

## Chapter 7

# Cross-border contracted care in Belgian hospitals

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### Introduction

Belgium is a small country with long borders. Health care facilities are always close to one or the other border. Languages cross frontiers and cross-border flows of workforce have taken place for a long time. These factors have given Belgium long-standing experience with cross-border patient mobility. Several initiatives have been taken in the last decade to ease cross-border access to care, often initiated by local health care providers and sickness funds; several of these projects became possible with the support of the EU Interreg/Euregio projects.

Although patient flows to and from Belgium for pre-planned care have been somewhat larger than in most other EU Member States, they have remained a relatively marginal phenomenon even in Belgium. Cross-border care was traditionally mainly funded on the basis of the European Council Regulation (EEC) No. 1408/71 on the coordination of social security schemes, so Belgian prices and legislation applied to the care provided.

In recent years, however, patient flows into Belgium have been growing. Although statistics relating to these developments remain very scarce, the available data suggest that there has been a particularly large increase in the numbers of Dutch patients treated in hospitals in Flanders, the northern part of Belgium. It seems that it is not only patients who are coming to Belgium on their own initiative, but that foreign health purchasers are concluding contracts with Belgian hospitals to treat their affiliated members. This care is not necessarily funded through Council Regulation (EEC) No. 1408/71.

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

To explore these issues we carried out a case study to examine the following questions:

- What exactly is happening? How are cross-border contracts concluded, which actors are involved, what is the extent of cross-border contracting?
- What are the drivers for this enhanced cross-border mobility for all the players involved, in particular for cross-border contracting by Dutch health insurers and by the English National Health Service?
- What are the potential consequences, challenges and opportunities that arise from these developments?

Our research has been based on in-depth interviews with key actors and analysis of statistical databases.

The chapter first looks at the historical, legal and structural developments that have led to the innovative cross-border contracts between Belgian providers and Dutch and English purchasers. The content and workings of the contracts are explained, while numbers relating to patient flows to Belgium are presented to give an idea of the extent of the phenomenon. The drivers, obstacles and implications of patient mobility are then examined before concluding with some (hopefully) thought-provoking observations.

### **Cross-border contracting in practice**

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

## Contracts between Dutch health insurers and Belgian hospitals

Initiatives have been taken on the Dutch-Belgian border for decades to ease access to cross-border care. One such initiative is in the Dutch region Zeeuws-Vlaanderen where, since 1978, inhabitants have had the possibility of receiving some, mainly highly specialized treatments in specified Belgian hospitals (van Tits and Gemmel, 1995). Zeeuws-Vlaanderen is a region with low population density. Local health care infrastructure was reduced in the 1970s and only one hospital remained. Geographically, historically and culturally this region is more oriented towards Belgium than to other regions of the Netherlands.

Another initiative is the Euregio Meuse-Rhine, covering parts of the Netherlands, Belgium and Germany, where, since 2000, patients from the three countries can receive predefined treatments across borders (Carnotensis and Coheur, 2002; Coheur, Carnotensis and Assent, 2004). This process was initiated by health insurers and health providers from the three countries and in a second stage received support from public authorities of the involved countries.

Both these initiatives envisage that treatments are paid for according to Council Regulation (EEC) No. 1408/71.

Following the *Kohll* and *Decker* rulings, the Dutch authorities advised sickness funds to conclude contracts with foreign providers when they intend to systematically offer their members the possibility to be treated abroad (CVZ, 2002). The Dutch reading of the ECJ rulings implies the “exportation” of the Dutch national health care system, in which contracting is a key feature. The system in the Netherlands is based on health insurance, where compulsory health coverage is administered by sickness funds (non-profit organizations) for the public insurance scheme and by care insurers (for-profit or non-profit organizations) for the privately insured (Den Exter et al., 2004; <http://www.zn.nl>). All insurers providing statutory cover have a legal duty to deliver care to their affiliated members. To fulfil this obligation, insurers conclude contracts with health care providers as the public scheme is based on a benefit-in-kind system. Contracting is thus central to Dutch compulsory insurance and is seen as a means to control quality, volume and costs of health care (AIM, 2002). Insured members are free to choose between contracted hospitals.

