, European Observatory on Health Systems and Policies: 137-156.

⁵⁹ Wilt and Franssen (2003). Grensoverschrijdende Zorg in de Euregio Rijn-Waal - Onderzoek naar redenen en naar tevredenheid met de verleende zorg. Nijmegen, Medical Technology Assessment, University Medical Centre, St Radboud: 30.

⁶⁰ Ibid, p. 27.

■ GERMANY – THE NETHERLANDS – BELGIUM
MEUSE-RHINE



One of the oldest and most active Euregios, Meuse-Rhine is home to several cross-border initiatives in the field of health care. The region is characterised by its cultural proximity as well as by the **fluidity** and **multitude of its borders**: not only do three international borders go through the region, but so do two provincial and hence linguistic borders internal to Belgium. As a result, Euregio Meuse-Rhine is composed of five members (regional authorities): on the German side, the region of Aachen; on the Dutch side, the Province of Limburg; on the Belgian side, the Province of Liege (French-speaking), the Province of Limburg (Dutch-speaking) as well as the German-speaking Community (which is a federal entity of Belgium with authority in specific areas)⁶¹.

The total population of the regional entities amounts to some 3.9million people⁶². The table below shows how population sizes as well as health care facilities differ considerably between the three parts of the region:

	German area	Dutch area	Belgian area
Population ⁶³	1 300 000	750,000	1 800 000
Hospitals ⁶⁴	26	4	27
Specialists/1000 inhabitants ⁶⁵	1.6	0.8	1.4

In 1994 a special committee was set up to give recommendations on cross-border health care in the Euregio⁶⁶. Some years later, a wide-reaching **Interreg II** project was initiated. Formally named “Cross-border Project in the Euregio Meuse-Rhine with the perspective of a more free access to health care in the border-region, accompanied by the hospital sub-project “cross-border care for patients” (analysis,

⁶¹ See website of Euregio Meuse-Rhine: http://www.euregio-mr.org/emr_site/index.php.

⁶² http://www.euregio-mr.org/emr_site/site_fr/emr/volk.php.

⁶³ Ibid.

⁶⁴ Grunwald, C. A. and R. Smit (1999). Grensoverschrijdende zorg - Zorg op Maat in de Euregio Maas-Rijn; evaluatie van een experiment. Utrecht, NZI (research institute).

⁶⁵ Ibid.

⁶⁶ Drespe, A. (1999). Op. cit.

action, development of scenarios and conventions)^{67 68}, the project lasted almost three years between 1997 and 1999. Different objectives were defined as the project was expected to lead to concrete actions such as:

- cooperation between health insurers and hospitals so as to increase accessibility to care for the Euregio population (through the harmonisation of procedures, information exchanges and collaboration)
- cooperation through agreements and harmonisation related to the cross-border access of certain medical services, as well as exchange of information on the supply, demand and use of health care

The Euregio initiative was composed of **several sub-projects**; all aimed at promoting cross-border health care (e.g. through better communication between doctors, a better match between supply and demand across the border or better coordination between hospital facilities) while some were designed to facilitate patient mobility in particular.

ZONA project

One such project, **ZONA** (standing for the abbreviation of “Care Close-by” in Dutch), aimed at providing **vital health care services** to specific target groups of the population and to base access and availability on proximity and complementarity in the region⁶⁹. E.g. in the area of paediatric heart surgery, the hospital in Maastricht was not able to perform cardiac operations which meant that the approximately *60 yearly cases* had to be referred to Utrecht University Hospital (NL) 200km away. Under ZONA, these patients could instead be treated in Aachen University Hospital only 30km away while the costs of the cross-border transfers were settled between the Dutch and German project partners⁷⁰.

ZOM project

Other pilot projects are so-called ZOM and IZOM. Whereas ZOM initially allowed one-way mobility of Dutch patients, IZOM has developed to facilitate “multi-way” mobility between the three countries.

ZOM (Dutch abbreviation for “Zorg op Maat”, i.e. “Made-to-Measure Care”)⁷¹ was set up as an **experiment** between April 1997 and late 1998 by two large Dutch insurers, CZ and VGZ, which have a strong predominance in the region. The aim of the initiative was to allow **Dutch inhabitants access to German and Belgian health care facilities, including specialist care, in the Euregio**. To this end, Dutch patients needed a referral letter from their GP and an E112+ form (which gives automatic access to cross-border care without a prior authorisation) from their insurer. The Dutch public authority, CVZ (Health Care Insurance Board), helped to adapt the E112+ forms and an easier access procedure. In the two neighbouring countries, the German sickness fund AOK and the Belgian sickness fund CM assisted CZ and VGZ by agreeing to inform regional German and Belgian health providers about the importance of transferring medical information on Dutch patients to their GP back home. Since the easing of cross-border access fell under the E112 framework, official tariffs and legal provisions in Germany and Belgium applied when mobile Dutch Euregio patients were treated there. To settle the costs of treatments, German and Belgian providers in the Euregio would just declare the costs to the Dutch sickness funds through E125+ forms. Yet, the actual patient route of ZOM was arguably long and complicated as patients faced some five different stages, both administrative and medical, with several different institutions and waiting times in between stages.

⁶⁷ In French : *Projet transfrontalier dans l'Euregio Meuse-Rhin dans la perspective d'un accès plus libre aux soins de santé dans la région frontalière, accompagné du sous-projet hospitalier «soins transfrontaliers aux patients » (analyse, action, développement de scénarios et conventions).*

⁶⁸ Coheur, A., P. Carnotensis, *et al.* (1999?). Interreg II - Projet transfrontalier dans l'Euregio Meuse-Rhin/ Grensoverschrijdend project in de Euregio Maas-Rijn (Final Report), Espace social européen et santé: 56 pages.

⁶⁹ Ibid.

⁷⁰ Drespe, A. (1999), *op. cit.*

⁷¹ What follows on the “ZOM” project is from Grunwald, C. A. and R. Smit (1999), *op. cit.*

In terms of medical care, the scheme covered both **specialist** and **hospital treatments**, but excluded some highly specialised care. The type of pathologies which patients went to Belgium and Germany for most often related to ophthalmology, dermatology, gynaecology, orthopaedics and internal medicine, while the type of care ranged from actual medical treatments, examinations, diagnosis, second opinions and other. In the 20 or so months of the experiment, cross-border care with the E112+ form was used almost 1,800 times; CZ affiliates counted for 1,500 of these. In terms of **patient numbers**, 578 CZ members had used the scheme once or more in the first 17 months of the project which compared to the 380 433 insured members of CZ in the region, amounted to just 0.15%.

Two patient surveys on the ZOM project were carried out by an independent Dutch research institute (the NZi)⁷². A first questionnaire asked patients, who had received their E112+ form in 1997, about their opinion on information concerning the project, on their incentives and aspirations related to cross-border care. Another questionnaire sent out in mid 1998, asked people about their experiences with cross-border care in particular with regards to procedures and after-care. Some interviews were also carried out with local Dutch doctors.

The patient surveys provided interesting insight into patient mobility in region:

- Most users of the E112+ scheme were **already familiar** with going to Belgium and Germany. Over 50% of respondents had an earlier experience with cross-border care
- One third of patients had been treated more than five times abroad. This group was composed mostly of retired frontier workers which after retirement saw their rights to health care transferred from Belgium or Germany (where they had previously worked) to The Netherlands where they lived.
- **People using the E112+ most were those living closest to the border.** The choice of whether to go to Belgium or Germany was strongly influenced by where patients lived, but overall 65% went to Germany.
- As to the reasons why people had crossed the border for health care, a series of different motivations were underlined (presented here in order of importance)⁷³:
 - **Waiting times:** almost 90% of respondents declared faster access to health care as a reason
 - **Type and quality of care:** 78% of respondents said that care abroad was more thorough/complete and 72% that treatment was different compared to The Netherlands. Three examples given in the report are orthopaedic after-care where physiotherapy is included in the treatment in Germany, in oncology where more alternative therapies are available in Germany and in ophthalmology where German doctors are quicker to make use of laser-treatments. 70% of respondents also stated obtaining results faster as well as good after-care as arguments for using cross-border care
 - **Patient-provider relation:** arguments concerning the more personal aspects of health care and how respondents felt as patients were all rated highly. The five proposed reasons of being taken more seriously, not being treated as a number, complaints being better understood, being listened to and being better informed about ones illness scored between 55% and 70%
 - There were important regional differences in how arguments were valued. In the south-eastern part of the Dutch province of Limburg, **geographical proximity** was declared by 73% of respondents as a reason for going across the border. Yet, in the central-eastern part of Limburg, geographical accessibility only scored 9% while **cultural, personal** or **linguistic proximity** were more valued. The fact of always having been treated abroad, more appropriate care abroad for the patient's personal case and feeling more comfortable with the language abroad were rated at 32%, 43% and 23% respectively
- On the **practical procedures** of accessing cross-border care, over half of respondents found that there was room for improvement and in particular that there was a need for simplification as too

⁷² For full details of the surveys, see Grunwald, C. A. and R. Smit (1999), Ibid.

⁷³ Ibid. p. 26-28, 31, 34.

many institutions were involved, the duration for which an E112+ form was valid should be extended and waiting time to receive authorisation should be shortened

- On the whole, cross-border patients were content with the care they received abroad, as 67% declared themselves “**very satisfied**” and 23% said to be “satisfied”

According to the authors of the report and based on data from the two Dutch insurers, the **use of the ZOM scheme remained very limited** due to insufficient information, lack of referrals by Dutch doctors, unfamiliarity with the systems abroad and a complicated E112+ procedure susceptible to delays and likely to confuse patients. **Dutch doctors** were unaware of the quality of care abroad as well as of their foreign colleagues’ qualifications and professionalism. At the same time, they feared that their role and position could be undermined by the cross-border movements as they could lose influence over mobile patients. This also led the authors to conclude that “[t]he regional care *insurers* are **active** in exploring the advantages and disadvantages of cross-border care. They are also in charge of the initiatives and processes of change. The regional care *providers* in the Dutch part play a **passive** role”⁷⁴.

We would argue that this is an important point as it highlights the necessity for having all stakeholders actively involved and committed to making cross-border patient mobility function. Ignorance and fear lead to misconceptions and reluctance to cooperate, slowing processes down and hindering the movement of those in need of health care.

IZOM project

Following the ZOM experiment, **IZOM** (“Integratie Zorg op Maat”) was initiated. The preparation phase of IZOM took place between 1998 and 2000 with important coordination measures between insurance bodies of the three systems⁷⁵. With the next generation of the EU inter-regional programme, Interreg III 2000-2006, IZOM continued to develop and the signing in July 2000 of a **protocol between Dutch, Belgian and German authorities formalised cooperation**. Since October 2000, IZOM has facilitated access to care for the population of the entire Meuse-Rhine region. Patients **no longer need prior authorisation** when going across the border for “**general care** provided by specialist doctors, on both therapeutic and diagnostic levels, the prescribing of medicines within this framework of treatment and the relevant hospital care”⁷⁶. After a 2-year experimental period (Oct 2000 – Oct 2002), the project was extended for a further two years until 2004.

As ZOM did, IZOM functions within the framework of European Regulations 1408/71 and 574/72, which means that the legal arrangements on health care (e.g. on provision, funding, insurance cover etc) of each of the three countries are left intact⁷⁷. The simplification of access procedures has been part of the collaboration effort of the regional insurance bodies.

According to a **patient survey** carried out by the regional insurers, addressing people who used cross-border care between October 2000 and January 2001, IZOM has several **advantages**: shorter distances (to obtain health care), shorter waiting times, communicating with providers in mother tongue, different treatment methods and a more personal approach to the care. The insurance bodies estimated that some *1.800 patients* had accessed cross-border care under IZOM in the 4-month period, 1.406 of which took part in the evaluation.

⁷⁴ Ibid, p. 10, free translation, italics in original.

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

⁷⁶ Coheur, A. (2001). *Cross border care - New prospects for convergence*. European Integration and Health Care Systems: A Challenge for Social Policy, Ghent, Belgium.

⁷⁷ Coheur, A., Carnotensis P., J. Assent (2004). *Interreg III - Soins de santé sans frontières dans l'Euregio Meuse-Rhin, IZOM Project (Evaluation Report 2004)*.

Interestingly, **two broad patient groups** could be distinguished based on the survey results: a first group composed of active and retired **frontier workers and their families**, used to receiving health care in the neighbouring country and living close to the border; a second group, somewhat less homogenous and living further away from the frontier, composed of persons who **prefer treatment methods** on the other side of the border, who are not satisfied with the care provided in their own country, and who go abroad hoping to find alternative solutions or treatments not available at home. Finally, **three major factors** were singled out as influencing the use of cross-border care: i) the absence of health care supply at home; ii) the awareness of supply abroad; and iii) the amount of disseminated information on cross-border options⁷⁸.

Two years after the qualitative survey, a quantitative evaluation of IZOM was carried out to assess the **financial impact** of the project in the three countries. Based on data of Dutch, Belgian and German public authorities collected between 1999 and 2003, the study⁷⁹ sheds light on patient flows in the Euregio. Important movements of patients were registered between The Netherlands and Belgium, as well as from Belgium to Germany, but less so in the opposite direction. The differences in intensity of patient flows can according to the study be explained by factors such as **language, type of health care provision and price differences** as well as the **availability of health care** in the country of residence in comparison with that abroad. The authors give the example of the German-speaking community in Belgium which cross the border to Germany to receive health care in their mother tongue and benefit from services in-kind with lower co-payments than in Belgium. Another example are the numerous Dutch patients going to Belgium to avoid waiting lists at home, while significantly less Germans go to Belgium probably due to sufficient health care supply in Aachen and to the limited availability of German-speaking facilities outside Germany. The figures on the costs of patient flows illustrate these differences: in 2003, the cost of treating Dutch patients in Belgium under IZOM came to 2.5million Euro – that of treating German patients to just 1.500 Euro.

The report concludes that there has been a rather slow but constant increase in costs over the 4-year period, but that the amounts remain marginal considering that more than 3 million people live in the Euregio Meuse-Rhine⁸⁰.

German-speaking community of Belgium



Within the Euregio Meuse-Rhine it should also be mentioned that the **German hospital** St Josef in Prum and the **Belgian hospital** St Joseph located in St Vith cooperate in the field of medical imagery as patients are sent from the Belgian to the German hospital for tomographies. The stakeholders see this cooperation as presenting important advantages and after some years the collaboration was intensified

⁷⁸ Carnotensis, P. and A. Coheur (2002).

⁷⁹ Coheur, A., Carnotensis P., J. Assent (2004).

⁸⁰ Ibid.

in 1998. For the Belgian German-speaking population this sort of cooperation presents the advantage of increasing health care available in their native language. There were also plans to adapt the electronic systems of the two hospitals⁸¹.

■ BELGIUM – THE NETHERLANDS

Patient mobility and cooperation between Belgium and The Netherlands is greatly facilitated by the fact that there is **no language barrier** between the two countries, as the northern part of Belgium is Dutch-speaking⁸². Yet in addition to this linguistic advantage, there are **pockets of proximity**, Euregio Scheldemond and Limburg, where the **border is particularly fluid** as it runs through local communities which share the same dialect, history, cultural attributes and/ or feeling of belonging. While cooperation in the field of health care has been running for decades in Scheldemond, in recent years new forms of cooperation have emerged as Dutch sickness funds and Belgian hospitals have begun to conclude cross-border contracts e.g. in the Limburg area. To some extent, these innovative contractual practices are logical next step following the IZOM project as there is continuity in the participating stakeholders.

A. Initial phases of cooperation

Euregio Scheldemond



Together the two Belgian Provinces of East and West Flanders and the Dutch Province of Zeeland form the Euregio Scheldemond. In November 1989 the Governors of the **three provinces signed a declaration** on cross-border cooperation and the region has since 1991 benefited from EU funding through **Interreg**. The region has a population of some 2.9 million people, 2.5mill of whom live in the Belgian provinces⁸³.

Regional cooperation to ease cross-border health care has been going on for three decades due to both the population's multi-dimensional **proximity** and to the **scarce medical services in Zeeuws-Vlaanderen**, which is part of Zealand but is geographically cut off from the rest of The Netherlands. A study carried out by a Dutch and a Belgian research institute⁸⁴ in the mid 1990s examined the extent to

⁸¹ Drespe, A. (1999), EUREGIOsocial - Euroregionale Zusammenarbeit im Gesundheitswesen. Brussels, European Social Insurance Partners.

⁸² On patient mobility between Belgium and neighbouring countries, see also Baeten, R. (2000), De gevolgen van de Europese eenmaking voor de organisatie en de verstrekking van de gezondheidszorgen in België – Patiëntenmobiliteit en grensoverschrijdende zorg. Brussels, Belgium, Observatoire social européen: 58.

On Belgian-Dutch cross-border cooperation in the field of health care, see also Jorens, Y., C. Salamon, *et al.* (2005). Naar een rationalisatie van de EG-Coordinatieverordeningen inzake sociale zekerheid? Ghent, Belgium, University of Ghent: 257.

⁸³ <http://www.euregioscheldemond.org/eng/index.asp>.

⁸⁴ IVA Tilburg (NL), Institute for Social Sciences Policy Research and Advice, and Vlerick Management School, Gent (B).

which the cross-border sharing of health care facilities could solve the problem of **structural under-capacity** in Zeeuws-Vlaanderen. The research was commissioned by the European Fund for Regional Development (Interreg I), the Dutch insurer OZ and the provinces of East and West Flanders and Zeeland.

The report⁸⁵ provides some interesting data on patient mobility patterns in the region. Due to local under-capacity in health care, the **Zeeuws-Vlaanderen arrangement**⁸⁶ was set up in the mid 1970s to facilitate access to Belgian hospitals for OZ members and gives inhabitants of the area access to care in Belgian hospitals including for cardiology, nuclear medicine, haemodialysis, radiotherapy, plastic surgery, respiratory and rheumatic treatments and some paediatric care.

Data from the year 1993 showed that 85% of admissions were for planned care (either highly specialised or basic). The university hospital in Gent registered *722 intra-mural hospitalisations* of patients from Zeeuws-Vlaanderen, while St Jan hospital in Bruges registered *539*, both mainly for highly specialised care. On top of these numbers should be added people who received extra-mural care in eight different Belgian hospitals – the number exceeding two thousand patients in 1993.

Asked about the most important reasons for referring patients to Belgian hospitals, local Dutch GPs said that the availability of **highly specialised treatments**, requests from patients themselves and the absence of waiting lists in Belgium were the key factors.

According to results from a **questionnaire** sent to 140 **Belgian GPs** in the border-region, of whom 45 responded, there was also out-flow of Dutch patients for **ambulatory care**. 35 out of the 45 Belgian GPs were treating Dutch patients, totalling at least 545 patients. Conversely, Dutch GPs treated ca *140 Belgian patients* (mostly frontier workers). Interesting to note is a certain **cross-border rivalry** between Dutch and Belgian GPs, as some of the former thought that Belgian doctors could be too friendly and exaggerate attention towards the patient, while some of the latter questioned the quality of Dutch health care and advocated the greater freedom in practicing medicine in Belgium e.g. in referring patients and prescribing drugs.

The research concluded that due to the **one-way flow of Dutch patients to Belgian providers**, it would be difficult to find a win-win solution on the demand side to the problem of Zeeuws-Vlaanderen since there was no reciprocal demand for cross-border care from Belgian patients. Furthermore, it noticed that it was becoming **more difficult to control patient flows** to Belgium as Belgian doctors tended to refer to Belgian specialists and hospitals instead of referring patients back to The Netherlands. Large out-flows of Dutch patients would be negative both for Zeeuws-Vlaanderen by threatening the survival of local health care facilities, and for the Belgian health care system as hospitals' per diem tariffs were subsidised publicly.

The study highlights a **tension** between allowing **free mobility** and free choice for patients, and **safeguarding local health care infrastructure**. The final recommendation of the report is that a long-term, structural approach to cross-border cooperation, which takes into account the differences of the respective health care systems, can be a feasible solution for Zeeuws-Vlaanderen⁸⁷.

A study carried out ten years after the Euregio Scheldemond report, showed that the key priorities for the regional insurer OZ remains to protect Zeeuws-Vlaanderen health care facilities against closure while at the same time serving the population's medical needs and expectations. **Cross-border**

⁸⁵ VanTits and Gemmel (1995). Samenwerkingsnetwerk - Ziekenhuizen in de Euregio Scheldemond (Haalbaarheidsonderzoek). Tilburg/ Gent.

⁸⁶ The so-called arrangement is not a formal regulation as such but rather a scheme to facilitate access. Participants in the agreement are on the Dutch side the insurer OZ, Dutch Ministry of Health and the Health Care Insurance Board, and on the Belgian side the National Institute for Sickness and Invalidity Insurance, the associations of sickness funds of East and West Flanders and the hospitals UZ Gent and AZ St Jan Brugge. See VanTits and Gemmel (1995). It should be mentioned that the Zeeuws-Vlaanderen arrangement might change after 2007.

⁸⁷ Ibid, p. 93-100.

contracts have been a way to combine the two concerns as they **control patient flows while allowing mobility**⁸⁸.

B. Recent developments: Direct cross-border contracting

Partly as a continuation of the long-standing and purposeful experience in Scheldemond and partly as a result of changes on the Dutch domestic scene, new forms of structured cross-border cooperation have developed in recent years. Most notable and innovative is the **direct contracting** between **Dutch health insurers** and **Belgian hospitals**. These initiatives for cross-border health care between Belgium and The Netherlands take place independently of the Euregio frameworks and do not operate according to the E112 provisions.

The Belgian case-study⁸⁹ of the Europe for Patients project was precisely set up to investigate the new practices and mechanisms of cross-border contracting – as a structural arrangement for patient mobility – and what impact it could have⁹⁰.

Explaining cross-border contracting and patient flows

The research found that the cross-border contracts are **modelled according to standard Dutch contracts** whereby the purchaser (insurer) and provider (hospital) agree on which treatments and types of care to include in the agreement. **Prices, medical standards and legal aspects however follow Belgian official requirements**. Yet, Belgian public authorities are not involved in these practices. On the other hand, the competent Dutch public body (CvZ) is overseeing the contracts which cover publicly insured people and the largest Belgian sickness fund, CM, plays a part as the **third signing party** in contracts with Dutch insurers OZ and CZ. This means that the CM acts as a middleman for the two Dutch insurers by assisting in establishing contacts with Belgian hospitals and setting up arrangements since the CM is familiar with the Belgian system. Furthermore, CM has an important function in checking that the right tariffs are applied by Belgian hospitals when they invoice for treatments carried out on Dutch patients, which are affiliated with OZ or CZ.

Contracting began in the late 1990s and by mid 2005, **four insurers** (OZ, CZ, VGZ, Achmea) had contracts with Belgian hospitals.

In terms of *how* mobility occurs, for Dutch patients affiliated with one of the four insurers, there are no differences in the **usual referral route** from their GP if they go to Belgium and they can choose freely between Dutch and Belgian contracted providers. Indeed, data from the two sickness funds with longest experience in cross-border contracting (OZ and CZ) indicated **increases in the numbers** of affiliates going to Belgium.

Explaining why cross-border contracting takes place

As to *why* this new form of organised patient mobility for planned (i.e. non-emergency) cross-border care takes place, the research revealed several reasons. For Dutch insurers, **waiting lists** in The Netherlands, an increasingly competitive insurance market, linguistic proximity with Belgium, having millions of affiliated members living close to the Belgian border, the good reputation of Belgian providers, comparatively cheaper Belgian prices for health care, and looking for a way to put **pressure**

⁸⁸ Glinos, I. A., N. Boffin, R. Baeten. (2005). Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives. Brussels, Observatoire social européen: 89.

⁸⁹ Ibid.