The Dutch transposition of the court rulings also implies that treatment abroad may not be refused if the patient cannot be treated in a contracted hospital within the waiting times defined in the “Treek” norms (Dutch norms defining acceptable waiting times) for the treatment in question (CVZ, 2004). As long as there is no law defining the levels of reimbursement for care received in another Member State, sickness funds are obliged to reimburse the total costs of this care (CVZ, 2004).



**Figure 7.1** Location of Belgian hospitals that have contracts with Dutch insurers and/or the NHS.

Source: Adapted from <https://europa.aok.de/aok.index.jsp>

Based on these official instructions, four Dutch health insurers have so far concluded direct contracts with Belgian hospitals: CZ, Achmea, VGZ and OZ. The first three constitute the largest insurers in the Netherlands and together account for 6.5 million affiliates (out of the 16.3 million people who are insured). Most of the clientele of CZ and OZ are in the regions bordering Belgium. CZ and OZ as well as several of the Belgian hospitals with which they have concluded contracts were also involved as partners in the initial projects for relaxation of cross-border care in Zeeuws-Vlaanderen and in Euregio Meuse-Rhine, so good contacts between the players already existed prior to actual contracting.

Under certain conditions, and subject to prior authorization from their health insurer, patients can still go abroad for non-contracted care. This care can be paid for on the basis of Council Regulation (EEC) No. 1408/71 for sickness fund patients or through the reimbursement of costs for privately insured patients.

Dutch patients in need of non-urgent hospital care need a referral letter from their general practitioner, regardless of whether they go to a contracted Dutch or Belgian provider. People are free to choose among contracted providers, but insurers can limit the forms of treatment that patients go abroad for by limiting the scope of contracts. This selection of treatments is generally based on the

existence of long waiting lists (mostly elective surgery) and on local shortages of care.

Most cross-border contracts stipulate that Belgian hospitals and doctors should be paid according to official Belgian tariffs. Medical procedures and practices as well as legal aspects of care provision are carried out according to Belgian norms.

To select Belgian hospitals, several insurers have strategies which include inspections and evaluation criteria addressing medical, organizational and logistical standards of the hospitals. Geographical location is an important selection factor and hospitals close to the border are more likely to be considered as potential contracting partners, especially for insurers with membership concentrated in the border regions with Belgium. Contracting in Belgium is a natural choice for Dutch insurers owing to the geographical as well as linguistic proximity of the two countries (Flanders, the northern part of Belgium on which this study focuses, is Dutch-speaking).

Belgian authorities are not involved at any stage of the cross-border contracting. Several attempts have been made to establish a bilateral agreement between the two countries yet these have not succeeded so far. On the other hand, the relevant Dutch public authority checks the contracts, but only those covering publicly insured patients. Also, the largest Belgian sickness fund, the CM, has an important role as it participates as a third contracting party in the contracts of two Dutch insurers with Belgian hospitals. Its role is to manage and control invoices and to check that Belgian official tariffs are respected in the cross-border cooperation.

#### Contracts between the English NHS and Belgian hospitals

In 2000–2001, the English Department of Health began to look to overseas care in the face of long waiting lists. A pilot project, “Treating Patients Overseas” (Department of Health, 2002), was launched in 2002, evaluating cross-border hospital care in France and Germany for a period of three months (February–April 2002), involving in total approximately 200 patients. Guy’s and St Thomas’ NHS Foundation Trust (GST) in London had a key role in the project as it established patient pathways and contracted with hospitals.

After the pilot project, the Department of Health wanted to expand the options of overseas treatment and, in 2002, launched a Europe-wide procurement exercise to identify suitable foreign hospitals by means of a careful assessment process. Providers offering good quality and value-for-money care were short-listed; among these were several Belgian hospitals which fulfilled the clinical, business and logistical standards.