⁹⁰ It should be noted that the Belgian case-study also examined contracting between Belgian hospitals and the English NHS. These contractual arrangements are described later in the present report, see section on UK – Germany/ France/ Belgium.

on domestic providers with monopolistic behaviour – are all motivations to contract with Belgian hospitals. On their side, Belgian providers are keen to attract foreign patients as it is a way to increase income, expertise and reputation. Dutch public authorities have also supported cross-border contracting as it ensures a structured approach to patient mobility and allows to better control the costs of care received abroad since there are waiting lists in The Netherlands and it has become easier to access health care in another EU Member State⁹¹. For the Belgian sickness fund CM, it is interesting to take part in contracting as it can watch the situation and create cooperation links with insurers in neighbouring countries. That so **many players have incentives** to either directly participate in the cross-border contracts or to promote them, combined with the fact that cooperation has been a **bottom-up process** with strong involvement of local stakeholders, have been decisive factors for the success of the direct contracting. Yet, the study reveals that it is important to make a distinction between two groups of Dutch patients:

- those **living in the border-regions** with Belgium and for whom cross-border care is an easy and comfortable solution as Belgian medical facilities might be even closer than Dutch ones and the Belgian border-region is felt as being on the doorstep
- those **living further away** from the border and for whom there is a trade-off between waiting for treatment at home or going across the border to Belgium, which is more vividly felt as 'abroad' and foreign

The distinction serves to highlight the importance of geographical and cultural proximity as people prefer to be treated where they *feel* close to home. Dutch insurers have noticed this difference, as border-region inhabitants cross the border in their thousands while affiliated members in the rest of The Netherlands are significantly less mobile.

The numbers of Dutch patients coming to Belgium have been growing in the last years: via the E112 procedure, 4000 Dutch patients came to Belgium in 1998 while 12,500 came in 2003; via contractual arrangements, the two Dutch insurers OZ and CZ registered that 5750 patients went to Belgium in 2002, while 7270 went in 2004. While these numbers are not directly comparable and would be complicated to explain without going into great detail, they do however indicate tendencies over time.

A patient survey

Precisely to understand the perspective of the Dutch patients coming to Belgium for contracted health care, a **patient survey** was carried out in 2004 in the Belgian case-study⁹². The survey addressed affiliates of insurers OZ and CZ who had received medical care in a Belgian contracted hospital. The main findings were that while shorter waiting times was the main reason for CZ patients to go to Belgium and 70% had a preference to be treated in a Dutch hospital if care could be delivered as promptly, OZ patients had an entirely different opinion. Almost 60% of OZ members did not prefer to be treated in a Dutch hospital and were instead attracted to Belgium because of the reputation of doctors and hospitals. Furthermore, 45% of OZ respondents had previously visited a health care provider in Belgium, while only 13% of CZ members had. Average distance to the Belgian hospital where treated was 41km for OZ patients, 51km for CZ patients.

Yet, the findings give even more insight when seen in the regional context. The members of OZ are concentrated in the provinces and coastal areas in the south-west of the country, notably the area of Zeeuws-Vlaanderen (part of the Zeeland Province) which is cut off from the rest of The Netherlands by

⁹¹ According to rulings of the European Court of Justice, patients have right to cross-border care when treatment cannot be provided in the home Member State "without undue delay".

⁹² Boffin, N. and R. Baeten (2005). Dutch patients evaluate contracted care in Belgian hospitals: results of a patient survey. Brussels, Observatoire social européen: 55.

the sea but is directly adjacent to Belgium. The area is **sparsely populated** and has experienced the gradual **closure of hospital facilities**. Due to local under-capacity in health care, the Zeeuws-Vlaanderen arrangement was set up in the mid 1970s to facilitate access to Belgian hospitals for OZ members who are “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 (...) 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 for health care, is an entirely integrated part of their lifestyle.”⁹³

The results confirmed the concept of fluid borders but also revealed that “fluidity” is not categorical but a matter of degree: members from both insurers cross the Belgian border in their thousands. Yet, **CZ patients would prefer to be treated at home if there were no waiting times, while OZ patients are just as happy being treated in Belgian hospitals.**

Continuity of cross-border care

While Zeeuws-Vlaanderen is separated from the rest of The Netherlands by a waterfront, the long and narrow Dutch Province of Limburg could be described as a *super border-region*⁹⁴. Surrounded by frontiers on all sides, Limburg is another illustration of a ‘**pocket of proximity**’ along a fluid border. Sharing the same dialect and culture, the inhabitants of **Dutch Limburg** and **Belgian Limburg** are said to be closer to each other, despite the Belgo-Dutch border running through the community, than to the rest of Belgium or The Netherlands. Geographically situated in the Meuse-Rhine Euregio, cross-border activities take place ‘spontaneously’ without always being linked to the Interreg framework. As a cross-border community, exchanges happen naturally.

A large study in 2003 examined how the **continuity of cross-border care** could be guaranteed for patients going from The Netherlands to Belgium for hospital care and then back to The Netherlands for after-care⁹⁵. As opposed to the ZOM and IZOM initiatives operating according to the E112 provisions under the Euregio framework, the focus of these two reports is cooperation via **cross-border contracts** concluded between **Dutch health care insurers and Belgian hospitals** in Limburg.

With several thousand people waiting to get faster treatment and Dutch insurers having to comply with maximum waiting times, cross-border contracts with Belgian providers are seen as a **solution to waiting lists** in The Netherlands. Yet for patients this means that the care path becomes a cross-border chain with several stages and several authorisation or access procedures. The **patient pathway** can typically look as follows:

- First contact with insurance company’s waiting list mediation service to see whether care abroad would be an option for faster treatment
- Visit at local GP (or specialist) for a referral letter
- Consultation with Belgian specialist which assesses the need for tests and hospitalisation
- If required, pre-operative tests, images etc are done, even if these have already been carried out in The Netherlands
- Pre-op laboratory and other results will be discussed either with the Belgian specialist or the patient has to go back for a visit with the local GP

⁹³ Glinos, I. A., N. Boffin, R. Baeten. (2005), op. cit. p. 44.

⁹⁴ Ibid.

⁹⁵ Engels, E. L. (2003). Grenzeloos geketend? Deel A - Explorierend onderzoek naar de transnationale zorgketen tussen Nederland en België. Maastricht, Universiteit Maastricht, Faculteit der Gezondheidswetenschappen.
Engels, E. L. (2003). Grenzeloos geketend? Deel B - Explorierend onderzoek naar de transnationale zorgketen tussen Nederland en België vanuit patiëntenperspectief. Maastricht, Universiteit Maastricht, Faculteit der Gezondheidswetenschappen.

- If after-care is necessary following discharge, it will be provided in The Netherlands. The Belgian specialist and/or a clinical nurse will prepare a written document for the Dutch care institution or doctor
- Medical devices, where required, are prescribed by the Belgian specialist, but must be purchased in The Netherlands otherwise the patient will not be reimbursed by his/her Dutch insurer

Possible **gaps** can be pointed out in the cross-border pathway. E.g. there is no oral communication between the Belgian specialist and the Dutch GP during hospitalisation or during after-care. On the other hand, there is a **multiplication of superfluous medical procedures** (and costs) when Belgian doctors disregard tests already done in The Netherlands. Also, going forth and back between doctors and different care institutions is likely to be unpleasant or confusing for the patient. During interviews, Dutch GPs also mentioned the **lack of knowledge** about Belgian specialists and the differences in MRSA strategies between the two countries as problems. From interviews with all the different stakeholders it became clear that no-one had a clear vision of the complete cross-border patient pathway and how it is organised. Stakeholders were unfamiliar with the other parties which lead to **uncertainty** about tasks and responsibilities in the chain of care. Furthermore, a conflict of interests was revealed between regional Dutch providers and insurers as to whom should coordinate cross-border patient mobility; the one who directs patient flows to some extent also controls financial flows. Usually medical providers arrange patient pathways among themselves, but insurers – as financiers – also want to play an active role in coordinating health care, not least across the border.

These problems become all the more important in the light of the figures on Dutch patients which go abroad for medical treatment: an estimated *30,000 people* received care abroad in 2002, up 50% from 2001. As the consumption of cross-border care increase, so will the demand for after-care and the necessity to develop sound structures and procedures for patient pathways abroad. Yet, the different phases of care, delivered by several providers in more than one country, are not connected to one another. Due to a **lack of clarity, of communication and of coordination** the continuity of care cannot be guaranteed. The report concludes that despite the possibility which Dutch insurers offer their members to be treated in Belgium, the stages of cross-border care are not yet connected enough to speak of a “borderless care chain”⁹⁶.

To find out how the cross-border care pathway was perceived from the perspective of its users, Dutch orthopaedic patients having been treated in the Belgian hospital ZOL (i.e. Ziekenhuis Oost Limburg, Hospital of East Limburg) were asked about their experiences⁹⁷. As only a dozen patients participated in the survey, the results should be seen as illustrations of **personal experiences** rather than general trends. Nevertheless, the accounts provide some colourful evidence of the practicalities of and **obstacles to patient mobility**:

- Before admission: while some GPs and specialists were positive towards the cross-border care option, others were far less supportive. Some GPs refused to give referral letters and/or the personal medical file to patients wishing to be treated abroad. There was one case in which a specialist explicitly asked the patient not to tell other Dutch specialists that he had mentioned the possibility of cross-border care.
- During hospitalisation: some problems due to differences in terminology, in registration procedures when entering the hospital and long travelling distances for visiting relatives.
- After-care: as the patients specifically selected for the survey received orthopaedic treatment and were all elderly, they all needed after-care. 8 out of 11 respondents had to arrange for after-care themselves (i.e. a spouse or a child did). When back in The Netherlands, there were some problems due to differences in the prescription of medication and in MRSA policies. Three patients had

⁹⁶ Engels, E. L. (2003a), op. cit., p. 56.

⁹⁷ Engels, E. L. (2003b), op. cit.

difficulties in accessing Dutch care institutions after treatment in Belgium due to fears of MRSA contamination. One patient had to stay longer at ZOL because there was no space available to be admitted in a Dutch care institution.

- Information: 5 out of 11 respondents said they would have wanted more information from their insurer on cross-border care before actually going abroad. The three people who experienced admission problems due to MRSA fear would also have liked to be better informed on these differences between Belgium and The Netherlands.
- Motivations: all 11 patients gave “waiting lists in The Netherlands” as the most important reason for going to the Belgian hospital. In second and third places came respectively that waiting in the waiting room was shorter and that family and friends had also been to the hospital.

The patient experiences underline the ‘segmentation’ of the care path as there are several difficulties in going from one phase of care to the next. Despite this, patients were **very satisfied** with the treatment received in the Belgian hospital. The report concludes that the patient perspective should be seen as valuable complementary findings to the bottlenecks and difficulties which were identified by the other stakeholders and reaffirms the need for more coordination to ensure the continuity of cross-border care⁹⁸.

■ THE NETHERLANDS – BELGIUM / GERMANY FIVE EUREGIOS

Cross-border Urgent Medical Assistance

In 2000, a research report was published on the situation of cross-border emergency care along The Netherlands’ borders with Belgium and Germany⁹⁹. The purpose of the study was to identify the “opportunities and impediments... in the area of cross-border urgent medical assistance at administrative, judicial, operational and equipment employable level and which solutions may be submitted to tackle existing bottlenecks”¹⁰⁰. As the research covered a large geographical area, the border-regions were divided into five entities according to existing Euregio structures, that is: Scheldemond, Meuse-Rhine¹⁰¹, Rhine-Waal, Rijn-Ems-Ijssel and Ems-Dollard¹⁰². Several treaties and agreements for cooperation between public authorities at either country, regional or local levels have facilitated cross-border urgent medical assistance.

In the **Scheldemond Euregio**, severe trauma patients from the Dutch part benefit from having access to excellent medical facilities on the Belgium side at the hospitals of Ghent and Bruges. While Zeeuws-Vlaanderen (Dutch area in Scheldemond) is sparsely populated, has **limited emergency services** and is **geographically cut-off** from the rest of The Netherlands, it has the advantage of being easily accessible from Belgium. Within the framework of a European project (under Interreg programmes I and II), patients from the area are served by an emergency helicopter and a mobile medical team specialised in intensive and acute care (a Mobile Emergency Group) from the St. Jan hospital in Bruges. Another **Belgo-Dutch cooperation agreement** was signed in April 1993 between the municipality of Essen (B) and the province of North Brabant (NL), recognising the Franciscus hospital in Roosendaal (NL) as the competent hospital¹⁰³. The accord allows Belgian patients in the area of Essen to receive

⁹⁸ Engels, E. L. (2003)B, op. cit., p. 51.

⁹⁹ Post, B. and P. Stal (2000), Cross-border Urgent Medical Assistance - Belgium, Germany, The Netherlands. Nijmegen, ITS, University of Nijmegen Foundation.

¹⁰⁰ Ibid, p. 3.

¹⁰¹ Practices in the Meuse-Rhine Euregio have been described in greater detail in a previous section of the same chapter; here we only consider emergency care and follow the structure of report by B. Post and P. Stal (2000).

¹⁰² Ibid, p. 4.

¹⁰³ INAMI (2001). Les soins de santé dans l'Union européenne. Brussels, INAMI/ RIZIV.

Dutch ambulance assistance and be transported to nearby Dutch hospitals. A similar agreement was reached in 1997 between the Achterhoek region (NL) and Kreis Borken (D) to allow German ambulances to assist Dutch patients due to gains in distance and time to reach the patients¹⁰⁴.

An initiative involving all three countries was developed within **Interreg II** as the regions of Liege and Limburg (B), the Maastricht region (NL) and the Aachen area (D) cooperate in non-urgent medical assistance to allow the transportation of patients to cross-border hospitals, mostly between Germany and The Netherlands¹⁰⁵.

Based on a series of interviews with people involved in cross-border emergency care at all levels (medical, operational, administrative, political), the authors identified **numerous bottlenecks** of different nature which were obstructing cooperation in emergency care. It should be said that the bottlenecks were identified from the perspective of Dutch stakeholders.

In public **administration**, challenges were partly due to the multi-level public authorities in Belgium and in Germany. It was not always clear to what extent responsibility to make agreements lay at federal, regional or local level, while mismatches could also occur as legal measures on the provision of urgent medical assistance were taken at federal level but actual cross-border arrangements were shaped at local or regional level. Furthermore, **differences in political and legal structures** between The Netherlands and its two neighbours made it time consuming to reach agreements, just as it required important resources (personnel) for local institutions to understand the operational differences of the systems to ensure appropriate deployment of emergency care – resources they sometimes did not have.

From a functional perspective, questions over recognition and **accreditation of ambulances** had to be settled as they differ considerably between the countries (in Belgium all ambulances must comply with Belgian regulations, whereas in The Netherlands non-registered cross-border ambulances are exempted from Dutch legislation). Differences are also important when it comes to the qualifications and **competences of ambulance staff**. Whereas Belgian and German ambulance personnel are trained to give Basic Life Support, their Dutch colleagues are qualified to provide Advanced Life Support. In practice this means that Belgian and German personnel are not allowed to administer some treatments in The Netherlands which Dutch regulations require a qualified doctor or ambulance-nurse to carry out. Vice versa, Dutch emergency staff may only provide Basic Life Support in Belgium and Germany – they can only employ their more advanced skills under the supervision of a Belgian or German doctor. These differences also impact on the admission of patients into hospital as emergency department staff have to take into consideration that patients' condition might differ according to whether they are brought in by Dutch, Belgian or German ambulance crews.

Strict rules also apply on the deployment of medical vehicles on national territories, it is e.g. very difficult for a Belgian emergency communication room to call for the assistance of a Dutch ambulance due to the Belgian system of deployment. Conversely, German or Belgian ambulances are only allowed to cross the border with the consent of a Dutch emergency communication room. Problems also occur with the admission of patients into hospitals: according to Belgian law, accident victims can only be admitted to hospitals with an approved emergency service. This means that Belgian patients may solely be transferred to the St Franciscus hospital in Roosendaal as no other Dutch hospital has a recognised emergency department.

Other more **technical** bottlenecks were also found. Communication caused problems due to differences in radio frequencies, equipment and languages (on the Dutch –German border), while **judicial** aspects such as claims for damages, the use of medical drugs and traffic legislation on the use of optical and acoustical signals also had to be coordinated.

Last but not least, **financial** issues also posed problems as Dutch ambulance services were more expensive than in Belgium because they included the costs medical treatments; this was to the

¹⁰⁴ Post, B. and P. Stal (2000), op. cit.

¹⁰⁵ Ibid.

detriment of patients as Belgian sickness funds do not reimburse the costs of transportation by a Dutch ambulance to a Belgian hospital. In the project between the municipality of Essen and Roosendaal, it was settled down that the Belgian regional authority would cover these extra expenses.

Although the study focuses exclusively on cross-border urgent medical assistance, the problems and obstacles arising due to the fact of crossing borders – however fluid they are as in the Euregios – are illustrative of the challenges any patient mobility initiative might encounter. Talking about the general communication between countries, the authors suggest that “the success or failure of cross-border collaboration may be said to be contingent on mutual comprehension of the respective assistance systems”¹⁰⁶. Taking this a step further, the statement holds true whether patients go abroad for emergency or planned care, as the **reciprocal understanding of the respective health care systems** and their functioning is one of the prerequisites to successful patient mobility. As one of the authors points out in a later article, the planning of health care supply does not take into account the cross-border needs of populous areas and due to a national approach “patients are transported unnecessary distances in a failure to utilize more easily accessible cross-border provisions”¹⁰⁷. The author concludes, “[g]aining knowledge on [the] disparate systems and the opportunity to utilize the medical provisions of a neighbouring country potentially in closer proximity to those in the victim’s own country serves the interests of the patient.”¹⁰⁸

■ GERMANY – AUSTRIA BAVARIAN ALPS



Another example of **cross-border emergency care** is along the German-Austrian border¹⁰⁹ where German ambulances from Oberstdorf provide their services to the Austrian town of Kleinwalsertal. Conversely, Austrian emergency vehicles from Schärding serve the area of Neuhaus in Germany. The cross-border cooperation is mainly based on “personal and **informal agreements** between competent decision-makers”¹¹⁰. Interestingly, the author identifies a series of “**unresolved problems**” almost identical to those encountered on the Belgian-Dutch-German border¹¹¹, relating to the use of different sirens, the administration of medicines, rule on traffic conduct, payments (who has to pay what) and adds the question of whether patients suffering from highly infectious diseases should be allowed to be taken across the border.

¹⁰⁶ Ibid, p. 44.

¹⁰⁷ Post, G. B. (2004). “Building the Tower of Babel: Cross-border Urgent Medical Assistance in Belgium, Germany and the Netherlands.” *Prehospital and Disaster Medicine* 19(3): 235-244. p. 242.

¹⁰⁸ Ibid, p. 243.

¹⁰⁹ Allinger, H. (2005). *Cross Border Co-Operations Germany Austria*. EUROPEAN FORUM ON CROSS-BORDER HEALTH CARE Challenges and Perspectives, Venice, Italy.

¹¹⁰ Ibid, p. 2.

¹¹¹ Post, B. and P. Stal (2000), op. cit.

The author also mentions that there is **on-going cooperation between two hospitals** in the border-region as Braunau hospital (Ö) and Simbach hospital (D) are situated within 2km of each other. The Austrian hospital has been under reconstruction for ten years during which Austrian patients were admitted in Simbach and treated by Austrian doctors and nurses. There are also plans for future cooperation in specific departments to diminish the costs of reconstruction and make substantial savings, developing areas of expertise and intensifying the exchange of patients – the author even calls it the “**European Hospital**” Braunau/ Simbach¹¹².

■ GERMANY – SWITZERLAND REGION OF CONSTANCE



A German-Swiss agreement on social matters has made it possible for residents in the region of Lake Constance to have access to health care facilities on the other side of the border¹¹³. Participating **sickness funds cover the costs** of their members' treatments abroad following prior authorisation. The scheme also covers specialised care as a German patient receiving radiotherapy in Switzerland would have his/her cancer treatment entirely covered by the German sickness fund of affiliation.

■ FRANCE AND ITS BORDER-REGIONS

Examining where the concentration of health-related cross-border initiatives lies on the borders of France¹¹⁴, one notices the abundance of patient mobility projects on the north-eastern borders, especially with Belgium and Germany, while the southern borders with Italy and Spain appear to have less numerous cross-border projects. The distinction between fluid and rigid borders mentioned in the introduction, comes into play here as the frontiers between France, Germany and Belgium have been changing throughout history encouraging exchanges between border-region communities to develop as they often share a common traditions and languages. The southern borders are on the other hand characterised by physical barriers such as mountain chains which tend to hinder cross-border flows. Yet, in some cases, it is precisely the relative geographical isolation, which has led to some noteworthy possibilities for patient mobility, as in the Pyreneans.

Furthermore, France has signed **bilateral agreements** with several of its neighbouring countries most recently with Germany and with Belgium. On 22 July 2005, a framework agreement was signed

¹¹² Allinger, H. (2005), op. cit., p. 8-9.

¹¹³ Drespe, A. (1999), op. cit.

¹¹⁴ Bassi, D., O. Denert, *et al.* (2001), *Etat des lieux de la coopération transfrontalière sanitaire*. Rennes, Mission opérationnelle transfrontalière, Editions de l'école nationale de la santé publique.

Denert, O. (2004). *La coopération transfrontalière sanitaire*, Mission Opérationnelle transfrontalière.

Harant, P. (2006). Hospital cooperation across French borders. *Patient mobility in the European Union - Learning from experience*. M. Rosenmoller, M. McKee and R. Baeten. Copenhagen, European Observatory on Health Systems and Policies: 157-177.

between the government of the French Republic and the government of the German Federal Republic on “cross-border cooperation in health care”. A similar bilateral agreement was signed on 30 September 2005 with Belgium. Indeed, the two bilateral accords are very comparable as they both state that the objectives of cross-border cooperation in health care are to ensure better access and guarantee the continuity of care for the border-region populations (people residing or staying in the border-zone), to optimise the supply of health care and the sharing of knowledge and facilities. To these aims, the Franco-German agreement adds the objective of guaranteeing a faster recourse to emergency services. The accords also set out which regions in the respective border-zones are concerned, how practical cross-border arrangements are to be set up, which measures they must take into account (cross-border exercising of medical professionals, continuity of care, patient transport, criteria for the quality and safety of treatments, funding necessary for the cooperation) and how cross-border care is to be financed (either based on EU Regulations or specific tariffs)¹¹⁵. The agreement with Germany in addition contains an article specifying that health care professionals delivering emergency assistance do not need authorisation to deliver cross-border services in the other country¹¹⁶. It should be mentioned that similar agreements appear to be under way with France’ southern neighbours Italy and Spain where local actors in the border-regions have been cooperating since long. Long-standing cooperation highlights the need for cross-border access to care while the decision from the French State-level to negotiate bilateral agreements shows the importance for central authorities to be involved in the cross-border developments happening at local/ regional level. A “Declaration of intent or agreement protocol” was signed in October 2005 between the French and Spanish ministers of health and signalled the political will on both sides to create the first European cross-border hospital¹¹⁷.

Due to France’ geographical position and the material available it is possible to give a relatively complete picture of patient mobility on France’ borders and illustrate the meaning of fluid and rigid borders.

¹¹⁵ (2005). Accord cadre entre le Gouvernement de la République française et le Gouvernement de Royaume de Belgique sur la coopération sanitaire transfrontalière.

It should be noted that the framework agreement is not yet in force as it has to be approved by the French and Belgian parliaments first.

¹¹⁶ (2005). Accord-Cadre entre le Gouvernement de la République française et le Gouvernement de la République fédérale d’Allemagne sur la coopération sanitaire transfrontalière (Not yet in force).

See also Harant, P. (2006), op. cit.

¹¹⁷ <http://www.espaces-transfrontaliers.org/indexsite.php>.

■ **BELGIUM – FRANCE – LUXEMBOURG**
WALLONIA – LORRAINE – LUXEMBOURG



With a population of over 2.5million people, the **Interreg region** of Wallonia-Lorraine- Luxembourg covers the border areas of the Belgian Province of Luxembourg, the Grand Duchy of Luxembourg and the border *départements* of French Lorraine. Considering the shared history, the cultural and linguistic proximity (French being the common tongue) as well as the economic space¹¹⁸, one can indeed talk about a **fluid border** running across the three communities.

Since July 2002, the undertaking Luxlorsan (“LLS” or Luxembourg Lorraine Santé), made up of **French and Belgian sickness funds and two public bodies in Luxembourg**, has lead the project “Recherche et action transfrontalière”¹¹⁹, partly financed under the Interreg IIIA programme¹²⁰. With the double objectives of improving access to health care systems and the realisation of economies of scale, in particular through rational use of health services, the project has developed several studies which form the basis for action lines¹²¹. One such study was the LLS **survey** “Mobilité et coopération transfrontalière” (Cross-border mobility and cooperation) carried out in 2003. The results, complemented by data from hospital registration systems of all three sides, revealed that **4511 hospital stays of “non-resident patients”** had been registered in 2001 by hospitals in the LLS zone. The flows of mobile patients were as follows¹²²:

- The hospitals of Luxembourg received 1150 patients residing in Belgium (44.2%) and 787 patients from France (30.4%). The vast majority of Belgian and French patients (87%) were insured in Luxembourg, which indicates that these patients were frontier workers and their families.
- Belgian hospitals in the province of Luxembourg registered 510 patients living in France (70.1%) and 199 coming from GD Luxembourg (27.4%)
- French hospitals in Lorraine received mainly people residing in GD Luxembourg (1160 patients, i.e. 85%) and only few from Belgium (143 patients).
- It should also be mentioned that 11.7% of the total patient flux in the LLS zone concerned German patients treated mainly in GD Luxembourg.

As to which **pathologies** mobile patients were treated for, many cases concerned emergency care. Hospitals in Lorraine admitted a majority of foreign patients for illnesses related to the osteo-articular

¹¹⁸ Luxlorsan (2004). Offre de soins et mobilité à l'intérieur de l'espace transfrontalier Lorraine - Grand-Duché de Luxembourg -Province de Luxembourg, Groupement Européen d'Intérêt Economique (GEIE).

¹¹⁹ (2005). “Atténuer "l'effet frontière".” *Interregactions - LA LETTRE DU PROGRAMME INTERREG III-A WALLONIE LORRAINE LUXEMBOURG*(4): 1.

¹²⁰ http://www.espaces-transfrontaliers.org/en/detail_projet.php?idprojet=69.

¹²¹ (2005). “Atténuer "l'effet frontière", op. cit.

¹²² Luxlorsan (2004), op. cit.

system, but other treatments included oncology, radiotherapy, neurosurgery, cardiac surgery and transplants. Hospitals in the Grand Duchy registered main causes for hospitalisation of foreign patients (in 2002) as being traumatic lesions (16%), disorders of the osteoarticular system, muscles and conjunctive tissue (12.9%) and cases related to pregnancies and births (11.4%). Yet, more complex pathologies, separate from emergency care, were also treated as 5-10% of hospitalisations concerned tumours or disorders of the respiratory or digestive systems. As their counterparts, Belgian hospitals received mainly emergency cases, 22.66% of foreign patients being registered under “traumatism, poisoning and other external causes” and 17% under “factors influencing the state of health”. According to the authors of the study, it is possible “to distinguish **three types of mobility**, characterised by particular motivations: the flows of **frontier workers**, the flows prompted by the **regional insufficiency** of health care supply and **spontaneous flows**”¹²³. While the reasons for cross-border emergency care in a border-region are obvious, the above-mentioned “regional insufficiency” refers to the absence of an academic hospital as the Centre Hospitalier Universitaire of Nancy (FR) is located on the very limit of the Interreg area and is therefore geographically far away from important parts of the regional population.

Patient flows also take place in the context of broader hospital cooperation, e.g. between the Association Hospitalière du Bassin de Longwy (Mont-Saint-Martin, France) and the Cliniques du Sud Luxembourg (Arlon, Belgium) in the fields of medical imagery (scanning, nuclear medicine, IRM...) and neuro-surgical and neuro-vascular illnesses. Economies of scales are also achieved between the two hospitals as specific laboratory tests are only carried out in Belgium due to the limited number of tests. Furthermore, “triangular cooperation” was launched in June 2004 with the signature of a convention between the Association Hospitalière du Bassin de Longwy, the Cliniques du Sud Luxembourg and the Centre Hospitalier de Luxembourg (Luxembourg) to create a network of care in neuro-sciences with the aim of improving the quality and proximity of care for patients and their families in a field where providers and facilities are limited¹²⁴. This willingness of hospitals to cooperate across borders had also been highlighted in another LLS survey which was carried out in 2002 on the topic of “Mobilité et coopérations interhospitalières” (“Mobility and inter-hospital cooperation”). The survey showed that three out of four hospitals, which took part in the survey, were interested in developing cross-border cooperation (50 institutions were questioned with a response rate of 64%). The same positive picture emerged from direct interviews with the management of hospitals¹²⁵.

Some further aspects are worth noticing. Firstly, the cross-border movements are not limited to the hospital sector as the use of **primary health care** facilities is more widespread among frontier workers in Luxembourg than the use of hospital services. Secondly, it is noted that there exists a flow of medico-social patients from France to Belgium, as Belgian care facilities and infrastructure for the elderly and for people with special needs are particularly well-developed¹²⁶.

¹²³ Ibid, p. 264.

¹²⁴ http://www.espaces-transfrontaliers.org/docdivers/revuedepresse/rdep2004_0618.html and http://www.espaces-transfrontaliers.org/affiche_projet.php?affiche=projet/proj_luxlorsan.html.

¹²⁵ Luxlorsan (2004), op. cit., p. 253-263.

¹²⁶ Luxlorsan (2004), op. cit.

On French elderly patients in Belgian homes, see also Nizet, P. (2005). Les Français préfèrent nos homes/ Pas de tracas pour la ministre/ "Parfois trois demandes par jour". *Le Soir* and Rocour, V. (2005). La Belgique attire les résidents français. *La Libre Belgique*.

■ FRANCE – BELGIUM

As mentioned above, a bilateral agreement was signed in 2005 between France and Belgium to facilitate cooperation in the field of health care. It provides a legal framework for local stakeholders to conclude and implement specific cross-border agreements suited to the local needs. The State-level agreement aims at improving access to health care in the border-regions, ensuring continuity of care and developing the sharing of capacity and knowledge¹²⁷.

■ FRENCH THIÉRACHE – BELGIAN THIÉRACHE



The Transcards project

An illustration of an **organised zone of free access** to health care services is the *Transcard* project between the French region of Thiérache (comprising nine cantons) and the Belgian Thiérache (seven communes)¹²⁸. From October 1998 to October 2000, the project received **EU funding** from the European Commission which meant that studies necessary for the experiment were carried out and the first arrangements were set up¹²⁹. The **experimental project** was then launched in May 2000 to facilitate the administrative procedures when treating local patients on either side of the border. As the experiment proved to be successful, it was decided to **permanently establish the 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 took effect from January 2003¹³⁰. Founded on the principle of cross-border zone of unconstrained access to health care, the project extends the social security cover in a border-region of 140.000 inhabitants¹³¹ allowing people to be treated on either side of the border simply by presenting their identity and social insurance cards¹³². The **interoperability** of the French and Belgian cards is guaranteed in eight cooperating institutions and avoids patients to have to use the E112 forms and ask for prior authorisation¹³³. The initiative thus

¹²⁷ Harant, P. (2006), op. cit.

For a complete overview of cross-border agreements between Belgium and France, see Jorens, Y., C. Salamon, *et al.* (2005). *Naar een rationalisatie van de EG-Coordinatieverordeningen inzake sociale zekerheid?* Ghent, Belgium, University of Ghent: 257, p. 220-221.

¹²⁸ CPAM de Maubeuge and CPAM de St Quentin (2004). *Evaluation annuelle TRANSCARDS 2003*, CPAM de Maubeuge/ St Quentin.

See also Harant, P. (2006), p. 159-161.

¹²⁹ www.sesam-vitale.fr.

¹³⁰ CPAM de Maubeuge and CPAM de St Quentin (2004), op. cit.

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

¹³¹ Denert, O. (2004), op. cit., p.15.

¹³² Coheur, A. (2001), *Cross border care - New prospects for convergence*. European Integration and Health Care Systems: A Challenge for Social Policy, Ghent, Belgium.

¹³³ De Backer, op. cit.

greatly facilitates patient mobility, improves patient choice through the larger number of available health care facilities and promotes the complementarity of health care supply in the border-region¹³⁴.

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**. Regarding the cross-border cooperation it is noteworthy that according to one director of a French hospital participating in the project, one of the strengths of Transcards is that formal cooperation structures have been replaced by **well-functioning interpersonal relations** between the medical actors in the region¹³⁵.

The Transcards Convention provides for an assessment report to be prepared on a yearly basis by the main insurance bodies involved. The two complete evaluations^{136, 137} carried out for 2002 and 2003 conclude that there is an apparent disequilibrium in the number of patients which use health care facilities across the border as French patients constituted 88% of total patient mobility within Transcards in 2002 (corresponding to 525 cross-border movements of French patients vs. 70 of Belgian patients) and 87% in 2003 (608 French movements vs. 89 Belgian). Yet, this asymmetry is balanced out at the financial level as the 'average cost per flow' for Belgian patients was much higher than for their French neighbours in 2003 (approx. 1950 EUR vs. 100 EUR). This difference in costs was due to the type of care which patients crossed the border for: while French people used Belgian facilities for mostly ambulatory care, the Belgians went to France for treatments requiring hospitalisation. In other words, there is cross-border **complementarity** in the provision of care and a **near-equilibrium in the supply of and demand** for health care, which prove the usefulness of the Transcards arrangement.

Yet, in its report, the 'Mission Opérationnelle Transfrontalière' distinguished two **administrative hindrances** to patient mobility: on the French side, the large proportion of rural workers cannot benefit from the Transcards system because their sickness fund (the 'Mutualité Sociale Agricole') is not part of the agreement. Furthermore, as Thiérache is a socio-economic disadvantaged region, it has a high proportion of people which on the French side benefit from the reimbursement under the Universal Health Cover (Couverture Médicale Universelle), yet this restitution system does not apply if they are treated in Belgium.

Despite these two hindering factors, the overall success of Transcards means that it is now being considered to **extend the concept** to the region of the French Ardennes and the East side of the metropolitan area of Lille, before widening the scope to the entire French-Belgian border by 2007¹³⁸.

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

In the same region as the Transcards project is a **pioneering initiative** and example of a **cross-border agreement** between two health care institutions: the convention set up in June 1994 between the hospitals of Tourcoing and Mouscron¹³⁹ (please see map in previous section). The French hospital has had difficulties in responding to the demands for dialysis but is specialised in the treatment of infectious diseases such as AIDS. On the other side of the border, the Belgian hospital is able to absorb the exceeding demand for dialysis and sends some of its patients to the infectology department in

¹³⁴ Colson, P., C. S. F. Chimay, *et al.* (2002), *Accès simplifié aux soins hospitaliers en Thiérache grâce à la carte SIS et la carte Vitale*. Paper presented at Seminaire: "Coopération Transfrontalière Sanitaire", Lille.

¹³⁵ Denert, O. (2004), *op. cit.*, p.15.

¹³⁶ CPAM de Maubeuge and CPAM de St Quentin (2004), *op. cit.*

¹³⁷ CPAM de Maubeuge and CPAM de St Quentin (2003). Evaluation annuelle TRANSCARDS 2002, CPAM de Maubeuge/ St Quentin.

¹³⁸ *Ibid.* p. 15.

¹³⁹ Bassi, D., O. Denert, *et al.* (2001), *op. cit.*
Baeten, R. (2003), *op. cit.*

Tourcoing¹⁴⁰. The **complementarity** between the two institutions is what drives cooperation in this case, but contextual factors such as the very short distance between the two hospitals (around 2km), the cultural and linguistic **proximity** of the local communities as well as the intensive professional cross-border flow which has existed for decades all greatly facilitate patient mobility¹⁴¹. As an activity report puts it: “the border which separates [the two hospitals] has always been artificial”¹⁴².

After a few years of operation, an **evaluation** report¹⁴³ covering the period from June 1996 to June 1997 showed that a total of *12 patients* residing in Belgium were or had been treated in the French hospital. Of these, four patients had started treatment in the first year of the cross-border arrangement (June 1994 – June 1995), six patients in the second year, and two patients in the third year (June 1996 – June 1997). On the Belgian side, a total of *four patients* residing in France had received or were receiving care in the Belgian hospital; three being admitted the first year and one in the second year. No patient had been admitted under the convention between June 1996 and June 1997. Although these numbers remain small it should be remembered that for dialysis and treatment of infectious diseases such as HIV/ AIDS, patients have to go to the hospital on a regular basis. As the patient makes several and repeated visits to the hospital, short distances and ease of access become crucial for patient comfort and safety.

The overall assessment of the cooperation in 1997 was “fully satisfactory” as patients surveyed said to be satisfied about the quality of care received, the proximity and accessibility of the hospital where treated, the less tiring journeys and the feeling of security in case of emergency, which all contributed to an improvement in quality of life. Furthermore, health care providers were satisfied with the cooperation and the links between different players (sickness funds, hospitals, GPs, specialists and patients) had also been satisfactory. Yet, a few problems were also highlighted as Tourcoing hospital had experienced important delays between the admission of patients and obtaining an E112 form, which lead to delays in the reimbursement of costs for the hospital. Furthermore, there was a need to improve general information on the convention and its functioning and to look into why there was a stagnation of French patients admitted in the Belgian hospital¹⁴⁴.

Other sources also describe the inter-hospital cooperation as being successful. Bassi, Denert et al. mention that between 1994 and 1999, a total of **20 French and 17 Belgian patients** received treatment in the two hospitals¹⁴⁵, while De Backer explains how the initial success has led the two hospitals to cooperate and exchange services in the field of medical imagery. It appears that an additional *one thousand magnetic resonance images* (MRI scans) have been carried out at Tourcoing for Belgian patients while some *300 scintigraphic* tests have been carried out at Mouscron hospital for French patients¹⁴⁶.

¹⁴⁰ 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.

¹⁴¹ (2002). Accessibilité et mobilité transfrontalière en santé. Initiative Communautaire Interreg III. Programme France - Wallonie - Flandre 2000-2006. Rapport d'Activités.

¹⁴² Ibid, p. 6.

¹⁴³ (1997). Convention entre le centre hospitalier de Mouscron et le centre hospitalier de Tourcoing - Evaluation de la convention juin 1996 à juin 1997. Complémentarité transfrontalière entre la Belgique et la France.

¹⁴⁴ Ibid, p. 19-20.

¹⁴⁵ Bassi, D., O. Denert, *et al.* op cit.

¹⁴⁶ 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.

■ FRANCE – ITALY PROVENCE-ALPES-CÔTE D'AZUR – IMPERIA



Cross-border hospital cooperation between the French and Italian Riviera

Inter-hospital cooperation between French hospital in Menton and the Italian Riviera has taken place since 2000 in order to meet the needs of the population on both sides of a very **fluid border-region** with high activity levels and extensive exchanges. Several elements encouraged this cooperation. The **geographical position** of the Menton hospital was decisive as it is located close to the Italian border, is relatively isolated between the Mediterranean Sea and the mountains and is at a short distance from major hospitals to the west (in France but also in Monaco). As a result, it was necessary for Menton to assert its function as a local hospital and it therefore turned towards the east, i.e. to the Italian region of Imperia and in particular the border-cities of Vintimiglia and Bordighere respectively 5km and 10km away¹⁴⁷. Furthermore, a **health centre was closed** down in Ventimiglia on the Italian side and Italian border-region patients were not covered when treated in the Menton hospital¹⁴⁸. The French hospital therefore sought how to extend the social security cover and an **agreement** was signed in February 2002 establishing a “Cross-Border Health Community” between on the one side the Menton hospital “La Palmosa” and the local French health insurer, and on the other side, the local Italian health authorities of the Imperia region, which manage the supply of hospital care and acts as a third-party payer. The accord **merges the facilities** and competences of one French hospital, two Italian hospitals as well as one Italian dialysis centre and covers a population of 130.000 people in Menton, Imperia and Bordighera. The agreement received backing from local political actors and aims to facilitate free access to health care for the border-region population as well as to develop **complementary in the supply of care through cross-border planning**. When set up, the hospital cooperation also had a ‘synergy effect’ as the participating Italian institutions possessed a scanner, an IRM and dialysis facilities which were not available in Menton at the time¹⁴⁹. Furthermore, in 2003 a cross-border perinatal centre was set up in Menton where pregnant women from both sides of the border can receive care and advice from a Franco-Italian medical team¹⁵⁰.

It should also be mentioned that collaboration in the health sector builds on a pre-existing framework as agreements on cross-border cooperation was signed between the cities of Menton and Ventimiglia as early as in 1991 and between France and Italy in 1993¹⁵¹, while Menton with its 40.000 inhabitants was

¹⁴⁷ Romanens, C. (2002). *Le Centre hospitalier de Menton vers un hôpital transfrontalier*. Séminaire: "Coopération Transfrontalière Sanitaire", Lille.

¹⁴⁸ Denert, O. (2004). La coopération transfrontalière sanitaire, Mission Opérationnelle transfrontalière, p. 17.

¹⁴⁹ Bovas, M. (2002). Alpes-Maritimes - Menton invente l'hôpital transfrontalier. *La Tribune*. Menton.

¹⁵⁰ Denert, O. (2004), op. cit.

¹⁵¹ Romanens, C., G. Pagliari, et al. (2003). *La cooperazione sanitaria tra il Centro Ospedaliero "La Palmosa" di Metone e la ASL 1 Imperiese*. European Week of Public Health, Brussels.

labelled as a pilot site for cross-border cooperation by the French State in 1997 in areas such as water, transport etc. In addition, the European Interreg III secretariat on Franco-Italian collaboration was set up in Menton in 2001¹⁵².

■ FRANCE – SPAIN FRENCH CERDAGNE – SPANISH CERDAGNE



Pioneering project of first cross-border hospital

The Cerdagne border-region on the plateau of Cerdan is situated between the East Pyreneans and the Spanish region of Catalonia making it particularly **isolated**. Major cities are only reachable via sinuous mountain roads and Perpignan is 100km away while Barcelona is 140km away. Furthermore, Cerdagne is scarcely populated with 15,000 inhabitants on each side of the border, but the two communities are historically, socially and culturally very close and share the same language, Catalan¹⁵³. Furthermore, the area receives an important inflow of tourists, in high season the total population goes up to 130,000 people, and has four lakes and 10 ski resorts¹⁵⁴.

On the **French side, medical facilities are limited**. There are no surgical or obstetrical services in French Cerdagne, and the closest clinics offering these facilities are at least one hour driving away. Yet, **access to Spanish health care is easier** as the hospital of Puigcerda is situated on the border and is very well-equipped¹⁵⁵. Since 1996 when relations started with the French authorities, the hospital acts as de facto emergency clinic for local French patients. Between 1997 and 2002, *French patients treated in Puigcerda increased with 84%*. Yet, several technical difficulties existed: E111 and E112 forms were not always applicable when French patients were brought into the hospital, which meant that patients had to pay upfront, and the Spanish tariff system did not give an incentive to cross-border cooperation. In 2000 and 2001, the hospital was not remunerated for 52% of the costs of services provided to French patients¹⁵⁶. To redress this situation, Puigcerda hospital signed an **agreement** in 2002 with the hospital of Perpignan and the regional French health authority so as to be retrospectively reimbursed for emergency care provided since January 2001¹⁵⁷. A **second convention** was signed in 2003 between the Puigcerda hospital and the health insurers of the French region of Languedoc Roussillon to ensure that the hospital would be reimbursed for emergency and obstetric care given to

¹⁵² Bovas, M., op. cit.

¹⁵³ Denert, O. (2004), op. cit.

¹⁵⁴ Bonnier, C., M. Morlon *et al.* (2003). *De la Coopération Transfrontalière Sanitaire en Cerdagne vers un Projet d'Hôpital Transfrontalier*. Les rendez-vous européens de la Santé transfrontalière - Libre Circulation et Régulation, Lille.

¹⁵⁵ Denert, O. (2004), op. cit.

¹⁵⁶ Bonnier, C. (2003). "La coopération transfrontalière: une solution pour la Cerdagne." *URCAM de Franche-Comté*: 61-63.

¹⁵⁷ Tobar, M. and M. Morillas (2002). *Coopération transfrontalière sanitaire en Cerdagne*. Séminaire: "Coopération Transfrontalière Sanitaire", Lille.

French insured patients¹⁵⁸. According to this agreement, **invoices are based on tariffs which have been previously agreed.**

Since the agreement was signed, the maternity services at Puigcerda hospital have gone from 20 to *100 births annually*¹⁵⁹. This has also to be seen the light of the closure in 2001 of the maternity clinic in Prades (French side) which meant that patients in the Cerdan plateau had to travel 90min to access maternity facilities¹⁶⁰.

Inspired by this well-functioning cross-border cooperation, a study was carried out in 2003 involving an array of local and regional French and Spanish health care actors (and co-financed by the European Commission's **Interreg** III fund) on the possibility to build a new, truly **cross-border hospital**¹⁶¹. If this project materialises, it will be the first ever hospital to be **planned, managed and funded jointly** by two countries, or more specifically by the autonomous region of Catalonia and the French health authorities. With a capacity of 50 beds, it will serve patients from the 'twin-communities' of Spanish and French Cerdagne and thus solve the problems of difficult hospital access for French patients and of cross-border reimbursement. The project is received with enthusiasm on both sides and it is foreseen that the hospital will employ staff from both sides. Building works were planned to start in 2005 with the hospital being functional by 2007¹⁶², but in late 2005 the expected timeline was for works to begin in late 2006 and the hospital opening by end 2008¹⁶³. It is expected that the cost of the project will arise to 26million EUR, of which 10.4mill will come from France and 15.6mill from the government of Catalonia¹⁶⁴.

It is also interesting to notice the strong political dimension of cross-border cooperation in the region, as some authors go as far as to ask whether "the "reunification" of Cerdagne could start by cross-border cooperation in the field of health care so as to lead in the long-term to a reunified Cerdagne with its administrative centre in Puigcerda?". This **regionalist drive** has deep roots and go back to the 12th and 13th centuries when there were attempts to unify the two regions in a trans-Pyrenean kingdom¹⁶⁵.

Another example of cooperation across the Pyreneans is the **contract** between a Spanish insurance fund and French hospital for assistance in case of **accidents** relating to the work place¹⁶⁶. In 1999, the **Spanish insurance** fund MUPA, Mutua de Accidentes de Trabajo y Enfermedades Profesionales de la Seguridad Social (Social insurance fund for work-related accidents and professional illnesses) located in Lleida and the **French hospital** Centre Hospitalier de Saint-Gaudens concluded a contract (still in force) which foresees that an affiliated worker in need of health care presents himself with a consent form from MUPA and his company to the hospital. The hospital is paid by MUPA within 2 months.

¹⁵⁸ Ibid.

¹⁵⁹ Bagué, G. (2004). Primer hospital transfronterizo. *El País*. Giron.

¹⁶⁰ Bonnier, C., M. Morlon *et al.* (2003), op. cit.

¹⁶¹ Denert, O. (2004), op. cit.