Simultaneously with the procurement process, the London Patient Choice Project was set up in October 2002 with funding from the Department of Health. Its objectives were to improve waiting times and satisfaction for patients in London, and develop the necessary capacity and a working system to promote patient choice. London Patient Choice contacted the GST because it was interested in sending London patients overseas as part of the wider choice system being put in place. The GST proposed the options of Belgian and German hospitals. London Patient Choice chose Belgium because of the high quality of hospitals, easy travelling from London and the option of direct contracting with the support of the government, as a bilateral framework agreement was being discussed between the English Department of Health and the Belgian Health Minister. Discussions on the bilateral agreement were initiated partly because the Belgian authorities were eager to ensure that the cross-border contracts would not harm the Belgian system by giving rise to waiting times for Belgian patients or by putting upward pressure on prices (Vandenbroucke, 2002). Also, the English authorities wanted to ensure that Belgian providers would not charge higher prices to English patients. The agreement, which guarantees the integrity of the Belgian system, was signed in February 2003.

Seven Belgian hospitals concluded contracts with the NHS in 2003. Of these, five contracts were extended until 31 March 2007 and only covered knee and hip replacements, as these were treatments for which waiting lists were particularly long and which take up considerable hospital capacity. Sending these patients abroad had the greatest impact within the NHS by freeing resources. The two contracts which were not extended concerned NHS cardiac patients; they were terminated in March 2004.

Unlike the contractual agreements with the Dutch purchasers, contracting for NHS patients is centralized. The GST acts as Lead Commissioner on behalf of four London NHS trusts which have chosen to take part in the overseas programme. NHS trusts are consortia of hospitals responsible for delivering hospital care to the local population. The four trusts participating in the overseas programme are: University Hospital Lewisham (South-East London); Bromley Hospitals NHS Trust (South-East London); Barnet and Chase Farm Hospitals NHS Trust; and Barking, Havering and Redbridge Hospitals Trust. It is only the GST which signs the contracts with the Belgian hospitals, but which patients are selected to be sent abroad depends on the needs and requirements of each trust. The entire system is based on local trusts offering choice to their patients.

Clear criteria for selecting patients were defined. Only patients in need of knee or hip replacements having been on waiting lists for at least six months, who

lived in the catchment area of a participating trust and who had no important co-morbidities were considered for going overseas.

Patients were referred to Belgium within the framework of their NHS trust, with specialists in the trusts acting as referring doctors. Patients who were offered overseas treatment and accepted it attended an “overseas assessment clinic”, that is, an out-clinic consultation at their local hospital trust, which was attended by the medical team from the Belgian hospital which the patient would be sent to.

Quality of care was ensured through the assessment of the hospitals abroad based on strict qualification requirements and through the detailed description of treatments included in the contracts, defining procedures, clinical services, performance standards and discharge criteria.

NHS contracts define so-called “package prices” – one price for an entire knee or hip replacement – which includes all the components of the treatment. These prices are the equivalent of the average cost for this treatment for a Belgian patient (based on the Belgian tariffs and on a fee-for-service basis). This had been stipulated as a condition in the bilateral agreement.

A total of 432 NHS patients with hip and knee problems have been treated in the five contracted hospitals between May 2003 and November 2004. Although the contracts continue until 2007, the flow of patients to Belgium has completely stopped since September 2004, partly because London Patient Choice’s budget for the overseas programme ended in April 2004, but also because more capacity became available in England.

Concerning the contracts for cardiac surgery in two Belgian hospitals, only 21 patients were treated in Belgium between March and October 2003.