¹⁶² Ibid.

¹⁶³ (2005). *Common Cross-border Hospital Cerdanya*. European Forum on Cross-border Health Care: Challenges and Perspectives, Venice, Italy.

¹⁶⁴ <http://www.espaces-transfrontaliers.org>.

¹⁶⁵ Bourret, C. and J. Tort i. Bardolet (2002). *Maîtrise de l'information, amélioration des systèmes de santé et aménagement du territoire. L'exemple de la Catalogne et de la région Midi-Pyrénées*. Les journées d'études des systèmes d'informations élaborées, L'île Rousse.

¹⁶⁶ (1999). Contract: Concierto de Condiciones y Tarifas de Asistencia Sanitaria por Accidentes de Trabajo. Lleida, Mutua de Accidentes de Trabajo y Enfermedades Profesionales de la Seguridad Social & Centre Hospitalier de Saint-Gaudens.

■ ESTONIA – LATVIA
VALGA – VALKA



A comparable illustration of potential inter-hospital cooperation across a border is provided by the Valga-Valka project. Once a single town, Valga/ Valka was divided into an Estonian part (Valga) and a Latvian part (Valka) after 1918. During the Soviet era the two towns each developed their social infrastructure and two hospitals, one in Valga, one in Valka, were built within a 2km distance of each other. After independence and economic transition in the 1990s, the Estonian hospital was being under-used while the Latvian hospital was faced with a pressing need for renovation. As both serve a relatively limited local population it is financially unsustainable to have two teams of emergency services on-call at the same time. Two other areas have also been identified as suitable for cross-border cooperation, namely obstetrics and joint ambulance services. Furthermore, in August 2005 the Valga municipality opened a tender for a 10-year master-plan (financed by the EU Baltic Sea region Interreg IIIA programme) for the development of a common plan for specialist, nursing and ambulance care provision¹⁶⁷.

Yet it should be noted that to date the cooperation project remains at the planning stage. Despite this, the Valga-Valka case is a noteworthy illustration of possible joint facilities and cross-border complementarity between two neighbouring hospitals.

¹⁶⁷ Jesse, M. and R. Kruuda (2005). Patient Mobility in the European Union: Case study Estonia. Tallinn, Estonia, PRAXIS: 67.

■ NORTHERN IRELAND – REPUBLIC OF IRELAND¹⁶⁸



The “Europe for Patients” case-study on patient mobility between Northern Ireland and the Republic of Ireland shows that despite **initial enthusiasm** with and potential benefits from cross-border cooperation in health care services, actual cooperation and mobility have been less important than expected. Lack of funding flexibility, lack of political involvement and the **reluctance** of local health care providers who fear cross-border cooperation is a way to rationalise existing local services, have made it **difficult for projects to develop** – even though patient mobility could improve the services which patients receive. Some of the projects which have worked out are described below.

Hospital cooperation

Altnagelvil (NI) and Letterkenny (RoI)

Cooperation has been on-going for several years between Altnagelvil Area Hospital in Londonderry and neighbouring Letterkenny General Hospital, partly based on an **official agreement** guaranteeing that cooperation would not undermine local services but rather widen them so as to attract patients from the entire region. Following an agreement on oral and maxillofacial surgery, the Altnagelvil hospital has **extended its catchment area** to include the population of the North West Health Board (RoI), saving some patients to travel almost 200 miles to Dublin. Furthermore, it grants the viability of the specific service at Altnagelvil hospital as it now serves a population of ca 600,000.

In the field of neo-natal intensive care, the Northern Ireland hospital also provides its services to babies from Letterkenny hospital, while victims of road accidents and women in need of urgent obstetric treatment are brought to the nearest of the two hospitals independently of where they live.

Monaghan (RoI) and Craigavon (NI)

Due to long **waiting lists** for hernia surgery at Craigavon hospital, a **pilot project** was set up for patients having waited more than 18 months to be operated at the Monaghan hospital.

Daisy Hill Hospital (NI)

Despite capacity problems for local patients from N.I., a limited number of patients from Dundalk (RoI) suffering from renal diseases in the final stages have access to **haemodialysis services** at Daisy Hill

¹⁶⁸ Jamison, J., H. Legido-Quigley, *et al.* (2005). A solution in search of a problem? - Cross-border health co-operation in Ireland. Armagh, Northern Ireland, Centre for Cross Border Studies: 38.

Hospital in Newry (south-eastern part of Northern Ireland). This saves the patients from travelling ca 60 miles to Dublin for dialysis 2-3 times a week. Out of 90 patients being treated at Daisy Hill, *five* were from the Dundalk area.

4.2 Patient mobility due to relative weaknesses or shortcomings in national system

A series of different push factors were identified as influencing patient mobility by encouraging people to seek health care abroad: inadequate availability of services within the national health care system often signalled by waiting lists, lack of competence or under-capacity at home; differences in price levels; and/or the perception of quality of care at home compared with that abroad. These negative drivers will be looked at in turn.

4.2.1 Patient mobility due to waiting lists, lack of competence or lack of capacity at home

■ DENMARK

Waiting lists and free choice of providers

In July 2002, new legislation on “**Extended Free Choice of Hospitals**”¹⁶⁹ introduced the so-called **guarantee to treatment** which ensures that Danish patients have a right to be treated in private clinics in Denmark or at foreign hospitals, providing that:

- Waiting times for treatment exceeds 2 months in the patient’s region of residence
- The private/ foreign hospitals have an agreement with the organisation representing the Danish regions or with the health authorities of a region which can choose to make individual agreements with private or foreign providers

In Denmark, it is the regions which are responsible for running public hospitals, maternity clinics and other medical centres which belong to the public health care system. Managing the hospital sector is the regions’ biggest task and amounts to approx 52% of total regional spending¹⁷⁰.

Previously, free choice of hospitals only applied to public national providers, yet in 2002, choice was extended to cover private and foreign providers if waiting times exceed the 2-month target. Some 130 agreements have been concluded with Danish private clinics and 13 with foreign hospitals (only private), of which 10 in Germany and 3 in Sweden. This prevalence of Danish providers is reflected in the patient flows which occurred from 1 July 2002 to 31 December 2003¹⁷¹:

- In total, 26.093 patients were treated under the ‘Extended Hospital Choice’ scheme
- Of these, only 344 (1.3%) were treated in German and Swedish hospital
- Treatments concern mainly orthopaedic surgery or cataract operations

More recent data from the Danish Ministry of Health show that from July 2002 until October 2004, almost 42.000 patients used their right to ‘extended free choice’ and were treated privately in Denmark or abroad¹⁷².

¹⁶⁹ Amtsrådsforeningen, H. S., Finansministeriet og Indenrigs- og Sundhedsministeriet (2004). Rapport fra arbejdsgruppen om evaluering af det udvidede frie sygehusvalg (Report from the working group on the evaluation of the extended free choice of hospital) www.im.dk.

¹⁷⁰ <http://www.arf.dk/Sundhed/TalOgFakta.htm>.

¹⁷¹ Ibid.

¹⁷² Indenrigs- og Sundhedsministeriet. (2004). Resultater paa sundhedsomraadet (Results in the health sector). Copenhagen, Indenrigs- og Sundhedsministeriet (Ministry of Internal Affairs and Health). www.im.dk.

Based on these data, it seems fair to say that there is a real need for health care which the public sector has not been able to meet within due time and which has therefore been absorbed by private providers as a result of the 'guarantee to treatment'. There has been a flow of patients within Denmark **from public to private** providers, but *not* any significant movement of patients abroad – presumably because the Danish private health care sector meets the needs of the population.

Furthermore, as Danish patients have free choice of public hospitals, independently of county location and waiting times, there is considerable **inter-regional patient mobility**. In 2003, around *130.000* patients (representing ca. 11% of total number) chose to be treated in another county than the one they resided in¹⁷³.

Contracting and payment

Direct contracts are concluded between the Danish regions and the private/ foreign hospitals. Providers wishing to deliver health care under the extended free choice scheme must present documentation regarding the treatment offer including experience, professional qualifications, on-call facilities, equipment standards, medical principles etc, as well as waiting times and patient rights.

Agreements between the signing parties are based on a standard contract containing the general conditions of the agreement as well as an annex with the arrangements specific to the treatment. The scope of the contracts is clearly defined so that the private/ foreign providers exclusively can carry out treatments contracted for. **Prices** are also **fixed in the agreements** and are **based on Danish DRG tariffs**.

A **survey** carried out among **providers showed some disagreement** as to the level of the tariffs in the contracts as the public hospitals believe they are too high while many of the private/ foreign hospitals see them as too low. The latter argue that they have extra costs in form of various taxes (e.g. VAT and on wages); the former argue that private/ foreign clinics do not have obligations and ensuing expenses in terms of education, research and on-call services and that the tariffs do not include medical devices or post-operative training, for which patients are referred back at their local hospital. Furthermore, some public hospitals were **suspecting** the private/ foreign hospitals of **cream-skimming** patients by either refusing to operate patients with a difficult medical profile or by refusing to include potentially risky and expensive treatments and procedures in the contracts. On the other hand, private/ foreign hospitals argue that there are no real negotiations during the contracting, that the **DRG tariffs** are imposed and fixed at a level that does **not always allow for 1st class treatments** e.g. in the choice of lenses in cataract operations.

According to the report, private for-profit hospitals can be expected to select the easiest patients and contract the easiest treatments to ensure that their expenses will be covered by the set tariffs. Yet, this implies that some patients – those whose treatment requires costly equipment, long hospital stays or is unforeseeable – will not be able to benefit from the extended free choice of hospitals. Furthermore, the public hospitals **suspect** the private/ foreign providers of **supplier-induced-demand** as they carry out more tests before and after treatment than would be done in a public institution. It should be mentioned that ambulatory consultations are charged at the same rate in the DRG-system independently of length and content. Different definitions about what constitutes ambulatory care and what constitutes in-hospital care has also led to disagreements in how patients are registered. To avoid such problems, the report recommends that **tariffs in the contracts be calculated based on the costs of services actually provided** and that a definition be included on ambulatory and in-hospital care¹⁷⁴.

As to the payment of care, it is the region of residence which is in charge paying when patients make use of the guarantee to treatment in contracted public or private settings in Denmark or abroad. A

¹⁷³ Ibid.

¹⁷⁴ Ibid.

separate invoice is sent for each patient treated and payment takes place within the following month. The invoices have to include a series of data to be valid and the private/ foreign provider must send a letter of discharge as well as other relevant material (medical file, test results etc) to the local hospital. For highly specialised treatments abroad or for non-protocol experimental treatment abroad or in private hospitals in Denmark, it is a State-level authority, the National Board of Health, which pays¹⁷⁵.

Patient flows to Germany

An interesting feature of the cross-border patient mobility is the involvement of a **middleman** between the Danish and German stakeholders. '**PatientLink**'¹⁷⁶ is a representative organisation of 8 German hospitals (both public and private), which acts as a mediator between the Danish authorities, hospitals and patients, on the one side, and the German hospitals, on the other. It participates in the negotiations, the coordination and planning of the care, and participates as a **signing party** in the agreements between the **Danish health authorities** (the regions) and the **German clinics**. Invoices for the Danish patients are also sent to PatientLink which transfer them on to the Danish regions. The **funding** of PatientLink comes **from its German member hospitals**. According to a representative from the organisation, 265 Danish patients have been treated in Germany through PatientLink between July 2002 and early 2005¹⁷⁷ mostly for major, non-life-threatening surgery such as hip-, knee- and shoulder-replacements.

It should be noted, however, that PatientLink has not had any agreements with Danish regions since the end of 2005 as the contracting parties were not able to agree on prices and other stipulations concerning the provision of hospital care¹⁷⁸.

PatientLink is only active in Denmark, but works in partnership with '**GerMedic**'¹⁷⁹, another organisation specialised in the **transfer of international patients to Germany**, which represents 110 German hospitals. Behind these bodies, is The Committee for Promoting German Medicine in Foreign Countries¹⁸⁰ which is a political working group set up in 1998 with the aim "to provide serious and reliable information about the high quality of medical services available in German specialist hospitals"¹⁸¹. The Committee is backed by the German Federal Government but is funded through the yearly contributions from the 110 member hospitals. The Committee acts as a '**health care ambassador**' as it actively promotes German hospital expertise and services worldwide¹⁸².

Experimental care

A **second opinion scheme** was introduced on 1st January 2003 with the Danish Parliament allocating 2.7 mill EUR to set up the programme allowing **critically ill** patients (mostly suffering from cancer) to seek advice and authorisation from an expert panel to go abroad for experimental treatment after all treatment options have been tried in Denmark¹⁸³. The panel is composed of two experts selected by the National Board on Health¹⁸⁴.

¹⁷⁵ (2004). Cross border care in Danish health care legislation and comments to the questionnaire. Copenhagen, Danish Ministry of Internal and Health Affairs.

¹⁷⁶ <http://www.patientlink.dk>.

¹⁷⁷ Hauch, P. (2005). Patientbevaegelighed - danske patienter i Tyskland (Patient mobility - Danish patients in Germany). Private communication (telephone conversation and email).

¹⁷⁸ <http://www.patientlink.dk/>.

¹⁷⁹ <http://www.germedic.de/>.

¹⁸⁰ <http://www.committee-german-medicine.de>.

¹⁸¹ Ibid.

¹⁸² Hauch, P. (2005), op. cit.

¹⁸³ Pedersen, F. S. (2005), Kraeftpatienter vil til udlandet (Cancer patients want to go abroad). *Berlingske Tidende*.

¹⁸⁴ Sundhedsstyrelsen (2004), Kraeftlaeger sparer paa ny behandling (Cancer doctors economize on new treatments), Sundhedsstyrelsen. www.sst.dk.

In 2004, a total of 440 cancer patients presented themselves before the expert panel, which advised around half of the patients to seek experimental care abroad or follow further therapy in other Danish hospitals. Take up of the 'second opinion' option has increased sharply as 310 patients made use of it in 2003¹⁸⁵. On its side, the National Board on Health approved to cover the expenses for experimental treatment in another country for 68 patients, while other patients had their overseas treatments paid by the region of residence. A proportion of patients did not travel abroad as their medical condition worsened¹⁸⁶.

It should be mentioned that the second opinion scheme was set up partly as a result of the considerable number of Danish cancer patients previously choosing to go abroad on their own initiative and paying for treatments that in many cases were uncertified and extremely costly for the patients¹⁸⁷.

■ NORWAY

Project for waiting list patients

A national 3-year project called "The Medical Treatment Abroad Project" was set up in Norway in January 2001 for **waiting list** patients in need of **elective surgery**. The overall aim of the project was to reduce waiting lists and the Norwegian Parliament had in November 2000 granted one billion Norwegian crowns for the purchase of care abroad¹⁸⁸. Over the first two years of the project, *10.000 treatments* had been carried out abroad. An **official patient survey**¹⁸⁹ was carried out in Norway covering the period between January 2001 and October 2002 on this "patient bridge" to access overseas health care. With a response rate of 71%, corresponding to 3419 patients, the survey results reveal that the top three destination countries were Sweden (where 48% of patients went), Denmark (33%) and Germany (17%). The rest of the patients went to France, Finland, Spain, England or Austria. Out of **55 foreign hospitals** which had an agreement with the Norwegian health authorities, the top three destination hospitals were one in Denmark (private hospital Hamlet which received around 1/3 of Norwegian patients) and two in Sweden (Axess Elisabeth hospital and Dalsland hospital, with respectively 13% and 12% of patients).

All **patients** benefiting from the cross-border care had been on waiting lists, but for varying time periods:

- 52% had been waiting for up to one year when they were offered the option to go abroad
- 20% had been waiting between one and two years
- 12% had been waiting for 2 to 3 years

Patients most often went abroad with health problems relating to the muscular or skeletal system, the circulatory system, or the urinary or sexual organs.

Overall, patients were **very satisfied** with the different aspects of overseas treatment. From HELTEF's patient survey it emerged that the most negative points in the cross-border process had been the experience of the journey home, the after-care and the attitudes of some Norwegian health care providers.

¹⁸⁵ Indenrigs- og Sundhedsministeriet (2004), op. cit.

¹⁸⁶ Pedersen, F. S. (2005), op. cit.

¹⁸⁷ Ibid.

¹⁸⁸ Nesse, O. (2001). *Norwegian Patients in EU Hospitals - The Medical Treatment Abroad Project*. European Integration and Health Care Systems: A Challenge for Social Policy, Ghent, Belgium.

¹⁸⁹ HELTEF (2003). *Evaluering: Pasienterfaringer i kjøp av helsetjenester i utlandet*. Nordbyhagen, HELTEF.

Contracting and patient pathway

To select which foreign hospitals would treat waiting list patients, the Norwegian National Insurance Administration (NIA) sent out an enquiry to approx 20 hospitals which had expressed interest in receiving patients. The enquiry outlined the conditions regarding services and quality standards. **Norwegian experts examined** the offers received from the foreign hospitals in terms of **medical profile (quality criteria, infection as well as complication rates), prices and judicial aspects**. Next, **negotiations** were launched, each hospital in question was inspected and by late 2001 some 15 contracts were concluded between NIA/ Medical Treatment Abroad Project and hospitals in Sweden, Denmark, Germany and France. In addition to the above-mentioned selection criteria, aspects such as similarity in the approach and tradition of health care were also taken into account, hence favouring the Scandinavian neighbouring countries¹⁹⁰.

As to the treatment route, the first step consisted in a waiting list patient receiving an offer to go abroad from the local hospital. If the patient accepted the offer (s)he would go to the local hospital for an evaluation. The local hospital then sent a referral for overseas treatment to the National Insurance Administration, which in turn sent out a request to the contracted foreign hospitals. The patient would then receive a concrete offer from the NIA and the transport would be organised. From the moment which the NIA received the referral, the patient was considered not to be on the local hospital's waiting list anymore and the NIA would take over responsibility for the patient¹⁹¹.

A final evaluation report¹⁹² of the 3-year project concludes that overall the experience was successful taking into account that:

- Initially, there was significant opposition towards the project from domestic hospitals and doctors
- Patients were very satisfied with the treatments
- Several patients experienced **problems with having necessary controls carried out at Norwegian hospitals**
- There were only very few cases of infections
- Contacts with foreign hospitals have given Norwegian providers insight in new treatment methods and have contributed to better treatment procedures in domestic hospitals
- Norwegian hospitals and doctors have been satisfied with how the project was implemented
- Overseas treatment was relatively expensive

Several reports^{193 194} highlight how **Norwegian providers** expressed their scepticism towards overseas care and argued that since the problem was one of capacity, **money would be better spent on Norwegian health care facilities** and that some waiting times could be justifiable. Other arguments used concerned the quality of care, that too many patients were sent out unnecessarily and problems of infectious hospital diseases. This latter issue received widespread coverage by the Norwegian media and prompted the National Insurance Administration to carry out controls on patients before and after treatment abroad. The results showed that the risk of infection was minimal.

New legislation on lack of competence and on patient rights

¹⁹⁰ Nesse, O. (2001), op. cit.

¹⁹¹ HELTEF (2003), op. cit.

¹⁹² SINTEF (2003?), Prosjekt Kjoep av helsetjenester i utlandet - en slutevaluering (Project Purchasing health care services abroad - a final evaluation), SINTEF. http://www.sintef.no/cgi-bin/MsmGo.exe?grab_id=9&page_id=10751488&query=helsetjenester+utlandet&hiword=HELSETJENESTE+HELSETJENESTEN+HELSETJENESTENE+HELSETJENESTENS+UTLAND+UTLANDEET+helsetjenester+utlandet+

¹⁹³ Nesse, O. (2001), op. cit.

¹⁹⁴ Trygdeetaten (2004). Bidrag til behandling i utlandet etter § 5-22 (Subsidy for treatment abroad according to § 5-22) http://www.trygdeetaten.no/Generelt/Pub/Rapport_kjop_av_helsetjenester_i_utlandet%20.pdf , Trygdeetaten: 28.

Since the end in 2003 of the 3-year nation-wide project to tackle waiting lists, national legislation has been adopted on **overseas treatment in cases of lack of competence** in Norway. According to a report by the Norwegian health authorities published in mid 2004, *216 patients* went abroad in 2002 due to insufficient competence in the national system, while *395* went in 2003¹⁹⁵. The most prevalent diagnosis for being granted authorisation to go abroad were tumours, illnesses related to the nerve system and to the circulatory system. Sweden and Denmark were the top two destination countries as in the 3-year project, fewer patients went to Germany (about 8%) but in contrast ca 7.5% went to England (compared with 0.1% in the project).

Legislation foresees a subsidy for health care treatment abroad in case of lack of competence in Norway. Since the late 1990s, it has been possible for Norwegians to go abroad for treatments on the **conditions** that appropriate care was not available in Norway and that the illness was considered life-threatening or greatly invalidating. The subsidy to go abroad was first stipulated in the law on the national health care system and afterwards in the law on patient rights. **Treatments received abroad were thus initially paid by the national system but are now financed by the regional health authorities**. Since 2004, the new law on **patient rights** lays down that if the **target date for treatment** (set individually for each patient) is not respected in the region of residence or if there is lack of medical competence in Norway, the patient has the right to be treated abroad before the set target date¹⁹⁶. Health authorities have made agreements with foreign providers and it is the health region where the patient lives which pays for the treatments. No assessment has yet been carried out as it is too early, yet the 3-year pilot project seems to suggest that there is a need for foreign care since thousands of waiting list patients chose to go abroad to gain access to faster treatment (by mid November 2001, approx *4000 patients* had received care overseas through the Medical Treatment Abroad Project¹⁹⁷).

Cross-border cooperation agreements with Schleswig-Holstein¹⁹⁸

Prior to both the patient bridge and to the new legislation on patient rights, several cross-border agreements were signed. As a first step in October 2000, the Norwegian Prime Minister and the Minister-president of Schleswig-Holstein discussed the framework conditions for concrete cooperation to treat Norwegian patients. In February 2001, a delegation lead by the health minister of Schleswig-Holstein (Heide Moser) met the Norwegian health minister (Tore Toenne) in Oslo, while the hospital association of Schleswig-Holstein made an offer of 8.700 treatments in 25 hospitals to the Norwegian health authority. A few months later, in April 2001 the hospital association and the Norwegian health authority signed an agreement covering three hospitals in Schleswig-Holstein. Between 2000 and 2002, more than **700 Norwegian patients** were treated in Schleswig-Holstein in the framework of the "patient bridge" project to tackle waiting lists.

■ SWEDEN

Stockholm Care AB – highly specialised treatments for foreign patients¹⁹⁹

Stockholm Care represents six hospitals in Stockholm County (Karolinska University Hospital, St Erik's Eye Hospital AB, Noortalje Hospital AB, Sodersjukhuset Hospital AB, Sodertalje Hospital and Danderyd

¹⁹⁵ Ibid.

¹⁹⁶ Aarsland, M. (2005). Patient mobility - literature review. Personal communication (email) from Norwegian authority for public health insurance.

¹⁹⁷ Nesse, O. (2001), op. cit., p.4.

¹⁹⁸ Landesregierung Schleswig-Holstein (2002). Grenzüberschreitende Inanspruchnahme von Gesundheitsleistungen, Schleswig-Holsteinischer Landtag.

¹⁹⁹ All the information in this section is taken from the official website: <http://www.stockholmcare.se/company.html>

Hospital AB). It defines itself as the “export company for the hospitals in Stockholm” and concentrates on treating foreign patients by offering “people living outside Sweden access to the resources of the Stockholm County Council for highly specialised treatments”. Furthermore, the company owns and runs the Swedish national bone marrow donor registry. According to its website, the hospital delivers “a complete range of diagnostic and treatment facilities including CT scanners, MR imaging, PET camera, gamma knife, ultrasound and scintigraphy” to patients coming from some 70 different countries. The company was established in 1991 and has since then admitted more than *6000 patients* mainly from Scandinavia, Russia and Greece. The hospital centralises all care provided to foreign patients in the Swedish capital as patients are redirected to Stockholm Care even if their first contact point is one of the local county hospitals. Not surprisingly, the clinic is very patient-friendly by arranging “transportation and accommodation for patients in hotels or apartments”, assisting with visa procedures and interpreters while its “patient hotels” are conceived so as to meet “the needs of whole families that come from abroad”.

When seeking treatment at the clinic, the patient must send a complete medical file in English for a specialist to examine. The patient will then receive detailed information about treatment options, length, costs etc. An appointment can be booked once the clinic receives advanced payment while the final invoice is sent to the patient upon completion of the treatment.

■ MALTA – THE UK

Local availability of services and under-capacity

Due to its geographical isolation and **small population size**, Malta has been involved with patient mobility for over three decades²⁰⁰. Considerations such as the number of patients, start-up costs and availability of the required expertise all influence the choice of health authorities on whether to provide specific health care services or whether to send patients abroad. A **bilateral agreement** was signed 30 years ago between Malta and the UK so as to allow the referral of Maltese patients to the UK for **specialised hospital treatments**. This agreement has been very successful partly due to the excellent links between health care professionals, to the fact that there are no linguistic barriers and to the long-established links between the two countries. To be sent abroad, a patient must be referred by his/ her doctor to the “Treatment Abroad Advisory Committee” which assesses all requests based on the following criteria: the treatment must be part of the national health care package, must not be available in Malta nor be experimental, and has to be evidence-based. Once authorisation to referral abroad is granted, the Treatment Abroad Section steps in and organises all the aspects of the care pathway (transportation, admission and accommodation for the patient and relatives). Furthermore, protocols have been created for the referral of patients to foreign centres of excellence so that procedures are clearly defined for the preparation and transfer of patients according to different categories (e.g. intensive, highly dependent or unconscious patients)²⁰¹.

The link between the availability of services in Malta and patient mobility is clearly illustrated by numbers of patients treated in the UK: in 1993, ca *550* patients were sent to the UK, while in 2003 this number had fallen to less than *250* patients. What occurred over the 10 year period was the introduction of cardiac surgery and magnetic resonance imaging into the Maltese health care package²⁰².

²⁰⁰ Muscat, N. (2004). Cross Border Purchasing and Provision of Health Care - The Maltese Experience, Ministry of Health, the Elderly and Community Care.

²⁰¹ Muscat, N. A., K. Grech, *et al.* (2006). Sharing capacities - Malta and the United Kingdom. *Patient mobility in the European Union - Learning from experience*. M. Rosenmoller, M. McKee and R. Baeten. Copenhagen, European Observatory on Health Systems and Policies: 119-136.

²⁰² Cachia, J. M. (2004 (?)). Cross-Border Care: Provision of Highly Specialized Hospital Services to Island Populations - A case study of the Maltese Islands, Ministry of Health.

The services for which Maltese patients are sent to the UK are characterised by high costs and small volumes of patients which need super-specialised diagnosis and treatment facilities such as complex transplantations and surgery as well as difficult paediatric cases. Providing this care locally would be too costly; referring abroad is the only other option if the choice has been made to offer the population these health care services²⁰³.

It should be mentioned that both Maltese doctors and patients express high degrees of satisfaction with the referral scheme to the UK, although one of the problems most often highlighted by Maltese patients is the financial costs they have to incur, especially if travelling several times, although the government and the main Maltese charity organisation do contribute to the expenses²⁰⁴.

■ THE UK – GERMANY/ FRANCE/ BELGIUM

Waiting lists

In 2001-2002 a **pilot project** was launched by the National Health Service in the UK which allowed **190 NHS patients** to be treated in hospitals in France and Germany after having waited in the NHS for extended periods^{205,206}. Three 'pilot sites' (composed of health authorities, local hospitals and local health care purchasers) in the South East of England participated in the project to increase patient choice and assess the impact of overseas treatments in particular on waiting lists. A total of 109 patients were treated in La Louviere Polyclinic in Lille (France), the rest were treated in one of eight hospitals or one day-case clinic in Western Germany (Cologne, Hanover and Hamburg). Most **operations** involved either major joint replacements or ophthalmologic surgery.

One pilot site contracted directly with La Louviere hospital, whereas the two other pilot sites cooperated with the German providers through two **German middlemen**, GerMedic and German Medicine Net, or a **UK middleman**, Guy's and St Thomas' Corporate Development Team. The functions of these intermediaries were to link and contract with the German hospitals and coordinate the practical aspects of the cooperation. The treatments were purchased by the pilot site which patients came from and payments were based on a fixed price per patient.

When the project started, it was estimated that around 300 NHS patients would go overseas for treatments²⁰⁷, yet only one third of the estimated number actually went. According to an article written half-way through the project, the experience was running smoothly and the director of La Louviere hospital gave positive feedback and would like to pursue the cooperation²⁰⁸. The French hospital had made important **adjustments** to cater for the preferences and habits of the NHS patients by offering British television channels, daily English newspapers, bilingual medical and care-taking staff, translations of all documents and afternoon tea, while an Anglican priest would visit the hospital regularly. Furthermore, according to the Birch and v. Boxberg report²⁰⁹, NHS patients treated in Germany gave very positive feedback on the German medical staff, quality of care and facilities but despite this, the project encountered several **problems**. According to the UK Department of Health fewer patients were sent to Germany than anticipated because contracting with hospitals was more time consuming than expected, patient selection was 'conservative', UK doctors were not cooperative and

²⁰³ Ibid.

²⁰⁴ Muscat, N. A., K. Grech, *et al.* (2006), op. cit.

²⁰⁵ Lawson, K., P. West, *et al.* (2002). Evaluation of Treating Patients Overseas - Final Report. York, York Health Economics Consortium, Dept of Health (University of York): 96 pages.

²⁰⁶ Birch, I. and M. v. Boxberg (2004). The International Market for Medical Services: the UK-Germany Experience. London, Anglo-German Foundation for the Study of Industrial Society.

²⁰⁷ Butler, P. (2002). Q&A: treatment abroad. *Guardian Unlimited*.

²⁰⁸ Quille, F. (2002). La clinique de la Louvière (Lille) aux petits soins pour ses patients anglais (Tea time, teles britanniques et pasteur anglican). *Le Quotidien de Médecin*.

²⁰⁹ Birch, I. and M. v. Boxberg (2004), op. cit.

there were limited financial means to send patients overseas. UK doctors on the other hand expressed concerns over who would be held responsible for complications, **reluctance** to let patients be treated by one doctor and receive follow-up care by another and mentioned lack of resources. German providers, on their part, complained about barriers of insufficient communication on medical data and lack of feedback.

The project and its relative success thus highlight the need to inform referring doctors about the cross-border option so they confidently can refer patients abroad. The presence of long waiting lists are not enough to encourage patient mobility as all the actors which are involved in the mobility process need to be convinced of the safety and utility of patient mobility.

These findings are very similar to those of the Belgian study in the Europe for Patients project which focuses on NHS patients treated in Belgium²¹⁰. Four NHS **Primary Care Trusts** have established **direct contracts** through the NHS Lead Commissioner with several **Belgian hospitals**. The contracts exclusively cover treatment for hip- and knee-replacements for which there are long waiting lists within the NHS. **Prices, payments, patient pathways, referral and medical procedures, quality of care and legal aspects etc are all meticulously included in the very detailed contracts**. Between May 2003 and September 2004, *ca 600 NHS patients* were treated in Belgian hospitals through direct contracting, yet at present the patient flow has stopped. As in the German example above, patients have expressed very positive experiences, yet some local NHS providers have showed opposition to scheme and made cooperation difficult. Furthermore, funding for patient mobility to Belgium has stopped.

It should be mentioned that a bilateral framework agreement on “the referral of NHS patients to Belgium” was signed in February 2003 between the Belgian and English health care authorities “to encourage closer cooperation... for optimizing the efficient use of resources and skills”²¹¹.

■ REPUBLIC OF IRELAND – NORTHERN IRELAND/ UK

The National Treatment Purchase Fund (NTPF)²¹²

Set up in 2002 to tackle **waiting lists** for treatments in public hospitals and part of the national Health Strategy of the Republic of Ireland, the NTPF was initially intended for adults having waited at least one year and children waiting for over six months, but for some types of care waiting times have been decreased to three months for adults as well as children. Care provided under the scheme is **free of charge** and more than 36,000 patients have gained faster access to treatment through it.

On the practical level, the NTPF arranges and **purchases care** in mainly private hospitals within the Republic of Ireland and in **private hospitals** in Northern Ireland and the UK. Patients who qualify can be referred either by their health board, hospital, specialist or GP. **Travel arrangements are provided for under the scheme including for an accompanying person** if the patient goes to the UK. Liaison officers have been appointed at all participating hospitals acting as the first contact point for patients, explaining how the NTPF works and being in charge of transferring patients’ medical files from their GP to the treating doctor. Usually follow-up care takes place with the local GP, but if necessary the Fund will arrange for out-patient consultations with the specialist which operated the patient. Participating doctors have to be registered with the Medical Council and hospitals have been assessed according to quality standards.

²¹⁰ Glinos, I. A., N. Boffin and R. Baeten (2005), Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives. Brussels, Observatoire social européen: 89.

²¹¹ (2003). A Framework for Cross-Border Patient Mobility and Exchange of Experience in the Field of Healthcare between Belgium and England.

²¹² <http://www.ntpf.ie/home/>.

Regarding patient mobility from the Republic of Ireland **to Northern Ireland**, around *1,000 patients* have been treated at a private clinic near Londonderry, most of which came from close-by Donegal but also from elsewhere in the Republic, for treatments such pain management and neurology. *Ca 600 patients* have been treated in **England**. Yet taking into account that over 30,000 patients have been treated via the NTPF in private hospitals within Ireland, one can speak of patient mobility from the public to the private system, rather than from one country to another.

Treatments covered by the NTPF include: cataracts, varicose veins, hernias, gall bladders, prostate, tonsils, plastic surgery, cardiac surgery, and knee and hip operations. The scheme has generally been **successful** although some hospitals continue to have waiting list patients for longer than 12 months²¹³.

²¹³ Jamison, J., H. Legido-Quigley, *et al.* (2005). A solution in search of a problem? - Cross-border health co-operation in Ireland. Armagh, Northern Ireland, Centre for Cross Border Studies: 38.

■ SPAIN – PORTUGAL

Shared capacity and waiting lists

An **interstate agreement** on patient mobility was signed between Spain and Portugal in February 2004 to allow patients and health care professionals to move between the two countries²¹⁴. According to the Spanish health minister, the agreement constitutes the foundation of an **'Iberian health network'**. In recent years, cooperation in the field of health care has boomed both with regards to professional mobility and education, but also in relation to patient mobility as **Portugal is sending waiting lists patients for treatment in Spain**. In 2003, the Portuguese health authority paid Spanish providers 140 million EUR. The aim of the agreement is to encourage hospitals which provide cross-border services and to facilitate access to health care especially in border-regions.

4.2.2 Patient mobility due to differences in price and co-payments

Patient flows motivated by the financial gains which patients can make due to price **differences between 'home' and 'abroad'** often go in the direction from the old to the new Member States. Typically, this kind of mobility is for care not, or only partially, included in the national health care package and for which patients have to make relatively expensive out-of-pocket payments at home; it therefore becomes interesting at a personal level to look for the 'best deals'. In border-regions, differences in the out-of-pocket payments between two neighbouring health care systems can be a drive for patient mobility as patients can seek treatment where personal contribution is smallest.

It should be noted that good sources on this type of mobility is scarce and that material often amounts to anecdotic illustrations from newspapers and magazines. Yet, with this caution in mind regarding the **quality of the literature**, the various articles still give useful insight into what might be new trends in patient mobility.

■ GERMANY/ DENMARK/ THE UK – POLAND

German, Danish and British patients buying dental care and aesthetic surgery in Poland – "European quality at Polish prices"²¹⁵



The Polish city of Szczecin near the German border is experiencing an impressive in-flow of Danish and German patients who come for dental care and plastic surgery as it is 50% cheaper compared with the

²¹⁴ Bosch, X. (2004). "Spain and Portugal agree to eliminate medical borders." *The Lancet* 363: 627.

²¹⁵ Zoltowska, M. (2004). La Pologne, fournisseur de dents neuves et de gros seins. *Libération*: page 8.

tariffs they would pay at home. These treatments are not covered by the national health care system and it therefore becomes interesting for patients who are paying out-of-pocket to look for most attractive offers.

Polish clinics attract Danish and German patients not only with the 'unbeatable' prices but also through the patient-mobility-friendly **package arrangements** which include travel and accommodation at very attractive rates. **Geographical location** is an important factor, especially when patients need to come back for a series of treatments e.g. in dental surgery. Szczecin is 8 hours away from Denmark and 140km away from Berlin airport, and transport is either organised by travel agencies, which offer package 'holidays' including bus journey and stays at luxury hotels, or by the clinics themselves, which collect patients by car at Berlin airport. In general, there is a concentration of cross-border providers in western Poland²¹⁶. The **language** obstacle has also been addressed, as all local staffs at the clinics speak German and English. Furthermore, with the development of low-cost airlines, patients have also started arriving from the British Isles. According to one interviewed Polish dentist: "We've had patients from Germany and Denmark for several years. Ryanair is now bringing in people from Britain and Ireland."²¹⁷

There are some indications that the flow of foreign patients is significant, although exact numbers are difficult to get hold of. One plastic surgeon interviewed said to carry out 25 operations per month with 97% of his patients being German. At one dental clinic, Danish patients arrive in numbers every Monday morning. With eight patients being taken care of by the six dentists at the clinic, while its laboratory works day and night to save time, one can talk about 'chain production'²¹⁸.

Yet as these patient mobility patterns are very new "government statistical agencies have little idea of the size of the trend"²¹⁹ – although the development is obvious in western Poland as medical and dental clinics have signs in German and English.

Furthermore, the presence of the **Danish company 'Avmintand'**²²⁰ (literally "Ouch-my-tooth") acting as an intermediary between Danish patients and Polish dentists, is noteworthy. The agency **advertises via the Internet** on dental care in Poland as well as seven other EU countries (France, the UK, Spain, Sweden, Turkey, Germany and Hungary) and its site contains names, addresses and descriptions of the clinics and forms to fill in to get directly in contact with these. It also provides information on what the public health insurance covers. Concerning **quality** of the clinics advertised, the website simply declares that "the dentists mentioned have studied in countries with the same or higher standards as in Denmark"²²¹ and that if the agency receives a justified complaint, the dentist in question will be removed from the website. 'Avmintand' also takes part in the practical aspects by preparing the patients and sending the list of names to the clinics in advance, services for which it receives a commission.

Another similar broker agency is the **Polish "Travel Medical"** which has mainly British customers, who can now more easily afford to travel to Poland with the emergence of central European low-cost airlines. As such, it is a whole new market which has opened up after the EU enlargement in 2004²²².

A study²²³ published in a German journal on dental care made an assessment of what impact reforms could have on patient mobility for dental treatments as costs for dental prosthetics would not be reimbursed from 2005 in Germany. Before 2005, reimbursement levels were comparatively high as 35% - 50% of costs had to be paid by the patient.

²¹⁶ Cienski, J. (2005). Polish health services quick to cash in on eager EU patients. *Financial Times*: 4.

²¹⁷ Wagstyl, S. and R. Anderson (2005). Budget flights boon to east Europe's gentle dentists. *Financial Times*. London: 2.

²¹⁸ Zoltowska, M. (2004), op. cit.

²¹⁹ Cienski, J. (2005), op. cit., p.4.

²²⁰ <http://www.avmintand.dk>.

²²¹ Ibid.

²²² Cienski, J. (2005), op. cit., p.4.

²²³ Baulig, C., U. Weibler-Villalobos, *et al.* (2004). "Evaluation von Ergebnisqualität und Kosteneffektivität zahnärztlich-prothetischer Versorgung im (Nicht-EU-) Ausland." *Deutsche Zahnärztliche Zeitschrift* 59(4): 230-235.

Analysing 60 cases of patients having been treated abroad (3 in the EU; 25 in Eastern Europe; and 32 in Turkey) between January 2001 and October 2002, the research found that complicated and expensive treatments abroad (costing more than 2,500 Euro) were likely to necessitate **supplementary treatment** in Germany, while simpler and less costly dental interventions could be financially interesting for patients as there was a lesser **risk of complications**. Of 81 treatments (bridges), 53% were deemed to necessitate further dental care by the medical service of the of the MDK sickness fund (of Land Rheinland-Pfalz). In 100% of cases there was no conformity certificate attached to invoices on the materials used. The study concludes that “[o]nly simple dental appliances seemed to establish a positive financial and clinical outcome” and that “dental care outside the European Union has to be strictly reconsidered from that patients’ view both from a clinical and economic aspect”²²⁴.

Yet it should be stressed that the criticism of foreign dental care is relative, as the authors themselves concede the limits of the study due to an over-estimation of negative aspects and an under-estimation of the quality of dental care abroad; the sample of 60 patients was not random or representative; and there was no comparison made with the quality of care which patients treated in Germany received.

■ HUNGARY

Patient flows from Austria for dental care



The situation on the border between Hungary and Austria has similarities with what is happening in Poland as described in the section above.

The Hungarian city of Sopron, 8km away from the Austrian border²²⁵, has around 300 dentists for a population of 50.000 people, which constitutes one of the highest concentrations of dentists per inhabitants in the world (and the situation is similar for pharmacies, opticians and cosmetic surgery²²⁶). Due to the tariffs for dental treatments which are three to four times cheaper than in Austria, Switzerland and Germany, patients from these countries but also from Italy and The Netherlands arrive in their thousands to Sopron and to other Hungarian cities close-by like Szombathely and Mosonmagyaróvár²²⁷. As in the polish cases, dental clinics help patients finding **cheap flights and accommodation**.

Confronted with this ‘merciless competition’²²⁸ Austrian dentists have, according to *Le Figaro*, taken their Hungarian peers to court and have won over one hundred cases on illegal advertising in Austrian newspapers, as the law in Austria prohibits medical publicity in the press. Indeed, reaching potential patients across Europe through **advertisements** in the **local press** and on the **Internet** has been one

²²⁴ Ibid, p.230.

²²⁵ Picard, M. and F. Schmidt (2004). A l'Est, les nouvelles dents sont moins chères. *L'Hebdo*.

²²⁶ Burger, R. (2004). Mobility of patients and health professionals. Personal communication (email).

²²⁷ Picard, M. (2004). Tourisme dentaire en pays magyar (Les voyages pour raison médicale se développent). *Le Figaro*.

²²⁸ Ibid.

of the most important tools of the Hungarian dentists. There is some indication that **50% of the Austrian population** has already crossed the border to access the cheap Hungarian dental care²²⁹, and one dentist interviewed in Sopron said that 99% of his patients were from Austria²³⁰. In addition, foreign patients come for serious and costly interventions.

An important factor which facilitates patient mobility is that Austrians get reimbursed for care received in another country (whether in the EU or not) as Austria does not apply any restrictions to the **Kohl and Decker principle**²³¹. According to one dentist, dental care delivered in Hungary costs the Austrian state 50-70million EUR every year. Unsurprisingly, the reaction among Austrian dental medical profession has been one of profound unease and apprehension. Furthermore, a certain 'campaign of **denigration**' is taking place as **Austrian dentists** as well as their association try to tell patients that if they go to Hungary, the work will be badly done and will have to be redone. According to the president of dentist association (ZAEK) 80% of patients treated in Hungary have had problems²³².

Austria is not the only country to have an important out-flow of dental patients; thousands of people from **Switzerland** are also attracted by the low tariffs and not just in Hungary, but also in Romania and even Russia. Yet, according to one Swiss dentist, the reaction among the profession has been less antagonistic (but admittedly rather cynical) as the Swiss dentists realise the interest they have in providing the **follow-up care** when numerous patients come back with complications following treatment abroad²³³.

Furthermore, as another Swiss dentist points out, there is the legitimate question of whether serious dental treatments such as implants can be given in the space of just one week as the **risks of intolerance** and infections are high. Except from people coming from Vienna who can reach the Hungarian border-cities on a day-trip, most patients stay for one week as '**dental tourists**' in the city where they are treated.

Patient flows from the rest of the EU for dental care

Yet, the very competitive prices do not only attract patients from neighbouring countries²³⁴. Dental clinics in Budapest also receive significant numbers of patients from the **UK, Ireland, Germany and Northern Europe**. The same "**all inclusive**" approach applies as transport from the airport, long consultations also during weekends, and sometimes even accommodation and excursions, are organised for the foreign patients, e.g. by **intermediary brokers** such as "Dental Travel" or "Smilesavers". After the first email contact is established, the agency will propose a clinic and, together with the dentist, a time table for the treatments as well as the precise tariffs. According to an example in the article, having a bridge of ten units done in the UK would cost 9,000 Euro. Going to Hungary for the same treatment with travel and accommodation expenses on top, would come to only 2,600 Euro.

In an interview, the director of the National Institute for Stomatology in Budapest said to be certain of the high quality of the education and training which Hungarian dentists receive, but admitted that the outlook of increasing income rapidly by treating foreign patients could entail a **risk of lowering the quality** of care. On their side, the brokers claim to make a strict selection of the dentists they propose to foreign patients based on qualifications, experience, knowledge of languages and technical equipment. Furthermore, **treatments are guaranteed** from three to five years. One English patient treated in Budapest through "Smilesavers" had seen a television documentary on dental care in Hungary after which he made a Google search and found the broker, which from London organised the

²²⁹ Ibid.

²³⁰ Picard, M. and F. Schmidt (2004), op. cit.

²³¹ Spiegel, B. (2005). Patient mobility - literature review. Personal communication (email) from officer at the Ministry of Social Affairs, Austria.

²³² Picard, M. and F. Schmidt (2004), op. cit.

²³³ Ibid.

²³⁴ Cojean, A. (2005). Beaux Sourires de... Budapest! *Le Monde* 2.

entire treatment. According to this patient, it saved him from waiting six to nine months in England and paying “exorbitant prices”.

Yet, according to representatives from French dentists’ organisations, while a protectionist approach within the EU would be wrong, there could be concerns over civil responsibility in the event of defections, over **abbreviated treatments** due to **time pressure**, neglecting maintenance and the traceability of materials used²³⁵.

■ AUSTRIA/ ITALY – SLOVENIA²³⁶

Dental care and spa treatments

The Slovenian study in the Europe for Patients project highlights how past cross-border cooperation links with Austria and Italy continue to be relevant today. The lower prices for some medical procedures and the **partial privatisation** of some health care services in Slovenia, such as dentistry, together with the **increasing co-payments** which Italian and Austrian patients are faced with, is a combination which has contributed to patient mobility into Slovenia. The mobility is concentrated in the border-regions and in specific health care services such as dental care and spa treatments. A survey among 730 Slovenian dentists (of which 40% responded) revealed that an estimated *11,000 Austrians* and *7,000 Italians* had received treatments in the years 2000-2002. It seems to be mostly people with capacity for out-of-pocket payments or with wide private insurance covers which cross the border to Slovenia. In Austria, for example, where private health spending is comparatively high, some private insurance schemes with expensive premiums cover services from private providers as well as thermal cures, physiotherapy and rehabilitation.

■ FINLAND – ESTONIA²³⁷

Spa tourism

Another country-specific part of the “Europe for Patients” project, was the Estonian study which indicated comparable tendencies to those present in Slovenia as a significant number of foreigners visit **Estonia’s spas**. 70% of spa visitors come from abroad, mainly from neighbouring countries **Finland** and **Sweden**, but increasingly also Russian and German tourists come for thermal cures. Between 1994 and 2004, the number of foreign “tourists” in the Estonian spa resorts increased from *12,000* to almost *200,000*.