#### Extent of the phenomenon

It is extremely difficult to obtain numbers on cross-border patient mobility that are reliable, comparable, complete and easy to interpret. Purchasers have their own numbers, most hospitals have some figures, while public authorities also have some data. Statistical data can include ambulatory and/or intramural care; day nursery and/or clinical nursery; care provided in contracted and non-contracted hospitals; care provided to people according to nationality or according to the place of residence; care provided to sickness fund patients and/or privately insured patients; care provided through Council Regulation (EEC) No. 1408/71 or not; and emergency care can be included or excluded. Sometimes these distinctions are made explicit, but very often they are not.

**Table 7.1** Accepted periods of contracted care in Belgian hospitals by year and by insurer (N=25 884)

Year	Health insurer		Total	Index
	CZ	OZ		
1999		1 553	1 553	100
2000		2 203	2 203	142
2001	452	2 482	2 934	189
2002	2 979	2 769	5 748	370
2003	4 617	1 562	6 179	398
2004	5 775	1 492	7 267	468
<b>Total</b>	<b>13 823</b>	<b>12 061</b>	<b>25 884</b>	

Source: Carenet

### Patients treated in Belgium via contracting

The information system “Carenet”, used by two Dutch health insurers contracting with Belgian hospitals, provides the figures shown in Table 7.1. The table shows the numbers of Dutch patients treated in Belgian hospitals contracted by the two Dutch health insurers, CZ and OZ, which cover the majority of the border-region population and which have concluded most contracts with Belgian hospitals. The treatments in question include ambulatory care and inpatient care in these hospitals. Affiliated members of the two insurers can, with prior authorization, also go to other Belgian hospitals or to the contracted hospitals for treatments not included in the contracts. However, these patient flows do not appear in Table 7.1. Furthermore, the numbers do not include patients from other Dutch insurers treated in Belgium. Yet the figures do give an indication of ongoing developments. The table shows a steady increase in periods of care involving CZ patients while those involving OZ patients decreased after 2002. The difference between the volumes of CZ patients and OZ patients also reflects the very different policies of the two insurers, as the OZ together with local doctors encourage patients to be treated in a local Dutch hospital which otherwise could face closure, risking damage to local health services.

Analysis of data by hospital reveals concentration of CZ and OZ patients in a limited number of Belgian hospitals. Of the CZ patients, 2608 (44.3%) treated in Belgium in 2004 through contracted care were treated in one particular hospital that has a local function and 822 beds. The data also suggest that, in the initial phase after signing a contract, there is a considerable increase of patients going to the hospital in question, but that after some time there seems to be a degree of stabilization. The increase in CZ patients is thus largely due to contracting with additional hospitals. Yet, as the developments are very recent, prudence is called for when interpreting the numbers.

**Table 7.2** *Foreign patients treated in Belgium under E112*

	<b>Dutch patients</b>	<b>Total numbers</b>
1998	3 970	10 773
1999	4 915	11 262
2000	6 262	14 061
2001	7 539	16 019
2002	9 254	17 085
2003	12 526	22 477

Source: INAMI-RIZIV

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

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

#### Patients treated under the E112 scheme in Belgium

Programmed care abroad can be provided and paid for through direct contracts between providers and purchasers, through out-of-pocket payments by the patient with possible reimbursement by the purchaser or through the procedure foreseen in Council Regulation (EEC) No. 1408/71 on the coordination of social security schemes in the European Union. These patients are treated under the so-called E112 form.

According to the European Commission, Belgium was the EU Member State with the highest number of patients treated under E112 (even in absolute numbers) in 2000 with a total of 14 061 persons (CEC, 2003). Table 7.2 shows the development over time of these patient flows to Belgium.

The data, which include ambulatory as well as inpatient care, show a steady increase in the volumes of patients treated under the E112 scheme in Belgium

and particularly of Dutch patients who in 2003 made up over half of these patients. However, the numbers do not include patients receiving Belgian health care under projects which increase access to cross-border care (mainly the Interreg/Euregio projects), who are treated through a “soft” version of the E112.

### **Drivers of cross-border contracted care**

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

Based on the analysis of the material we have collected in the case study, mainly from interviews with stakeholders, the following drivers and obstacles for cross-border contracted care were revealed.

Searching for answers to the problem of waiting lists

An obvious driver behind cross-border contracts are waiting lists: they motivate health authorities and purchasers to look for solutions abroad and encourage patients to accept travelling long distances in exchange for faster access to treatment (CVZ, 2002).

Waiting lists are perceived as a failure of the national system to deliver health care to the population and, as public dissatisfaction grows, purchasers are forced to look for alternatives. Expanding capacity within the national system requires long-term planning, investment and time, while resorting to care abroad can have immediate results.

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

The rulings of the European Court of Justice

Cross-border contracting has been promoted by the rulings of the ECJ on the reimbursement of costs for health care received abroad. Health care systems that are unable to provide the necessary care to their populations “without

undue delay” have to offer patients the possibility of being treated abroad. Contracting with foreign providers makes it possible for purchasers to control patient flows as well as the quantity, quality and type of care provided in other Member States.

#### Increased competition among Dutch insurers

Since the late 1980s, reforms in the Dutch health care system have introduced more competition among health insurers, with a system of risk pooling among the sickness funds which now receive budgets. The budgeting system is an incentive for funds to buy and organize care in the most cost-effective way and they negotiate with care providers on the content and prices of services (AIM, 2002).

One effect of increased competition is the emergence of increasingly commercial behaviour among Dutch insurers as they strive to decrease their costs and please their affiliates. Contracting with Belgian hospitals can be one strategy to ensure faster and cheaper care as well as care perceived to be of better quality for their members. Belgian health care is generally perceived by the Dutch as being technologically advanced and of high quality. Furthermore, prices in Belgium appear to be somewhat cheaper than in the Netherlands. Prices paid by foreign purchasers to Belgian hospitals do not, however, cover the full capital costs of facilities, as these are mainly funded through subsidies from the public authorities, unlike the situation in the Netherlands (CVZ, 2002:13; Visser, 2001).

#### Competitive behaviour of Belgian hospitals

On the whole, there is overcapacity in the Belgian acute hospital sector. Many hospitals are structurally underoccupied because of decreases in average patient stays. This causes financial problems because hospitals continue to have major fixed costs that are not covered by their income. As financing is mainly activity-related and based on the number of patients, hospitals have a clear incentive to attract as many patients as possible, both national and foreign. Hospital supply is not hierarchically structured and there are no task divisions between hospitals. This means that hospitals compete on the type of services they offer. Some smaller hospitals have made investments and have attracted renowned specialists or have purchased expensive apparatus as a means of competing. Attracting foreign patients offers a means to cover these expenses. For larger hospitals, additional foreign patients can be a source of extra income, but can also be an opportunity to continue to specialize and offer top-quality clinical care, to make important investments and reach an optimal activity level necessary to expand their competence and experience (Jorens et al., 2005).

### Financial interests of Belgian hospital doctors

As Belgian doctors (including hospital doctors) are paid on a fee-for-service basis, they have a direct financial incentive to treat more patients as it increases their income. Additional patients also mean increased experience, competence and prospects for career development.

### Breaching the monopolies of home providers

Cross-border contracting can also be seen as a strategy for purchasers to break national monopolies by enlarging the pool of providers. Having the alternative of contracting abroad not only means that demand for health care is better satisfied as supply is increased, it also serves as a “threat strategy” to warn national providers that they could lose patients and contracts as purchasers turn to providers in other countries (CVZ, 2002:13). The very possibility of going cross-border puts pressure on national providers to improve their performance and/or lower their prices. In the English NHS, cross-border contracting aimed, for instance, at putting pressure on the domestic private sector to lower their prices for contracts with the NHS. Lack of supply and of providers within the system is thus effectively circumvented by resorting to supply from outside.