In addition to “spa tourism” there are also patient flows to Estonia for **price sensitive health care services** such as **dentistry** and **aesthetic surgery**. According to some dentists in larger cities, 10-30% of their clientele are foreign patients.

4.2.3 Dissatisfaction with the system and/ or perceived lower quality at home

Strictly speaking, the Greek and Italian illustrations do not rely on experiences of cross-border *cooperation* as such but rather explain **what motivates people** to go abroad. Although the material is dated, it has been included because literature on Southern Europe is limited. Furthermore, the Greek and Italian cases are noteworthy because they crystallise how dissatisfaction can influence patient

²³⁵ Ibid, p. 21.

²³⁶ Albrecht, T., R. Pribakovic, *et al.* (2005). Patient Mobility in the European Union: Case-study Slovenia. Ljubljana, Slovenia, IVZ-RS Institute of Public Health of the Republic of Slovenia: 49.

²³⁷ Jesse, M. and R. Kruuda (2005). Patient Mobility in the European Union: Case study Estonia. Tallinn, Estonia, PRAXIS: 67.

mobility as it 'pushes' people to avoid the national system and to look for health care abroad, while the belief that '**abroad is better**' pulls potential patients to other countries. Lastly, both cases also show how official structures and procedures may impact on mobility.

■ ITALY

Patient mobility within and out of Italy

Data on the use of E112 and E111 forms show that Italians were very inclined (and more so than other Europeans) to go abroad for health care in 1980s²³⁸. Even though the figures are dated the possible factors which encourage Italians to seek care abroad are still of interest because they may shed light on the drivers behind patient mobility.

According to G. France, a key element was that there were few limitations on the demand side as **structures and legislation were permissive** of patient mobility. It was comparatively easy to obtain E112 forms (almost 26.000 requests were authorised in 1987 compared to 303 in France, although the number of requests is unknown) and Italian national health care system had a very liberal approach to patient choice. Patients (and their GPs) had almost unlimited freedom of choice of the provider which included reimbursement for care delivered in **non-contracted, private hospitals**, anywhere in the country and abroad if the care had been authorised because timely care was not available 'at home'. Furthermore, low esteem and scepticism towards the national health care system among patients and doctors in some regions contributed to the **willingness to go abroad** and there was a general attitude that the central government did not spend enough on health care. Also, as it is regions which grant E112 authorisations but it is the Ministry of Health which pays, regions have an incentive to **shift financial burden** on to central level.

Yet, there is not just an important flow of patients going from Italy to other EU countries; there are also considerable **inter-regional flows**. Interestingly, very similar reasons explain patient movements *out* of the country as those which explain flows *within* Italy.

Intra-regional flows^{239,240, 241}

In 1991, there were 580.000 inter-regional transactions for hospital care within Italy. According to G. France this important volume of patient flows could be explained by patients' dissatisfaction with the quality of care in the home or surrounding regions and by the **low opinion** of southern health care services expressed by local as well as northern doctors leading to the poor reputation of local services. Furthermore, medical costs of extra-regional care are not borne directly by the region and it is very easy for patients to get authorisation from their doctors to go to another region. This leads the author to assert that patients "overcome their aversion to distance by their desire to obtain higher quality, using hospitals with a higher reputation than they attribute to hospitals located in their home or nearby regions"²⁴² and to suggest that people's perception are more decisive than the reality. Furthermore, structural factors such as freedom of choice in the national system and the financing system of extra-

²³⁸ France, G. (1993). *Cross Border Care: The Italian Experience*. Paper presented to the Conference Health Care Financing and the Single European Market - Working Group "Cross Border Care", Brussels.

²³⁹ France, G. (1994). *Elements for Explaining the Use of Cross-border Care by Italian Patients*. Paper presented to the conference "Health Care Financing and the Single European Market", Maastricht.

²⁴⁰ France, G. (1997). "Cross-border flows of Italian patients within the European Union." *European Journal of Public Health* 7 (supplement) (Number 3): 18-25.

²⁴¹ France, G. (2001). *Evolution of Health Care Reform in Italy (First Draft)*. European Health Care Discussion Group, London School of Economics.

²⁴² France, G. (1994), op. cit. p.11.

regional care, which neither penalises nor rewards mobility thereby contributing to **easy authorisation**, also play in favour of patient mobility.

*International flows*²⁴³

In 1987, there were 25.000 health care 'transactions' cross-border movements from Italy. According to studies of Italian oncology patients in French hospitals, the following push and pull factors were behind patient mobility:

- **Negative influences:** reputed low quality of Italian care; long waiting lists in the home system, lack of nursing support, poor relations with doctors and difficult obtaining information in the national system
- **Positive influences:** good reputation of French hospitals and medical staff and the way in which they treat and take care of patients; furthermore the French hospitals try to alleviate the emotional costs of cross-border care by having **Italian-speaking staff**, brochures and administrative forms in Italian, and by offering accommodation for patients and their relatives at special rates. National doctors have an important role in choosing a foreign provider for their patients and **doctors' negative attitudes** towards the national system influence their patients. In this sense, there is a certain **institutionalisation of poor reputation** of the national system which justifies the use of foreign care and the easy authorisation of the E112 procedure. Interestingly, going abroad may be seen by patients as 'doing something' actively about their health situation, in which case travelling and distance are not seen as negative factors but rather as part of a positive and pro-active action²⁴⁴.

Yet, whereas decisions about whether to go abroad were made by doctors and patients in the past, the system has been changed and it is now the Local Health Care Enterprises (public purchasers) which determine whether care is clinically effective and whether it can be delivered in Italy²⁴⁵.

More recent data show that 21,300 Italians requested prior authorisation to be treated abroad in 1999, of which 16,280 cases were through the 1408/71 procedure²⁴⁶. Importantly, virtually all demands (91.5%) for authorisations were granted which illustrates the permissive institutional setting. Indeed, Italy is together with Luxembourg, the only EU Member State where the volume of E112 requests exceeds 10,000 as in most other countries the number of demands for authorisation is between 500 and 1000 per year²⁴⁷.

■ GREECE

Patient mobility out of Greece – the “Greek escape”

According to one study which tries to explain the important (or excessive) out-flow of patients from Greece²⁴⁸ there is apparently a link between increased provision of top-clinical services in Greece and the additional demand for the same type of care abroad, which suggests that there might be **supplier induced demand** for cross-border health care. Furthermore, there appears to be an economic

²⁴³ See G. France (1993), (1994), (1997).

²⁴⁴ France, G. (1994), op. cit., p. 14.

²⁴⁵ France, G. (2001), op. cit, p.7.

²⁴⁶ European Commission (2003). Report on the application of internal market rules to health services - Implementation by the Member States of the Court's jurisprudence. Brussels, DG Internal Market, European Commission.
http://europa.eu.int/comm/internal_market/en/services/services/docs/2003-report-health-care_en.pdf

²⁴⁷ Ibid. p. 16 and annex.

²⁴⁸ Kyriopoulos, J. E., M. Gitona, *et al.* Cross-border Flow of Health Care: the Greek Experience. Athens, Athens School of Public Health - Dept of Health Economics.

dimension to patient mobility as there is a positive relation between payments for foreign care and total health expenditure and GDP. The main medical reasons for going abroad are heart diseases and neoplasms which imply that the facilities most used abroad are **high technological services** (open heart surgery, neoplasms, transplantations).

Interestingly for the reasons behind patient mobility, satisfaction is higher among Greeks treated abroad than those treated in Greece (although it is not clear from the study how this is measured) and survey results show an **overwhelming willingness to be treated overseas** when people are asked to consider their past health care experiences. In 1992, 72.3% of patients already treated in Greece would travel for treatment abroad "according to previous experience", while 95.1% of those previously treated abroad would go again if they had to choose²⁴⁹. It is with this in mind that the authors speak about the "Greek escape" and consider it to be a serious problem which should be tackled at political level.

A macro- and micro-analysis of pre-authorized care was also carried out to assess the reasons behind the out-flow of Greek patients. At the macro-level it was found that there was an upward trend in demand for cross-border health care over a 5-year period (1988-1992) and that expenditure (including public and private) for hospitalisations abroad rose from 52 million US\$ to 90 million US\$^{250,251}. According to the authors this was due to:

- Overall improvement of the socio-economic level of the population:
 - increased per capita income
 - increased national health expenditure
 - extensive social security cover since the NHS was set up in 1983
 - better information on the overseas treatment options from providers
- Lack of certain medical specialities (in particular diagnostic and surgical) within the country
- Government decision to **lift any bans on patient mobility** as a way to remedy to the shortages in national health care provision

The micro-level analysis was based on data concerning 4658 patients belonging to five sickness funds, treated abroad (EU and non-EU) with pre-authorization for the total cost of 83.4 million US\$ (with a mean cost of 17,812 US\$) in 1991. Demand for cross-border health care is related to high-tech services and the illnesses most often treated abroad concerned cardiovascular diseases (31%), neoplasms (12%) and the nervous system and sense organs (12%).

The study revealed some important social, organisational and economic concerns:

- **Social inequalities:** as sickness funds each have their socio-economic profile (private sector; civil servants; bank employees; self-employed tradesmen; rural workers), the utilisation of cross-border health care has an equity dimension. While 37% of people going abroad are from the private sector and their sickness fund spent 4% of its budget on foreign care, the sickness fund of bank employees used 6.5% of its expenditure on overseas care although its members only represented 8.2% of all people treated abroad. Furthermore, while 2.627 bank employees were hospitalised abroad per 1 million insured members, the corresponding proportion for rural workers was only 76. As the authors

²⁴⁹ Kyriopoulos, J. E., I. Drakou, *et al.* Cross-border Flow of Health Care: the Greek Experience - Facts and Figures. Athens, Athens School of Public Health - Dept of Health Economics.

²⁵⁰ Kyriopoulos, J. and M. Gitona (1996a), *Cross-border Health Care in Greece: Macro and Micro-analysis of the pre-authorized care*. Paper presented at the final meeting EU-Concerted Action "Health Care Financing and the Single European Market", Rome.

²⁵¹ Kyriopoulos, J. and M. Gitona (1996b). "Hospitalisation à l'étranger de patients grecs." *Journal d'Economie médicale* 14(3): pp.181-191.

put is: “the criteria of the use of cross-border health, in Greece, are not mainly based on the patients’ real needs but on the individual’s income and type of [sickness fund] coverage” 252.

- **Procedures:** 92% of patients went through the internal arrangements of their fund or via bilateral cooperation between countries, insurers or hospitals, while only 8% went via the E112 procedure. 84% of the former group went to the UK, while 41% and 40% of the latter group went respectively to France and Germany. This ‘under-use’ of E112 is attributed to bad management of patient mobility: the absence of a uniform, national policy on cross-border care means that patients instead are using the internal legal provisions and the bilateral arrangements of each fund.
- **Sickness funds** are the ‘channel’ through which patients gain access to cross-border care – and as each fund has its socio-economic profile and its own rules on pre-authorisation, it can be assumed that access to overseas health care acquires a **socio-economic dimension** – an assumption which is consistent with the above data
- Patient mobility is happening at the **detriment of the health care system** as “the upward trends observed are having a highly adverse impact on social security budgets, thus prolonging and exacerbating the **crisis in the finances** of the health care sector”²⁵³.

With these concerns in mind, the authors suggest the following recommendations:

- national suppliers (public and private) should be given motives (e.g. flexible managerial arrangements) to deliver more care and thus absorb the excessive cross-border flows
- there should be a unification and administrative simplification of cross-border procedures so as to have a national structure for patient mobility instead of the individual sickness funds’ approach which leads to differentiation in the access to foreign treatments
- the supply of health care should be adjusted to the needs of the population

²⁵² Kyriopoulos, J. and M. Gitona (1996a), op. cit. p.12.

²⁵³ Ibid. p. 14.

Conclusions

At the beginning of this literature review we set out to examine patient flows across Europe, to identify the types of patients, actors and factors which contribute to patient mobility, and to highlight the similarities and differences between cross-border initiatives as well as the broader implications they might have, bearing in mind that any literature review is limited by the availability of material. The scope of the review was defined as covering “concrete examples (...) where at least one patient moves across a border to be treated by a health care provider” (ch.1); with this focus in mind we carried out a literature search and the subsequent analysis. Yet it should be mentioned that it was not always an easy task to find and get hold of existing material, that documents do not all live up to the same quality standards and that by definition we could only include practical experiences which we found written material on. We are aware that there might be a certain bias in the review in terms of representativeness as some larger and better funded projects tend to be more documented and as we might not know about material in languages we do not cover (mainly from the ‘new’ Member States). As a consequence, some regions and countries have been described and analysed more extensively than others – without necessarily meaning that nothing happens in other parts of the EU, just that we have not found documentation in it.

To understand patient mobility we looked at “what goes on where and why”. This approach combines the geographical element of mobility to see where patients are moving from and to, the operative element to see who (patients and other players) is involved in which arrangements to make patient mobility function and the analytical element to understand the reasons behind mobility.

In a sense, the literature review has been a mapping exercise of what goes on in Europe. One of the lessons of the study appears to be that it is very difficult to draw general, sweeping conclusions about patient mobility, its direction and purposes. Patient flows do not e.g. just go from the South to the North nor do they emerge just as a result of waiting lists. To make sense of this wilderness, we have tried to systematise the information gathered by creating a *typology* – hopefully nuanced enough to allow for the differences in the experiences ranging from Malta to Norway and from Portugal to Hungary, yet simple enough to make a multi-faceted phenomenon like patient mobility more comprehensible. As we from the outset defined the focus of the literature review to be on examples “where at least one patient moves across a border (...)” (ch.1), it was natural to start our typology with patients, then to look at the types of borders which patients cross and finally to examine the actors and arrangements which surround the mobile patient.

Patients

At an early stage of our research we identified two broad types of patients: patients receiving foreign care because they happen to be abroad when they fall ill (tourists and long-term residents) and people going abroad to seek health care, either because they live in border-regions or because of some relative disadvantage in the national health care system. However, the focus has been on the latter of the two as the motivations of the patients who seek foreign health care and the arrangements which surround these patient flows, are more extensively described in the literature.

We made one assumption common to all patients – they want to be treated as close to home as possible in a system they feel familiar with, but *under some circumstances they might be willing or even prefer to be treated abroad*. The willingness or preference to go cross-border can be explained and analysed through what could be termed the five key drivers/ determinants of patient mobility:

- **Familiarity/ proximity:** This driver is naturally more present in border-regions where the same local community lives on each side of the frontier. Where there is a shared feeling of closeness

people will prefer to cross the border to receive health care not just because it is geographically closer but also because they feel more familiar with the setting. The alternative is often travelling longer distances within the country of residence to providers and facilities which they perceive as more foreign e.g. due to cultural and linguistic differences. In this sense, distance and proximity should not merely be measured in kilometres; they also depend on people's perceptions and the value attached to them.

It should however be said that it can be difficult to define where a border-region begins and where it ends. Do Dutch patients living 30km away from the border count as border-region population? According to our definition, what distinguishes the border communities is that the border separating them is rather superficial and not perceived as a separation as such – the border is fluid and is a local setting for intense exchanges whether for work, leisure, social activities, or indeed health care.

- **Availability:** Two different dimensions are present when we consider availability of health care as a motor for patient mobility – availability in terms of the *quantity* of services and availability in terms of the *kind* of services.
Insufficient capacity leading to waiting times and waiting lists in the national system can make people go abroad. In such cases, the treatment required *does exist* at home but is not available within certain time limits. Where health care purchasers have recognised that there is an acute problem of under-capacity in the national system, they have sometimes turned to the solution of allowing patients access to foreign health care services, as e.g. in England, The Netherlands, Denmark and Norway.
On the other hand, when some kinds of services *do not exist* in the national system patients might also be willing and allowed to go abroad. Not all highly specialised treatments requiring hi-tech equipment are available in all countries, e.g. when limited national or regional population sizes do not justify the presence of expensive facilities. In these cases, patient mobility is an alternative to costly, uneconomical investments for public authorities
- **Financial costs:** Prices and co-payments, or rather differences in prices and co-payments, can be a driver for patient mobility when going abroad for treatment presents important savings for the patient. There are two characteristic aspects of the financially motivated mobility: the type of care and the destination of patient flows. Regarding the care patients go abroad for, it is treatments excluded from the national health care benefit basket or for which there are important co-payments. Because patients have to pay out-of-pocket in the home system they have a strong incentive to look for cheaper alternatives. This means that the destination of patient flows is directed towards countries where costs are comparatively lower. Although the examples in the literature only provide anecdotic evidence, the trends invariably show that these patient flows go towards the 'new' Member States (Poland, Hungary, Slovenia) and that they originate from countries with higher price levels (England, Ireland, Denmark, Germany, Switzerland...).
- **Perceived quality:** Dissatisfaction with the health care provided in the national system can also lead people to go for treatment abroad as the patients perceive foreign health care services as being of higher quality (in many countries this demand for 'better' health care will be absorbed by the private sector).
- **Bioethical legislation:** Although the least-documented type of patient flows and existing material is only anecdotic, it is perhaps the most controversial form of patient mobility when people go abroad to seek medical assistance because legislation in their home country does not allow the specific treatment. Cases include 'abortion tourism', 'fertility tourism' and even euthanasia.

Whatever the driver, it is the *difference and comparison* between the option to stay at home and the alternative to go abroad which influence the patient's choice. Drivers influence both border-region patients travelling abroad for familiarity and patients travelling abroad due to relative disadvantages in the national system (one of the other four drivers); the difference between the two groups is one of degree – it will probably require stronger push and pull factors to make the second group go abroad for health care as populations in border-regions often do not consider crossing the border as going abroad.

Borders

Frontiers are decisive because they constitute the geographical and spatial setting in which patient mobility takes place. The focus here has been on movements across international borders, i.e. between two countries which either share a common border or which are geographically further apart. When international borders separate two neighbouring countries they sometimes also constitute a regional border, i.e. they run through a region and a community which despite being separated by a border sees itself and lives as one entity.

In addition, frontiers present a separation between two distinct health care systems when a patient crosses from one system into the other; in this sense, access procedures to obtain health care in another Member State can be seen as an administrative bridge between two systems. A third aspect of borders is the value they have in people's minds; they can be perceived as more or less present, as a real dividing line or as an artificial demarcation. Based on these three dimensions (geographical, administrative and subjective) we have distinguished two types of borders, namely fluid borders and rigid borders, where the characteristics of "fluid" and "rigid" have to be considered with all three dimensions in mind. A fluid border can be described as a border which is physically and geographically easy to cross, which does not present an administrative barrier and which is not perceived as a separation as such. People do not see "the other side of the border" as foreign territory and the cross-border movements of patients are thus facilitated. In contrast, rigid borders are characterised by geographical and natural elements which create a physical separation, such as mountains or water, by heavy administrative access procedures which hinder most patient flows and by the unfamiliarity and foreignness felt by the populations living on each side of the border vis-à-vis each other (e.g. due to speaking different languages). Clearly, fluid borders are most prevalent in border-regions where cross-border movements and exchanges are part of everyday life and where the domino-effect (as described above) is present when one form of cross-border mobility, e.g. for working or leisure reasons, is likely to generate other forms of mobility, e.g. to seek cross-border health care.

Actors and arrangements

If borders represent the setting in which patient mobility takes place, then actors and arrangements constitute the functional context for patient movements. Actors can broadly be regrouped into patients, providers, purchasers, public authorities and middlemen, and they can operate at the local, regional, national or European level.

Based on the examples in the literature, one is able to discern some trends across Europe. It appears that the locally organised patient mobility is more likely to develop across fluid borders and/ or within a broader context of regional cooperation. This is not surprising since local actors understand the specificity of their region, are aware of patients' needs and therefore see the necessity in having administrative and funding mechanisms which allow mobility. This can be done through free access zones as in Thiérache region between France and Belgium, or through simplification of authorisation procedures. Yet while many of these arrangements have been initiated from the local level, the public authority responsible for funding cross-border health care must be involved which in many cases are State-level authorities. The wider context can also play an important role as locally organised patient

mobility can be one of many elements in the broader cross-border cooperation between two regions or indeed between two hospitals which aim at promoting exchanges and learning from each other. On the other hand, a very different situation arises where there are waiting lists or lack of highly specialised medical care. The reviewed literature showed that state-level authorities are often involved in the mobility arrangements when there is a problem of appropriate care in the national system, although this could be due to a bias in the available literature. In some cases, patient mobility is the direct consequence of the decision taken by national health authorities to institutionalise the use of foreign health care capacity in the national system. This decision can be based on small population numbers at national level (the Maltese experience looked at here, but Luxembourg could be another example) or at regional level (e.g. the Dutch region of Zeeuws-Vlaanderen) in which cases it is not economically viable or cost-effective to set up certain (expensive) health care facilities. Cross-border contracts between purchasers in one Member State and providers in another Member State is a way to 'internalise' foreign health care capacity into the national system as e.g. happens when Dutch insurers contract with Belgian hospitals to let their affiliated members have access there. Experimental care is another area where national health authorities might be under pressure to let patients to go abroad when treatments are not available in the country (as illustrated by the Danish case).

From the experiences it becomes clear that the actors involved, the level at which they function and whether an initiative happens bottom-up or top-down is structurally determined as it depends on the organisation of the entire health care system, the power relations between actors, the levels at which decision-making and implementation take place – aspects which 'spill over' into the cross-border setting and influence patient mobility. If e.g. purchasing of health services and financial responsibility lie at the local level, then it is local authorities, and not national health authorities, which will be involved in cross-border cooperation, contracting etc. This is demonstrated in the Scandinavian examples where health care is devolved and in the Pyreneans where French State-level health authorities cooperate with Catalan regional-level health authorities. Furthermore, it is interesting to notice how local actors and arrangements can push State-level authorities to accept the relaxation of access procedures to cross-border health care and motivate central authorities to seek bilateral agreements with governments of neighbouring countries as a way to remain involved in the cross-border developments and frame the processes so as to not lose influence over what is happening on the periphery of national territory.

When there are personal (financial) incentives in going abroad due to important price differences, it is patients themselves and possibly commercial agents which initiate cross-border mobility. If the cheaper provider is just across the border, patients can relatively easily organise the care and travel themselves, as in the case of Austrians going for dental care in neighbouring Hungary; if the provider is further away, a commercial middleman is likely to help the patient in organising the care and transport in 'package deals'. It is interesting to notice that price-sensitivity as a driver for patient mobility can motivate people to travel longer distances beyond just the neighbouring country. Similar patterns of personal incentives appear to exist when patients go abroad to obtain care which is not available for bio-ethical and/ or legal reasons in their home country, as for example with abortions or fertility treatments. Last but not least, where dissatisfaction with the quality in the national system 'pushes' patients abroad, it can be the permissive administrative structures which allow dissatisfaction to 'escape' to foreign health care providers who are perceived as being better.

If countless combinations thus seem to emerge from the literature, which can appear to have little in common, it is possible to distinguish three broad categories of practical/ financial arrangements.

→ **Arrangements based on EU Regulation 1408/71**

Arrangements for non-emergency cross-border care can be according to the 'classical' E112 procedure with prior authorisation to access health care services in another Member State, or arrangements can be based on a softened version of the E112 form when prior approval is made

automatic. The softening of the procedure usually takes place in a border-region setting where purchasers and providers agree to cooperate and ease cross-border access to care as is seen in many border-regions of 'mainland' Europe (France, Germany, The Netherlands and Belgium). In contrast, the original E112 procedure does not involve any extra cooperation efforts. For patients it can be more or less difficult to obtain prior authorisation depending on the country where they live – the literature show it was particularly easy for some Italians and Greeks who wished to go abroad for what they perceived as better care.

→ **Institutionally arranged care**

These arrangements are based on some sort of agreement between cross-border partners. The purchasing party can be a public purchaser when e.g. the NHS sets up national programmes for patients to go abroad as in England, Malta and Norway, it can be a regional health authority as in Southern Jutland in Denmark or it can be a health care insurer as in The Netherlands. The other side of the agreement is the providers of care, usually hospitals or clinics and can be either public or private institutions. The actual agreements can range from formal contractual arrangements to gentleman's agreements, and can be embedded in bilateral framework agreements between Member States. It should also be mentioned that the purpose of the agreements is not necessarily to purchase health care, as in some (rarer) cases signing parties agree on co-financing medical equipment and sharing of facilities so that patients from both sides of the border can access the facilities in question (as on the French-Spanish border or the German-Danish border).

→ **Self managed care**

In these arrangements it is the patients and possibly commercial middlemen which take the lead generally for treatments not included in the national health care basket or for which there are long waiting lists at home. When the care obtained abroad is part of the benefit package patients can in some cases claim reimbursement from the public funding authority back home (also called the Kohll and Decker procedure after the famous ECJ ruling).

Self-managed care implies that that the collection of information on cross-border care options, the organisation of the care appointments, travelling and crucially the payment of the treatments is done by patients themselves (with possible restitution), by a private insurer or a commercial broker acting as a middleman.

Factors influencing patient mobility

The volume and direction of patient flows can vary enormously, from a few patients crossing the border to thousands of patients travelling considerable distances. It is not easy to pinpoint what makes the volumes of patients swell or fall but some features appear decisive:

- Distance and/ or ease of travel: patient numbers are more important when travelling across the border for health care is comfortable. This partly explains why patient mobility is so developed in many border-regions, but it also holds true between neighbouring countries when access routes and transportation means are easy e.g. for the thousands of Austrians going to Hungary for dental care. Yet patients' assumed aversion to travelling long distances can also be overcome if transportation is well-organised – either via publicly funded programmes for sending patients abroad, or through privately arranged consumer-friendly 'package deals' which include care, accommodation, transportation and even tourist activities for the mobile patient. Here it should also be mentioned that the emergence of low-cost airlines has also contributed to the increasing numbers of people travelling for health care, not only because fares are cheaper but also because more destinations have become available.

- Permissive structures for accessing health care abroad: the more open borders and the easier access procedures are, the more patients will be able to travel. This can be seen in border-regions where special arrangements allow patients to move more freely; in countries where there is a liberal approach to granting prior authorisation for cross-border care through the E112 procedure; and in settings where an NHS purchaser or a health insurer contracts with health care providers in another country to give affiliates access. Yet, some purchasers and some contracts allow more patients to move than others. In the case of the English NHS overseas scheme for waiting list patients, only patients requiring a hip- and knee-replacement (and very few cardiac patients) were selected to be treated in Belgian hospitals and during the 16 months of the project only some 600 patients went to Belgium. In comparison, the Norwegian patient bridge allowed patients to go abroad for many different types of care and within the first two years of the project 10,000 treatments had been given to Norwegian patients abroad.
- Availability of care in the domestic private sector: we have seen how demand for health care not satisfied at home can “transform” into patient mobility, e.g. in the event of waiting lists in the public system. Yet, if this demand can be absorbed by private health care providers in the country where the patient lives, mobility is likely to flow to the domestic private sector rather than across the border. This has been the case both in the Danish and Irish national programmes for shortening waiting times by contracting with private clinics at home and with providers abroad (private and/ or public). Numbers from Denmark showed that over an 18-month period approx 26,000 patients benefited from the measure and were treated outside the public system, yet only 1.3% of these went to foreign contracted providers (in Sweden or in Germany). Similar trends are observed in the Republic of Ireland where more than 30,000 waiting list patients have been treated in private clinics in the country, while some 1,000 patients have travelled to Northern Ireland for treatment and around 600 patients to England.
- Learning by doing or chain reaction: patient mobility can generate patient mobility. The positive experiences and positive feedback from patients who have returned back home after successful treatment abroad is likely to encourage more patients to venture outside the national borders. Furthermore, a first successful initiative might also encourage purchasers and providers to extend their cross-border cooperation and thus to allow more patient flows to take place. This chain reaction can be observed in several border-regions across the EU, but also among waiting list patients and people obtaining cross-border care on their own initiative. As the practice of going abroad for health care becomes more widespread, the concept of travelling for medical care becomes more familiar, initial reluctance is overcome and more patients take the step to actually go across the border.

These dimensions are thus likely to influence the volumes of patient flows. It should be noted, however, that one of the main difficulties when studying patient mobility is to find exact figures on how many patients move. It has been almost impossible to obtain reliable data which are comparable in a systematic way but where present in the literature the size of patient flows has been included in the report.

In addition to the four factors affecting the volumes of patient flows, more circumstances can be distinguished in the literature as having a positive or a negative effect on mobility.

As plain as it may seem, actors' willingness to make patient mobility function is perhaps the most decisive condition for success. Yet willingness is closely linked to information and knowledge – the better informed actors are, the more likely it is that they will take part in new arrangements.

Together the importance of information and of stakeholder involvement appear to be the two issues most often highlighted in the reviewed material as prerequisites for well-functioning patient mobility – that all involved stakeholders understand how the system across the border works and realise what benefits cross-border care can entail. For health care purchasers one benefit can be that cross-border contracting expands the pool of providers with whom to contract and gives them more leeway to make good deals. For public authorities of the sending country, a beneficial aspect of cross-border care is that it presents a solution to under-capacity or lack of highly specialised care in the home system. For medical providers, foreign patients can increase income, experience and expertise; for providers in the country of residence patient mobility might be a way to tackle the highly unpopular problem of waiting lists.

Conversely, unwillingness from actors and negative perceptions are likely to have adverse effects. If local doctors see patient mobility as a threat to the care they provide and the responsibility they feel toward their patients or if smaller hospitals feel their livelihoods threatened in a limited catchment area, they are most likely to hinder patient flows. Important out-flows of patients can lead to cross-border rivalry as domestic providers might feel their position is at risk. Furthermore, a recurrent issue in the literature is how ignorance and uncertainty about the health care system 'on the other side', the quality of care, which treatment methods are used, the professionalism of foreign providers etc. in many cases result in local providers' unwillingness – a reluctance which they sometimes pass on to their patients. Yet problems can also be of technical nature for those already involved in patient mobility as the practical arrangements can be time consuming and labour-intensive. The setting up of contracts, coordinating funding mechanisms, exchanging medical and administrative information, managing patient pathways, adapting to system differences etc. often require considerable efforts, the benefits of which might take time to ripen, or might never materialise, which discourages participation. On the other hand, several experiences show that if obstacles are overcome then a "learning by doing" process sets in, mutual trust is built up between stakeholders and a first successful initiative can lead to further cooperation. It is also noteworthy how cross-border cooperation in a more general context between neighbouring regions or in a more specific context between border-region hospitals, can enhance efforts devoted to patient mobility.

While sweeping generalisations are risky it seems fair to say that patient mobility happens for a reason; it must be worthwhile for all stakeholders if it is to work. For patients, there is always something better, faster, cheaper across the border, otherwise they would stay in their own country. For providers, purchasers, insurers, commercial middlemen and public authorities, there is always something to gain from cross-border cooperation, otherwise they would not participate in the arrangements surrounding patient mobility.

Implications

Patient mobility makes demand for medical care in one country meet supply of medical services in another. Yet as patients cross borders between countries they simultaneously cross from one health care system into another which can have important impact for the systems involved.

In situations where patients are sent abroad due to insufficient capacity or absence of some treatments at home, patient mobility avoids public authorities to have to make costly investments which would take time to bear fruit due to the long-term nature of efforts to improve capacity in the health care system. Also, in some areas with small population numbers it might not make sense from an economic point of

view to set up expensive facilities, to have on-call services functioning just kilometres apart or provide treatments for rare diseases which require costly equipment. Sharing facilities in border-regions can also be taken one step further when local stakeholders decide to co-fund and co-organise health care infrastructure or when neighbouring hospitals decide to merge activities to complement each other. Patient mobility can thus lead to economies-of-scale as more people make use of services and equipment e.g. scanners or dialyses apparatus in a hospital; by treating foreign patients the hospital in effect expands its catchment area beyond the national borders. This can happen both at the regional level when local patients use hospitals in the border-region and at the state level when e.g. Maltese patients go to England for highly specialised treatments. In this sense, patient mobility alleviates the health care system which sends patients out while potentially contributing to hospitals in the receiving system achieving their optimal case-mix of patients and the turnover point for expensive medical machinery.

Yet a foreign patient arriving in a hospital will have a different effect on the receiving system depending on whether treatment is organised via the E112 route, the institutionally arranged care route or via the self-managed care route. In the former case, patients are integrated into the receiving system as if they were affiliated there; in the latter case, patients and especially the entire institutional set-up which surrounds the mobile patients introduce new elements into the receiving system as tariffs, quality standards, medical procedures etc. which are agreed upon in the contractual arrangements often follow the requirements and practices of the sending country, and not of the country where care is actually delivered. The risk is thus that a new system with its own tariff setting and medical protocols develops in parallel to the global system of the receiving country thereby creating new pressures and challenging established power balances between health care actors. Such developments should be monitored as e.g. higher fees charged in the parallel system could push prices up in the public system and/ or lead domestic providers to favour the more lucrative business of treating foreign patients. Interestingly, the impact of cross-border care might well be the opposite in the sending country where turning to foreign providers puts pressure on domestic providers, especially in the private sector, to remain price competitive. For domestic providers in the public sector, the possibility of seeing large patient flows leaving the country can have the effect of improving services and friendliness towards patients. Yet large outflows of patients can also present a challenge to the public system (and the budget) if patients can bypass the national gate-keeper procedure by going abroad. Also, patient mobility might solve only one part of the capacity problems at home: when people come back home after surgery which could not have been delivered within due time in the national system, they often will require after-care and rehabilitation treatments for which there might also be waiting lists. Patients in effect just move a step up in the health care chain but are likely to encounter the same problems of delays.

Patient mobility is often depicted as a marginal phenomenon in Europe as the overall numbers of patients which receive cross-border care remain minor compared with total populations. The present literature review has tried to redress this picture by providing as much evidence as possible – or as available. Material has been challenging to get hold of; material has been of very different quality and has often been incomparable; last but not least, a bias sneaks into any literature review as by definition only experiences and practices for which material has been found, can be described and analysed. Being mindful of these limitations, the literature review hopefully provides new insight into “what goes on where in Europe” and thereby reveals the impressive amount of effort, time, innovative thinking and resources which go into making patient mobility work. That numerous stakeholders in virtually all European countries go to great lengths to initiate, promote, develop or improve patient mobility indicates its vast potential in a border-free Europe and suggests that patient mobility together with its possible far-reaching consequences ought not to be ignored.

Annex I - Guide used for analysing the literature

GENERAL CHARACTERISTICS

- Name of the cross-border project/ experience/ initiative
- Location: where does it take place, between which countries and/ or which regions?
- Distance: how far do patients need to travel for accessing cross-border care? How far would they have to travel to access domestic care?
- Time period: when was it launched and for how many years was/ is it running?
- Scale of the cross-border movement: any data on how many people it involved?
- Objectives and success: did the project have any pre-defined aims and were these achieved?
- Who has written the report/ article? What was their motive (to inform, to advocate, to clarify etc)?
- What is assessed in the report/ article? What is its objective and focus?
- Has the author followed a particular methodological approach, e.g. by carrying out surveys, interviews? How has data been collected?

ACTORS

Which *actors* are active in the cross-border project?

- The type of PATIENTS
 - Are patients referred by a doctor in their own country?
 - Do patients go on their own initiative?
 - Are they seriously ill or only suffering minor health problems?
 - Any pathologies mentioned?

→ What type of care do the patients go abroad for?

IN-PATIENT

- Hospital
- Long-term care

OUT-PATIENT

- Diagnosis and pre-care acts (e.g. imagery, tests etc)
- Specialist care
- Primary care (with a GP, nurse...)

PRODUCTS

Pharmaceutical products

Medical devices

- The type of PROVIDERS which deliver the cross-border care, is it:
 - Hospitals?
 - Individual providers? GPs or specialists, and which type of specialists?
 -
- The type of PURCHASER which buys and/ or pays for the care abroad, is it:
 - Sickness funds?
 - Private insurers?
 - The national health care service?
 - Patients themselves?
 - Are there more than one purchaser involved?
 -
- PUBLIC AUTHORITIES: do they have a role in the specific cross-border activity?

FACTORS

Which *factors* are present in the cross-border experience?

- The type of HEALTH CARE which patients go abroad for, is it:
 - Emergency care?
 - Planned care?
 - Hospital care?
 - Day-hospitalisation?
 - Ambulatory care?
 - Highly specialised care?
 - Basic health care?
- The type of MOBILITY
 - Does the cross-border activity take place in the border-region?
 - Do people travel abroad because their country (i.e. national purchaser(s)) is buying care in another country?
 - Is it a one-way or two-way flow of patients?
 - Do people go abroad because of poor access to health care in their own country/ their region, e.g. because of waiting lists?
 - Do people go abroad because they prefer and choose freely to do so?
 - Is the mobility part of larger cross-border, regional activities?
 - Is the patient movement 'spontaneous'/ 'natural' or organised/ 'imposed' (i.e. are patients going by their own free will or are they encouraged to go)?
 - Other...
 -
- The type of COOPERATION/ CONTEXT
 - Are there contractual arrangements?
 - Is mobility based on informal agreements?

- Does the mobility take place within a broader context of regional cross-border cooperation?
-
- The type of PAYMENT METHODS
 - How is cross-border health care paid for?
 - Who pays? The patient – and is (s)he reimbursed afterwards? An insurer? The national health care system?
 - How do the payment flows occur? Through which steps? Directly or via several phases (e.g. E112)?
 -
- The type of PRACTICAL PROCEDURES – how does the cross-border movement happen in practice?
 - Are there structured and clearly defined procedures for mobile patients?
 - What are these procedures?
 - In case of no formal procedures, how do patients access cross-border care?
 -
- DECISION-MAKING and INITIATIVE-TAKING
 - At which level are decisions about cross-border cooperation taken? National, regional or local?
 - Which actors are involved in the decision-making?
 - Which actors are involved in the functioning of the cross-border experience?
 - Does the cross-border initiative take a 'bottom-up' or 'top-down' approach?
 -
- OTHER FACTORS
 - Are there any other noticeable and noteworthy factors which have an impact on patient mobility in the particular project?
 - Particular geographical circumstances?
 - Linguistic proximity?
 - Cultural proximity?
 - Other...
 -
- PROBLEMS and POLICY CONCLUSIONS
 - Does the report highlight any problems/ challenges/ difficulties in relation to patient mobility and/ or the project in question?
 - Does the report/ article come with recommendations or conclusions on e.g. how to improve the situation, how to solve potential problems etc?

Annex II - The technical characteristics of the reviewed literature

(1997). Convention entre le centre hospitalier de Mouscron et le centre hospitalier de Tourcoing - Evaluation de la convention juin 1996 à juin 1997.

Complémentarité transfrontalière entre la Belgique et la France.

- Material: evaluation report
- Author: not specified
- Objectives: assess the cross-border cooperation and patient flows between the two cooperating hospitals in the period June 1996 and June 1997, and make comparisons with previous years

(1999). Contract: Concierto de Condiciones y Tarifas de Asistencia Sanitaria por Accidentes de Trabajo. Lleida, Mutua de Accidentes de Trabajo y Enfermedades Profesionales de la Seguridad Social & Centre Hospitalier de Saint-Gaudens.

- Material: contractual agreement
- Authors: the two signing parties
- Objectives: establish cross-border cooperation

(1999). Flere soenderjyske patienter til Flensborg (More patients from Southern Jutland to Flensborg), Soenderjyllands Amt.

- Material: electronic newsletter
- Author: Danish County of Soenderjylland
- Objectives: inform the local population about health care options across the border

(2001). Flere soenderjyder kommer hurtigere i behandling (More people from Southern Jutland get faster treatment), Soenderjyllands.

- Material: electronic newsletter
- Author: Danish County of Soenderjylland
- Objectives: inform the local population

(2001). Interreg III-aftale underskrives (Interreg III agreement is signed), Soenderjyllands Amt.

- Material: electronic newsletter
- Author: Danish County of Soenderjylland
- Objectives: inform the local population

(2001). Samarbejde hen over graensen (Cooperation across the border), Soenderjyllands Amt.

- Material: electronic newsletter
- Author: Danish County of Soenderjylland
- Objectives: inform the local population

(2001). Straalebehandling paa kortere tid (Radiation therapy with shorter waiting times), Soenderjyllands Amt.

- Material: electronic newsletter
- Author: Danish County of Soenderjylland
- Objectives: inform the local population

(2002). Accessibilité et mobilité transfrontalière en santé. Initiative Communautaire Interreg III. Programme France - Wallonie - Flandre 2000-2006. Rapport d'Activités.

- Material : activity report
- Author : not specified, most probably one of the involved actors
- Objectives: description and assessment of projects

(2002). *Seminaire: "Coopération Transfrontalière Sanitaire"*, Lille. Mission Opérationnelle transfrontalière; Ecole Nationale de la Santé Publique; Fédération Hospitalière de France.

- Material: conference presentations
- Authors: actors involved with cross-border cooperation
- Objectives: give an overview of cross-border experiences

(2004). Cross border care in Danish health care legislation and comments to the questionnaire. Copenhagen, Danish Ministry of Internal and Health Affairs.

- Material: information note
- Authors: officers at Danish Ministry of Health
- Objectives: inform members of High Level Group on Health Services and Medical Care

(2004). Hurtigere hjælp ved ulykker (Faster assistance at accident scenes), Soenderjyllands Amt.

- Material: electronic newsletter
- Author: Danish County of Soenderjylland
- Objectives: inform the local population

(2004). Koeber plads paa tyske sygehuse (Purchasing capacity in German hospitals), Soenderjyllands Amt.

- Material: electronic newsletter
- Author: Danish County of Soenderjylland
- Objectives: inform the local population

(2005). "Atténuer "l'effet frontière"." *Interreg'actions - LA LETTRE DU PROGRAMME INTERREG III-A WALLONIE LORRAINE LUXEMBOURG*(4): 1.

- Material: article in the newsletter of the Interreg III Wallonie Lorraine Luxembourg programme including an interview with Henri Lewalle, co-ordinator of a regional cross-border observatory on health care
- Author: journalist (?)
- Objectives: make known the work and aims of the new LuxLorSan initiative in cross-border health care

(2005). *Common Cross-border Hospital Cerdanya*. European Forum on Cross-border Health Care: Challenges and Perspectives, Venice, Italy.

- Material: presentation for conference held 24-27 October 2005 in Venice
- Author: co-ordinator of the cross-border hospital project (?)
- Objectives: present the common hospital project and the particularities of the Cerdanya region to the conference audience

Aarsland, M. (2005). Patient mobility - literature review.

- Material: personal communication (email)
- Author: officer at Norwegian national authority for public health insurance (Trygdeetaten)
- Objectives: provide information about Norwegian legislation on cross-border health care

Albrecht, T., R. Pribakovic, et al. (2005). Patient Mobility in the European Union: Case-study Slovenia. Ljubljana, Slovenia, IVZ-RS Institute of Public Health of the Republic of Slovenia: 49.

- Material: research report, part of EU-funded "Europe for Patients" project
- Authors: researchers at Slovenian public health institute
- Objectives: to provide information on patient mobility from Austria and Italy, especially the border-regions, into Slovenia

Allinger, H. (2005). *Cross Border Co-Operations Germany Austria*. European Forum on Cross-border Health Care: Challenges and Perspectives, Venice, Italy.

- Material: presentation for conference held 24-27 October 2005 in Venice
- Author: doctor from economics department, University of Passau
- Objectives: present the cooperation initiatives between Germany and Austria in the fields of emergency care and hospital care, and the possible impact

Amtsrådsforeningen, Hovedstadens Sygehusfællesskab, Finansministeriet og Indenrigs- og Sundhedsministeriet (2004). Rapport fra arbejdsgruppen om evaluering af det udvidede frie sygehusvalg (Report from the Working Group on the evaluation of the extended free hospital choice).

- Material: assessment report
- Authors: association of regional authorities, Copenhagen's hospital association, Danish Ministry of Health
- Objectives: evaluate the experiences of free choice of hospitals and assess whether changes are necessary

AvMinTand (2005). www.avmintand.dk

- Material: internet site
- Author: Danish middleman acting as broker between Danish patients and European dentists
- Objectives: advertise about dental care in other countries, inform and put people into contact with dental clinics in eight different European countries

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

- Material: chapter in Belgian journal of health economy
- Author: external expert
- Objectives: inform stakeholders of the health care sector about the general situation and developments in cross-border health care and patient mobility, with a focus on Belgium

Bagué, G. (2004). Primer hospital transfronterizo. El País. Giron.

- Material: article in Spanish national newspaper
- Author: journalist
- Objectives: inform readers about innovative cooperation of a cross-border hospital

Bassi, D., O. Denert, et al. (2001). Etat des lieux de la coopération transfrontalière sanitaire. Rennes, Mission opérationnelle transfrontalière, Editions de l'école nationale de la santé publique: 64 pages.

- Material: inventory
- Authors: actors involved in cross-border cooperation
- Objectives: make a record of cross-border cooperation in French border-regions based on survey results

Baulig, C., U. Weibler-Villalobos, I. Korner and F. Krummenauer. (2004). Evaluation von Ergebnisqualität und Kosteneffektivität zahnärztlich-prothetischer Versorgung im (Nicht-EU-) Ausland. *Deutsche Zahnärztliche Zeitschrift* **59**(4): 230-235.

- Material: article in German journal of dental care
- Authors: two authors from the medical service of the sickness fund Rheinland-Pfalz, and two authors from the Institute for Medical Biometry, Epidemiology and Informatics of the Mainz University
- Objectives: evaluate the clinical and financial outcome of patients receiving dental care abroad (in non-EU Member States) – to warn (or discourage?) about the possible implications of going abroad for dental care

Birch, I. and M. v. Boxberg (2004). The International Market for Medical Services: the UK-Germany Experience. London, Anglo-German Foundation for the Study of Industrial Society.

- Material: research report
- Authors: researchers supported by a bi-national institute
- Objectives: assess the situation and potential problems in establishing cross-border cooperation in health care

Boffin, N. and R. Baeten (2005). Dutch patients evaluate contracted care in Belgian hospitals: results of a patient survey. Brussels, Observatoire Social Européen: 55.

- Material: research report based on patient survey; part of the Belgian case-study in “Europe for Patients” project
- Authors: researchers from an independent Belgian research institute
- Objectives: describe and analyse the results of a patient survey on the motivations and experiences of Dutch patients treated in Belgian hospitals

Bonnier, C. (2003). “La coopération transfrontalière: une solution pour la Cerdagne.” *URCAM de Franche-Comté*: 61-63.

- Material: article in the newsletter of the Regional Association for Health Insurance Agencies of Franche-Comté
- Author: responsible for hospital issues in the regional sickness fund of Languedoc-Roussillon
- Objectives: explain the particularities of the Cerdagne region, the current situation of cross-border cooperation and the incentives to extend the collaboration

Bonnier, C., M. Morlon, et al. (2003). *De la Coopération Transfrontalière Sanitaire en Cerdagne vers un Projet d'Hôpital Transfrontalier*. Les rendez-vous européens de la Santé transfrontalière - Libre Circulation et Régulation, Lille, France.