### The features of and complementarities between health care systems

In both the Netherlands and England, cost–containment measures in the health care sector have mainly been based on supply restrictions. The Belgian health care system, on the other hand, tends to control health care expenditures through the demand side, for instance with comparatively high co-payments. These differences have led to two systems with supply shortages neighbouring a system with supply abundance. In a setting of geographical proximity, it is the complementarity between undersupply and oversupply which encourages cross-border care arrangements.

### Increasing competition among Belgian sickness funds

The CM, the largest Belgian sickness fund, insuring 40% of the Belgian population, plays a key role in the cross-border contracts between Dutch sickness funds and Belgian hospitals. Several motives can stimulate their involvement in cross-border contracts. Although they receive a fee for their services, financial incentives are probably not the main driver. Cross-border contracting seems rather to be a strategy for national and international positioning in the changing landscape of health insurance in public schemes. On the Belgian national scene, some competition between sickness funds has been introduced

in the 1990s and funds must bear a part of their expenditures. However, sickness funds do not currently have many instruments to control costs, as they have to reimburse all care provided to their affiliates at tariffs set at national level and provided by all registered providers. Some sickness funds hope to be given tools in the future to control their costs, such as the possibility of concluding contracts with selected providers. By being involved in cross-border contracting, the sickness fund in question can anticipate potential reforms and establish preferential relationships with Belgian providers. Keeping an eye on patient flows so as to avoid the emergence of waiting lists for their own affiliates or to prevent upward pressures on Belgian prices are also motives. On the international scene, cross-border cooperation between sickness funds also creates preferred relationships. This can mean comparative advantages for the sickness funds involved when they want to offer services to their members for care abroad. It could also lead to the creation of international chains of sickness funds and cooperation to offer supplementary health insurance to their members.

#### Patients voting with their feet

Last but not least, it is patients who opt to receive care abroad. Faster access to care is a motivation for both Dutch and English patients; going to Belgium for treatment offers an alternative to prolonged waiting in the national system. For Dutch patients, factors such as habits and language may also be influential, as Dutch people living in the border region are accustomed to travelling to Belgium, distances are short and those who have had positive experiences with Belgian health care in the past often go back (Box 7.1 overleaf).

### **Obstacles to cross-border contracted care**

#### Lack of cooperation from domestic providers

While competition may lead to a conscious effort by national providers to improve their services, it might also make local providers more eager to keep patients “at home”.

National providers can be a hindrance to patient mobility as they prefer purchasers’ money to be invested in the national system rather than streaming out of the country; consequently, foreign providers are viewed as competitors. In some cases, this rivalry amounts to direct obstruction by refusing to hand over patient files to the foreign providers (Smeets, Bruinsma and Straetmans, 2002). Belgian hospitals complained about the reluctance of some Dutch general practitioners to refer patients abroad. There seems also to be some reluctance among specialists working in hospitals and general practitioners

**Box 7.1** *Quotations from Dutch patients having been treated in Belgian contracted hospitals*<sup>28</sup>

The following selection of quotes illustrate the patient perspective:

Man aged 46: "... Friendliness and professionalism was equal in both hospitals [one Dutch and one Belgian hospital] but making an appointment was more fair and easier in Belgium..."

Man aged 48: "... Positive was the prompt examination, no waiting time. With a referral card from the GP, no appointment, very easy to arrange... I was less pleased with the communication between staff and patient. They did not explain to me what they found. The diagnosis was given to me in a closed envelope for the GP..."

Woman aged 30: "... I am very satisfied, especially about service and speed, and I recommend it [going to Belgian hospital for treatment] to everyone. Moreover: I did so a couple of times because there are plenty of candidates for Belgium because of these stupid waiting lists in the Netherlands..."

with close links to local specialists, to give after-care to patients coming back from treatment in Belgium. Yet in general most Dutch general practitioners have been cooperative and supportive of cross-border mobility, especially in the border regions and in cases of long waiting lists. Some Dutch sickness funds also try to involve local care providers when making cross-border agreements in order to avoid hostile attitudes among the domestic providers (CVZ, 2002).