- Material: presentation at conference held in Lille on 5 December 2003
- Authors: representatives from two regional health insurance bodies and from the French Ministry of Social Affairs
- Objectives: explain the particularities of the Cerdagne region, the current situation of cross-border cooperation and the reasons for intensifying collaboration to the conference audience

Bosch, X. (2004). “Spain and Portugal agree to eliminate medical borders.” *The Lancet* **363**: 627.

- Material: article in UK medical journal
- Author: reporter
- Objectives: describe recent developments in the cooperation between the two countries

Bourret, C. and J. Tort i Bardolet (2002). *Maîtrise de l'information, amélioration des systèmes de santé et aménagement du territoire. L'exemple de la Catalogne et de la région Midi-Pyrénées*. Les journées d'études des systèmes d'informations élaborées, L'Ile Rousse, France.

- Material: presentation at conference held at Ile Rousse on 14-18 October 2002
- Authors: researcher (?) at French university of Marne-la-Vallee and representative from the Catalan public health service, *CatSalut*
- Objectives: explain the differences between the French and Catalan health care systems and how telemedicine as well as cross-border cooperation could improve services to citizens by creating a unified health region. Strong regionalist message

Bovas, M. (2002). Alpes-Maritimes - Menton invente l'hôpital transfrontalier. *La Tribune*. Menton.

- Material: article in French economic and financial newspaper
- Author: reporter
- Objectives: inform readers about hospital cooperation

Burger, R. (2004). Mobility of patients and health professionals.

- Material: personal communication (email)
- Author: researcher involved with cross-border cooperation through the "healthregio" project (Interreg IIIA)
- Objectives: explain the situation of cross-border care in Austria

Butler, P. (2002). Q&A: treatment abroad. Guardian Unlimited.

- Material: article in UK national newspaper
- Author: reporter and interviewee
- Objectives: inform readers about the innovative scheme of sending NHS patients overseas

Cachia, J. M. (2004 (?)). Cross-Border Care: Provision of Highly Specialized Hospital Services to Island Populations - A case study of the Maltese Islands, Ministry of Health.

- Material: evaluation report
- Author: officer at Ministry of Health
- Objectives: explain the local situation and the reasons for purchasing health care abroad

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

- Material: assessment report
- Author: co-ordinators of the Euregio project Meuse-Rhine (from two Belgian sickness funds)
- Objectives: present and evaluate the experimental project "IZOM" as well as the results of a patient questionnaire carried out within the project

Claes, A. (2005). Europe for Patients project.

- Material: personal communication (email)
- Author: director of heart and lung centre at Lund hospital (Sweden)
- Objectives: inform about cross-border project with Danish hospital

Coheur, A., P. Carnotensis, et al. (1999?). Interreg II - Projet transfrontalier dans l'Euregio Meuse-Rhin/ Grensoverschrijdend project in de Euregio Maas-Rijn (Final Report), Espace social européen et santé: 56 pages.

- Material: assessment report

- Author: cooperating partners of the Euregio Meuse-Rhine project, among others from Belgian and Dutch sickness funds
- Objectives: describe a series of different projects on cross-border health care in the Euregio and evaluate whether they have achieved their objectives

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

- Material: conference paper
- Author: co-ordinator of the Euregio project Meuse-Rhine (from Belgian sickness fund)
- Objectives: explain what happens in practice to the conference audience

Coheur, A. (2001). "Integrating care in the border regions - an analysis of the Euregio projects." *Eurohealth* 7(4): 10-12.

- Material: journal article
- Author: co-ordinator of the Euregio project Meuse-Rhine
- Objectives: explain the trends of patient mobility in the border-regions

Coheur, A., Carnotensis P., J. Assent (2004). Interreg III - Soins de santé sans frontières dans l'Euregio Meuse-Rhin, IZOM Project.

- Material: assessment report
- Authors: coordinators of the Euregio project (from two Belgian sickness funds)
- Objectives: evaluate the financial impact of the IZOM project in terms of the costs which patient flows generated in the Euregio

Colson, P., C. S. F. Chimay, et al. (2002). *Accès simplifié aux soins hospitaliers en Thiérache grâce à la carte SIS et la carte Vitale*. Séminaire: "Coopération Transfrontalière Sanitaire", Lille.

- Material: conference presentation
- Authors: involved stakeholders (doctor and hospital director)
- Objectives: explain the workings and success of the cross-border cooperation

Committee for Promoting German Medicine in Foreign Countries (2005) http://www.committee-german-medicine.de/cms/front_content.php?idcat=3

- Material: internet site
- Author: German association of political and medical stakeholders
- Objectives: 'medical diplomacy', provide specialist information and promote medical care in German hospitals to foreign users/ purchasers

CPAM de Maubeuge and de St Quentin (2003). Evaluation annuelle TRANSCARDS 2002, CPAM de Maubeuge/ St Quentin.

- Material: yearly evaluation report
- Authors: the actors involved (two French sickness funds)
- Objectives: examine the quantities of cross-border treatments

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

- Material: yearly evaluation report
- Authors: the actors involved (two French sickness funds)
- Objectives: examine the quantities of cross-border treatments and compare with year before

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

- Material: article in Belgian journal for medical professionals
- Author: secretary general of Belgian sickness fund
- Objectives: explain the reasons behind and the benefits from cross-border cooperation

Denert, O. (2004). La coopération transfrontalière sanitaire, Mission Opérationnelle transfrontalière: 19.

- Material: French thematic journal
- Author: inter-ministerial organ supporting cross-border projects
- Objectives: provide follow-up and explanatory information about current cross-border projects

Drespe, A. (1999). EUREGIOsocial - Euroregionale Zusammenarbeit im Gesundheitswesen. Brussels, European Social Insurance Partners.

- Material: report
- Author: researcher (?)
- Objectives: mapping and describing German Euregios' cross-border cooperation activities in health care

Engels, E. L. (2003). Grenzeloos geketend? Deel A - Explorierend onderzoek naar de transnationale zorgketen tussen Nederland en België. Maastricht, Universiteit Maastricht, Faculteit der Gezondheidswetenschappen.

- Material: analytical report
- Author: MSc student at the University of Maastricht
- Objectives: explain the "trans-national care path" of Dutch patients receiving treatment in a specific Belgian hospital, the actors involved, the different stages and procedures of the patient pathway and the various bottlenecks

Engels, E. L. (2003). Grenzeloos geketend ? Deel B - Explorierend onderzoek naar de transnationale zorgketen tussen Nederland en België vanuit patiëntenperspectief. Maastricht, Universiteit Maastricht, Faculteit der Gezondheidswetenschappen.

- Material: analytical report
- Author: MSc student at the University of Maastricht
- Objectives: explain the "trans-national care path" of Dutch patients receiving treatment in a Belgian hospital from the perspective of the patients

EuregioGezondheidsPortaal

http://www.euregiogezondheidsportaal.nl/euregioportaal/index.php?id=z_7_0_&L=2

- Material: internet site
- Authors: the German sickness fund "AOK Rheinland - Die Gesundheitskasse" and Dutch sickness fund "CZ Actief in Gezondheid"
- Objectives: provide up-to-date and concrete information on the options of cross-border health care in the three Euregios of Meuse-Rhine, Rijn-Maas-Noord and Rijn-Waal

Euregio Meuse-Rhine

http://www.euregio-mr.org/emr_site/index.php

- Material: internet site
- Author: the Euregio Meuse-Rhine Foundation
- Objectives: provide information on the Euregio, its members, activities, projects, news etc.

Euregio Scheldemond

<http://www.euregioscheldemond.org/eng/index.asp>

- Material: internet site
- Author: the partners of the Euregio Scheldemond
- Objectives: provide information on the Euregio, its members, its economic and demographic composition, its activities etc.

European Commission (2003). Report on the application of internal market rules to health services - Implementation by the Member States of the Court's jurisprudence. Brussels, DG Internal Market, European Commission.

- Material: Commission staff working paper
- Author: DG Internal Market
- Objectives: evaluate the situation on how Member States have applied the ECJ rulings on the reimbursement of care received in another Member State

Espaces Transfrontaliers

<http://www.espaces-transfrontaliers.org/> and

http://www.espaces-transfrontaliers.org/en/detail_projet.php?idprojet=69

- Material: internet site
- Author: Mission Operationelle Transfrontalière, a French inter-ministerial body specialised in supporting cross-border projects
- Objectives: provide complete information on activities, projects etc taking place in the border-regions between France and one of the eight neighbouring countries

France, G. (1993). *Cross Border Care: The Italian Experience*. Paper presented to the Conference Health Care Financing and the Single European Market - Working Group "Cross Border Care", Brussels.

- Material: workshop paper
- Author: researcher
- Objectives: analyse data on Italian cross-border flows of patients

France, G. (1994). *Elements for Explaining the Use of Cross-border Care by Italian Patients*. Paper presented to the conference "Health Care Financing and the Single European Market", Maastricht.

- Material: conference paper
- Author: researcher
- Objectives: examine the reasons for Italian patient mobility

France, G. (1997). "Cross-border flows of Italian patients within the European Union." *European Journal of Public Health* **7 (supplement)**(Number 3): 18-25.

- Material: article in European journal
- Author: researcher
- Objectives: analyse the flows of Italian patients to European countries

Frost, R. G. (2000). Efterbehandling af brystkræftpatienter i Flensborg af borgere fra Soenderjyllands Amt (Follow-up treatment of breast cancer patients in Flensburg of citizens from Southern Jutland County), Soenderjyllands Amt: 13.

- Material: research report
- Author: officer at Danish County of Soenderjylland

- Objectives: describe the waiting list debate and explain how the County has found a cross-border solution for cancer patients

Glinos, I. A., N. Boffin, et R. Baeten (2005). Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives. Brussels, Observatoire Social Europeen: 89.

- Material: research report, part of EU-funded “Europe for Patients” project
- Authors: researchers from an independent Belgian research institute
- Objectives: describe and analyse the procedures and incentives of Dutch and English patients travelling to Belgium for hospital treatment

GerMedic (2005) www.germedic.de/

- Material: internet site
- Author: German company acting as broker between foreign patients and German hospitals (in partnership with more than 100 hospitals)
- Objectives: inform consumers about the advantages of German hospital care with the aim of attracting foreign patients who are waiting for treatment in their own country (directed towards Danish, English and Dutch patients)

Grunwald, C. A. and R. Smit (1999). Grensoverschrijdende zorg - Zorg op Maat in de Euregio Maas-Rijn; evaluatie van een experiment. Utrecht, NZI (research institute).

- Material: report
- Author: two researchers of the independent Dutch research institute NZI
- Objectives: evaluate the “ZOM” experimental cross-border project in terms of its functioning, possible consequences and the factors which stimulate or hinder the movement of Dutch patients in the Euregio Meuse-Rhine

Harant, P. (2003). *Hospital Cooperation in Border Regions in Europe*. HOPE Conference and Workshop: Free movement and cross-border cooperation in Europe : the role of hospitals & practical experiences in hospitals, Luxembourg, HOPE and EHL.

- Material: conference presentation
- Author: member of cross-border hospital organisation (HOPE)
- Objectives: present the result of a HOPE study on hospital cooperation

Harant, P. (2006). Hospital cooperation across French borders. *Patient mobility in the European Union - Learning from experience*. M. Rosenmoller, M. McKee and R. Baeten. Copenhagen, European Observatory on Health Systems and Policies: 157-177.

- Material: book chapter
- Author: official from the French Ministry of Health
- Objectives: describe and explain border-region cooperation between France and neighbouring countries

Hauch, P. (2005). Patientbevaegelighed - danske patienter i Tyskland (Patient mobility - Danish patients in Germany).

- Material: personal communication (telephone conversation and email)
- Author: officer working at German middleman PatientLink in Denmark
- Objectives: explain how Danish patients can go to Germany

HELTEF (2003). Evaluering: Pasienterfaringer I kjøp av helsetjenester i utlandet. Nordbyhagen, HELTEF.

- Material: evaluation report
- Author: Norwegian health care research institute
- Objectives: examine and assess Norwegian patients experiences with treatment abroad based on patient survey

INAMI (2001). Les soins de santé dans l'Union européenne. Brussels, INAMI/ RIZIV: 18.

- Material: report
- Author: Belgian public authority (National Institute for Sickness and Invalidity Insurance)
- Objectives: explain the principles and practices of cross-border health care in the EU, Belgium's position and patients' rights to free movement

Indenrigs- og Sundhedsministeriet. (2004). Resultater paa sundhedsområdet (Results in the health sector). Copenhagen, Indenrigs- og Sundhedsministeriet (Ministry of Internal Affairs and Health).

- Material: information brochure
- Author: Danish Ministry of Health
- Objectives: inform the population about developments in the health care sector and waiting times

Ingels, G. (2001). Operation i Danmark kortar väntetiden. Kristianstadsbladet.

- Material: article in Swedish local newspaper
- Author: reporter
- Objectives: inform local readers about how a Swedish patient chose to avoid waiting times by undergoing heart surgery in Denmark

Jacobs, W. (2005). *Praxisbericht: Verträge mit ausländischen Leistungserbringern Europaweite Gesundheitsversorgung*. AOK im Dialog: "Europa für die Versicherten gestalten", Berlin.

- Material: presentation for European conference (with focus on Germany, The Netherlands, Belgium)
- Author: chief executive of AOK sickness fund
- Objectives: describe the various cross-border cooperation activities of the AOK sickness fund and the success they have had

Jamison, J., H. Legido-Quigley, et al. (2005). A solution in search of a problem? - Cross-border health co-operation in Ireland. Armagh, Northern Ireland, Centre for Cross Border Studies: 38.

- Material: research report, part of EU-funded "Europe for Patients" project
- Author: researchers at independent Irish/ Northern Irish policy research institute and from the London School of Hygiene and Tropical Medicine
- Objectives: provide information on motives, expectations and needs of Irish patients receiving care across the Irish border and to compare current cross-border cooperation practices with earlier ones

Jesse, M. and R. Kruuda (2005). Patient Mobility in the European Union: Case study Estonia. Tallinn, Estonia, PRAXIS: 67.

- Material: research report, part of EU-funded "Europe for Patients" project
- Authors: researchers at Estonian independent not-for-profit think tank

- Objectives: provide information on patient mobility to and from Estonia, on the Estonian population's attitude to cross-border care and on the possible impact of patient mobility on the health care system

Kyriopoulos, J. and M. Gitona (1996). Cross-border Health Care in Greece: Macro and Micro-analysis of the pre-authorized care. Paper presented at the final meeting EU-Concerted Action "Health Care Financing and the Single European Market", Rome.

- Material: conference presentation
- Authors: academics
- Objectives: explain the challenges posed by Greek patient mobility

Kyriopoulos, J. and M. Gitona (1996). "Hospitalisation à l'étranger de patients grecs." *Journal d'Economie médicale* **14**(3): pp.181-191.

- Material: article in French medical journal
- Authors: academics
- Objectives: examine the cross-border hospitalisation of Greek patients

Kyriopoulos, J. E., I. Drakou, et al. Cross-border Flow of Health Care: the Greek Experience - Facts and Figures. Athens, Athens School of Public Health - Dept of Health Economics

- Material: academic publication
- Authors: academics
- Objectives: explain the challenges posed by Greek patient mobility

Kyriopoulos, J. E., M. Gitona, et al. Cross-border Flow of Health Care: the Greek Experience. Athens, Athens School of Public Health - Dept of Health Economics

- Material: academic publication
- Authors: academics
- Objectives: explain the challenges posed by Greek patient mobility

Landesregierung-Schleswig-Holstein (2002). Grenzüberschreitende Inanspruchnahme von Gesundheitsleistungen, Schleswig-Holsteinischer Landtag.

- Material: communication from the government of the Land of Schleswig-Holstein
- Author: government official (?)
- Objectives: inform about the general situation of cross-border health care in the Land

Lowson, K., P. West, et al. (2002). Evaluation of Treating Patients Overseas - Final Report. York, York Health Economics Consortium, Dept of Health (University of York): 96 pages.

- Material: assessment report
- Authors: research team from academic institution
- Objectives: evaluate the pilot project set up by the Department of Health for treating patients abroad

Muscat, N. (2004). Cross Border Purchasing and Provision of Health Care - The Maltese Experience, Ministry of Health, the Elderly and Community Care.

- Material: background paper
- Author: officer at Ministry of Health, Malta
- Objectives: inform members of the High Level Group on Health Services and Medical Care

Muscat, N. A., K. Grech, et al. (2006). Sharing capacities - Malta and the United Kingdom. *Patient mobility in the European Union - Learning from experience*. M. Rosenmoller, M. McKee and R. Baeten. Copenhagen, European Observatory on Health Systems and Policies: 119-136.

- Material: book chapter
- First author: officer at Ministry of Health, Malta
- Objectives: describe and explain the particularities of Malta as a small country, the patient flows to the UK for highly specialised treatments and the provision of health care services to tourists.

National Treatment Purchase Fund

<http://www.ntpf.ie/home/>

- Material: Irish internet site
- Author: the National Treatment Purchase Fund, an initiative of the Irish NHS to reduce waiting lists
- Objectives: provide information to the Irish population about the options of receiving treatment outside the NHS (in the private sector, in Northern Ireland or in the UK) to reduce waiting times

Nebling, T. and H.-W. Schemken (2006). Cross-border contracting: The German experience. *Patient Mobility in the European Union: Learning from experience*. M. Rosenmoller, M. McKee and R. Baeten. Copenhagen, European Observatory on Health Systems and Policies: 137-156.

- Material: book chapter
- Authors: respectively, researcher at University of Bayreuth (Germany) and officer at AOK-Rheinland sickness fund
- Objectives: describe and explain border-region cooperation and in particular cross-border contracting between Germany and neighbouring countries (The Netherlands, Belgium, Austria, Czech Republic)

Nesse, O. (2001). *Norwegian Patients in EU Hospitals - The Medical Treatment Abroad Project*. European Integration and Health Care Systems: A Challenge for Social Policy, Ghent, Belgium.

- Material: paper presented at European conference
- Author: project coordinator at Norwegian Insurance Administration
- Objectives: explain the context, reasons, functioning and experiences with the national project for purchasing health care abroad

Oresundskomiteen and Oresund direkt. (2003). Health Care without Borders in the Oresund region. Copenhagen (?), Oresundskomiteen: 19 pages, appendix 12 pages.

- Material: report
- Authors: two regional cross-border organisations
- Objectives: inform patients and citizens about their rights in the Danish-Swedish cross-border region

PatientLink (2005). www.patientlink.dk

- Material: Danish Internet site
- Author: middleman working for German hospitals
- Objectives: make publicity and inform Danish public about the possibility to avoid waiting lists and be treated in German hospitals

Pedersen, F. S. (2005). Kraeftpatienter vil til udlandet (Cancer patients want to go abroad). Berlingske Tidende.

- Material: article in Danish national newspaper

- Author: reporter
- Objectives: inform the readers about recent developments of cancer patients seeking second opinion

Picard, M. (2004). Tourisme dentaire en pays magyar - Les voyages pour raison medicale se developpent. *Le Figaro*.

- Material: article in French national newspaper
- Author: reporter
- Objectives: inform the wider public about new trend in “medical tourism”

Picard, M. and F. Schmidt (2004). A l'Est, les nouvelles dents sont moins cheres (In the East, new teeth are less expensive). *L'Hebdo*: 3.

- Material: article in Swiss weekly magazine
- Authors: reporters
- Objectives: inform readers about new trend in “medical tourism”

Post, B. and P. Stal (2000). Cross-border Urgent Medical Assistance - Belgium, Germany, The Netherlands. Nijmegen, ITS, University of Nijmegen Foundation.

- Material: research report
- Authors: researchers from the independent Dutch institute ITS, Institute for applied social sciences, part of the Radboud University
- Objectives: examine the opportunities for and obstacles to cross-border urgent medical assistance in the five Euregios of Scheldemond, Meuse-Rhine, Rhine-Waal, Rijn-Ems-Ijssel and Eems-Dollard

Quille, F. (2002). La clinique de la Louviere (Lille) aux petits soins pour ses patients anglais (Tea time, tees britanniques et pasteur anglican). *Le Quotidien de Medecin*.

- Material: article in French daily medical newspaper
- Author: reporter
- Objectives: inform a medical audience on the practical aspects of cross-border cooperation and treating NHS patients in a French hospital

Romanens, C., G. Pagliari, et al. (2003). La cooperazione sanitaria tra il Centro Ospedaliero "La Palmosa" di Mentone e la ASL 1 Imperiese. European Week of Public Health, Brussels.

- Material: conference presentation
- Authors: local health care stakeholders
- Objectives: present the local experience

Schnack, D. (2003). “Grenzüberschreitende Gesundheitsversorgung.” *Schleswig-Holsteinisches Arzteblatt*(1): 2.

- Material: journalistic article in regional medical publication
- Author: journalist (?)
- Objectives: describe the Schleswig-Holstein government’s motivation regarding cross-border care and explain what cooperation takes place with Denmark, Norway and England

SINTEF (2003?) Prosjekt Kjoep av helsetjenester I utlandet – en slutevaluering (Project Purchasing health care services abroad – a final evaluation), SINTEF.

- Material: internet site
- Author: SINTEF (Institute for Industrial and Technical Research at Norway’s Technical School)

- Objectives: summarise the key findings of the evaluation report

Spiegel, B. (2005). Patient mobility - literature review.

- Material: personal communication (email)
- Author: officer at Austrian Ministry of Health
- Objectives: inform about the situation in Austria

Stockholm Care AB (2006). <http://www.stockholmcare.se/company.html>

- Material: Swedish Internet site
- Author: hospital specialised in treating foreign patients
- Objectives: inform and attract foreign patients to the Stockholm Care clinic which exclusively offers care to foreign patients, mostly for highly specialised treatments

Sundhedsstyrelsen (2004). Kraeftlaeger sparer paa ny behandling (Cancer doctors save on new treatments), Sundhedsstyrelsen.

- Material: news coverage
- Author: Danish National Board on Health
- Objectives: inform the population about health related news in the Danish media

Sygehusdirektoratet (2002). Svensk invasion paa Amtssygehuset i Gentofte en succes (Swedish invasion at the County Hospital in Gentofte - a success). Copenhagen, Sygehusdirektoratet, County of Copenhagen.

- Material: press release
- Author: public institution of hospitals
- Objectives: describe the experiences of actors involved in the Danish-Swedish cooperation

Toftgaard, C. (2005). Straalebehandling i Tyskland (Radiation therapy in Germany).

- Material: personal communication (email)
- Author: officer at Danish county of Soenderjylland
- Objectives: inform about local Danish patients going to Germany for treatment

Trygdeetaten (2004). Bidrag til behandling i utlandet etter § 5-22 (Subsidy for treatment abroad according to § 5-22) Trygdeetaten: 28.

- Material: report
- Author: Norwegian national authority for public health insurance
- Objectives: explain the sharp increase in the cost of treatments received abroad

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

- Material: analytical report
- Authors: researchers from a Dutch institute for social scientific research and advice
- Objectives: examine the situation of a Dutch hospital group in Scheldemond, the stakeholders' perspectives and the patterns of patient flows to propose suggestions on how to improve the situation

Wagstyl, S. and R. Anderson (2005). Budget flights boon to east Europe's gentle dentists. Financial Times. London: 2.

- Material: newspaper article
- Authors: journalists

- Objectives: explain readers how the rise in low-cost airlines has had an impact on mobility towards Eastern Europe, and notably has encouraged some forms of patient mobility

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- Material: research report
- Author: two researchers from Medical Technology Assessment department of a Dutch university centre in cooperation with German sickness fund AOK Rheinland
- Objectives: explain the incentives and levels of satisfaction of German patients receiving treatment at the Dutch hospital UMC St Radboud

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- Material: article in French national newspaper
- Author: journalist
- Objectives: inform readers of the national newspaper about new “options” in Poland

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