The key role of national providers as referrers and their sometimes uncooperative attitudes was mentioned by Belgian hospitals treating English NHS patients. One Belgian hospital manager described how the Belgian medical team never met the orthopaedic surgeons at the London hospital during scheduled outpatient clinics and it was impossible for Belgian surgeons to contact their London colleagues. According to the same manager, another problematic aspect was referral letters, which had to be signed by English specialists stating that they were handing over responsibility for "their" patients to Belgian doctors. In one London hospital the head of the orthopaedic department had refused to sign referral letters for patients to go to Belgium. Paradoxically (or perhaps not), the Belgian hospital manager interviewed had the feeling that the happier the patients were with their Belgian treatment, the more sceptical were the English doctors.

According to interviewees in Belgian hospitals, the NHS programme would have had more success if communication had been better between United

<sup>28</sup> Quotes gathered from the patient survey carried out in 2005 by Observatoire social européen.

**Box 7.2** *Illustration of an unwelcoming attitude in one United Kingdom hospital*

A Belgian hospital team described how their duty to carry out the overseas assessment clinics as foreseen by the contract was obstructed by their London counterpart. When the Belgian Lead Commissioner and the doctors came to the NHS trust to carry out the clinics, both pre-surgery to select patients and post-operation to check on patients' progress, there were no consultation rooms available for the Belgian team. They were eventually given one of the worst equipped rooms in one of the hospital's oldest wards. There was a very old bed in the room, but no desk and no chairs for patients suffering from hip and knee problems. Belgian doctors themselves had to arrange for there to be a desk, while two old chairs were eventually found elsewhere and brought into the room. Moreover, they met no one from the hospital except for one nurse.

Kingdom and Belgian doctors; this would also have benefited patients (Box 7.2). The official explanation from the GST about why the patient flow stopped is that London Patient Choice's budget for the overseas programme ran out in April 2004. One could also suggest a national pride factor as top political figures in the United Kingdom perceive it to be shameful that the country has to send patients abroad for care. As financial and political support for patient mobility faded away, and as local providers in most cases were uncooperative, patient mobility to Belgium came to an end.

#### Lack of information and confidence

There is no financial disincentive for Dutch or English doctors or hospitals to send patients abroad. Yet ignorance about the quality of care in other countries, fear of "importing" hospital infections, a sense of responsibility towards patients, professional distrust of the "unknown", etc. might contribute to providers' reluctance to send people abroad. Differences in national legislations and tariff-setting also deter cross-border cooperation (CVZ, 2002). Furthermore, Dutch doctors are suspicious of Belgian supplier-induced demand as Belgian doctors might perform unnecessary treatments on Dutch patients because it is lucrative.

#### Unwillingness of actors

Problems arising from uncooperative attitudes, mistrust, lack of exchange of information, etc. highlight the need for goodwill from all actors. Our research suggests that national doctors in particular are important in two ways: as referrers they can channel patients, and as the professionals that patients

usually trust most and being the first contact point, doctors can influence patients' choices about where to be treated.

For patient mobility to function effectively, providing better access to care, all actors should be informed about how the system works and about the advantages it can offer. Home providers must be willing to inform and refer their patients abroad and to ensure quality of care and appropriate after-care; national providers must be willing to cooperate with foreign colleagues.

Increasing the referring doctors' knowledge about cross-border care could result in easier patient flows. The case of Zeeuws-Vlaanderen is an illustration of the importance of information, as efforts were made to increase Dutch referring doctors' familiarity with treatment options in Belgium and patient flows became easier as a result.

### **Potential impact of cross-border contracting on the health care systems**

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

For the "exporting" system

#### ***Better performance owing to more competition***

Resorting to health care abroad introduces a competitive element to the national health care scene. When the option of going abroad for treatment exists, national providers become aware of the risk of losing patients and income and therefore have an incentive to improve by delivering faster and better services to patients or to decrease their prices. One Dutch insurer gave the example of a Dutch hospital, situated very close to several important Belgian hospitals, where waiting lists for heart surgery had decreased significantly (to a few weeks) compared to another hospital located in the middle of the Netherlands where people were waiting six months. Another Dutch sickness fund had clear indications that the local hospital was performing much better in terms of waiting lists, while also striving to become more patient-oriented, and was attributing this to the risk of a significant outflow of patients to Belgium if the local hospital did not offer improved services to the local population. The NHS Lead Commissioner noticed that some doctors were more prepared to work harder and do extra sessions after having heard about the scheme to send patients awaiting hip and knee surgery abroad. Furthermore, the explanation given by the Lead Commissioner from the NHS,

in letters justifying termination of contracts with two Belgian hospitals in January 2004 after just six months and only 21 patients, was that the NHS was “in a position to be able to meet the government’s waiting list targets for cardiac surgery” implying that hospitals and doctors had striven to tackle waiting lists. Indeed, no NHS cardiac patients were treated in Belgium after October 2003 while the government targets came into force from March 2004.

### *Circumventing cost-containment mechanisms*

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

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

One study reveals that more examinations, scans and laboratory tests are invoiced for Dutch patients from the Zeeuws-Vlaanderen region treated in Belgium than for comparable patients treated in the Netherlands and that these tests, as judged by Dutch doctors, are often unnecessary. It also appears that some procedures have been carried out twice, once in the Netherlands and once in Belgium (Visser, 2001:55–58).

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

For the “importing” system

### *Risks of waiting times and pressure on prices*

Foreign patients treated in Belgium are encouraging commercial behaviour in Belgian hospitals. Yet, when hospitals’ incentives to attract extra patients (and

income) meet foreign purchasers' interest in shopping for best deals, there could be a risk that hospitals start to favour foreign over national patients. This risk is accentuated if hospitals can charge higher prices when treating foreign patients and if foreign purchasers are willing to pay because the prices proposed by the Belgian hospitals remain lower than what they would have to pay at home – which is a realistic scenario in the Belgian-Dutch and Belgian-English cross-border context. So far, several cross-border contracts stipulate that only official Belgian tariffs may be charged and there are no signs as yet that Belgian hospitals are charging higher prices to Dutch insurers. Yet, the risk remains.

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

We did not find indications of increased waiting times for Belgian patients. However, it would be extremely difficult to ascertain increasing waiting times in the Belgian context, as there is no official registration and Belgian providers are highly unlikely to admit that they give priority to foreign patients. The data on Dutch patients show that foreign patients are concentrated in specific hospitals and specific hospital services, which signals that prudence is called for. Jorens et al. (2005:137) argue that the share of available capacity used for foreign patients should be controlled as hospitals have so far failed to define what is desirable.

A key issue is that Belgian hospital tariffs do not cover real costs. Medical tariffs, as defined by the Belgian health authorities, are based on average costs and hospitals cannot charge more for serious pathologies to cover real costs. Also, tariffs only partially include hospitals' investment costs as these are subsidized by the public authorities. This partly explains why Belgian prices are lower than Dutch prices.

### **Legal uncertainty and the involvement of public authorities**

A concern for actors involved in cross-border contracting between Dutch insurers and Belgian hospitals is that the arrangements are taking place in a legal no-man's-land. There is a clear demand from all involved stakeholders for more clarity and legal certainty about the practices in which they are involved. A bilateral agreement between the two countries, leaving enough flexibility for actors to continue with the existing arrangements, would be a possible solution.

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

### **In conclusion**

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

An EU-level framework for cross-border contracts between providers and purchasers could be an adequate instrument to increase legal certainty for all the players involved and to guarantee that, in the long run, all patients, those

in search of care across the border and those being treated in their national system, continue to take advantage of this increased patient mobility.

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

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

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

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

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

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